Asperger's in the therapy room

Following a packed workshop generating a huge amount of interest, **PETER FLOWERDEW** introduces the first in a series of articles about working with clients who have been, or may be, diagnosed with Asperger's syndrome.

AS I WRITE this it is exactly three years since I started working with my first client who had a diagnosis of Asperger's syndrome. This client was referred to me because of my interest in people on the autistic spectrum. Much of my skill in tuning to their experiential world is due to my relationship with my grandson, and my desire to help other children on the autistic spectrum with whom I have come into contact through the work of my charity which provides counselling and psychotherapy to young people between the ages of 9 and 25.

I currently have five private clients who either recognise themselves, or have formal diagnosis, as having Asperger's syndrome and four others who have strong enough traits that they need to be taken into account. I also have two teenage clients and supervise therapeutic work with three others.

When I began this work I approached it in the same way I would working with someone of different ethnicity and culture: making no assumptions; asking the client to educate me about their relational and experiential world. As I worked more with the adult clients I realised that I was dealing with such a difference of relational experience and subjective meaning and perception that I found the task of entering their subjective world far more challenging than any cultural difference. One of my clients was able to convey to me his perceptions, thoughts and feelings (somatic reactions) in a variety of situations and relationships with such clarity as to reveal to me what was more like a parallel universe, and that is my current state of conceptualising the relationship between the subjective reality of neuro-typicals (NTs) and the subjective reality of those with Asperger's syndrome (Aspies). The NTs think that they understand what the Aspies are communicating, but they don't; and the Aspies do their best to understand what is going on around them in a world defined by social dynamics that are invisible to them. There is misunderstanding, misattunement, hurt and grief for all concerned.

This has at times been a very uncomfortable ride. I had to question what psychotherapy has to offer this client group; what is the form of the therapeutic relationship; and in particular the ethical issue of what is actually up for change and what is beyond change because of the neurobiological basis of Asperger's. The question of an appropriate style and appropriate objectives for therapy is far from being an academic issue because, unfortunately I have now met a number of Aspies who have had very negative experiences of Rogerian style counselling, and I now have a clear insight as to why this modality is fundamentally unsuitable for Aspie clients.

What I have heard from many Aspies is that of all the psychological and therapeutic models available it is Transactional Analysis that is most accessible and most useful to them. I was extremely fortunate in that, that first client had many years of TA training and used TA to make sense of the behaviours of the people around him and to manage relationships in his private life and at work. We have not only been able to use TA models and concepts in the therapy sessions, my client has also been able to reframe some elements to express the differences in the experiential world of the Aspie and the neurotypical.

I presented a workshop at this year's conference entitled Asperger's in the therapy room: working with a different kind of mind. The greatest problem I had in preparing the workshop was condensing the information I had into such a limited time while still delivering something coherent and useful. This was hugely enhanced by my TA-trained Aspie client offering to assist me. We endeavoured to create an experience that combined a didactic presentation with a dialogue between representatives of the NT and the Aspie universes, which would also be a demonstration of the

'What I have heard from many [clients] is that of all the psychological and therapeutic models available it is Transactional Analysis that is most accessible and most useful to them.'

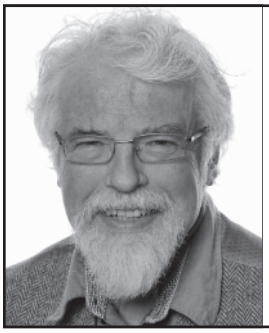
‘It is a regular experience for me to feel privileged and humbled by the courage and generosity of spirit that [a person with Asperger’s syndrome] brings to the therapeutic relationship.’

communication style and the pacing required in any therapeutic dialogue. The attendance for the workshop, the number of people identifying that they had either a private or professional relationship with an Aspie, and the response from those attending to what we offered them was beyond our expectation.

We are developing an Aspie 101, a parallel to the standard TA 101 where core theory is re-presented in a way that describes Aspie personality and communication; games and scripts from an Aspie perspective and the stroke economy and relational needs of Aspies. We intend to present the TA101 and Aspie 101 in parallel; two projectors two screens two commentaries, with a dialogue between the two presenters, in a manner similar to that we used at the conference. The hope is that the NTs will gain a greater insight into the world of Aspies and be more skilled in creating relational space in which they can experience being welcome and safe and Aspies can gain some insight into the inner world of NTs and gain some control of how NTs perceive them. Because of the challenges of creating this channel of communication between the Aspie experience and the NT experience this parallel presentation will truly represent an ‘I′m OK – you′re OK′ collaboration between me and my clients and it is a regular experience for me to feel privileged and humbled by the courage and generosity of spirit that they bring to the therapeutic relationship.

In addition to this, I wish to share with the TA community what I have learnt about identifying and working with Aspie characteristics and I intend to present a series of articles in this magazine on the nature of Asperger′s syndrome, its basis in neurobiology, the childhood experience and adaptations of children with Asperger′s, which is often not diagnosed until adulthood, the implications for therapeutic work with people with these characteristics, and the adaptation of classical TA to provide concepts and tools to empower Aspie clients.

These articles will capture the emergent and tentative nature of my attempts to capture the Aspie experience within a TA framework. It seems to me that it is probably also the emergence of a process whereby neurobiology and psychological tests, which allow us to identify different kinds of minds, are assisting the development of different kinds of therapy for these different kinds of mind. I hope that the articles will be both interesting and useful to the TA community.



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Asperger's in the therapy room – 2

In the second of his series of articles about working with clients who have been, or may be, diagnosed with Asperger's syndrome, **PETER FLOWERDEW** asks 'what does it mean to be an Aspie?

WHAT DOES IT mean to be an Aspie is a remarkably difficult question to answer, considering how profound its effects can be.

But first, some thoughts on the language we use.

People diagnosed with or identifying with Asperger's Syndrome generally refer to themselves as 'Aspies'. Non-Aspies are referred to as Neurotypical', often abbreviated to NT. This choice of language implies an acceptance that Asperger's has a neurobiological basis; that it relates to a different kind of brain, and 'different' does not mean 'inferior'. Not all people with a diagnosis of Asperger's Syndrome appreciate this language though, so I always check out with the individual as to what words they prefer to use to distinguish these two groups.

With my clients, we often refer to NTs as earthlings in a light-hearted recognition that people with Asperger's often feel that they are living amongst aliens, that it is as if they came from another planet.

I also often abbreviate 'Asperger's Syndrome' to AS; not to be confused with the common abbreviation of Autistic Spectrum!

Yuko Yoshida (2007) uses the term 'majority' for the neurotypical population, thereby recognising a minority having a different but coherent psychology, designated by Asperger's syndrome by the majority – and I am sensitive to all the implicit power and privilege when a majority defines a minority as 'less than' – and that is inherent in the diagnostic manuals, as they focus on 'deficits'.

But even within the frame of reference of the medical model, there is a significant point to be made:

- The World Health Organisation [WHO 1992:6, 8-9] sees the Diagnostic Manuals as defining Impairment – something that a minority lacks, a deficit, a limitation when compared to the majority, eg weak legs.
- The deficits are only significant when they are associated with Distress and Dysfunction – and dysfunction is an inability to perform some function that is considered 'normal' by the majority, eg can't walk up the stairs.
- This becomes a Handicap when the majority do not accommodate the needs, eg no ramps for access.
- The existence of handicap depends on the awareness and choices of the majority. It is essentially a social construct.

But I also notice, in passing, that the majority do not experience deficit, distress, dysfunction or handicap when faced with an exceptional talent of a minority, for example, musicians, graphic artists, quantum physicists; they are secure within the privileged position of the 'majority' of 'normal people. Many Aspies possess significant talents which can be recognised and developed, in the appropriate context, for the benefit of all involved.

So, what is Asperger Syndrome?

There is no consensual definition or diagnosis for Asperger's Syndrome. As my teenage clients might say 'Get over it'.

But there is 'something' that is real, that is important and needs our response, and is also difficult for us to define precisely.

Diagnostic manuals

I must admit to a deep scepticism about the principle of using 'normal' [Francis 2013:Ch1] as a basis for defining 'disorder'. First, 'normal' is remarkably difficult to nail down, and the defining of 'normal' in the context of a particular time and culture creates the potential for any 'minority' to experience discrimination, stigmatisation or oppression as has happened with political dissidents, homosexuals and ethnic minorities.

Given those problems – and Alan Francis, who led the development of DSM4, writes a whole book on it – the manuals exist and have their uses. In DSM4 there is/was a distinction between Autism and Asperger's Syndrome, but in DSM5 there is a single category, Autistic Spectrum Disorder. The significance of the change has yet to filter through, but an American study [Grandin and Panec, 2014:112] indicates that only 28% of those diagnosed with Asperger's Syndrome under DSM4 would receive a diagnosis under DSM5, so, more than 70% have been defined as not having a problem – *really*? That is likely to

‘Not everything that steps out of line, and is thus 'abnormal', must necessarily be 'inferior'. Hans Asperger.’ (1938)

have major impact on the services and support made available and I have enormous concern for the emotional wellbeing and educational outcomes for young people with these traits.

If I have to refer to a diagnostic manual, to facilitate communication with other professionals, I prefer ICD10:

• it represents an international collaboration and avoids both some of the risks of cultural prejudices and the suspicions of vested interests

• as a ‘world document, individual countries should be using it as the starting point for their own diagnostics

• it is used by GPs and the desktop version contains information and support that GPs will offer to patients, so it is useful for a therapist to know what that is

• and there is also a multiaxial diagnostic manual specifically for working with children and adolescents, which is useful in my work with children.

So this is the manual I use. (See box 1)

Autism (F84.0) and Asperger’s (F84.5) have a separate, differential, diagnosis in ICD10 and its differentiation from Autism is that it does not include any developmental delay, particularly around the development of speech and cognition, nor any difference in average intelligence in school age children from the ‘normal’ population.

The existence or absence of developmental delay around speech and cognition is likely to have an impact on the child’s subjective experience of relationships, and therefore on script development. The attribution of meaning, the defensive adaptations; the development of personality, is likely to be different. For this reason, I prefer to keep High Functioning Autism (developmental delay) and Asperger’s Syndrome (no developmental delay), distinct, even though, in an adult client, the capacities and capabilities that you can measure might be the same. The diagnosis is all about deficits, from an NT perspective.

Temple Grandin [Grandin, Panec, (2014)] argues that raising autistic children needs to be less about focusing on weaknesses, and more about fostering their unique contributions. Asperger's can be turned into a gift, not a disability.

Box 1: A Summary of ICD10 Criteria for Asperger’s Syndrome

Social interaction

There are always qualitative impairments in reciprocal social interaction. Generally, not as extreme or as debilitating as in infantile autism.

These take the form of an inadequate appreciation of socio-emotional cues, as shown by

• a lack of modulation of behaviour according to social context;

• poor use of social signals and

a weak integration of social, emotional, and communicative behaviours;

• and, especially, a lack of socio-emotional reciprocity

Communication: Elements in common with autism

Qualitative impairments in communications are universal. Generally, not as extreme or as debilitating as in infantile autism.

These take the form of:

• a lack of social usage of whatever language skills are present;

• impairment in make-believe and social imitative play;

• poor synchrony and lack of reciprocity in conversational interchange;

• poor flexibility in language expression and a relative

• lack of creativity and fantasy in thought processes;

• lack of emotional response to other people’s verbal and nonverbal overtures;

• impaired use of variations in cadence or emphasis to reflect communicative modulation;

• and a similar lack of accompanying gesture to provide emphasis or aid meaning in spoken communication.

Restrictive and repetitive activities

A restricted, stereotyped repetitive repertoire of interests and activities.

Additional characteristics

The disorder differs from autism primarily in that there is no general delay or retardation in language or in cognitive development.

Most individuals are of normal general intelligence but it is common for them to be markedly clumsy.

The condition occurs predominantly in boys (a ratio of about eight boys to one girl).

Note: The lower proportion of girls diagnosed could be because their social environment contains more opportunities for social learning, allowing them to mask the diagnostic characteristics.

A therapeutic stance

It is my belief that:

- there is a neurological basis for differences between the majority and the AS population
- the different relational needs and style of the AS population causes them to experience difficulties in socialising and in conforming to the expectations and standards of the majority
- these consistent negative experiences produce script decisions and therefore script systems that are different to those of the majority and are characteristic of AS
- that therapeutic work with a different kind of script, with a different kind of mind, with a different kind of brain, requires a different kind of therapy.

I am exploring what that therapy may look like in terms of theory, models, process and outcomes.

What I anticipate is that continuing developments in neurobiology and genetic studies will inform psychotherapy in the development of different therapies for different minds.

A new approach to diagnosis

Temple Grandin postulates three 'phases' in the history of the identification and treatment of autism and Asperger's:

- the search for a cause, in terms of psychoanalytic theory
- the search for a distinguishing set of symptoms to determine a diagnosis
- and now a treatment based on identification of a basis for each symptom.

She anticipates a precise biological identifier for each symptom, but I fail to see any technology that can identify the significance of specific neural interconnections, which is how our lived experience is encoded. Current technology identifies the development or activation of areas of the brain and can inform but not prescribe therapeutic work.

However, because AS involves a range of characteristics, each of which may be evident to a different degree in each client, I do think that addressing or accommodating each characteristic as a separate entity is valuable in this case. The diagnostic systems in the medical profession give us observable cues, but they do not connect us to the lived experience of an Aspie.

For a person with autism or Asperger's, it is a way of being in the world; it colours every experience sensation perception thought and emotion. They do not respond to the world in the way we expect to because they have different systems of perception and communication. We find difficulty in trying to communicate with somebody who has a different language and different culture. It is far, far, more difficult to try and enter into the experiential world of someone whose sensory, perception, and information processing systems are different to our own but to not even attempt this is damaging and destructive both to Aspies and to NTs, damaging to us in the quality of our humanity.

Identifying Asperger traits in private practice

Baron-Cohen's AQ Scale: Professor Simon Baron-Cohen FBA is Professor of developmental psychopathology at Cambridge University and Director of the University's Autism Research Centre. This is a screening instrument that can be used from four years of age through to adulthood. He uses the designation AS as an abbreviation for Autism Spectrum, and says adults who are 'high functioning', which would include Aspies, can fill in the questionnaire for themselves. So I present and use his questionnaire as a quick and useful informal assessment of the degree of the traits of Asperger's syndrome a person manifests. (Baron-Cohen 2008)

A high score on this questionnaire is not in itself a reason to be referred for a diagnosis; there must also be elements of distress and dysfunction; eg they are being bullied, or are becoming depressed, or have high levels of anxiety, or are not fulfilling their academic or occupational potential.

The first 10 questions from the questionnaire are shown below. The subject answers by selecting strongly or slightly agree, or strongly or slightly disagree. If you answer disagree or strongly disagree with items 1, 3, 8 and 10 that would get you four points on the AQ scale. If you answer agree or strongly agreed to the other items, that would get you another six points on the AQ scale, ie you are now up to 10 Asperger traits. There are 50 items like this in the questionnaire so everyone ends up with the score somewhere between zero and 50. Everyone is somewhere on the scale.

1 *I prefer to do things with others rather than on my own*
2 *I prefer to do things the same way over and over again.*
3 *If I try to imagine something I find it very easy to create a picture in my mind*
4 *I frequently get so strongly absorbed in one thing that I lose sight of other things*
5 *I often notice small sounds when others do not*
6 *I usually notice car number plates or similar strings of information*
7 *Other people frequently tell me that what I've said is impolite, even though I think it is polite*
8 *When I'm reading a story, I can easily imagine what the characters might look like*
9 *I am fascinated by dates*
10 *In a social group, I can easily keep track of several different people's conversations*

0 to 10 = low

– 93% of the general population fall in this range;

11 to 22 = average (M-17; F-15)

– 99% of diagnosed AS score over 26;
23 to 31 above average
– 80% of diagnosed AS score over 32;
32 to 50 very high. (AS=35)

I have a Word version of this questionnaire, which I am willing to share with anyone who e-mails me on peter_flowerdew @hotmail.com.

I was interested in the spread of those who come to therapy. I gathered results from a sample of my clients

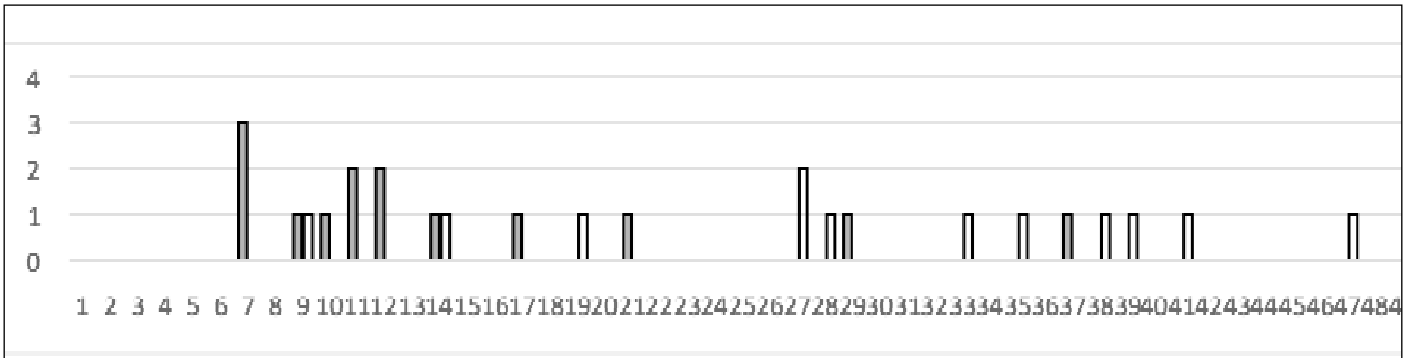

Figure 1: Results from spread of all clients in therapy

and my students, the students being in therapy, and I plotted the results into a graph (see figure 1, above).

