

## “BETTER STRANGERS”: USING THE RELATIONSHIP IN PSYCHOTHERAPY FOR ADULT PATIENTS WITH ASPERGER SYNDROME

J. RUSSELL RAMSAY,  
EDWARD S. BRODKIN,  
MARY R. COHEN,  
JOHN LISTERUD, AND  
ANTHONY L. ROSTAIN

*University of Pennsylvania School of  
Medicine, Philadelphia*

ELIZABETH EKMAN,  
*Kognitiv Beteendeterapi teamet i  
VästSverige, Göteborg, Sweden*

*Requests for the assessment and treatment of Asperger Syndrome (AS) are on the rise. AS is a pervasive developmental disorder characterized by significantly impaired social competence but intact intellectual functioning. Adult AS patients often present for psychotherapy with anxiety, depression, and problems navigating their social worlds. The challenge facing psychotherapists is to establish workable therapeutic relationships with patients who have fundamental problems understanding and engaging in relationships in their daily lives. The aim of this article is to present strategies for adapting psychotherapy, particularly the therapeutic relationship, for the treatment of adult AS. The authors briefly review the phenome-*

*nology of AS and discuss strategies for using the therapeutic relationship to address the social functioning problems of this disorder.*

**Keywords:** Asperger syndrome, social skills, therapeutic relationship, psychotherapy, cognitive behavior therapy, adults

*I do desire we may be better strangers.*

William Shakespeare, “As You Like It,” Act III, Scene ii

This article will address the psychotherapeutic treatment of adult patients with Asperger Syndrome (AS). AS is a neurodevelopmental disorder characterized by impairments in social interaction; restricted, repetitive, and stereotyped patterns of behavior, interests, and activities; but no clinically significant delay in language and cognitive development (*DSM-IV-TR*; American Psychiatric Association [APA], 2000). The social impairments of AS patients appear to be related to deficits in theory-of-mind and other forms of empathy (Frith, 2004), as discussed below. Psychotherapy for AS patients should be informed by an awareness of these deficits.

More specifically, the aim of this article is to address a unique conundrum facing psychotherapists who treat high-functioning adults with AS: How does a therapist establish a workable therapeutic relationship with a patient whose fundamental problem is the inability to understand and engage in social relationships in his or her daily life? Our objective is to present strategies for adapting psychotherapy, particularly the use of

---

J. Russell Ramsay, Edward S. Brodtkin, Mary R. Cohen, John Listerud, and Anthony L. Rostain, University of Pennsylvania School of Medicine; Elizabeth Ekman, Kognitiv Beteendeterapi teamet i VästSverige, Göteborg, Sweden.

Edward S. Brodtkin is a recipient of a Burroughs Wellcome Fund Career Award in the Biomedical Sciences. This investigation was supported by National Institutes of Health, Mentored Clinical Scientist Development Award KO8-MH068586 from the National Institute of Mental Health.

We thank Hollie Levy, Lisa Mimmo, and Jennifer Elliott for their helpful comments on a draft of this article.

Correspondence concerning this article should be addressed to J. Russell Ramsay, Department of Psychiatry, University of Pennsylvania School of Medicine, 3535 Market St., #2027, Philadelphia, PA 19104-3309. E-mail: ramsay@mail.med.upenn.edu

the therapeutic relationship, for the treatment of high-functioning adults with AS.

There are two features of the therapeutic relationship that we emphasize in the treatment of adult patients with AS. First, therapists are in a position to provide information and explicit guidance regarding various aspects of social relationships, information many AS patients find very helpful. Second, the therapeutic relationship provides a very useful laboratory for helping AS patients learn and practice how to better handle social situations. Given their deficits in theory-of-mind and other forms of empathy, and their subsequent problems understanding the unspoken rules of interaction, adults with AS will need help planning “what,” “when,” “how much,” and “what not” to do in social situations. Thus, establishing and maintaining a relationship with an adult patient with AS requires different approaches than therapists typically use with other patients, and this relationship, in turn, sets the stage for therapeutic interventions focused on increasing patients’ social functioning.

To achieve our objectives, we will briefly describe the clinical phenomenology of adult AS and how it affects social functioning. We will then discuss how the symptoms of AS affect the relationship with a therapist, and we will present strategies for fostering a therapeutic relationship with adult AS patients. We will also present therapeutic strategies for using this relationship to address patients’ social functioning difficulties that are central to AS. Before proceeding with our description of AS in adults, however, we should provide definitions of the terms “empathy,” “theory-of-mind,” and the “therapeutic relationship” that will be used throughout this paper.

Empathy has been described as a uniquely human capacity and characterized as the “glue of the social world” (Baron-Cohen & Wheelwright, 2004). The word derives from the German term *emföhlung*, translated as “to project yourself into what you observe” (Titchener, 1909, as cited in Baron-Cohen & Wheelwright, 2004). Empathy can be further broken down into the constituent constructs of affective empathy and cognitive empathy (Baron-Cohen, 2003). Affective empathy can be conceptualized as an observer’s emotional response to another’s emotional reaction (e.g., “I feel your pain”). Cognitive empathy, also referred to as “theory-of-mind,” refers to the observer’s ability to infer another’s emotional state (e.g., “I understand why you feel the way you

do”). Following this line of thinking, sympathy could be thought of as a subset of these empathy categories, reflecting an observer’s desire to do something to alleviate another person’s suffering based on her or his emotional and cognitive response to the suffering being witnessed (e.g., “I want to do something to help you”) (Baron-Cohen, 2003; Baron-Cohen & Wheelwright, 2004).

