Asperger's Syndrome: A Client-Centered Approach

Michaella Buck and David P. Buck

Intercollege, Cyprus

Abstract

The authors provide a historical and descriptive explanation of Asperger's Syndrome. They assert that Client-Centered Therapy is appropriate with clients who lack the affective emotional relatedness between people. Also, they present a case study involving the application of Client-Centered Therapy with a client suffering from Asperger's Syndrome.

Asperger's Syndrome: A Client-Centered Approach

Asperger's Syndrome (AS) is understood to be a pervasive developmental disorder caused by a neurological defect in the functioning of the brain (Kirby, 2001). The prevalence of AS is reported to be one in 250 people, with a male-to-female ratio of four-to-one (Jacobsen, 2003). However, the prevalence of AS may be higher. Jacobson (2003) suggests that the high cognitive and language functioning of some individuals with AS may result in sizeable numbers of mis-diagnoses. Some theorists regarded AS to be environmentally caused, and concluded that parents played the crucial role in AS etiology (Bettelheim, 1967). Other, more recent research, gives no credence to such environmental theories (Davison, 2001) and suggests a biological basis for AS (Barlow, 2005).

Author Note: Michaella Buck is Associate Professor and Head of the Social Sciences Department, Intercollege, Cyprus. She is the author of four books and numerous scholarly articles. David P. Buck is currently the Director of the Counseling and Psychotherapy Center at Intercollege, Cyprus and was a co-founder of the Institute of Person – Centered Learning, UK and the Institute for Personal and Professional Development, Greece. They confirm that the client and his parents have given their consent for the writing and publication of this case study.

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History and Defining Characteristics of Asperger's Syndrome

Hans Asperger (1944), a Viennese pediatrician, first described a pattern of impaired cognitive, social, and linguistic abilities of four boys he treated. Asperger noticed that, while the boys he treated shared many of the same diagnostic criteria as patients with autism, his four boys demonstrated higher ability than patients with autism. This main differentiation between the two disorders was noted in the years of research that followed, with Aspergers regularly being referred to as highly functioning autism, or "autistic psychopathy." It was not until after Asperger's death in 1981 that the term Asperger's Syndrome was given to AS (Wing, 1983). Subsequently, the more predominant and most widely associated clinical features of Asperger's Syndrome (AS) have been identified. These include: qualitative impairment in social interactions and occupational areas, narrow interests, restrictive patterns of behavior, speech and language peculiarities, and restrictions in communication (Szatmari et al, 1989, Aston, 2003). Additionally, research has shown that normal intelligence and superior skills in a given area are accompanied with two defining traits: the inability of those diagnosed with AS: (1) to develop an understanding of mental states, and (2) to predict and explain the mental states of others (Bowler, 1992).

Individuals diagnosed with AS experience difficulties in conceptualizing and understanding others. Their ability to understand the feelings of others by observing body language, and to respond accordingly, is compromised. Additional difficulties exist for those with AS including sensory processing both in perception and its analysis (Cole, 1991), the understanding of facial expressions and emotional states, and difficulty in non-verbal communication (Lee, 2000). Some of the most devastating effects are the absence or loss of facial animation during social interaction. According to Svobodova (1996), when humans talk to someone they "answer" not only with words, but also with look, tone of voice, and the whole expressive play of face and hands. Such interactions are not pursued by those who have struggled with AS. Rather, AS diagnosed individuals actively avoid looking face-to- face, evade complex signals of mood in others, and are overwhelmed by attempts to do so (Cole, 1999).

Rather than showing developmentally appropriate interests, people with AS tend to fixate obsessively on circumscribed topics like weather, facts about computers, airline schedules, and maps. It is this fixation with facts that has some psychologists referring to AS as the "little professor syndrome" (Barlow, 2005). These differences in reading body language cues, understanding other people, and fixating on facts can present profound

difficulty in navigating social interactions. The tendency toward a formal style of speech and an obsession with facts over people, can lead to judgements of eccentricity. This "eccentricity" is amplified in odd postures and ill-coordinated, awkward movements (Jacobsen, 2003). Stereotyped patterns of behavior may be manifested in self-stimulatory behavior and repetitive motor mannerism such as hand flapping or finger twisting.

