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Modified Schema Therapy as a Needs Based Treatment for Complex Comorbidities in Adults with Autism Spectrum Conditions

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Abstract: This paper introduces a modified schema therapy conceptual model termed Schema Therapy Modified for Autism Spectrum Conditions (ST-MASC). Schema therapy is underpinned by a comprehensive case conceptualisation that guides intervention with the aim to better meet the needs of the individual, thus improving mental health. This individualised, needs-based approach lends itself to treating complex comorbidities in adults on the autism spectrum. However some modifications to the conceptual model are necessary to accommodate neurodevelopmental differences. The first proposed modification extends the model to include core features of autism spectrum conditions and associated coping strategies in case conceptualisation. The second proposed modification introduces needs considered specific to autism spectrum conditions alongside the core emotional needs central to the schema therapy model. It is hoped these extensions to the schema therapy model facilitate the development of a needs-based, rather than symptom-based, treatment approach for complex comorbidities in adults on the autism spectrum.

Keywords: autism; schema therapy; modified treatment; therapy; autism spectrum condition

Why modify schema therapy for adults on the autism spectrum?

Autism spectrum condition (ASC) is a lifelong, neurodevelopmental condition that can present as comorbid or overlapping with a range of psychiatric conditions (Lai & Baron-Cohen, 2015). As such, it is imperative that therapeutic interventions to treat these comorbid and overlapping psychiatric conditions are adapted to suit the needs of individuals on the autism spectrum. While there is some evidence that modified cognitive-behavioural and mindfulness-based therapies are effective when treating acute comorbidities such as anxiety and depression in adults on the autism spectrum (Moree & Davis, 2010; Spek, van Ham, & Nyklicek, 2013), there is a dearth of information regarding therapeutic approaches for more complex, chronic comorbidities that may present as intertwined with autistic features. The diversity of psychiatric conditions that can co-occur with ASCs suggests a diversity of therapeutic approaches is likely required, especially given some psychiatric conditions require more specialised therapeutic approaches in the general psychiatric population. Schema therapy is one such therapeutic approach, developed for individuals with complex, chronic, and characterological presentations who demonstrate limited responsivity to other treatment approaches (Young, Klosko, & Weishaar, 2003).

There are currently trials underway looking at the effectiveness of schema therapy for individuals on the autism spectrum, with a particular focus on the efficacy of cognitive-behavioural versus experiential techniques (Vuijk & Arntz, 2017). However, given the schema therapy model takes a developmental perspective on the formation of complex mental health presentations and ASCs are

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characterised by neurodevelopmental differences, it is important that the wider theoretical framework is modified to allow for differences in the development and presentation of complex comorbidities in the ASC population. This paper will propose modifications to the schema therapy conceptual model to develop an alternative treatment framework termed *schema therapy modified for autism spectrum conditions* (ST-MASC). This proposed ST-MASC model brings concepts from the schema therapy literature and combines them with concepts from the ASC literature, in conjunction with clinical observations and experiences, to develop the starting point for a theoretically sound and individualised treatment approach for complex comorbidities in adults with an ASC.

The schema therapy model

In clinical practice, schema therapy is underpinned by an individualised case formulation that allows flexible, responsive therapeutic intervention while adhering to the conceptual model. It is based on the understanding that schemas are foundational systems that arise from early experiences and develop to make sense of self, others, and the world (Young, Klosko, & Weishaar, 2003). *Early maladaptive schemas* develop when a child's core emotional needs are not adequately and consistently met during childhood. While the original schema therapy model was not based on populations with diagnoses of ASCs, early maladaptive schemas clearly develop in individuals with ASCs. Further, these schemas can originate, at least in part, from the mismatch between person and environment that occurs when an individual on the autism spectrum is living in an environment that is shaped to meet the needs of neurotypical individuals. Clinical observations indicate the most common early maladaptive schemas in this population include: The *defectiveness* schema, experienced as a sense of being fundamentally flawed, broken, different, or unlovable; the *social isolation* schema, experienced as a pervasive sense of not fitting in with any group or community; and the *mistrust* schema, experienced as an expectation of being hurt, humiliated, targeted, or abused by others. These observations are consistent with a recent meta-synthesis of literature on the impact of school environment on individuals with ASC by Williams and colleagues (2017) who found that difficulties associated with ASC, interpersonal relationships, and accessibility of school setting all impacted on how children with ASC made sense of themselves as being different, with the majority of individuals having experiences that led to interpreting their differences from typically developing peers as negative.

