Chapter 39: Helping autistic children

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Introduction

Autism is a highly heritable neurodevelopmental condition, with prevalence estimated at 1 in 100 people worldwide (Elsabbagh et al., 2012). Autism is diagnosed by behavioural presentation, and although there is substantial variability both within autistic people across the lifespan, and between autistic individuals, a set of core diagnostic criteria are relied on by clinicians. These criteria are broadly categorised in two ways: (1) distinctive patterns of social communication and interactions with others, and (2) restricted or repetitive behaviours or interests (American Psychiatric Association, APA, 2013) (for a comprehensive overview of the current autism research, see: Fletcher-Watson & Happé, 2019).

Given the emphasis on social and communication difficulties in the diagnostic criteria of autism, and the pivotal role they play in development generally, these domains are commonly key targets for autism interventions. Here, we first provide an overview of different types of traditional social interventions and evaluate their effectiveness and validity. We also present some of the possible risks associated with such interventions, and suggest a number of means for autistic children to develop social and communication capacities on their own terms, in both family and educational settings. We end by considering some other factors essential for understanding the social development of autistic children in context and informing development and delivery of supports.

Social communication skills

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Social communication can be broadly defined as responding to and/or sharing of information, feelings, or thoughts with another person (Mundy et al., 1986). A distinctive profile of social communication is a core diagnostic feature of autism and is apparent in the initiation, response, and maintenance of social interactions (Vicker, 2009). Rarely acknowledged but implicit in this definition, as applied to autism, is that the “other person” being communicated with is from the ‘neurotypical’ majority - or at least is not autistic. This is important to recognise, given the significant body of research suggesting that issues in communication are not necessarily due to autistic differences in isolation, but a breakdown in understanding between groups of people with different ways of experiencing the world (e.g., between autistic and neurotypical people) (Milton, 2012).

In terms of non-verbal social communication abilities, autistic children can follow an atypical skill-development pathway for components such as gesture, posture, mutual gaze, eye-contact, pointing and showing, and using expected facial expressions (Jarold et al., 2013). These behaviours are thought to be integral to joint attention and hence to developing opportunities for emotional reciprocity, and the shared enjoyment of interests (APA, 2013). In terms of verbal communication, autistic children frequently exhibit delays and differences across multiple aspects of language, including vocabulary (Mitchell, 2006), phonology (Kjelgaard & Tager-Flusberg, 2001), and conversation-based skills including turn-taking during conversation, structuring narratives, and taking another’s perspective (Paul, Landa & Simmons, 2014). The autistic language profile can encompass hyperlexia (Newman et al., 2007) and multilingualism (Uljarević et al., 2016) though problems with normative language pragmatics are more consistently apparent: for a review of social communication skills and autism, see Kalandadze et al. (2018).

Early social communication skills are important in the development of more sophisticated aspects of social cognition and language development and provide the potential for cascading effects on subsequent social abilities later in development (Wetherby et al., 2007). Joint attention skills at two years are associated with higher expressive language scores on

standardised language assessments later in childhood (Thurm, Lord, Lee & Newschaffer, 2007). Fundamental social and communication skills such as joint attention, imitation and play provide a basis for differences in more complex cognitive skills, such as theory of mind (Charman et al., 2000) and referential and reciprocal communication skills that underpin interactions (Bottema-Beutel et al., 2020). As a result of the social and communication differences autistic children show, and the impact of early skills on later developmental outcomes, many interventions for autistic children focus on targeting foundational social and communication skills.

Intervention delivery

Interventions for autistic children can be delivered in a range of ways and vary across many parameters. Some interventions have a broad scope and incorporate training across multiple skills and domains, whereas others target one particular behaviour or skill. Interventions also vary widely in intensity, from short interventions with one hour of training per week over the course of a few weeks, to interventions with up to 40 hours of training each week across a number of years. In research studies, interventions are most commonly led by trained therapists or special education practitioners working with children in a clinical or education setting. However, in “real-life” settings, interventions are most frequently delivered by non-specialists, including caregivers, who are supervised by trained professionals (Lord et al., 2020). Below we present some of the most common social and communication interventions for autistic children alongside their respective theoretical frameworks.