Client-Centered Therapy

The central hypothesis of Client-Centered Therapy is that individuals have within themselves vast resources for self – understanding and for changing their behavior and attitudes (Rogers, 1986). If a psychotherapist creates a caring atmosphere and is successful in conveying attitudes of genuineness, empathy, and unconditional positive regard, there is high probability that a client will respond with constructive personality change (Rogers, 1989; Rogers, 1986). Client-Centered Therapy offers an holistic paradigm of human experience and is built on the trust that individuals can set their own goals and monitor their progress toward these goals (Rogers, 1986). The therapeutic relationship is one of collaboration, in which clients are experts on their own experiencing (Sollarova, 2005). The relationship between therapist and client is viewed as the most healing part of therapeutic process (Raskin, 2000; Bozarth, 1998).

The treatment of people with AS was mostly focused on enhancing their communication and daily living skills (Baron – Cohen, 1985) which points at the domain of behavioral approaches, and their central premise that AS can learn some of the skills they lack. However, a very different opinion was developed by Bettelheim (1974) who believed in the importance of establishing a relationship with a person in the autistic spectrum. He emphasized the importance of a warm loving atmosphere to encourage a sufferer to enter the world, and thus empathy and unconditional positive regard should be incorporated into the therapeutic process. This is one of the very few references to a Client – Centered Approach, and to the positive influence of the therapeutic relationship in facilitating human growth.

It is always difficult to work effectively when a client feels involuntarily pressured into a therapeutic relationship. With an individual suffering from AS it may be even more daunting since the concept of empathy does not exist. Feelings are not apparent other than an occasional display of anger. Individuals diagnosed with AS exaggerate the temperament of others, and can produce either a passive or controlling aggressive personality (Gillberg, 1989). Further, lack of empathy, inability to be "in

someone's shoes," and a limited emotional spectrum inhibits the ability of clients diagnosed with AS to interact with others, to understand another's state of mind, and monitor their own effective emotional relatedness.

Asperger's Syndrome and Client-Centered Therapy

The presumed disparity between offering an empathic relationship by the Client-Centered therapist, and the inability of the AS diagnosed person to be empathic, may appear to negate the use of Client-Centered therapy with AS clients. Until recently, the psychiatric world dismissed Client-Centered therapy as irrelevant for work with severely disturbed clients. However, Client-Centered theorists and practitioners have bridged the gap between the use of Client-Centered therapy and "difficult diagnoses," refuting arguments that Client-Centered therapy is inappropriate for serious psychological problems (Cochran & Cochran, 1999; Demanchick, Cochran, & Cochran, 2003; McCulloch, 2000; McCulloch, 2002; Sommerbeck, 2003; Tursi & McCulloch, 2004). As a consequence, Client-Centered therapy has been used with people seeking a personal growth experience, as well as with individuals diagnosed with "difficult diagnoses." The following case study illustrates a Client-Centered therapist approaching an individual diagnosed with AS.

Case Study

Client V. Z. was diagnosed with AS at the age of 10 years. A very dedicated and observant mother noticed that not everything seemed right with her son. She noticed a vast discrepancy between his intellectual and social abilities, and found his behavior and development unacceptable. Although socially aware, he did not display what she considered "inappropriate" reciprocal interactions with peers when conversations revolved around himself. After various tests, V.Z. was diagnosed as autistic. However, V.Z. demonstrated a high cognitive functioning, an efficient command of the English language, an extraordinarily rich vocabulary, and a clear and precise formulation of his thoughts. As a result, further tests followed and V.Z. was diagnosed with Asperger's Syndrome (AS). Confirmation that he was not stubborn or lazy brought great relief to the family and they felt relief from the fear of bad parenting. However, the news was coupled with disappointment for V.Z.'s parents when they were told there was no cure for the disorder and no drugs to treat it.

