CULTIVATING THE DESIRE FOR CONNECTION: AN INITIATORY JOURNEY

by

BETH ERIN CAIN CURTIN

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

MERIDIAN UNIVERSITY

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This clinical case study has been accepted for the faculty of

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In loving memory of my Grandpa Cain
ABSTRACT

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BETH ERIN CAIN CURTIN

Since the identification of Asperger’s syndrome in 1944 by an Austrian pediatrician named Hans Asperger, and its inception as a diagnosis in the 1990s, the number of children diagnosed with Asperger’s syndrome has been dramatically increasing. Those with Asperger’s syndrome are considered to be on the Autism spectrum and typically present with a lack of nonverbal communication skills, empathy, and social understanding. Currently, the diagnostic difference between high functioning Autism and Asperger’s syndrome is minimal.

This clinical case study documents the therapeutic progress of a reclusive 13-year-old girl, who chose to create her own imaginary social world with inanimate objects because she was unable to make intimate connections with her peers. This study illuminates the therapeutic struggles that are common when working with clients on the Autism spectrum who have comorbid diagnoses.

A multi-modal treatment approach was implemented over the course of three and a half years. In addition to addressing the social deficits that are common in children with ASD, this study incorporates techniques used to support her social anxiety, depression, and attachment struggles.
A major learning in this study is that attachment struggles and ASD are not mutually exclusive. My client encountered difficulties in connecting with, and having the desire to connect with, her peers. This was due in part to her perspective-taking impairments and her difficulty understanding her social environment due to ASD, and in part because she was adopted from an orphanage in China at the age of nine months. An imperative aspect of the process of working with her was to tease apart and address both her attachment issues and the social difficulties she presented with, due to ASD.

Imparting cognitive tools to enhance social skills, utilizing imagination-based practices, and building a strong therapeutic bond made it possible for my client to make significant strides within her social environment. In addition to the above techniques, the myth “Psyche and Eros” was useful as a therapeutic context to bring deeper meaning to my client’s transformative process.
ACKNOWLEDGEMENTS

This case study represents the symbolic ending of a very long journey. I am blessed to have had such a supportive family to help me through this long and arduous process. First and foremost I want to thank my husband, Ian Curtin, who supported me throughout this experience. I am grateful for the many hours he put in editing my drafts and taking care of the everyday tasks so that I could focus on my project. I could not have done it without him. I also want to thank my parents, who encouraged me and supported me on my journey. They helped me to stay focused in times when I felt distracted or defeated.

I truly enjoy being a therapist and am so appreciative of the education I received at Meridian University. Through my education, I was able to cultivate capacities that will serve me for the rest of my life. My newfound understanding refreshed my passion for helping other people. I am so grateful for the community that I created at Meridian and for all of the support I have received throughout this adventure.

Lastly, I want to recognize my client and her family; I appreciate their willingness to participate in this case study and their trust in me over the last three and a half years. The school that I work for and that she attends is a truly amazing place, filled with lots of talented and caring people. Thanks again to all those I have mentioned for they have been an integral part of this process.
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CHAPTER 1

INTRODUCTION

Clinical Topic: Asperger’s Syndrome

This clinical case study explores Asperger’s syndrome, a neurodevelopmental disorder that is currently defined by social learning deficits, may include sensory integration dysfunction, and an intense commitment to selected fields of interest.¹ Due to the evolution of diagnostics, Asperger’s syndrome is in the process of being discontinued in the fifth edition of the *Diagnostic and Statistical Manual (DSM-V)*. My client was originally diagnosed with Asperger’s syndrome at the age of 10. In light of this transition, my client was diagnosed with autistic disorder, more commonly referred to as Autism spectrum disorder (ASD), at the age of 14.

According to the fourth edition of the *Diagnostic and Statistical Manual (DSM-IV-TR)*, the primary differences in Autism and Asperger’s are that the people diagnosed with Asperger’s syndrome do not exhibit early learning delays in language or cognition.² People who are diagnosed with Asperger’s syndrome and Autism display impairments to varied degrees in social interaction, communication, and perspective taking. They also have a tendency toward restricted, repetitive patterns of behavior, as well as special interests and activities. Some people with these diagnoses also demonstrate sensory integration dysfunction and often struggle with components of language, including non-literal language, making inferences, and problem solving.³ Children with Asperger’s syndrome present with milder symptoms than children with high functioning Autism,
which is why so many kids with Asperger’s syndrome are diagnosed in elementary school rather than at 18-22 months.

According to the U.S. Center for Disease Control and Prevention (CDC), 1 in 88 American children are diagnosed with ASD.\(^4\) This statistic has increased significantly since the year 2000 when 1 in every 150 children was diagnosed with ASD.\(^5\) Included in the umbrella of ASD are children with Asperger’s syndrome, children with autistic disorder and children with pervasive development disorder-not otherwise specified (PDD-NOS). According to the CDC, in America, as of 2008, 1 in every 252 females are diagnosed with ASD while 1 in every 52 males are diagnosed with the disorder.\(^6\)

Researchers are still searching for the reasons as to why there is a significantly higher rate of ASD found in males than females.

No conclusive biological evidence has been identified as the cause for ASD. Susan Folstein and Robert Schultz have created a number of biological theories to help understand the neurological component of Autism and Asperger’s syndrome. There is a predominant theory that there is a genetic component; however, Folstein and her team of researchers have yet to prove anything conclusively.

The most commonly used methods of treatment for people of the Autism spectrum stem from the cognitive behavioral perspectives and practices. More specifically, *social cognition therapy* has been developed to break down the social nuances of everyday life so that children on the Autism spectrum can be more socially successful. Social deficits can be extremely debilitating in those with ASD. Social deficits often inhibit a person’s ability to understand the perspectives of others, which then leads to a significant difficulty creating and maintaining relationships with others.
These deficits, therefore, make it tough for an individual with ASD to participate in a peer-based community, which often leads to social anxiety and depression.

Tools used in social cognitive therapy include a variety of visually based group therapy lessons that help teach children to play and communicate more effectively. Michelle Garcia Winner created social cognitive therapy by utilizing traditional cognitive-behavioral therapy techniques and adding a social focus. Her psychoeducational program, *think social*, has provided an avenue for clinicians to help those with ASD bridge some of their social gaps.7

The psychodynamic perspectives that directly relate to Asperger syndrome revolve around addressing attachment issues, which facilitates social abilities. Not all children with Autism have attachment difficulties. However their social deficits can contribute to a lack of desire to attach to others. John Bowlby, author of *A Secure Base*, researched and wrote about the importance of the mother-child bond and it affects on relationships throughout the child’s life. Most of his theories are based solely on neurotypical children; however, he describes the connection between the lack of attachment/insecure attachment and its influences on social anxiety.8

From a sociocultural perspective, with the number of children being diagnosed with ASD continuing to increase, researchers and psychologists are looking at the cultural and social impact that this current epidemic is having on society. The increase in people being diagnosed with Autism leads researchers to be concerned about the biological and environmental components that may be contributing to this diagnosis. Many researchers, including Winner, are creating different programs to aid these children in successfully transitioning into autonomous adulthood.9 However, we are yet to see
enough transitional resources implemented to enable many of these students to develop socially and emotionally into fully functioning, self-sufficient adults in the larger societal context. There are a number of resources available for families to help their children who struggle with social impairments, but they are often quite expensive.

This clinical case study offers examples of how imaginal approaches to ASD can be cultivated in a number of different ways. Studies have shown art therapy, play therapy, group therapy, and music therapy have all been successful modalities in work with children with ASD. Pamela Wolfberg wrote the book *Play & Imagination in Children with Autism*, which includes various case studies on children with ASD using play therapy, art therapy, and group therapy.¹₀

From an imaginal perspective, many of the struggles that plague individuals with ASD involve their inability to effectively engage the peer principle.¹¹ Aftab Omer, writing from the perspective of the imaginal psychology paradigm, developed the theory of four modes of experiencing, which include the mother principle, the father principle, the peer principle, and the collaboration and integration of all three.¹² The peer principle is founded on the ability to create intimate connections with others. When intimate connections are made, the peer within us is capable of trivializing differences with the common goal of finding community.¹³ The social deficits inherently associated with people with ASD make true intimacy on a collaborative level significantly more difficult for many of these individuals. The application of imaginal psychology in psychotherapy with this population is invaluable to the sustainability of communities, which support these individuals. Very few studies have attempted to understand and treat children with
ASD from the imaginal psychology perspective, but hopefully this clinical case study will encourage further research.

In looking at this clinical case study as a whole, my client had a number of complicated presenting problems that were intensified by her social deficits. To alleviate her social anxiety, Leigh created an imaginary social environment that revolved around the personification of 27 wushu spears. Wushu is a traditional form of Chinese martial arts that either involves hand-to-hand combat in the form of boxing or maneuvers involving spears. She chose to create her own imaginary environment because she did not feel safe engaging socially with her peers.