To summarise the two highest scoring males have a diagnosis of Asperger syndrome. Those scoring 35 and above easily identify with the criteria for the diagnosis.

But there was a hole in the centre of the results: females in the lower half, with a couple of males; males in the upper half, with a couple of females. The upper group corresponds to the range that captures 99% of Aspies. I experience the clients in that group as demonstrating the Aspie qualities that I will describe in the next article. I am the lowest scoring male – so far.

The question I've asked myself when the results from women began clustering near the bottom was: 'So what is the opposite of an Aspie?'

Until next time.

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Asperger's in the therapy room – 3

In the third of his series of articles about working with clients who have been, or may be, diagnosed with Asperger syndrome,
PETER FLOWERDEW looks at the psychology of Asperger's.

THERE ARE FIVE major theories used to understand the behaviour and psychological profile of people with autism and Asperger's [Baron-Cohen 2008:51ff]. Three of them, considered here, give a framework to understand almost all of the social problems that Aspies experience, and indicate where TA may be able to help.

Weak central coherence

I am going to suggest a different name for this feature, but 'weak central coherence' is the designation widely used in the literature. As usual in medical models it focuses on deficit, whereas I think it useful to identify a difference. I call it: Detail vs context.

The postulation is that people with Asperger syndrome have problems integrating information to make a coherent global picture. Instead, they are said to focus on the small local details in a scene.

The Neurotypical (NT) mind is more likely to attend to gist rather than the nitty-gritty, the AS mind is more likely to attend to the detail than to the overview. These tendencies are described as 'strong central coherence' and 'weak central coherence' respectively.

One of the tests for this characteristic is called the 'Embedded Figures Test' (see Figure 1). Aspies tend to spot the embedded shape quicker than NTs.

As I do not have copies of this these formal tests I explore the same talent using the more available 'Where's Wally?' cartoons. The little book that I keep handy is: M Handford's (2011) *The Phenomenal Postcard Book*. London. Walker Books.

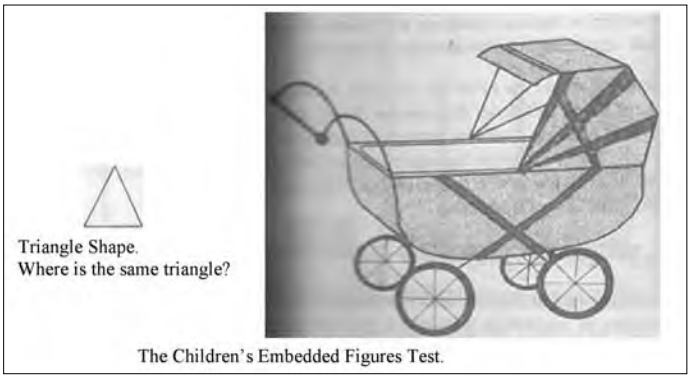


Figure 1: The Children's Embedded Figures Test

Neurotypicals usually take several minutes to find the hidden figure, Wally. Almost without their being aware of it, their attention is diverted by the humour in the many little scenes in the picture.

Aspie clients flip through the pages – 'there he is; there he is' – usually with no comment on the scenes depicted. Their brain is engaged in pure pattern recognition without any distraction from finding social meaning in the scenes.

Attention to detail

This ability to 'spot the difference', usually applied in life as 'spot the defect' has provided Aspie clients with employment as varied as:

– a plasterer: the client produced perfect walls; when I asked 'what do you do that is different?' he pointed out a number of defects in the plastering in the room we were in, none of which I had noticed before
– a tiler: the client produced perfectly regular tiling in a sports centre and in the homes of aristocracy
– a bricklayer: the client produced perfect brickwork for millionaire homes
– engineering: several clients were employed debugging and improving safety-critical software
– record keeping: working administratively in a variety of situations from the NHS to archaeological digs.

These examples, particularly the last two, also relate to an Aspie tendency to become absorbed in a 'special interest' and a very common need, a drive, to create order and predictability.

Bottom up vs top down

Aspies and NTs also tend to perform differently to The Navon Test of local versus global perception. In this test large letters are formed from small letters, for example a one large letter 'A' would be formed from a number of

‘Children with autism and Asperger syndrome are slow to understand deception.’

small letters for example ‘Hs’.

Aspies tend to register the small letter first, and then ‘see’ that this makes a larger letter. NTs tend do it the other way around.

Aspie clients might notice a tree, then another (different) one, and another – and then register that this is a wood, where an NT would see a wood, then look at the trees.

Researchers refer to this tendency to focus on detail as local bias, and it seems to have a neurological basis. The Connectivity Theory (Baron-Cohen 2008) claims that in autism and Asperger’s syndrome there is short-range over-connectivity – more nerve cells or neurons making lots of local connections in the brain – but long-range under-connectivity, that is, fewer neurons making connections between more distant brain areas.

Mindblindness

Imagine living in a world where you could see and understand physical things but were ‘blind’ to the existence of: thoughts; beliefs; knowledge; desires; intentions.

You may experience these things yourself, but not detect them in or attribute them to others – you would exist inside a social bubble, cut off from the information that gives meaning and context to social life.

The significance of the loss of ‘why?’

Imagine you are watching a short video. It shows someone walk into a bedroom, walk around while looking around, and walk out.

Now, write down what you imagine might be the reason for him doing this:

– maybe he was *looking* for something he *wanted* to find, and he *thought* it was in the bedroom

– maybe he *heard* something in the bedroom, and *wanted to know* what had made the noise

‘While the typical 9-year-old can interpret another person’s expressions from their eyes, to figure out what they might be thinking or feeling, children with Asperger syndrome tend to find such tests far more difficult.’

– maybe he *forgot* where he was going: maybe he really *intended* to go downstairs.

A mindreader can generate a longish list of such ‘maybes’ to explain this behaviour – and it is a safe bet that most of them will be based on projecting or attributing mental states.

In the examples above, the mental-state words are printed in italics to make it easy to pick them out.

Mindreaders have the capacity to imagine or represent states of mind that we or others might hold.

A mindreader’s thinking about mental states is prefixed by ‘maybe’ because we are never 100 percent sure what we or others are thinking (since mental states are to some extent hidden from view).

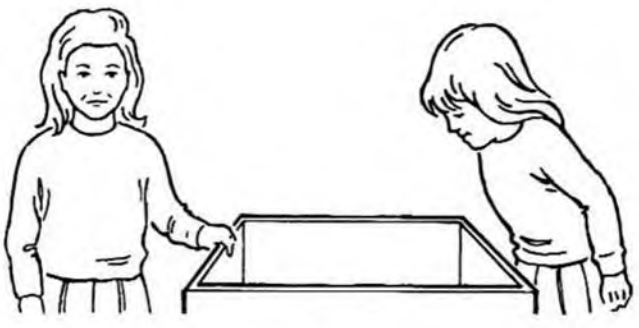
Nevertheless we find it easy to imagine what others may be thinking.

Developmental difficulties

A typical 14-month-old child shows joint attention (such as pointing or following another person’s gaze), during which they not only look at another person’s face and eyes, but pay attention to what the other person is interested in. Children with autism and Asperger syndrome show reduced frequency of joint attention, in toddlerhood. They point less, look up at faces less and do not turn to follow another person’s gaze as much as a typical child.

The typical 24-month-old child can engage in pretend play. When they interact with someone else who is pretending, they need to use their mind-reading skills to be able to understand that in the other person’s mind, they are just pretending. Children with autism and Asperger syndrome show less pretend play, or their pretence is limited to more rule-based formats. For example, they may simply follow a make-believe script from a movie, or science fiction, where the pretend world is specified in terms of a set of ‘facts’ about that pretend universe.

The typical 3-year-old child can pass ‘the seeing leads to knowing test’ (see Figure 2). To pass the test question,



Sally touches the box Anne looks inside the box

Figure 2: The ‘seeing leads to knowing’ test

Deception

The Snow White story also reminds us that mindreading is not only important when it comes to making sense of and predicting other people's behaviour, but it is also key to deception.

Deception is easily understood by the typical 4-year-old child. While this may be socially discouraged, the fact that typical children understand deception and may attempt to deceive others is a sign of a normal Theory of Mind(ToM). This is because deception is nothing other than making someone else believe that something is true when in fact it is false. It is the process of manipulating another person's mind. Children with autism and Asperger syndrome are slow to understand deception, again a sign of a delay in the development of ToM. This means they are more at risk of being exploited for their gullibility. They tend to assume everyone is telling the truth, and may be shocked by the idea that other people may not say what they mean.

This makes them vulnerable to a particular form of bullying, involving misdirection and misinformation.

the child needs to notice that while Sally touched the box, Anne actually looked into it, and since seeing is one way to get knowledge, Anne is the one who must know what's in the box. Children with autism and Asperger syndrome are delayed in passing this test.

The typical 4-year-old child can understand the existence of a 'false belief': the child can understand that, in the story of Snow White, the girl is being deceived by her wicked stepmother who wants her to believe the apple is tasty, while all the while it contains poison.

The typical 9-year-old child is capable of figuring out what might hurt another's feelings and what might therefore be better left unspoken, ie they can recognise faux pas. Children with Asperger syndrome are delayed by around 3 years in this skill, such that it is only when they are about 12 years old that they perform at the level of a typical 9-year-old, despite their normal IQ.

While the typical 9-year-old can interpret another person's expressions from their eyes, to figure out what they might be thinking or feeling, children with Asperger syndrome tend to find such tests far more difficult. This persists into adulthood.

Conclusion

A strength of the mindblindness theory is that it can make sense of the social and communication difficulties in autism and Asperger syndrome, and that it is universal in applying to all individuals on the autistic spectrum. Its shortcoming is that it cannot account for the non-social features, such as sensory sensitivity and synaesthesia.

A second limitation of this theory is that while mindreading is one component of empathy, empathy also requires an emotional response to another person's state of mind. Many people on the autistic spectrum also report that they are puzzled by how to respond to another person's emotions.

This second limitation is addressed by the biaxial diagnostic tool associated with the systemising empathising theory, which allows us to identify different kinds of minds, and answer the question – so what is the opposite of an Aspie?

That will be in the next part published in the winter 2016/17 issue of *the Transacational Analyst.*

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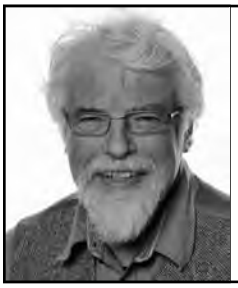

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Asperger's in the therapy room – 4

In the fourth of his series of articles about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** continues his look at the psychology of Asperger's.

THE EMPATHISING-SYSTEMISING THEORY explains the social and communication difficulties in autism and Asperger syndrome by reference to delays and deficits in empathy, while explaining the areas of strength by reference to intact or even superior skill in systemising.

Empathy

• *Cognitive empathy*: this encompasses Theory of Mind, or mindreading, the cognitive component of empathy – knowing what is going on.

• *Affective empathy:* this is about having an appropriate emotional reaction to another person's thoughts and feelings – knowing how to respond.

Remember that even when they pick up and decode social cues, many Aspies still do not know how to respond. They are however able to learn this is a cognitive skill and adult Aspies often have an awesome repertoire.

Baron-Cohen offers an Empathy Quotient (EQ), questionnaire on: *www.autismresearchcentre.com* to be filled out by an adult about themselves, or by a parent about their child. Both cognitive and affective empathy are assessed. (There is a Child EQ, an Adolescent EQ, and an Adult EQ.) Ten examples from the EQ are shown below. If you agreed with items 1 and 3, this would get you two EQ points. If you disagreed with the remaining items, this would give you a total of 10 EQ points.

Examples from EQ Questionnaire:

1. I can easily tell if someone else wants to enter a conversation.
2. I find it difficult to explain to others things that I understand easily, when they don't understand them first time.
3. I really enjoy caring for other people.
4. I find it hard to know what to do in a social situation.
5. People often tell me that I went too far in driving my point home in a discussion.
6. It doesn't bother me too much if I am late meeting a friend.
7. Friendships and relationships are just too difficult, so I tend not to bother with them.
8. I often find it difficult to judge if something is rude or polite.
9. In a conversation, I tend to focus on my own thoughts rather than on what my listener might be thinking.
10. When I was a child, I enjoyed cutting up worms to see what would happen.

(www.autismresearchcentre.com)

In this case, the higher your score, the better your empathy. On this scale, people with autism spectrum conditions score lower than comparison groups.

According to the empathising-systemising theory, autism and Asperger syndrome are best explained not just with reference to empathy (E) (below average) but also with reference to a second psychological factor, systemising (S), which is either average or even above average. So it is the discrepancy between E and S that determines if you are likely to develop autism or Asperger syndrome. To understand this theory better, we need to turn to the concept of systemising.

Systemising

Systemising is the drive to analyse or construct systems. These might be any kind of system. What defines a system is that it follows rules, and when we systemise we are trying to identify the rules that govern the system, in order to predict how that system will behave. These are some of the major kinds of systems:

• *collectible systems* (eg distinguishing between types of stones)

• *mechanical systems* (eg a videorecorder or a window lock)

• *numerical systems* (eg a train timetable or a calendar) abstract systems (eg the syntax of a language or musical notation)

• *natural systems* (eg weather patterns or tidal wave patterns)

• *social systems* (eg a management hierarchy or a dance routine with a dance partner)

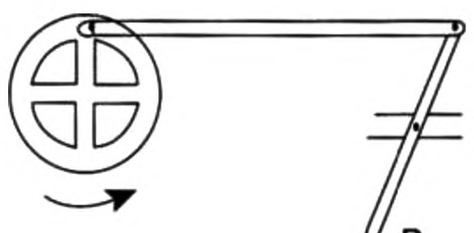
• *motoric systems* (eg throwing a Frisbee or bouncing on a trampoline).

In all these cases, you systemise by noting regularities (or structure) and rules. The rules tend to be derived by noting if A and B are associated in a systematic way (eg the musical note E is always five tones above the musical note A; or in 1995 the Car of the Year was a Fiat Punto). A second step in systemising is to consider if the evidence allows you to conclude that A causes B (eg turning this electrical switch to the Up position causes this light to go on; or moving the Ayesha hydrangea from acidic to alkaline soil causes its colour to change from blue to pink).

The evidence for intact or even unusually strong systemising in autism and Asperger syndrome is that such children performed above the level that one would expect on a physics test (see Figure 1). Children with Asperger syndrome as young as 8-11 years old scored higher than a comparison group who were older (typical teenagers).

A second piece of evidence comes from studies using the Systemising Quotient (SQ). The SQ is another questionnaire that works in a very similar way to the EQ and AQ. You simply say if you agree or disagree with each statement as a description of you. (There is a Child SQ, an Adolescent SQ, and an Adult SQ. See *www.autismresearchcentre.com*).

The questionnaire below lists 10 sample questions, each of which is asking you about how interested you are in different systems.If you disagreed with items 5, 7 and 9 below you would get 3 points on the SQ. If you agreed with the remaining items, that would earn you another 7 points on the SQ, making a total of 10. The higher your score, the stronger your drive to systemising. People with high-functioning autism or Asperger syndrome score higher on the SQ compared with people in the general population.



If the wheel rotates as shown, P will:
a) move to the right and top
b) move to the left and top
c) move to and fro
d) none of these

Figure 1: Physics test

Examples from SQ Questionnaire:
1. I find it very easy to use train timetables, even if this involves several connections.
2. I like music or book shops because they are clearly organised.
3. When I read something, I always notice whether it is grammatically correct.
4. I find myself categorising people into types (in my own mind).
5. I find it difficult to read and understand maps.
6. When I look at a mountain, I think about how precisely it was formed.
7. I am not interested in the details of exchange rates, interest rates, stocks and shares.
8. If I were buying a car, I would want to obtain specific information about its engine capacity.
9. I find it difficult to learn how to program video recorders.
10. When I like something, I like to collect a lot of different examples of that type of object, so I can see how they differ from each other.

(www.autismresearchcentre.com)

The strength of the empathising-systemising theory is that it is a two-factor theory that can explain the cluster of both the social and non-social features in autism and Asperger syndrome:

• below-average empathy is a way to explain the social communication difficulties

• average or even above-average systemising is a way of explaining the narrow interests, repetitive behaviour and resistance to change/need for sameness.

