FEMINIZING THE SPECTRUM:
RAISING AWARENESS OF FEMALES WITH AUTISM SPECTRUM DISORDER

A Field Practicum Report
Submitted to the Faculty of Social Work
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Abstract

The following is a field practicum report discussing my experiences at Autism Services of Saskatoon in Saskatoon, Saskatchewan. My focus during this field practicum was on females diagnosed with autism spectrum disorder. I was able to gain an understanding of the reasons behind the imbalanced ratio of males and females being diagnosed with autism spectrum disorder (ASD) and understand the lived experiences of females with ASD. I discovered that males and females display symptoms of autism in differing ways, thus leading to misunderstandings, misdiagnosis, and missed diagnosis for females. Also within this field practicum, I was able to educate others about the realities of females diagnosed with ASD and begin a discussion regarding their experiences and how this diagnosis impacts their lives, their families, and the roles these females play in society. This report uses the feminist perspective as the basis for understanding why females with ASD are being misdiagnosed, misunderstood, and under diagnosed.

Through this practicum opportunity, I was able to gain an understanding of the services offered by the Autism Intervention Program (AIP program) and the Mental Health and Wellness division of Autism Services of Saskatoon, as well as the roles I could play in the organization as a graduate level social work intern.
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Introduction

My journey to obtaining a master of social work degree included completing a field practicum consisting of 450 hours. During the months of July to October 2018, I was fortunate enough to complete this field practicum at Autism Services of Saskatoon. During my time at Autism Services, my goal was to assist in the improvement of current programs and development of new programs and services for clients. The primary focus of this practicum was to gain an understanding of females who had a diagnosis of autism spectrum disorder (ASD) or females with symptomologies consistent with those of ASD. My practicum experience proved to be so much more than what I anticipated at the time I outlined this goal. I was able to work with an array of clients, families, and professionals who widened my understanding and ability to work with this population. I was granted the opportunity to peruse various resources on my journey to understanding those with autism, specifically females with autism.

The reason for my interest in females specifically was that my previous work experience exposed me mainly to males diagnosed with ASD. I wanted to broaden my reality to include and understand the female experience of ASD and my desire to utilize feminism as the theoretical framework for my work was solidified within my first week at the practicum. I began reading and delving into the literature regarding females on the autism spectrum and the feminist approach was particularly relevant to critically analyzing the predominantly male focus of autism diagnoses, treatment and services. The feminist foundations were also helpful in examining and critiquing the male-dominated research of autism spectrum disorder, therefore feminist theories and approaches are the theoretical foundation on which my work is based and will be woven throughout this document.
There were numerous rich conversations and learning moments that galvanized me to focus on females on the spectrum. This newly found passion regarding females diagnosed with ASD led me to plan and organize an experimental project which I called “She-Tribe”. I conceptualized it as a one-day retreat for women with ASD and assumed the day would be near magical in terms of togetherness, learning, and collective fun for a neglected and ignored population of women. However, to my dismay, She-Tribe turned out not to be what I expected it to be. Not one woman registered or showed up, and as such the retreat could not be delivered. I was devastated and felt I had failed, but it turned out to be an incredibly valuable learning moment. The hard lessons this experience taught me increased my self-awareness and reflexivity, both of which promoted critical understanding of the topic and led me to further explorations during my practicum. This report offers a glimpse into my experiences at Autism Services of Saskatoon, a brief examination of current literature regarding females diagnosed with autism, and a review of the feminist approach that is the theoretical foundation of this work.
What is Autism?

Autism spectrum disorder (ASD) is defined as a lifelong neurodevelopmental disorder that is typically apparent within the first three years of life (Autism Canada, 2018). Autism is a spectrum disorder, meaning that the severity of the primary symptoms of this condition can vary vastly amongst individuals with this diagnosis. People with ASD can have varying verbal and non-verbal communication, different social interaction skills, and may exhibit an array of rigid, repetitive behavior mixed with an insistence on routine whereby any change in the routine is met with resistance. Lastly, another symptom observed amongst those with ASD is a hyper- or hypo-sensitivity to sensory stimuli (Loomes, Hull & Mandy, 2017).

Prevalence of Autism Spectrum Disorder

According to the 2018 Canadian Press, National Autism Spectrum Disorder Surveillance System Report, approximately 1 in 66 children are diagnosed with ASD and male children are identified with autism spectrum disorder four times more frequently than females (Public Health Agency of Canada, 2018). It is estimated that 1 in 42 males and 1 in 165 females are diagnosed with ASD. Over 50% of children and youth receive their diagnosis of ASD by age 6, and 90% by age 12.

Autism spectrum disorder is treatable but not curable, and early intervention is the key to improving the lives of children diagnosed with ASD. Treatment at any age is considered beneficial in lessening the symptoms of ASD and acquiring the necessary skills to promote optimal outcomes. Individuals do not grow out of autism; however, with support and treatment plans, children can learn like other young people and are able to thrive in their world.
What are the Causes of Autism?

The cause of autism is not yet known, but research suggests that an inherited predisposition to autism may exist (Szabo, 2012). Some researchers suggest that the cause of autism spectrum disorder is an atypical genetic make-up. Although the specific genes remain unknown, scientists suspect a genetic contribution as it is estimated that 15-20% of children diagnosed with autism have various genetic mutations that contribute to their condition (Szabo, 2012). Additionally, family history has been linked as a contributing factor. If a family has a first child diagnosed with autism, there is a nearly 20% increased probability that a second child will also have autism. The probability of having a third child diagnosed with autism is further increased to 32% (Hansen et al., 2019; Ozonoff et al., 2011; Szabo, 2012). Also linked to increased risk of having a child diagnosed with autism is a child born to an older father or an older mother (Szabo, 2012 & Autism Speaks, 2018).

Premature birth or low birth weight are early indicators that have been linked to a diagnosis of autism as approximately 5% of babies born weighing less than four pounds are diagnosed with autism spectrum disorder (Johnson et al., 2010). Also, siblings born less than one year apart are three times more likely to be diagnosed with autism as compared to children born three years apart (Cheslack-Postava, Liu & Bearman, 2011; Szabo, 2012).

What are the Diagnostic Criteria for Autism Spectrum Disorder?

The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) states that, in order to be diagnosed with autism, one must meet three criteria. The first criterion is a persistent deficit in social communication and social interaction with specific challenges in verbal or non-verbal social communication, an absence of social interactions, and a lack of peer relationships that are suitable to the developmental level.
The second, is exhibiting rigid, repetitive, restrictive behaviors and interests which are marked by motor or verbal movements or sensory issues, extreme loyalty to routines, and ritual-type behaviors and obsessive interests. Finally, the above criteria must be exhibited in early childhood (Happe, 2011).

**Who Diagnoses Autism?**

Unfortunately, diagnosing ASD is not as simple as administering a blood test or participating in other medical testing. Assessment is done purely through observation and information provided to a certified practitioner regarding an individual’s ability to communicate, the exhibited rigid and repetitive behaviors, and developmental levels according to the age of the individual. Most often, a team is necessary to make an official ASD diagnosis. This team often consists of, but is not limited to, a pediatrician, occupational therapist, speech and language pathologist, psychologist, and social worker. In some situations, a psychiatrist or psychologist will diagnose ASD (Autism Canada, 2018). There is a lack of female-specific diagnostic tools that can recognize or detect female symptomology of ASD (Attwood et al., 2016). This lack of female-specific assessment tools contributes to the vast amount of misdiagnosed and under-diagnosed females with ASD (Eaton, 2018; Nichols, Moravcik & Tetenbaum, 2009). Attwood et al., (2016) suggest that the current ASD assessment tools may not recognize the subtler, less severe, and less intrusive symptoms of autism experienced by females with ASD. This will be examined in depth later in the paper.
Autism Services of Saskatoon

From July 3 to September 28, 2018, I was privileged to complete a 450 hour practicum at Autism Services of Saskatoon as part of the Master of Social Work program at the University of Regina. Autism Services of Saskatoon is a charitable organization dedicated to providing a number of services to individuals and their families who are diagnosed with or awaiting a diagnosis of autism spectrum disorder. The services offered by Autism Services of Saskatoon include, but are not limited to, advocacy, support, education, recreational, social, and residential services. All individuals diagnosed with or awaiting diagnosis of ASD, along with their families, qualify for services. Services offered by Autism Services of Saskatoon are voluntary and clients (families and individuals) reach out for services as they wish.

Programs Offered by Autism Services of Saskatoon

Autism Services of Saskatoon offers five types of services to persons living with ASD and their families. The services include Family Programs, Adult Support Programs, Mental Health and Wellness, Little Tots Program, and the Autism Intervention Program (Autism Services of Saskatoon, n.d.). Each area of service offered by Autism Services of Saskatoon will be explained in this in the section below.

Family Programs. The Family Programs service provides recreational programming for children, youth, and young adults diagnosed with or awaiting diagnosis of ASD. The goal of the Family Programs is to promote general health and well-being for families and clients as many diagnosed with ASD are uncomfortable or unable to participate in team activities due to cognitive, behavioral, and motor skill challenges.

Adult Support Programs. Adult Support Programs consists of residential group homes as well as adult day programming and opportunities for enrichment. The primary focus of Adult
Support Programs is to preserve a home-like atmosphere for the residents and enhance quality of life for participating individuals and residents.