My work with Leigh had attachment as a prominent focus of our therapy, because she was adopted at nine months old from a Chinese orphanage. Leigh’s Chinese culture was also an important consideration in our work together. Leigh was one of two Asian students in her school environment and her parents were not of Asian descent. It was important to help Leigh embrace her Chinese cultural heritage.

Ultimately, I chose this case study because I found my client completely captivating. Like many children on the Autism spectrum, she had a number of comorbid conditions that were exacerbated by her social deficits. Leigh was unique and our process included a number of strategies that incorporated imagination-based practices as well as social cognitive strategies. She truly wanted to make changes in her life so that she could be more socially successful in the world.
Personal Exploration of the Asperger’s Syndrome

I remember the exact events that led me to want to work with children with ASD. I was 10 years old and was wearing my purple leggings and my favorite green top. I was on my way to the play structure to meet up with my friends for lunch recess. We had played in the same spot on the same set of monkey bars everyday for years. I was a little late because I had to check in with my teacher about a homework assignment. My friends approached me as I was coming to meet them and they let me know that I was no longer their friend. They began to call me names, and I ran away crying. I remember crying in the girl’s bathroom until my teacher found me. I was in fifth grade and that was the beginning of a very long and difficult year. I was already a pretty anxious kid. I remember reviewing every interaction I could remember to figure out what had gone wrong. I had played with many of these girls for years. Some of them lived right down the street from me. As the days progressed and the bullying got worse, I found others to play with. My mother tried to intervene. She came to the school and met with the other girls’ parents, which ultimately made the situation worse. Those girls did not want to play with me, and forcing us to reconcile our differences without talking about what happened was superficial and not productive. I could not apologize because I had no idea what I had done. After a few attempts to bridge the differences, I ended up choosing to avoid these girls as much as I could. We still played sports together and occasionally I was forced to interact with them at birthday parties outside of school. By the summer before sixth grade I had met a new group of friends, but my social anxiety was extremely acute and my self-esteem was pretty low. I did not trust myself to be myself. I never understood what had happened to create such a social rift.
Although I was always a fairly anxious child, I became much more hyper-vigilant about the way in which I interacted with my peers after this event. I created a new persona for myself. I was the listener and the supporter. I became a people watcher and enjoyed observing social interactions. I was not the leader anymore, because I did not trust myself enough to be a leader and was too afraid of being rejected. It was not until graduate school that I began exploring what it really meant to be a good leader.

Part of my transition into being a good leader has been my work with children on the Autism spectrum. Many of my clients have had far worse social experiences than I had; these experiences had crushed them emotionally. I dedicated my work to these kids. I wanted to give them a sounding board to reflect on their social interactions with their peers. I also wanted to provide them with a safe environment where they could work on their social skills while building their self-esteem. Bullying is an epidemic in many public schools, and many teachers lack the tools to effectively support proactive social interactions. The lack of overall supervision in public schools during unstructured play times is a huge contributing factor in bullying. Children on the Autism spectrum often do not know how to appropriately engage with their peers because they miss many of the social cues that indicate how their play partner is feeling about them.

After a few months of group and individual therapy with Leigh, I knew that she was the one that I was meant to do my case study on. She and I shared a lot of similar personality traits, including a desperate need to control our environments. She was very open about her past and she was also willing to modify her behavior once she realized that having social interactions with peers was something that she wanted. I found her
story to be unique and refreshing. Leigh’s overall progress was a testament to her determination and her willingness to engage in a transformative journey.

I was driven to explore the topic of Asperger’s syndrome because I wanted to contribute to the body of literature currently available to support clinicians in working with these children. There are many ways to support social growth. A multidisciplinary approach, including imagination-based practice, social cognitive strategies, and attachment building techniques made a huge difference in my client’s life. The process has ultimately changed the way in which I work with my clients and will hopefully encourage further research in transformational practices with this population.

Framework of the Treatment

I worked with Leigh at a nonpublic school in Petaluma, California, that serves a variety of students, including those with ASD, emotional disturbances, and learning disabilities. Leigh is one of 85 students that attend this nonpublic school, which serves students ages five to eighteen years old. In addition to her regular academic schedule, Leigh receives 30 minutes a week of coaching in anger and anxiety management, 60 minutes a week of small group social cognition, and as of 2010 she began seeing me for an additional 60 minutes of individual therapy after school. This nonpublic school predominantly focuses on supporting the social, behavioral, and academic growth of students on the Autism spectrum. The diagnostic and therapy clinic attached to the school served the 85 students that attended the school at the time of the study and a number of students in the community that come for social playgroups and social cognition groups.
after school. In addition to social cognition therapy, the clinic provides speech and language services and occupational therapy services.

Leigh enrolled in the school that I was working at in August of 2008. After numerous incidents of behavioral outbursts and a noticeable increase in reclusive behavior, her IEP team suggested that she receive individual therapy to address her social anxiety. In October of 2008, Leigh began individual treatment with me. I also took over her social cognition group to help expedite the therapeutic alliance. At the time, I also taught a weekly social skills class and social-based physical education. I was in Leigh’s classroom a lot and was called in frequently in the beginning to help support her when she was in crisis. I saw Leigh for the first two years for both individual and small group sessions. In 2010, Leigh transitioned into seeing a new social cognition specialist for her small social group sessions. I have continued to see her every week for her individual sessions during the school day, and I see her for her individual sessions after school. She continues to see me every week. We have been working together for the last four and a half years.

Over the course of the last four and a half years we have used many materials to support the therapy, including art materials, media recommendations, photography, video-taping, and online clips. Leigh is a very visual learner and we often use the white board to map out social situations.

Confidentiality and Ethical Concerns

I have given my client and her family a pseudonym to protect the family’s privacy. Since the school that I work for is fairly well known in the area, I have not
included the name of the school and have changed its location to help support my client’s confidentiality. When I was trying to get consent from Leigh’s parents to use our work for my clinical case study, I called them on the phone to introduce the idea to them, and then I scheduled a meeting so that we could talk about the logistics of the case study. Leigh’s parents, Steven and Lora, were more than happy to sign the consent form providing that Leigh was okay with the process. I had some initial concerns about how her knowledge of the study would affect our therapy. At the time of consent she and I had been working together for almost two years. She was really excited about being part of the study.

There was only one incident where I felt that the case study affected the therapy. In 2012, toward the end of the writing process, Leigh was feeling particularly vulnerable and began the session with “I don’t know if I want to be a part of your study anymore.” Internally, I was coming apart, but I began to track my experience. Rather than reacting, I was able to engage the part of me that was curious about this sudden turn of events. I was able to work with her through this process and what came out of it was that she was afraid that when I was done with my paper that I would abandon her. She had recently had her IEP meeting, which included her transition plan, and she was anxious about having to graduate in two years. She wanted to feel in control. Leigh and I worked through her anxiety; I reassured her that I had no intention of leaving and it ended up strengthening our attachment.

I received regular clinical supervision to support this process as well as had wonderful training from a number of different sources inside and outside the agency. My clinical supervisor’s therapeutic orientation was in cognitive behavioral therapy and
social cognitive therapy. He was open to my use of imagination-based practices and was very supportive of the process.

The only ethical dilemmas that I occasionally encountered were feelings of being torn between balancing the wishes of my client and the wishes of her parents. My first priority was to my client, and I was lucky to have a teenage client who was very open with her family and was fine with me checking in with her mother once a month to update her on what we were doing. Leigh and I would always check in beforehand to discuss what she was comfortable with me talking to her Mom about, and we often were able to find a balance so that the container remained safe for her. Occasionally she would let me know that her Mom needed to talk to me. Leigh rarely ever asked about what we talked about, which was due to being a part of a family with very good communication skills.

Client History and Life Circumstances During Therapy

Leigh’s estimated date of birth was August 5, 1995. Her biological family history is unknown. Leigh was reportedly found abandoned at a bus stop in Shanghai when she was approximately one month old. Leigh lived in an orphanage in China that at the time had 600 children living in it. According to her mother, while Leigh was in the orphanage, she had very little or no human interactions. Her bottle was often propped up against the side of the crib because there was not nearly enough staff to care for 600 hundred children at the time. Steven and Lora Jacobs adopted Leigh at the age of nine months. Initially, Leigh was apathetic and unresponsive; however, she began to make significant strides in the first few months of living with the Jacobs. According to doctor and parent
reports, Leigh’s milestones were delayed, some more significantly than others. She received early intervention support that included physical therapy, occupational therapy, and speech and language therapy, until she was three years old.