In the case of treating adults with AS, we describe the therapeutic relationship as a partnership between the patient and the therapist with the objective of helping the patient to understand and to improve his or her functioning. While this definition is applicable to many types of patients, the process by which the therapeutic relationship evolves with AS patients is often quite distinct. Individuals with AS describe being mystified by interpersonal relationships and the reactions of others toward them. Thus, in our experience, these patients are more likely to derive benefit from therapists who are active in session and give directions, suggestions, and information, than from therapists who rely on reflection, emotional encouragement, and the notion that patients must discover their own answers to their problems. Said differently, AS adults are in need of therapists who help make visible what had previously been invisible in social situations. In the next section we briefly discuss the phenomenology of AS and how it results in problems related to social competence and reciprocity.

### Asperger Syndrome in Adult Patients

First noted and reported by the Austrian pediatrician, Hans Asperger, who in 1944 (translated by and cited in Frith, 1991) observed four boys with “severe and characteristic difficulties of social integration,” it took 50 years for AS to become officially recognized as a diagnostic category in the *DSM-IV* (APA, 1994). While currently categorized as a Pervasive Developmental Disorder (PDD; APA, 2000) usually first diagnosed in infancy, childhood, or adolescence, there are increasing numbers of individuals who first seek help for their symptoms in adulthood.

When diagnosed in childhood, AS is often detected later than other PDDs, with the average age of diagnosis in one study being 11 years for AS and 5.5 years for autism (Howlin & Asgharian, 1999). These findings suggest that childhood AS is often hidden by a combination of mild symptoms (relative to some of the more severe

cognitive symptoms of autism), presence of a particular area of skill that masks social problems (e.g., computers), and/or being able to handle the social demands of primary school (Frith, 2004). Likewise, many higher functioning adults with AS can “hold it together” in limited social settings with a single-minded concentration on an academic or vocational skill that allows them to make use of their often well-developed systematic thinking abilities (Baron-Cohen, 2003). However, as they encounter difficulties handling the almost unavoidable social demands of adult life, these adults may be encouraged to seek help in psychotherapy, often at the urging of their families, employers, academic advisors, or significant others (Frith, 2004; Slater-Walker & Slater-Walker, 2002).

Individuals with AS are often lumped together with individuals diagnosed with autism who are of normal intelligence, so-called High Functioning Autism (HFA). There is controversy about whether AS and HFA differ qualitatively or quantitatively (Frith, 2004; Howlin, 2002; Miller & Ozonoff, 2000). The main proposed difference between AS and HFA is that patients diagnosed with AS tend to have better language and poorer motor skills than patients diagnosed with HFA (Miller & Ozonoff, 2000), although there is quite a bit of variability within each diagnostic category. However, it has proven difficult to demonstrate a true difference between AS and HFA, leading to a growing consensus that both conditions are part of the high functioning end of the autism spectrum rather than being distinct disorders (Howlin, 2003, 2004). Regardless of whether or not the proposed differences between AS and HFA warrant separate diagnostic categories, available psychotherapies for these clinical populations have not reached a level of specificity to warrant differentiating these disorders for the purposes of this paper. Thus, we will use the term AS to refer to those adult patients who fall at the high functioning end of the autistic spectrum.

### *Symptoms and Diagnosis*

AS is a blend of symptoms that reflects impairments in social reciprocity, nonverbal communication, and imagination that is accompanied by a restricted range of interests and stereotyped behaviors. These symptoms, however, are not accompanied by language delays, mental retarda-

tion, or adaptive functioning problems commonly seen in autism (Frith, 2004). The symptoms of AS seem restricted primarily to the social domain.

The complex, multifaceted construct of social competence is difficult to assess in a systematic way and there are few standardized social assessment instruments available (Attwood, 2003). The instruments that have been developed are in their infancy and are used primarily in research and in specialty clinics where the focus is on studying AS and related social learning disorders. There is a large overlap of scores of adult AS patients and controls on many of these instruments. Further, these instruments have not been used in pre-post tests of the effectiveness of social skills training for AS. A comprehensive clinical interview, including direct probing of patients’ social functioning, continues to be the standard approach for diagnosing AS in adult patients.

AS individuals often display a wide range of functioning levels, which can make the diagnosis difficult for many clinicians. Many higher functioning AS adults are employed and are married with families. These high-functioning AS adults often have developed adequate social behaviors to handle brief, straightforward conversations. What they often lack is an understanding of other people’s unspoken intentions or motivations in communication, their “hidden agendas.” Clinicians should look for patients with patterns of repeated terminations of employment or difficulties with coworkers that do not seem to be associated with poor job performance or obvious interpersonal conflicts. AS adults do not understand “office politics” and, therefore, make repeated mistakes in their dealings with others at work. These patients are often unaware of the role their social behavior may have played in their work problems.