V.Z.'s family was upper middle class with a strong bent towards education and social acceptability. The male line consisted of a strong military

tradition with many of the ancestors reaching the highest ranks. V.Z. had two siblings, both educated at one of the country's most prestigious schools. V.Z. also attended one of the country's famous public schools. There he succeeded academically due to his high cognitive functioning, well developed verbal skills, and ability to set clear goals. However, V.Z. made little progress as a "team person," stayed detached from the feelings of others, and made no lasting relationships with classmates or housemates. After graduation he attended a university where he studied History and graduated with honors. He always said: "I wasted my time at University because I didn't bother to interact with anyone."

V.Z. was aware of the fact that he displayed no natural social skills. Unable to read social cues well, and with little or no empathy, his behavior was often not accepted by others. For V.Z. it was too complicated to recognize the feelings of others and behave accordingly. Thus he very often behaved in a socially unacceptable way resulting in deeper and deeper social isolation.

V.Z. had been taught some social mores from his dedicated parents. These included: How to politely shake hands when being introduced to people, how to not always be fully "honest" when asked your opinion (especially regarding ladies fashion), how close to stand to someone, and how to tell when people are angry even when they are smiling. These teachings helped V.Z. compensate and cope with AS while maintaining his place in his family and their social standing. V.Z. came to therapy as a result of great pressure from his father, and having been persuaded by his parents that he needed to think about some kind of career.

V. Z. was very much aware of his problem. He knew his diagnosis and symptoms, he knew there was no cure, and thus it is a life – long disorder. He did not expect to "get better" from therapy, and he did not expect anything from therapy. The difficulties to produce changes in his rigid and inflexible world were obvious to him and often repeated by him during the sessions. However, he had a clearly stated goal: to find the most suitable career path for himself and to utilize therapy in this manner.

Therapy started in 2004 and lasted 10 months. Difficulties in verbal and especially poor non-verbal communication were continually frustrating him. He found non-verbals almost impossible to read, accurately transmit and comprehend. Motor dyspraxia reflected in clumsy body language, especially gestures, limited facial expressions, inability to give messages with his eyes, avoiding eye contact, peculiar stiff gaze, pedantic monotonic speech, sometimes stilted and repetitive, and difficulty in sensing social space were only a few of non – verbal communication problems which attracted his

attention and became a topic for discussion brought by him to many sessions. The therapist communicated to V. Z. acceptance in a clear way, through accepting his rules about communication. For instance, the therapist learned very early that it was not OK to touch, even a pat on the arm and shoulder. V. Z. responded in a flat, emotionless voice: "I do not like to be touched."

During the sessions, V. Z. realized that he did not truly understand the nuances of the language and had difficulty with language pragmatics. Difficulty in reading and integrating social cues resulted very often in the misinterpretation of literal and implied meanings of other person's words. It was a big puzzle for him to grasp puns, metaphors, symbolic meanings, and exaggerated language as is seen in the following example. When a very close member of his family died V. Z. described the death to the therapist as a part of life. V.Z. stated "You are born, you live, and you die. It's a fact." When asked how old his relation was, he said "85." The therapist commented that it was quite a reasonable number of innings (referring to the lengthy number of years V.Z.'s relation lived to a large number of innings in a game of cricket), V. Z. replied: "I do not approve of equating life and death with sport."

Part of the therapist's learning process was increased awareness of communication handicaps, both on verbal and non-verbal level. In order to develop the relationship, the therapist attempted to avoid any double meanings, ambiguous and abstract analogies, innuendos, and sarcasm. Dealing with such holistic processing was too demanding for V. Z. to interpret. However, communication did not represent the only problem. In what V.Z. called his "clumsy social approach," social pragmatics tended to be weak as well. According to V. Z., he was a person not wearing a social mask and therefore he had to face a lot of difficulties, as is illustrated in the following example. A formal dinner was organized by V.Z.'s parents at which certain duties were expected from him. He said these duies made him feel uncomfortable. "I don't like formal dinners. I don't want to listen to gossipy nonsense for two hours." The rules of social interaction seemed a mystery to him and he found the art of small talk impossible to master. For him there was no social laughter, no pretense. He showed anger to those who said something stupid. He would confront people if he thought theywere lying. His behavior brought trouble with his father who was intolerant of his son's anger.