Leigh’s ability to regulate her emotions had always been a difficult task. Her parents reported that she had pretty intense tantrums when she was a young child. As she got older she would lash out by bending or breaking items or occasionally turning to the self-destructive behavior of biting herself. Leigh also has had a series of obsessions throughout her life. Each obsession lasted approximately two to three years. The obsessions we worked with in therapy were her wushu and tai chi weapons and then subsequently her horse vaulting equipment. Leigh struggled with anxiety and depression. She was diagnosed with nonverbal learning disorder at the age of eight years old, Asperger’s disorder at the age of 10, and then ASD and Mood Disorder-NOS at the age of 14. She was on medications to help stabilize her mood.

Leigh had a hard time interacting with peers. Her conversation skills improved through our work together, but she continued to prefer to interact with adults instead of her peers at school. Both Leigh and her mother claim she never played, even as a young child. She did best when she had a task to perform. Reportedly, when she was six she enjoyed fishing and often chose to gut the fish afterwards. She truly loves science and aspires to be a surgeon or a chef one day. Leigh likes writing, even though the task can be daunting for her, and she also enjoys arts and crafts. At the time of this writing, Leigh takes therapeutic riding lessons and enjoys caring for the horses.
Progression of Treatment

Leigh and I began treatment in October of 2008, and I have been seeing her consistently for the last four and a half years. Her family sought school-based treatment to help her manage her high levels of anxiety and depression. The first two months were spent listening to how miserable she was at school and hearing about her imaginary social environment that she created, which included her husband “Jimmy.” Leigh complained of somatic pains in her legs and joints. She described herself as weak and clumsy.

The next year was spent collaboratively creating weekly social goals and anxiety goals to help her slowly change her reputation with her peers and manage her anxiety. During this phase of our work she modified her behavior significantly. The weekly goals continued for a little over two years. In addition to the weekly goals, we worked on strategies and problem solving in the therapy setting. We built imagination-based practices, as well as art and dream work into our therapy. It took around eight months of seeing her in the therapy setting, and in the classroom numerous times a week, to build the therapeutic alliance. At the time of this study, Leigh was still a regular client of mine and the work she had done in therapy had significantly changed her outlook on life. She had become able to be more self-reflective and balance her inner impulses with her desire to make a positive impression her peers. Her depression had changed from a chronic state to short episodes that were situational-based. Leigh’s anxiety was still a prominent part of her life but she had acquired tools to manage it. Her chronic somatic pains disappeared after the first six months on anger and anxiety management. Occasionally she complained of body pains, but I came to realize that they were often an indicator that she was struggling to manage something in her environment. Overall, she had drastically changed
the way she saw herself in relationship to others and she was continuing to build a strong sense of self-love and acceptance.

**Learnings**

My major learnings began with the realization that my client had attachment difficulties due to the first nine months of her life. In this case, early attachment to a primary caregiver was not directly affected by ASD, but because of the ASD it was inherently more difficult to develop intimate relationships with others due to her social deficits. Early attachment issues and ASD are not mutually exclusive. Children with ASD often have sensory integration issues and can also have a hard time being soothed by their primary caregiver. Both of these phenomena might impact the attachment process. This knowledge ultimately led me to believe that comorbid factors can inhibit a strong attachment to the primary caregiver but that it may not be directly due to ASD. I also learned that imagination-based practices, in addition to social cognitive therapy, is an effective way of working with children with ASD. I found that one of the most important learnings was the necessity to set aside my agenda and follow the lead of the client. Many of the tools that Leigh and I used to help her express herself were created in the moment based on the material that was present in that moment.

Lastly, in working with my client, I realized the importance of treating the whole client. Children with ASD often have comorbid challenges that are exacerbated by their social deficits. It was imperative to take the time to truly understand how ASD affects the other aspects of the client and then use strategies that work with the social deficits to treat the anxiety, depression, and attachment issues.
Personal and Professional Challenges

My biggest challenge in this process was finding an endpoint from which I could begin writing about the progression of treatment. I would think that I had found a good spot to close the process, and then a few weeks later we would have an amazing session. I finally got to the point where this project had been put on hold long enough that it was time to begin regardless of where Leigh was in her process. Not having a conclusive ending was really difficult for me. It was hard to have a story that did not have an ending.

I chose this case because I was profoundly changed by this experience. She pushed me to reflect more clearly upon my own projections, and she helped me to compartmentalize my experience so that I would not impede her experience. She was not going to have a neurotypical teenage experience, and it took me a while to realize that she did not necessarily want that. At times, it was difficult to be able to support her in her individuality because it would often lead her to be more isolated from her peers.

Professionally, I felt challenged by having to integrate the social expectations of her parents and teachers while trying to meet Leigh where she was. For example, initially Leigh’s parents wanted her to have a friend. When we started therapy, Leigh was nowhere near being capable of friendship. She had a hard time having a conversation that did not revolve around her current obsession and she did not really want a friend. She wanted to be accepted at school. So we started there, and from there, she eventually began to make school acquaintances.
CHAPTER II

LITERATURE REVIEW

Introduction and Overview

The discovery of Autism spectrum disorder (ASD) in the 1940’s has motivated numerous researchers to conduct studies in an attempt to understand the complexity of this socially based, neurodevelopmental disorder. In the last 10 years, there has been a push to help regulate and socialize individuals with ASD through a diverse array of therapies. Unlike many psychological disorders, ASD presents in many different forms, but primarily revolves around social deficits. Asperger’s syndrome is at one end of the Autism spectrum. Typically, children with Asperger’s syndrome present as higher functioning than those with high functioning Autism. According to the DSM-IV the main differential between Autism and Asperger’s syndrome is that there are no language delays associated with Asperger’s syndrome.¹ Those with Asperger’s syndrome have been known to have savant qualities in specific, preferred areas of learning. Because high functioning Autism and Asperger’s syndrome are on the same spectrum, many of the studies include and use both samples for their research.

Currently, the diagnosis of Asperger’s syndrome is up for dispute. According to an article written by Heather Adams, in the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, Asperger’s syndrome will be grouped in the same category with Autism and no longer have a designation of its own.² A number of individuals with Asperger’s syndrome are upset about their diagnosis being subsumed
into the Autism category, specifically because there is a social stereotype that people with Autism are lower functioning and less intelligent than those with Asperger’s syndrome. However with the merging of these two diagnoses, more services will be provided for those who originally were diagnosed with Asperger’s syndrome.ii

This literature review will focus on the biological, cognitive/behavioral, psychodynamic, sociocultural, somatic and imaginal perspectives and practices that have been developed to better understand and serve those who have been diagnosed with Asperger’s syndrome. In addition to the primary focus of social deficits affiliated with Asperger’s syndrome: social phobia, depression, anxiety, sensory integration, behavioral issues, and attachment issues commonly comorbid with ASDs, including Asperger syndrome, will be covered.

There are a number of different methods and theories that have been developed by the Autism community to try to help minimize the social and emotional stress that many who are diagnosed with Autism suffer. This field continues to change and develop in hopes of eventually finding a cure and to better understand the etiology of Autism and its increased growth around the world. This literature review encompasses the topic from a number of different sources of research to give a broader and more extensive evaluation of the research on Asperger’s syndrome in relationship to ASD.

**Biological Perspectives on Asperger Syndrome**

Researchers have created a number of biological theories to help understand the neurological component to Autism and Asperger syndrome. No conclusive biological evidence has been identified as the cause for ASDs. Although there is a predominant
theory that suggests that there is a genetic component, scientists have yet to prove anything conclusively. There are a number of theories on the use of psychopharmacology to help regulate children with Autism, but at this point we are only able to address symptoms that are comorbid to Autism, (i.e., anxiety, hyperactivity, depression etc.)

Currently, multiple neurobiological studies provide evidence that males with Autism have an enlarged brain circumference. Robert Schultz found “selective enlargements of the occipital lobe, parietal and temporal lobes but, importantly, not frontal cortex.” The enlargement of the brain has yet to be specifically studied in relationship to the etiology of Autism. However, when the brain is enlarged many of the neurological networks are unable to connect, which might be the reason that symptoms like facial recognition are often lost in children with Autism. The frontal lobe, in particular, is used for impulse control, and if the size of the frontal lobe is not congruent with the rest of the brain, delays in certain functions of that part of the brain might result.

Impulse control, both physically and verbally, as well as facial recognition are commonly inhibited in people with Autism and Asperger syndrome. However, as of yet there have been no definitive studies on Asperger syndrome in relationship to brain size.

Over the years, many people have hypothesized a genetic component to Autism. Susan Folstein, in collaboration with a number of other scientists, looked further into this hypothesis and developed the border Autism phenotype BAP. The BAP was created to define characteristics that may not be directly diagnosable but allude to traits found in those with Asperger syndrome and Autism. In the research of Folstein, Volkmar and Gillberg, based on their label of BAP, there is an 11% chance that children with Asperger syndrome will have a parent who has been diagnosed with Asperger syndrome. Further,
there is a 46% chance of at least one first degree relative having BAP, and 25% chance it will be a parent. Although it has yet to be proven conclusively, there is a good chance that there is a genetic link in people on the Autism spectrum. The question that remains is whether there is an environmental component connected with the genetic component that creates the neurological impairments that exist in Autism and Asperger syndrome.