This is because when you systemise, it is essential to keep everything constant, and only vary one thing at a time. That way, you can see what might be causing what, rendering the world predictable. And to check if the pattern or rule you have identified is correct or consistent, it is essential to repeat the sequence over and over again.

Just as a spider cannot help but spin webs — that is what they are evolved to do — so (according to this theory) the person with autism or Asperger syndrome just has to systemise everything. That is how their brain works. The content of their narrow interests reflects how they are strongly drawn to systemisable information.

Reconceptualising repetitive behaviour and narrow interests in Asperger syndrome

An advantage of the empathising-systemising theory is that it reconceptualises the repetitive behaviour and narrow interests in people on the autistic spectrum. Whereas the weak central coherence theory sees these as a sign of something missing in the brain (the ability to integrate or perceive at the global level), the idea of strong systemising sees these same behaviours as the result of intelligent behaviour (detailed analysis of systems, however small).

Systemising in Asperger syndrome

Sensory systemising
wearing the same clothes every day
insisting on the same foods each day
Motoric systemising
practising skateboarding moves or frisbee moves
learning knitting patterns
Collectible systemising
collecting the complete set of Warhammer or Pokemon
making lists and catalogues
Numerical systemising
rapid calculation of prime numbers
solving maths problems
Motion systemising
analysing exactly when a specific event occurs in a repeating cycle
enjoying riding on merry-go-rounds
Spatial systemising
studying maps
developing drawing techniques
Environmental systemising
knowing the names of the DVDs lined up on the bookshelf, in order
insisting that nothing is moved from its usual position in the room
Social systemising
learning the names and rank of every person in a battalion
insisting on playing the same game whenever a child comes to play
Moral systemising
insisting on other people following social rules
becoming a whistle-blower
Natural systemising
learning the names of every kind of tortoise
learning the Latin names of every plant and their optimal growing conditions
Mechanical systemising
taking the toaster apart and reassembling it
fixing bicycles
Vocal/auditory verbal systemising
imitating accents
collecting words and word meanings
Systemising action sequences
watching the same movie dozens of times
analysing dance techniques
Musical systemising
mastering an instrument
analysing the musical structure of a song

Reconceptualising 'learning style' in autism spectrum conditions

Like the weak central coherence theory, the empathising-systemising theory is about a different cognitive style (a different style of thinking and learning). Like that theory, it also posits excellent attention to detail (in perception and memory), since when you systemise you have to pay attention to the tiny details. This is because each tiny detail in a system might have a functional role. In one cell phone, which is a mechanical/electronic system, one button may have a completely different function to the same button in a different make or model phone. In a mathematical calculation, changing one number in the sequence will totally change the workings of the system (the answer you get). So details matter.

The difference between these two theories is that: the weak central coherence theory sees people with autism spectrum conditions as drawn to detailed information (sometimes called local processing) for negative reasons, because of an alleged inability to integrate.

The empathising-systemising theory sees this same quality (excellent attention to detail) as being highly purposeful: it is being done in order to understand a system. Attention to detail is occurring for positive reasons: it is in the service of achieving an ultimate understanding of a system (however small and specific that system might be).

The extreme male brain theory

The empathising-systemising theory has been extended into the extreme male brain theory of autism. This is because there are clear sex differences in empathising (females performing better on many tests of this) and in systemising (males performing better on tests of this). Seen in this light, autism and Asperger syndrome can be conceptualised as an extreme of the typical male profile. This view was first put forward by the paediatrician Hans Asperger in 1944.

This theory is effectively just an extension of the empathising-systemising theory. That theory posits two independent dimensions, E (for empathy) and S (for systemising), in which individual differences are observed in the population. When you plot these, five different 'brain types' are seen.

The extreme male brain theory is a relatively new theory that may be important for understanding why more males than females develop autism and Asperger syndrome. It remains in need of further examination.

Statistics: describing properties of sets of results

Baron-Cohen presents his results in a form familiar to those who are interested in the range of results that you get when you measure a particular property, such as height or income, across a large number of examples or subjects. In more technical language, 'a specific

parameter is sampled across a specified population'.

Statistics are about 'how we say things' about these collections of numbers; hopefully, they are 'interesting things'! Usually the first measure used to describe results would be 'the average value'.

Unfortunately, the language in which these things are talked about is a foreign language to most people, and the language itself becomes a problem; for example, the word 'average', as in 'average income'.

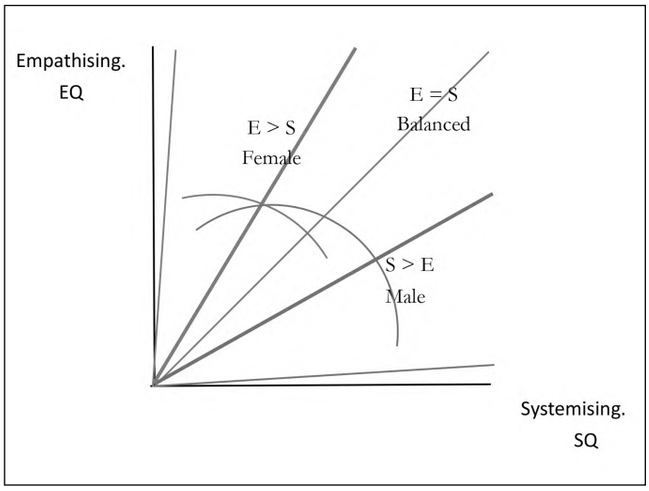


Figure 2: EQ and SQ scores on axes of graph

A mathematician would want to know if that is:

- the mean value – the sum of all the measurements divided by number of measurements
- the median value: half the measurements are smaller than this value and half are higher
- the mode value – the most frequently occurring value – the peak of a graph of the results.

One of five kinds of mind

If we place the EQ and SQ scores on two axes of a graph (see Figure 2), then equal scores on each axis would represent a 'balanced mind', as indicated in the diagram. Typically women score higher on the empathising scale, so their scores would tend to lie above this line; while men typically score higher on the systemising scale, so their scores would tend to lie below this line. This is indicated by the male and female lines and the spread of results is indicated by the associated arcs.

Finally, there are the Extreme Empathisers and the Extreme Systemisers and that last category corresponds to Aspies. So, we can suggest the existence of five kinds of brain; and the results fit this idea quite well (see Figure 3).

The theory is that these brain types are neurobiologically based and the prediction is that more females are likely to have a brain of Type E, and more males are likely to have a brain of Type S. People with autism spectrum conditions, if they are an extreme of the

Extreme Type S	Individuals whose systemising is above average, but who may be challenged when it comes to empathy	S >> E Equates to Asperger's
Type S	Individuals whose systemising is stronger than their empathy	S > E
Type B (for balanced)	Individuals whose empathy is as good (or as bad) as their systemising	S = E
Type E	Individuals whose empathy is stronger than their systemising	E > S
Extreme Type E	Individuals whose empathy is above average, but who may be challenged when it comes to systemising	E >> S The intuitive empath. In TA we identify this with 'The Little Professor.' In therapy it may correlate to 'The Highly Sensitive Person'

Figure 3: Brain types predicted by the empathising-systemising theory

male brain, are predicted to be more likely to have a brain of Extreme Type S.

Two dimensions

Reflecting on writings – Attwood, T. (2007); Baron-Cohen, S. (2008); Blakemore J. E., et al. (2009); Mc Gilchrist, I. (2009) – there is a theme of pairings, and putting them together seems significant to me.

Left Brain	**Right Brain**
Systemising	Empathy
Analytical	Experiential
Narrow focus of attention	Broad focus, vigilant
Dialectic discourse	Dialogic discourse
Detail	Context
Bottom up	Top down
Objective focus	Subjective focus
Male	Female

These pairings will be more understandable when the neurobiological differences between NT and Aspie brains are presented. But first, consideration of the sensory and perceptual differences that may need to be taken into consideration when doing therapy, and how that impacts on the process. This will be considered in the next article.

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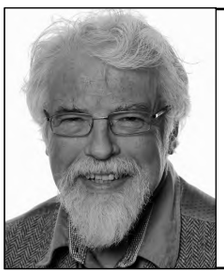

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TA and Asperger's – New TA theory presented and validated at a workshop event in Bristol

'It was like Aspies glimpsing that there was a better world and that they can learn the skills and be empowered.'
Christine Russell, co-presenter

On 11-13 November 2016, Peter Flowerdew, with Aspie co-presenters Richard Hall and Christine Russell presented, for the first time, a reframing of the standard TA101 material re-framed to describe and model the different mind, personality structure, transactional style and scripting of Aspies; nicknamed 'The Aspie TA101'. This was a two-screen event – standard TA on one screen, the translation to the Aspie-world on the other.

Nearly forty people attended: Parent-Aspie-Children pairs, Aspie-Aspie couples, Aspie-NT couples and individual Aspies, as well as psychotherapy professionals. 'By having this group of attendees and their questions, the workshop connected directly to lived experience, while being grounded in current academic research on Asperger's, and expressed through TA' said Richard Hall.

The objective had been to give NTs an insight into the subjective world of Aspies, and vice versa, and in that way, create a dialog between these two subjective worlds. For that to occur the Aspie TA had to make sense to both the NTs and the Aspies, and it did. The effect was amazing, as evidenced by the quote from Christine above.

Richard and Peter will be presenting this material at the **National Conference on 21 April**; all three will be at the **MIP Conference, in Manchester, on 15 October;** and Peter is presenting at the **European Summer School 13 and 14 May, in Zagreb.**

Asperger's in the therapy room – 5

In the fifth of his series of articles about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** looks at sensory sensitivity and perceptual issues.

IN ONE SENSE it would have been more logical to begin the exploration of the issues of working with Aspie clients with the sensory experience that they have, and then build up logically, through the way that it is processed, and then how this influences the psychological aspects that, in turn, lie behind the behaviour that draws our attention to someone with Asperger's.

That would be logical and would probably appeal to an Aspie. However, now that we have an understanding of the characteristics of the cognitive and relational processes of an Aspie, the deep impact of the fact that many Aspies also have different sensory experiences to neurotypicals (NTs), can now be more fully appreciated. We have a context in which to fit this information in; and that works for the NTs.

One of the axioms of Transactional Analysis is that all parts of our mind have positive intent. When we experience behaviour from another person that does not quite fit the context of the present moment, we seek to understand the way in which the person is seeking to achieve what they perceive as a good outcome even if in the current context it appears self-defeating, or at least not an optimal way of managing the situation. This approach has to be the way we approach our attempts to understand the experiential world of an Aspie. However bizarre the behaviour may appear to us, it has positive intent and purpose behind it.

Some of the most difficult behaviour for NTs to understand is the behaviour used by Aspies to manage sensory processes that are not part of our experience. What can make things more difficult is that it seems that no two people on the autistic spectrum have exactly the same sensory perceptual experience. If you wish to do therapeutic work, teach, or manage a person with Asperger's it is essential that you learn from them any sensory difficulties that they experience.

Hypersensitivity and hypo sensitivity

Aspie clients often describe what they would call hypersensitivity to various sensory stimuli. In fact they may be:

Hypersensitive: the sensory channel is to open, there is too much stimulation for the brain to handle.

Hyposensitive: the sensory channel is not open enough, too little of the stimulation gets in.

'White noise': the channel creates its own stimulus, a form of faulty operation, and the message from the outside world is overcome by this internal noise.

It is possible for the same sensory channel to be normal or to have one of these three characteristics at different times. A sensitivity to fluorescent lighting is common, they perceive the flickering of the tube at mains frequency. The contrast between a bright beam of light through a window and the shadow alongside it can be too intense. The texture of material against the skin can be felt like sandpaper or the heavy weight of a thick blanket might be soothing and comforting. In the following definitions some common over or under sensitivities are listed. The extremes can be seen in autistic children. They are generally not as extreme with Aspies.

Hypersensitivity

• *Hyper-vision*: their vision is too acute. For example, for a child fascinated with specks of dust floating in sunlight, the specs are like butterflies. Another child may be fascinated with touching hair as it is like string.

• *Hyper-hearing*: they might be able to hear some frequencies that only animals normally hear or they can hear conversations or traffic that is far away and inaudible to other people. My grandson dislikes being around arguments or crowded places, there is too much noise. He covers his ears if a fire engine or ambulance goes past. Having a haircut is a nightmare because the sound of the scissors cutting hair terrifies him.

• *Hyper-taste/hyper-smell*: they have a sense of smell compatible to that of dogs. The smell of particular foods, of particular perfumes, and even of particular people, can be overwhelming.

• *Hyper-tactility*: they over react to touch. Some cannot

bear to be hugged. Some cannot bear the touch of certain materials. Some can be so sensitive that an unwanted touch can trigger a panic attack. My grandson refuses to allow anyone to wash his hair the sensation of water on his head is intolerable.

Some Aspies are aware that their barrier to being hugged has cut them off from soothing and comforting contact and this has added to their anxieties in social situations.

- *Vestibular hypersensitivity*: they experience difficulty changing the direction of movement and are poor at sports. They have a low tolerance for any activity that involves movements or quick changes in the position of the body. They feel disorientated after any activity involving running jumping or turning suddenly.
- *Proprioceptive hypersensitivity*: they have difficulty manipulating small objects, catching or kicking a ball, and may take up odd postures.

Hyposensitivity

This is more common in infantile autism. The individual experiences not getting enough information, their brain can feel empty and stop processing and they are not really seeing anything or hearing anything, they are just there. It might then create stimulation to get their brain going again by waving their hands around or rocking backwards and forwards making strange sounds or hitting their head with their hands.

- *Hypo-vision*: they can experience trouble figuring out where objects are as they see just outlines and even bright lights are not bright enough. They may stare at the sun or walk around something running their hand around the edges so that they can understand what it is.
- *Hypo-hearing*: they seek stimulation by sound, for example listening to electrical equipment, enjoy and are excited by crowds or sirens or fairground music. They often create sounds themselves to stimulate their hearing – banging doors, tapping things, vocalising.
- *Hypo-taste hypo-smell*: children with hypo taste/hyper-smell, chew and smell everything they can get – grass, coal, Play-Doh, perfume, or worse.
- *Vestibular hyposensitivity*: they enjoy and seek all sorts of movements and can spin or swing for a long time without feeling dizzy or being nauseated. My grandson goes into a deeply relaxed almost trancelike state when lying in the kind of swinging cradle that has recently appeared on playgrounds. He can go on the fastest spinning roundabout for any length of time whatever and will not be dizzy when he comes off it. When we take him out in a car he literally bounces up and down with the pleasure of the movement. Often when we arrive at our destination he doesn't want to get out of the car, the journey is the pleasure, what we plan to do when we arrive is not so significant to him. The greatest treat of all is a ride on a steam train.
- *Proprioceptive hyposensitivity*: they have difficulty knowing where their bodies are in space and are therefore perceived as clumsy. They are often unaware of their own body sensations, for example my grandson can walk barefoot on gravel with no apparent discomfort. They can appear sloppy, leaning against people, furniture and walls.

Researchers suggest that hyper- and hyposensitivity causes all autistic behaviours, withdrawal from social interaction and communication, stereotypic behaviours and self-stimulating behaviours. They can be considered as the child's attempts to treat himself and either to normalise his sensory channels or to communicate his problems.

Literal perception

Therapists tend to look at the world and draw connections, make meaning, and interpret what they perceive. Aspies do not do this. They see things as they are. They take what they see at face value without judging or interpreting them; this is called 'literal vision'. I find deep irony in the fact that many NTs spend a lot of money on courses on mindfulness and meditation in order to access this clear and uncontaminated image of the reality we inhabit. If you value this way of seeing the world, your Aspie clients will teach you to look at your environment in a different way.

This is true to an amazing level of perception. Our brain takes signals from the optic nerve and constructs a perception of 3D space. It is convincing, and it is a construct. Our brain evolved to make accurate representations of the natural world. It can be fooled. This is what we experience when we see optical illusions. Aspies generally do not see optical illusions they see what is actually drawn. When we glance at patterned wallpaper our brain decodes the pattern and then literally paints it onto the surfaces around us. We do not actually 'see' each element of the pattern. Many Aspies do see each element of the pattern, and it can take them time and effort to process that data in a conscious way.

You may recall from an earlier article the client who was a professional plasterer. His plastering was perfect because he would see every flaw every defect in the surface and correct it. I observed, to him, that the plastering in the room we were in looked perfect to me, and he immediately pointed out for all five defects in the plastering that were clear and obvious to him, I only noticed them when they were pointed out. Similarly, the client who was a professional tiler, again he laid perfect tiles time after time, thousands of times. Any defect glared at him and was intolerable.

Apart from not noticing defects in interior decoration, an advantage of the NT brain's ability to fill in gaps and not get caught on detail, is that we learn to focus on what is important and significant in our environment and

therefore process the necessary information more efficiently. Aspies tend to not be able to discriminate 'foreground' from 'background'. Their brain does not discriminate relevant and irrelevant stimuli, there is no filter. Sometimes it seems that every detail is recorded. For example I saw a program where an Aspie looked at a view over London then went into a room and reproduced that view in every detail. What was interesting was that he did not draw overall outlines and then gradually fill in more and more detail, as I have seen NT artists do, but simply drew a detail, and another detail, and another, until all the details have been drawn. This is sometimes referred to as Gestalt vision.

