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SAGE Publications
and The National
Autistic Society,
Vol 3(3) 255–271;009275
1362-3613(199909)3:3

Adolescents with Asperger syndrome

Three case studies of individual and family therapy

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ABSTRACT Clinicians in the field of autism are increasingly identifying individuals with Asperger syndrome. Individual and family therapy for individuals with this condition has received little attention in the literature. This article presents three case examples of individual and family therapy with male adolescents diagnosed with Asperger syndrome. Common presenting issues and treatment interventions are summarized that may apply to others diagnosed with this condition.

KEYWORDS *adolescents; Asperger syndrome; family therapy; individual therapy*

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NOTE *The names used in each case study were changed to protect the identity of the young men and their families.*

Introduction

One approach to addressing the needs of individuals with Asperger syndrome and their families is through individual and family psychotherapy. In the literature, however, there is almost a total absence of discussion of psychotherapy for individuals with this condition. A subgroup that might particularly benefit from therapy is the *adolescent* with Asperger syndrome. These adolescents struggle with the process of individuating from their family, frequently experience low self-esteem, and have to deal with an increasing self-awareness that they are different from their peers. Mental health concerns such as depression and anxiety may exacerbate the problems faced during this developmental transition. Parents often report that they need professional support with respect to their adolescent, and these adolescents themselves recognize the need for therapy.

Both individual and family therapy can be helpful in treating people with Asperger syndrome and may be an integral component of an overall treatment plan. However, some professionals argue that in most cases of high-functioning autism or Asperger syndrome psychotherapy is not indicated, although it has been used successfully with and without pharmacological interventions (Gillberg and Ehlers, 1998). Mesibov suggests that 'individual counselling can be valuable for adolescents and adults with

autism if appropriate goals are pursued in reasonable ways' (1992, p. 144). He proposes that the poor outcome of psychotherapy with autistic individuals may reflect the psychoanalytic approach used historically versus the use of counselling itself. Further, a one-to-one therapeutic relationship with a high-functioning individual with autism gives them the 'structure, guidance, information, and support that they need to function more effectively in society' (1992, p.145). Mesibov notes that understanding the individual's worldview, developing rapport and trust, assisting them in analysing their thoughts, feelings and perceptions, facilitating their understanding of the impact of their behaviours on others, and helping them deal with day-to-day situations, can lead to successful therapeutic involvement.

It has been recognized that individuals with Asperger syndrome frequently suffer with mental health problems such as depression and anxiety (Ghaziuddin and Greden, 1998; Tantam, 1991), possibly as a result of their becoming more aware of their isolation and inadequate social skills (Attwood, 1998). Attwood (1998) also suggests that the emotional development and transition to adulthood for an adolescent with Asperger syndrome may be both delayed and prolonged. Possibly the most significant source of information on emotional issues comes from the flood of rich first-hand descriptions of the experiences of those with high-functioning autism and Asperger syndrome (Barron and Barron, 1992; Carpenter et al., 1992; Cesaroni and Garber, 1991; Grandin, 1990; 1994; Grandin and Scariano, 1986; Happé, 1991; McKean, 1993; Ratey et al., 1992; Sacks, 1995; Sperry, 1998; Williams, 1992; 1994). These accounts give the therapist valuable insights into their 'inner world' which may be used in determining the process and content of individual psychotherapy.

Although there are few accounts of appropriate interventions for emotional problems in people with Asperger syndrome, a recent report by Hare (1997) described the use of cognitive-behavioural therapy with a 26-year-old man who exhibited severe depression and self-injurious behaviour. Through use of the Beck Depression Inventory (Beck et al., 1961) and a diary in which the subject recorded his activities, thoughts and feelings, material for the sessions was gathered. Dysfunctional beliefs were challenged in the process of therapy, leading to improved scores on the Beck Depression Inventory.

The purpose of this article is to present three case studies of individual and family therapy involving adolescent boys diagnosed with Asperger syndrome. The author saw these families in a social service agency and in his private practice. Two out of the three cases discussed have finished treatment. For these two cases, 3-year follow-up information will be provided. Overall themes in the cases will be summarized along with treatment interventions that clinicians may generalize to this population.