Developmental interventions

In developmental interventions, the child’s natural exploration of their environment is viewed as a fundamental aspect of development to be built on with supportive “scaffolding” (Wood et al., 1976), modelled by a familiar adult, such as a caregiver or teacher. These developmental principles are still at the forefront of some of the most influential autism interventions. Research has highlighted the importance of joint attention in early development and as an effective component of early interventions (Kasari et al., 1988; Wong

et al., 2015). This focus on adult-child interactions is evident in some of the most recognised

intervention approaches for autistic children today (see e.g., Green et al., 2010; Kasari et al., 2015).

Parent-mediated developmental interventions aim to specifically train caregivers to adapt their own style of interacting with their child, to enhance both responsiveness and sensitivity during interactions. In recent years, several types of these interventions have been tested empirically, the most recognised being the *Preschool Autism Communication Trial* (PACT; Green et al., 2010; Pickles et al., 2016).

The PACT (Green et al., 2010) is a parent-mediated and video-aided intervention that aims to increase social communication competencies. The intervention focuses on preverbal, pragmatic, and language development through optimising parent interactive behaviours with the child in naturalistic contexts (Green et al., 2010). Improved dyadic interaction is hypothesised to have cascading effects on the child's later developmental abilities. Results from a randomised controlled trial initially showed that there was little change in social and communication outcomes in the short-term, but a benefit in terms of parent-child dyadic social communication in the intervention group (Green et al., 2010). However, a 6-year follow-up indicated a long-term reduction in assessment scores measuring core challenges associated with an autism diagnosis (Pickles et al., 2016).

Although the conclusions across parent-mediated interventions are generally mixed (Pizzano & Kasari, 2020), parent-mediated interventions can have positive outcomes in important areas outside of social and cognitive skills, such as decreasing stress in parents (Nordahl-Hansen et al., 2018) and improving parent strategies when interacting with their child (Ingersoll et al., 2017; Kasari et al., 2015).

Applied Behaviour Analysis

Applied Behaviour Analysis (ABA) is a comprehensive approach that targets a broad range of behaviours and skills, such as motor development, adaptive behaviours, and social communication skills, including language development. Interventions are comprehensive in time

and frequency, often ranging from 20 to 40 hours per week and typically delivered for a year or longer

Discrete Trial Training (DTT) is a technique used to teach behaviours that can be broken down into small chunks (e.g. teeth brushing). The first chunk of a task is repeated until the child elicits the target response. Following reinforcement and extensive practice of the desired response, the next steps of the skill are slowly incorporated until the task can be completed in full.

Early Intensive Behavioural Intervention (EIBI) is a comprehensive intervention approach that incorporates both one-to-one DTT for more foundational skills, and naturalistic training for more complex communication skills including joint attention. EIBI uses similar reinforcement principles to DTT, but sessions take place in a more naturalistic setting, and are instigated by the child's interest in a particular toy or activity (Klintwall & Eikeseth, 2014).

In terms of the effectiveness of ABA approaches, research suggests that intervention effects do not generalise beyond the intervention environment, and behaviours learnt during interventions are rarely reproduced in novel settings (Kovshoff et al., 2011). A meta-analysis of autism interventions highlights that many studies fail to implement rigorous methodological designs such as randomised control trials (RCTs). Out of the studies that have implemented RCTs to date, there is inadequate collective evidence for change on any selected outcome (Sandbank et al., 2020). ABA approaches have also faced intense scrutiny in the last two decades, with significant concerns around both the ethics and outcomes of ABA interventions. Many of the criticisms have been raised by autistic adults who have participated in ABA therapies themselves (McGill & Robinson, 2020).

Naturalistic Developmental and Behavioural Interventions

Social communication interventions for autistic children are frequently situated somewhere along a continuum between the behavioural and developmental perspectives. Schreibman and

colleagues (2015) defined these as Naturalistic Developmental Behavioural Interventions (NDBIs). These have three central elements: training a wide range of skills rather than specific skills in discrete trials; emphasising a naturalistic learning context; and including a plethora of elements and strategies to boost learning across various settings.