The ability of the NT brain to 'fill in gaps' rather than process all stimulate is not restricted just to vision. We can use our experience of similar situations to assess what we are hearing and what we are feeling, which, much of the time, allows us to filter out distractions when, for example, working in an open plan office. Aspies can be very sensitive to audio distractions; one person was disturbed by the ticking of a clock, another by the never ending footsteps on the carpeted floor.

The inability to filter foreground and background information means that Aspies can perceive more accurately, but also receive a larger amount of information, and large amounts of unfiltered, and unselected, information can lead to information overload. One client reported that if she attended a business meeting in the morning she needed the rest of the day to process all that information. There was considerable frustration on both sides when managers presented her with multiple choice questions and did not understand that she would not be able to give them an answer until the following day.

It is this Gestalt perception that also makes it difficult for Aspies to accommodate change. If a picture is moved or an item of furniture is at a different angle the Gestalt is different so the environment is now unfamiliar. The same is true of all routines, if something goes differently they do not know what to do. All of this creates anxiety, stress and confusion.

It can surprise many people that an Aspie will have much more trouble with a slight change to a plan or room than with bigger more dramatic changes. A major change is a complete new Gestalt; but with a small change there is confusion and the need to make an adjustment to an existing Gestalt. The world is proving to be unpredictable and inconsistent and this triggers deep anxiety. The Aspie brain already seems to be programmed for anxiety and life situations seem to trigger it more often.

Dysregulation

If there is one idea to keep in mind, it is that of emotional dysregulation. When we are well regulated emotionally, we are most able to perform tasks, to be creative, to participate in activities, and to navigate the social world. Our neurological systems help by filtering our excessive stimulation, telling us when we're hungry or tired, or when to protect ourselves from danger. Aspies, mainly due to their different neurology, are unusually vulnerable to everyday emotional and physiological challenges. So they experience more feelings of discomfort, anxiety and confusion than NTs and also have more difficulty learning how to cope with these feelings and challenges.

Barry Prizant (2015) considers that difficulty staying well-regulated emotionally and physiologically should be a core, defining feature, of autism and Asperger's syndrome. He considers it unfortunate that professionals have long overlooked this, focusing on the resulting behaviour instead of the underlying causes.

Dysregulation, or rather managing or avoiding dysregulation, is behind almost all 'typically Aspie' behaviour. Its most extreme manifestation is in meltdowns and shutdowns.

Meltdowns and shutdowns

If you are working with young people you are almost certain to be faced with the challenge of helping your client to cope with meltdowns. If you are working with adults you are almost certain to be faced with the challenge of helping your client to cope with shutdowns. In my experience, in both cases, there is a need to inform, educate, and support other people who are in relationship with the Aspie to recognise and reduce the triggers to these events. There is a place for the therapist to act as an interpreter and advocate for the Aspie in schools and workplaces. The nature and the boundaries of this role are the focus for ongoing reflection and development, but is, I think a key element of what TA practitioners can offer to a client with Asperger's.

Meltdowns

This is the term used to describe the emotional outbursts, more accurately, the emotional dysregulation of children on the autistic spectrum. They can have an immense impact on the quality of family life, the ability of the child to access mainstream education, and strain the general tolerance and goodwill of the adults around the child that is essential to the child's well-being.

'A meltdown begins with anger and ends with crying' (Thompson 2009:13). Crying is the child's means of communicating distress to the adults around them, and this is the clue for what is needed from the adults in this situation.

Meltdown is usually an involuntary reaction to the interruption of an expected routine, thwarted access to a preferential activity (waiting can be hard) or being confronted by an anxiety provoking situation, which may include sensory sensitivities that we are not aware of.

Children make adaptations to optimise the responses

they get from other people. Some Aspie children will use the dramatic impact of meltdown behaviour to train those around them to give way to their demands, in a similar way to which a two-year-old may throw a tantrum in the supermarket to be allowed to keep the bar of chocolate that they have just picked up. This too, from the Aspies point of view is a constructive adaptation, but not socially effective. It usually requires the disinterested enquiry of the therapist to distinguish the distress response from the socially-motivated display. The ability of parents, carers and teachers to differentiate these two types of situations is crucial for the socialising of the child.

A genuine meltdown is not a demonstration of disobedience. Usually the child is frustrated or terrified. Children on the autistic spectrum show similarities to those with OCD, with intolerance for changes in schedules and an insistence that activities are carried out in the same way on each occasion. We do not think of a young person with a hand washing compulsion as being a spoilt child, but that is frequently the reaction to the meltdown of an AS child.

As TA practitioners we are well placed to understand that behaviour is a communication and to help our clients and others to correctly decode the meaning of the behaviour.

Shutdown

Some of the elements that have been discussed, that are part of an Asperger's presentation, come together in any social situation, to create anxiety and stress, and possibly a situational overload. This is illustrated in Figure 1, below.

I have accompanied Aspies in business meetings, multi-agency assessments, and disciplinary or legal procedures. In each case, I have found that my client is overwhelmed by the information processing and speed of communication and the speed of decision making imposed on them. A greater or lesser degree of shutdown is the result. I intervene, to buy them time, and to try to influence the process.

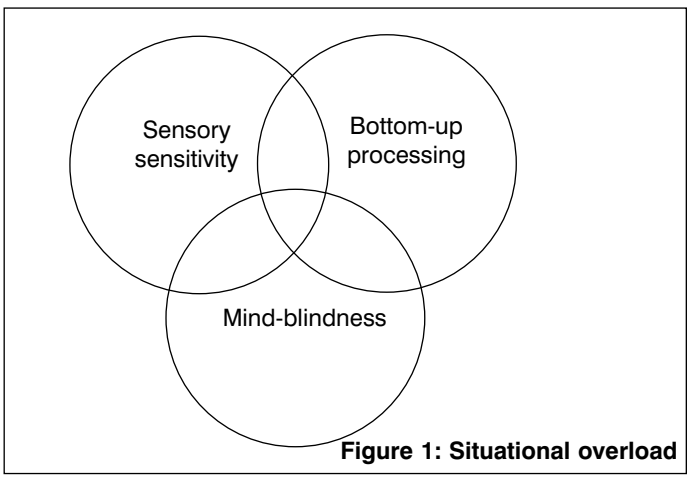

Figure 1: Situational overload

For example the triad above might present in a business meeting as follows – I write from the perspective of the Aspie:

Sensory sensitivity:

– 'The meeting is in a small side office. Five of us are fitting into a small space around the table. The physical closeness and the smell of the people is unpleasant. The lights are too bright. The room has no soft furnishings and sound echoes making it difficult to distinguish words.'

Gestalt processing:

– 'The manager begins by reading out the agenda. I cannot find the piece of paper in the pile in front of me and I cannot listen while I am searching for the paper.'

– 'The manager asks me if I am comfortable, would I like to move to another seat around the table, do I have any other items I would like to have on the agenda. A thousand answers filled my head I do not know what to say.'

– 'I am still looking for the piece of paper.'

– 'Someone is walking past the door, the sound distracts me, are they coming in; what would I do.'

– 'The manager is looking straight at me, I know that she wants an answer. I do not know what to say. I say 'I'm fine'; that seems to work.'

Bottom up processing:

– 'I find it applies to many aspects of ordering information, analysing an architectural drawing, a legal document or writing an essay or presentation.'

– 'At the last meeting I did explain to this manager giving me information and instructions verbally did not work for me. One idea was to provide a whiteboard on which the tasks that I have been given could be written in the order that they were important to other people because they could not understand that I cannot guess what their priorities are.'

– 'The manager pulls out a catalogue and points to a number of whiteboards that could be ordered. She wants me to choose which one I want. In order to know which size of board to choose I have to visualise myself in the office, using the board going through a day's work, and then I can understand what features I need. I cannot do this in a meeting. I need a quiet place with no distractions in order to focus and visualise these tasks. I try to explain this to her, but she does not understand. I ask for the catalogue, and tell her I will inform her of my choice later in the day, then let's move on.'

– 'Ten minutes into the hour and I am already feeling overwhelmed.'

Theory of mind:

– 'I do not understand why they cannot move me to a quieter area. They keep saying that they want me to feel part of the team, but how can I feel part of the team if I cannot complete my tasks because of the distractions of all the telephone conversations and people moving

around me. (They assume that she would 'feel isolated' in another area.)'
– 'My supervisor is staying very quiet. I think she must be annoyed with me. I don't know what to do. (She simply has no contribution to make to the current discussion).'
– 'My anxiety level is rising. I think this is all going wrong.'

Shutdown can be viewed as an involuntary mechanism whereby the brain shuts off certain systems in order to protect the level of functioning of other systems.'

Researchers (Williams, 1996, quoted in Bogdashina, 2003) identify three basic forms of shutdown:
1. Shutdown in the ability to simultaneously process sensory information and thought, feeling, body sensations or the monitoring of intentional and voluntary expression.

a) All processing capacity may be diverted processing incoming sensory information, no connection may be made to responding to that information.

The person remains aware of what is happening around them but is incapable of responding verbally. An experience that is described as 'all other-no self'.

b) Or the person may make a response to information already received and processed but cannot at the same time process any more information. An experience that is described as 'all self-no other'.
2. Shutdown in the ability to simultaneously process sensory information on several channels at once. This can take three forms:

a) Temporary systems shutdown: this works by shutting down the ability to process information on the number of channels so that information can be efficiently processed in whatever channel or channels are remaining. This can affect the processing of body awareness, touch, taste, smell, vision or hearing. They can be partial or almost total for any one sense.

i) Partial systems shutdown means that only a part of processing may fall out of a particular sense. The subject may continue functioning by shutting down different systems each for a short period of time.

ii) Total systems shutdown means that, for example, eyes and ears continue to function but the brain doesn't process any meaning to what is being seen or heard. These states are referred to as tuning out or a whiteout.

b) Extended systems shutdown: this works by shutting down a particular system, in order to handle information overload, over an extended period of time: hours, days, months, years.
3. Shutdown in the ability to maintain conscious and voluntary processing, which also may be temporary or extended. Information continues to be processed, but out of conscious awareness, leading to the experience of 'unknown knowing'.

Therapeutic considerations

We now have a map, a framework, in which to understand how an Aspie client may be experiencing their world, the significance they attach to those experiences; and I have already indicated some ways in which we are placed to be able to assist them and the NTs who are a part of their lives.

My favourite quote from Ian Stewart (1992) is that Eric Berne made states of mind visible, now what a gift that would be to give an Aspie. Teaching them about ego states, and how to identify them; about transactions, especially crossed transactions; about games and scripts gives them insights into the NT world, gives concepts and vocabulary, now we can talk – it is empowering, it is a start.

The second gift we have to offer is that we talk in pictures, we create diagrams that explain how relationships work, and Aspies tend to be highly visual and not so good with verbal communications. Tony Attwood (2003:83) quotes an Aspie teenager saying 'I have the picture in my mind not the thousand words to describe it'. Paxton and Estay (2007:51) report on the efficacy of visual means to help Aspies to comprehend abstract concepts, learn social conventions, and develop relational skills. They state that these examples demonstrate that information is digested best if it is created in a visual format, and the challenge is to adapt therapy, which is mostly based on talking, to a visual mode.

So what I want to share with you is some of the things I have learnt from my Aspie clients, expressed in terms of TA theory, and mostly in diagrams.

Contracting

But first, some thoughts on the challenge of setting up a therapeutic relationship with the client who may not have an understanding of the expectations of the therapeutic relationship or the ground rules associated with therapy. They may require more or less specific instruction in turn-taking and sharing of information, and the therapist may need to tolerate monologues of the special interests of a client, when this represents the client's sincere attempt to communicate the experience to the therapist. Some may need to understand what information the therapist needs to know, when telephone contact is appropriate and available. The client may also need an explicit statement that therapy can help them with their problems when they work with the therapist as a partner. One problem in contracting is that the client is likely not to have the same perspective on the difficulty that parents, a teacher, partner, or employer, or the therapist perceive. They are therefore not going to bring that perspective, an NT perspective, into the therapy room. If they do not perceive something as a problem they will not discuss it, unless the therapist asks a very specific and

focused question, to bring it into the client's awareness that other people's willingness to engage with them or support them is being affected by this issue.

Exploration

I have found working with Aspies very challenging because every assumption I have about what is perceived, the meaning and significance of it, has to be built from the ground up with each individual. How can I possibly attempt to make a change in someone's subjective world until I have explored that subjective world? While the Aspie world is alien to the NT, unless we make the attempt to perceive it, we may well retraumatise our Asperger clients, rather than help them. They can be left feeling degraded and rejected.

If we can understand the perceptual processing and meaning making behind behaviours, not only can we more easily accept the behaviours, but we can also suggest ways either for altering them, or communicate their purpose and meaning to other people in the NT world so that we can make a space for them in what they experience as an alien world.

Pacing

The pace of work will also be much slower than with NT clients because Aspies need more time to process new information and to formulate their responses. With adult clients it is possible to contract that they will report on anxiety, confusion or frustration within the session. With younger clients I have found it helpful to allow them to decide whether to come to the session or not, whether to have it face-to-face or by telephone. I believe that this gives them a rare experience of autonomy and is congruent with the statement that this is their space to use in the way they find most helpful. They will take this absolutely literally, and the freedom to choose, logically, includes the option to say 'no thank you'. The mother of one young client, to whom I had given these options, told me in a rather puzzled tone of voice that sessions with me were the only weekday activity that he anticipated with excitement and asked to come to.

Notes, diagrams and lists

Paxton and Estay (2007:78) report that concepts discussed during therapy are understood more easily when accompanied by written notes or diagrams. One of their clients said 'I can't hear it until you write it down.' The notes and diagrams facilitate understanding and integration of concepts.

I myself, also being highly visual, regularly use a flipchart to make diagrams and lists, and when I suggest to the clients that they might like to take the pages with them they are usually visibly pleased. Note that I make an explicit offer. I frequently give very specific 'permissions', usually as a result of noticing a hesitation or slight agitation. An Aspie will be trying to work out 'what are the rules here?' and I consider it a typical element of an Aspie script to not ask for what they would like to have, or need, because they cannot anticipate what the other person's response will be, and the uncertainty is inhibiting and anxiety provoking.

When I am offering notes, diagrams or particular kinds of interventions the client will often be less reticent or resistant if I offer some normalising assurance, such as 'it is quite normal in therapy to …' or 'therapists usually …' or 'I find it helpful if ….'

I usually suggest what topic, issue or concept we might talk about next time – to give structure and reduce potential anxiety. Sometimes the client will come with pages of notes they have made. This I take as an indication that spontaneous verbal communication is not their preferred style. I will ask them to talk about what they have written, then take the notes from them at the end.

So… we are ready.

Why use TA?

TA provides concepts and tools that can provide insight into the different experiences of Aspies and NTs and can facilitate understanding and communication.

And that is the focus of the next article in the Summer 2017 issue of *the Transactional Analyst*.

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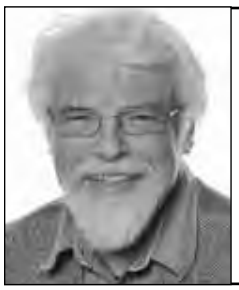

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Asperger's in (and outside) the therapy room – 6

In the sixth of his series of articles about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** looks at Transactional Analysis as a gateway to dialogue

TRANSACTIONAL ANALYSIS PROVIDES a gateway to dialogue between two worlds – and the gift of autonomy for Aspies. The two elements to the title of this article show how my understanding of how Transactional Analysis can be useful when working with Asperger's clients, has developed, and how I now perceive that what I and my clients call 'Aspie TA' can facilitate a profound dialogue between the Neuro-typical NT population and the Aspie population.

I also believe Mindblindness to be the most debilitating element of being an Aspie trying to negotiate an NT world. The surprise in this journey of discovery for me, has been the impact on Aspies of having a way to understand and adapt to the states of mind of NTs. The statement Ian Stewart made in his book on Eric Berne, 'Eric Berne made states of mind visible', triggered my awareness that TA can provide is a cognitive tool for Aspies to give them insight into other people's states of mind. With that insight, they can begin to perceive other people's motives; and there is, at last, an answer to the question 'why?'. With that answer, they are better positioned to choose who to trust, and who to avoid, in personal and in business life. Anxiety diminishes.

Many NT interventions intended to help Aspies 'fit in', all too often reinforce a 'Don't be you' injunction. In contrast, the insights from applying TA help Aspies to navigate the NT world. TA provides a tool for awareness, supports autonomy and provides an experience of intimacy; a doorway to autonomy for Aspies. This is not my belief, it is the reported lived experience of the group that I have been working with. Every model that I share with you has been validated by Aspies having said 'yes, that is my world, my experience'. Their joy has been having in their friends and family, particularly their partners, say 'now I understand; that makes sense'.

