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https://doi.org/10.15017/2233870

出版情報：九州大学総合臨床心理研究. 10, pp.83-90, 2019-03-27. 九州大学大学院人間環境学府附属総合臨床心理センター
バージョン：
権利関係：

Bulletin of Center for Clinical Psychology and Human Development, Kyushu University
Vol. 10, pp. 83－90.

Facilitating Parent Resolution of Autism Diagnosis: Examples of Best Practices and Implications for Clinical Training

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Abstract

Adjusting to the diagnosis of a child's significant medical or developmental condition is one of the most stressful challenges that many parents will ever face, with potentially profound consequences for the development of the child and the healthy functioning of the family. The diagnostic resolution model, which is rooted in the theories of child attachment, has emerged as useful framework for conceptualizing and studying the family's adjustment status and consequences. This article summarized the diagnostic resolution construct and some of the empirical research associated with it. It also proposes some examples of best practice that have been used by exemplary autism programs (e.g., TEACCH Autism Program) to support families in their adjustment, especially around the time of formal diagnosis. Finally, the importance of assessing all families for their resolution status and for intervening with families at risk for problems in adjustment needs to be recognized by professional providers who currently work with these families and by clinical training programs who are preparing the next generation of providers.

Keywords:

The human condition (and, perhaps, all life as we know it) is essentially the challenge of adjustment—adjustment in the context of universal forces that prompt us toward growth and the full actualization of our potential, and forces that eventually diminish our competencies and prompt the final resignation that defines our finite existence. This ongoing drama of adjustment is evident in every domain of human endeavor, from religion to science to literature and the arts, and in every aspect of daily human activity, no matter how seemingly trivial or consequential.

Mental health is just one aspect of this process of adjustment and it is the focus of a cadre of professional care providers and scientists who have chosen this area as their life's work. Psychologists (and others) have made a commitment to improving the mental health of members of their community and to the well-being of communities around the world. They have made a commitment to improve the human condition. And to protect against the diminishing resources of each established generation, they have developed systems of educating and training new generations of professional care providers who will begin the drama anew with, hopefully, more knowledge and resources than what was previously available.

This article is an exploration into the concept and practice of *diagnostic resolution* and its implications for the immediate clinical care and education of individuals with autism spectrum disorder (ASD), and the longer-term outcomes for these individuals and their families. Diagnostic resolution has emerged as an important aspect of a family's adjustment to a child with any significant and chronic medical or developmental condition. The following section will briefly summarize some key findings from the empirical literature regarding family adjustment, with a more detailed discussion of understanding how parents deal with (resolve) the emotional distress, uncertainty, and inability to move forward that can be a consequence of a formal diagnosis. Whenever possible, factors that seem to facilitate diagnostic resolution in parents following a child's diagnosis of ASD will be highlighted. And finally, some proposed best practices for integrating these factors into applied clinical work and in clinical training programs will be explored. The TEACCH (Treatment and Education of Autistic and related Communication-handicapped CHildren) Autism Program (formerly Division TEACCH) at the University of North Carolina at Chapel Hill will be presented as a model of effectiveness for promoting family adjustment to ASD.

Family Adjustment and Diagnostic Resolution

The stress associated with conditions that threaten the normal, healthy development of one's child consistently ranks among the most challenging that many parents will ever experience. Health conditions that typically lie outside of one's control, that may not be well understood, that may be chronic or portend lifelong struggles, and that may carry some risk of social stigma (e.g., physical deformity or inappropriate behavior) can be particularly challenging for families to adjust to. And, yet, this is the very situation that many families currently find themselves in, and it has been a focus of attention of many clinicians and researchers, both historically and currently, who work with these families.