Other biologically-based research focuses on the psychopharmacology available to support the symptoms associated with Autism. Currently, there is no psychopharmacological drug that addresses the social cognitive deficits associated with ASD. According to Andres Martin, people with ASDs are given a wide range of treatments, which often utilize the serotonin and dopamine pathways to address issues of aggression, impulse control, and self-mutilation in lower functioning individuals, and anxiety, obsessive-compulsive disorders, and depression in higher functioning individuals with ASD.

Comorbid psychopathology is fairly common in individuals that have been diagnosed with ASD due to genetics and the distress that accompanies being unable to successfully cope with their environment. Temple Grandin, a well known speaker in the Autism community and currently diagnosed with ASD, has on many occasions alluded to the fact that having Autism is like being dropped off on a planet where the social dynamics of the culture are alien and the individual lacks the pretenses needed to get by while trying to figure it out. There are no drugs that can help people navigate the nuances of a world they are innately unequipped to understand. However, drugs do help mitigate the anxiety that is produced by being put in that situation.
Digby Tantam’s research explains the high rate of additional diagnoses in children with Asperger syndrome and how these psychological impairments are triggered by the failure to adapt to new social challenges. According to Tantam, the core symptoms of Asperger syndrome, in addition to the neurological and physical impairments that often come with the diagnosis, cause the distress and disability of Asperger syndrome. The social impairments and the psychological distress that is associated with being an outcast or targeted by typical functioning peers can be so great that additional psychological disorders are created. The most common comorbid disorders are affective disorders, anxiety-related disorders, and conduct disorders. The most effective treatment usually includes a combination of; psycho-education, social change, psychotropic medications, and counseling.

Scott Bellini examined the social cognitive deficits in adolescents with ASD that contribute to the breakdown in social communication and the social anxiety and depression common in adolescents with ASD. He compared the anxiety accompanying ASD to that which is associated with conduct disorder. Adolescents with Asperger syndrome are found to have a significantly higher level of anxiety in comparison to children with conduct disorder, with 35% meeting the 10 criteria for generalized anxiety disorder. Because this is such a prevalent occurrence in these children, educators and parents have a responsibility to help support these children in the schools and social environment. Social wounding for all children is destructive, but those who have an added social deficit have more difficulty gaining perspective on their problems and appear to put themselves in harm’s way far more frequently than other children do.
In an original research study of children between the ages of 4-6 with an ASD, Joseph Kim theorized that as teenagers the children would be more apt to be diagnosed with additional anxiety or mood disorder than their neuro-typical peers. Kim conducted follow up testing in the group and found that 6-7 years after the original diagnosis there was a much higher prevalence of anxiety and depression in the youth with Autism than in that of their neuro-typical peers. There was no difference between those with Autism and those with Asperger syndrome. Findings indicate that being diagnosed with ASD puts a child at risk for developing anxiety and depression in adolescence.

These doctors and researchers, Belini, Kim, Tantam, and Martin, all saw the profound biological impact that Autism can have on an individual. They, along with many others, note the urgency of finding ways to mitigate the impact of psychological stressors on people with Autism. However, until the etiology of Autism can be determined, it will remain difficult to find adequate psycho-pharmacological treatment for these individuals.

**Cognitive Behavioral Perspectives on Asperger Syndrome**

Cognitive/behavioral approaches are commonly used with children with Autism. More specifically, *social cognition therapy* has been developed to help children with ASD break down the social nuances of everyday life so that they can be socially successful. Tools used in social cognitive therapy include a variety of visually based group therapy lessons that help teach children to play and communicate more effectively. Michelle Garcia Winner created a social based psycho-educational program called *think social*, which helps address a number of the core social impairments that contribute to the
label Social Deficits. Simon Baron-Cohen developed the theory of mind reading that is also a key element in addressing theory of mind deficits in individuals with ASD. Theory of mind is the ability to comprehend the intentions, states of mind, and beliefs of others, and understand that these thoughts are different from one’s own. Behavioral modification practices are often successful with children on the Autism spectrum, usually implemented by a behaviorist and/or therapist. Common practices include positive reinforcement systems, visual aides, and behavioral extinction techniques.

Michelle Garcia Winner took traditional Speech and Language techniques mixed with cognitive-behavioral therapy and added a social focus, creating social cognitive therapy. Over the last decade, Winner has created a curriculum that addresses the core social and emotional deficits in children with Autism. Her treatment model is called the ILAUGH model. The ILAUGH anagram represents:

I = Initiation of communication
L = Listening with eyes and brains
A = Abstract and inferential thinking
U = Understanding perspective
G = Gestalt processing: Getting the big picture
H = Humor and human relatedness

This model was created to give teachers, therapists, parents, and speech and language pathologists a framework from which to assess the triad of impairments most common for children with ASD: Communication, socialization and imagination. Winner’s approach helps them break down the social dynamic for children with Autism and Asperger syndrome so that they can begin to understand the basics of being a part of a community. Social cognitive therapy can be a very long process.

Beginning at a young age, typically developing children are able to develop and master the skill of mind reading, which has also been referred to as theory of mind.
(ToM). As mentioned previously, ToM is the ability to infer that other people have thoughts, beliefs, desires, and intentions separate from one’s own. People who have this ability then use this information to interpret what others’ say, are able to predict what they might do, and make some sense of their actions and behaviors. According to Howlin and Baron-Cohen, children with Autism have what they have coined *mind blindness*, which is an inability to innately be a mind reader. The skill of mind reading, however, can be taught through specific practices that breakdown the nuances of social communication and provide routine steps for children with mind blindness. These practices, when successful, increase the student’s ability to relate successfully to their peers.

Frances Abell wrote an article on ToM in relationship to delusional beliefs, with the specific focus on those with Asperger syndrome. Based on his research, cognitive theorists hypothesize that there is a correlation between delusional thinking and impaired ToM. Forty-seven people with Asperger syndrome were studied, all of whom had previously been assessed for delusional thinking. The most common form of delusional thinking in people with Asperger is directly connected with their social anxiety and self-consciousness. Commonly, these delusions present themselves in the form of persecutory delusions and grandiose delusions. Abell’s study failed to find that delusional beliefs correlated to ToM impairments. Perspective taking impairments can present as persecutory or grandiose, but due to the inability to take in and assess certain social situations can cause misunderstandings to occur frequently with this population. Abell’s findings prove the extent to which social impairments may debilitate those on the Autism spectrum.
Alison Blackshaw continues to explore the impact of ToM impairments in people with Asperger’s syndrome. Because ToM deficits directly impact one’s ability to understand the bigger picture, which is directly correlated to perspective taking, Blackshaw studied the episodes of paranoia in people with Asperger’s syndrome in relationship to impaired ToM. Blackshaw compared the group with Asperger’s syndrome to a control group of neuro-typical individuals. She found that people with Asperger’s syndrome had higher incidents of paranoia and lower incidents associated with ToM impairments. However, findings showed that the paranoia tends to be concentrated around self-consciousness. This study also found no conclusive evidence that a relationship exists between paranoia and ToM impairment. Abell’s results appear to be very similar to those of Blackshaw that were inconclusive and based on Simon Baron-Cohen’s work with ToM. One would hope for further research in this area.

Some children on the Autism spectrum have been diagnosed with emotional disturbances due to their reaction to social isolation and bullying. In one case a child was wrongly diagnosed with depression rather than Autism. In this particular study, written and conducted by a Kristine Cooper, the female child was misdiagnosed due to her presentation of flat affect and social isolation. She was diagnosed with depression rather than high functioning Autism. Both of these disorders can be treated with cognitive behavioral strategies, however, the root of the therapy is different, and Cooper’s case spurred further efforts to find criteria to help differentiate the diagnoses.

Tony Attwood has written a number of books on Asperger syndrome to help therapists, teachers, paraprofessionals, and parents access resources and techniques to help those with Asperger syndrome. Attwood includes information on applied behavior
management and reinforcement systems. In addition, this book includes historical information on Asperger syndrome as well as tools and methods to help the child be successful at home and in the school setting. Attwood touches on the IEP process and the additional services that children with Asperger syndrome might need, including a sensory schedule and social skills training. Social cognitive therapy is commonly used with anger and anxiety management as well as within the structural guidelines of the social skills curriculum.  