Schreibman et al. (2015) list, among others, the Early Start Denver Model (ESDM); Pivotal Response Treatment (PRT); Enhanced Milieu Teaching (EMT); Joint Attention, Social Play, Engagement, and Regulation (JASPER); and Social Communication/Emotion Regulation/Transactional Support (SCERTS) as examples of NDBIs. ESDM, PRT and EMT have their roots in ABA, whereas JASPER and SCERTS are more developmentally oriented. Nevertheless, all these interventions incorporate a combination of developmental and behavioural theory (Schreibman et al., 2015; Pizzano & Kasari, 2020). Here we present the most established of these interventions in terms of research and use - JASPER, ESDM and PRT - to discuss in detail.

Joint Attention, Social Play, Engagement, and Regulation (JASPER) is theoretically grounded in developmental science where joint attention, imitation, and play skills are viewed as the foundations of social communication (Kasari et al., 2006). The intervention is centred around play-related opportunities between the adult and child, promoting dyadic partnerships, with a mutual focus towards the same object and/or event, and joint engagement in the activity.

During the intervention procedure, which is typically around 30 minutes a day, the adult follows the child's interests and activities to encourage social communication attempts from the child (Kasari et al., 2006). To initiate and sustain engagement in the play setting, behavioural strategies are used, such as expanding on child initiations and correcting feedback (Kasari, 2006;). JASPER is the most empirically tested intervention approach using RCTs. The results from these studies indicate an increase in joint attention, joint engagement, and emotion regulation behaviours (Kasari et al., 2006; Shire et al., 2019). In one specific RCT, child and adolescent mental health professionals trained preschool teachers to implement an 8-week JASPER intervention. Results showed that the intervention group had increased use of joint attention behaviours and spent more time initiating and maintaining joint engagement (based

on standardised assessments) compared to the control group, (Kaale et al., 2012) and these findings were present at a follow-up one-year later (Kaale et al., 2014). This is one of few effectiveness studies that have tested an early intervention outside of a highly controlled clinical environment.

The Early Start Denver Model (ESDM) is an intervention, developed for use with young autistic children aged between 12 and 48 months, that integrates ABA with developmental perspectives (Dawson et al., 2010). It is a comprehensive intervention that teaches skills across nine developmental domains (Fuller et al., 2020), and typically consists of around 20 hours of training per week. Systematic reviews indicate that ESDM may moderately increase expressive and receptive language use, and increase scores on cognitive abilities (Fuller et al., 2020; Sandbank et al., 2020).

Pivotal Response Treatment (PRT; Koegel et al., 1999) is a naturalistic intervention model originally derived from the ABA tradition that targets key areas in the child's development. PRT distinguishes itself from ABA interventions by prioritising motivation, response to multiple cues, self-management, and social initiations from the child. Training is carried out in play settings within a child's natural environment, usually at home or school. The developers of PRT highlight the importance of focusing on the child's strengths rather than difficulties. There is evidence that PRT may increase children's expressive language levels and amount of neurotypical social interactions, however the current evidence is limited and of poor quality (Ona et al., 2020).

TEACCH

Treatment and Education of Autistic and Communication Related Handicapped Children (TEACCH) was developed by Schopler and Mesibov in the 1960s (Mesibov et al., 2005).

Although originally developed for school-aged children, it has been adapted to fit all age groups, including younger children. The TEACCH model focuses on multiple areas of learning and development, including cognition, social communication, language, motor development, and repetitive behaviours and restricted interests (Pizzano & Kasari, 2020). A key feature is the working relationship between parents and professionals to optimise a child's developmental

outcome (Van Bourgondien & Schopler, 1996), with the intervention tailored to fit the individual needs of each child. Another central feature is the focus on visualisation and structure, for instance using pictograms to structure daily activities (Virues-Ortega et al., 2013). This focus on visualisation and structure is thought to provide predictability and routine for the child.

Meta-analyses indicate marginal effect of TEACCH on available standardised outcomes measuring social communication, cognitive skills, language and perceptual skills (Sandbank et al., 2020; Virues-Ortega et al., 2013). Although evidence for efficacy is scarce in terms of findings from rigorously designed studies, key features of the model have been highly influential on later intervention approaches (Pizzano & Kasari, 2020); in particular using visual supports and structured plans as useful strategies for autistic children (Wong et al., 2015).

