

SPECIAL CONSIDERATIONS IN CHILD CUSTODY EVALUATIONS FOR CHILDREN WITH HIGH-FUNCTIONING AUTISM SPECTRUM DISORDER

with Foreword by Sol R. Rappaport, Cecily Kanter, and Kara Anast

Asperger's Disorder, which now is subsumed under Autism Spectrum Disorder (ASD) in the *DSM-5*, is increasingly being identified in children and adolescents. As a result, professionals in family law courts will have more exposure to children with ASD. However, there are limited guidelines and few published studies directing how family court professionals should take into account the unique needs of these families. This article will provide the reader with an understanding of high-functioning ASD, the impact it has on the family, and comorbid issues. This article provides specific suggestions for how evaluators should assess families when a child has ASD and will provide guidance for attorneys and judges.

Keypoints for the Family Court Community:

- The rate of autism has increased in recent decades leading to more children with autism being involved with family court professionals.
- Attorneys, judges, and mental health professionals working in family court need to understand high-functioning autism and its impact on children, parents, and their families.
- Families with children with high-functioning autism require custom-made parenting plans that address the unique needs of the child.
- In developing parenting plans, family court professionals need to consider comorbid disorders when dealing with children and adolescents with autism.
- Family court professionals should have additional training and expertise when working with families where a child has high-functioning autism.
- When families of children with autism are involved in family court, they present a broad range of unique factors which impact educational issues, parenting plans, decision making, treatment, and the entire family system.

Keywords: *Asperger's Disorder; Assessment; Autism Spectrum Disorder; Child Custody Evaluation; Children of Divorce; Divorce; and Family Court.*

INTRODUCTION

Professionals involved in the legal system are increasingly coming into contact with families where a child has an autism spectrum disorder (ASD). With the increase in incidence of autism, (Centers for Disease Control and Prevention [CDC], 2015, August; Fombonne, 2003) lawyers, judges, and mental health professionals involved in the legal system should have a good understanding of this disorder and its impact on families. Children with ASD who are high functioning (previously diagnosed as Asperger's disorder [AD]) present unique challenges for those in family court (Birnbaum, Lach, Saposnek, & MacCulloch, 2012; Jennings, 2005). The level of functioning and needs of children with ASD who do not have intellectual or language impairments are significantly different from those on the lower end of the spectrum, or what historically has been referred to as autism. Their needs are also different from neurotypical children. This knowledge can directly impact recommendations and decisions made about families where a child/adolescent has high-functioning ASD. Without this knowledge, evaluators may misinterpret a child's or parent's behavior leading to

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untrustworthy conclusions and recommendations. Attorneys may not have the knowledge and data to guide their clients toward an appropriate settlement or conduct a proper direct or cross-examination, and judges may make decisions that may not be in the best interests of the children without a greater understanding of this disorder and its impact on families.

The purpose of this article is fivefold. The first goal is to describe children and adolescents with high-functioning ASD and discuss the impact of AD's recent removal from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*; American Psychiatric Association [APA], 2013). The second goal is to discuss the impact of a child having high-functioning ASD on the family and its functioning. Third, we address issues of comorbidity and the importance of understanding that many children with ASD also have other psychological/psychiatric issues. Fourth, we describe the manner in which parents of children/adolescents with high-functioning ASD may appear different than other parents in the divorce process. Finally, we address unique factors that evaluators, attorneys, and judges should consider as a part of the child custody evaluation process and parenting plan recommendations specific to families where a child has high-functioning ASD.¹

AD, ASD, AND HIGH-FUNCTIONING AUTISM. WHAT ARE THE DIFFERENCES?

Until 2013, AD fell under the category of pervasive developmental disorders in the *DSM-IV-TR* (APA, 2000). Pervasive developmental disorders are described as pervasive and severe impairment in several areas, including "reciprocal social interaction skills, communication skills, or stereotyped behaviors, activities, and interests" (APA, 2000, p. 69). Now the *DSM-5* (APA, 2013) directs that "individuals with well-established *DSM-IV* diagnosis of autism disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder" (p. 51). However, people who were not previously diagnosed as having AD may not meet the new criteria.

The *DSM-5* criteria are more stringent than the *DSM-IV-TR* criteria, which explains why some children will not be able to obtain a diagnosis of ASD even though they would have met the criteria for AD in the *DSM-IV-TR*. This had led some to believe that many people on the high end of the spectrum will not be diagnosed with autism under the *DSM-5* even though they meet the criteria using the *DSM-IV-TR* (Maenner et al., 2014). Maenner et al. (2014) found that approximately 80% of children who meet the criteria for an ASD under *DSM-IV-TR* also meet the criteria for the *DSM-5*. Obviously, approximately 20% do not. Jabr (2012) reports that several recent studies suggest that it will be more difficult for undiagnosed people with high-functioning autism to obtain a diagnosis of ASD due to the stringent requirements in the *DSM-5*. For example, he cites the work of Mattila (2011, cited in Jabr, 2012) who found that of 26 eight-year-olds with an IQ of 50 or higher who met criteria for ASD in *DSM-IV* only 12 qualified under *DSM-5*. However, if the threshold for ASD was lowered to require only two instead of three symptoms in the social interaction and communication group, 25 of the 26 qualified. Frazier et al. (2012) and Mandy, Charman, and Skuse (2012) also found the *DSM-5* to be more restrictive than *DSM-IV-TR*. As a result, disputes may arise in family court between parents and professionals about whether a child has ASD.