In further efforts to discover useful ways to manage behaviors associated with Asperger syndrome, such as aggressive acting out, Kate Sofronoff conducted a study on parent management training. She wanted to determine whether modification of aggressive behavior would occur if the parents were the ones changing their behavior rather than the child with Asperger syndrome. Parent trainings were held in a one-day workshop and with 6 individual sessions. Results showed a significant decrease in aggressive behaviors and an increase of social interactions within the first 4 weeks in children with Asperger syndrome. The techniques that were taught to the parents were methods developed by a number of different people, including techniques by Winner and Carol Gray, such as social stories and comic strip conversations. These two latter strategies, which introduce vignettes of appropriate behavior in complex social situations, provide practical help to cultivate accountability and social understanding by specifically breaking social interactions. Sofronoff notes that even with the parent trainings and the success that comes from them, group and child interventions might also be needed.
Psychodynamic Perspectives of Asperger Syndrome

The psychodynamic perspectives that directly relate to Asperger syndrome revolve around the attachment and therapy practices that cultivate social connection. Not all children with Autism have attachment difficulties, however their social deficits can contribute to a lack of desire to attach to others. In early infancy, it is common for children with Autism to have difficulty being soothed by their mother. Some children with Autism reject physical contact due to sensory integration issues. Sensory integration dysfunction is simply defined as an inability to organize sensory input; children who struggle with this deficit often have adverse reactions to stimuli, including, but not limited to, noise, touch, and texture. These adverse reactions make it more difficult for the mother and the child to bond. With support and over time, children are often able to learn to regulate their sensory systems so that they can integrate sensory stimuli. There are a number of psychodynamic theorists and practitioners that both directly and indirectly address the attachment issues that often co-occur with social isolation. In addition, many children with ASD are adopted, which can further complicate the early attachment process.

In 2005, Lesley Cullen-Powell did an exploratory study on children with Autism and their attachment to their primary care giver. Specifically, she focused on how the lack of desire to be touched can affect a child’s attachment to the mother. The method included a massage-based intervention. Cullen-Powell found that touch, in the form of massage, rather than traditional hugging or holding, was very successful with children with Autism. She found that within a calm, safe, and quiet environment, children who naturally shy away from their caregivers’ touch, are able to be comforted by them.
through massage. Cullen-Powell also found that children with Autism, who are assumed to have attachment difficulties based on their lack of desire to be touched at an early age, are able to be treated successfully with this technique. The more notable concern is their inability to mirror others, engage in parallel play, and comprehend facial expression, all skills that are formed in the early attachment relationship with the mother or primary caregiver.  

Frances Vertue wrote an article on attachment and social anxiety called, “From Adaptive Emotions to Dysfunction: An Attachment Perspective on Social Anxiety.” Vertue breaks down the important nuances of social interaction. Within this context, the deficits around the ability to socialize can lead to varied degrees of social anxiety. Vertue associates this with attachment theory. He elaborates on the importance of social relationships in connection to emotional health and wellbeing. There are a number of treatments recommended to aid social connection, one of which is structured play therapy. Children on the Autism spectrum struggle to learn from their neuro-typical peers and therefore need play skills broken down to better enable them to learn to play without being rejected or lost in the process.  

In his book, *Inscapes of the Child’s World*, John Allen further explains Vertue’s point on the importance of structured play therapy; he illustrates a number of Jungian techniques, including art and play therapy, used when working with children on the Autism spectrum. Allen uses examples from his work with children and includes copies of drawings and paintings that he has interpreted. Jungian art and play therapy show counselors, teachers, and parents how to utilize these techniques in the context of working with emotionally fragile children.
Another psychodynamic approach to attachment issues was developed by attachment theorist John Bowlby. In this book, *A Secure Base*, Bowlby incorporates a number of psychoanalytic theories as well as his own perspectives on early attachment. Bowlby’s research has shown the importance of the mother-child bond and how this translates to relationships throughout the child’s life. Most of his theories are based solely on neuro-typical children, however he describes the connection between the lack of attachment/insecure attachment and its influence on social anxiety. According to Bowlby, attachment theory focuses on three primary principles:

1. The primary status and biological function of intimate emotional bonds between individuals, the making and maintaining of which are postulated to be controlled by cybernetic systems situated within the central nervous system, utilizing working models of self and attachment figure in relationship with each other.

2. The powerful influence on a child’s development of the way he is treated by his parents especially his mother.

3. That present knowledge of infant and child development requires that a theory of developmental pathways should replace theories that invoke specific phases of development in which is held a person may become fixated and/or to which he may regress.

This theoretical lens is at the core of the psychoanalytic framework used by many professionals in their reparative work with children who have social attachment issues.

Victoria Ryan conducted a study that focused on attachment as it applies to setting therapeutic limits in child-centered play therapy. The researchers tested and analyzed different reactions from the children during nondirected play from adults in an effort to test attachment. The data was inconclusive; however, there were significant differences in behavior between the children with insecure attachment and the children with secure attachment. The theory behind the research was based on Bowlby’s
attachment theory, further proving Bowlby’s extensive contributions to psychological theory and practice.\textsuperscript{34}

D. W. Winnicott is a world-renowned psychoanalytic psychologist who focused his work, of over 20 years, on how one develops the capacity to play and to relate to others. His book, \textit{Playing and Reality}, addresses the importance of attachment to the mother, as well as the creative process through which the child sees the world at the beginning stages of life.\textsuperscript{35}

Similar to Winnicott’s early work, which focuses on early attachment and play, Costanza Colombi conducted a research study on the developmental stages of play in children with Autism, namely, imitation, joint attention, and understanding of other people’s intentions.\textsuperscript{36} Imitation is one of the earliest forms of play, often demonstrated by games like peek-a-boo, where the mother is covering her eyes and surprising the child, and then the child mirrors that action. Joint attention is the next step in early play, where two children are able play together and maintain their attention on one set of toys, for example building a block tower together. Colombi found that children with Autism had significant deficits in imitation and joint attention but were able to understand the intentions of others regarding the action of the objects. This was an unexpected finding and has been cross-referenced with success in other articles. Although this is an emerging splinter skill, it gives hope for the effectiveness of early structured play-based methods with children with ASD. If children understand intentions of others but struggle to imitate or share joint attention with other playmates, it raises the question in what ways are they picking up this skill. Regardless of the many questions that arise, the more that children
with Autism are exposed to structured and unstructured group play, the more skills they will pick up and integrate.\textsuperscript{37}

Allen, Bowlby, and Winnicott have all done extensive work with children in relationship to attachment and play therapy. These methods can be used in working with children with ASD; however there needs to be more guidelines for the children to follow. With children with ASD, play often needs to be heavily scaffolded with visual supports and regular cueing. Behavior models and reinforcement systems have been created to aid therapists using these models to help children on the Autism spectrum.

David Oppenhiem, writing about how to work with children on attachment, includes a diverse selection of research on attachment and trauma theory. He emphasizes the importance of considering trauma and attachment therapy when working with children on the Autism spectrum who were adopted, fostered, or who have survived major trauma.\textsuperscript{38}

Jeffery Simpson also focuses his extensive research on the findings around adult attachment and the theoretical models that support the therapeutic process. There has been far less information recorded on adult attachment, yet there are many adults who suffer from an inability to create and maintain close relationships. When attachment issues are not addressed, patterns of verbal, physical, and emotional abuse can destroy the fragile relationships that have been created. Often these destructive patterns are cyclical in the family of origin.\textsuperscript{39} Children on the Autism spectrum, whose parents do not seek out therapeutic services for their children, often have a tendency to isolate, and they struggle to make it in the world successfully. Social deficits can inhibit one’s ability to be
successful in the workplace regardless of one’s level of intelligence. Being able to socially navigate ones environment is essential for independence.

**Sociocultural Perspective on Asperger Syndrome**

Current studies show that roughly one in every 100 children are being diagnosed with Autism; researchers and psychologists are looking at the cultural and social impact that this current epidemic is having on society. The increase in diagnosis leads people to be concerned about the biological and environmental components that may be contributing to this diagnosis. From a sociocultural perspective, there are concerns about the social impairments that restrict the individual’s ability to be successful in society regardless of their intelligence. Many researchers and theorists are creating different programs to aid these children so they may successfully transition into autonomous adulthood. However, we are yet to see the transition resources implemented to the extent that it is needed in the larger societal context. There are a number of resources accessible for families to help their children who struggle with social impairments. In addition to the regional centers and parent groups, there are specialty programs that address the social/behavioral aspects of this diagnosis. The Autism community is a culture in itself. Over the last 10 years, there has been an increase in awareness of Autism, and the support around the needs of these children and their families has significantly improved.

Neil Humphrey wrote an article called, “Make me Normal,” based on a compilation of interviews with 20 young adolescents with Asperger syndrome and high functioning Autism in mainstream middle schools in the United Kingdom. Adolescence is a trying time for most youth, but it is particularly difficult for those who struggle with
social deficits as well as co-morbid learning disabilities or sensory integration
difficulties.\textsuperscript{40} The focus of the research was to understand these adolescents’ perception
of being on the Autism spectrum. Their expressed their desire to fit in and their inability
to socialize successfully. This article truly speaks to the difficulty that these individuals
have making connections within this society.