Our value base

Without wishing to bring political issues into the forum TA community, it is simply a fact that the experience of the referendum on Brexit and the election of the new president of the US disturbed me profoundly, even more in their process than in their outcome. You can smile now, as I admit that it came as a shock to me to become aware that a lot of people, maybe half of the adult population, in the UK, and the US, did not share my value base. That fact had been staring me in the face, in the content of news broadcasts every day, every year, of my adult life, but it had not registered in its depth and implications until now. The section on the Value Base of TA in the TA101 seems to me, now, the most significant, the foundation of the whole thing, rather than a bit of intellectualisation to get past, to get onto 'the good stuff' on ego states.

The way in which I seek to be with people has been, for as far as my memory reaches, the OK-OK position that Berne and his students have aspired to. Here, as I write, in my imagination, I hear a collective groan, especially from TSTAs that I know, who hear that phrase said so glibly so unthinkingly by many people. So here is how I understand the statement, 'I'm OK, you're OK':

I'm OK, You're OK – people are OK

Every person has worth and value, whatever their behaviour.

In practice: 'It is fine for you to be who you are; and I will give you the right and space for you to be you; provided you give me the same right and the same space for me to be me.

Difference is interesting, not a threat:

Different perspectives provide more options, therefore offer more resourcefulness and resilience.

Making space for difference is an invitation for me to deepen and develop my humanity.'

Goodwill is essential but not enough; we also need insight and skill. Otherwise, it is just words.

The other two core values are:

- 'everybody can think' and Aspies tend to excel at that and like to be around people who value that
- 'and they can change a decision', but that can be more difficult for Aspies than for NTs, because so much effort has gone into the decision in the first place.

Our values directly lead to three things that are experiences by Aspies in the presence of people who hold

these values: 1) we take time to make clear explicit contracts: which suits the relational style of Aspies and reduces social anxiety;2) we take time to listen, and we are genuinely interested in their subjective reality; 3) we can provide the experience of being welcome and of being safe.

I would usually say 'safe and welcome' – being the fundamental needs of every child; needs that remain with us all our life. With Aspies I reverse the order, because, for 'me' to feel welcome, someone else has to welcome 'me' and if I experience being genuinely welcome, then I will feel safe, and validated – meeting the first two of the fundamental relational needs identified by Erkine, Mursund and Trautman [1999].

In the workshops that I have presented with Aspie co-presenters over the past fifteen months, the experience of feeling welcomed, safe, valued and with 'kind' people, genuinely interested in them, in itself, has been a transformation. To quote one co-presenter:

'I have never experienced the like: a room of people who were genuinely interested in my experience, who were sensitive to my sensitivities and appreciative of my honesty. They called me brave and extraordinary, and made me believe it. They were a special sort of "kind"',

The participants were all therapists, counsellors and students working for my charity.

I am constantly amazed at how the Aspies whom I work with are impacted by experiencing the quality of relationship offered by TA practitioners and how they embrace, explore and expand the theory and models.

Our models: the power of diagrams

What I want to share with you now, is how a dialogue with Richard (my client and co-presenter at the last two UKATA conferences and nine days of workshops), led to an insight that TA already had a model that allowed us to demonstrate to NTs the nature of mindblindness, and bring home the need for NTs to alter their communication style to create a dialogue with Aspies.

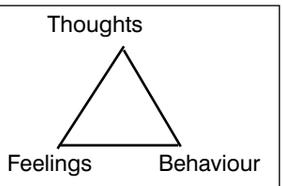
My original profession was engineering, and Richard is an engineer. Sharing the disciplines of engineering and the concepts and models of TA gave us an immediate cognitive resonance, which is the Aspie equivalent of mutuality. However, Richard has trained in Organisational TA, and I in Psychotherapy, so our models and way of thinking occasionally do not line up. In my training mode, I strive to teach a basic model of TA that is coherent and internally consistent, and is useful – the recognised qualities of a 'good' theory. Multiple, alternative, perspectives can then add depth and subtlety by embellishing the strong coherent core. I am passionate about that. So, when Richard presented a line of thought he was exploring, using a model developed by Taibi Kahler (1978), very different from the one I use, which is based on Ian Stewart's analysis (1992) of Eric Berne's writing (1961) not only did I fail to understand his point, but I was also distracted at the time by concern for the potential for confusion in the little band of very literal minded Aspies that I had been teaching TA to, and who have become friends (a word hardly used by Aspies until now), so they discuss things among themselves. That uncomfortable moment could have faded into memory, but it niggled at the back of my mind. I had read Taibi's book, and intuitively I knew that this model had something to say about mindblindness, and that Richard was on to something.

So here is the model that emerged, fully formed, in one image, concerning three aspects of reality that I present as three co-existing 'worlds': the objective world, our subjective world and a co-created intersubjective world.

To model mindblindness

We begin with an ego state:

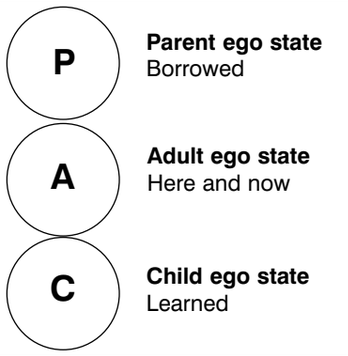
The term ego state is intended only to denote states of mind and their related patterns of behaviour as they occur in nature...



Then our model of personality

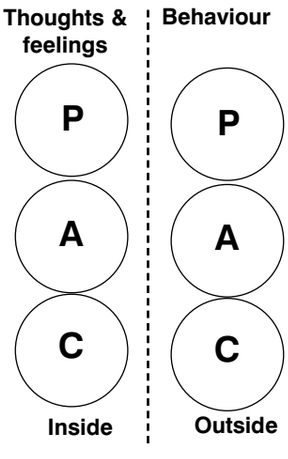
Structural analysis postulates only that such ego states can be classified and clarified and that in the case of psychiatric patients such a procedure 'is good' (Berne, 1961, p30)

(Stewart and Joines 2012, p21)



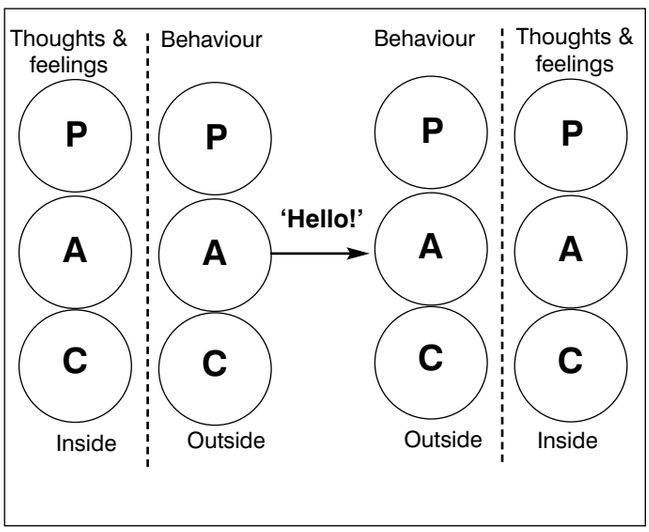
Then we separate the ego state model into two elements: thoughts and feelings, which are 'inside', not visible; and behaviour, which is visible on the 'outside' (Kahler, 1978, p3,10)

What is visible on the outside is a part of **objective reality**. What is experienced on the inside is part of that person's **subjective reality**



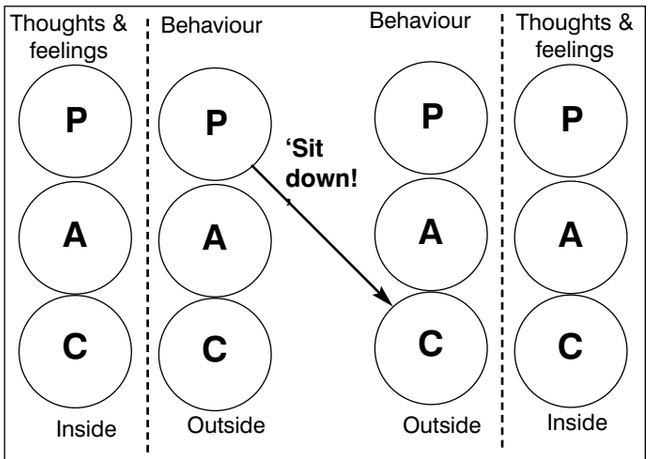
Relevant to therapy, is that for some Aspies their subjective reality comprises only their thoughts. They need to be taught both to recognise the somatic signature and the name of the feelings they are having. I have addressed this in my booklet *Asperger's in the Therapy Room*.

First, we use this model to look at look at transactions between two NTs, people who can 'mindread'.



In the observable, objective world, the behavioural aspects of the transaction are available to both people.

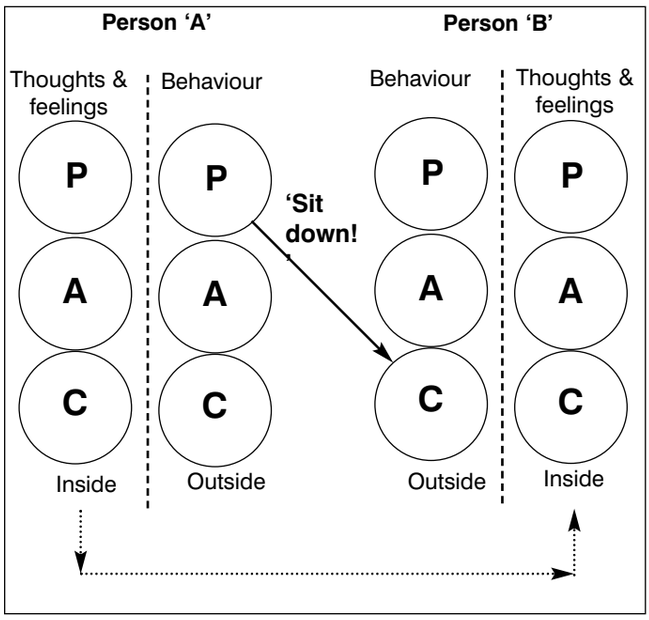
With the information so far, we might think that a ritual is taking place. If we were witnessing this, the tone of voice and body language might indicate the meeting of close friends, or lovers. Keep this in mind as you read on.



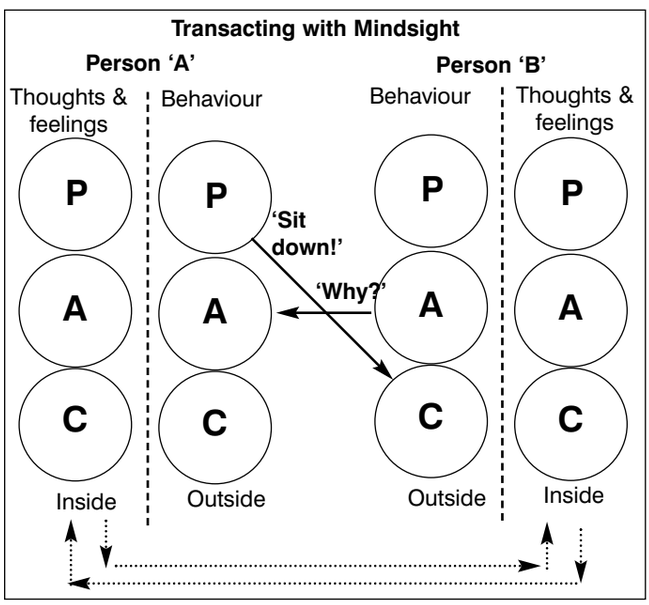
The thoughts and feelings associated with initiating the stimulus in this transaction are part of the **subjective world** of this person **'A'**

The thoughts and feelings associated with receiving the stimulus in this transaction are part of the **subjective world** of this person **'B'**

The following diagram illustrates how the thoughts and feelings associated with 'A' initiating the stimulus can be sensed and interpreted intuitively, by the recipient, 'B'. That information becomes part of the subjective world of 'B'.



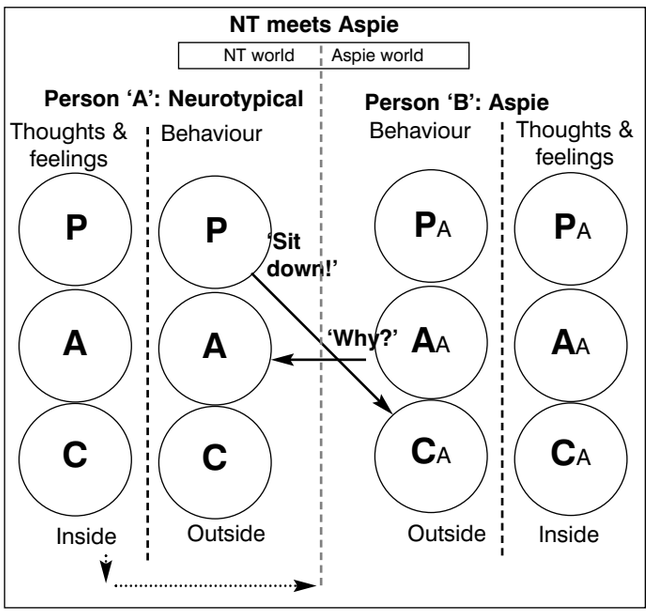
The shift in the **subjective world of 'B'** can be intuitively sensed by 'A', and becomes part of the information that they use to understand the relational significance of the verbal, observable response to their original stimulus.



This non-verbal, intuitive understanding constitutes the **intersubjective world** co-created in the interaction.

The observable A-A response will be experienced as congruent or incongruent with the intersubjective experience; i.e. person 'A' may or may not perceive an ulterior transaction, and that may or may not be related to Script.

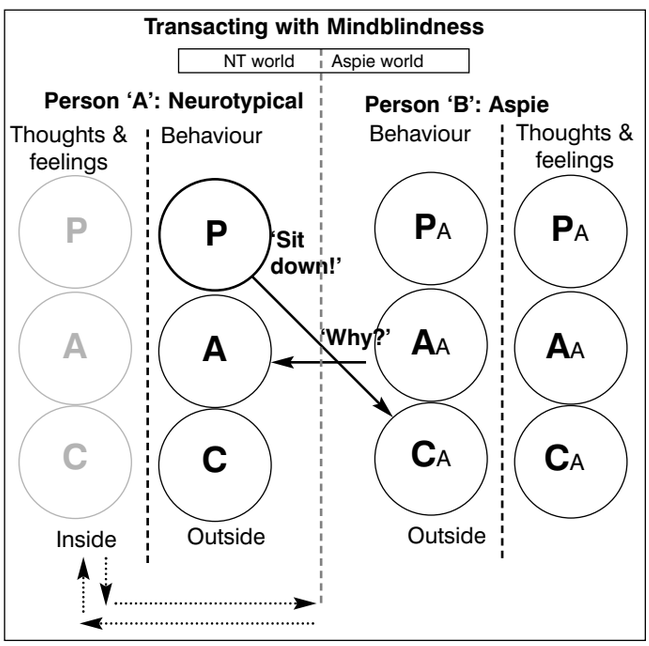
Now let's keep Person 'A' as an NT, and make Person 'B' an Aspie.



This diagram illustrates two important things:

1. the Adult of the Aspie functions in a different way to that of the NT, and that difference is reflected in archaic ego states too, as I shall discuss next time;
2. the subjective world of the NT is invisible to the Aspie.

Now let us look at it from the Aspie's point of view.



Because the subjective world of the NT is invisible to the Aspie, they cannot respond to it. The intersubjective world is not part of their reality. That is the single most important sentence in this article:

'The intersubjective world is not part of their reality.'

These two people live in totally different subjective worlds.

It is as if there is an invisible wall that blocks and distorts communications

I think of it this way:

It is as if the NTs can hear the theme music in the soundtrack of life. It tells you what is likely to happen next – a murder or a kiss.

The Aspies cannot hear the music of life.

Because the NT has sent an unambiguous psychological level message, their expectation is that the other person understands that message, and therefore understands the thoughts and feelings, the attitude, behind it.

Not realising that the message has not got through, the message that is returned from the Aspie, with an absent or inappropriate psychological message, as perceived by the NT, is likely to be perceived as a discount.

This is a particular example of a stroke filter, as the response will have an impact on the NTs thoughts and feelings, as indicated by the line from 'the wall' to their inner states.

On the principle that the perceived psychological message determines the behavioural outcome, the prospects do not look good for our Aspie.

Fully absorbing the implications of this diagram will help TA practitioners to make their own thoughts and feelings, especially strokes, explicit (verbally communicated) to their Aspie client.

The consequences of living in a world that does not accommodate Mindblindness

Anxiety Shame Isolation

'...and so I decided...
sometimes it's better to be alone as
nobody can hurt you.'

And I reply*:*

'But nobody really wants to be alone ...
teach me how to be with you.'

‘If an Aspie cannot hear what you think and what you feel, they probably do not know what you think and what you feel. If they have a slight sense of it, they don’t know what to do with it.’

If an Aspie cannot hear what you think and what you feel, they probably do not know what you think and what you feel. If they have a slight sense of it, they don't know what to do with it.