According to *DSM-5*, ASD is characterized by "persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communication behaviors, and skills in developing, maintaining and understanding relationships" (APA, 2013, p. 31). Additionally, to fit the diagnosis the person should manifest restricted and repetitive patterns of activities, behaviors, and interests (APA, 2013). AD, or high-functioning autism, now encapsulated by the diagnosis of ASD, can be distinguished from traditional views of autism by addressing language issues. The language delay found in autism is not found in high-functioning ASD, as children with high-functioning ASD reach their language development in a timely manner (Baron-Cohen & Hammer, 1997). In AD, the impairment in communication may include a delay in or complete lack of spoken language (APA, 2000). In ASD there were often associated cognitive impairments but in AD (high-functioning ASD) there are not significant delays in the acquisition of language and cognitive abilities typically fall into the normal range (APA, 2000). Because social,

communication, and repetitive difficulties are found in both disorders, they are commonly referred to as being a part of a spectrum or continuum, with AD/high-functioning ASD on the end closer to normal functioning (Baron-Cohen & Hammer, 1997). Children with high-functioning ASD and classic autism tend to have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age (CDC, 2015, February). In addition, children with each of these disorders may be overly dependent on routines, highly sensitive to changes in their environment, and/or intensely focused on inappropriate items (CDC, 2015, February). The symptoms of people with ASD will fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms.

RATES OF ASD AND DIVORCE

ASDs are on the rise (CDC, 2015, August; Fombonne, 2003). The CDC (2015, August) first reported in 2007 that about 1 in 150 children had ASD (based on 2002 data from 14 communities). In 2009, it was reported that 1 in 110 children had ASD (based on 2006 data from 11 communities). In 2012, the CDC (2015, August) reported that 1 in 88 children had ASD (based on 2008 data from 14 communities). The estimated prevalence of ASD has increased roughly 29% since 2008, 64% since 2006, and 123% since 2002. As a result, it will likely become more prevalent in family court cases than in the past.

Currently, the CDC (2015) estimates that 14.7 per 1,000 children age 8 have been identified with ASD. This equates to 1 in 68 children (CDC, 2015). There are significant gender differences in the rate of ASD and high-functioning ASD, with the latter being a subset of people with ASD. Estimates are that there is a 4:1 or 5:1 male:female sex ratio in classic autism (Rutter, 1978, cited in Baron-Cohen & Hammer, 1997). In high-functioning autism the sex ratio is even higher, favoring males (Baron-Cohen & Hammer, 1997). The rate may be as high as 9:1 (Barlow & Wolf, cited in Wing, 1981) but a recent study by the CDC found it to be approximately 5:1 (CDC, 2015).

There is an ongoing debate over the divorce rate among parents of children with a disability. Weiner (as cited in Sobsey, 2004) stated that the divorce rate for families with a disabled child is 70%. However, other research does not support this statistic. Seltzer, Greenberg, Floyd, Pettee, and Hong (2001) followed 7,000 Wisconsin high school graduates over time and found no difference in divorce rates for parents of children with disabilities than from all other parents. Only a few studies have assessed the divorce rate of parents with a child with autism. Hartley et al. (2010), using a sample size of 391 parents of children with ASD and a matched representative sample of parents of children without disabilities, found that parents of children with ASD had a higher rate of divorce. Parents of a child with ASD divorced at a rate of 23.5% versus 13.8% for the comparison group. The rate of divorce for parents of a child with ASD remains high throughout childhood and into early adulthood, while the rate of divorce for parents with children without ASD decreased after around age 8. Hartley et al. (2010) also found that younger mothers who had a child with ASD and had other children born before their child with ASD were predictive of divorce. According to Hartley, parents appear to be at greatest risk of divorce during the first 8 years of their child's life if they have a child with ASD. Other differences, such as younger maternal age when the child was born and having the child born later in the birth order were also predictive of divorce. Freedman, Kald, Zablotzky, and Stuart (2011), using data from the 2007 National Survey of Children's Health, found that there were no significant differences in the rate of divorce of parents of children with diagnosis of ASD. Thus, there are conflicting data as to whether there is a higher divorce rate among parents whose child or children have autism. Regardless, with the increasing rate of ASD in American society, there will inevitably be an increase in family law cases in which a child has ASD.