Spouses of AS adults frequently encourage them to seek therapy because the AS spouses are withdrawn and disconnected from their families. These adults often spend long periods in solitary activities and do not participate in family life. They often describe feeling uncomfortable with family vacations away from home, and socializing with extended family during holiday events.

A diagnosis of AS in adulthood is made when there is historical evidence of persistent abnormalities in reciprocal social interaction, nonverbal communication, and imagination that do not reflect a recent deterioration in functioning (Tantam, 1991). Clinicians should take note of pa-

tients who present with inappropriate nonverbal expressiveness (e.g., odd speech or posture, or an inability to recognize social cues); unusually special and narrow interests or collections; difficulty conforming to implicit norms for social behavior; lack of close peer relationships; or physical clumsiness (Tantam, 1991). What were mild difficulties in childhood may have become more problematic with the increased social demands in all areas of adult life.

Social anxiety is common among adults with AS, but we propose that this anxiety derives from a different source from the anxiety experienced in social phobia. Individuals with social phobia experience anxiety characterized by an overabundance of catastrophic thoughts about possible embarrassing outcomes or negative scrutiny by others. Adults with AS, on the other hand, have anxiety related to their inability to anticipate what might happen in a social situation. Thus, individuals with social phobia are made anxious by what they misinterpret; individuals with AS are made anxious by what they cannot interpret.

### *Prevalence*

Prevalence and incidence data for adult AS are lacking. The prevalence of childhood AS in the 1970s was estimated at about 4 in 10,000, about the same prevalence cited for autism (Howlin, 2002). The only published epidemiological research on AS indicates a prevalence rate of 36 in 10,000 in a sample of Swedish children ages 7 to 16 (Ehlers & Gillberg, 1993, as cited in Howlin & Asgharian, 1999). More recently, the childhood incidence of AS was reported as 8.4 per 10,000 (Chakrabarti & Fombonne, 2001, as cited in Ozonoff, Rogers, & Hendren, 2003). Samples of children diagnosed with AS yield gender ratios on the order of 9:1 males to females (Howlin & Asgharian, 1999).

The increases in the incidence and prevalence rates of AS over the years are thought to reflect better awareness and recognition of symptoms rather than an actual increase in their occurrence, though controversies abound regarding other possible causes of the increases (Baron-Cohen, 2003; Chamberlin, 2004; Tidmarsh & Volkmar, 2003; Wing, 1996). Yet another source of confusion is the problem of "shifting diagnosis," whereby individuals are classified as having autism at one stage of life and are reclassified as having AS at another. It seems the adult patients with AS that

are the focus of this paper are frequently un- or misdiagnosed until they encounter problems in adulthood.

### *Developmental Course into Adulthood*

The data on adult outcomes of children diagnosed with AS and on individuals first diagnosed with AS in adulthood are sparse (Frith, 2004). Most individuals diagnosed with AS in childhood who were monitored into adulthood continued to be socially isolated and to have some degree of interaction difficulty (Howlin, 2002; Howlin, Mawhood, & Rutter, 2000; Mawhood, Howlin, & Rutter, 2000). Furthermore, these individuals first diagnosed with AS in childhood may have more severe symptoms than the higher functioning individuals who are first diagnosed in adulthood. Very few of the individuals first diagnosed with AS in childhood married, had sexual relationships, or established close friendships later in life. Most individuals participated in some form of work, though it was predominantly sheltered, supported, or volunteer work. Almost none of the individuals lived independently, often living with their families-of-origin. Most AS individuals had persistent difficulties with socially immature, inappropriate, and/or rigid ritualistic behaviors.

Just as there is a dearth of comprehensive epidemiological and adult outcome data for AS, there is also a lack of data regarding the frequency of and risk for comorbid psychiatric problems (Frith, 2004). Comorbid conditions seen in children with AS include anxiety, obsessive-compulsive traits (including inflexibility and behavioral rigidity), attention deficit disorders, depression, bipolar disorder, aggression, Tourette's syndrome, and schizophrenia (Klin, Sparrow, Marans, Carter, & Volkmar, 2000; Klin & Volkmar, 2003; Volkmar, Klin, & Pauls, 1998). There is a higher incidence of depression and anxiety among adult patients with AS than would be expected by chance, although more research is needed (Frith, 2004; Howlin, 2002).

Once diagnosed, treatments available for adults with AS are limited and based on clinical anecdote rather than on systematic study. The next section reviews the current state of affairs regarding treatment of adult AS.

### *Treatments*

Pharmacotherapy can be helpful in managing comorbid obsessive-compulsive, mood, and anx-

iety symptoms associated with AS (Towbin, 2003). However, currently available pharmacotherapies are not effective in treating the core deficits in social interactions. Most adults with AS seeking treatment require additional therapeutic interventions targeting their social functioning.

In our experience, adults with AS often seek psychotherapy at the urging of other people in their lives. The notion of reaching out to others for help is a foreign one for most AS adults. Sometimes the presenting problems for therapy are a direct outgrowth of their social functioning difficulties, such as negative work performance evaluations, complaints of socially inappropriate statements or behaviors at work, or extreme isolation at home. Some higher functioning adults with AS, however, may enter therapy to address mood or anxiety problems, only later to realize that their problems and symptoms are consistent with AS.