After V. Z.'s question if he should go to the dinner or not, the therapist responded that it was up to him, but it might be good preparation for mixing with colleagues if he goes to graduate school. After gazing out of the window for about 2 minutes, V. Z. agreed that it might be of use if he went to the dinner and practiced being tolerant. From anyone else this irony

would be found amusing, but of course for V. Z. there was no irony. He did not feel confident to rely on being spontaneous in social situations. To compensate for this handicap he preprogrammed himself for what he thought he should do in a specific social situation. He processed his social interaction efforts through his area of strength which was logical and rational thinking, especially sequential thinking dealing with the coding and decoding of meaning in terms of the relationship of elements within a sequence. He rationally figured out what he should do in a social situation, step by step. By contrast, it was the last thing the therapist wanted to do during the therapeutic sessions – to rehearse and reinforce his approach by adopting behavioral methods because it would mean teaching him to rely forever on "a pianist's finger exercises".

On the contrary, the therapist accepted him as a person who is struggling to live with difficulties and trying to find a meaning for his life. The therapist facilitated his thinking processes in order for him to construe and experience events, and to explore alternatives and discover solutions for himself.

Like many people who have struggled with AS, V.Z. was prone to becoming anxious if his routine was deflected. Minor or significant changes and transitions were difficult for him to adjust to as well as upsetting. Ignoring National Holidays and the therapist's right for a private program he showed up for a cancelled session. Whilst it has been suggested that the founding of routine and preferring sameness is a result of anxiety as a primary characteristic (Attwood, 1989), during therapy this kind of anxiety was minimized by accepting the client's needs and by having and following the routine.

During early sessions, for long periods he would "star – gaze" and it was difficult for the therapist to stay with him in his silence. The avenue to his inner world led through his specific interest, related to the area in which he excelled: history. He was a learned historian with a deep knowledge of facts, and in order to be able to discuss with him historical happenings, the therapist had to revise. A great deal of the time was spent in discussing historical events with a small portion of the time actually spent in any form of psychotherapy. It required of the therapist an acute awareness and situational empathy. There were times when his opinions were contradictory to the therapist's sense of values; however, the therapist took into account the client's own view of reality. V.Z. would make rational comments regarding the loss of life in some remote part of the world, which of course would release some pressure from the food chain. He would make these rational comments without any feelings of empathy or sadness. Those feelings did not

exist for him. He grasped reality at a high intellectual level, with abstract thinking, often lacking concrete thinking and common sense. He might be familiar with what could be on another person's mind, however, he knew that he was unable to effectively apply knowledge, identify the perspective and behave accordingly. Being a prolific reader, he did not enjoy fictional reading that focused on interpersonal relationships. It was too difficult for him to understand the different perspectives in the interpersonal relationships and the understanding of feelings and thoughts in contrast to facts that are simple. However, in the course of therapy, he was able to get in touch with more personal issues. Although due to reading and discussion he was aware of the concept of love and that there were many versions of that emotion, he knew that he would never experience those feelings. He decided that marriage and family was not an option for him at least during the earlier part of our relationship. He revealed that he rarely had sexual feelings and masturbated on rare occasions. He described it as "a pretty useless activity". The therapist was never sure if this was part of the syndrome or just the idiosyncrasy of V.Z.

Pressure was being put on him by his father to embark on some kind of career. During the therapy, the possibilities were explored. The big portion of therapy was devoted to the facilitation of alternatives in thinking. "Is there another way" - being a frequent intervention. After a considerable amount of discussion V.Z. decided that he would like to do post-graduate studies. Where should he go and what should he study? An agreement was made to explore all the possibilities and discuss the outcome at the next session.