ASD AND COMORBIDITY

Children with ASD may have other psychiatric difficulties as well (Kuusikko-Gauffin et al, 2008; Mazzone, Ruta, & Reale, 2012). Ghaziuddin, Weidmer-Mikhail, and Ghaziuddin (1998) found that

65% of their subjects with autism also had a history of psychiatric illness at the time of the study and 2 years later. Mazzone et al. (2012) summarized a variety of studies and suggested that the rate of mental disorders among people with ASD is over 70%. The *DSM-5* states that “about 70% of individuals with autism spectrum disorder may have one comorbid mental disorder, and 40% may have two or more comorbid mental disorders” (APA, 2013, p. 58). Those involved in the family court system should understand comorbidity in order to properly develop parenting plans for families. Evaluators, attorneys, and judges need to be able to differentiate which problematic behaviors are a function of high-functioning autism versus a comorbid diagnosis. This analysis is critical to developing a parenting plan that meets the needs of the child at issue. Professionals in family court may need to weigh whether to focus more on features of autism or comorbid issues when developing parenting plans and be able to articulate the reasons for their decision.

It is not easy to detect and recognize another psychiatric comorbidity as a result of it being masked by the autistic symptoms (Mazzone et al., 2012). Many children with high-functioning ASD may have other psychiatric difficulties that are often attributed to the ASD rather than recognizing it is a separate disorder, such as obsessive-compulsive disorder (OCD). This makes it difficult to make a decision about the appropriate diagnosis and treatment strategies (Mazzone et al., 2012). Individuals with high-functioning ASD can display difficulties in processing and explaining their feelings and emotions. As a result, the information obtained to diagnose these individuals is often provided by family members and other professionals working with the individuals (Mazzone et al., 2012). Mazzone et al. (2012) states,

In the clinical practice, various psychometric instruments, such as clinical interviews, self-report questionnaires and checklists, are widely used to assist in the diagnosis and they constitute a valuable support for clinicians. However, these diagnostic tools have been designed and standardized to spot different clusters of psychopathological symptoms referring to the general population and they may not be appropriate to ASD.

Psychiatric disorders associated with ASD can be broken up into three groups: internalizing disorders (depression, OCD, and anxiety), externalizing disorders (attention deficit/hyperactivity disorder [ADHD], disruptive behavior, and conduct disorder), and tic disorders and other disorders such as Tourette’s syndrome and schizophrenia (Mazzone et al., 2012). Depression is frequently seen in people with high-functioning ASD and this may be the result of difficulties coping and the social stigma associated with autism (Ghaziuddin et al., 1998; Mattila et al., 2010; Mazzone et al., 2012). Mazzone et al. (2012) found that estimates of depression range from 17% to as high as 70%. People with high-functioning ASD often have more difficulties with social anxiety when compared to healthy control individuals (Kuusikko-Gauffin et al., 2008). Kuusikko-Gauffin et al. (2008) found this to be true even in the situation in which the symptoms of the social anxiety were clinically intersecting with the social problems characteristic of a typical person with high-functioning ASD. Kuusikko-Gauffin et al. (2008) reported that 57.1% of adolescents with high-functioning ASD exceeded the cutoff on a self-report measure regarding anxiety. Lugnegård, Hallerback, and Gillberg (2011) found that comorbid anxiety disorders were found in 56% of people with high-functioning ASD. Matilla et al. (2010) found that 56% of children and adolescents in their study also had an anxiety disorder.

OCD is a particularly difficult disorder to discriminate as a result of many symptoms overlapping with the high-functioning ASD symptoms. Ruta, Mugno, D’Arrigo, Vitiello, and Mazzone (2010) found that children with high-functioning ASD showed higher regularities of compulsive hoarding, repeating, and ordering when compared to the typically developing children and children with OCD. The children with OCD showed significantly higher frequencies of contamination and aggressive obsessions and checking compulsions when compared to the typical children and children with ASD (Ruta et al., 2010). Mazzone et al. (2012) found that people with high-functioning ASD are likely to have similar frequencies of obsessive compulsive symptoms as people with OCD but that children with high-functioning ASD report more compulsions and obsessions than typical children.

There are also higher rates of externalizing problems among children with high-functioning ASD (Mazzone et al., 2012). According to *DSM-IV-TR* criteria, a child who is diagnosed with AD cannot

also be diagnosed as having ADHD (APA, 2000). However, *DSM-5* considers ADHD as one of the possible comorbid disorders under the criteria for ASD. The *DSM-5* (APA, 2013) states:

Individuals with ADHD and those with autism spectrum disorder exhibit inattention, social dysfunction, and difficult-to-manage behavior. The social dysfunction and peer rejection seen in individuals with ADHD must be distinguished from the social disengagement, isolation, and indifference to facial and tonal communication cues seen in individuals with autism spectrum disorder. Children with autism spectrum disorder may dysregulate, or exhibit what some people refer to as tantrums, due to an inability to tolerate a change from their expected course of events. In contrast, children with ADHD may misbehave or have a tantrum during a major transition because of impulsivity or poor self-control (p. 64).

Some studies estimate that approximately 28% of children with ASD also have ADHD while others suggest that rates may be much higher (Mazzone et al., 2012). Matilla et al. (2010) found that 50% of children and adolescents with high-functioning ASD also had a comorbid behavior disorder. Thus, when working with families in which a child has ASD, it is important to recognize that conduct problems may be a separate issue from the ASD.