**Mental Health and Wellness.** The Mental Health and Wellness team is the newest branch of service at Autism Services of Saskatoon. The service was introduced to respond to the needs of clients and their families who struggle to maintain emotional and mental health due to the unique challenges that can accompany a diagnosis of ASD. It is the goal of the Mental Health and Wellness Team to raise awareness regarding the mental health issues that may accompany a diagnosis of ASD as well as to create a safe, accepting environment for clients to begin their journey to better health and wellness. Individual, couple, and family counselling is provided as well as an array of groups to assist in building resiliency and skills to better face the overwhelming world that such a diagnosis represents.

**Little Tots Program.** The Little Tots Program is designed for children aged 1-6 years who require support in specific targeted behaviors, such as paying attention, imitation, language and communication, play, socialization, motor skills, life skills, and pre-academic skills. A crucial component of the Little Tots Program is the inclusion of parents as active participants in collaborating to create clinical goals for their children at all stages of intervention.

**Autism Intervention Program.** The final branch of service offered by Autism Services of Saskatoon is the Autism Intervention Program (AIP). AIP provides individualized programming based on the Applied Behavioral Analysis framework with programming that encourages social skills, peer engagement, and family interaction. The AIP team, led by a director, consists of behavioral therapists, specialized autism consultants, an occupational therapist, and a speech and language pathologist. The goal of the AIP team is to equip children with skills for independent functioning, active participation in society, and positive meaningful
relationships with family and friends. Although I was a member of the AIP team, I primarily observed therapeutic sessions between clients and professional staff such as speech and language therapist and the occupational therapist. I was not directly involved in offering services to the AIP caseload. During my field practicum, I was a team member of both the Autism Intervention Programs team as well as the Mental Health and Wellness team. As a team member of the Mental Health and Wellness team, I provided direct counselling and advocacy services to both children and adults either diagnosed with ASD or those who are impacted by ASD, such as family members of those living with ASD.

**Autism Services of Saskatoon’s Mission and Vision**

The vision and mission statement is proudly displayed and can be immediately seen upon entering the Autism Services of Saskatoon building. Their vision is for all individuals with autism spectrum disorder to have the opportunity to live with dignity and to reach their potential. The mission states that Autism Services of Saskatoon continuously strives to deliver the highest standard of support, advocacy, and service to individuals with autism spectrum disorder and their families and caregivers. The vision and mission is upheld in every programming goal, group, and individual interaction with people diagnosed with ASD and their families and caregivers.

As a social worker, the mission and vision statement of Autism Services of Saskatoon align with many of my ethical, professional and personal beliefs. For instance, I believe that despite any difficulties or diagnosis, it is essential and a right for all people to feel a sense of belonging and have a sense of dignity. In addition, dignity for all clients is a core value in the social work Code of Ethics (CASW, 2005), thus, this is a value shared with Autism Services and an ethical professional requirement for me as a social worker.
The mission and vision statement of Autism Services includes advocacy, support and offering the highest standard of service to clients. This portion of the mission statement aligns with the ethical value of social workers to pursue social justice for all. The value to advocate and support clients is another example of shared beliefs with Autism Services that facilitated my integration into the work of this organization (CASW, 2005).

Although the Autism Services team consists of several disciplines, the vision and mission statement was the overarching umbrella to all of our work, despite what role you played as a staff member. The values and mission of Autism Services of Saskatoon fully aligns with the Social Work Code of Ethics (CASW, 2005), which helped in ensuring that this was an appropriate and fulfilling practicum opportunity.
Goal and Objectives of Field Practicum

Upon securing the practicum at Autism Services of Saskatoon, I felt confident in my understanding and experience in working with those diagnosed with autism, due to my previous experience working in the capacity of a school social worker. This employment allowed me the honor of providing support through direct counselling, behavior and academic planning as well as advocating for those living with a diagnosis of autism. It was during this employment that I came to believe I had a grasp of the autism spectrum and diagnosis. To work effectively with this population as a school social worker, I did extensive reading and review of literature relating to the symptomology as well as best practices for working with this population of students which contributed to the understanding I had and what I thought was autism spectrum disorder. However, upon entering my practicum, I soon discovered I had but a limited understanding of autism and there was so much more to learn and know. The experiences and knowledge I had of those diagnosed with autism prior to entering this practicum were severely limited compared to the experience and knowledge I gained through the practicum. As a school counsellor, I had a basic knowledge of the stereotypical traits and symptoms of someone diagnosed with autism. My previous knowledge did not include any notion of the gender difference that exists between males and females exhibiting ASD symptomology. I set out in this field practicum to increase my knowledge about females diagnosed with ASD and began by pulling on what I thought was a thread. I ended the practicum with an unraveled garment of questions without answers due to the lack of scholarship on females with ASD. This unraveled garment now fuels my passion and my future goal is to work to find out more about this population in an attempt to reweave a more gender inclusive garment. The next section of this document will be a more in-depth look at each
of the objectives outlined in my field practicum proposal and a description of how each was achieved, or not achieved, and why.

My learning goal, as set out at the beginning of the practicum, was to assist in the development and improvement of programs and services offered by Autism Services of Saskatoon. I did much more and achieved other unanticipated goals; I contributed to public education and awareness of females on the autism spectrum within the agency and the entire community. Females diagnosed with ASD are an under-recognized population within the community and a newer venture for the agency itself having little exposure to this population prior to this practicum.

Objective 1

The first objective for this practicum was to expand my knowledge regarding the symptomology, best practices, and diagnostic criteria of autism spectrum disorder.

This objective was met while I was scouring the research regarding females diagnosed with ASD. To best understand females living with ASD, I had to gain an understanding of males diagnosed with ASD as well. Understanding males was essential as it was the early belief that this was the only population that could have ASD symptomology. Thus, I came to understand ASD through mostly literature involving males. This objective was also met through the counselling performed with clients diagnosed with autism spectrum disorder or those individuals affected by ASD in some way. Additionally, upon entering this field practicum, I had knowledge regarding applied behavioral analysis, which has been proven effective as a best practice in working with those diagnosed with autism. I was also allowed the opportunity to converse with professionals who diagnose individuals with ASD. This provided me with an opportunity to ask
questions and gain an understanding regarding the symptomology, best practices, and the diagnostic criteria of ASD.

**Objective 2**

The second objective identified for this practicum was to use cognitive behavioral therapy in clinical counselling with those diagnosed with ASD.

I was able to offer clinically supervised counselling to various individuals, both those diagnosed with autism and those who have been affected by the diagnosis in some capacity. I supported clients using different strategies often associated with cognitive behavioral therapy, strength-based therapy, as well as solution-focused therapy.

**Cognitive behavioral therapy (CBT).** Cognitive behavioral therapy (CBT) is an active, time-limited, direct and structured approach that focuses on the clients in the here and now (Corey, 2001). The therapist supports the client in recognizing patterns or cycles of negative cognitions that affect their feelings and moods. The goal of this approach is to shift the client’s cognitions to a more functional level thereby changing their moods and realities (Meier & Boivin, 2011). The therapy is based on the idea that changing one’s thoughts changes feelings and behaviors (Martin, 2018; Corey, 2001). The central principle of CBT is that one’s thoughts, feelings, and behaviors are components of an integrated system (Corey, 2001; Curwen, Palmer & Ruddell, 2000; Porter, 2014). This approach was appropriate during my field practicum as it is quick and solution-oriented and can be used to address a number of different issues across a wide age span of clientele (Corey, 2001). CBT often includes such helpful strategies as goal-setting, ideas for coping with stress and anxiety, identifying and challenging negative thoughts, and identifying enjoyable activities (Patterson, 2009). I used all of the aforementioned CBT strategies in supporting the clients of Autism Services of Saskatoon as an MSW student practitioner.
Donoghue, Stallard and Kucia (2011) state that although the evidence is limited, there is feasibility that CBT is a potentially assistive treatment for those living with the diagnosis of ASD. With the reality of CBT being an effective therapeutic measure, it is critical to state that in utilizing CBT with this population, adaptations must be considered. These adaptations are necessary to recognize as well as compensate for the interfered social skills that is a symptomology of ASD (Wood et al., 2009). An inability to recognize the symptomologies of ASD during the therapeutic process will result in ineffective intervention and frustration or even humiliation of the client due to the lack of success felt by the client. In utilizing cognitive behavioral therapy, a therapist must have an understanding of the cognitive needs of the client and adapt accordingly (Donoghue et al., 2011). For example, to ensure understanding and clarity on the part of the client, a helping professional may have to alter wording and limit jargon as those living with ASD see the world in black and white, literal terms. Any language that does not align with the way clients with ASD see things may be confusing to them and may interrupt the therapeutic process. Additionally, the pace of the therapeutic process must be appropriate for the comfort and ability of the client. It is crucial that the therapist maintain clear expectations of the client while providing specific, transparent feedback (Donoghue et al., 2011). It may also be important and helpful to utilize visual aids, such as timers and diagrams during therapeutic sessions (Wood, et al., 2009). This is to ensure client understanding, as those with ASD often have an increased understanding through pictures rather than words alone (Hare, 1997). Future research and rigorous trials are necessary to further explore the effectiveness and further adaptations needed when utilizing CBT with those who live with a diagnosis of autism spectrum disorder (ASD).
In addition to CBT, I also used some strength-based therapy techniques which are described below.