Considerations for intervention and practice

There are a number of factors to bear in mind when considering interventions for autistic children. First, although autistic children by definition share some commonalities, there is a high degree of heterogeneity between individuals (Georgiades et al., 2013), both in terms of cognitive and behavioural profiles and how children respond to different interventions. Furthermore, profiles often change across development (Bal et al., 2019), and what could be effective early in childhood may not be applicable later in development. The key message here is that there is not a one-size-fits all approach for interventions.

Second, questions surrounding clinical effectiveness of interventions and recommendations of best practice remain unanswered. Methodological challenges include a lack of studies deploying rigorous study designs such as RCTs (Sandbank et al., 2020), and measurement issues (Nordahl-Hansen et al., 2016; Yoder et al., 2013).

Third, it is important to question what actually constitutes a positive effect from intervention. The majority of social communication interventions describe positive outcomes in normative terms; assuming that the desired outcome of a social communication intervention is to make a child less autistic and more neurotypical. Yet, as we discuss next, this is not the desired outcome

from the perspective of most autistic people. It is vital that we reconceptualise the aims and outcomes of social interventions to ensure that interventions prioritise the needs and experiences of autistic children.

Risks of intervention

Autistic community concerns

Many members of the autistic community hold concerns regarding the potential long-term consequences of some common approaches for autism intervention. These criticisms are typically centred around two concepts that autistic advocates consider to underpin many autism interventions: “compliance” and “normalisation”.

Compliance

Concerns around compliance relate to intervention techniques that teach the recipient to perform (or not perform) particular behaviours in response to prompts. Most commonly, these techniques are employed in behavioural interventions, including ABA and related methods. Objections to these approaches stem from the perception that behaviourist techniques teach absolute compliance, with minimal regard for the intrinsic motivations that underlie behaviour. In anecdotal reports (e.g., Bascom, 2012), autistic adults who have received (or witnessed) behavioural intervention have recounted the use of painful and distressing techniques designed to reinforce and/or discourage particular behaviours (Sibley, 2015). Some autistic adults have described experiences of post-traumatic stress, persisting decades after the cessation of intervention, which they attribute to these behaviourist techniques (Sparrow, 2015).

Advocates’ objections to teaching compliance within autism interventions seem particularly relevant since autistic people may be more compliant than non-autistic people. Preliminary evidence suggests that autistic people rate themselves higher than non-autistic people on a self-report measure of compliance and are more likely to comply with unreasonable requests in an experimental context (Chandler et al., 2019).

Normalisation

The goal of many autism interventions, both compliance-based and otherwise, relate to what the autistic community calls “normalisation”. Normalisation refers to interventions that teach a recipient to engage in typically non-autistic behaviours, and/or to suppress typically autistic behaviours, and thus to become “indistinguishable from their normal friends” (Lovaas, 1987, p. 8). Autistic adults argue that these strategies do not teach autistic people valuable skills, but instead that they must hide their true selves in order to be accepted, leading to poor self-esteem and self-worth (Milton, 2014). Anecdotal reports from autistic adults who have (with or without intervention) developed the ability to present as non-autistic highlight the potential ramifications of this behaviour, which is known within the autistic community as “masking” or “camouflaging” (Ratto et al., 2018). Research has corroborated autistic adults’ experiences, finding that camouflaging is common in autistic adults and is associated with anxiety, depression, and even suicidality (Cassidy et al., 2020); camouflaging behaviours may be present even in childhood (Wood-Downie et al., 2020).

Broader concerns

Advocates have raised a number of broader concerns regarding the promotion and delivery of autism interventions. For example, behavioural interventions are often described as the gold-standard autism therapy, despite limitations regarding the quality of the current evidence base (Sandbank et al., 2020). A typical intervention regime may involve intensive intervention of 20-40 hours per week, beginning as early as possible in a child’s development. This can result in a significant financial burden for parents (Wilkenfeld & McCarthy, 2020), and a gruelling schedule for young autistic children (Sparrow, 2015). Despite these

drawbacks, this type of approach is often recommended (Sandbank et al., 2020), and may be promoted to parents as the only effective therapeutic option available to their child.

The emphasis on compliance- and normalisation-based interventions has led to a lack of attention paid to alternative approaches. Research examining the effectiveness of autism intervention tends to rely on outcomes measures assessing a person’s level of autistic traits (French & Kennedy, 2018), with a reduction in autistic traits considered a successful outcome;

this is in spite of evidence that autistic adults and parents of autistic children prioritise real-world outcomes like wellbeing, support, happiness, and mental health (Autistica, 2016; McConachie et al., 2018). The social validity of autism interventions has rarely been examined; when it has, validity has been established based on the perceptions of parents, teachers, and other stakeholders rather than autistic people (Callahan et al., 2017).