Tourette's syndrome is also commonly found in school-aged children with high-functioning ASD. Studies suggest that 20% of children with high-functioning ASD also have Tourette's syndrome (Ehlers & Gillberg, 1993). Mattila et al. (2010) found that 14% of children with high-functioning ASD also had Tourette's syndrome and that there was an overall rate of tic disorders (which includes Tourette's) of 38%. For many years, autism had been considered an early diagnosis for psychosis (Mazzone et al., 2012). There are not many studies completed exploring the connection between autism and psychosis (Mazzone et al., 2012). Systematic studies of schizophrenia in children have found high rates of childhood-onset schizophrenia being preceded by or comorbid with ASD (Dvir & Frazier, 2011).

Comorbid disorders are not the exception with high-functioning ASD but rather a common feature. There may also be multiple comorbid psychiatric disorders, thus making assessment and treatment more difficult for a child with ASD. This may lead to complications for assessments in family court settings as well. These children often need a variety of support services and assessments, which at times may need to occur while conflict is heightened during litigation. Parents as well as professionals need to understand that some difficulties experienced by children and adolescents with ASD are not solely a function of ASD, but may be a function of another disorder.

Family court professionals need to be able to develop/recommend a parenting plan that takes into account a child's difficulties related to autism, as well as challenges associated with a comorbid diagnosis. Professionals should never paint by the numbers (Gould & Stahl, 2001) yet many times there are consistent responses to common problems. For example, many children with high-functioning ASD struggle with transitions. Children and adolescents with ASD often need more preparation for transitions, and transitions are often more difficult for them. Family court professionals need to assess and consider this issue in determining parenting plans. Furthermore, those with a comorbid diagnosis may have even more difficulties adjusting to and understanding changes and transitions than those without a comorbid diagnosis. Given the long-standing problems associated with autism, professionals need to consider problems associated with autism as the foundation for developing parenting plans, and then, in addition, take into consideration those needs or issues that are a function of a comorbid diagnosis.

THE IMPACT ON PARENTS AND THE PARENTAL INFLUENCE ON CHILDREN

Due to the severe and pervasive nature of ASD, the level of stress involved in raising children with ASD is high (Baron-Cohen & Hammer, 1997; Hughes, Plumet, & Leboyer, 1999; Montes & Halterman, 2007). Parents of children with ASD have reported higher levels of stress than parents of children without disabilities and parents of children with other developmental disabilities, including but not limited to Down's syndrome, cystic fibrosis, and fragile X syndrome (Bishop, Richler, Cain, & Lord, 2007; Donovan, 1988; Rao & Beidel, 2009; Weiss, 2002).

Parental stress has been extensively studied with respect to social support (Bromley, Hare, Davison, & Emerson, 2004; Hassal, Rose, & McDonald, 2005). Lower levels of social support have been found to be consistently associated with higher levels of stress in parents of children with ASD and other disabilities (Bromley et al., 2004; Hassal et al., 2005). Low levels of social support are a common predictor of anxiety and depression in mothers of children with ASD (Boyd, 2002; Wannamaker & Glenwick, 1998). Parents of children with ASD may also experience increased stress due to their child's atypical behavior. Angold et al. (1998) looked at parents' perception of burden and found that parents of children with externalizing behaviors reported more burden than did parents of children with other types of problems. Furthermore, the greater the level of a child's impairment, the higher the burden experienced by parents. These studies tend to suggest that difficult or unusual behavior may be what leads parents of children with ASD to experience higher levels of perceived negative outcomes. These parents need more social support than many others, which needs to be considered as parenting time determinations and other recommendations are made. Parents may need time away from their children to access their social support networks and may benefit from involvement in support groups for families with children with special needs. In divorce proceedings, these parents may rely more on their attorneys for support than other parents, which can be emotionally draining for attorneys.

Parents of children with disabilities are more likely to experience anxiety, depression, distress, somatic complaints, and other difficulties as well (Gray, 2002; Weiss, 2002). When mothers and fathers experience the same family stress or conflicts, the way they interpret the stress is much different, with mothers experiencing it as more detrimental than fathers (Gray, 2003). Mothers of children with disabilities report that the major impact their child's disability has on their life is with respect to their careers; as the majority of mothers studied were only employed outside of the home part time (Gray, 2003). They also reported grief and ambivalence about the amount of time they have to commit to their disabled child (DeMyer, 1979). Mothers of disabled children report that they are the primary caretaker and primary person to take their children to doctor visits, an often difficult experience (Gray, 2003). Mothers with children with high-functioning ASD report that doctor visits caused them the most anxiety and stress because their child's disability is not well understood (Gray, 2003). Mothers are also often charged with presenting their families to the outside world and this presentation is presumed to be a direct reflection of their parenting abilities (Gray, 2003). Mothers may experience more stress due to the social pressure that often accompanies the expectation that mothers are often more responsible for the care of their children than fathers. Therefore, mothers reported a significant impact on their stress and anxiety as it relates to their child's behaviors. If their child's behaviors were poor in public, mothers assumed that others would look negatively on their abilities without taking into account their child's disability (Gray, 2003). Mothers have also been found to have a much higher rate of social anxiety than fathers of children with high-functioning ASD but with both having more social anxiety than parents whose children do not have ASD (Kuusikko-Gaufflin et al., 2013). The social anxiety the parents experience is likely a fear of humiliation and/or embarrassment in social situations, often leading to avoidance of and distress in social situations. It is critical for evaluators, attorneys, and judges to understand that, even though fathers may not experience the same level of stress as mothers in regard to their child's difficulties, this does not inherently mean mothers cannot handle the children well.