**Strength-based therapy.** A strength-based therapeutic framework focuses on strengths found within the client(s) rather than on their shortfalls or failures (Meier & Boivin, 2011; Sharry, 2004). The objective of the therapist is to work with the client(s) to build upon the positive qualities and experiences of the client to alter their beliefs and instill resilience in the client(s). It is the goal of strength-based therapy to bring to the forefront the client’s strengths as a basis for building resilience and a more positive outlook on life. This type of therapy is used to assist with an array of mental health issues, such as depression and anxiety (Padesky & Mooney, 2012). Many of the individuals I supported described feeling anxious and depressed or were diagnosed as such. Thus, I often used the strength-based approach to encourage and work with the client(s) to recognize their own inner strengths and, together, we would build upon those strengths. Additionally, I believe there are strengths in every human being, thus, this therapeutic framework was one I could readily use to support all clients as a universal approach regardless of their age, class, gender or other social locations. In addition to using the strength-based model of therapy, I also incorporated the practices and techniques found in solution-focused brief therapy.

**Solution-focused brief therapy.** Solution-focused brief therapy (SFBT) does not focus on the past experiences or stories of the client(s) (Flamez & Watson, 2014). Instead, SFBT focuses on possible solutions to the difficulties described by the client (Berg, 2004; Flamez & Watson, 2014). The solutions focus on the present day and the future hopes of the client. The basis of SFBT is that clients hold the answers to their difficulties (Berg, 2004; Meier & Boivin, 2011). This therapeutic model describes the essence of my belief about people. I believe individuals hold the solutions to their difficulties. It is with support and guidance that these
solutions surface for the client. Therapists support answers coming up to the surface rather than providing the solutions.

Another component included within SFBT is goal-setting. Clients are asked to set goals, which are the foundation and often the finale of the therapeutic process (Trepper et al., 2010). I believe that goals should be the basis of any therapeutic intervention as, without goals, how does one measure the journey and success of the therapeutic work of the client and therapist.

In utilizing SFBT with clients diagnosed with ASD, it is imperative that a therapist be cognizant of the understanding and language level of the client. It is also important that the helper be aware and understand the social skill delays that exists as part of ASD symptomology. This therapeutic approach is based on verbal language between the client and therapist as well as the observable, non-verbal communication of the client (Smock, Jordan & Turns, 2016), therefore, these social skill and language delays may impact the therapeutic process.

In using the afore-mentioned therapeutic approaches, I fully achieved my second objective during my time at Autism Services. I had desired to use cognitive behavioral therapy but ultimately also used several other therapeutic frameworks, thus developing an eclectic approach to supporting clients. This placement, and the opportunity it afforded me to use three therapeutic approaches in practice, contributed immensely to my growth and enabled me to develop a model of practice based on the exposure to not just cognitive behavioral therapy but multi modal therapeutic approaches.

Objective 3

The third objective identified for this practicum was to assist in the design and development of programs for individuals who access Autism Services of Saskatoon and their families.
This objective was partially met through the design of “She Tribe” which was a one-day retreat for women, aged 18 and older, diagnosed with ASD or those who believed they might be autistic. My goal in planning this retreat was to form a community where there was acceptance, advocacy, and a social outlet for this population of women. I wanted an understanding of what they needed to feel supported. Furthermore, I wanted to obtain participant input into the planning of a possible ongoing women’s group that would be based on their needs. I wanted to listen to the women and let their stories, needs, and desires inform and lead the group processes.

Unfortunately, the She-Tribe retreat was less than successful as a program but became an important and valuable tool for self-reflection. It assisted me to truly understand the complexities of program planning as I realized along the way that I had made assumptions about the target population in designing She-Tribe.

When the development and delivery of She-Tribe did not go as planned, I saw the need to teach, influence, and bring awareness about females diagnosed with ASD. To bring about awareness, I developed an education night called Autism in Pink. Almost 40 individuals were present to hear about females with ASD, thus sparking an interest in the lived realities, needs, interventions and services required by females diagnosed with ASD. In addition, I am optimistic that the parents and professionals who attended Autism in Pink made new discoveries which can unleash different ways of thinking and caring for females diagnosed with ASD. The presentation was an incredible opportunity to display the learning I had achieved and to urge others to take notice of this forgotten population.

When I began my field practicum at Autism Services, I knew I wanted to make an impact specifically at the micro and even mezzo levels. I believe I was able to do so. And this has contributed to Autism Services, as an organization, gaining a better understanding and
knowledge base regarding females with ASD than they had prior to my practicum. It is in
gaining knowledge and understanding through presentations such as Autism in Pink that stigma
decreases and females on the spectrum are no longer a new idea. Instead, females diagnosed with
ASD are an understood, welcomed, important part of society. I will continue to bring awareness
and advocate for the importance of recognizing the dynamic and diverse needs of females
diagnosed with autism spectrum disorder.

**Objective 4**

The fourth and final objective for this practicum was to gain an understanding of the
underlying factors contributing to the number of females diagnosed with ASD, their needs,
implications, and issues pertaining to this phenomenon.

I spent the majority of my time in my field practicum focused on this objective as this is a
highly under-researched, and under-recognized population. They sparked my interest and I knew
that I wanted to gain an understanding of this dynamic population. As may be apparent from this
report, this placement has sparked a new passion within me and I feel that this gap within the
field of autism deserves this much-needed attention.
Practicum Activities

Females Diagnosed with Autism Spectrum Disorder

The primary focus of my field practicum at Autism Services of Saskatoon was gaining knowledge and an understanding of females diagnosed with autism spectrum disorder. During my initial meeting with my field supervisor, she spoke of a woman recently diagnosed with autism spectrum disorder. My curiosity and excitement piqued with her story. I knew I needed to learn and gain an understanding of females on the autism spectrum. I needed to understand the stories and realities of females with autism compared to the world of males with autism spectrum disorder. Leading up to my field practicum at Autism Services of Saskatoon, I had begun to wonder how females diagnosed with autism differed from males diagnosed with autism spectrum disorder. Although I had heard of and previously worked with males diagnosed with autism, I wondered why I had never heard of females with autism. These questions and many more drove my quest to find out as much as I could about female experiences with autism spectrum disorder.

The Rise and Demise of the She-Tribe Retreat

Moving forward with a focus on females with ASD, I began to develop a one-day retreat for women diagnosed with ASD or those who think they may have autism spectrum disorder. To begin this process, I needed to understand all I could about girls and women with ASD. I began to read the literature, and do my best to become versed in the topic of females with ASD. After reading current literature and gaining an understanding, I had the honor of listening and learning from the same woman my field supervisor had told me about in our initial meeting. This meeting was one of the best, most inspiring moments of my practicum. In this meeting, this resilient and inspiring woman stated, she “could never really find her tribe in younger years”. This was the beginning of planning She-Tribe. Creating the She-Tribe retreat day was fluid and ever-changing
as I read literature and spoke to women diagnosed with ASD. I asked women signing up for the retreat day to come to Autism Services of Saskatoon for an initial meeting, if it was possible, cognizant that I did not want to make this initial meeting a barrier to attending She-Tribe. The initial meeting was scheduled to be clear and concise regarding the activities of the day to decrease any apprehension or anxiety that might arise in attending a day such as this. Additionally, I wanted to get a sense of the level of functioning of the women to ensure the planned activities of the day were appropriate. I also wanted to know where they received the information regarding She-Tribe in an attempt to support further releases of information to this particular group. I created an entrance and exit survey for the women to complete on retreat day in an attempt to gather data to evaluate the impact of the retreat, advocate for, and inform the development of She-Tribe into an ongoing women’s group.

She-Tribe was cancelled due to receiving no registrations for the program and it forced me to critically review where I had erred in designing the program. In this self-reflection, I gained an understanding of why females with ASD were not signing up. I realized that I had done too much, too fast, for this budding population. I returned to the literature and asked myself more questions and pondered the demise of She-Tribe while I did so.

I questioned the delivery of the She-Tribe retreat. It dawned on me, as an afterthought, how self-centered it was to assume that a population plagued with anxiety and depression would attend a full day of unknown activities, in an unknown location, with unknown people. The day was to be an opportunity to come together to socialize. However, socializing is emotionally and mentally draining and is a struggle for most people on the spectrum.

As my awareness grew, I realized several other flawed assumptions in planning She-Tribe. I assumed that women diagnosed with ASD felt isolated and lonely. However, this is not
the case. In speaking with women with this condition, they suggested they need quiet and alone
time to reset before having contact with others. They stated they did not feel lonely or isolated
but rather this time was a necessity. Through She-Tribe, I had hoped to gain retreat participants’
input into the creation of a social community that I presumed they desired. However, my
assumption was incorrect. Several of the women that I read and watched videos about were
content with their social outlets and thus perhaps did not need the social group opportunity that I
was suggesting.

The demise of She-Tribe was a good reminder of the dearth of societal understanding
about the unique peculiarities of females on the spectrum and the need for public education.
Through this process, I was also able to acknowledge that there was much I needed to learn
about their needs as I could not design a program for a population I did not fully know.
Education, acceptance, and resources for women with ASD are critical as it is easy to
pathologize unique features of a population, seeking to address or cure what those with lived
experience wish we would accept. I realized society, myself included, had much work to do
before a day of gathering, socialization, relaxation, and fun would be needed or meaningful. This
humbling process helps me see marginalized populations differently rather than projecting
deficiency discourses and solutions upon them.