Case example 1

Family and treatment history

Brian was the first-born of two boys. His mother reported that, although he was a bright baby, he was extremely irritable and prone to temper outbursts. When Brian was 3 years old, his father left the family. Although teachers in his first years of schooling noted that Brian had a likeable personality, they also observed chronic problems in the areas of impulsivity, social skills, behaviour, anxiety, organization and egocentricity. He was then moved to a private school for children with learning difficulties and received play therapy.

Over the following years, Brian had numerous psychological and psychiatric assessments. At the age of 14, his behaviour became very difficult at home; there was conflict between him and his mother, and Brian had begun to threaten her physically. He was admitted to a residential treatment centre where he participated in individual, group and family therapy. At the age of 15, Brian was diagnosed with Asperger syndrome. Shortly after this, he was prescribed Buspar (buspirone) which his family doctor later changed to Paxil (paroxetine).

Presenting problems

The author initially saw Brian in therapy prior to his 16th birthday when he was being discharged from the residential treatment centre. He presented as a young man of at least average intelligence and very articulate, but socially very immature. Brian and his mother were concerned that conflict between them would begin upon his returning home. Brian's mother said that her son antagonized her with behaviours such as repetitive and perseverative questioning about topics of interest, inappropriate behaviour at social gatherings, and continual attention-seeking. Brian felt his mother favoured his brother and did not treat them equally. He often misinterpreted his mother's anger as directed at him, when she was actually angry about something else. Sibling conflict was a problem noted by all family members. Both Brian and his mother felt they were too close and professionals had described their relationship as 'enmeshed'. His relationship with his father was quite distant, and Brian harboured anger towards him for abandoning the family, and for his lack of interest in his life. Brian's behaviour was often difficult within family therapy sessions, as he appeared to have little tolerance for confrontation by either the therapist or his mother. At these times, he would yell, swear or seek attention through inappropriate behaviour such as interrupting or burping.

Intervention

As an adjunct to family therapy sessions with the author, Brian attended individual therapy sessions every 2 weeks at another local agency. In these sessions he discussed issues such as his self-esteem, sexuality and dating, and his relationships with his parents. The author saw Brian and his mother once monthly. Occasional sessions included Brian's brother. Time was also regularly scheduled with a one-to-one community worker to provide him with a 'buddy' to coach him in community social situations.

Family sessions provided a forum in which Brian and his mother could 'problem-solve' around issues at home. One major problem was the conflict between Brian and his mother. This was reduced by negotiating difficult issues in therapy, ensuring that Brian's mother had some respite, facilitating Brian's social involvement with others outside the family, and helping him to structure his free time. Family sessions also provided an opportunity to slow the communication process between Brian and his mother, and helped each to have a fuller understanding of the other's perceptions of a situation. Brian experienced great difficulty in understanding his mother's or brother's perceptions, particularly in a conflictual and emotionally laden situation. 'Time-outs' were used by Brian and his mother to provide a 'cooling-off period' before negotiating a difficult issue at home. This meant that both would agree to have some time alone during a conflict so that a situation would not escalate. They could later return to the problematic issue when they were calmer.

Another role of family therapy was to help Brian and his mother to work on his perseverative topics of conversation. Brian's perseveration was a concern to his mother, as it frequently involved socially inappropriate comments about racial, political or religious issues, sometimes when there was company at the house. One way this problem was addressed was for Brian to learn about his topics of interest (e.g. religion, politics) on his own, rather than insisting that his mother or others discuss them with him. The times that Brian's mother spent with him were also more explicitly scheduled. At these scheduled times, they would choose a topic of conversation or activity they enjoyed. In addition, because Brian's perseveration became worse in groups and social situations he was allowed to ask for permission to leave in the presence of company.

In family therapy sessions, Brian was encouraged to boast about his success in achieving the explicit behavioural goals defined in the identified problem areas. When his behaviour was challenging in the session, the therapist addressed the feelings that may have been underlying the behaviour, suggested a more appropriate response, and set clear limits as to behaviours that were not tolerable in a session (such as swearing or name-calling). Giving Brian money in the form of an allowance for meet-

ing goals was encouraged, and assisted Brian's mother to identify improvements in her son's behaviours. Family therapy also helped Brian and his mother to identify emotional cycles that both of them experienced (individually and as a family), and to explore how these might be prevented. For example, particular stressors were identified for both of them (e.g. large family gatherings, school examinations), and strategies to support each other during these times were discussed. Brian's depression and anxiety were major antecedents to conflict between them. It was therefore helpful to identify the symptoms of anxiety and depression that Brian experienced. The issue of independence was also addressed, as during this period Brian requested more freedom, but was far less socially competent than his peers. Small steps towards greater independence were set out. For instance, before Brian could travel to a city many hours away, he had to prove to his mother that he could take short day trips independently. Education about Asperger syndrome occurred throughout treatment, primarily by identifying those behaviours related to the disorder, and those that were typical of any adolescent.