In another qualitative study in which Robert Jones interviewed five individuals
with Asperger syndrome, four main topics emerged: finding strategies for supporting
communication and comprehension, role-playing as being non-autistic, the use of the
Internet as a way to maintain social relationships, and a supportive Asperger community.
Findings emphasized that those on the Autism spectrum often resort to social connection
online to create a sense of community. It is easier for them to fit in online but they are
more likely to be victims of predators due to their overly concrete way of thinking.\textsuperscript{41}
Online it is often difficult to navigate social nuances due to the lack of opportunity to
read facial expressions and difficulty with nonliteral language. However, due to an
overall high level of awareness around their particular disabilities and a desire to
maintain social connectedness to the best of their abilities, many on the Autism spectrum
are motivated to create social networks online.

In an article titled “Applying Common Identity and Bond Theory to (the) Design
of Online Communities,” Yuquing Ren applied bond theory and attachment theory to
their online community sample. In addition to affecting how the community was created,
the design of it was what influenced the types of people who participated. There was a
large percentage of the sample of participants who identified themselves as being on the
Autism spectrum. For some it is a source of connection, for others it is a preferred
method of contact, but often creates a lack of desire to connect with people outside these communities. It can also create a false sense of connection, and increased social isolation.\textsuperscript{42}

Culture has a strong influence on the identity of an individual. Jay Rojewski, highlights the many trials and tribulations of adopting a child from China. New parents potentially face delayed attachment to their new child, mental health concerns around supporting the cultural needs of the child, and then potentially adopting a child with special needs.\textsuperscript{43} Some of the hurdles he elaborates on begin with having a mixed race family and the attachment issues that arise do to delayed adoption as international adoption of children from China often takes six to nine months to complete. When adopting a child from a different culture it is important to support the child in embracing their heritage and building a strong sense of identity. Rojewski also elaborates on the effects of orphanages on young Chinese babies.

An exorbitant amount of foreign adopted children are born with or have special needs based on their experience in the womb and being institutionalized in an orphanage. Ruth Lyn Meese developed her theory on the impact of being in an orphanage on children who have been adopted. Between the decade of 1993-2002, 137,272 children were adopted from oversees and brought into the United States. Many of these children were institutionalized at least one year if not more. Although orphanages vary from institution to institution, common themes are poor health care, inadequate nutrition, limited options for cognitive stimulation, and lack of a steady caregiver.\textsuperscript{45} This does not include the rate of impoverished or drug addicted mothers who gave up their child, so these children are bound to have early struggles.\textsuperscript{44}
Children who are adopted at a late age or spend extensive time in a foster home may have significant struggles. The primal wound that is often inflicted in these situations, can be a trying reparative act for both parties, especially if it is cross-cultural. David Howe conducted a multi-model long-term intervention that was applied to children with attachment issues based on the criteria that they were adopted at a late age or in a foster home. This specific group of research participants had a history of abuse and/or neglect prior to their current placement. The study concluded that short-term cognitive behavioral approaches are less effective with this particular population and suggests the need for a multi-model intervention. The multi-model intervention in the study includes play therapy, holding therapy, sensory work, relaxation, and reprocessing techniques.

Chloe Lancaster and Kaye Nelson did a research study on three families who adopted eight children from China. Lancaster and Nelson report a number of common themes, including: a lack of being prepared for the fear and grief; attachment challenges; struggles in schools; behavioral burn out; a need for counseling; difficulty in finding strategies to build community and validating ethnic identity and acculturation; and the time needed to create a family bond. Lancaster and Nelson report that as of 2009, 80% of children adopted from overseas began their life in an orphanage. Because the rate is so high, researchers are correlating attachment disorders, cognitive delays, and behavioral deficits directly to post-institutionalized children. Lancaster suggests more specialized forms of family therapy are needed to directly work with families with children who have been adopted from overseas.

Nancy Verrier wrote a book on a topic similar to David Howe called, *The Primal Wound: Understanding the Adopted Child*. This book talks about the deep loss that
comes from separation from the birth mother. With this primal wound being the basis of adoption, the process of attachment and bonding can be difficult for the adoptive mother. Issues of abandonment and rejection are common in children who have been adopted, but repair is possible with patience, encouragement, love and commitment.\(^5\) This is especially pertinent to children with ASD who are adopted.

**Somatic Perspectives to Asperger Syndrome**

A common component of Autism is dysfunction in sensory integration (DSI). As mentioned earlier, DSI is the inability to organize and regulate sensory input. Many children on the Autism spectrum struggle to regulate themselves, which can present to the unknowing eye as behavioral issues. Those with this impairment may present with a range of dysfunctions, from oversensitivity to noise, to the inability to palate certain textures, to having a strong visceral reaction to any form of touch. All of these alter the way these individuals move through the world successfully.

Ayres developed a theory on sensory integration, which can be managed through a regular sensory diet.\(^5\) Depending on the extent of the sensory dysfunction, the diet includes regular systematic actions that help support the regulation of the sensory input. According to Ayres, sensory integration is “the neurological process that organizes sensations from one’s own body and from the environment and makes it possible to use the body effectively within the environment.”\(^5\) Kranowitz states, “Dysfunction in sensory integration occurs when the brain inefficiently processes sensory messages coming from the person’s own body and his or her environment. Generally, red flags of DSI are unusual responses to tactile, vestibular and proprioceptive sensations- the
sensations of touching or being touched, of moving and being moved. Kranowitz coined the term the *out-of-sync child* and believes that through different forms of adaptive activities that the child with DSI can metabolize his/her environment more successfully. Such dysfunctions within the realm of the five senses are usually attended to by an occupational therapist who designs treatments that can be implemented in the classroom or within the occupational therapy sessions.

Janet Kern examined the relationship between age, the severity of Autism, and the extent of sensory dysfunction. Kern stated “The ability of a person to respond to unexpected stimuli in their environment is a fundamental characteristic of mammalian behavior and is necessary for functional performance. Based on this theory and her research, Kern found that DSI is directly correlated to the extent of the severity of Autism; however, after the age of 13, the dysfunction no longer directly correlates with the severity of Autism. Although sensory dysfunction does impact adolescents and adults, Kern’s research suggests that there is a maturation process to sensory integration. Kern believes that sensory processing problems are not selective, they are global. These include impairments in auditory, visual, touch, and oral processing. Due to her findings, Kern suggests that sensory dysfunction should be considered a part of the disorder and should be assessed with diagnosis.

Winnie Dunn referenced Hans Asperger in her study. In 1944, Hans Asperger noted a significant impairment in sensory processing behaviors in the children that he studied. Dunn has found similar impairments in the children that she has studied who have been diagnosed. Both Dunn and Kern agree on the necessity of having DIS as a criterion for ASD in the *DSM*. Dunn states that in today’s school system the classrooms
are set for a “one size fits all” type mentality, which is why children with sensory
dysfunction struggle to be successful and have behavior issues. If the classroom adapts to
meet the sensory needs of these children, there will be more overall success in the
classroom. Children with Asperger syndrome are often intelligent enough to be
successful in mainstream schools but are often hindered by the lack of sensitivity toward
their sensory needs. Visually, large colorful bulletin boards and hanging art projects can
be overwhelming. If multiple classrooms with different teachers and environments can
trigger meltdowns due to sensory overload. A regular sensory diet, created to successfully
meet the needs of the child, can make huge difference.

Isabel M. Smith, who researched motor functioning in relationship to Asperger’s
syndrome, hypothesizes that individuals with Asperger’s syndrome have a more
prominent motor functioning deficit in comparison to their IQ than those with high
functioning Autism. She suggests that this might be a criterion to consider when
redefining the differences in high functioning Autism and Asperger’s syndrome.
Individuals with Asperger syndrome have been noted to have a particular “clumsiness.”
This clumsiness is more prevalent in children with Asperger syndrome than those with
high functioning Autism, especially in area of gait, balance, and typical gross motor
milestones. Perhaps this differentiating criterion will be reflected in the DSM-V, where
Asperger’s syndrome will be integrated into the ASD diagnosis.

Imaginal Perspectives to Asperger Syndrome

Imaginal perspectives in relationship to Autism have been cultivated in a number
of different ways. Studies have shown art therapy, play therapy, group therapy, and music
therapy have been successful methods for working with children with Autism. Animal assisted programs have also helped with creating social and emotional attachments to other beings. Special needs dogs have been trained specifically to help create social situations for children with ASD. Drama and yoga practices have also proven to be therapeutic ways of interacting with children with ASD. As children on the Autism spectrum tend to prefer parallel play versus imagination based group play, therapists are trying to create situations that might merge these two types of play. One way they are doing this is by working with the children’s special interests and introducing them to a group therapy dynamic. Group play can be anxiety provoking, but when the group is led by a trained therapist, skills that are not typically learned by peers can be cultivated in the group therapy setting.