Psychological research in the area of parent/family adjustment to medical and developmental disorders in children, in general, has largely focused on attempting to understand and characterize more adaptive and less adaptive responses to these kinds of severe stresses that can impact a family, and the consequences of how families respond. Adaptive responses are those that seem to preserve or even enhance family functioning (i.e., protective factors) and maladaptive responses are those that seem to interfere with or impair family functioning (i.e., risk factors). A number of review articles and chapters have summarized the earlier research in this area. One general conclusion from this research is that parents of children with significant developmental challenges report a higher level of stress than do parents of typically developing children (e.g., Schopler & Mesibov, 1984). Parents of children with ASD, on the other hand, have been found in some studies to report significantly higher levels of stress than do both the parents of typically-developing children and the parents of children with developmental disabilities other than ASD (e.g., Schieve,

Blumberg, Rice, Visser, & Boyle, 2007; Schopler & Mesibov, 1984). Uncertainty around the cause of the disorder, limited access to effective treatments, anxiety about long-term outcomes, and the stress of the day-to-day management of symptoms have been offered as possible explanations for the differences in parent perceptions, with generally greater challenges associated with parenting a child with ASD.

Most clinicians are generally attuned to the range of responses that parents show to the results of a medical/psychological evaluation of their child's developmental strengths and weakness (including any conclusions about diagnosis). More recently, more formal descriptions and empirical investigations into the cognitive and emotional processes that underlie parents' responses to their child's diagnosis have led to the construct of *diagnostic resolution*. The term "resolution" typically refers to situations in which there is confusion, conflict, or hesitancy about a course of action. These characteristics can reflect an external reality between two or more individuals (e.g., unresolved interpersonal issues) or they can become internalized as preoccupations as in the case, for example, of a parent traumatized by the news of his or her child's diagnosis. If unresolved, this stress can lead to adverse consequences affecting many aspects of a parent's functioning and the functioning of the family (cf. Marvin & Pianta, 1996).

Diagnostic resolution, as it is currently defined, is rooted in the concepts and writings of the child attachment literature (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1980). Parents who are believed to be unresolved to their child's diagnosis may struggle to develop/maintain a mostly sensitive, empathic, and positive parenting style that allows for the child to develop a secure attachment to that parent. According to the child attachment literature, a secure attachment to the parent figure provides the foundation for much of the child's subsequent learning and development vis-à-vis his or her interactions with the immediate physical and social world (e.g., Bowlby, 1980).

Marvin and Pianta (1996) developed the child attachment/parent diagnostic resolution construct further by providing a working definition of diagnostic resolution; creating an assessment technique, Reaction to Diagnosis Interview (RDI), to categorize parents as resolved/unresolved; and extending the concept in research with children with chronic developmental disorders. Parents who are resolved to their child's diagnosis are no longer in "crisis mode," can more effectively manage grieving the "loss of their perfect child," are more positively oriented to the present and future, are less likely to blame themselves for their child's condition or focus on factors outside of their control, accept the child's strengths and weaknesses, and have a more balanced and realistic perspective that includes consequences that are both "blessings" and hardships (cf. Marvin & Pianta, 1996). In one study (Marvin & Pianta, 1996) using a sample of 70 mothers of infant and preschool children with cerebral palsy (a chronic developmental disorder) about one-half of the mothers were categorized as resolved to their child's diagnosis. About 80% of the children in this group were considered to be securely attached. In contrast, only about 20% of the children of mothers who were not resolved to their child's diagnosis were classified as securely attached. When compared to other studies comprised of different chronic developmental disorders (e.g., prematurity, cystic fibrosis, congenital heart disease, Down's syndrome) and typically-developing children, the researchers concluded that having a chronic developmental condition increases the risk to the child of developing an insecure attachment to a caregiver. However, the risk of the child developing an insecure attachment can be mitigated if the caregiver is resolved to the child's condition (Marvin & Pianta, 1996).

Subsequent studies have provided additional support for the reliability and validity of the diagnostic resolution construct and have extended its application. For example, Sheeran, Marvin, and Pianta (1997) compared a group of mothers of children with chronic neurological disorders (cerebral palsy, epilepsy) to mothers of children without medical disorders on measures of diagnostic resolution, parenting stress, marital adjustment (both wife and husband ratings), and social support. Mothers who were classified as resolved to their child's diagnosis reported less parenting stress and more benefits from social support than did the unresolved mothers. Although their reported level of marital satisfaction was similar in the two groups of mothers—resolved and unresolved—the *husbands* of resolved mothers reported significantly greater marital satisfaction than did the husbands of the unresolved mothers. Also, preliminary analysis suggested some differences in the coping styles of both resolved parents and unresolved parents with the latter group being characterized as using less effective stress coping strategies and more defensive orientations to their situation (see also Barnett et al., 2006 for their commentary of parent coping strategies).