Current situation

Brian and his mother continue to feel the need for individual therapy for Brian and he is now being seen in therapy by the author every other week. Since conflict in the family has been reduced considerably and Brian is a young adult, it was felt that family therapy was no longer appropriate or necessary. In addition, when Brian turned 19, he was no longer eligible for individual counselling at the local children's agency. He continues to take Paxil (paroxetine), which has been successfully reduced from 40 mg to 20 mg per day. There are no plans, however, to discontinue the medication at this time. Now age 20, Brian has been more successful socially, and went on an international trip with his peers. He held a student job during the school year and was competitively employed during the summer at a local amusement park. He is now attending a local college and is taking a programme in travel and tourism, one of his favourite topics. Brian has attended therapy with his mother and individually for 70 1-hour sessions over a period of 4½ years.

Case example 2

Family and treatment history

Andrew was the first-born son of two boys and a girl. His parents first noted peculiarities in his speech development at the age of 14 months. Discrepancies in other areas of development became apparent as he grew older. Professionals gave conflicting reports about the nature of his difficulties including diagnoses of attention deficit disorder, learning disabili-

ties, giftedness, and language and communication problems. Other professionals diagnosed the source of Andrew's behavioural problems as marital discord. Andrew's parents were understandably confused and dismayed at the range of diagnoses that they received. At the age of 12, Andrew received a diagnosis of pervasive developmental disorder; not until a few years later was the diagnosis of Asperger syndrome given. The family doctor put Andrew on Tofranil (imipramine).

Presenting problems

Just before being seen in therapy, Andrew's parents noted a dramatic increase in tension between themselves and their son. This included emotional outbursts from him directed towards his parents, in part precipitated by anxiety. He would also manipulate his parents to give him what he wanted through perseverative requesting and crying. Following these episodes, Andrew's parents felt angry and resentful that they had been manipulated by him. It appeared that even the simplest of interactions between Andrew and his father would become antagonistic because of Andrew's rigidity and poor social skills. Both parents wondered if they had responded appropriately in many parenting situations, particularly considering the conflicting diagnoses that they had been given in the past. They expressed the wish that the quality of their interactions with their son improve through participation in therapy.

Summary of interventions

The first months of therapy involved only Andrew's parents, with Andrew attending sessions on occasion. During family sessions, it was noted that strong emotional reactions from Andrew's parents appeared to escalate family conflict, and resulted in their feeling guilty and hopeless. It was also evident that Andrew's parents attempted to reason with him when he became perseverative. This led to further conflict, precipitating more anxiety and perseveration on Andrew's part. In response to this pattern, it was recognized that boundaries between Andrew and his parents needed to be more clearly defined. This was achieved by exploring his parents' feelings about Andrew in couple sessions and by them spending more time together as a couple. New parenting strategies were employed, such as avoiding emotional engagement, trying to discover the function (if any) of the perseveration (e.g. an expression of anxiety or uncertainty), and interrupting the perseveration with redirection. Andrew's parents expressed concern that during these conflicts, Andrew was displaying 'sociopathic tendencies' as he appeared to have no understanding or consideration of the feelings of other family members. This was reframed as his lacking 'theory of mind' (Baron-Cohen, 1995).

As Andrew's parents gained knowledge of how Asperger syndrome affected him, they were better able to educate extended family members who had previously been critical of how they dealt with their son. Andrew's parents now felt that they could rely on the family more for support. Parenting discussions provided an opportunity to discuss successes they had with Andrew, and what they did to contribute to these successes. Andrew's parents continued, however, to discuss their fears and worries about their son and his future.