I planned She-Tribe during the first three weeks of my placement at Autism Services.
Although at this time I felt like I had nothing more to learn on the subject of females and ASD, I
soon recognized I did not know as much as I thought I did. I continued my learning journey and
immersed myself in the literature again and continued to learn from the population itself by
talking to women who live with a diagnosis of ASD. The lack of registration for She-Tribe
brought me face to face with the fact that I had erred in my judgement; but by this time, the
information regarding the day was already out there. My guilt and regret galvanized me into getting involved in public education as a form of advocacy for females diagnosed with autism spectrum disorder.

**Sharing is Caring: Education and Awareness**

In my venture to share the information I had gathered regarding females diagnosed with autism spectrum disorder, I created communication tools that described females with autism and how their symptomology differed from male symptomology. I realized this was where I needed to start and where I should have begun at the beginning of my practicum. I wanted to share the information regarding the differences between male and female ASD symptomology. For over 30 years, autism research and diagnostic tools have been based on the male phenotype and stereotypical symptoms as exhibited by males. There is a lack of female-specific knowledge, which leads to assumptions that males and females with ASD present symptomology in similar ways (Attwood et al., 2016). As suggested in Appendix A, which is a document entitled: *Gender-Specific Symptoms of Autism Spectrum Disorder*, there are several differing symptomologies between males and females diagnosed with ASD. I created a gender-specific brochure with female symptoms of ASD that the agency will distribute in the future to raise awareness of females on the spectrum. Along with the creation of this brochure, I also created a PowerPoint presentation representing the realities of females on the spectrum. Again – this information will be used by the agency at a later date that is appropriate for their ongoing programming and service delivery.

In order to distribute information on females diagnosed with ASD, my professional associate and I decided that I would host an information and awareness evening called Autism in Pink. This evening was well attended with approximately 40 people including parents and
professionals alike demonstrating that the immediate need is indeed information and knowledge. I presented the attendees with gender-specific information on female symptomology of ASD. I shared with the crowd the “aha” moments of my research regarding females diagnosed with ASD. Additionally, the brochure that I had created was distributed to the attendees. The comments and feedback gathered through the exit surveys completed by participants were overwhelmingly positive as many appreciated the much-needed acknowledgement of females. It was a great opportunity to start to acknowledge and share the differences between male and female symptomology of ASD. It is obvious to me by the number of attendees for the evening, as well as the numerous comments inviting more knowledge, that information regarding this population is lacking and welcome.

**Counselling**

Another opportunity that arose during my internship at Autism Services Saskatoon was to offer counselling (under clinical supervision) to individuals, couples, and families who had been diagnosed or impacted by ASD. The caseload I had was diverse, including individuals who had a diagnosis of ASD, parents of children with ASD, and siblings of those with ASD; which exposed me to multiple perspectives into the ways that ASD affects various individuals. The framework I used in counselling was strength-based therapy. The strength-based focuses on the client’s existing strengths (Padesky & Mooney, 2012). This is a positive approach, as typically the counselling support offered at Autism Services of Saskatoon is focused on adapting to autism spectrum disorder (ASD) as a lifelong condition that will always be present. It is irrational to focus on the symptoms and pathology when neither the patient nor service provider has any chance of eradicating them; therefore, focusing on the strengths and positives to improve resilience and coping is seen as being an effective approach for this population (Padesky &
Mooney, 2012). In my opinion, finding strengths in others is pertinent to others being their best. This resilience-building therapeutic approach was conducive to working with individuals, couples, and families receiving services at Autism Services of Saskatoon. Autism Services gave me a great opportunity to work with a population to which I had not previously had a lot of exposure.

**Home Visits**

Lastly, while I was completing my MSW student practicum at Autism Services of Saskatoon, I was able to attend home visits with clients of Autism Services. The purpose of these home visits was to check in with parents and clients to problem solve, validate, and provide any support that was necessary to ensure the success of the individuals and family units. I was able to participate in home visit intake meetings with families and individuals at the initial stage of them accessing services with the agency. These in-home intake meetings are the first interaction between potential clients and Autism Services with a two-fold goal of gathering information and goal-setting with the family, as well as sharing with the families and individuals information about the services they can access through Autism Services of Saskatoon.
Literature Review

The focus of this literature review was on examining the latest literature regarding girls and women diagnosed with autism spectrum disorder. Included in the review are the gender differences in autism, the rationalization for the vastly unbalanced ratio of males versus females diagnosed with ASD, and the comorbid diagnoses that often accompany a diagnosis of autism for females. Additionally, this section briefly discusses mothers diagnosed with autism spectrum disorder.

Researchers suggest that males are more commonly diagnosed than females at a ratio of four males to every one female (Bargiela, Steward, & Mandy, 2016; Dworzynski et. al, 2012; Haney, 2016; Lai et. al, 2012; Loomes, Hull & Mandy, 2017). This imbalanced ratio motivated me to do further research into females diagnosed with ASD. It was previously thought by researchers that males and females display the same or similar symptomology of autism spectrum disorder (Szalavitz, 2016). More recently, this myth has been proven wrong; in fact, much research suggests that males and females exhibit autistic tendencies in remarkably different ways (Braithwaite, 2018; Mandy, 2018; Szalavitz, 2016).

Gender Differences in Symptomology of Autism Spectrum Disorder

There are several differences in how males and females experience autism spectrum disorder. With the core diagnostic symptoms being the same, the difference lies in how these symptoms are exhibited. Both males and females exhibit the core symptoms including delays in their language and social communication as well as restrictive, repetitive patterns of behavior, interests, and activities. The difference is in how these symptoms manifest themselves and the degree and intensity of the symptoms (Szalavitz, 2016). A detailed description of gender symptom differences in autism can be found in Appendix A.
The Unbalanced Ratio: More Males than Females Diagnosed with Autism

Bargiela, Steward, and Mandy (2016) found that females often go without diagnosis or are misdiagnosed or mislabeled. The researchers also suggest that if females are diagnosed with ASD, it is not until later in life, as opposed to males who typically receive diagnosis before the age of six years. Scholarship on lack of diagnosis and misdiagnosis of females theorizes that girls are able to camouflage their symptoms (Bargiela et al., 2016; Braithwaite, 2018; Lai et al., 2012; Mandy, 2018). Camouflaging can be defined as the ability to cover up or mimic others to cope in social situations that are uncomfortable or unknown territory for the autism spectrum disorder population. The camouflaging and compensation displayed by females makes it difficult to recognize their symptoms of ASD, thus diagnosis is not made, resulting in females requiring a more intensified exhibit of autistic traits. Additionally, literature suggests that females are either being mislabeled or not being diagnosed with ASD in cases where they also exhibit symptoms of other mental health disorders. It is suggested that the symptoms of mental health challenges often overshadow the symptoms of ASD (Eaton, 2018).

Another theory explaining the high prevalence of males within the autism community is that current diagnostic tools and screenings are based on, and validated with, males (Bargiela et al., 2016). The tools have a male bias and lack gender sensitivity as they reflect male realities. There is a need for diagnostic measures that are gender-specific if there is to be a more accurate gender ratio in the ASD community. Braithwaite (2018) also suggested that society has systematically underreported the actual number of females on the spectrum. She believes that the different ways females and males are socialized has assisted in diagnostic criteria inadequately identifying females with ASD. As autism has previously been identified as more prevalent amongst men, females are unlikely to be considered for such a diagnosis. Lastly, as Mandy
(2018) described, there is both bias and a stigma about obtaining a diagnosis of ASD and professionals are biased against giving females a diagnosis of autism. This bias is based on the idea that ASD is seen as a male condition and that females can camouflage their symptoms in ways that males cannot. I have come to know through life experiences that there is, at times, a large misconception amongst society that those diagnosed with a disability are “less than” those without a disability. More specifically as it relates to females living with an ASD diagnosis, the stigma involves the idea that women diagnosed with autism spectrum disorder are not as capably able to mother a child as compared to women without the same diagnosis. Although there is absolutely no truth to this belief, there are people who believe this, unfortunately, reinforcing this stigma.

**Mothers Diagnosed with Autism Spectrum Disorder**

There are several online articles and self-disclosure blogs posted by mothers with autism describing their experiences in parenting their children. After scouring the literature, I was unable to find any qualitative or quantitative peer-reviewed research specifically addressing women with ASD as mothers. There are countless articles and bountiful information for mothers of children diagnosed with autism, but an obvious gap in scholarly information exists regarding women diagnosed with ASD who also have the title of mother.

The proportion of adults with autism who have children is unknown. Also unknown is how likely it is that a parent with autism will have children also on the spectrum (Deweerdt, 2017). There are “hidden pools” (Hill, 2017) of mothers who have remained undiagnosed who are now recognizing symptoms in themselves through researching the behavior of their own children. In researching the symptoms exhibited by their own children who have been diagnosed with ASD, mothers identify themselves as hosting similar symptoms. The mothers continue their
journey of seeking answers for their own symptoms, leading to the eventual diagnosis of ASD. Upon receiving a diagnosis of autism, mothers are often secretive about their condition (Hill, 2017). Mothers with ASD suggest they are often questioned and even investigated by Child Protective Services regarding the safety and well-being of their children based on the diagnosis of ASD (Hill, 2017). An ASD diagnosis is equated to an inability to protect and ensure the safety of their children (Pacton, 2016). These investigations are often not substantiated and are ultimately dismissed, but the damage from the humiliation and intrusion of going through a Child Protective Services’ investigation is already done. Mothers with autism admit to living in fear of authorities questioning them or even apprehending their children due to their condition (Hill, 2016, 2017).