Custody evaluators need to understand that there are gender differences in how parents of children with ASD cope with stress and to not overpathologize coping strategies. Gray (2003) noted that men and women use coping strategies and resources differently. There is a distinction between problem-focused and emotion-focused coping strategies. Problem-focused coping strategies focus on attempts to cope with the situation by changing the nature of the problem. Emotion-focused coping strategies focus on activities that distract the attention of the person affected by the stressful situation. Such activities include expressing feelings and withdrawal (Gray, 2003). Men are more likely to use the problem-focused coping strategies and women emotion-focused coping strategies (Gray, 2003). Mothers are also more likely to express or vent their feelings and frustrations than fathers (Gray, 2003). There are ways to help reduce the amount of stress parents experience. The support from a

spouse can have a great impact on buffering the stress of raising a child with ASD (Weiss, 2002). In family litigation this support is typically not available.

CONSIDERATIONS IN FAMILY COURT

It is important to have an understanding of ASD, and particularly high-functioning ASD, when working with families during litigation. Some issues to be considered include the financial burden of raising a child with ASD. It is estimated that it costs over \$17,000 more per year to raise a child with ASD compared to a child without ASD (Lavelle et al., 2014). Child support should be set in accordance with the actual costs involved in raising a child with ASD. Custody evaluators, attorneys, and judges should understand the impact having a child with high-functioning ASD has on the family system and most importantly understand how parenting plans may need to be different than with neurotypical children. Custody evaluators need to understand the unique educational needs of these children as well as how to assess for it. Attorneys and judges need this same information so that they can better assess whether or not a custody evaluator's report and recommendations are trustworthy. The following are specific recommendations that court advisors, whether it be a custody evaluator or a guardian ad litem, need to consider and assess when a child in a family has high-functioning ASD.

EDUCATIONAL ISSUES

1. Advisors to the courts such as guardians ad litem and child custody evaluators should gain a thorough understanding of the school systems in the areas where they conduct evaluations. During the evaluation, the evaluator should investigate where each of the parents will reside and compare the services available in each district. Furthermore, the evaluator should assess whether the parents have spoken to the directors of special education in those districts and the level of each parent's involvement in the educational process. Evaluators should contact the special education directors to inquire about what services can be provided, how they are provided, and where they are provided. For example, some districts may be able to meet a child's needs within the public school setting, while other districts may not have the resources and may send a student to a program at another school within the district, to a school outside of the district, or to a private therapeutic day school. Evaluators should become familiar with the special education services that can be provided for children with ASD. To further investigate issues, evaluators should talk to the student's teachers, review Individual Education Plans (IEPs) and speak to other people who have been involved in the development of the IEP to obtain a thorough understanding of the child's needs as well as what specific therapeutic services can be provided. Evaluators and attorneys for children who are making recommendations about children's needs should also be familiar with common treatment modalities that schools may employ including applied behavioral analysis, social stories, social skills training, cognitive behavioral therapy, and occupational therapy. By having an understanding of these types of services, attorneys and evaluators will be in a better position to assess which school best fits the needs of the student with high-functioning ASD.
2. Related to the above, evaluators should address whether the child needs after-school care and what each potential district can provide. Some schools will provide what is referred to as "extended day" for children who need additional help/services. Also, some districts can provide year-round schooling for children with special needs. If an evaluator/attorney does not know about this, s/he may not know to ask. Special education directors in potential districts can provide information on the availability of additional programs where the child may reside.
3. Evaluators and attorneys should ascertain each parent's involvement with the school in a more in-depth manner than is typically done in custody evaluations. Specifically, evaluators

should assess each parent's involvement in attending parent-teacher conferences, back-to-school nights, and other school events. Evaluators need to know each parent's involvement in the development and implementation of the IEP. It is important to assess which parent has been more supportive of the child receiving services and with which parent the school prefers to work. This can help lead to developing a parenting plan that is more likely to ensure that a child's needs continue to be met.

4. Evaluators need to understand the distinction between a *DSM-5* diagnosis of ASD and how federal law defines autism in relation to special education services. The individual with Disabilities Education Act has a more broad definition than *DSM-5*. Yet, it states that a student is not eligible for services as a student with autism if the child's educational performance is primarily adversely affected due to a comorbid emotional disturbance. If a student has a diagnosis of ASD, and the multidisciplinary team at the school concludes that the child's educational functioning is primarily adversely affected by emotional problems, then the student would not be eligible for special education services under the eligibility of autism. Becoming familiar with both section 504 of the Rehabilitation Act of 1974 and the IDEA is helpful so that evaluators understand the rights of the students and families they are serving. Assessing the parents' knowledge of their rights is also important to determine the ability of each parent to effectively advocate for their child. Evaluators also need to be familiar with Response to Intervention and how this may relate to students with high-functioning ASD. A custody evaluator needs a thorough working knowledge of educational law and parental rights.