If we wish to create dialog, we have to adapt to their need.

‘If you don't say it; I don't know it'.

Thank you for your patience with this article. The concepts are easier to communicate interactively, but the magazine allows me to reach out to create awareness in more members of our community.

Maybe you could come to the workshops advertised under ‘Events’ on the Contact Point website: Life that Includes Asperger's: Creating a Dialogue between two Different Kinds of Mind.

Next time: An ego state model that captures neurodiversity.

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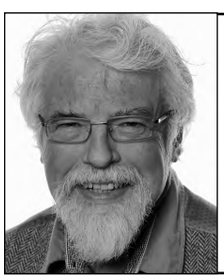

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Asperger's in (and outside) the therapy room – 7

In the seventh of his series about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** shows how he uses TA to create understanding, dialogue and to offer the experience of mutuality

RECENTLY I WAS at an EATA summer school and Mark Widdowson was beginning the keynote presentation for the day. As he stepped forward to start talking, he stopped, looked round him in a puzzled sort of way, walked across to the side of the room, and dragged a flipchart stand across to the centre of the floor. Then he turned to the audience and said, 'I just realised that I will probably have a compulsion to draw circles sometime in the next hour; have you noticed how TA people have this deep need to draw circles?'

Not only was that a wonderful 'very Mark' kind of way to get the attention of every person in the room, but it also indicated how central ego state models are to our way of thinking and discussing what goes on in and between people. So, my greatest satisfaction has been in producing two ego state models to help people to understand what goes on inside and between Neurotypicals (NTs) and Aspies.

Introducing the concept of ego state to Aspies

Aspies, especially teenagers and children, often do not understand that thoughts, feelings, and actions are related to each other, until they see it diagrammed out. Avoiding the temptation to draw circles, I like Paxton & Estay's diagram (Paxton & Estay, 2007), because it also indicates that thoughts and feelings can pull us in different directions. (See Fig. 1)

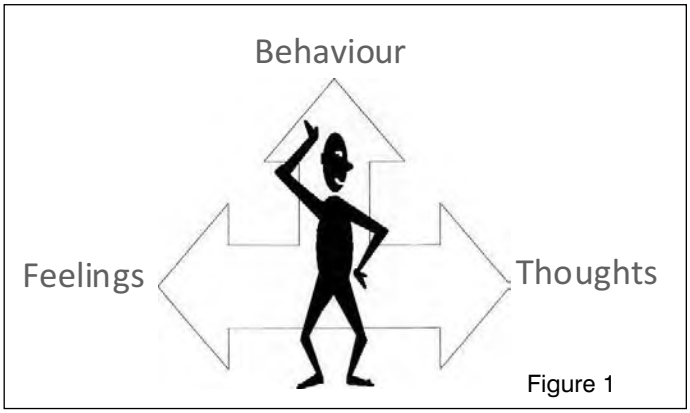
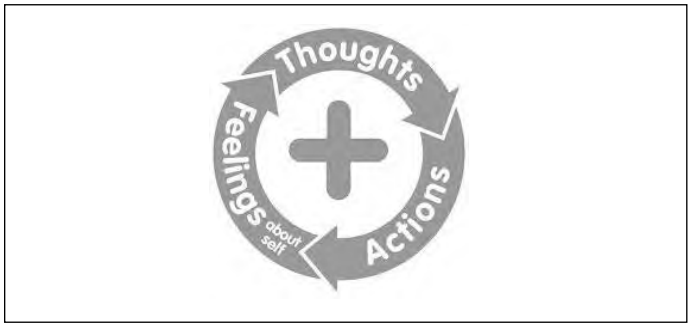


Figure 1

The superimposed person connects the concept to the individual. A photograph of the client's face can be used in this place in the diagram, further connecting the thoughts feelings and actions to the client.

Then this diagram is about how to respond to our awareness of thoughts and feelings.



If we are in the present moment:

- the cycle begins with awareness of feeling
- then we think about what we want to do about that feeling
- then we decide on an action
- and the outcome of the action affects how we feel.

If we are in a Child place it is more likely that we will be 'imagining' all sorts of 'bad stuff' and create an anxiety, which will influence how we act in this situation: from thought to feeling to actions – the wrong way around the circle!

Just providing such images promotes an exploration, a conversation, that gives us an insight into the client's inner world. The final message of the image is that choosing a different action can change how we feel about ourselves.

Below (Fig. 2) is a version of the diagram I use with adults, based on the Gestalt cycle. It addresses both the translation from physical, somatic, responses, to awareness of a feeling that can be named (the therapist may need to name it) and to how to respond to that awareness. Injunctions can be added to indicate how the

cycle can be broken: Don't Feel; Don't Think; Don't Feel; Don't Succeed; Don't Enjoy.

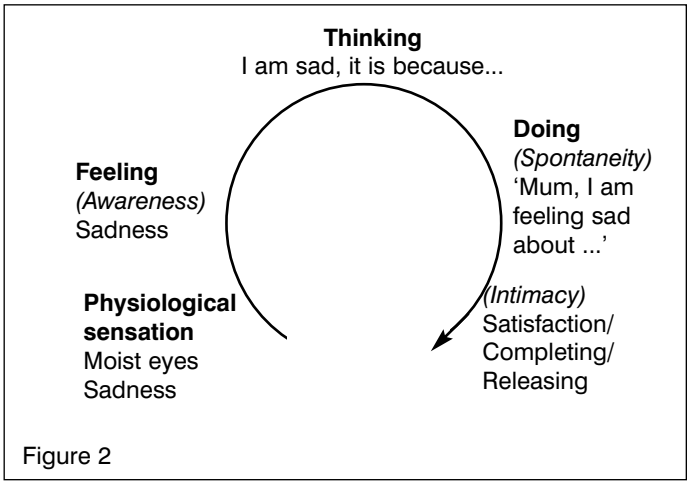


Figure 2

These kinds of issues may indicate defences, as they would with NTs, and we would be inclined to challenge them. If they are defences they might actually be necessary coping strategies, not to be challenged; and they may be primarily neurobiologically based, not up for editing, simply to be noted. Taking the process slowly, and carefully, is necessary; and draw whenever you can.

The habitual patterns of feeling and thinking, with their associated habitual behavioural responses can be gently identified and a technique, called Cognitive Restructuring – which I will talk about in a later article on discounting – is very useful in this context.

Some will recognise in that sentence a slight reframing of one of Eric Berne's descriptions of an ego state, so that is what I address next.

A structural ego state model that accommodates empathising/systemising neurodiversity.
(Abbreviated to 'the neurodiverse model' in conversations with or about Aspies, but acknowledging that there are other dimensions of neurodiversity.)

In the fourth article in this series (Flowerdew, 2016, pp23-27) I outlined Baron-Cohen's empathising-systemising theory (Baron-Cohen, 2008) it was only when engaging in the TA compulsion to draw circles during a workshop that I realised that Baron-Cohen was talking about a difference in Adult functioning between NTs and Aspies, and that this could be diagrammed.

The Neurodiverse TA Adult
• Baron-Cohen measures two neurobiologically based parameters:
– a Systematising Quotient (SQ), and,
– an Empathising Quotient (EQ)
• He detects a bias away from the balance towards empathising in women and a bias from the balance towards systematising in men.
• He also identifies two extremes:
– Very high systematising and very low empathising: Aspies
– Very high empathising and very low systematising: the intuitive empath; which I identify with a capacity nicknamed 'the little professor' in TA.
• Other elements in this diagram are taken from Kahneman (Thinking Fast and Slow), and from Siegel (The Developing Mind). (See Fig.3)

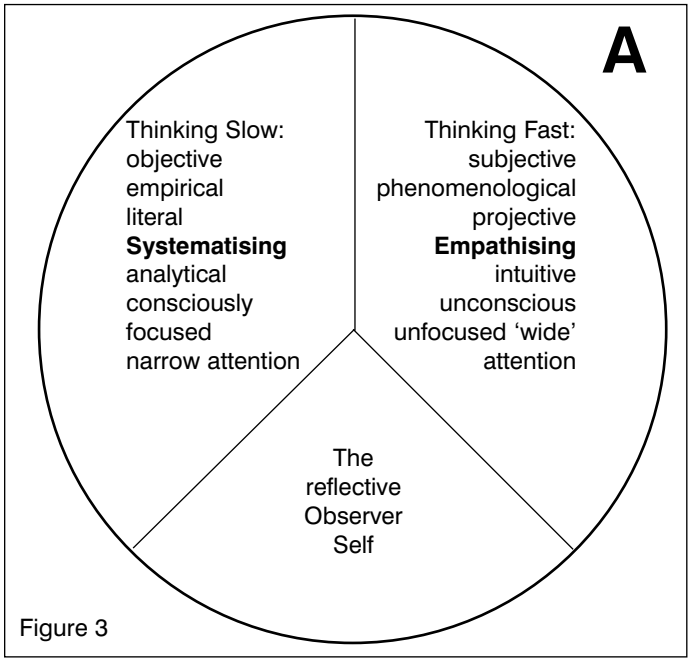


Figure 3

The Aspie Adult
• Aspies have lower than average EQ
• The functions associated with: Thinking Fast – subjective, phenomenological, projective, and unconscious 'wide' attention – are much reduced compared to NTs.
• They rely heavily on focused slow thinking and focused, detail oriented, attention
• Their emotional regulation depends on being given the space and time for their style of understanding.
(See Fig. 4)

I realised that the reflective, observer self seems largely 'intact' in my Aspie clients, and seems to be developed in adolescent years, paralleling the development of the adult cognitive abilities. Part of my current explorations is to discern the nature of differences in the 'feel' of NT and Aspie self-reflective, self-aware processes, once protocol level script is addressed.

The next insight also occurred in a circle-drawing situation. I find it hard to imagine that there is any reader of this magazine who is not familiar with this diagram. (See Fig. 5)

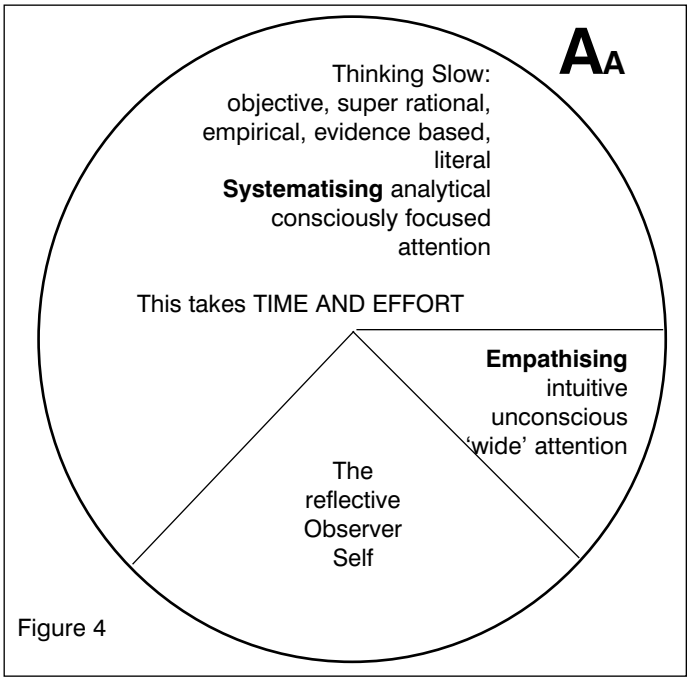


Figure 4

So, if you cannot read the thoughts and feelings of another person, how are you going to internalise those to form a Parent ego state? And if my Adult does process social significance, and is not producing intuitive schemata, then my Child ego states will be very different from those of an NT.

An Aspie Parent, P_A, appears to be a collection of survival strategies based on following the rules imposed by others. It is fundamentally oppressive.

An Aspie Child, C_A, seems to be a collection of more or less effective strategies for avoiding disapproval from NTs without understanding what is disapproved of.

It becomes easy to see how, logically, the Aspie fundamental existential position of I'm not OK; You're not OK is formed.

So, now we can compare the NT version, with the Aspie version. (See Figs 6 and 7)

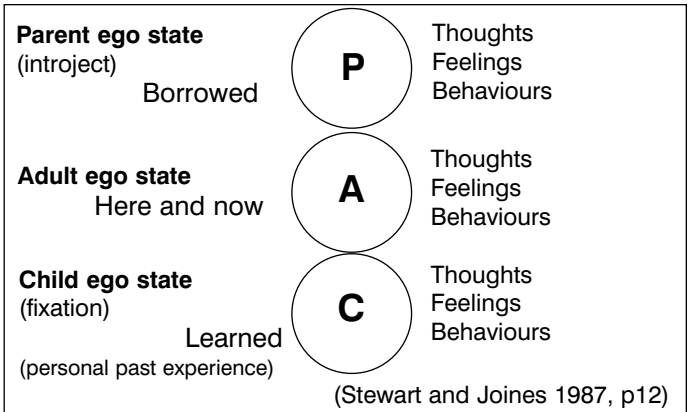


Figure 5: First-order structural diagram

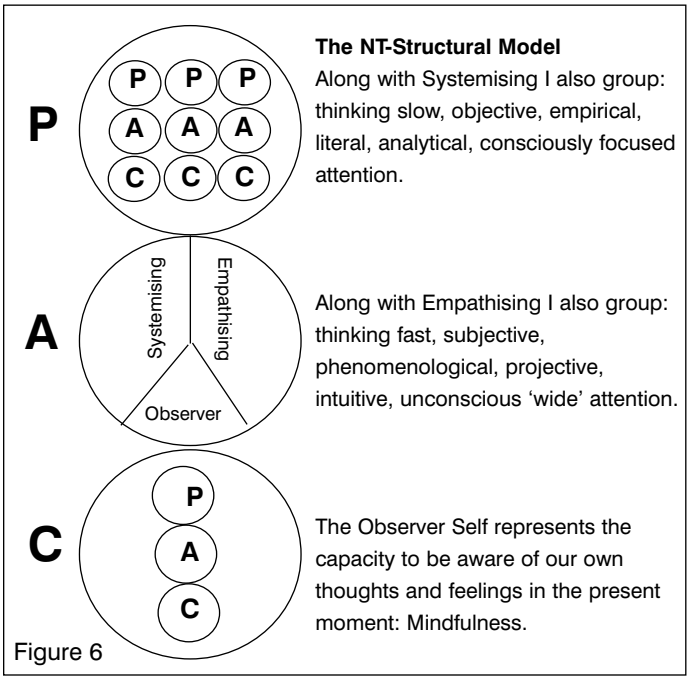


Figure 6

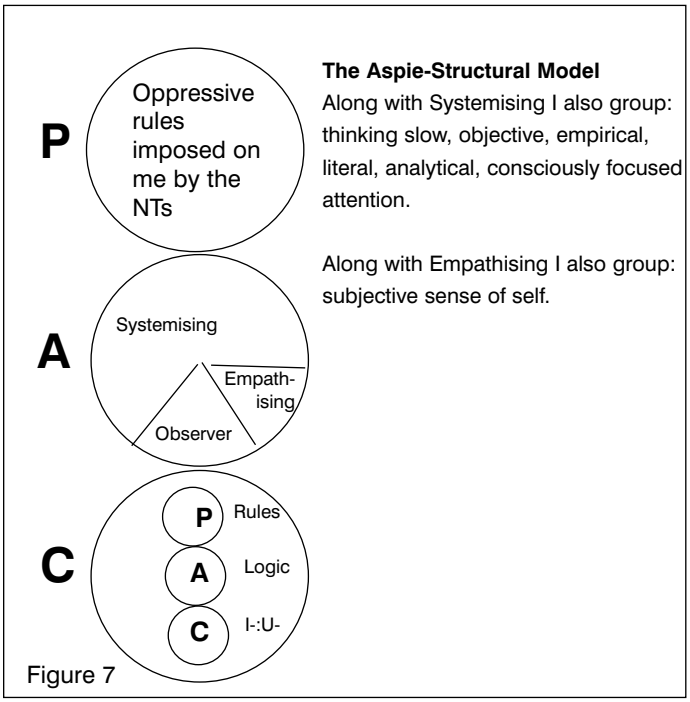


Figure 7

Considerations for therapy

When I am talking to Aspies who have spent their whole lives 'trying to fit in'; 'to look normal'; 'to not bother people' – I hear a relentless 'Don't be You!'

One Aspie said 'I can't please People, I just try hard not to annoy them'. Another said: 'I just try to move on, leaving no wake, not a ripple' – sounds like 'Don't Exist' to me.

For an Aspie the experience of being with someone who understands their way of being in the world – who

will create a space where they are welcome and safe; who is genuinely interested in their subjective reality; who will adapt their style and the environment to meet their needs – is transformational.

'I should pause here, to acknowledge the overwhelming kindness I experienced during this weekend. I would say it was a rare privilege, but that would be incorrect, as I have never experienced the like: A room of people who were genuinely interested in my experience, who were sensitive to my sensitivities and appreciative of my honesty. They called me brave and extraordinary, and made me believe it. They were a special sort of "kind", … I was truly moved.'