An autobiographical account by a mother with ASD stated that if she had known she was on the autism spectrum, she might have contemplated not having children at all. Another mom admitted that she had one child prior to being diagnosed with ASD and chose not to have any more for fear of passing ASD to her children (Hayward, 1999; Hill, 2017). It is a sad and unfortunate reality that our society is not more accepting and supportive of mothers with ASD and their children. The fear of their child facing judgment and isolation greatly influences women’s decisions to bear children (Kim, 2014). It must be an extremely difficult decision for a female to base the life decision of having children on the fear of passing on ASD. Additionally, it is suggested that the lack of research and support of parents diagnosed with ASD interferes with their decision to become a parent. Due to the lack of knowledge and support and the fear of the judgment people with autism face, society may be ill-prepared for the wave of individuals diagnosed with autism who are entering their childbearing ages (Deweerdt, 2017).
Parents, not only mothers, who have received the diagnosis of autism spectrum disorder often describe a lack of support (Blakemore, 2015; Pacton, 2016). They feel isolated from not only other parents in general but also isolated from other parents with ASD. Online forums are often the only opportunity for parents with ASD to find the support of other parents also diagnosed with ASD. According to a parent diagnosed with ASD (Deweerdt, 2017), these online blogs and forums are often plagued by people who see ASD as a misfortune and comments often gush sympathy over the diagnosis. However, this parent goes on to describe that not all parents see ASD as a sympathy-inducing situation and instead embrace the diagnosis.

Sensory issues are often a symptom of autism spectrum disorder and mothers with ASD are no exception. As mothers, they often face sensory overload issues but are forced to ignore and overcome their own sensory overstimulation to ensure the needs of their children are met first and foremost (Deweerdt, 2017). Additionally, if a mother with ASD is parenting a child with ASD, there may be competing sensory needs between mother and child. For example, what comforts one, may overstimulate the other. An example of this is a mother having an aversion to touch while her child requires touch for sensory comfort. Mothers will fulfill their own sensory needs only after the sensory needs of their children with ASD have been met. The sensory input that a mother must endure is endless, including the crying baby, sensations of breastfeeding, the constant touch, and the barrage of questions a toddler can ask. This can be overwhelming for a neurotypical mother let alone a mother with the sensory sensitivities that accompany living with ASD.

Although there is very little data regarding this reality, teen pregnancy among females with ASD does occur. Snyder (2016), a contributing writer to the book, *Asperger’s and Girls*, found out later in life that she was indeed diagnosed with autism as a child but had not
previously been privy to the information. She disclosed in the book that she, like other female teens with ASD, had gotten pregnant at a young age. Being vulnerable, naive, and unaware of the inner workings of how a female was impregnated, she entered into a relationship in an attempt to fulfill a desperate void of someone to love and accept her. Females with ASD are vulnerable as they may be unaware of when males are sincere in their desire to be in a relationship.

Mothers on the autistic spectrum face interruption in their daily routine which, combined with ASD, may be incredibly overwhelming and lead to anxiety-induced meltdowns (Purple Ella, 2017). Executive functioning skills, defined as the cognitive procedures that enable individuals to plan and follow through with daily events, may be lacking in someone who has autism (Deweerdt, 2017; Sandham, 2017). When a woman has the job of motherhood, it is necessary to plan, organize, multitask, focus, and carry through with daily activities for herself and her family. These are all part of executive functioning skills that are challenging for someone on the spectrum, making parenting tasks difficult (Deweerdt, 2017). However, these executive functioning deficits can be met by establishing a rigid, repetitive schedule, as several people with autism have found to be helpful; and that is for others simply a symptom of their condition. Oftentimes, children find this rigid, repetitive, predictable schedule helpful as well.

There is also a group of mothers diagnosed with autism who are parenting children also diagnosed with autism spectrum disorder. Mothers with ASD parenting children diagnosed with ASD come with advantages. This population of mothers feels they have an increased awareness of their child because of the shared diagnosis (Rudy, 2019). Mothers diagnosed with ASD suggest they share similar needs and challenges with their children, adding to their understanding. Moms with ASD suggest neurotypical mothers would not have these experiences
to add to their understanding of their child’s diagnosis of ASD (Deweerdt, 2017; Hill, 2017; Rudy, 2019).

Lastly, mothers who are diagnosed with ASD acknowledge their complete exhaustion in having to pretend to be typical when facing a social situation (Deweerdt, 2017; Hayward, 1999; Sandham, 2017). Taking part in a socially interactive situation that requires great cognitive and emotional energy is difficult for people with ASD. As a result, participation in social interactions which are often tasks of mothers, such as parent-teacher conferences, mother and baby groups, and taking children to their group activities; is incredibly taxing on mothers with ASD. Additionally, mothers on the spectrum find teaching these social interaction skills to their children difficult. It is a daunting task to educate children about social interaction skills when the skill being taught is abstract or nonexistent in the mother attempting to teach it (Deweerdt, 2017).

With increased understanding of the female symptomology and better screening tools for females facing a diagnosis of autism spectrum disorder, there will be more reporting due to enhanced ability to screen and assess the number of girls with ASD, many of whom may go on to become mothers. The time to research, gain understanding, and provide resources to support mothers with ASD is now. It is crucial to gain an understanding of this population to create and offer better support networks. As social workers and other helping professionals, we have to be cognizant of what mothers with ASD face, and learn from them to gain understanding and knowledge. Additionally, we must not make assumptions or generalize that all persons diagnosed with ASD are the same. It is detrimental to this population to assume that how one mother is will define how all mothers on the spectrum are. Mothers with autism cannot be assumed to be unfit parents, lacking in parenting capacity or ability to provide for their children. Although there is a
lack of empirical research on the topic of mothers with ASD, the topic is vast, and more research is needed on the nature, prevalence, and manifestations, as well as how best to serve the large cohort of mothers on the spectrum who may currently be falling through the cracks. The large number of online support groups, messaging platforms, online comments, and blogs provide the proof of this extensive cohort of mothers diagnosed with ASD.
Feminism & Autism Spectrum Disorder in Females

What is Feminism?

Feminism can be defined as the belief that women should have equal rights to men in terms of social, political, and economic power (Reisenwitz, 2018). Cooke-Dicker (2008) defined feminism as the fight to end the oppression women face based on their sex, race, class, ability, age and sexual orientation. This author went on to suggest that feminism is a belief system that enables people to be the best versions of themselves through ending male domination. Feminist activism is the fight to overcome the inequality endured by women in both first and third-world countries (Friedman, Metelerkamp, & Posel, 1987; Reisenwitz, 2018).

There are four defined phases of modern feminism. The first phase of feminism occurred from the 1830s to the early 1900s and focused on women’s fight for equal contract and property rights. Women during this era realized they must gain political power, including the right to vote, in order to induce change in men’s and women’s equality (Cooke-Diker, 2008). The political itinerary of these women grew to include such issues as sexual, reproductive, and economic matters (Reisenwitz, 2018). And so, began the realization that women have the potential to contribute just as much as men, if not more.

The second phase of feminism occurred between the 1960s and 1980s. Following World War II, the second wave of feminism focused on women in the workplace and family, sexuality, and reproductive rights. One of the key contributions of the second wave of feminism, according to Cooke-Dicker (2008), was the denial of the traditional division of labor, where males were considered the breadwinners and women were homemakers. During this time, it was assumed that women had reached their goal of equality and the remaining feminist debates were often dismissed as “middle-class, white woman problems” (Reisenwitz, 2018). Equality continued to
be a goal during this second phase of feminism, specifically related to women in the labor force as well as women’s reproductive rights (Cooke-Dicker, 2008).

The third wave of feminism occurred from the 1990s to the 2000s. Cooke-Dicker (2008) suggested that the third wave of feminism continues to this day, with feminism having offshoots into various political and activist organizations. This wave focused on the different outlooks and alternate desires that feminists had. Thus, it was during this phase that several different feminist groups, each with their own ideologies and focus, evolved. Some of the different feminist groups are: liberal feminism, Marxist feminism, radical feminism, and socialist feminism, just to name a few (Friedman, Metelerkamp & Posel, 1987; Serra, 2015). The overarching work of this wave of feminism was a continuation of the work of the previous feminist movements. The fight continued to end inequalities between male and female wages as well as to address the reproductive rights of women. Local and international advocacy continued to end violence against women. This third wave of feminism continued to embrace advocacy for gender acceptance and to understand the true meaning of feminism (Reisenwitz, 2018).

The fourth wave of feminism began in approximately 2012 and continues today. This phase of feminism has largely embraced the internet, including social media sites, to create a constant connectivity (Chamberlain, 2017). This connectivity has women speaking out in record numbers and creates an even more concrete solidarity amongst women from countless nations. The World Wide Web has allowed women to band together in a way never before possible. The fourth wave of feminism continues the fight to overcome gender inequality, speaking up about sexual traumas against women, and advocating against discrimination (Chamberlain, 2017; Reisenwitz, 2018). Movements such as #MeToo can be considered a part of the fourth wave of
feminism. Feminism continues with passion, social influence, and power; demanding change for and about women.

