

## **Mental Health and Asperger's Syndrome: What Clinicians Need to Know**

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*The purpose of this paper is to explain what clinicians need to know and understand when treating individuals with Asperger's syndrome (AS). This paper addresses the presentation of AS and what clinicians need to focus on during intake, while establishing a therapeutic relationship, and the range and severity of comorbid issues within this population. The paper also discusses diagnosis of AS and the effectiveness of cognitive-behavioral therapy in the treatment of symptoms of AS and explains the use of medication and psychosocial support.*

**KEYWORDS** *Aspergers, cognitive-behavioral therapy, autism, therapeutic alliance*

### DEFINITION

In today's psychotherapy practice, we are seeing an increase in the number of clients with Asperger's syndrome (AS) seeking treatment for a variety of mental health issues. Frequently, clients present themselves for treatment without ever having been formally diagnosed. It is important to be familiar with AS and its characteristics before agreeing to treat these clients, as the emotional and cognitive structures of the AS client are quite different from those of neurotypical clients and, as such, a shift in the traditional therapeutic approach is indicated. AS, which currently exists as part of the general DSM-IV-TR classification of pervasive developmental disorders, is

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considered to be on the spectrum of autism disorders (ASD). It is defined as a developmental disability characterized by "Qualitative impairments in social interaction . . . and restricted, repetitive and stereotyped patterns of behavior, interests, and activities" (American Psychiatric Association *DSM-IV-TR*, 2000). The classification will change in the DSM V, however, with the elimination of Asperger's as a distinct diagnosis (DSM-V Proposed Revision, 2011). Instead, it will become part of the ASD classification, with the title *Asperger's syndrome* being eliminated.

In recent years, the number of individuals receiving a diagnosis of autism has increased dramatically. Current estimates are that 1 in 110 of children today have the disorder in some form (Rice, 2009). The prevalence of AS within these estimates is unclear, although it can reasonably be assumed that AS is a far more common diagnosis now than ever before.

### CLINICAL PRESENTATION

Persons with AS can present as aloof, detached, and disinterested in the world around them. They are often intently focused on one idea or topic and are easily distracted by details. Given their advanced verbal skills, often superior intelligence, and difficulty in reading social cues, the AS client can appear to be arrogant and condescending. A monotone speech pattern can be evident, and affect is often flat. It is important for the clinician to accept this presentation as a manifestation of the AS personality and not as an intentional sabotaging of the therapeutic alliance.

Individuals with AS struggle with the core psychological frameworks of theory of mind, central coherence, executive functions, and social cognition. Knowledge of these concepts and their role in the presentation of the AS client is essential to effective treatment. "A theory of mind is a concept of another person's mind. If we have a theory of mind, we can recognize that another person's belief is based on his experience or knowledge, and not necessarily on what we know to be true" (Baron-Cohen, Leslie, & Frith, 1985). A person with AS can understand another to the extent of the knowledge that person possesses. People with AS have feelings and may understand them in others on an intellectual level but might not understand how certain emotions are experienced by another individual.

Central coherence is the idea that we can acquire a larger meaning from different types of information. People with AS sometimes fail to see the general idea of information and will try to remember every single detail. With this comes an overload of information, which can trigger a different range of emotions such as frustration and anxiety (Gaus, 2011, p. 59). Executive functioning, conversely, is the idea of being able to focus our attention on something that is relevant and keep it on that while other things are happening.

Social cognition refers to the ability to recognize and understand other peoples' mental states. It also encompasses the innate idea to pick up and read social cues. Individuals with AS cannot process or understand these cues, which can cause undesirable schemas and increase co-morbid issues (Gaus, 2007, p. 43).

While considering the clinical presentation of a client with AS, it is essential to differentiate between the clinical features of Asperger's and mental health disorders, as the goal of psychotherapeutic treatment of an AS client is not to treat the Asperger's itself but the issues that are causing distress. It is important to note that for many clients with AS, their Asperger's features are an integral part of who they are and, as such, they are not looking for a "cure" but for help with the psychological and social issues that can be problematic. "Which (self) repairs are needed depend on who you are, and how bravely you can admit to what your strengths and challenges are" (Carley, 2008, p. 159).

### Presenting Mental Health Issues

Since persons with Asperger's perceive and understand the world around them differently than others, they can be as susceptible, if not more so, to mood and anxiety disorders. "These difficulties place them at risk of developing mental health problems, particularly anxiety, depression and obsessive compulsive disorder" (Donoghue, Stallard, & Kucia, 2011, p. 89).

As research begins to catch up with the increased diagnostic numbers, it is becoming apparent that mood disorders are a common, and treatable, issue for the AS population. A recent study by Lugnegard, Hallerbäck, and Gillberg (2011, p. 1913) indicate that many individuals with AS have experienced at least one episode of major depression. Others have just a single occurrence of depression due to environmental occurrences such as bullying and school issues. A considerably large group of individuals with AS will experience recurring depression that can be quite debilitating.