At the next session he announced that he decided not to check on Colleges but to improve the relationship with his father because two projects at the same time were not possible for him. After long discussion he concluded that the only thing that would please his father would be if he had a career even if he could easily just live comfortably on his savings for the rest of his life. It returned the therapy back to the starting point.

He happened to be an excellent writer particularly of facts. He decided that a course of journalism was the most appropriate due to his high academic achievements, ability to be responsible, a skilled professional and a gifted writer. However, being quite unskilled in social interaction and communication, the impossibility to feel moved, can he a person with Asperger have the creative imagination required of a writer? – was his crucial question. He decided to apply to four universities and he also put them in priority order. At the next session he said he wanted to bring the application forms. He did not. It was obvious he wanted to talk about something else. There was a long period of typical "star – gaze". Finally he announced that he

decided not to go to university because of arguments with his parents regarding the V.Z.'s wish to write on the application forms that he was an Asperger sufferer. The parents objected. The therapist responded "It seems important for you to tell the college authorities", and he responded "I never lie". It was one of very rare occasions when he expressed the emotion of anger and allowed the therapist to facilitate his feelings. However, very quickly he switched back to general discussion: "Why do people lie?" The therapist facilitated his hesitation if to send the application forms, and if he felt it necessary to tell the authorities at interview about Asperger if it seemed appropriate. V. Z. was pleased: "Thank you, you are not asking me to tell lies. I feel you care about me." "Yes, I do care and respect your integrity", was the therapist's response. This was another moment of movement. The therapist felt really close to him.

The outcome was that he was accepted at all four universities and a first article written by him – which was discussed many times during the sessions - was published. These achievements seemed to lift his self-esteem to a high degree. He really believed in himself. He actually said that when he won a Pulitzer Prize he would dedicate it to his therapist. Not for the first time the therapist had difficulty to hold back the tears.

At the last session we reviewed our work together. He admitted that at the beginning he thought it would be a waste of time and he was only coming to please his parents. After a while he discovered that the therapist was really interested in him and for the first time in his life nobody judged him. He stood up and the therapist stood up. V. Z. client stood still, put his hand to his head and, very correctly reading the therapist's feelings, said: "You look like you could do with a hug". "I would like that very much", was an honest response. After a hug V. Z. said: "Thank you, I doubt I would have achieved my self-confidence without your weekly input. I will let you know how I get on". He said these words in an emotionless way not realizing how much they would trigger emotions.

Was therapy successful? It was. V.Z. discovered the most suitable way forward for himself and we believe that his unique way of seeing the world would help him to become a great journalist. He experienced for the first time being treated as an adult without judgment of any kind and came away with a faith in himself. Did the quality of life improve for him? We think the potential for a more fulfilling life is more likely now.

Conclusion

In closing, it can be suggested that little is known about the lasting outcomes of AS. The lack of relatedness between AS sufferers and others is reflected in our difficulty in understanding them, which is the core of the problem. We are with Aspergers where we were 30 years ago with mental illnesses. Until recently, personal witnesses with AS have been absent. Now, slowly, reports are emerging. Based on our experiences, with appropriate psychotherapy, a person with the syndrome has the chance to eventually develop to an optimal level in terms of restrictions of the disorder. The difficulties to help them to produce changes in their world are obvious and therefore even small changes can be regarded as relevant. The presented case study showed that the severely disturbed individual can be met by C – C therapy. The therapist offered the same attitudinal conditions of congruence, unconditional positive regard, and empathy, as to any other client, and tried to understand his inner world in whatever way he wished to share. The outcome of the therapy testifies as to the particular power, effectiveness, and efficacy of applied C – C principles with an individual who suffers from AS. It is a very exciting result refuting the opinion about the unsuitability of C – C therapy for those suffering from serious mental and neurobiological problems. However, there is still vast scope for both further research into the disorder as well as practical therapeutic process to understand how the basic concepts of Client – Centered theory can be used to describe and understand the experiential world of clients with AS better, and thus to help them to optimize their lives.

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