Through her extensive work with play therapy and children with Autism, Pamela Wolfberg noted that regardless of the vast differences in social, cognitive, and linguistic capabilities, children on the Autism spectrum have very similar play impairments. Most notably, children with Autism struggle with spontaneous, diverse, flexible, creative, and imagine-based interactive play. These play deficits stem from impairments in joint attention, social imagination, and socioemotional reciprocity. When children on the Autism spectrum are left without specific play requirements, they will resort to rote, repetitive, and stereotyped play by themselves. Wolfberg created an integrated play groups model know as IPG. This type of play includes one to two children on the Autism spectrum (novice players), a neurotypical child as (expert player), and is guided by an adult. This mixture of novice and expert players led by an adult gives the children with social deficits an opportunity to learn through example in a safe and structured
environment. Often the adult guide will facilitate imagination-based play and then help the novice player navigate the play as the group plays.\textsuperscript{64} Wolfberg is one of many who are coming on board with the cultivation of directed play therapy to help the social deficits that affect children on the Autism spectrum.

Caroline Case explains the importance of cultivating imagination through art in the therapeutic setting. She demonstrates the value of art therapy with children who are preverbal and also explains how attachment can be cultivated through collective art projects with children and their families. Case also explains the importance of art therapy with children who are undergoing difficult transitional periods, such as divorce and loss.\textsuperscript{65} Art therapy is used with children on the Autism spectrum to problem solve social situations, as well as to work on personal expression.

Work with the imagination and children often includes working with their development of imaginary friends. Children create imaginary companions to compensate for difficult social relationships. Gleason did a study on children who had imaginary companions and/or personified objects (e.g., teddy bears). There is a fine line between the imagination and compensating for social anxiety or poor social connectedness. Gleason concluded that the act of creating imaginary friends is so common that it becomes maladaptive; it is also rarely studied.\textsuperscript{66} Children with ASD often prefer to play alone in their own world with their personal objects of interest, so often, imaginary play for children on the Autism spectrum is redirected to include others so that they do not become socially isolated.

Mary Ann Winter-Messier developed a strength-based model that incorporates the use of special interests. Because children with Asperger syndrome are often completely
captivated by a few subjects, Messier uses these interests as a way of helping them to cultivate connections with peers and the community. Messier believes that if you use the special interest to motivate the child, or as a reinforcement item, then the child is more apt to complete work at school, engage in conversation about that topic, and play with others around that subject.\textsuperscript{67} The more that the special interests are integrated throughout the day, the better the child will focus, engage, and participate. She believes that these areas will improve fine motor skills, executive functioning skills, academic skills, communication skills, social skills, and emotional strengths.\textsuperscript{68}

Animal-assisted therapy is often used in treatment of children diagnosed with high functioning Autism or Asperger syndrome to work on the insecure attachment problem. Assistance dogs are becoming more common for children on the Autism spectrum, because they create social situations for the children and provide a sense of security. In a study that focused on the therapeutic uses of animals with children with attachment issues, Parish-Plass found that children who have suffered insecure attachment due to abuse have a higher than average likelihood to do the same to their children. In this study, animals were introduced in the beginning stages of reparative work in hopes of healing some of the damage. Since children who have suffered abuse tend to have a mistrust of adults, the idea was that working with animals would help mend some of those wounds. The study’s findings suggest that a combination of therapy with the animals as well as with a therapist may help put an end to the intergenerational transmission of abuse.\textsuperscript{69}

Bernhard Weidle did a study on support groups for adolescents with Asperger syndrome and their families. Unlike many of the social-based methods discussed above,
Weidle was curious about enhancing self-esteem through structured groups. He broke the group into two sections. The first was a therapeutically theme-based and the second part was interactive and play-based, which the clients were more likely to continue to be motivated to attend.\textsuperscript{70} While the teenagers were attending their group, their parents were attending their own support group in a different area. After the study was completed the majority of the parents reported an increase in self-esteem in their children. They found that their child looked forward to the groups and were beginning to make connections with others in the group, all of which contributed to a more positive sense of well-being. The majority of the parents were pleased to make connections with other parents with children with Asperger syndrome and felt the community created through this process was invaluable for both them and their children.\textsuperscript{71} This study is just one of many that continue to help the social and emotional well being of families with children on the Autism spectrum.

In a similar study, Kevin P. Stoddart researched the benefits of family therapy to treat children with Asperger syndrome in Canada. Stoddart used a multi-model approach to therapy with three families, two of which successfully completed treatment over a number of years.\textsuperscript{72} The focus of the therapy was not only to increase positive communication, but also to help the families get services they need to be successful. Problem-solving is a major focus of the therapy. One of the mothers mentioned frustration with her son’s inappropriate social and racial slurs. Stoddart helped the family come to agreement on when and where certain comments were appropriate and how they could work as a family to support the social success of their teenager. Stoddart includes respite hours and social services in the intervention to help the teenagers begin to make
connections with peers so that they would not be solely dependent upon their parents for social interactions. Overall, Stoddart found that these methods were successful and should be considered when working with children and adolescents with Asperger syndrome.\textsuperscript{73}

In work that does not directly address Autism-related issues, Aftab Omer stresses the importance of cultivating capacities through exploring the passionate nature of the soul. \textit{Transformative learning practices} are an integral part of working with children because they support their process toward social and emotional independence. In an integrative seminar lecture series, Omer talks about the link between passion and wisdom and the importance of cultivating a relationship with the mythic imagination.\textsuperscript{74} Children on the Autism spectrum have a direct link to their passionate nature and what their soul needs. Therapists need to develop the language that will help them bridge the passion that they have with the expectations of the world around them; wisdom accompanies the ability to do that.

In her book, \textit{The Search for the Beloved}, Jean Houston provides a number of tools for working with sacred psychology, including the incorporation of myth. She highlights the Myth of Psyche and Eros and links this myth to the initiatory journey of the soul. Similar to Omer, she stresses the importance of having a commitment to transformational work. In working with children with ASD, the path to creating a successful initiatory experience that cultivates change can be supported through sacred psychology.\textsuperscript{75}
Conclusion

The therapeutic methods used across the six different perspectives provide a wide range of methods to address this ever-increasing population of people on the Autism spectrum. There is no single way to help people with ASD. The most important thing a parent, therapist, teacher, or paraprofessional can do is to use a multiple model approach in addition to reading as much information as possible on the disorder. There is still no cure for Autism and there is no medicine or quick fix to creating a more successful life for those on the Autism spectrum. However, there are a number of ways to significantly increase the quality of life for these individuals and their families, which includes: breaking down social experiences, creating supportive communities, managing other comorbid psychological disorders, and addressing sensory and attachment needs when they apply.

Early intervention programs continue to pop up around the country to address the social, emotional, and behavioral issues that arise in the early years of a child diagnosed with ASD. The sooner the family seeks help the better. However, it would be a mistake to assume that a child who has tendencies toward behavior issues or social isolation will always need the total extent of support resources available. When given the proper tools, many children become more independent. Other services to consider are occupational therapy, social therapy, nutritional therapy, and speech and language therapy.

There are a number of community support groups helping families who have children with ASD. The next step is providing more opportunities to those who are transitioning into adulthood. There is not a lot of support for young adults on the Autism spectrum. As we continue to educate ourselves as a society on Autism, my hope is that
with the studies that are in process we will continue to find new ways to support these individuals throughout their life rather than just at the beginning. More and more, vocational programs specifically designed to help people on the Autism spectrum are being developed. Some universities are developing Autism programs for those who meet the educational criteria to be successful but lack the executive functioning skills and living skills to be in the world independently.

Lastly, one of the most prominent concerns for parents who have children with special needs, particularly those with ASD, is the financial stress that is created. With nearly one in every 100 children being diagnosed with Autism, hopefully more and more special education classes will incorporate Autism-specific resources to help mitigate the need for private therapies and private schools. All too often, children with Autism are stuck in special education with children who have significantly lower overall IQ’s because of the sensory, social, and speech and language impairments. When put in the right situation with the right interventions, which does not mean that they will be successful in a regular public school classroom, many children with Autism and Asperger’s syndrome can obtain a high school diploma and go on to college. With the growing prominence of Autism, it is possible in the next 10 years we will see a change in the structure of public education so that more of these kids can remain in public school and be successful.
CHAPTER 3

PROGRESSION OF TREATMENT

The Beginning

In August of 2008, Leigh began attending a school for students with Asperger’s syndrome, high functioning Autism and other learning disabilities. Due to the extent of Leigh’s social cognitive impairments and overall anxiety, she began group social cognition therapy in August and was recommended for individual anxiety management in October. Leigh began individual therapy in October of 2008 to address her chronic anxiety, depression, and social impairments.