ASSESSMENT OF ASPERGER'S DISORDER/HIGH FUNCTIONING ASD

5. Evaluators, attorneys, and judges should familiarize themselves with tests/assessment tools designed for this population. Although custody evaluators will be unlikely to conduct diagnostic evaluations as a part of the child custody evaluation, they should be reading reports from evaluations that have been conducted. Understanding the tests/assessment measures used can help an evaluator decipher whether or not they agree with the assessment and can help them understand a child's needs. This includes having a working knowledge of the Autism Diagnostic Observation Schedule-2nd ed., Autism Diagnostic Interview-Revised, Gilliam Asperger's Disorder Scale, Asperger Syndrome Diagnostic Scale, Autism Spectrum Rating Scale, Gilliam Autism Rating Scale-3, and others. Evaluators should understand the level of functioning of children with high-functioning ASD in part by reviewing this data.
6. It is our belief that evaluators cannot obtain a thorough understanding of high-functioning ASD by merely attending seminars and reading research/books. Rather, they need experience in working with this population. We believe that only then can an evaluator fully understand some of the unique intricacies of this population of children and adolescents. Furthermore, without this experience an evaluator runs the risk of misinterpreting a child's behavior. For example, if a child does not interact much with a parent, make eye contact, or have a strong desire to be near the parent, it may be symptomatic of the child's condition, rather than a problem in the parent-child bond. The Association of Family and Conciliation Courts (AFCC) Model Standards for Child Custody Evaluation (2006) 5.11 states that "when evaluators lack specialized training in particular areas of concern for the evaluation, they shall either decline the appointment for the evaluation or seek professional consultation. . ." (p. 16). Evaluators who have limited experience with this population would be wise to obtain consultation.
7. Not all problematic or atypical behavior in a child with ASD is inherently a function of this diagnosis. Child custody evaluators should be able to assess for other problems/disorders as well. Sometimes a behavioral problem is not a function of any diagnosis, but rather just a problematic behavior that can occur in any child. Having an understanding of the interplay

between high-functioning ASD, other mental health problems, and ordinary behavior is vital when developing age- and developmentally appropriate parenting plans.

PARENT ISSUES

8. Evaluators need to understand that parents of children with high-functioning ASD can come across as obsessive and vigilant (Woodgate, Ateah, & Secco, 2008). For many of these parents, it is not that they were always this way, but that they have developed this coping strategy in response to working with support systems, such as schools, and other professionals who did not understand their children and did not meet their children's needs (Griffith, Totsika, Nash, Jones, & Hastings, 2012). These parents often have had to fight for their children to a greater degree than parents of children with other disabilities; parents must often be vigilant in their advocacy for their children (Saposnek, Perryman, Berkow, & Ellsworth, 2005). While pushy parents may not always be likable, these parents are often the ones who fight for their children and make sure their children get their needs met. This knowledge can assist evaluators and attorneys in understanding that parents of children with high-functioning ASD may act in a way that to some may appear unusual but in fact is understandable and helpful given the situation. This knowledge can help family court professionals be less likely to attribute a parent's behavior to a mental health issue when it is a functioning behavior in the situation.
9. Parents of children with high-functioning ASD may appear depressed, and anxious and experience burnout (Weiss, 2002) and a greater level of stress than parents of children without a child with disabilities (Epstein, Saltzman-Benaiah, O'Hare, Goll, & Tuck, 2008). They may feel stigmatized (Gray, 2002); have decreased parenting efficacy, and have more mental and physical health problems as compared to parents with neurotypical children (Karst & Vaughan Van Hecke, 2012). These difficulties may be in part a function of the strain of parenting a child with ASD without adequate support (both emotional and financial), as well as guilt and self-blame. This may especially be true for the main caregivers. Boyd (2002), in a review of the research, found that low levels of social support were the most common predictor of depression and anxiety in mothers of children with ASD. As a result, evaluators and attorneys should be mindful of the research when considering the mental health of the parties. A parent's personal difficulties may not be a function of significant mental health problems, but may be an ordinary and understandable reaction to the stress of being the main caregiver of a child with special needs. This knowledge can help lead to the development of parenting plans that take into account the current circumstances and needs of the family members.
10. Raising a child with high-functioning ASD is stressful and challenging. As a result, make sure to thoroughly assess for each parent's ability to manage his/her stress. Do they have friends/relatives as a support system? At times, parents may need a break, and when developing parenting plans evaluators need to not only consider the child's need for structure, routine, and stability, but also balance this with the parent's need for a break. Knowing the involvement of friends of the parents, stepparents, grandparents, and other extended family members is an important area to assess. The evaluator should assess how they support the parent, and if they are significantly involved, assess whether they understand the child's needs and the need for the child to obtain services. The AFCC Model Standards of Practice for Child Custody Evaluations states "evaluators shall assess each parent and any other adults who are currently living in a residence with the children and performing a caretaking role" (AFCC, 2007, p. 80). We believe that this standard should be extended to caretakers and proposed caretakers who are not living in the home but will have significant involvement with the children such as grandparents and day care providers. Each parent may have a different set of relatives or caregivers, and it is important to assess their knowledge of

high-functioning ASD and how to care for a child with special needs when developing parenting plans.