And when that person can provide accurate information that helps them to understand the world around them – that is life transforming. What I have just outlined is the creation of a therapeutic relationship that meets the client's Relational Needs [Erskine et al, 1999], and 'installs' a Nurturing Parent of the kind an Aspie needs to meet. This is the therapy of the Parent, Aspie style.

Providing a framework that allows an Aspie to make sense of the NT world: to understand ulterior transactions, to identify Games, to recognise script in action: to make states of mind visible, this has an impact that NTs can hardly imagine.

'My world is changing. I suppose this simple statement is open to many different interpretations but, I assure you, my world has never shown any signs of changing in the most important way. Until now.'

'I speak of the gradual unveiling of the NT world that is accompanying my deepening foray into Peter Flowerdew's particular brand of TA (Transactional Analysis). The reason why my usual cynicism about the possibility of such change is absent? Because this actually works. It makes sense to Aspie and NT alike. It provides common ground where before, there was none and, unlike other therapies and techniques, it is accessible to everyone.'

'I am experiencing a process of profound revelation, unfolding itself in exquisite slow motion, one realisation at a time. I am using it to shed light on the most inaccessible constructs of my life – places where I have feared to tread, because of their fragility: My sense of self, my professional persona, my relationship with my husband and son.'

This is the therapy of the Child, Aspie style. What has amazed me, is that it is so fast – and it can be done in a workshop. These quotes are from the blog of a co-presenter at the workshops we ran, and other Aspies have made similar statements after attending workshops. One-to-one therapy then provides the space to process such insights.

My own thinking is that mixed NT Aspie groups with some teaching and some discussion are probably optimal for change. You already know one half of 'TA that is inclusive of Asperger's', and the Asperger's half is what I will share in future articles. We know the power of TA to change lives, but I have discovered that we actually hold a greater gift than we realise. I set out to 'create dialogue between two subjective worlds' – succeeding in that has brought delight where there was only despair or resignation.

Next time: moving out of 'Not OK; Not OK'; one Aspie's journey.

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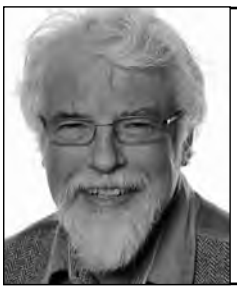

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Asperger's in (and outside) the therapy room – 8

In the eighth of his series about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** shows how demonstrating the concept 'I'm OK, You're OK' will be profound

WHAT DO YOU mean when you tell me that I'm OK? I mean that whatever you do or say, I affirm that you have an essential core self that has value, dignity and worth and that this core self has the potential and desire for growth and relationship.

What that means, on an operational level is: 'It is fine for you to be who you are; and I will give you the right and space for you to be you; provided you give me the same right and the same space for me to be me.'

And from this stance I hold that 'difference' is:
– interesting, not a threat
– offers opportunity for dialogue, providing more perspectives and options, so offers more resourcefulness and resilience
– an invitation to deepen and develop my humanity.

This stance affirms the intrinsic worth of each human being. We are born with worth; and, we also have to experience being valued in order to know it. Our therapeutic work focuses on restoring the belief in and experience of OK–OK relationships.

Four Existential Positions
Four levels of being and the resultant underlying attitudes

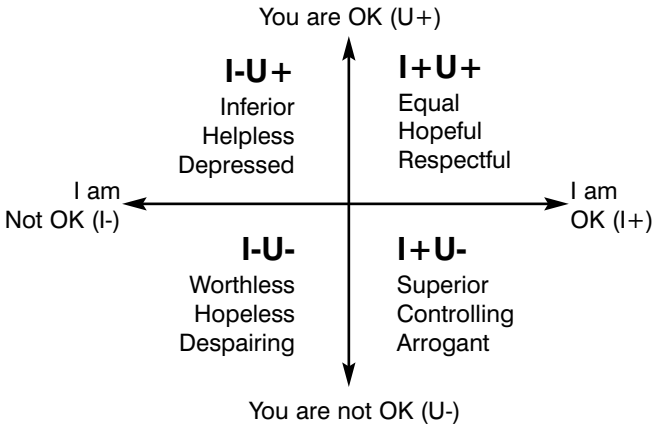

Figure 1: OK Corrall (Ernst, 1971)

Working with Aspies I have found the OK / not-OK grid (Ernst, 1971), see Fig 1, to be the single most important and easily communicated concept. Why? Because Aspies are invariably working from a Not-OK/Not-OK position. Suicidal thoughts are normal in Aspie World.

Of course, I'm not OK; and that is your fault
You defined me as not OK, so you are not OK too.

I have come to realise in my therapeutic work that recognising the Life Position is the real starting point for meeting the client, because social level roles and psychological level roles rest on the existential role (Law, 2006). The impact on an Aspie of sharing and explaining this diagram is huge, because it evidences that I, an NT, can recognise, articulate, and also demonstrate that I care about, a profound element of your inner world – The 'You get it!' experience is potentially transformative; the client experiences 'I am no longer alone in my subjective world'.

The power of 'You get it!' was driven home when one of my co-presenters, Chris, wrote a whole blog on the impact on a 25-year marriage to an NT of one weekend on an Aspie-NT workshop that they both attended. Here is just one part:

'We have talked and talked and talked. We have sat in silence, grinning at each other between intervals of hand-holding. He tells me he's less stressed now, and that he no longer feels the need to start conversations with "don't take this the wrong way" or to answer "it's nothing" when I ask why he's upset: He gets it.

'I go to work and experience the same old problems, the same lack of understanding, the same pressures and anxieties but somehow, they no longer seem to accumulate into the overwhelming assault that left me exhausted at the end of every day. I brush them off: The Most Important Person in my life "gets it".'

When I teach the grid in a TA101, I usually say something like: 'The only reality is the I am OK and you

are OK, but some people, through the relational experiences of their childhoods, have been taught or have come to believe that they are not OK, or some other person or group is not-OK, but the truth is that we are born OK and no-one can take it from us.'

However, the first time I presented that stance in an Aspie-NT group, it was met by incredulity by Aspies. I was taken aback by the number of people who openly challenged my statement. Some demonstrated a confused incomprehension – which I later understood to be 'I can't be OK', a challenge to their frame of reference, but most expressed anger and resentment towards NTs as a group – similar to that I met as a white person trying to do group therapy with black teenagers: 'You are white; whites are oppressors; therefore, you are an oppressor, don't try to fool us.' It took the first day of the workshop to get to 'maybe there is space here for me where it is OK to be who I am instead of trying to be what you want to see.' Aspies are trained to pretend to be NT – they install 'the emulator'.

I identified the injunctions of 'Don't be you' and 'Don't belong' as 'standard cultural programming' for Aspies; 'cultural' in that it does not come from a particular individual. The message is given and reinforced from all directions. And the internalised Oppressive Parent that I identified in the last article leads to a pattern of relating that we might identify with avoidant attachment, or a schizoid adaptation.

If you start from a false premise, you get false answers

So I say: 'If you start from the premise that I'm Not-OK and you're Not-OK then all the conclusions you come to mean that there is no kindness, no welcome, no one interested, no one to help – and no hope that it will ever be different. But here, in this room, you have experienced that there are NTs who care, who want to understand, who offer a welcome, and kindness and support – you have experienced it – it is real, so your premise is wrong. My presence and involvement, disproves your theory.'

That is the position we got to at the end of the first weekend. What I call 'the black swan effect' – everyone agrees that swans are big white birds until somebody sees a black swan. One exception demolishes the theory. (I like visiting the colony of black swans on the river Exe.)

And, surrendering the certainty of Not-OK/Not-OK, allows in hope.

After the first weekend that Chris attended she wrote:

I have waited for the 'welcome' that Peter speaks so passionately about, all my life. It seems so close now, I feel I can almost taste it. I cried when my (NT) husband asked if he could attend the course. We have a good marriage (25 years, next year) but there has always been a wall between us, that I have longed to remove. If we can really connect with each other after all these years – there is hope for us all. I think now, that perhaps that welcome has been there all along – just waiting to be discovered.'

And this led to the 'he gets it' experience that she describes in the quote above.

When you give an Aspie a grid

When we share concepts and models from what I would now call NT-TA, our 'normal' TA, with Aspies, they immediately apply them to make sense of their subjective world and gain insight into the thoughts, feelings, attitudes and motives of the people they meet – and they adapt and embellish them to fit their need.

Towards the end of one session with a newly-married Aspie man, with an NT wife, I pointed out that there were now two exceptions, his wife and me, to the 'they are Not-OK' basis of his script, so if life has to be logical, then he needed to surrender the Not-OK/Not-OK stance.

When he came back the following week, he took over the flip chart and gave me a presentation on his 'experiment' over that week. He created moments of reflection during the day – observer self – to gauge how OK he felt about himself and how OK he was with the people around him.

And he plotted the results:

The degree of OK-ness, which may be positive or negative, is measured on a scale; the measure for 'you' and the measure for 'me' are allocated to two axes, and the result is a scatter diagram, like Figure 2, below.

As he drew it, he told his story: first all his marks were in the I-, U- zone; then they began to oscillate between I-, U+, and I+, U-. He said that when he was in the I-, U+ zone he was aware that he felt like a rebellious, resentful child; and when he was in the I+, U- zone he felt like an angry controlling parent figure. And this is before I had talked to him about the existential positions

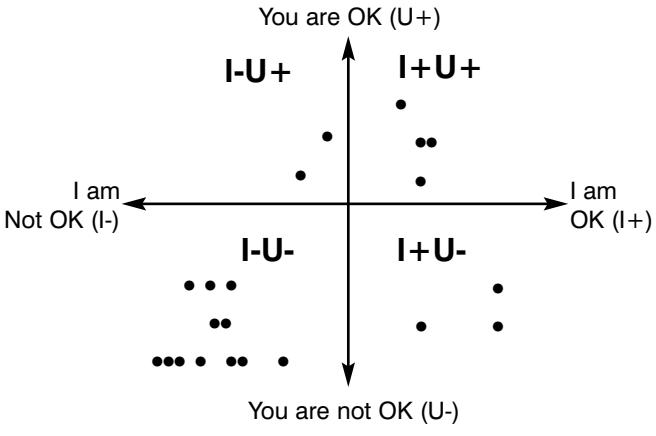

Figure 2: Using the grid as a tool for self awareness

of Victim and Persecutor roles. I was surprised and fascinated by his perceptive insights. It is unusual for a client to extrapolate from the TA I teach them. But then he said: 'The first time I put a mark in the I+, U+ zone, I am being myself, in Adult, and you are being yourself, in Adult, and we are getting on fine – was awesome, because I realised that having got there once, I could get there again; and that moving around the zones was normal, so I was less anxious about experiencing I-, U-.'

We had talked about open communication, asking for what he wanted in a way that he was likely to be heard, and ways to challenge discounts, in previous sessions and now he had used those tools to make the shifts that he had recorded.

He had experienced self-efficacy, the key to autonomy. And he had experienced that the majority of NTs at his place of work had goodwill towards him.

It also seems a pattern that when I teach TA to Aspies they 'adopt and adapt' and in doing so, extend my own appreciation and awareness of the significance of the models we have.

An Aspie-NT Dialogue

With their permission, I refer to three Aspies, two males, one female, within these articles. They act as co-presenters and advisers in the workshops that we present. Much of the thinking and reflection behind these articles has occurred within the monthly day-long meeting that I facilitate and they take turns in hosting, with two partners and two other psychotherapists. This group has produced a website: www.thedifferentengine.net to assist people in accessing the TA based models and skills that promote Aspie -NT dialog. This website will front a new charity dedicated to creating and sustaining dialogue between Aspies and NTs, providing appropriate training to employers, and supporting therapists and counsellors to work ethically and effectively with Aspie clients. You will understand why we are also particularly keen to share with parents and teachers: please make them aware of what we have to offer. Let's teach adults how to keep Aspie children out of that I-, U- place.

Postscript

I find that every interaction with Aspies teaches me something, especially when I step outside of the therapy room. Whether or not I refer to them by person in an article, I share all my articles with the group I described above, first, as a matter of respect and courtesy, second, as a matter of ethics. This article has been challenging for me to write and challenging for some of them to read, and out of the emerging dialogue came the observation that for an Aspie the presentation made more sense if the part on protocol was boxed in and made separate. The material in the first part of the article had a clear structure, and a happy ending in that these approaches

Early Script: Aspie protocol

AS I INDICATED in the previous article (Flowerdew 2017:39-2) the Child ego state of an adult Aspie presents as a series of cognitively-based strategies, that can be described and justified, and represents the individual's best efforts to avoid disapproval and rejection, and is constructed primarily in the teenage years, with its recycling of earlier needs (Levin, 1988; Mellor & Mellor, 2009) and the development of cognitive abilities.

As indicated in my article (*ibid*), the reduced Empathising Quotient that characterises the Aspie kind of mind, implies a reduced ability to develop the schemata that characterise the unconscious implicit memory (Siegel, 1999) associated with script conclusions and adaptations (Erskine, et al, 1999) arising from repeated breaks in attunement between parent and child, which we address in standard, NT, therapy.

I am thinking here of the Aspie child's first experiences of interactions with others which must be different from those of an NT child because of the reduced functioning of the neural networks responsible for recognising and 'reading' faces, the basis of mindblindness (Baron-Cohen, 1997). This means the foundation of script, protocol, has to be fundamentally different for an Aspie baby, and I have been wondering how severe that difference might be when the reading of emotional states is the prime communication channel between mother and child.

I was sitting next to Richard Hall, my co-presenter at the Manchester Institute for Psychotherapy Conference in October last year, listening to the keynote speech from Professor Gregor Zvelc, and he began to play a video of the 'frozen face experiment' (https://www.youtube.com/watch?v=apzXGEbZht0) in his introduction to the video I thought 'what if every face you saw was frozen?' and as the mother presented her 'frozen face' to the baby, Richard flinched. I have met the flinch response before, in my work with survivors of abuse.

The clear distress of the child in the video, the unconscious immediate reaction of my Aspie colleague – I think the protocol script of an Aspie can only be the place of despair and anxiety that we identify by I-, U-. So, I believe the prime function of the therapeutic relationship is to create the visceral experience of welcome and safety, and to constantly, consistently, demonstrate that, in this space, 'You are OK, teach me how to be with you'.

are so empowering for Aspies – so the protocol section is better made visibly separate to show it is something new, and where we are going in the future – so went the thinking.

My first reaction was resistance – the article is written for NTs and is fine for NTs. My second thought was – let's put the box around it – as an experiential piece of learning. We, NTs expect Aspies to fit in around our preferences, so maybe the lesson here is to adapt to accommodate to meet an Aspie's preferences – as a gift, as a kindness. So, I did that, as you can see; and as I did it, I thought – 'how interesting, the painful protocol is all walled off, boxed in and separated – so as not to spoil the "happy ending".' At the same time that I was having that discussion with myself, the Aspie was also having an internal discussion along the lines 'How come I need that boxed in? Am I projecting my discomfort onto the words?' Well, we shall talk about it. Keeping an OK-OK place and sharing our process, we create more space for insight.

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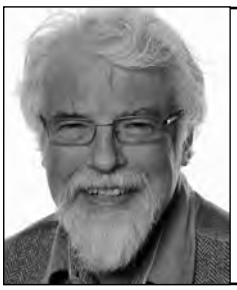

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Asperger's in (and outside) the therapy room – 9

In the ninth of this series about working with clients who have been, or may be, diagnosed with Asperger syndrome, **PETER FLOWERDEW** looks at creating dialogue by 'weaponising' the discount matrix

I BELIEVE THAT the contents of this series is relevant to all fields of TA. To create a quality of relationship between an NT[1] and an Aspie[2] that fosters mutual understanding, acceptance, valuing and trust is not just for individual therapy in the therapy room:

– It is relevant in working with couples and families; a number of Aspie/NT couples have reported profound positive changes to their relationships and parents have obtained an insight into the challenges their children have and understanding and support are the result.

– It is relevant to providing a learning environment adapted to the needs of Aspie children; a number of counsellors, teachers and parents have recognised Asperger's traits in their schoolchildren, and adapted their expectations and relational style accordingly, and some very young children have received a formal diagnosis, releasing funding and support for them in school.

– It is relevant to teaching members of organisations, how to create a working environment and a quality of working relationships that permit Aspies to be integrated and to thrive, contribute to and enhance the success of the organisation. I have attended meetings with HR personnel, and line managers, to resolve relational and communication problems involving Aspies working in local government, in schools and in commercial organisations – in each case the resolution of the perceived problem has led to positive outcomes in terms of performance, job satisfaction and mutual valuing and trust.

The topic of this article is a tool, a technique, that adds to the repertoire of my clients, both NT and Aspie, but it was first developed to confront denial with people addicted to mood altering chemicals, and then taught to teenagers, as a tool for assertiveness. I then modified it slightly for my work with couples, as a tool to identify and challenge discounting, thus resolving Rackets and Games in the relationship; and forming the ground for a warm, affectionate, intimacy.