Individuals with AS are highly susceptible to increased levels of anxiety and stress due to their altered thought processes. "... as some patients have described (they have to) 'work harder' just to appear 'normal'" (Gaus, 2007, p. 84). As they are often aware of the difference in thought, individuals become sensitive to how people view them, and with that sensitivity comes unwanted and often unnecessary attention. An issue as well with executive functioning, doing the simplest task, can cause over-thinking or an over-classification of the task that can cause worry and stress. The combination of these factors can cause an anxiety disorder.

Obsessive compulsive disorder (OCD) is another common anxiety disorder with AS. Individuals with AS tend to have an intense focus on a specific area of interest, while the compulsive side of the disorder comes from a rigorous and set routine of activities that generally have no real functional

value. This in and of itself does not constitute OCD according to the DSM IV T-R. What clinicians need to look for in individuals with AS are obsessive and compulsive habits that cause anxiety and which the individual knows are not normal and would like to fix (Gaus, 2007 p. 86).

It is possible that clinicians might miss or overlook a mood disorder based on the underlying developmental disorder, which is known as "diagnostic overshadowing" (Gaus, 2007, p. 32). For example, an intense focus on one area of interest can lead to excessive speech about that topic and consequently can be interpreted as a manic or hypo-manic episode, as is usually seen with bi-polar disorder. It is, therefore, important to see whether there is a family history of bi-polar disorder and to work on a differential diagnosis.

The stress and difficulty of not being able to regulate or express emotion effectively can cause sudden outbursts, a streak of rage, depressive tendencies, and other symptoms of mood disorders. Emotions that are often expressed during an initial session are feelings of worthlessness, loneliness, and other conventional symptoms of depression. Clinicians need to be aware of direct and specific questions that need to be asked in order to gauge the proper emotions. Thought processes and communication style of most AS individuals are very different from those of a neurotypical individual.

## Treatment

### DIAGNOSIS

As the awareness of AS increases, it stands to reason that many children with AS being seen by clinicians have already been diagnosed, either by a psychologist, neurologist, psychiatrist, or other professional. In the case of adults, however, this is not always the case. Many AS adults have been either misdiagnosed or simply been written off as "quirky" or as "loners." Once again, differential diagnosis is important in not only ensuring the appropriate treatment but to begin to manage the damage caused by inaccurate or harmful diagnoses.

In situations where no formal diagnosis is presented but AS is suspected, there are clear indicators that can be used to support diagnosis. Does the client make eye contact? Is the speech pattern emotive, or is it idiosyncratic? Does discussion of emotions confuse, frighten, and/or anger the client? Is affect flat? Does the client repeatedly return the discussion to a single, nonrelated topic? It is not always clear from the initial interview that AS may be present; in some individuals, presentation may be more subtle.

Obtaining a family history is key in confirming a diagnosis. Since ASD is suspected to have genetic roots, often there is a family member who may not have been officially diagnosed but was considered to have been "odd." In addition, examining early childhood development can be useful. Did the

client speak and read at an early age? Did he or she have difficulty making and keeping friends? Was the child often engrossed in solitary, regimented play? As AS may also cause motor skill deficits and sensory issues, questions regarding these concepts can also be helpful.

There are a number of clinical assessment tools now available to guide diagnosis. The Adult Asperger's Assessment (Baron-Cohen, Wheelwright, Robinson, & Woodbury-Smith, 2005) is a frequently used means-tested tool used by professionals. The Childhood Asperger's Syndrome Test (Attwood) is a parent's tool that is relatively short and easy to complete. Simple checklists based on DSM-IV criteria can also be helpful.

#### THE EFFICACY OF COGNITIVE BEHAVIOR THERAPY

Cognitive behavior therapy (CBT) can be considered a teaching and learning therapy. It allows individuals to take a look at themselves through the use of logs and thought pattern charts to obtain a clear picture of their maladaptive thinking and of ways to change it. This same type of therapy can be applied to individuals diagnosed with AS. CBT has the ability to help with mental health issues, show positive social interactions, and teach the skill of being able to read social cues. For example, using worksheets and picture exercises, you can show and help an individual with AS tune into specific emotions by comparing emotions to faces. Worksheets can also teach a client how to properly engage in positive interactions with others, and to maintain and facilitate a conversation. As skills are increased, the anxiety created by attempting to "fit in" to the neurotypical world is often greatly reduced, as Temple Grandin, noted autistic self-advocate mentions, "More knowledge makes me act more normal" (Grandin, 1995).