11. Evaluators should ask how parents have informed themselves about ASD. Have the parents attended seminars on ASD? Have either or both joined support groups?
12. Evaluators should pay close attention to which parent first noticed the child having difficulties and which parent was more involved in making sure the difficulties were addressed and obtain a thorough history of every professional with whom the child has been involved, how the professional was chosen, who went to appointments, and who followed through with recommendations. Assess each parent's beliefs regarding the use of medication and what has been prescribed, why it has been prescribed, and whether the parents have been supportive of it, and if not, the reasons for this. Our experience has been that in many families one parent is much more aware of their child's difficulties, more accepting of them, and more willing to make sure their child gets the necessary services. This needs to be given considerable weight when determining what is in the child's best interests. While often evaluators pay close attention to which parent has been more involved and which parent the child is closer to, it is in the best interests of the child to get the services s/he needs and the parent who is more willing to do this needs to be given considerable weight in the determination.
13. Evaluators should assess the parent's understanding of the unique needs of their child. For example, some children will have a hard time getting used to two different buses for school while others do not. If a particular child struggles with transitions and change, it may be important for the child to only take one bus to school. Evaluators need to determine the parents' understanding of this and assess for how this can be accomplished. Evaluators should obtain a clear understanding of where each parent plans on residing following the divorce, the reasons for it, and its impact on the child's daily life. We worked with one family where the nonresidential parent had midweek overnights, but in the morning drove the child to the regular bus stop so that his routine could remain the same. This worked well for the child, but may not work well in all families, depending on their level of conflict and ability to cooperate. This needs to be taken into account when developing parenting plans.
14. Children with high-functioning ASD can dysregulate and have what many think of as meltdowns. Evaluators should assess which parent is best able to handle these meltdowns and also which parent is better at reducing dysregulating behavior by identifying when a child is becoming upset/agitated; implementing sensory strategies, such as the use of soothing techniques; and can implement other strategies to prevent further dysregulation. It is also important to assess each parent's willingness to work with the other in being consistent with their use of sensory strategies. This can impact whether the child can handle a more shared parenting schedule or if one parent needs to be the main caregiver the majority of the time.
15. Assessing the level of cooperation between the parents related to the child's services is vital. While assessing parental cooperation is an expected part of any evaluation, it takes on additional meaning for families where a child has ASD. For example, are both parents willing to live near each other so that in-home services can be done at both homes. If services cannot be done at both homes, are the parents supportive of bringing the child over to the other parent's home where services can be obtained? Can the parents allow the child(ren) to take objects back and forth between homes, especially if it provides comfort for them? This again can impact the type of parenting plan that family court professionals recommend.
16. Assessing the degree of flexibility between parents is an important component of a child custody evaluation for any family, but especially where a child has ASD. When a child emotionally dysregulates when it is time to go to the other parent's home, is the other

- parent understanding of the fact that the child may be late or will the parent assume/believe the other parent is trying to dominate their time.
17. Because of the research supporting a possible genetic inheritance of autism (CDC, 2015, February), evaluators should make sure to assess for the possibility that either parent may be on the spectrum, or possibly have features of ASD. Evaluators need to have an understanding of the features of high-functioning ASD in children and adults (Birnbaum et al., 2012; Jennings, 2005). Understanding these features will assist evaluators in developing appropriate parenting plans by taking into account the unique needs of these children and parents (Birnbaum et al., 2012). For example, if a parent also has features of ASD, it may be difficult for them to follow a flexible parenting schedule. S/he may also come across as more rigid in an evaluation. Evaluators need to understand and take into account that a parent with features of ASD may not be attempting to be resistant to being flexible, but rather does not have the capacity to be as flexible as other parents.
 18. Although not typically under the purview of a custody evaluator, guardians ad litem, attorneys, and judges must consider the additional costs of raising a child with ASD. It has been estimated to cost more than \$17,000 per year to raise a child with ASD as compared to a child without a disability (Lavelle et al., 2014). Medical expenditures for children and adolescents with ASD were between four and six times greater than for children without ASD (Shimabukuro, Grosse, & Rice, 2008). Thus, deviations from standard child support guidelines may need to be considered.