Psychosocial interventions for children with AS have primarily targeted the domain of special educational services, particularly programs using applied behavioral analysis within structured environments (Howlin, 2002). In terms of managing social behaviors, most treatments for children focus on intensive behavior modification of problematic habits and developing prosocial behaviors for use in school. Social skills groups and cognitive-behavioral therapy (CBT) for older children and adolescents with AS that focus on day-to-day problem-solving, often including family training, reportedly can be helpful (Attwood, 2003).

In terms of treatments for high-functioning AS adults, there is less guidance than is available for children and adolescents. Drawing from the behavior modification approaches used with children with AS and the usefulness of CBT in treating comorbid mood and anxiety symptoms, individual CBT has been adapted for AS and employed along with psychoeducation to enhance social and empathy skills in adult patients (Attwood, 2003; Cardaciotto & Herbert, 2004; Hare, 1997; Howlin, 2002). Psychoanalysis and other psychotherapies emphasizing symbolic constructs, introspection, and interpretation have not been found to be helpful in understanding and treating AS (Frith, 1991; Wing, 2001).

CBT is based upon the cognitive model of psychopathology that posits that cognitions and beliefs are influential in the development and

maintenance of psychiatric problems (Beck, 1976). AS certainly is not caused by maladaptive or distorted thoughts. However, the negative experiences associated with growing up with AS are thought to contribute to the development of negative belief systems about the self, the world (i.e., experience), and the future—the classic cognitive triad (Beck, 1976).

These negative beliefs about social situations and patients' social skills may not necessarily be entirely inaccurate or distorted. In fact, most adults with AS whom we treat have had many social rejections, have been targeted for teasing or bullying, and in some cases have been outright emotionally or physically abused. They tend to "float through" the social milieu without really knowing how to handle it, or they avoid it altogether. However, to the degree that these negative beliefs become over generalized, create self-defeating behavior patterns, and/or contribute to the development of mood and anxiety problems, they are amenable to treatment with CBT approaches. CBT also targets the cognitive rigidity and literalness that may limit the perspectives of AS adults in various situations (Hare, 1997).

Many AS young adults, for example, develop extreme aversions to all social situations and become isolated due to their history of repeated social rejection by their peers (Tantam, 2003). Although their subsequent avoidance makes sense as a defense, it may not be adaptive in the current social context, such as when an individual has a paranoid reaction to a neutral situation. Cognitive modification involves thinking through the implication of certain thoughts (e.g., "My coworker knocked a file off my desk on purpose") and revising them in a manner more adaptive to the current social context (e.g., "My coworker apologized and picked up the file for me, so maybe it was an accident.") (Attwood, 2003).

In addition to focusing on understanding an individual's cognitions, a second appeal of the CBT model is its experiential component. Using role-play during session or setting up specific behavioral experiments to practice between sessions helps patients learn and use specific social skills. Patients are encouraged to gradually implement these skills in their daily lives and to gain exposure to social situations they previously avoided.

CBT can also be of particular benefit in helping individuals address comorbid mood and anxiety problems. Any form of individual therapy

for AS, however, must be augmented with the practice of offering straightforward advice about handling life problems and social situations to adult patients (Attwood, 2003; Howlin, 2002). There are case studies of CBT used with adult patients with AS and either depression (Hare, 1997) or social anxiety (Cardaciotto & Herbert, 2004), each reporting improvements in comorbid symptoms and some features of AS, such as decreased self-injury and increased use of prosocial behaviors.

Social skills groups have been developed for AS patients of all ages, though their availability is not yet widespread, particularly for adults. The appeal of groups is that they provide an opportunity for individuals with AS to learn they are not alone in their struggles and to have contact with others who are "like-minded." Furthermore, the group format affords an opportunity to replicate problematic social situations, to get behavioral feedback, and to practice new skills in a structured environment. One criticism of these groups, however, is that despite learning new skills, AS patients often have difficulty generalizing these skills outside the group (Howlin, 2004). Thus, to increase their effectiveness, social skills training must provide an experiential component. Activities such as going to a bookstore and initiating a conversation, or phoning someone and inviting the person to a movie are ways to gain exposure to using social skills in daily life. When extreme anxiety interferes with follow-through on these assignments, trained social skills coaches may be enlisted to accompany patients. Coaches provide immediate feedback and guidance as patients practice their skills in the community. Another approach is to plan a social event (e.g., party) in which the participants have a chance to practice their skills with others outside the group (Cohen, 2005).

In the next section, we will discuss how these social difficulties affect the relationship with a psychotherapist who is trying to help an adult patient with AS improve social functioning. In particular, we discuss strategies for establishing and maintaining a therapeutic relationship that the patient will find beneficial.

### **Using the Therapeutic Relationship in Psychotherapy for Adult AS**

We should state at the outset that psychosocial treatment paradigms for adult AS are just now

emerging and are based wholly on anecdotal evidence, as there are no extant studies of clinical effectiveness. CBT is a logical paradigm with which to address the specific social problems faced by adults with AS because it tends to be more directive and problem-focused than other approaches, and it targets the automatic, in-the-moment reactions of AS patients (Attwood, 2003; Cardaciotto & Herbert, 2004; Hare, 1997; Howlin, 2002).