The schema therapy conceptual model states that once early maladaptive schemas have begun to develop, individuals then learn to mitigate to the uncomfortable feelings elicited by early maladaptive schemas by developing *surrender* (go with the feeling), *over-compensatory* (act in opposition to the feeling), and/or *avoidance* (flee the feeling) coping responses. Ultimately, all three of these responses are maladaptive as their collective function is to ease discomfort rather than to allow corrective experiences to update schemas and meet core emotional needs. Schema therapy aims to modify these ingrained patterns and provide corrective emotional experiences to reduce early maladaptive schema activation while fulfilling the core emotional needs that were frustrated during childhood.

Modification 1: ASC-driven coping responses

The ST-MASC model suggests two extensions to the original schema therapy model when working with individuals with ASCs. The first extension proposes that individuals with ASCs develop a

combination of surrender, over-compensating, and avoidant responses to their own profile of core autistic features to manage living in a predominantly neurotypical world. Young, Brewer, and Pattison (2003) found that very young children with autism primarily exhibit core-deficit linked behaviours, then develop secondary features to cope with the core-deficit as they grow older. Translated into schema therapy language, one might say very young children present as surrendering to their individual profile of early autistic features then subsequently develop a range of over-compensating and avoidant coping responses throughout their life to adapt to living in a largely neurotypical world. Over-compensating includes responding in opposition to the internal urge, and so would likely have considerable overlap with the concept of camouflaging that develops to mask autistic features through developing a discrepancy between external presentation and internal experience (Lai et al., 2017). Over-compensating could include both masking through inhibiting autistic impulses as well as compensating for underdeveloped skills (Hull et al., 2017), as both involve acting in opposition to the original impulse, urge, or feeling. Avoidant coping responses include strategies to avoid being in a predominantly neurotypical world—or to avoid particularly neurotypical aspects of the world—potentially presenting as comorbid agoraphobia, social phobia, substance abuse, or avoidant personality symptomology. Table 1 provides illustrative examples of how these three responses might present in adults on the autism spectrum in relation to a sample of specific early autistic features, though each individual will have developed their own combination of contextually dependent coping responses to a broader range of early autistic features.

Table 1

Illustrative examples of coping responses to manage early autistic features.

Early Autistic Feature: Limited eye contact	
Surrender	Makes little eye contact, may stare at the floor or past people.
Over-compensate	Focuses on making eye contact, may appear to stare at times or make too much eye contact. May miss parts of the conversation as effort is put into making eye contact and appearing "normal" rather than genuinely engaging in the interaction.
Avoid	Avoids situations involving face to face interaction through complete isolation or primarily interacting via messaging.
Early Autistic Feature: Limited reciprocity in interactions with others	
Surrender	Interactions seem one sided. Individual is not attuned to, nor synchronised with, social partner. Interactions feel parallel rather than reciprocal. May be unresponsive or may talk about own interest at length.
Over-compensate	Individual focuses on social partner and responding to their bids in a learned manner. May subjugate own needs and preferences. The interaction may lack attunement and genuine reciprocity as the individual is focused on being overly responsive to their social partner rather than allowing a natural back and forth flow. Individual may present as overly compliant and have difficulty initiating conversation around their own preferences and interests.
Avoid	Avoids social situations/face to face interactions, though may interact via the internet, especially around areas of interest. May use drugs or alcohol in place of connecting with others, or to tolerate interpersonal contact.
Early Autistic Feature: Difficulty transitioning	
Surrender	May engage in same task for long periods of time and resist any prompts to transition. Conversations seem one sided/like a monologue and the individual may continue speaking about the same topic even after the topic has changed.
Over-compensate	Avoids engaging in tasks for long and appears to flit between tasks/have a short attention span. Engages only in uninteresting tasks so as to ensure task-switching can occur when necessary.
Avoid	May use drugs and alcohol. May avoid engaging in activities/certain environments in order to avoid difficulties transitioning between tasks.
Early Autistic Feature: Differences in sensory processing	
Surrender	Experience frequent reactions to sensory stimuli. May present as seeking sensory input, (e.g., touching people's hair) or reacting intensely to sensory input (e.g., become highly agitated by the noise of someone chewing). Sensory preferences are clear and loved ones may begin to alter their behaviour in line with the individual's sensory profile. Texture/taste preferences may contribute to restricted eating behaviours.
Over-compensate	May present as *sensory subjugation* by putting effort into tolerating sensory overload, denying themselves sensory seeking, and/or a disconnection from sensory needs. This may result in dysregulation, difficulty concentrating, and high autonomic arousal.
Avoid	May engage in highly controlling behaviours to avoid sensory discomfort. It may not be obvious to others that these behaviours are related to sensory processing. Alternatively, drugs and alcohol may be used to avoid feeling sensory discomfort.