In a longitudinal study using the mothers of young children, Barnett and colleagues (Barnett et al., 2006) investigated the impact that two types of congenital disorders (neurological disorder, disfigurement) have on family functioning (stresses in the financial, social, and personal domains; child attachment) and the possible role of diagnostic resolution in mitigating adverse consequences. Their findings support the previous research indicating mothers who are classified as being resolved to their child's diagnosis are found to have more secure relationships with their children and report less stress in the family than do mothers who are classified as unresolved. Further, their findings also suggest that, although diagnostic resolution status appears to be stable, some medical disorders may be more difficult for parents to resolve than others, and that some parents who initially struggle with their child's condition can adjust over time. The authors propose that professional interventions to help families cope with chronic medical conditions may be useful.

The potential to help families mitigate the adverse consequences of a serious medical condition involving their children with timely and effective interventions was reiterated in a study by Lord, Ungerer, and Wastell (2008) who assessed both mothers and fathers of children born with the metabolic disorder phenylketonuria (PKU). Parents who were classified as being resolved to their child's diagnosis reported fewer symptoms of stress, suggesting that diagnostic resolution, in itself, may be an important resilience factor for families dealing with a significant threat to their child's long-term health. The authors argue for the importance of clinically assessing parents' reactions to their child's diagnosis and providing psychosocial support for those at risk of

maladjustment.

Based upon child attachment theory and preliminary empirical findings, adjusting to a child's diagnosis not only has implications for the secure emotional attachment of the child to the caregivers and for the healthy functioning of the family, it can also help establish a foundation for a more optimal developmental trajectory for a child with ASD. Wachtel and Carter (2008), for example, investigated characteristics of healthy parent-child interactions in two groups of mothers of children with ASD—those who were more emotionally resolved to their child's medical condition and those who were not. Mothers who were classified as resolved were more engaged with their children in play and able to stimulate them cognitively (Cognitive Engagement), and they were also more positive and encouraging during the play interactions (Supportive Engagement) than were mothers who were unresolved (while controlling for several child characteristics and maternal depression). The researchers suggest that parenting style is associated with parent adjustment to the diagnosis of ASD, which may be a critical, albeit often overlooked, aspect of parent-directed early intervention with young children with ASD. In addition, Wachtel and Carter (2008) developed and tested a dimensional scale for the diagnostic resolution construct to reflect their belief that coming to terms with a child's diagnosis is a complex and dynamic process that can be better represented as a continuum of parent responses rather than discrete classification categories.

More recently, Oppenheim, Koren-Karie, Dolev, and Yirmiya (2009) and Milshtein, Yirmiya, Oppenheim, Koren-Karie, and Levi (2010) investigated associations between the diagnostic resolution status of parents of children with ASD and other factors. Oppenheim and colleagues considered a dimension of parenting style, *maternal insightfulness* (another construct from the child attachment literature that involves a parent's capacity to see things from the child's point of view) (Ainsworth, 1969), diagnostic resolution, and their association with child attachment status. The researchers found that mothers of children with ASD who were more invested in seeing the child's perspective and more resolved to the child's diagnosis were more likely to have more securely attached children than mothers of children with ASD who were less oriented to the child's perspective and less resolved to their child's condition. Milshtein et al. (2010) incorporated groups of mothers and fathers of children with ASD to look at resolution status, parent coping style, and specific parent characteristics (age, gender, IQ, broad autism phenotype status, perceptions of how raising a child with ASD has impacted the family) and specific child characteristics (age, gender mental age, adaptive behavior, diagnosis type, time since diagnosis). Like most other studies, these researchers classified about half of the parents as resolved to their child's diagnosis. Surprisingly (but also like previous studies), the time since the diagnosis was not a significant factor in whether the parent was classified as resolved/unresolved (elapsed time since initial diagnosis ranged from 6 months to 10 years in this study). Also, mothers (but not fathers) who were unresolved to their child's diagnosis reported that raising a special needs' child negatively impacted the family.