After the first year of involvement in therapy, Andrew's parents began to express the need for individual therapy for Andrew, then 13 years of age. In individual sessions, he presented as socially awkward, though he was expressive and articulate which made him a good candidate for therapy. In individual sessions, several themes were noted. First, Andrew's self-concept appeared poor in that he viewed himself as 'retarded', somebody with 'problems', and unable to behave in socially desirable ways. Difficulty modulating and expressing his feelings was also a concern. There was an emerging recognition of the significance of his diagnosis and how it affected him.

Dreams that he discussed in sessions appeared to reflect feelings about the tentativeness of his friendships with peers and the lack of power he felt in these relationships. The importance of a therapeutic relationship with Andrew was demonstrated as he revealed his fears and concerns about peers' perceptions of him. This was explained to Andrew as a typical adolescent worry. In part, it also reflected his difficulty in gauging the thoughts and perceptions of others. Because Andrew was suspicious about his peers and depression was queried, he was seen by a local psychiatrist who diagnosed him with schizophrenia, paranoid type. Andrew's parents disputed the diagnosis, as did others who knew him (including the author), and additional support had to be provided to the parents because of this diagnosis. The author introduced Andrew to another teenager with Asperger syndrome and he began to attend a social skills group.

Support to Andrew and his parents was gradually ended. Family and parent sessions in the final months of involvement focused on helping him to have time away from his much younger siblings. Given that Andrew was their eldest child, his parents needed to differentiate the behaviours and issues that represented normal adolescent struggles with those that reflected Asperger syndrome. Assistance was also provided to Andrew and his parents in the school system by helping them to find an appropriate classroom placement that would lead to greater academic success, and educating school personnel about Asperger syndrome. Andrew and/or his parents were seen for 57 sessions over a period of 4 years.

Current situation

Three years following the end of therapy, Andrew is now 19. In the follow-up interview with Andrew and his mother, she called him 'a dream' and noted that people comment on how polite her son is. He will attend high school for one final year and plans to go to college for graphic arts or horticulture. He has contacted the services for people with special needs at the college; they are aware of his diagnosis of Asperger syndrome and how it affects him. Andrew's mother reported that he has many friends, and Andrew added that he is 'working on getting a girlfriend'. He has been successful as a local volunteer worker and is an excellent driver. He continues to have some anxiety and uncertainty in social situations, but he feels he can ask his parents for advice. He uses no professional supports at this time. Andrew now discusses some symptoms and behaviours he had as a child. For example, he talks about his extremely acute senses, and how he coped and continues to cope with this. He has been off medication for 5 years, and his parents feel that there is no longer a need for this. He continues to need time alone, though not more than any adolescent would, and has developed a variety of interests as opposed to the restricted range of interests he had when younger.

Case example 3

Family and treatment history

Grant was the second-born child in his family. Grant and his parents had an extensive history with professionals; however, his parents expressed frustration that they had never felt satisfied with professionals' explanations of his problems. When he was 8 years old, Grant became very socially withdrawn and talked little. At this time, he was diagnosed with an adjustment reaction with disturbance of affect and conduct, a learning disability, and elective mutism. He was enrolled in a day treatment programme at a local hospital. After 2 years, he was partially integrated into regular classes and enrolled in a social skills group. At 14 years of age, he was placed in a classroom with a student with high-functioning autism. Seeing many similarities between his own behaviour and those of his classmate with autism, Grant suggested to his parents that he himself had autism. This prompted his parents to pursue another series of assessments. At the age of 15 years, he was diagnosed with a depressive disorder, obsessive-compulsive disorder and Asperger syndrome. The family met the author shortly after this diagnosis. They expressed relief that they finally had a diagnosis that could account for all of Grant's difficulties. Grant presented as an adolescent of at least normal intelligence. He sometimes had difficulty expressing his thoughts and appeared anx-

ious and socially awkward in sessions. His eye contact was unusually intense.

Presenting problems

When Grant and his family first presented for family therapy, his parents identified his anger as the major problem. The bulk of the conflict occurred between Grant and his father. There was some conflict with other family members, though it was less intense. Seemingly trivial things would upset him, such as a family member stating something incorrectly, especially when it pertained to his specific interests (the weather and baseball). At times, the conflict escalated to the point of Grant punching a wall. Grant noted that he was extremely sensitive to the tone of voice others used with him, and had difficulty gauging the intensity and nature of the feelings that family members expressed. His parents wished to gain a better understanding of Grant as a result of therapy, especially since his recent diagnosis. All family members recognized that they were very close to each other, sometimes too close, which resulted in conflicts and hurt feelings.