There are several critiques of feminism as a whole, as well as critiques regarding individual feminism typologies. However, for the purpose of this report, I would like to focus on one particular critique, that being that feminism across all waves has focused on typical functioning females and has neglected women who have a disability (Serra, 2015). Serra (2015) wrote, “Women with disabilities are invisible to feminism and the strands is due to different social and cultural factors, which historically have awarded women with disability a vulnerable role within society” (p. 104). Although I recognize this critique and even agree with its connotation, the reality is that all women, in one way or another, have gained some rights and recognition through the fights and advocacy work of feminist movements over the years. Although women with disabilities may not have been a specific group that feminists fought on behalf of, there remain overarching benefits for all females, such as the right to vote. I absolutely believe that there is a long way to go to obtain equality and justice for those with disabilities; however, I also think it is unjust to suggest that women with disabilities have been invisible to feminism. With this in mind, I carry forth with feminism as my guiding theory in my work with females diagnosed with high-functioning autism.

**Feminism and Women Diagnosed with High-functioning ASD**

Reisenwitz, (2018) stated that feminism can be summed up by five core beliefs. These core beliefs include (1) sexism exists; (2) sexism against women is continuing, persistent, systemic, cross-cultural and deep-seated within society; (3) equal rights and opportunities should exist for men and women; (4) women are social and intellectual equals to men; and (5) women should be given recognition and treated equally to men. These core values underlie the lack of
recognize and the lack of understanding of females diagnosed with high-functioning autism spectrum disorder.

**Sexism exists.** Sexism can be defined as prejudice or discrimination based on one’s gender (Reisenwitz, 2018). The Autism Diagnostic Observation Schedule (ADOS) questionnaire, the preferred test used in diagnosing ASD, is sexist. This tool was designed by a male, based on male symptoms of ASD, and the research to ensure the quality of this assessment was also based on males. It is obvious that females were in no way considered when this tool was created. The unfortunate circumstance is that this is the tool that continues to be used as there is no gender-specific tool for diagnosing ASD. This tool is useful in diagnosing males; however, females will continue to be misdiagnosed or have a missed diagnosis because the ADOS is designed for males. Thus, several females will continue to go through life with questions, not knowing the answers because they are females. Additionally, due to the lack of diagnosed females, the research being conducted regarding autism is largely focused on males based on male symptoms. This is yet another display of sexism.

Sexism against women is ongoing, persistent, systemic, cross-cultural, and deep rooted (Reisenwitz, 2018). Autism can be found in all cultures and amongst all socio-economic levels. The unfortunate sexist reality faced by females diagnosed with autism exists. It exists across all cultures and amongst all socio-economic realities. The examples and situations described within this report will affect all females with ASD, regardless of their cultural background or socio-economic reality.

Society has a picture of girls being giggly, fun-loving, sometimes emotionally driven, social creatures. Women are thought of as an extension of these girls, with a love of nurturing also mixed in. There are specific feminine roles within society. What happens if these roles do
not define you as a girl or a woman because you do not fit into this societally created mold of a
girl or woman? What if one is the opposite of giggly and social and does not understand
emotions at all, is there something wrong? If so, do I tell anyone? These are examples of the
exact questions a female with ASD symptoms may face. Because of societal stigma and
construction of what girls and women are supposed to be like, many females camouflage their
symptoms, acting like someone they are not. It is unacceptable that a female cannot be proud of
who she is and act like who she really is out of fear of stepping outside the societal vision of
what is female. This vision of female, perpetuated by, for example, pop culture that shows
neurotypical females as the norm, continues to be heavily influenced by what men desire.

The misdiagnosis that females with ASD symptoms often face is also often due to the
reality that they are females. For example, imagine a middle-aged woman proclaiming to her
doctor that she just does not feel like herself and she is worried about facing social situations as
they are often distressing and confusing for her. This situation would possibly end in a diagnosis
of depression and anxiety, a prescription, and perhaps a conversation about premenopausal
options. According to the World Health Organization (2018), women experience depression,
anxiety, and somatic complaints at a rate three times higher than their male counterparts. This
statistic may also lend itself to the above scenario ending in a mental health diagnosis rather than
recognition of the woman’s underlying ASD symptoms. Being a female will affect the likelihood
that ASD is even considered as a diagnosis rather than depression and anxiety. In addition,
females are frequently under-diagnosed and under-recognized as having ASD stemming from the
initial definitions of autism when it was assumed that females could not have ASD.
Unfortunately, some professionals still believe this, adding to the misdiagnosis or missed
diagnosis of females with autism spectrum disorder.
Equal rights and opportunities should exist for men and women. Through my practicum experience at Autism Services of Saskatoon, it became apparent to me that females diagnosed with ASD not only want equality with males but they desire equality with neurotypical females. I heard stories from women diagnosed with ASD about their hardship in obtaining and maintaining employment. It was their belief that they were excluded and even let go from certain employment positions because of their symptoms of ASD. They spoke of occasions when they were passed over for employment or promotions because they were neurodiverse and later found out that the position was given to a neurotypical female. The women that I worked with acknowledged their desire to be treated and looked at as a typical girl, teen, or woman, and this story was repeatedly echoed in my work with these women as they desired equality with neurotypical counterparts.

After sending out invitations to various organizations for Autism in Pink, several respondents remarked that they were pleased to see that females diagnosed with ASD were finally being acknowledged. Several professionals who accepted the invitation to attend the evening stated they had a good knowledge base regarding males diagnosed with autism but had never even considered or heard of the gender differences between males and females with ASD. This is another example of the readily available information regarding males but not females.

Women are social and intellectual equals to men. This is the one belief that I would specifically choose to critique from the five core beliefs of feminism as described by Reisenwitz (2018). A symptomology associated with autism spectrum disorder is the struggle with socialization. This symptom is not contingent on gender, it is simply a stated reality of this disorder. Thus, trying to achieve social and intellectual equality may never make sense due to the diverse social and intellectual capabilities amongst those with ASD. I can fully understand and
support neurotypical women fighting for this value, but I would suggest that females with ASD are struggling to achieve equality with neurotypical females as well as with males. Therefore, perhaps a better way to state this feminist belief is to suggest acceptance of all intellectual and social abilities, despite their gender. It would be great to have an overall, general societal acceptance of all abilities and social stances.

**Women should be given recognition and treated as equals to men.** Feminism continues to fight for equality of females with males. In addition to this, I would hope that feminism would ensure that it recognizes females with diversity, including those diagnosed with autism spectrum disorder. Females with high-functioning autism offer a different perspective, which may greatly benefit the ongoing feminist activism. I believe it is critical that feminism include all types and diverse abilities of women. Feminists are not a white, middle-class, average ability-only group. It is important to be inclusive of the diverse groups that comprise the female gender. As women, we do not need to try to assimilate diversity to what we believe is female. Instead, we must widen, and accept diversity; or we are at risk of fighting amongst ourselves and activism may be in jeopardy of coming to a standstill.

I chose feminism, as opposed to other theories, to guide my work with females diagnosed with autism because I soon came to recognize that although all females are living in a male-influenced reality, females living with ASD have an added layer to cope with. The recognition of symptomology of ASD was initially done through a male dominated lens, making it difficult to define and recognize this condition in women. Additionally, the tools utilized to diagnose ASD have been exclusively created for males by males, often creating an environment for missed diagnoses or misdiagnosis. In the early days of autism, the disorder was thought of as an exclusively male disorder and there has been little research into females with this disorder until
recent times (Mills & Kenyon, 2013). Furthermore, Braithwaite (2018) suggests that the way in which females and males are socialized contributes to the assessment tool failures in detecting ASD amongst females. Females are taught to fit into social situations, blend in and act as others are acting; being blunt is a social blunder (Braithwaite, 2018). There have been stories of hurdles that females faced in accessing medical care to obtain a diagnosis as compared to the more timely diagnosis of males. Braithwaite (2018) described a mother fighting seven years for a diagnosis for her daughter when it took three years to get the diagnosis for her son. Her fight for her daughter took many twists and turns of misdiagnosis, misunderstandings, and mistreatments. The mother described her young daughter being refused care as doctors described their reluctance to diagnose her as they suspected, “she may grow out of it” or “she is so pretty” (Braithwaite, 2018). The mother described not being taken seriously about her concerns regarding her daughter; as a result, her daughter was not able to access supports in a timely manner. As a neurotypical female, I recognize power imbalance between males and females; it is even more difficult to fathom having those same gender disadvantages combined with the additional inequalities of having ASD. Women with disabilities often lack the opportunities of the mainstream society and are said to be the most marginalized population in society (United Nations General Assembly, 2000). Race, age, language, ethnicity, culture, religion, and disability are factors that often interfere with the female population gaining full equality with their male counterparts (United Nations General Assembly, 2000). Women with disabilities such as ASD face a twofold discrimination, that of their gender and of being an individual with a disability. Because of this discrimination and bias, women with disabilities often face added disadvantages compared to males with disabilities and women with no disabilities (United Nations, 2015). O’Reilly (2003) stated that men with disabilities are nearly twice as likely to be employed
compared to women with disabilities. This is just one example that illustrates the unequal and unjust distribution of power between men and women. It has been stated that the global literacy rate is 3% for adults with disabilities and as low as 1% for women with disabilities (United Nations, 2015). Lastly, women and girls with disabilities are said to experience increased rates of gender-based violence, exploitation, and sexual abuse as compared to women and girls without disabilities (United Nations, 2015).