Coming to terms with the diagnosis of a child's significant medical condition is a challenge for any parent, but the severity of the challenge for some parents may not be apparent to even the most sensitive and compassionate care providers during the typical diagnostic disclosure meeting. Clinical impressions and the emerging empirical literature suggest that parents' failure to resolve their child's diagnosis results in impaired parent and family functioning; delays in accessing treatment and educational programs, and other important services; and suboptimal developmental outcomes for the child. It is the position of this article that the knowledge, tools, and techniques necessary to assess parents for difficulties in adjusting to their child's diagnosis and to support all families in this regard are currently available and that some best practice models exist. The following section presents a discussion of some current best practices in clinical assessment and counseling to help parents effectively adjust to their child's diagnosis of ASD or other disabling condition.

Facilitating Family Adjustment and Promoting Optimal Outcomes

Traditionally, clinical psychologists have specialized knowledge and skills in clinical assessment, psychotherapy, and the empirical evaluation of both. Consequently, they are especially well-positioned to be able to assess parents' risk for having difficulty adjusting to their child's diagnosis and their resources for effectively coping. However, not all clinical psychologists work in settings where they are responsible for assessing/diagnosing developmental disorders and providing psychosocial interventions to children and their families. And, although the factors that contribute to parents resolving their child's diagnosis are still being investigated, there are examples of programs and practices that seem to be effective in addressing some of the adjustment challenges that families of newly diagnosed children face.

One example of such a program is Division TEACCH (now called the TEACCH Autism Program) at the University of North Carolina at Chapel Hill School of Medicine. TEACCH was one the first state-wide autism programs in the United States and has been recognized internationally as a model of excellence for providing comprehensive services to individuals with autism and their families. The TEACCH approach to collaborating with families and community agencies to provide state-of-the-art, comprehensive evaluations has not only been the "gold standard" in North Carolina since its beginning in the 1970s, but it has served as model for programs and providers all over the world. Although the term diagnostic resolution does not appear in the TEACCH literature, the TEACCH approach strives to create optimal conditions for clients and families to be able to integrate information from their child's evaluations (including diagnostic labels) with their own understanding of their child, to evaluate treatment options, to implement appropriate treatment strategies, and to preserve or enhance healthy family functioning. In the following discussion, some suggestions for ways of thinking about best practices in this area and some illustrative examples from the TEACCH program may serve as reminders for current practitioners and guidelines for ongoing professional development, including for trainees who are preparing to work with these families.

Assessment as Treatment

Clinical practitioners and researchers alike have noted that one of

the easiest ways to change a person's behavior is to simply pay attention to the behavior. Clinical assessment is the art and science of paying attention to a person's behavior. The *process* of conducting a clinical assessment with an individual can be, in itself, therapeutic. Establishing positive rapport (e.g., unconditional positive regard) that is necessary for the client's cooperation satisfies some basic human needs for social engagement, social validation, and social reciprocity. When working with individuals with ASD, establishing rapport is no less important but is sometimes quite challenging (Kroupa & Quinn, 2018). The *content* and resulting profile from the evaluation not only provides clinically useful information but, hopefully, provides a broader and deeper understanding of the person's strengths and challenges, which may be intrinsically of value to the client and to those in the client's social network. When previously unknown or poorly understood weaknesses are identified and accepted, a client may feel supported and encouraged. The best assessment experiences are based on the collaboration between the professional and the client and, although most providers profess to prioritize a collaborative relationship, some contemporary healthcare institutions (and individual practitioners) remain hierarchical and paternalistic, and a true collaborative relationship can be quite elusive.