The clinical suggestions offered here reflect the approaches being used and refined at the authors' respective clinics for the treatment of high-functioning adults with AS. Among the authors are clinical psychologists and psychiatrists with diverse and overlapping clinical and research interests of assessment, clinical treatment and outcomes, genetics of social behavior, and life span view of developmental disorders. Each of the more experienced authors have over 20 years of clinical background in treating AS in patients of all ages. Thus, although currently based on clinical anecdote, the strategies suggested here are based on strong clinical experience and review of the existing clinical literature. It is hoped that these strategies will soon be empirically tested in clinical studies of adults with AS.

### *Challenges Encountered in Psychotherapy With AS Adults*

Most AS patients pursue psychotherapy only because someone else has suggested they need to get help. Nondirective, exploratory treatments without specific behavioral goals that have relevance for a patient's daily functioning will likely result in the patient becoming frustrated and withdrawn, and the therapist feeling ineffective. Inviting a significant other familiar with the patient to early sessions helps the therapist get third party information about the patient's functioning. Motivational interviewing techniques (Miller & Rollnick, 1991) that include a discussion of a patient's motivation for engaging in social interactions and that highlight areas of dissatisfaction for the patient are helpful in eliciting workable treatment goals that are relevant for the patient.

Poor nonverbal communication is another common issue encountered when treating adults with AS. The patient may have poor eye contact, poor voice modulation, inappropriate affect, or other idiosyncratic communication tendencies.

The patient may make frequent and elaborate references to favorite movies or use odd metaphors, the meanings of which are not readily apparent to the therapist. At the same time, AS adults can be extremely concrete and literal in their comments. When an AS patient says he or she has not spoken to someone for a week, it could well be a literal rather than a figurative statement.

Similarly, therapists should be mindful that their statements could be interpreted literally and be misunderstood. For example, the first author was in an initial meeting with a college student with AS and the patient's mother. The mother commented that it seemed she and her son had been "in a constant battle" since he started college. The young man disagreed vehemently, citing times he did not say anything to his mother (i.e., did not "battle"), examples of specific dinners that were cordial, and other exceptions that, to him, invalidated her use of the term "constant." He subsequently challenged each comment she made about his functioning because her opinions had been deemed unreliable due to her "inaccurate" wording.

The aforementioned example also illustrates how some adults with AS have developed a set of codified rules for how others should act that are based on the individual's egocentric viewpoint (Attwood, 2003). When faced with distressing situations, infractions of these rules and their perpetrators are catalogued by the AS individual, who may then have problems "letting go" of these slights. These infractions may well be accurate, but the standards to which others are held are unrealistic in the give-and-take of the social world.

Although these sorts of behaviors may become the focus of modification in therapy, it is often better to introduce these observations carefully, after having a few sessions to observe them and to become better acquainted with the patient. A stronger alliance is required before delving into these behaviors, unless these issues represent the patient's explicit goals for therapy or if the patient mentions them first. Whenever offering feedback, it is helpful to provide the rationale for the feedback as being in the spirit of providing useful information in the service of achieving the patient's stated goals.

It may seem odd to discuss the importance of being attentive to patients who are characterized as being unaware of such social niceties. How-

ever, AS adults often present for treatment with histories of negative social experiences. They often are understandably sensitive to being criticized and ridiculed, particularly by someone new and unfamiliar to them. On the other hand, they appreciate people who "stick by them," who make an effort to understand their problems, and who offer specific guidance. To reduce the likelihood of misinterpretation, patients can be queried about their thoughts in response to the therapists' statements and behaviors. By becoming more aware of their own interpretations of their therapists' comments and that these reactions sometimes can be inaccurate, adults with AS can learn to reassess their interpretations of people's comments and actions in other contexts. Furthermore, the therapist gains credibility in the patient's eyes as a useful source of information about social interactions. Thus, based on the patient's previous experience of similar situations occurring within the therapeutic relationship, he or she may be more receptive when the therapist suggests that there may be more than one way to interpret or to handle a social situation..

In fact, it is often less the technical competence of the therapist that is challenged in treating AS adults, than it is her or his empathic fortitude (Beebe & Risi, 2003). That is, the therapist often has difficulty gauging how well therapy is progressing from the reaction of the patient, which may lead a therapist to question his or her effectiveness. Some patients with AS may come across as downright rude, such as the patient who began his initial session by critiquing the wording of the intake questionnaires, including taking offense at questions about family history, which he considered invasion of privacy. In another case, a new AS patient said bluntly that he did not like his therapist's tie. Therapists, a professional group that prides itself as being able to establish rapport with patients, may become frustrated when their typically effective relationship-enhancing and empathy skills do not help them connect with AS patients. Therapists must be mindful of their negative reactions to AS patients and how these reactions might lead them to subtly disengage from the therapeutic relationship. This detachment may replicate how other people respond to the AS patient in daily life. On the other hand, these observations and reactions help to inform potentially beneficial interventions if they are integrated tactfully and judiciously into therapy.

In the next section, we discuss how to overcome these challenges and foster a therapeutic relationship that is adequately supportive of the needs of the AS patient to keep him or her engaged in treatment.