The ST-MASC model refers to these core-deficit linked behaviours and secondary coping responses as being ASC-driven, in the spirit of adopting strengths-based language. In ST-MASC we work with both schema-driven and ASC-driven elements of presentation and distinguishing between these elements is crucial to guide the therapeutic approach. When working with schema-driven patterns, we aim to both reduce early maladaptive schema activation and change maladaptive coping responses to adaptive coping responses that meet needs. However, when working with ASC-driven patterns we aim to accept core autistic features and change maladaptive coping responses to adaptive coping responses that meet needs. As such, ongoing assessment of the origin and function of presenting issues to differentiate schema-driven patterns from ASC-driven patterns is essential.

Modification 2: ASC specific needs

The schema therapy conceptual model starts and ends with core emotional needs; early maladaptive schemas first begin to form early in life when a child's core emotional needs are not consistently met, so the primary goal of schema therapy is to assist clients to have their needs met in adult life (Young, Klosko, & Weishaar, 2003). This process involves healing the schemas that arose from chronic frustration of needs as well as changing the coping responses that were once adaptive but are no longer so.

Given meeting needs is central to schema therapy, and both explains the genesis of schemas and gives direction to the therapeutic process, it is important to consider whether there are additional needs specific to individuals on the autism spectrum. As such, the second extension of the schema therapy model includes the following proposed ASC specific needs: attunement and co-regulation across the life-span; routine, predictability, and sameness; titration of sensory input; freedom to focus on interests; and social and practical guidance.

Attunement and co-regulation across the lifespan acknowledges the need for support in recognizing and responding to one's own internal world, including emotional and physiological states. *Routine, predictability, and sameness* acknowledges the need for a stable and reliable base from which the individual can feel safe to explore and make change on their own terms. *Titration of sensory input* acknowledges that adults on the autism spectrum often have sensory processing differences that can impact on central nervous system arousal. *Freedom to focus on interests* honours the depth and focus of the autistic mind and considers periods of uninterrupted time to explore intense interests can facilitate wellbeing. *Social and practical guidance* arises from the understanding that adults with ASC may need some guidance in navigating a predominantly neurotypical world, particularly in the areas of social and practical functioning. These proposed ASC specific needs have been identified through practice-based evidence, specifically clinical observations of the needs of individuals on the autism spectrum, in the context of core diagnostic features, commonalities in presentation, and therapeutic successes. These ASC specific needs are intended to be used in conjunction with, not instead of, the core emotional needs described by Young and colleagues (2003). It is important to note that surrender, over-compensating, and avoidant responses are not inherently adaptive or maladaptive, but rather become maladaptive when they occur at the expense of meeting core emotional or ASC specific needs. As such, these needs become our reference point to determine which presenting behaviours are adaptive and which are maladaptive. Without an understanding of these needs, we run the risk of attempting to reduce adaptive behaviours that appear unusual or pathological on the surface but help

to meet needs or increasing some maladaptive behaviours that are neuro-normative or appear to be healthy on the surface but do not help to meet needs.

Summary of the therapeutic approach

This ST-MASC model aims to provide therapists with a framework for conceptualisation in order to guide the direction of treatment, rather than to provide a prescriptive treatment protocol. It is preferable that the therapist is well attuned and remains sufficiently flexible to respond to the needs of the client during therapy sessions, rather than focusing on teaching the model to the client or following structured protocols. The primary goal of ST-MASC is not to symptom reduction, but rather to shift deeply ingrained cognitive, affective, and behavioural patterns with the aim to meet core emotional and ASC specific needs thus promoting mental health and wellbeing. Meeting core emotional and ASC specific needs in session- directly and through imagery- provides a corrective experience which begins to develop alternative healthy schemas thus forming the foundation for wider and deeper-level change. As ST-MASC is guided by the case conceptualisation, the course of therapy and type of therapeutic intervention may differ greatly between individuals. ST-MASC also promotes systemic change through helping key supports within family, educational, and occupational systems to understand the individual and better meet their needs. These extensions of the original schema therapy model can also be applied when a previously undiagnosed individual is identified as having an ASC during the course of schema therapy, as the case conceptualisation can be revised to include ASC specific components in the ST-MASC framework.

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