Building on this field practicum, as I move forward in my career, I will continue to advocate and bring about recognition and support for women diagnosed with ASD. This population has been unacknowledged and ill-supported since the dawn of autism spectrum disorder and it is my goal to contribute to changing this.
Challenges

The learning and growth I gained while completing my field practicum at Autism Services of Saskatoon was incredible and rewarding. Just as with most things in life, what one gains is often accompanied by a string of challenges and struggles that one must overcome. My experience at Autism Services did bring about challenges, both at the organizational level, and for myself personally. It was the process of enduring and reflecting on the challenges that assisted in my learning. It was the contemplation of these challenges that offered me the most education and certainly added to my overall experience. These organizational and personal challenges are examined more explicitly in the following section.

Organizational Challenges

There are only a few organizational challenges that were apparent during my time at Autism Services of Saskatoon. These challenges arose due to the lack of resources that the non-profit sector often faces. Unfortunately, a limited budget and resources dictate the programming that Autism Services has the capacity to offer. There are limited grants and several organizations bidding for the same grants. This makes it difficult for staffed positions to be permanent rather than temporary, and to make waitlists manageable. Autism Services of Saskatoon is afflicted with a need to complete grant applications, with the reality of temporary employee contracts, and with long waiting lists that continue to grow because of the great work and programs offered to individuals and families. There are ripples that extend from these challenges: Are employees willing to continue to work in term positions? Are clients going to continue to wait for crucial services? Do the clients experience a negative backlash due to the waitlist? It is important to clarify that these examples are realities for all non-profit organizations and are not exclusive to Autism Services.
An additional challenge faced by Autism Services is other organizations’ beliefs that Autism Services is the only organization that can assist those diagnosed with ASD. For example, it was not uncommon for those diagnosed with ASD to be refused counselling services by other agencies and to be sent to Autism Services for counselling. As Autism Services specializes in this specific population, other organizations believed they could not provide the necessary support because of this diagnosis. This not only adds to the waitlist at Autism Services, but it also reinforces a stigma and idea that those with autism cannot be supported in the same way as a neurotypical individual. It reinforces the belief that autism is a defect; a deficit that cannot be supported by an organization not specializing in the disorder. Additionally, these organizations overlook the fact that mental health conditions can co-exist with a diagnosis of autism spectrum disorder and the individuals could benefit from other supports and services. Many organizations ignore the mental health needs of this population even though they often far outweigh the autism symptoms. The assumption is that the symptomology of autism obscures other needs, and a denial of service based on this diagnosis is the end result.

Another challenge faced by Autism Services is the limited age criteria of those who can access the organization’s services. For example, Autism Services can only provide occupational and speech therapy to those under the age of five. After that age, it is the responsibility of the school or privately funded therapists to provide the required therapy. Again, this limitation is due to the tight resources available to Autism Services. There are individuals who are unfortunately receiving little to no support because of the age restrictions under which Autism Services operates due to the lack of resources to offer additional support.

An occasional challenge faced by Autism Services of Saskatoon is the cancelling of therapeutic groups because of the lack of registrations and interest in the offered group. The
groups that are offered at Autism Services require a minimum number of participants in order for the group to be viable. If this minimal number of participants is not met, the group will be postponed or cancelled until numbers increase. This is a frustration for both the employees facilitating the program and the participants who did indeed register for the cancelled program.

I also faced personal challenges in completing my field practicum at Autism Services. Some of these challenges revolved around females specifically diagnosed with ASD. Other challenges involved my level of comfort and limited exposure and knowledge regarding those diagnosed with autism spectrum disorder. I look at my personal challenges in more depth below.

**Personal Challenges**

I encountered an array of challenges throughout my field practicum. Some of these challenges seemed huge and others minute, but overall these challenges assisted in my learning, lending a critical thinking lens as well as an analytical framework for increased understanding of myself and the field placement. The largest and perhaps most obvious challenge I faced was the reality that there were no registrations for the She-Tribe retreat that I had spent the majority of the first half of my practicum planning and organizing. At one time, it seemed disheartening and deflating that the work, sweat, and tears that went into planning this event was all for naught. I had spent hours preparing surveys, coming up with the perfect activities for the day, and booking a venue that I thought would be perfect for such an exciting day long retreat. However, what I originally thought was a horrible, misguided, uninformed, assumption-ridden mistake was actually not a mistake at all. In fact, looking back, I gained more understanding because of She-Tribe not occurring than I ever would have otherwise. I needed to understand why. Where did I go wrong? What needed to be different? It was in reflecting on these questions that I recognized what needed to be altered for future endeavors and no longer having She-Tribe as the focus of
my work allowed me to see a larger picture. I was able to explore the literature and talk to women diagnosed with ASD, gaining insight all the way along. Looking back, although the She-Tribe program did not proceed as planned, it was no longer the challenge I initially thought it was but rather just the opposite. It provided the motivation to take a different direction entirely due to self-reflection and the further literature review I undertook to understand the demise of She-Tribe.

In addition to my errors and oversights in planning She-Tribe, in hindsight, I did not know what I thought I knew when I was in the depths of planning this event. Although I had hours reading the literature and made several discoveries in reading about females diagnosed with ASD, it was not until I made a deep dive into the literature available on this phenomenon that I really grew. I began devoting much of my days and evenings to truly understanding the reality, reading all that I could, watching videos and real exposés into the lives of women diagnosed with ASD. My family would listen to me go on and on while all along I could tell they were thinking, “Enough already, Mom. Can we talk about something else?” It became much of what I would think and talk about and share with all who would listen. I needed to know more and, once I learned more, I asked myself more questions about females diagnosed with ASD. I am by no means an expert on this topic, but I desire to keep learning about it, and I believe that there will always be more questions to be answered.

Another challenge that I encountered when planning the She-Tribe retreat was that I was reliant on other professionals to advertise and get the word out about She-Tribe. I did not have a client base to shoulder-tap to suggest their participation nor is there a group that exists in Saskatoon to advertise such an event. I asked those who are on the front lines of diagnosing women to advertise and refer potential and interested participants. I am unsure of the beliefs and
understanding of these professionals regarding such an event. I do not believe this was the reason for the demise of She-Tribe, but I will always wonder if they followed through on advertising or shoulder-tapping their clients.

It was also a challenge to be uninformed about the data regarding the community of women aged 18+ diagnosed with autism spectrum disorder. Perhaps Saskatoon does not have a population that meets the criteria as set out in the planning of She-Tribe. The data regarding the number of women with ASD in Saskatoon, Saskatchewan, or Canada does not exist and the lack of information does not lend well to planning an event for such a targeted population. I found that out by trial and error.

Another overarching challenge for me was the reality that females diagnosed with autism spectrum disorder have gone for over 30 years without recognition that their needs, symptoms, and realities are different from those of males with the same diagnosis. It is difficult for me to wrap my head around why it took decades to notice and begin to pay attention to females diagnosed with ASD. It is difficult to understand why females were not given the appropriate recognition through study and research until just recently. Males and females are different, so why would we expect them to exhibit similar symptomology of ASD. It is heartbreaking to think of the unrecognized females who went through life with these symptoms, knowing they were different but not being given a proper explanation. These women were not supported and, in some cases, were even treated for an inappropriate diagnosis, which they may or may not have had. It is unfortunate that up until recently the research that did exist regarding autism was based on adolescent males and how they exhibited the symptomology of ASD.

It is equally unfortunate that the diagnostic tools currently being used to diagnose ASD are based on symptoms shown by males with ASD. Although there is a screening tool for ASD
being developed based on the symptomology exhibited by females, there is yet to be a diagnostic tool specific for females. These are challenges that I faced in working with females diagnosed with autism spectrum disorder and will continue to contemplate in moving forward with my work with this population.

In addition to these challenges was a personal challenge related to the skill set needed to provide counselling support to those diagnosed with ASD. As a school counsellor, I feel versed in performing the counselling role with a younger population between the ages of 6 and 14 years, along with their families. A different skill set is necessary to provide counselling support to people diagnosed with ASD and a comorbid mental health condition. There are social skill interruptions as well as social connotations that are unconsciously used in a therapeutic session that this population may not be inherently aware of. In addition, the black and white, rigid thinking demonstrated by many diagnosed with autism took some getting used to. One must say what one means, and mean what one says, and avoid any jargon or gestures that a neurotypical individual might be able to understand. A person diagnosed with autism may not understand, leading to misunderstandings or even a rupture in the therapeutic relationship.

In the school setting, it is our practice to chase those not attending school or not following through on a required task so, in my time at Autism Services, I found myself reaching out and following up clients who did not attend appointments. This was not the typical practice at Autism Services as clients come on a voluntary basis and have asked for the services. It would require a great amount of time to chase clients, taking time away from those who indeed want services. I believe that I fell into the patterns of my experience in my regular workplace in a desire to offer and reoffer opportunities for support to clients. However, I was reminded that there is a waiting list for services and we must provide services to all in a timely manner.
Upon beginning my field practicum, there was systemic concern that my field supervisor (referred to as a professional associate) was from a different discipline than me. Although the psychology and social work disciplines have different beliefs and even alternate focuses, having a field supervisor with a background and training in psychology did not in any way hinder or interfere with my experience. I would suggest that working with a supervisor from a different field added to my knowledge and allowed me to look at alternative perspectives that I might not have contemplated had I worked under another social worker. While I received specific social work context from ongoing consultation with my academic supervisor, who is a social worker; I believe that my field supervisor and I were able to complement each other and promote growth in each other that might not have otherwise occurred. Despite our differing educational backgrounds, we were both dedicated to helping others and this was our shared goal.
**Ethical Considerations**

During my field practicum at Autism Services of Saskatoon, I upheld the Canadian Association of Social Workers’ Code of Ethics (2005). I fully respected each person to the fullest and was non-judgmental and accepting of all people. I did all that I could to ensure that each person I came into contact with, clients and colleagues alike, knew they were important and valued. I embraced and respected the diversity of the client population I served. I do not know what it is like to have a diagnosis of autism; therefore, I would never pretend to have an abundance of knowledge regarding the experience. I can study the literature, watch videos, and ask questions, but this will never allow me the full understanding of the lived experience.