### *Establishing a Supportive Therapeutic Connection*

A good starting point for establishing the therapeutic relationship with AS patients is to learn about their inner experiences. Even before identifying their presenting problems, simply showing an interest in their hobbies and collections or having them explain their metaphors or media references helps AS patients feel less anxious. Carrying out a sustained conversation with a new therapist is an anxiety-provoking situation to which the individual with AS is probably not accustomed. Talking about topics familiar to them helps AS patients become more comfortable with the therapy setting and to feel understood by the therapist.

We have observed that some adults with AS have difficulty explaining their internal reactions in response to open-ended questions. Clinicians may have to adapt their method of inquiry to use more direct, specific questions or to give several examples from which the patient can choose which response best matches her or his experience. In rare cases, adults with AS have such difficulty managing the clinical interchange that it may be helpful to write down a question on a piece of paper to allow the individual to focus on the written words instead. Learning how to effectively communicate with an AS patient also guides the therapist in terms of how to present therapeutic interventions, whether by using the patient's metaphors to explain them, by writing them down for a patient to read, or by some other method.

The therapist also observes the patient's paralinguistic (e.g., speech rhythm, inflection) and nonverbal paralinguistic (e.g., facial expressions, eye contact, posture) communication in session. While the content of statements can be addressed from the first session in the spirit of collaborative understanding, feedback about nonverbal behaviors may be too much information for a patient to handle in an early meeting with a new therapist. However, when the therapist observes a problematic and recurring nonverbal behavior pattern, introducing the topic with a rationale for doing so

and stating that the information is being shared in the spirit of being helpful is a useful way to set the stage for a therapeutic discussion.

Providing information is another way to engage AS patients in therapy. Discussing the procedures of psychotherapy and pragmatic details (e.g., length of session, where to wait) help to reduce patients' worry about these issues. Setting an agenda for each session is important. It is also helpful to clarify appropriate topics for sessions, including coming up with helpful guides for improved interaction, and being available to answer patients' questions about social situations. Such an approach normalizes the process of examining problematic interaction patterns and developing alternative behavior patterns to be employed. Therapists' feedback and interventions then become a natural outgrowth of the collaborative relationship with patients.

Some therapists may be reluctant to assume the role of being social advisor to their AS patients. We agree that this is a role to handle judiciously and that therapists must be mindful of potential biases in the information they are providing. However, information about social norms, including attire and hygiene when appropriate, is vital for AS patients and what they desire to help them make sense of their social worlds. In general, we have found that AS patients simply want basic behavioral recommendations (e.g., say "see you later" at the end of a conversation). The extent to which therapists broach controversial topics (e.g., religion, politics) is usually to suggest when to avoid bringing them up (e.g., "Do not discuss religion or politics with someone you've just met"). Addressing social norms in various situations, such as making small talk or handling workplace conversations, is often a focus of social skills groups for AS. Reviewing these issues in individual psychotherapy, either concurrently with group participation or alone, allows the discussion to be personalized to the specific needs of the patient.

It is the expectation of reciprocity of communication that creates problems for individuals with AS. Many AS patients tend to engage in extended monologues about topics of personal interest that often leave listeners feeling bored. When faced with interactions that are not clear-cut, and are therefore more stressful, AS adults might make statements or display behaviors that could be off-putting to others. For instance, high-functioning individuals with AS sometimes are

promoted to positions in their jobs that require them to act as supervisors or team leaders. When training coworkers how to use new computer software, for example, an AS individual might sound patronizing or arrogant in his or her manner of speech or by providing excessive details. Depression or anxiety can result when the individual experiences difficulty managing this transition to a new position at work and is subjected to negative feedback from others. Therapists may warn AS patients early in treatment that they will interrupt them at various times in order to ask questions or to provide immediate feedback about their communication style. The therapist and patient could work together to devise acceptable methods for signaling when the therapist has something to interject (e.g., raising a hand), clarifying that this sort of intervention is a special feature of the therapeutic relationship. The goal of such feedback is to convert monologues to dialogues.

Regardless of the types of presenting problems for which AS adults seek therapy, it is useful to define them using specific examples of situations encountered in their day-to-day lives. These specific examples provide a starting point for using the therapeutic relationship as a laboratory for developing new social behaviors.

#### *Laboratory for Changing Social Behaviors*

Adults with AS often describe knowing that they have problems in social situations but not knowing how to change them. A man with AS wrote that his unquestioning approach to social situations “prevents me from attempting to change negative situations into positive ones in a timely manner or even at all” (Shore, 2001, p. 87). Thus, many traditional CBT interventions augmented with experiential exercises can be helpful for adult patients with AS.

AS patients often have distorted attributions which require cognitive restructuring (Attwood, 2003). Common cognitive distortions seen in adult AS patients include interpreting situations in all-or-nothing terms (e.g., “I’m right and I must prove this”) and engaging in magical thinking, the tendency to overestimate the likelihood of hoped-for outcomes and ignoring steps they could take to influence an outcome (e.g., “The clerk should see that I want to buy this item”). Some individuals with AS have a tendency to assign blame to others for events that they per-

ceive as beyond their control. Targeted individuals are held responsible for negative situations and become the focus for retribution or grudges, absolving the AS adult from personal responsibility (Attwood, 2003).