The elusive practice of collaboration. In the traditional model of medicine, the physician's role is to diagnose the condition, inform the patient (and family), prescribe a treatment, and/or arrive at a disposition that may include further monitoring/assessment, in-house treatment, or an outside referral. In large part, medical school training was designed to develop a trainee's competencies in these skill sets that would eventually result in the conferring of medical expert status on successful graduates. In the traditional medical model, information may flow in both directions, but expertise flows from the physician to the patient. So-called "allied" healthcare professionals (e.g., psychologists, speech/language therapists, occupational and physical therapists, etc.) trained in medical schools are also exposed to the same traditional practice model (diagnose/inform/prescribe/treat/refer) that is also informed by their specialty's knowledge base and specialized techniques. Complementary (and, in some cases, contrary) healthcare practice models have also been developed, in part, as our knowledge of how biological, psychological, and social factors contribute to our contemporary ecological understanding of "health" and "disease/disorder."

The *collaborative model* of healthcare is an example of an innovation in clinical practice and training that is rooted in the principles and practices of the traditional medical model, but which places new emphasis on valuing the contributions of everyone involved and in the shared responsibility for addressing concerns. The collaborative model clearly places the focus of the healthcare provider's attention on each client (client- or person-centered approach), not only in terms of employing an "objective" understanding of a client's symptoms but also in elevating for consideration an individual's subjective experience and *worldview*. In this model, expertise is more broadly defined (e.g., professionals may have clinical expertise, clients have personal expertise) and responsibility for assessment and treatment are more equally shared. In this author's experience, the collaborative model of clinical practice and training is especially well suited for intervening with parents of a newly diagnosed child with ASD to help them integrate the new information, resolve possible internal conflicts, and mobilize them for constructive action.

The collaborative model is a cornerstone of the TEACCH approach (e.g., Mesibov, Shea, & Schopler, 2005). With every contact and at every level of staff responsibility, families are met with a personable, nonjudgmental, and nonauthoritarian demeanor that is a natural fit, not only with the program's leaders, but with all new hires. Professional pretense and institutional artifacts (e.g., required use of titles, excessive use of professional jargon, white medical coats) that seem to place greater value on the contributions of some (professionals) over those of others (patients) are de-emphasized. Families are considered equal and valued members of the assessment and treatment teams. Parents watch the assessment activities with their child through a one-way mirror and are encouraged to offer their suggestions and interpretations, and, as appropriate, help with the testing. Parents are also educated about the nature of autism and the techniques for assessing it during their child's evaluation. By the time the interpretive conference begins most parents are significantly less guarded and, in many cases, anticipate what the results will be. Consequently, they are rarely "shocked" by the evaluation findings, are gratified that positive traits and results are highlighted, and feel empowered to become active participants in their child's treatment. This atmosphere and process seems to provide optimal conditions to assess each parent's risk of adjustment difficulties and to support each parent's highly personal process of coming to terms with the realities of their child's condition.

Building on strengths. It has long been a basic tenet of pedagogy that new skills are easier to teach if the student's learning style, learning strengths, and interests (e.g., sources of intrinsic motivation) are incorporated into the lesson plan. Of course, this will depend on how well the student's learning style, strengths, and interests have been assessed. A comprehensive assessment of individuals with ASD combines formal and standardized assessment tools with testing-of-limits procedures and informal assessment techniques. In actual practice, limits in the knowledge and skills of the examiner, and limits of time are usually enough to result in a less-than-ideal final product. Similarly, even if detailed and relevant information about a student's learning style, strengths, and interests are revealed from a comprehensive evaluation, time, expertise, materials and other resources, and personal creativity may be necessary for a therapist or teacher to tailor make a treatment or educational program. In many cases, where resources are lacking, "good enough" is the best outcome.

The TEACCH approach was developed during a time with mothers were blamed for their child's disorder (e.g., "refrigerator mothers") and many individuals with autism were "warehoused" in large institutions away from their families. Viewing autism as a neurodevelopmental disorder and focusing on what individuals could do rather than on what they could not do was revolutionary at the time and gave hope to thousands of families. Now, even though the strength-based approach to learning is well established and is continually being "re-packaged" (e.g., positive behavioral supports), there is still a tendency for parents,

teachers, and professionals to become overly narrow in their perspective (e.g., tunnel-vision) and overly punitive in their response, especially when stressed. A good deal of the success of the TEACCH approach can be attributed to the effectiveness of their assessments in identifying a child's emerging skills and on accommodating treatment strategies to their idiosyncratic processing and learning preferences. The focused problem-solving and positive orientation also serves as model for parents who may be struggling with the challenges of raising a child with ASD.