#### THERAPEUTIC ALLIANCE

As with any other therapy, the first and most important step is to develop a mutual trust between the therapist and the client. "In psychotherapy, we try to understand what something means to our patients in order to understand the people we are with, whether or not they fit our usual way of understanding" (Jacobson, 2004, pp. 576–577). When working with individuals diagnosed with AS, it is important for a clinician to understand that a therapeutic alliance will take longer to establish and will become established differently. There are several reasons for this, with the most important being that individuals with AS are not able to communicate as well as neurotypical clients with regard to their reason for coming into therapy. Individuals with AS can seem guarded and reserved because they will not talk or will just state basic facts about themselves with no feeling or emotion attached. This can cause a strain on obtaining an alliance and takes increased time to gain trust and fully understand the needs and wants of the client.

## MEDICATION

An important factor to consider in the treatment plan of co-morbid conditions in AS clients is medication. The medications of choice for most mood disorders in the general population are the SSRI anti-depressants, although medical research seems to indicate that this mode of treatment may not be efficacious (Williams, Wheeler, Silove, & Hazell, 2010). Medications such as Prozac, Zoloft, and Lexapro *may* have the effect of reducing anxiety and OCD, therefore opening the door for skills work to be more effective. Additionally, other medications are sometimes used to treat conditions that interfere with functioning, such as stimulants for focusing and hyperactivity and antipsychotics for aggression, repetitive behaviors, and self-injury. It is essential that there is consultation with an appropriate physician and ongoing coordination of treatment plans to ensure optimal benefit.

## PSYCHOSOCIAL SUPPORT

When treating the AS client, it is important to consider the person's environment, supports, and family. Working with AS children presents a particular set of challenges, as today's Asperger's child may be receiving a host of other services, including social casework; physical, speech, and occupational therapy; special school placements; educational supports, and the like. These services can be invaluable in helping clients improve their coping skills, and coordination and consultation with other involved professionals should be pursued whenever possible. In addition, considering the family dynamic with regard to acceptance of the diagnosis, support of therapeutic work, and management of maladaptive behaviors is essential to effective treatment. Often, addressing issues in the family can be as important as one-to-one treatment in the office.

As AS has become a mainstream diagnosis, those with the syndrome have "found" their voice. There are numerous advocacy, self-determination, and support organizations in existence now that are invaluable sources of support to both the AS population and to those who strive to assist, engage, and enable them. Many of these organizations have become vocal in the push for society in general to accept the differences of AS individuals rather than attempting to "normalize" them. One of the most important components of clinical treatment, in fact, can be assisting such clients in accepting the diagnosis and celebrating the strengths that AS can bring, in addition to working on the deficits that can make life challenging.

## REFERENCES

- American Psychiatric Association. (2000). *DSM-V proposed revision autism spectrum disorder*. Retrieved from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=94>



- Baron-Cohen, S., Leslie, A. M., & Frith, U. (1985). Does the autistic child have a 'theory of mind?' *Cognition*, *21*, 37–46.
- Baron-Cohen, S., Wheelwright, S., Robinson, J., & Woodbury-Smith, M. (2005). The Adult Asperger Assessment (AAA): A diagnostic method. *Journal of Autism & Developmental Disorders*, *35*(6), 807–819. doi: 10.1007/s10803-005-0026-5
- Carley, M. J. (2008). *Asperger's from the inside out: A supportive and practical guide for anyone with asperger's syndrome*. New York, NY: Penguin.
- Donoghue, K., Stallard, P., & Kucia, J. (2011). The clinical practice of cognitive behavioural therapy for children and young people with a diagnosis of Asperger's syndrome. *Clinical Child Psychology and Psychiatry*, *16*(1), 89–102. doi: 10.1177/1359104509355019
- DSM-V-TR reference. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- Gaus, V. L. (2007). *Cognitive-behavioral therapy for adult asperger syndrome*. New York, NY: Guilford Press.
- Gaus, V. L. (2011). Adult Asperger syndrome and the utility of cognitive-behavioral therapy. *Journal of Contemporary Psychotherapy*, *41*(1), 47–56. doi: 10.1007/s10879-010-9159-8
- Grandin, T. (1996). *Thinking in pictures: And other reports from my life with autism*. New York, NY: Random House
- Jacobsen, P. (2004). A brief overview of the principles of psychotherapy with Asperger's syndrome. *Clinical Child Psychology and Psychiatry*, *9*(4), 567–578. doi: 10.1177/1359104504046160
- Lugnegård, T., Hallerbäck, M., & Gillberg, C. (2011). Psychiatric comorbidity in young adults with a clinical diagnosis of asperger syndrome. *Research in Developmental Disabilities*, *32*(5), 1910–1917. doi: 10.1016/j.ridd.2011.03.025
- Rice, C. (2009). Prevalence of autism spectrum disorders: Autism and developmental disabilities monitoring network, United States, 2006. *Morbidity, Mortality Weekly Report*, *58*(SS10), 1–20.
- Williams, K., Wheeler, D. M., Silove, N., & Hazell, P. (2010). Selective serotonin reuptake inhibitors for autism spectrum disorders. *Journal of Evidence-Based Medicine*, *3*(4), 231. doi: 10.1111/j.1756-5391.2010.01106.x