As well as family issues, Grant presented with several individual issues for therapy. All family members thought that he appeared depressed. They felt that he spent much of his time daydreaming and continually asked questions about why he had problems. It was evident that Grant felt little control over his difficulties and felt hopeless that he could change. He sadly expressed concern about his problems with peer relationships. He had some difficulty applying 'common sense' to social situations, especially when it involved being assertive. He was often bullied and teased at school. Grant said that he would like to learn about his diagnosis and regularly asked if certain behaviours were typical of others with Asperger syndrome. His parents voiced concern that he tended to use his disorder as an excuse for his behaviour problems and difficulties, rather than taking responsibility for them. He was receiving inadequate support with academic and social skills at school. Grant needed assistance to understand social norms and rules, as well as guidance in making decisions about day-to-day issues.

Summary of interventions

Several family sessions were held to allay family conflict. Both Grant and his parents agreed to a system under which anybody could call a 'time-out' if they felt a situation was escalating beyond a point that was tolerable. A process for solving problems after the time-out period was discussed with the family, keeping in mind Grant's need for clear and direct communication of emotions and inclusion in the problem-solving process. The use of raised voices was discouraged, and the need to remain calm in a conflict was stressed. It was evident that his parents would criticize Grant about his

behaviour in the midst of a fight, and that this would further escalate the situation. They were discouraged from doing this and encouraged to explain their reactions to his behaviour when emotions were less heightened. At times, Grant would have difficulty following his parents' cue for a time-out, so they implemented a monetary reward system that reinforced him when he followed through with the plan. Parents were educated as to how Grant's disability affected his skills in this process.

Individually, Grant was seen weekly for 6 months, and then every 3 weeks for another year and a half. He was educated about Asperger syndrome with the use of videotapes. Questions and problems regarding social situations were explored. For instance, problems with peers and situations at school were noted in a daily log. Because Grant felt that he could not make friends, he would tolerate a lot of teasing and mistreatment from the 'friends' that he did have. These scenarios were discussed and Grant was encouraged to develop his intuitive sense of what he should do. He was taught to be more assertive with peers and was coached in his efforts at making new and more supportive friendships. Other appropriate social behaviours were also explored. For example, he once asked, 'Should I cheer when the baseball game is on television although others don't hear me because I'm alone in the house?' A plan was set in place for Grant to obtain more support at school by sharing the diagnosis with school professionals, providing them with information about the diagnosis, and designating a specific staff person at the school to whom he could go if he needed immediate support. In an attempt to reduce his social isolation, he was introduced to another adolescent with Asperger syndrome (the adolescent in case example 2) and they began to see each other socially. Sexuality, developing relationships with females, and sexual norms were discussed. Understanding and controlling his emotional reactions were also themes in therapy. Grant recognized that he was very disturbed by even mild displays of emotion by others, and that much of his anger towards others was in fact anger that he felt about his abilities. In discussing encounters with others it was unusual for Grant to describe them in emotional terms. Instead, situations were detailed with behavioural and situational descriptions. Grant was therefore encouraged to express what he and others were *feeling* in a situation. He was enrolled in a peer support and social skills group with others with a pervasive developmental disorder. At the end of therapy, Grant's parents reported that conflict had been reduced altogether in the family. Grant expressed that he felt much happier and was more confident and insightful in social situations.

Current situation

Three years after the end of therapy, Grant is now 19 years old. He still lives

with his parents and is planning to go to college next year to take a Developmental Service Worker certificate to work with children with developmental delays. He will be connected with the support services for people with special needs at the college which will provide him with a peer tutor and give him extra time for the completion of his papers and exams. As a summer job, he worked as a painter and felt more successful in this than in working at a restaurant. At times, he can seem somewhat depressed, especially when he begins 'thinking philosophically' about his life problems, as opposed to thinking more pragmatically about how to solve them. His mother noted that there are occasional flare-ups of anger and anxiety, though they are much less intense than before. He has never needed to take medication. His mother described Grant as somewhat compulsive about his exercise routine which, in part, reflects his concern about how he appears to other people. Grant learned to drive a car and is a good driver. He has some friends but would like to have closer ones; he usually goes out to clubs or movies with them and prefers to be with other teenagers who do not have a disability. He has had two girlfriends.