Incorporating a systems perspective. Human beings are very complex creatures and their behavior can usually only be understood in context—the internal context of their perceptions, thinking, and feelings, and the external context of reinforcements and social expectations. Understanding a person's behavior in context gives it ecological validity. Unfortunately, ecological systems are not always well understood and not well assessed in a standard clinical evaluation. A systems perspective will sensitize an examiner of the need to assess not only a child's symptoms and behaviors, but the internal conditions and environmental triggers that contribute to the behavior. A systems perspective also sensitizes an examiner to the importance of assessing the functioning of individuals in a family, the marital relationship, and the family functioning, in general. A parent's ability to understand and integrate potentially distressing information about his or her child, and a parent's possible defensiveness around the likely diagnosis, can be assessed informally through interviews and observations that take place as part of the child assessment process (see previous discussion of TEACCH collaboration with families). Assessing a parent's psychological and social strengths and challenges can help the examiner construct a blueprint for how to proceed with presenting the evaluation findings, as well anticipate the need for follow-up or referral.

Treatment as Assessment

Even the most experienced and most competent clinicians will admit that there is sometimes a fair amount of luck or serendipity involved in a successful treatment outcome. Despite the profession's efforts to be evidence-based, client idiosyncrasies are such that most treatment protocols rely on trial-and-error. Perhaps, it is best to view the treatment process as an ongoing assessment of the client and their response to intervention. In this view, treatment "failures" simply provide an opportunity to deepen one's understanding of the client, with the hopeful goal of arriving at an effective solution. Clinical expertise may contribute to finding that solution sooner rather than later. And, in the case of particularly intractable symptoms, persistence and second opinions become the treatment of choice. Two aspects of best practice—*relationship-based treatment* and the *generalist/family practice model of treatment*—have good potential to assist parents who are having difficulty coming to terms with their child's diagnosis.

Relationship-based treatment. At the invitation of the American Psychological Association and in recognitive of his lifetime contributions, TEACCH founder and former program director, Eric Schopler, described the *specific treatment effects* and the *nonspecific treatment effects* that have shaped the TEACCH approach and contributed to its overall effectiveness (Schopler, 1987). Even though the TEACCH approach may be best known for its innovations in conceptualizing the autism learning style and in the use of visually-structured interventions (specific treatments) (Mesibov et al., 2005), Schopler considers the quality of professionals who embodied the TEACCH approach (nonspecific treatments) to be most significant in accounting for the success of the program (Schopler, 1987). The TEACCH approach is essentially a relationship-based approach.

There is a long tradition in clinical psychology that focuses on qualities of the therapist and of the therapeutic relationship that promote healthy adjustment and personal growth. More recently, an extensive empirical literature has emerged that explores the characteristics and effectiveness of relationship-based approaches to psychotherapy. The child attachment literature suggests that a parent's struggles to adjust to his or her child's chronic medical condition may lie, in part, in possible disruptions in that parent's own attachment history. A relationship-based approach could sensitize a healthcare provider to this possibility and may help the provider avoid some of the pitfalls and counterproductive responses that are sometimes associated with a challenging client. Success in the therapeutic relationship may untangle some of the parent's internalized conflicts and help them resolve his or her feelings about having a child with a disability.

The generalist/family practice model. One of the early innovations in the TEACCH approach to working with families with a child with ASD was its adoption of the generalist approach as its primary mode of service delivery to families. In the TEACCH model of assessment and treatment, a licensed psychologist directs the assessment process (including how parents are informed about the results of their child's evaluation), and directly or indirectly oversees the psychoeducational services to clients and families. To facilitate the assessment and treatment process, individual therapists are assigned to the parents (parent consultant) and to the client with ASD (psychoeducational therapist). The parent consultant becomes the main point of contact for the parents and typically develops a close, supportive relationship with each family. Although members of the TEACCH clinical staff typically have advanced degrees in related areas (e.g., special education, psychology, speech/language therapist, occupational therapist, etc.) they do not practice only within their specialty, but they are expected to develop a broad base of knowledge about ASD and treatment interventions so that they can assist families with a wide range of concerns and issues. This model is known as the generalist model of service delivery and was integrated into the TEACCH program during a time when autism was a rare disorder and the number of experts in the area was quite limited. Each member of the TEACCH staff had to develop his or her general knowledge and expertise to be able to help families. The generalist model is not unlike a family medical practitioner who provides a wide range of services to all members of a family and, in so doing, oftentimes develops a long-term and trusting relationship. Schopler observed that the effectiveness of this service delivery model in the TEACCH program was evidenced in the improved adjustment by the families, high satisfaction ratings of TEACCH services by parents, the willingness of families to advocate for the TEACCH program, and by high job satisfaction ratings by