The CBT approach of identifying and exploring automatic cognitions offers a helpful framework for AS individuals to understand their reactions and to recognize that there are alternative interpretations of these same social situations. Socratic questions presupposing that other people have reactions to a situation help to elicit the patient’s views (or lack thereof) of these reactions (“If these were your thoughts about the situation, what do you think the other person might have been thinking?”). Questions can also be used to highlight important objective cues (e.g., “Did anyone tell you they had a problem with what you said?”) and subjective cues (e.g., “Did anyone seem to be upset with you even if they did not say something? How would you tell if someone was upset other than them telling you?”). The responses help the therapist discern whether or not the patient considers others as having reactions and, if so, whether the reactions are reasonably empathic or if they seem to miss the mark and contribute to the patient’s difficulties. The therapist may illustrate examples of automatic cognitions by exploring the patient’s thoughts about something the therapist said or did, allowing the therapist to provide information about her or his thoughts. Likewise, the therapist may point out possible misinterpretations that could be made based upon the patient’s nonverbal communication style such as the lack of a smile. Such interventions rely on a therapeutic relationship based on an assumption that feedback will be constructive and focused on reducing social misinterpretations.

The use of pictures in sessions helps adults with AS to gain insight about how others may view social situations. Used within a CBT approach, these illustrations also help AS patients to functionally analyze their cognitive, emotional, and behavioral reactions to situational triggers. Illustrations provide a framework to help patients consider how another person might react to situational triggers. Simple stick figure drawings with empty thought balloons above each character are sufficient to illustrate thoughts individuals may have to various situations. This approach could be used to clarify misunderstandings that arise between the therapist and patient and then

applied to misunderstandings that occur for the patient outside of session.

In addition to dealing with problems related to errors of commission (e.g., distorted thoughts), CBT for adults with AS also explores errors of omission (e.g., social information overlooked or misjudged by the patient). For example, AS patients often do not notice when people make social overtures to them (e.g., smiling, greeting, flirting) and, thus, do not respond. Others may misinterpret the patient as being aloof or uncaring when, in fact, he or she simply missed the signal. The therapeutic relationship becomes an important vehicle for exploring the patient's social interactions, and therapeutic conversations provide opportunities for looking for available social cues that could be useful for the patient. The therapist may provide feedback about a patient's facial expression and may switch roles and encourage the patient to "read" the therapist's facial expressions. From these examples and with practice, the individual with AS can become more aware of others' reactions.

#### *Explicit Social Directions and Behavioral Suggestions*

Many AS patients ask explicitly for concrete advice on how to act in particular social settings. They are seeking concise strategies and often scripted dialogues to use in unstructured situations. AS individuals often lack an understanding of social conventions such as "small talk." A list of acceptable topics of conversation (and those to avoid) reduces their anxiety about committing social blunders. The use of these topics could be rehearsed in session for use in any number of situations such as with family, store clerks, co-workers, or with the therapist at the beginning or end of a session. Even an exercise as simple as walking down a city street with the goal of making eye contact with five passersby and saying hello to them can prove both challenging and informative for the adult with AS. The use of videotapes of therapy sessions and role-playing also allow patients to analyze their social behavior and become more attuned to their own body language, eye contact, and voice intonation. They must increase their awareness of nonverbal social cues to fully understand the reactions of other people toward them.

Another issue in conversation is learning its social "rhythm": when to interject comments,

how to avoid monopolizing a conversation, and recognizing when the other person is becoming bored. In addition to developing scripted topics, therapists can help AS patients to develop ways to gauge when to stop talking, when to ask questions, and when to end interactions. Some patients may be able to learn to recognize and respond to certain conversational behaviors, such as someone glancing at a clock as a cue that she or he needs to leave. Additional exercises such as "mirroring" the physical behavior of others and "summarizing" the ideas expressed by others provide much needed practice in focusing attention on readily available features of social interactions. Other patients, however, may find it helpful to have concrete conversational guidelines, such as the following: (a) during conversations, make eye contact and periodically look away—do not stare, (b) pause and give the other person an opportunity to talk after you have spoken two sentences, or (c) conversations during work hours should not last more than five minutes. These skills can be practiced in role-play exercises with a therapist.

#### **Summary**

Despite the significant social impairments that characterize AS, the therapeutic relationship stands out as an important one for AS adults who seek psychotherapy. For this relationship to be effective, however, both patients and therapists must be able to step outside of their respective comfort zones. Patients with AS face a challenge akin to learning a new language, trying to simultaneously learn new relationship skills while being active participants in social interactions. Therapists face the challenge of adopting substantially different roles from those typically adopted with other patients in order to help AS patients learn the normative social language from which they will eventually develop their unique voices. Although AS adults may not develop a high level of social skill, therapy can help them to become "better strangers" with others and gain improved social skills that will help them function better in their social worlds.