Evidence of risks from interventions

It is vital to consider the direct and indirect risks of intervention for autistic people, but there is a dearth of literature addressing this issue. Bottema-Beutel and colleagues (2021) reviewed the findings from 150 autism intervention studies, and found that only 11 explicitly mentioned adverse events; of these 11, four studies reported that an adverse event had occurred during the intervention period. None of the 150 studies conducted follow-up research to identify long-term consequences of intervention. To supplement this sparse data, the authors inferred implicit adverse events based on withdrawal from intervention and negative results on outcome measures; alongside reported adverse effects, approximately one-third of all the reviewed studies encountered an adverse event of some kind. This suggests a widespread under-reporting of adverse events in autism intervention research (Rodgers et al., 2020), and highlights the need for systematic study of the potential risks (as well as benefits) of intervention.

In response to the autistic community's concerns regarding autism interventions, a few studies have examined the potential for long-term adverse consequences. Kupferstein (2018) examined post-traumatic stress symptoms in autistic children who had received ABA. Based

on responses to an online survey, 41% met criteria for post-traumatic stress, compared to 29% of children who had not received ABA. Although Kupferstein's work has been critiqued due to methodological concerns (Leaf et al., 2018), and should be interpreted with caution, the findings are troubling. McGill and Robinson (2020) explored the long-term effects of ABA by collecting qualitative reflections from twelve autistic adults who received interventions as children. The majority perceived ABA to have had a detrimental or harmful impact in their lives, while two participants reported that their experience of ABA was beneficial. This work should also be interpreted with caution due to risk of bias. However, these findings constitute the first empirical

evidence suggesting that ABA may lead to long-term harm, and highlight the need for increased attention on the potential adverse effects of autism interventions more broadly.

Alternative areas of focus

Although some autism interventions have demonstrated impacts on cognitive and language development scores, the field is limited by poor quality study designs, lack of autistic-informed outcome measures and a failure to properly recognise and evaluate potential harms. With this in mind, are there other ways to offer autistic children support in the social sphere? While “intervention” refers to strategies intended to bring about a behavioural or other change in an autistic person, “support” generally refers to an external change or accommodation that can benefit autistic people. Although both may have their place to varying degrees for autistic children, there is currently a disproportionate emphasis on “interventions” and a lack of “supports”. We next discuss domains where supports for autistic children can be implemented that are consistent with the autistic community’s priorities.

Technologies

One alternative to play-based, parent-led, or therapist-delivered social skills training is to deploy technology as a method of social interactional and communication support. This presents advantages, not least because the popular stereotype of autistic people as being good with computers has some truth – autistic people often report high use of technology and frequently choose digital / computer-based learning and leisure options when available

(Mazurek & Wenstrup, 2013). Often, the motivational potential of technology has been harnessed in attempts to replicate in-person intervention models, by teaching fundamental, neurotypical social skills in a digital space (e.g., Fletcher-Watson et al, 2016). However, this deployment of technology suffers from the same objections that apply to non-technological approaches. Taught skills are normatively defined and rarely generalise beyond the learning environment of the technology itself (Berggren et al., 2018) and the quality of the evidence base remains weak (Grynszpan et al., 2014).

It may be more effective to consider the role of technology as a support for autistic children's own social and communication goals, rather than as a training environment for a narrowly defined behaviour set. For example, there are multiple voice-output communication aids (VOCAs) now available for use on tablets and smartphones, significantly more affordable than their hardware-based predecessors (Aydin & Diken, 2020). Attempts have also been made to use technology to re-create aspects of a social interaction to allow opportunities for practice (Saadatzi et al., 2018). This approach may have potential provided that the focus is not on 'successful' adoption of neurotypical norms.