TEACCH staff (Schopler, 1987). For these reasons the generalist model has endured. Other well-known and more recently developed treatment programs, such as the Early Start Denver Model (ESDM), have adopted the generalist model of service delivery for use in their treatment approach (Rogers & Dawson, 2010).

Evaluating the Effectiveness of Assessment and Treatment

The collaborative model of healthcare practice is consistent with the current emphasis on scientific skepticism and the empirical evaluation of both established and promising theoretical constructs and clinical techniques. But it does so by balancing the need for standardized (manualized) procedures with highly personalized approaches, the need for relatively more objective measures with those that are more socially valid, and the need for effectiveness established by statistical analysis sensitive to group differences with clinical intuition sensitive to individual differences. Balancing the "art" of clinical practice (personalized, subjective, innovative) with the "science" of clinical practice (standardized, objective, research-based) has been the hallmark of best practices and program effectiveness, and it has certainly has been another cornerstone in the TEACCH approach and its commitment to use the best available tools to evaluate empirically the program's effectiveness (e.g., G. B. Mesibov & Shea, 2010)

Implications for Clinical Training Programs

It is hoped that currently practicing professionals, especially those who routinely diagnose or work with children with learning and developmental disorders, will recognize the importance of assessing and assisting families in their adjustment to their child's special needs. It may be the case, that the most significant and widespread change in how professionals support families in this area will need to take place in clinical training programs that are responsible for preparing the next generation of professional care providers. Any program of excellence has a strong foundation of practice principles and priorities. Three foundational components of the TEACCH program—team building, mission commitment, and modeling best practices—will be discussed here, along with their implications for clinical training programs.

Build a Quality Team

Eric Schopler understood that a program of excellence could only be built on a foundation of quality individuals. Over the years, personal and professional qualities were identified and targeted in recruiting new staff at all levels (clinic directors, researchers, therapists, administrative assistants, etc.). Successful candidates typically had experiences with people with autism that stimulated their curiosity, their compassion, and their commitment. Successful candidates had usually established their professional credentials at a high level and, equally important, had personal qualities that would translate well into working with diverse populations in clinical and community settings. These qualities typically included a high degree of empathy, excellent interpersonal and communication skills, intelligence, critical thinking, insight into self and others, resilience, being principle-driven/ethical, humility, and a sense of humor—qualities that would allow them to collaborate with individuals with autism and their families at their most challenging times, as well as during everyday struggles and accomplishments.

Academic institutions are also interested in attracting the best candidates, but they typically have a very broad mission (especially at the undergraduate level) and applicants may only need meet the minimal requirements. At the graduate level, especially for competitive professional training programs, there may be additional considerations and requirements that govern how prospective applicants are recruited and selected. Selection procedures that allow for the best "match" between a program and a candidate (e.g., based on the needs and goals of each, personal qualities of staff and applicants, and shared worldview) are likely to contribute to a better experience and a better outcome for everyone involved. Once a program establishes a reputation for excellence, quality candidates tend to *self-select* thereby creating a steady-stream of highly qualified and enthusiastic individuals who already share the worldview and mission of the program. Of course, selecting new students or new staff is only the first step in the process that will, hopefully, enhance the clinical training program and advance the careers of the next generation of professionals-to-be.