I believe that I have brought attention to the injustice and discrimination faced by females diagnosed with ASD. For over 30 years, females have been looked at the same as males in the symptomology of ASD. I have created a conversation and brought attention to an issue that has long gone unrecognized. I initiated interest and awareness amongst my colleagues who attended Autism in Pink as well as the staff of Autism Services. Upon the completion of my field practicum, I was told that there was a continued and sustained interest among the staff of Autism Services regarding the research and presentation that I had done. As a social worker, one always wants to instill change and ensure social justice and it is gratifying to know that I upheld this social value through the pursuit of acknowledgement and supports for females with ASD and by advocating for further supports for others who use the services of Autism Services of Saskatoon.

As a professional, I have and will continue to ensure the needs of my clients are considered first and foremost, and do everything I can to meet those needs in a just manner. Additionally, I am an honest and reliable professional and I ensure appropriate professional boundaries in my work. I am committed to the responsibilities and ethical commitments of being
a social worker and adhere to them consistently, educating other professionals with whom I work in interdisciplinary teams and settings including Autism Services of Saskatoon where I interned and the school board where I work.

It is critical to ensure that client confidentiality is upheld and respected. At Autism Services, it is very clear both verbally and in writing that there are only three occasions when confidentiality will be broken: learning that someone is a risk to themselves or others, if subpoenaed by a court of law and, finally, if there is suspicion of child abuse. This is an ethical practice and I upheld the confidentiality of clients as well as employees at Autism Services. Additionally, as a practicum student, it was always the voluntary choice of the client to refuse my presence for any of the sessions or appointments at Autism Services. Every client was asked if I could be a part of their session prior to my involvement. This is necessary to allow clients the utmost confidentiality and respect for their dignity. Lastly, throughout my practicum, I attempted to gain more knowledge through examining the literature, videos, observation, and asking questions. This was done to ensure that I had an understanding and baseline knowledge of the clients to ensure I was offering the best possible service.

There were very few ethical dilemmas that I faced while completing my field practicum. In one instance, there was a possibility that a particular client might encounter me upon my return to my position as school counsellor. In a timely manner, I spoke with my supervisor and together we agreed that I would immediately disclose to the client my other job and allow the client the choice of whether or not they wanted to continue to work with me. I disclosed my other job to the client and offered to no longer be a part of his sessions if he was uncomfortable with my presence in any way. I wanted to ensure he was respected through my honesty and
transparency and the client was allowed the voluntary opportunity to refuse my presence. In this case, the client was completely comfortable, and I continued to offer services to the client.

In a second incident, a staff member was understandably upset with a school over a previous effort to advocate for the needs of a client. In her frustration, the staff member stated that schools should be forced to offer one-on-one support to children with ASD who are attending school. As a school employee, I experienced an instant trigger response. This trigger may be defined as transference. Looking back on this experience, I am not proud to say it, but, I wanted her to see things through my lens; I wanted her to understand the reality of working within the world of the school system. I vocalized that her expectation was not a reality for schools nor would every child diagnosed with ASD desire or need one-on-one support. In the end, we agreed to disagree and moved on. If I had not experienced the reality of working within a school and the constraints under which they work and serve children, perhaps I would have agreed with her. However, I do have the experience, exposure, and understanding of the schools which gave me a broader perspective regarding her expectations.

Overall, I found Autism Services to have good ethical practices. From informed consent to having separate team meetings to ensure client confidentiality, this organization upholds the CASW Social Work Code of Ethics (2005) in its policies, and practices.
Conclusion

Looking back on my field practicum experience, I foresee a need for further work that builds on this practicum and further exploration of this topic.

Future Directions

There are aspects of the topic of females diagnosed with high-functioning autism spectrum disorder that I believe require further consideration. Obtaining a diagnosis for these individuals is a long, grueling, expensive process. Often adult women are forced to pay for diagnostic services because the waiting list for government-funded services is frustratingly long. In addition, obtaining a diagnosis can be a difficult task given the lack of knowledge and experience our society has with this population. Society needs to take notice and respect the diversity of our population. There is an inordinate amount of time spent trying to assimilate diverse people into behaving in a certain way. This behavior is often associated with what we think is acceptable and normal rather than understanding and accepting who people are and what support is needed to ensure that they have the best life possible.

Research regarding females diagnosed with ASD is sparse. Slowly, there are gains being made with respect to research focused on the different gender-specific symptoms of ASD. However, there needs to be additional research completed regarding females diagnosed with ASD in regard to specific female roles, such as motherhood and pregnancy.

In addition to this research, a focus on developing gender-specific assessment tools for ASD is crucial to ensuring that no female goes misdiagnosed or endures a missed diagnosis. Marshall (2014) stated that females want to know what makes them different from others and, upon gaining this information, the accompanying understanding is comforting (Marshall, 2014). It is imperative that a female-specific, evidence-informed diagnostic tool be created that would
be effective in diagnosing ASD in females. As previously mentioned, there is a new female ASD screening tool; however, this is not used for diagnostics. Once a diagnostic tool is created and women are diagnosed, it will be easier to provide the necessary supports to ensure their mental health and well-being; as we know depression, anxiety, and suicide rates are higher amongst those with ASD (Botha, 2016).

**Personal Future Directions**

Returning to my work as a school counsellor after having completed this practicum placement, I am exponentially more informed about autism, specifically females diagnosed with ASD or those exhibiting symptoms of ASD. I will inform others of the reality that females face and assist others in recognizing the symptoms in hopes that we can change current practices regarding persons with autism spectrum disorder (ASD).

My field practicum experience at Autism Service of Saskatoon was more than I could have hoped for. This opportunity sparked a new passion and desire to bring light and acknowledgement to a population that has never before had the attention it deserved. In this case, male dominance has overshadowed a reality for females with ASD who have gone without recognition or support for over 30 years. Now is the time for change to occur; females matter and I am going to work to ensure this topic is never again buried under the depths of patriarchy and male dominance and this work is being undertaken through an initiative that I have developed: my #SheCantBeAutistic project.
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## Appendix A

### Gender Specific Symptoms of Autism Spectrum Disorder

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
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<tbody>
<tr>
<td>Less societal pressure to ‘fit in’</td>
<td>More likely to mask symptoms, camouflage to meet societal pressures to be social</td>
</tr>
<tr>
<td>Increased social difficulties</td>
<td>Able to socialize, hold short conversations, appear to have ability to ‘fit in’</td>
</tr>
<tr>
<td>Lack of eye contact</td>
<td>Observe and imitate to ‘fit in’ during social scenarios</td>
</tr>
<tr>
<td>Described as ‘odd’</td>
<td>More or too much eye contact</td>
</tr>
<tr>
<td>Externalizing behaviors to cope with anger, stress, and frustration</td>
<td>Internalizing behaviors contributing to anxiety and depressive episodes</td>
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<tr>
<td>Directly obsessive with people</td>
<td>Indirectly, passive-aggressively obsessed with people</td>
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<tr>
<td>More language difficulties</td>
<td>Tend to have superior language skills</td>
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<tr>
<td>More noticeable repetitive movements</td>
<td>Less repetitious behaviors often to blame for misdiagnosis or missed diagnosis</td>
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<tr>
<td>Specific, special interests differ from others in peer age range</td>
<td>Specific interests similar to peers, increased intensity of interest is concern</td>
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<tr>
<td>Less imaginative play</td>
<td>More imaginative play, often difficulty identifying reality and fantasy</td>
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<tr>
<td>May act out to avoid demands</td>
<td>Avoid demands by passively avoiding them</td>
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<tr>
<td>May be loud and interruptive</td>
<td>Hyper empathetic</td>
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<tr>
<td>Monotone, robot-like voice</td>
<td>Described as too quiet, shy</td>
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<tr>
<td>More likely to have comorbid diagnosis of ADHD</td>
<td>High pitched, childish voice</td>
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<tr>
<td>Engage in challenging behaviors to obtain objects</td>
<td>May be described as daydreaming as opposed to attentional difficulties</td>
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<tr>
<td>Collects information on objects</td>
<td>Gaining attention is the focus of challenging behaviors</td>
</tr>
<tr>
<td>Interest in factual books</td>
<td>Collects information on people</td>
</tr>
<tr>
<td></td>
<td>Interest in fantasy and fiction to escape reality and form imaginary friendships</td>
</tr>
</tbody>
</table>

* Adapted from *I am aspiengirl* by T. Marshall (2014, p. 146-150). This is a general and not extensive summary. Symptoms will vary according to age and intellectual ability.