Discussion of cases

Approach to therapy

The approach used in these cases does not strictly adhere to one theory, but is best described as systems-based (Leighninger, 1977; Seligman and Darling, 1989; von Bertalanffy, 1962) and structural (Minuchin and Fishman, 1981). For example, in planning treatment for these adolescents, issues such as appropriate boundaries between siblings and between the parent and child subsystems, healthy 'executive functioning' of the parental subsystem, and appropriate exchange of information and resources with systems external to the family, have been taken into account. A variety of other theories were used including: communication theory (Bandler et al., 1976; Watzlawick et al., 1967), role theory (Biddle, 1979), psychoanalytic theory (Brenner, 1973), and behavioural, cognitive, psycho-educational and developmental theories (Carter and McGoldrick, 1980; Turner, 1986). In addition, the information available on the specific needs and characteristics of individuals with Asperger syndrome found in both empirical studies and first-hand accounts has been used.

The judgement about whether individual, couple or family therapy is warranted depends on which family members are most affected by the primary presenting problem and amenable to addressing it. Thus, assessment needs to include a determination of whether interactional problems are best addressed using the resources of the whole family or whether, for example, differences in parenting style are best addressed within the con-

text of couples therapy. Despite the type of approach, these cases have shown the necessity for the needs of the adolescent to be considered in the context of the family. This is not to say, however, that the entire family needs to be present for therapy. If the adolescent is reluctant to meet a professional, very useful work can be accomplished with the couple in an attempt to address their adolescent's needs.

Engagement in therapy

The degree to which these three young men could articulate their experiences, their capacity for insight, their need for support, and their desire to address their problems were critical factors in deciding to proceed with therapy. Some of the most rewarding opportunities for the author to practise therapy have been with those adolescents who initially came at the request of their parents. When they realized that they were accepted despite their unique characteristics, and experienced the support of the therapeutic relationship, the transformation to being an active participant in the therapeutic process has been remarkable. Engagement of these adolescents in the therapeutic process may not be dissimilar to engaging any adolescent in therapy, but in this instance appropriate use of the adolescent's specific interests can assist in the joining process. If the adolescent feels stigmatized by attending therapy, it may be better if systemic issues are addressed instead. This may mean, for example, ensuring their participation in a local club or recreational activity to reduce their sense of isolation and increase opportunities for social skill development. Similarly, poor self-esteem could in part be addressed in the school context by providing the adolescent with a 'special buddy' and having strict consequences in place for peers who tease them. Families and adolescents may not feel that individual and family therapy is either appropriate or available, given that recognition of the need for therapy is a recent development in this group. It is therefore important that service providers discuss this option with them when it is available.

Diagnostic issues

One issue common to these cases is that the diagnosis of Asperger syndrome was made relatively late and all of these boys and their families had previously been given alternative explanations of their difficulties. It is important to question whether, had the diagnosis of Asperger syndrome been given earlier, these presenting problems would be as severe as they were. With increased recognition of Asperger syndrome and more clearly defined diagnostic criteria, it is hoped that professionals will more readily help families obtain an accurate diagnosis for their child, and show better awareness of their emotional needs. The author's clinical experience sug-

gests that many individuals with Asperger syndrome and their families are now correctly identifying the diagnosis for themselves. This trend reflects wider access to information about Asperger syndrome in books, through the media, and on the World Wide Web.

Mental health issues

The three cases described here illustrate that a variety of concerns related to the psychological and emotional well-being of adolescents with Asperger syndrome were addressed in individual or family therapy. Specific problem areas included: low self-esteem, understanding the diagnosis, empathy and perspective-taking, depression, anger management, anxiety, developmental transitions (e.g. adolescence to young adulthood), restricted interests and perseverations, and behavioural problems. These issues were addressed by giving the adolescents age-appropriate knowledge of their diagnosis to help them understand behaviours symptomatic of the disorder. Helping the young men improve their ability to empathize and understand the perspectives of others was accomplished through discussion of day-to-day social situations where empathetic understanding was important. This was especially crucial in the context of family therapy sessions where the adolescents were often asked to modify behaviour in response to the reactions of family members. In this instance, asking the adolescent to articulate or judge the feelings and perceptions of family members and confirming or disconfirming their perceptions was helpful. This also modelled a process for communicating about others' perceptions and feelings. Reducing depression, anger and anxiety with behavioural programming or medication was also necessary. Pragmatic steps to developing a less restricted range of interests were regularly reviewed with the family and adolescent. Finally, addressing the adolescent's sense of isolation by providing access to supports such as counselling, special friends or a peer support group was an essential element of these treatment plans.