Why the title? In the context of 'confronting', 'challenging' and 'standing up for yourself' stating 'where you stand' and what you want from someone who may not wish to 'concede', requires courage, and that means that on some level we are 'fighting'; and a tool to help us 'fight back' is a 'weapon'. I am going to share a simplification and re-framing of the discount matrix, to turn it into a tool, to empower people to confront, and challenge others, in order to discover who 'is on their side' and keep themselves safe in non-ideal relationships.

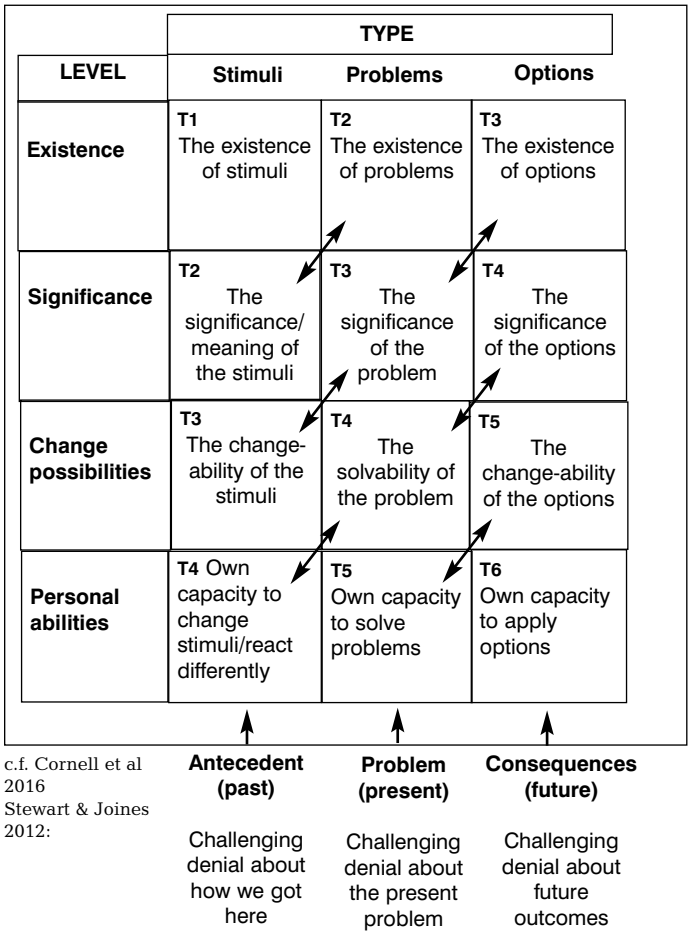

Figure 1: Reframing the discount matrix

Drug treatment

When I began my TA training I was working with clients who had addictions, mostly to heroin or alcohol and the

most exciting theory of the first year was the discount matrix: because here was a road map, a treatment plan, for working with denial. I loved it but it was the one piece of TA theory that I could not share with my clients; it was too complicated.

Over time I found myself discussing the *existence* and the *significance* of major problems that they were discussing; and the possibility and desirability of making different *choices*.

Discounting was almost always on the level of 'Significance'.

What I was intuitively doing was working in a single column of the matrix, as indicated at the base of Fig. 1.

The model of Antecedents, Behaviour, Consequences, was already being used by CBT trained therapists. Now I think of,

- Present: Accept that there is a difficulty.
- Past: What led to being in this difficulty.
- Future: What can be done to minimise the impact going forward or avoid this situation in the future.

Now, just one column of the grid is considered at a time, as shown in Fig. 2, and this was my CBTA (Cognitive Behavioural TA) approach to working with people on a community drug addictions program.

It indicates a clear line of contracting, from clarification of the problem to commitment to change that the client has identified as feasible for them, in a way that is easily communicated. It automatically gives responsibility to the client and clear indications of progress.

This diagrammed, structured, approach can also 'anchor' Aspies in an otherwise potentially stressful 'open-ended' process. Even the purpose of 'exploration' is given a place.

Anger management

When I started working with children, I realised that many had never had the resolution of difference, misunderstandings or disagreements modelled in their family. They would come, angry, frustrated, and in trouble because their angry feelings got expressed in angry behaviour; shouting, intimidation, violence; either emotional deregulation or behaviours that had been modelled for them.

They were experiencing something that angered them; other people were responding in a way that did not work for them. They were experiencing discounts; so now these steps became a tool for assertiveness. (See Fig. 3)

Some Aspies have trouble identifying their feelings, so they may need help to express the *significance* of what is happening in language that is meaningful to them and understandable by NTs. When working with clients who are developing friendships or romantic relationships, the *significance* is that 'I don't like/want that' – and in a relationship where you say you care, that should be reason enough for change. (See Fig. 4)

With most clients, we will draw this diagram with the statements to be made to the other person filled in below each step. Then I can coach them on how to say what they want to say. Then they take that with them. In one diagram we have the Awareness of what they want, the Permission to act on that awareness and the Program, the Adult means to deliver the message.

The most generalised form that I teach to students, Fig. 5, is framed as the 'bullseye' form of a negative conditional stroke – because you can hit every level of discount in one sentence.

Being able to express to another person what it is that reduces your comfort or trust in a relationship is the way

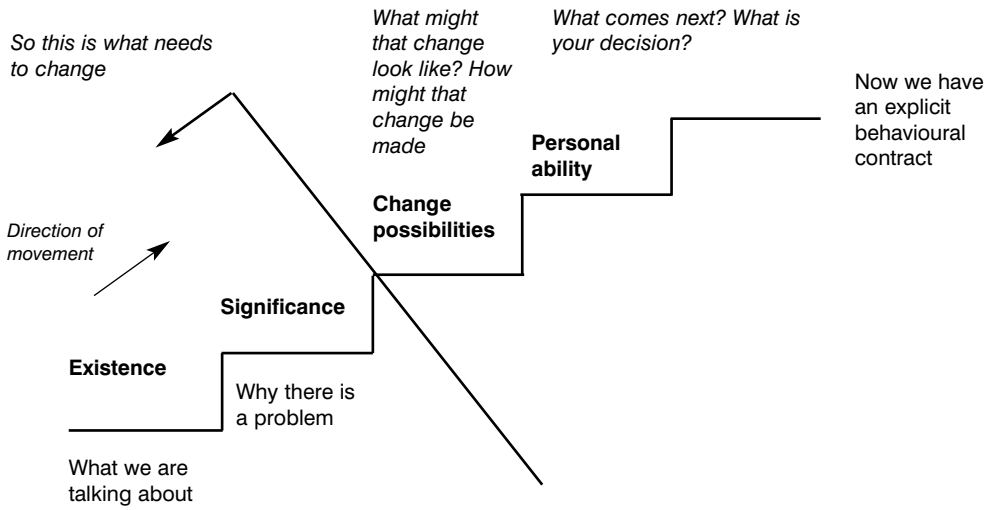

Figure 2: From denial to change. Diagramming a treatment plan

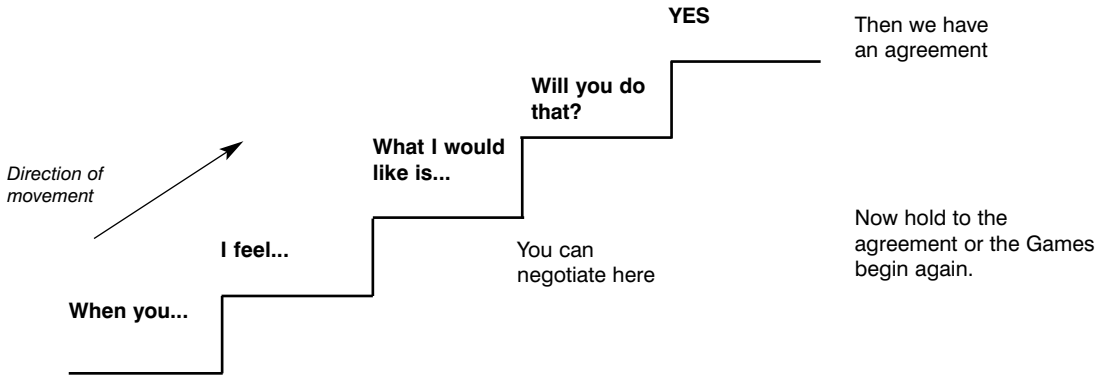

Figure 3: The version for assertiveness, Flowerdew, P. (2009)

to achieve a sense of safety. We cannot keep ourselves safe if we are unable to protest and be heard. So, I consider this the single most important tool in relationship building. My catchphrase is: 'if I can tell you what I don't like and expect to get less; and I can tell you what I do like and expect to get more; then this relationship is becoming more valuable to me".

A bit of theory

I am aware that in educational TA (Napper & Newton, 2000) and developmental TA (Hay, 1995) there are 'step' processes based on addressing levels of discounting. These, I understand to focus on the development of an individual or the management of change in an organisation. The tools I have outlined are designed to improve personal relationships by addressing Rackets and Games; they are fundamentally relational, can be placed within the model of Time Structuring (the next article) and can be understood as sub-elements of the discount matrix, as indicated in Fig. 6.

The steps can be applied to the present situation, to the antecedents or the consequences. If applied to all three, that creates the matrix (Fig.1). The steps and the matrix can be applied to 'self' or the 'other' or to the 'situation.

If the conditional negative stroke is not accepted, the

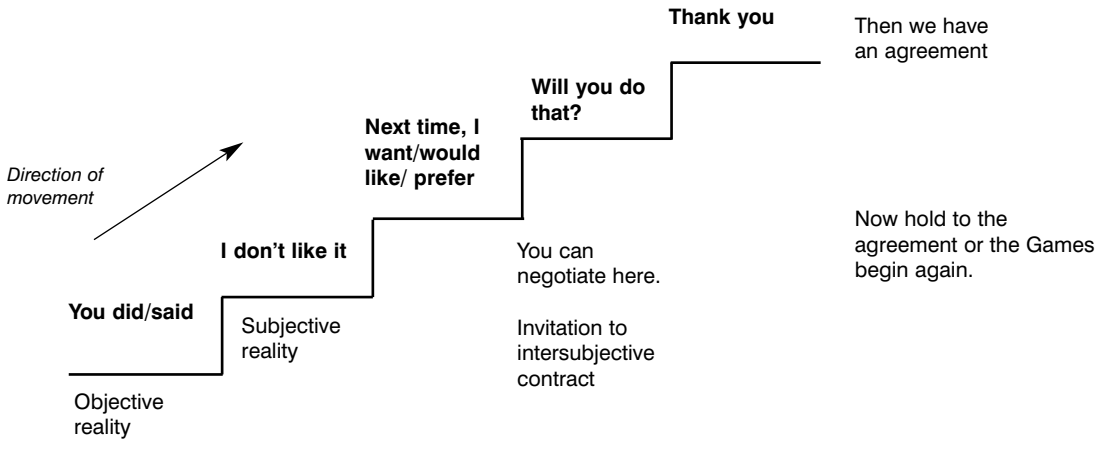

Figure 4: The version for building relationships, Flowerdew, P. (2009)

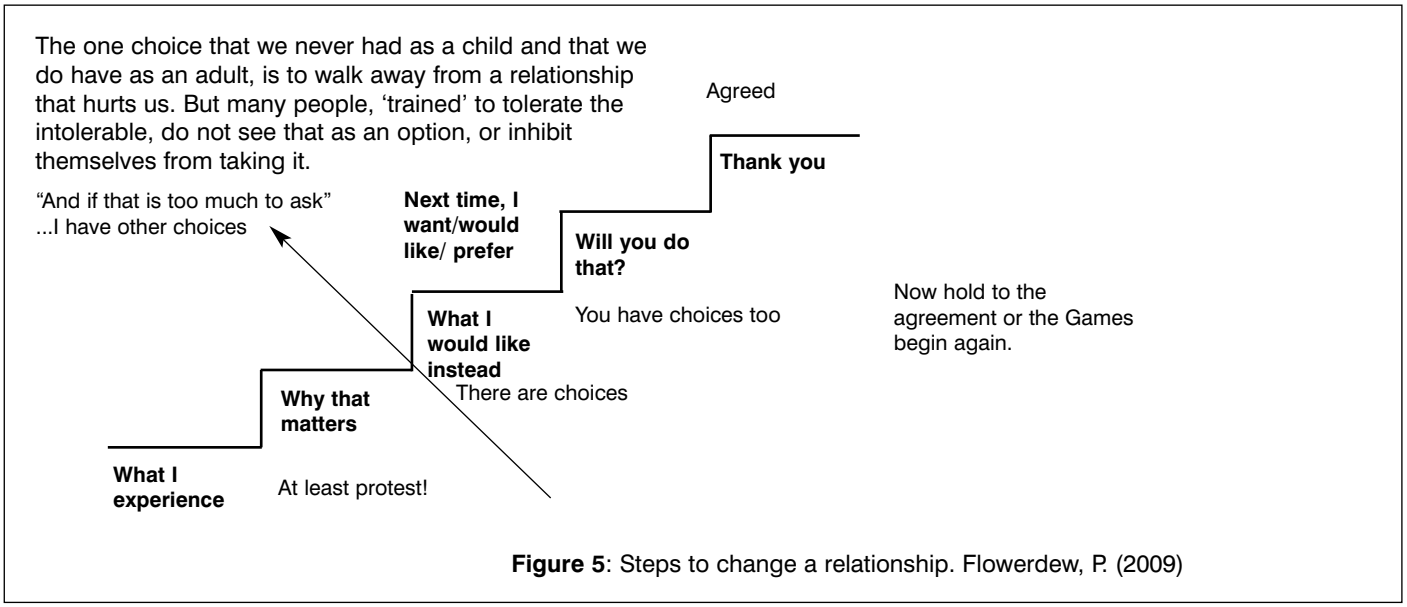

Figure 5: Steps to change a relationship. Flowerdew, P. (2009)

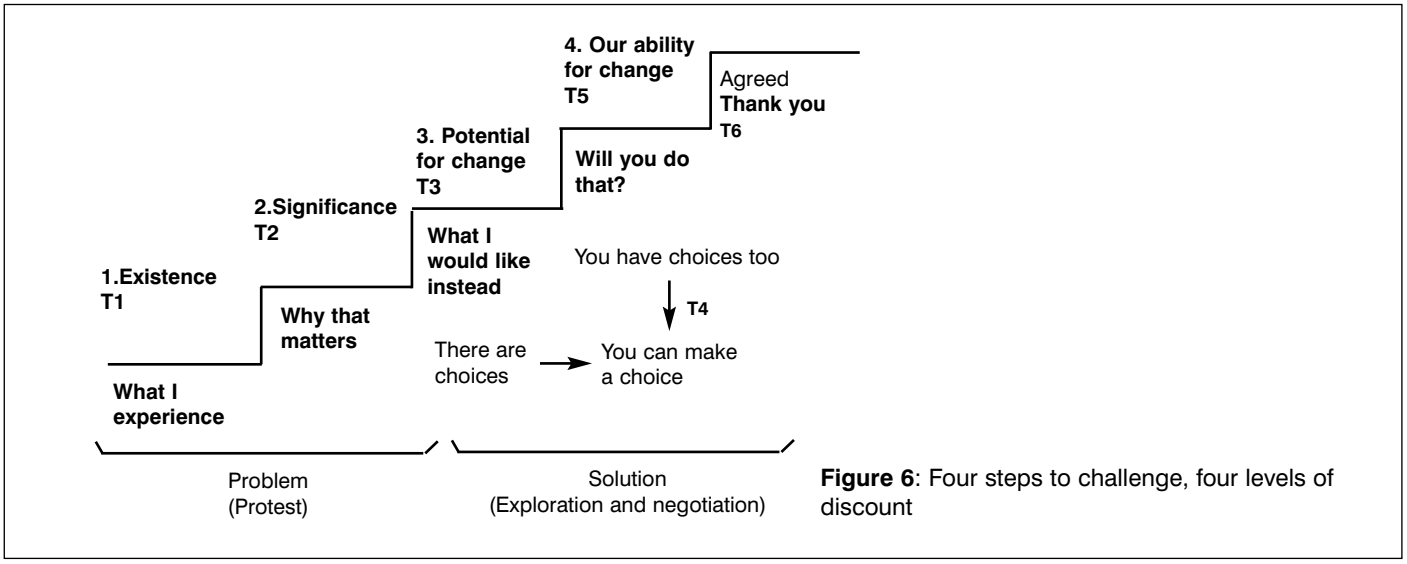

Figure 6: Four steps to challenge, four levels of discount

person using the tool can identify on which step the discount is occurring and address it; then move upwards through the remaining steps.

I hope that you find these tools useful for yourself and for your clients.

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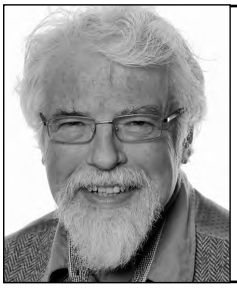
1 A Neurotypical: in this context, someone not an Aspie.

2 Someone with significant traits of Asperger's Syndrome –unhelpfully conflated with childhood autism in DSM5, but differentiated from it in ICD10



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