A number of studies have found that technology can provide a platform for play and social engagement by providing a motivating environment in which these can naturally arise (Alcorn et al., 2011, Laurie et al., 2019). During the primary school years, children may start to use technology as a way to scaffold their interactions. Interactions via chat functions in games like Minecraft, or during in-person multi-player play, provide a clear shared focus and mutually interesting topic of conversation (Heasman & Gillespie, 2019). Even when not actively engaged in playing, knowledge about video games, or the latest popular YouTube channel can be valuable playground currency that provides a solid basis for friendship (Durkin et al., 2015). In late primary years, text-based online communication with friends allows for more time to plan responses and the option to switch off if an interaction becomes overwhelming (Mazurek, 2013).

Crucially, for the majority of these purposes, technologies need not be autism-specific. Survey data from parents based across three European countries demonstrates that the technologies most commonly used by autistic children and young people are 'mainstream' - such as FacebookTM or Angry BirdsTM (Laurie et al., 2019). One obstacle here is that selecting good quality technologies and supervising their use can be a worry for some parents and practitioners. The BETA project (Building Evidence for Technology and Autism) provides a useful alternate evidence-gathering framework for autistic people and their supporters to select and deploy commercially available technologies (Zervogianni et al., 2020).

Developing friendships

A major challenge for autistic children growing up is managing their relationships with friends and classmates. Didactic social skills interventions are frequently attempted but rarely successful or generalisable. Even if effective on their own terms, these interventions risk teaching autistic children that it is their responsibility to modify who they are in order to become more likeable. This is at odds with children's human rights and best interests. A more constructive and supportive approach involves recognising that what autistic children want from friendship may not always adhere to expected norms (Calder et al., 2013) – though presuming that autistic children lack social motivation and thus prefer to be loners is also a mistake (Jaswal & Akhtar, 2019). In practice, supporting a child to identify and nurture their own model of friendship is essential.

Friendship development for autistic children should, in large part, involve educating the non-autistic people around them, since findings show that non-autistic children and adults make negative snap-judgements about autistic people that relate to social intentions (Grossman, 2015; Stagg et al., 2014). Conversely, providing opportunities for autistic children to be together, and benefit from a consequent shift in social expectations and informal peer support, should also be encouraged (Bertilsson-Rosqvist, 2017).

Educational inclusion and Social Identity

The school setting is a key context for developing and supporting one's social identity. Currently in the UK, there are 42,500 autistic children in mainstream education (DfE 2015), with the number of children rising comparably internationally (e.g., Lindsay et al., 2014). Yet, we currently know very little from autistic children themselves regarding how they can best be supported to thrive socially in school. The United Nations Convention on People with Disabilities (2006) advocates that children's rights should be embedded directly into the formulation of better practices to improve young people's outcomes and experiences, ensuring "their development to the fullest potential".

There can, however, be a significant disconnect between the school experience for autistic children and stated aspirations of inclusive school practices. There are long-established concerns

regarding the school experience for autistic children, with research commonly reporting feelings of unhappiness and dissatisfaction (Wittemeyer et al., 2011), experiences of bullying and victimisation (Rowley et al., 2012), and increased social exclusion (Humphrey & Symes, 2011).

Schools, therefore, have a duty to enforce effective anti-bullying policies and to deliver on inclusion responsibilities; rather than placing the onus on children to change their behaviour, mainstream schools should implement accommodations to promote inclusion and to prioritise how children would like to be supported. For example, incorporating children's special interests in the classroom (Wood et al., 2019), adaptation of timetables and the curriculum (Zilli et al., 2020), and support with daily transitions between activities and classes (Warren, Buckingham & Parsons, 2020) have been shown to be effective in increasing inclusion and incorporate the child's views into practice.

The Social Model of Disability and Intersectionality

In a world that is designed primarily to meet the needs of those who fall within the norm, autistic people are often disadvantaged and disabled. One model to explain this is the social-relational model of disability, which describes disability as comprising three key components: (1) *barriers to doing*, the socially imposed environmental and/or economic barriers that prevent or restrict a person's participation in certain activities; (2) *impairment effects*, which are the direct and unavoidable impacts of the impairment/s; and, (3) *barriers to being*, the psycho-emotional barriers, occurring at the personal or systemic level, that negatively impact an individual's sense of self (Cologon & Thomas, 2014). This model highlights how a person's own individual characteristics interact with their environment to create complex and varied experiences of disability.