PARENTING PLANS

19. Children with high-functioning ASD are more likely than other children to have difficulty with change and transitions (Jennings, 2005). Professionals involved in family court need to assess children's ability to handle transitions. Professionals should try to minimize the number of transitions and make sure transitions occur as a regular part of the child's routine. The transitions should be conducted as similarly as possible in order to provide consistency for the child. Furthermore, parents need to be educated that if their child has difficulty with transitions, it may not be a function of the other parent doing something wrong or on purpose. Furthermore, professionals and parents need to understand that while some children over time adjust to the changes and the transitions, children with ASD may take longer to make this adjustment or may continually struggle with some of the transitions and changes.
20. When there is high conflict between parents, evaluators at times recommend that transitions occur in public places. However, for a child with high-functioning ASD, a location that is loud and busy may create sensory overload for the child. While the assessment of a child's ability to manage transitions should be a part of every evaluation, evaluators also should assess what type of environment allows for the best transition so as to decrease the possibility of difficult transitions. If transitions cannot occur at the parents' homes, it may be better to consider pickups and dropoffs from school or at a mutually agreed-upon friend's home or other location where it may be quieter with fewer people present.
21. When considering various parenting plans, consider the child's psychological/developmental level of functioning, rather than their age (Jennings, 2005). A 14-year-old with high-functioning ASD, while having an average or above average IQ, may emotionally function like a much younger child. Assessing emotional maturity is an important factor in the development of appropriate parenting plans.
22. If the child custody evaluation includes adolescent children, evaluators need to inquire about the parents' plans for guardianship when the child turns 18. Evaluators may want to write the court to ascertain whether they should make a recommendation as to guardianship upon the child attaining the age of 18 or if joint conservatorship is appropriate. The

assessment process alone will provide the evaluator with information as to whether the parents have even thought about this issue and which parent, or both, have considered long-term planning. Also, by addressing this during the divorce process it may decrease conflict (Jennings, 2005) and the likelihood of returning to court.

23. At times evaluators are asked to make interim recommendations. Evaluators should assess a child's ability to move between two homes or whether on a temporary basis nesting (where the child stays in the home and the parents rotate coming in and out) is a better option. However, caution is noted as the AFCC Model Standards of Practice for Child Custody Evaluation standard 4.5 states "Evaluators shall refrain from offering interim recommendations or treatment interventions pertaining to custodial placement, access, or related issues" (p. 13). In a situation where there is an urgency to provide assistance on an interim basis due to high levels of conflict between the parents, the evaluator may wish to have the court order the evaluator to provide the pros and cons of nesting versus having the child temporarily go between two homes without making a recommendation of which should occur. This can be done either as general pros and cons for children and adolescents with ASD or it can be specific to the child(ren) in question. While we strongly recommend that evaluators follow the AFCC standards, we understand that there are some unique circumstances that arise where immediate input may be needed to protect the child(ren).
24. When developing parenting plans, siblings of children with high-functioning ASD need time with each parent away from the child with special needs (Jennings, 2005). Having this one-on-one time can be vital to these siblings and fun for the parents. A parenting plan scheduled with separate time for each child with each parent should be considered as a more significant issue than is typically the case. In some cases, the best interests of the children may be served by separating the siblings, but still making sure they spend some time together. This may allow each parent to be more effective in their parenting because they may only have to assist one child (or possibly more, but not all at the same time). If children are separated, the report needs to address the reasons as outlined in the section 5.8(b) of the AFCC Model Standards of Practice for Child Custody Evaluation.
25. If relocation is an issue, there must be a thorough investigation of the educational/therapeutic services that can be provided by the new school district and other services available in the area must be assessed. This must be weighed against both the services provided if the relocation is not granted and the ability of the child to adjust not only to a move and seeing one parent possibly much less frequently, but to a schedule that in some ways may be more consistent and in other manners be more disruptive. The schedule may be more consistent because if a child relocates and does not see the other parent much, the primary caregiver can have the child in a set routine that may be beneficial for the child. However, if the child is going to return to the other parent's home, it may be more disruptive for the child because the child may not be comfortable there and may not know the routine as well. Furthermore, it may be difficult for services to be provided in both locations. If both parents are knowledgeable about their child's needs and will work diligently to help their child and if the child can manage spending long periods away from each parent (e.g., the school year primarily in one home and the summer in the other), then relocation may work. On the other hand, if the parent who is not moving has significant difficulty accepting or acknowledging the child's difficulties, the child may not receive services during the summer when the child is with him/her. A parenting plan needs to be developed that allows the child to still receive the special services that are needed. If relocation is granted in this situation, it may be better for the child not to spend most of the summer with the other parent.

Children with high-functioning ASD present unique challenges for mental health professionals, attorneys, and judges involved in family court. Having a greater knowledge and understanding of the unique needs of families where a child has ASD will assist family court professionals in guiding these families during the divorce and postdecree process. It will allow judges to make more informed

decisions, attorneys to better represent their clients, and mental health professionals to better advise the court. Ultimately, it will help ensure that these children and families are better understood by those involved in the family court system that can lead to better outcomes for families.

NOTES

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1. For the purposes of this article, Asperger's Disorder and high functioning Autism may be used interchangeably. I have kept the original phrase Asperger's Disorder when referencing previous literature that addressed Asperger's Disorder but have used high functioning Autism Spectrum Disorder whenever I am not referencing specific citations.

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