Medication

The impact of medication on the treatment outcome in two of the cases presented is unclear. For example, progress was more significant when Brian was seen in individual therapy and his medication was reduced. Andrew stopped taking medication altogether. McDougle (1998) presents a very helpful review of medications used to address repetitive behaviours and thoughts. The use of medication has also been advocated by individuals with autism such as Temple Grandin (1990) and may be a useful element of treatment, especially in cases with more serious forms of depression, anxiety or repetitive thoughts and behaviours (Stoddart,

1998). Nevertheless, many families and the individuals themselves express concern about side effects and long-term implications of such medication. This can be an important issue to explore in therapy, and individuals may also need help in monitoring the effects of medication on symptoms such as depression and anxiety. This was accomplished in these cases through self-report in the sessions, the use of standardized measures, and accessing information from family members and school personnel.

Social skills

The social problems experienced by these young men were possibly the most challenging problems to solve. All the parents expressed concern that their adolescent had few or no close friends. The young men also needed support to deal with the teasing and rejection by peers. Social skills that were lacking were: making and maintaining friends, engaging in conversations, communicating about a range of interests, noting social subtleties, and responding appropriately to others' thoughts and perceptions. These issues were addressed by providing social skills training in individual, family or group therapy. What augmented this training was the involvement in community activities with normal peers where the adolescent felt accepted and had the opportunity for integration. It was also necessary to develop a plan and strategies to support social skill development in their schools. Finally, it was helpful to employ community one-to-one workers who could provide exposure to a variety of social situations and coach the individual in social situations.

Family issues

In keeping with a systems-based orientation, it is important to be aware that problems associated with Asperger syndrome can adversely affect the whole family. Similarly, issues in the rest of the family will affect the development of the individual with Asperger syndrome. These parents needed assistance in developing consistent parenting strategies, improving the adolescent's relationship with their siblings, coping with a new developmental stage (e.g. moving from adolescence into young adulthood), increasing their social supports, and monitoring their feelings about the diagnosis.

An essential component of treatment involved providing up-to-date information on Asperger syndrome and how it specifically affected their child. Facilitating an understanding of the adolescent's developmental stage and how it related to their behaviour or problems (e.g. 'the uncooperative adolescent') was helpful. Developing supportive sibling relationships and providing sibling support (e.g. support groups) or the use of one-to-one community workers helped to reduce the conflict and enmeshment often

found in these sibling relationships. Parents were reassured that their need for support (professional or non-professional) and coping strategies was normal; this set the stage for ongoing discussions of the adolescent's problems in the family. Interestingly, when couples were involved in therapy sessions, they reported that a secondary benefit of attending was that it allowed them a chance to have time to themselves; they were encouraged to take the opportunity to enjoy each other's company at a restaurant, for example, after the session. At times in this clinical work, these parents' personality characteristics and own mental health concerns needed to be discussed. Though not an issue in the above cases, one or both parent(s) may feel that they share some characteristics with their child with Asperger syndrome. This needs to be explored so that any feelings of guilt can be alleviated.

Conclusions

This article has summarized some of the issues facing individuals with Asperger syndrome, and underscored the need for therapy for emotional and psychiatric issues. Although the examples presented here highlight the experiences of adolescents with Asperger syndrome and their families, some issues noted may also be relevant to intervention with individuals of other ages.

In examining the outcomes of these cases, some important questions are raised. Although only recently diagnosed as having Asperger syndrome, these young men had been involved with service providers for some time; it is difficult to know what contribution these previous involvements had on treatment outcome. Services and intervention running concurrently with therapy may also have had a positive impact. The contributory role of a supportive family and school, and involvement in social skill activities, cannot be underestimated. In the future, it will be imperative to determine the contribution of these and other factors to the overall treatment outcome of individuals with Asperger syndrome. Hopefully this will lead to empirically based family and individual interventions as Asperger syndrome becomes more frequently recognized.

Acknowledgements

I would like to express gratitude to the families who gave their consent to use their experiences for this article..

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