Using the social-relational model, we can think of the autistic community as a minority social group who collectively face oppression (Walker & Raymaker, 2020). A large proportion of autistic people belong to at least one other minority group in addition to being autistic (Cascio et al., 2020). Stemming from Black feminist origins, the term "intersectionality" is commonly used to refer to membership of more than one minority group (i.e., people who sit at the intersection of

different minority communities). For people who belong to more than one minority group, the experience of oppression can be compounded. People with intersecting oppressed identities experience not only the same oppression as people in one or the other of those groups, but also unique facets of prejudice and disadvantage that apply to that combination of identities. Any effort to facilitate an autistic child's social development needs to consider other important aspects of their identity. Understanding children's intersectional experiences is vital for providing safe, relevant, and appropriate supports.

LGBTQIA+ autistic people

Research suggests that gender variance is common in autistic children, with autistic children between four (Hisle-Gorman et al., 2019) and eight (Strang et al., 2014) times more likely to experience gender variance compared to non-autistic children. Studies investigating sexual orientation focus on adolescents and adults, but there is considerable evidence for higher rates of non-heterosexuality in autistic young people compared to non-autistic peers.

To date, research regarding LGBTQIA+ autistic people has focused primarily on mental health, with findings suggesting that LGBTQIA+ autistic young people experience significantly poorer mental health than their cisgender, heterosexual autistic peers (George &

Stokes, 2018; van der Miesen et al., 2018). In light of this increased potential for poor long-term outcomes, it is critical that those who provide education and support to autistic children are cognisant of the intersectionality between the autistic and LGBTQIA+ communities. This should include, for example, ensuring that education regarding relationships and personal development is delivered in a manner that is inclusive of all gender identities and sexual orientations.

Black and First Nations autistic people and autistic People of Colour

There are well-established racial disparities in autism diagnosis: Black and Hispanic children have historically been less likely to receive an autism diagnosis, compared to White children (Durkin et al., 2017). Limited evidence suggests under-diagnosis amongst both Canadian and Australian First Nations people (Bailey & Arciuli, 2020; Lindblom, 2014). Among those who do receive a diagnosis, children from racial minorities face considerable diagnostic delays (Constantino et al.,

2020), often receive another diagnosis (particularly a conduct or adjustment disorder) prior to their autism diagnosis (Mandell et al., 2007), and tend to have less access to autism-related services (Thomas et al., 2007). Stakeholders who support Black and First Nations children and Children of Colour should be mindful of the possibility that these children may be autistic, and tailor supports for social development to meet the child's individual needs, regardless of the child's formal diagnostic status.

Any efforts to support the social development of autistic children from racial minority groups should be provided in a culturally safe and responsive manner. Professionals can develop cultural competence by working to build understanding of the barriers that racial minority groups face, examining their own privilege and biases, and integrating these insights to inform the care that they provide to Black and First Nations autistic people and autistic People of Colour.

Conclusions

Over the last twenty years we have seen a surge in autism intervention research. Interventions have become increasingly diverse, with a shift towards combined developmental-behavioural approaches and emphasis on earlier diagnosis and implementation. However, the evidence base is weak and poorly reported. As a result, there is no clear evidence for the efficacy of any intervention currently in use. Even where particular interventions produce change in aspects of social and cognitive development, it is not clear that such shifts are necessarily sustained, nor in an autistic child's best interests.

An alternative approach is to consider what supports, rather than interventions, an autistic child needs to thrive *on their own terms*. Such supports may employ the motivational and friendship-cultivating benefits of technology, facilitate opportunities for autistic people to be together, or focus on development of the child's own voice as a prominent influence shaping their school experience. Support should involve the people around the autistic child - parents, friends, and teachers - committing to acceptance and adaptation at least as much as is asked of the autistic child. In supporting autistic children, individually or collectively in a school or community, it is

essential to be informed about the experiences of autistic people as an oppressed minority, and the way these experiences intersect with other, overlapping marginalised identities.

As we have moved through its pages, this chapter has shifted from framing autism as a disorder to be resolved via intervention, to framing autism as a divergence to be respected via inclusive support and empowerment. This shift mirrors an ongoing evolution in autism research, an evolution that is very much in-progress at the time of writing. In line with this evolution, our recommendations for supporting autistic children's social development are to rethink deficit-based accounts of autism, highlight autistic children's perspectives and autonomy, and focus on inclusion and equality.

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