#### **References**

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic*

- and statistical manual of mental disorders (4th ed.). Washington, DC: Author.
- ATTWOOD, T. (2003). Frameworks for behavioral interventions. *Child and Adolescent Psychiatric Clinics of North America*, 12, 65–86.
- BARON-COHEN, S. (2003). *The essential difference: The truth about the male and female brain*. New York: Guilford Press.
- BARON-COHEN, S., & WHEELWRIGHT, S. (2004). The empathy quotient. *Journal of Autism and Developmental Disorders*, 34, 163–175.
- BECK, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: Meridian.
- BEEBE, D. W., & RISI, S. (2003). Treatment of adolescents and young adults with high-functioning autism or Asperger syndrome. In M. A. Reinecke, F. M. Dattilio, & A. Freeman (Eds.), *Cognitive therapy with children and adolescents: A casebook for clinical practice* (2nd ed.) (pp. 369–401). New York: Guilford Press.
- CARDACIOTTO, L., & HERBERT, J. D. (2004). Cognitive behavior therapy for social anxiety in the context of Asperger's syndrome: A single-subject report. *Cognitive and Behavioral Practice*, 11(1), 75–81.
- CHAMBERLIN, J. (2004, October). A toxic world. *Monitor on Psychology*, 35(9), 44–45.
- COHEN, M. R. (2005). *Social skills seminar curriculum for adults*. Manuscript in preparation.
- FRITH, U. (2004). Emanuel Miller lecture: Confusions and controversies about Asperger syndrome. *Journal of Child Psychology and Psychiatry*, 45(4), 672–686.
- FRITH, U. (Ed.) (1991). *Autism and Asperger syndrome*. Cambridge, England: Cambridge University Press.
- HARE, D. J. (1997). The use of cognitive-behavioural therapy with people with Asperger syndrome. *Autism*, 1(2), 215–225.
- HOWLIN, P. (2002). Autistic disorders. In P. Howlin & O. Udwin (Eds.), *Outcomes in neurodevelopmental and genetic disorders* (pp. 136–168). Cambridge, England: Cambridge University Press.
- HOWLIN, P. (2003). Outcome in high-functioning adults with autism with and without early language delays: Implications for the differentiation between autism and Asperger syndrome. *Journal of Autism and Developmental Disorders*, 33, 3–13.
- HOWLIN, P. (2004). *Autism and Asperger syndrome: Preparing for adulthood* (2nd ed.). New York: Routledge.
- HOWLIN, P., & ASGHARIAN, A. (1999). The diagnosis of autism and Asperger syndrome: Findings from a survey of 770 families. *Developmental Medicine & Child Neurology*, 41, 834–839.
- HOWLIN, P., MAWHOOD, L. M., & RUTTER, M. (2000). Autism and developmental receptive language disorder. A follow-up comparison in early adult life. II: Social, behavioural and psychiatric outcomes. *Journal of Child Psychology and Psychiatry*, 41, 561–576.
- KLIN, A., SPARROW, S. S., MARANS, W. D., CARTER, A., & VOLKMAR, F. R. (2000). Assessment issues in children and adolescents with Asperger syndrome. In A. Klin, F. R. Volkmar, & S. S. Sparrow (Eds.), *Asperger syndrome* (pp. 309–339). New York: Guilford Press.
- KLIN, A., & VOLKMAR, F. R. (2003). Asperger syndrome: Diagnosis and external validity. *Child and Adolescent Psychiatric Clinics of North America*, 12(1), 1–13.
- MAWHOOD, L. M., HOWLIN, P., & RUTTER, M. (2000). Autism and developmental receptive language disorder – a follow-up comparison in early adult life. I: Cognitive and language outcomes. *Journal of Child Psychology and Psychiatry*, 41, 547–559.
- MILLER, J. N., & OZONOFF, S. (2000). The external validity of Asperger disorder: Lack of evidence from the domain of neuropsychology. *Journal of Abnormal Psychology*, 109, 227–238.
- MILLER, W. R., & ROLLNICK, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- OZONOFF, S., ROGERS, S. J., & HENDREN, R. L. (Eds.). (2003). *Autism spectrum disorders: A research review for practitioners*. Washington, DC: American Psychiatric Press.
- SHORE, S. (2001). *Beyond the wall: Personal experiences with autism and Asperger syndrome*. Shawnee Mission, KS: Autism Asperger Publishing Co.
- SLATER-WALKER, G., & SLATER-WALKER, C. (2002). *An Asperger marriage*. London: Jessica Kingsley Publishers.
- TANTAM, D. (1991). Asperger syndrome in adulthood. In U. Frith (Ed.), *Autism and Asperger syndrome* (pp. 147–183). Cambridge, England: Cambridge University Press.
- TANTAM, D. (2003). The challenge of adolescents and adults with Asperger syndrome. *Child and Adolescent Psychiatric Clinics of North America*, 12(1), 143–163.
- TIDMARSH, L., & VOLKMAR, F. R. (2003). Diagnosis and epidemiology of autism spectrum disorders. *Canadian Journal of Psychiatry*, 48, 517–525.
- TOWBIN, K. E. (2003). Strategies for pharmacologic treatment of high functioning autism and Asperger syndrome. *Child and Adolescent Psychiatric Clinics of North America*, 12(1), 23–45.
- VOLKMAR, F. R., KLIN, A., & PAULS, D. (1998). Nosological and genetic aspects of Asperger syndrome. *Journal of Autism and Developmental Disorders*, 28(5), 457–463.
- WING, L. (1996). Autistic spectrum disorders. *British Medical Journal*, 12, 327–328.
- WING, L. (2001). *The autistic spectrum*. Berkeley, CA: Ulysses Press.