Articulate Values and Priorities

Much has been made in recent years of the importance of organizations developing their *mission statement* and, especially in the case of public service organizations, articulating a set of principles that guides what it considers to be best practice. There seems to be some consensus among organization experts that a shared mission among all members of an organization not only contributes to a healthy work environment, but it also increases productivity. There have also been some recent news articles that in the booming high-tech marketplace for the most talented individuals, collaborative, flexible work arrangements and meaningful work that addresses an important human problem or serves others provides stronger enticements for recruiting the top talent than do financial rewards alone.

Serving others, especially those who have challenges that they, themselves, did not create (such as individuals with disabilities and their families) can be an important motivating factor in one's career choice. Being part of a program of excellence and having the potential to develop a high level of competence will likely attract outstanding candidates. Being mindful of how a program's values and priorities are communicated to the public, in general, and to prospective students, in particular, is an important recruiting consideration. Each professional presentation or public service announcement, each professional publication or program brochure, each meeting with community professionals and parents, and, most important, each client contact provides an opportunity to articulate what is at the heart of each clinical training program.

Model Best Practices

Every professional-in-training has a base of knowledge that needs to be learned and a set of skills that need to be mastered. And for most established professionals, especially those in the healthcare areas, mastery always involves a never-ending journey. As such, *mentoring* has become a preferred mode for training new professionals and *professional self-care* has become a priority, both for safeguarding the public and for enhancing career longevity and satisfaction.

Mentoring. It is not going too far to say that working with parents

who have a child with a disability is some of the most important work a person can do, because parents are seeking help with the one thing that means more to them than anything in the world—their child. It is also some of the most challenging work that anyone can do, partly because of the range of human and other factors that one must consider and partly because the current level of knowledge and the availability of methods for making positive change are still quite limited. We are at a point where, in many cases, the Hippocratic oath "first, do no harm" is still the most prudent course of action. The use of experienced "guides" (mentors) has always been important in helping to train the next generation, and when working with children with disabilities and their families, it has emerged as one of the most efficient and effective ways of minimizing risk to clients and developing competencies in trainees. It is standard practice in the TEACCH program to anticipate a two-year period of mentoring new clinicians before independence is achieved. Of course, training new professionals requires a highly personalized approach. Not only do beginning trainees benefit from the lessons learned by the previous cohort, but mentoring allows the more advanced students to develop their skills in supervision, consultation, and interpersonal problem solving. And they become more confident in their own skills and professional demeanor.

Professional self-care. It is hard not to work with individuals with significant developmental disabilities and their families and not feel stressed—positively or negatively—on a regular basis. The level of stress that some of these individuals and their families experience daily cannot help but affect everyone else in their sphere of interaction, including those who have been trained to help. In some particularly difficult cases (e.g., involving the threat of personal harm), the professional care provider can become "traumatized," with the risk of injury, depression, "burnout," aggression, or withdrawal more likely. The importance of monitoring and effectively managing one's stress level is the basis of professional self-care. The responsibility of professional self-care is part of the ethical responsibilities of many professional organizations, including the American Psychological Association (Wise, Hersh, & Gibson, 2012). It is something that is not always modeled well in academic and other settings where long hours at work—sometimes to the neglect of one's health and relationships—may be expected. Directors of clinical training programs have a special responsibility to model this aspect of professional practice for trainees who may one day work with challenging clients (Zahniser, Rupert, & Dorociak, 2017).

Conclusions

Helping families adjust when a child is diagnosed with a significant medical or developmental condition that will have profound consequences for the entire family is one of the great challenges of professionals engaged in this line of work—and one of the great privileges. Facilitating parents' ability to resolve the distress and discouragement that frequently accompanies the disclosure of the diagnosis is emerging as a critical aspect of healthy parent adjustment and the long-term developmental outcome to the child. Although clinical best practices specific to the resolution of an ASD diagnosis are still under review, examples of such practices can be derived from established programs of excellence, such as the TEACCH Autism Program. Perhaps, the most immediate benefit for newly diagnosed families will come from recent graduates of clinical training programs that recognize the importance of assessing and intervening with families that are struggling to move forward to acquire the knowledge, skills, and resources that can lead to enhance family functioning and the best possible outcome for the individual with ASD.

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