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

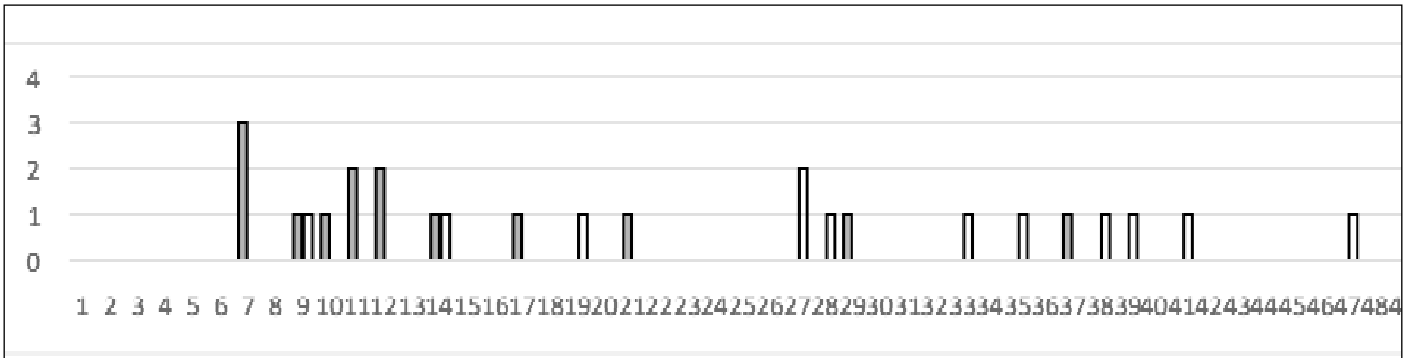

Figure 1: Results from spread of all clients in therapy

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.

References

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