In the first session, Leigh presented as a clean, uniquely groomed 13-year-old Asian female. She wore a traditional Asian silk outfit. Her hair was straight and shoulder length. At five foot two inches tall, she was relatively small in stature and had a slim to medium build. She was sitting in the seat furthest away from this therapist. She curled up into a ball in her seat and made no eye contact during the first session. Leigh mentioned that she was very anxious and had no desire to socialize with her peers. She expressed her dislike for the students in the classroom and she said she found little joy in the social times during the school day and much preferred to work and study. At the time, Leigh was the only female in her classroom. Throughout the session, she spoke loudly and quickly.

Leigh conveyed her vast knowledge of her problems, telling me that she had seen a number of therapists over the years, and no one had helped her. Leigh mentioned
chronic anxiety and depression. She also mentioned the extent of the medication she was taking to manage her anxiety and depression and added that she found it to be minimally helpful at best. Leigh complained of somatic issues, including sharp pains in her legs and fatigue during activities at school. She stated that on numerous occasions she was clumsy and felt awkward in her body. Leigh was receiving occupational therapy to help with her fine and gross motor coordination.

Leigh said that she did not like to be touched and tended to have large outbursts when accidentally touched by staff or peers in the classroom. Her interpretations of these encounters were often perceived as malicious and purposeful, when they were obviously accidental. This report, in conjunction with many other incidents she related, brought to light the extent of the perspective-taking impairments that Leigh struggled with at the time.

In the first eight sessions Leigh described her imaginary social environment, which revolved around her relationship to her “husband” who she described as a “wushu spear.” Wushu is a traditional form of Chinese martial arts that is broken into two disciplines. One discipline of this martial art is a form of Chinese boxing that incorporates hand-to-hand combat. The other discipline focuses on putting together maneuvers using traditional moves to create routines using weapons. The spear that was designated as her husband was named “Jimmy.” At this point in treatment, Leigh owned 27 different wushu spears and staffs, all of which were individually named and had different characteristics. She told me that her deepest desire was to be a wu-shu spear like her husband Jimmy. Leigh had been studying and practicing wu-shu on and off for a year. She struggled to manage the extent of the stress that came from being in close
proximity to people who “harm wu-shu spears.” Due to the nature of her classes, others competed with these spears, and while practicing the spears sometimes hit the floor, which sent Leigh into a panic. She had been asked to leave the class a number of times due to her erratic behavior. Leigh’s sensitivity to noise is not unusual for those on the Autism spectrum, and, in addition to a number of other sensory integration issues, noise was a trigger for Leigh.

Leigh parents’ main concerns were that she was not making connections with other people, she was isolating herself at home, and her self-destructive behaviors were increasing. Leigh had a history of bending and breaking household items as well as biting herself. Leigh has battled with anxiety and depression for many years. At the time of our work together, she was using her obsessions to escape. This is common in children with ASD. Leigh was adopted at eight months from an orphanage in China that had over 600 abandoned female infants. She was severely neglected during the first eight months of life, and a number of her symptoms can also be attributed to insecure attachment in addition to ASD.

Building the therapeutic bond took several months. Leigh was open to talking about her social world but had a hard time talking about the reasons for isolating herself from this world. In the meantime her spear obsession grew, pulling her further away from reality. Her imaginary social environment continued to become more and more complex; it began to include inter-social drama that occurred between the spears. Her obsession was having an increasingly negative impact on her ability to relate to her peers.

We began weekly therapy homework assignments. Leigh was very goal-oriented and enjoyed establishing a challenging goal to meet each week. One of her main concerns
was being able to be successful in her wushu class. That time was reserved for her and ‘Jimmy’ to be out in public. Due to the nature of the class, Leigh was expected to be a part of the group, but she would get easily overwhelmed by the amount of people in the room and the noises that happened when the spears would hit the ground. Anxiety management was the first step needed to build the therapeutic relationship. We created an anxiety 5-point scale. With this scale, she was able to determine how anxious she was at any given time, and we decided it was necessary to take a break from the group when she hit the three point degree on the scale or higher.

When she began to allow herself to take those breaks, her time spent in the group was actually more productive and less disruptive to the other students. What she did on those breaks varied; sometimes she would sit and take deep breaths, at other times she would dance to help manage the overwhelming amount of energy that often accompanied her anxiety. She began to advocate for herself by talking to the teacher about a place where she could take a break. She began to manage herself to the degree that she stopped having loud outbursts in the wushu classroom; she then began abruptly taking breaks and still disrupting the class, until she finally was able to discreetly leave the room to take a few breaths in a designated area. Her success in her managing her anxiety supported her progression toward trusting the therapy process.

Leigh’s trust was built by consistency. I saw her every week, and if I had to change the schedule of our meeting, I would let her know in advance and provide other times for her to choose from. I did not miss a session without letting her know. The sessions occurred during school hours in the beginning; I not only saw her in the therapy setting, I saw her periodically during the day as well. In the last year of our sessions
together, I began seeing her for an hour once a week after school as well. The trust-building progressed quickly. I knew all of the staff and the peers that she worked at school with so I could help her navigate her environment as well as help the staff to support her. If she was feeling uncomfortable about an interaction, I was able to support her in facilitating change. For example, a staff member who worked in the classroom often touched students lightly on the shoulder to redirect them. Leigh would blow up when touched and the staff member had no idea that what he was doing made her feel extremely uncomfortable. So she and I talked through the situation, and she was able to understand that he did not intentionally want to hurt her. With a lot of therapist support she agreed that we could let him know that what he was doing made her feel uncomfortable without the interaction ruining her day.

As she became more comfortable with her peers she began talking about her imaginary relationships with these swords. Many of her peers would humor her, but often confiding in them about her sword relationships resulted in her being further isolated from the group. She felt rejected and did not understand that the topic of having personified spears was what was making a negative impression on her peers. This rejection perpetuated her anxiety and her depression.

Initially, Leigh was failing socially in multiple environments: in the classroom, out in public, and in her wushu classes. Leigh was resistant to therapy, she claimed that her previous attempts at therapy were unsuccessful and that she was forced to engage in play therapy against her will. I decided to create therapeutic framework that treated her like an adult. This set the tone for her therapy. She wanted to be treated like an adult, and therefore we agreed to work on being accountable for her actions and the impressions she
was making on others was part of her responsibility. As time went on, more of the layers of her story unfolded. Mixed in with the social anxiety, depression, and mood instability was sexual identity confusion and low self-esteem. All of these issues created a very rigid social thinker who resisted connecting with others.

Incidents of crisis were minimal throughout the therapy process. There was an incident where Leigh felt extremely agitated about taking a vacation to Hawaii. She did not like the idea of traveling without her swords, and there were a few sessions where she mentioned suicidal ideation. Her suicidal thoughts centered around her feeling like she did not want to live if she had to be away from “Jimmy.” Leigh did not have a plan nor did she demonstrate risky behavior. She wanted to emphasize the stress that she was feeling about the pending separation between her and her sword, as well as the fact that there was a three-week break in school and she would not have therapy. I received extra supervision, and although I felt that there was no risk of her actually harming herself, I wanted her to know that her feelings of distress were being heard. We put together a suicide contract, and I let her know that my phone number was for emergencies only but that she was welcome to email me if she needed to feel connected. I then contacted her parents to let them know that she was anxious. We talked about some supports that they could put in place to help her be successful in tolerating the changes in her routine and environment on this vacation. These supports included devising plans that would give her a place to take a break, the individualized 5-point scale that we created, and a less bulky transitional item than the spear to take with her. Leigh decided to give “Jimmy” surgery and she took a part of him with her.
Following this vacation, Leigh went through an eight-month destructive phase, during which her anxiety was so overwhelming that she destroyed her father’s wushu equipment. During this time, her father’s health was poor, which provided a stressor that she could not escape from nor knew how to handle. Her inner child was scared and acting out in an effort to help regulate her turmoil; she also destroyed his equipment to help her assert her personal authority. In the end, this destructive phase was mitigated through a positive reinforcement system created in therapy with Leigh, her father, and myself, and her genuine desire to change. We came up with strategies to help her exert herself more constructively, and she tracked her behavior daily so we could see how often she felt the desire to destroy the equipment versus how often she actually did destroy the equipment. She found other means to exert this energy by bending her own swords, playing tennis, and wrapping herself up in weighted blankets. She was proud of herself once she felt in control again. Overall, she managed her symptoms fairly well and made a significant amount of progress over the three-and-a half years that constitute this case study.

**Treatment Planning**

My treatment plan for the first year began with setting the goal to establish a consistent, reliable, and structured foundation built on a strong therapeutic alliance. The primary goal was to help Leigh manage and treat her anxiety and depression. Part of the first few months of treatment was developing her ILAUGH profile. Leigh’s updated ILAUGH profile is included in her 2010 triennial review in the appendix. The ILAUGH framework helped to establish a greater understanding of specific areas of social strength and social deficit. Once the therapeutic alliance was established, Leigh and I set a goal
together to create an individualized 5-point anxiety scale and to use it. I also wanted to see her regulate her emotions more constructively by taking breaks appropriately. In addition, I wanted to see her develop further strategies to help her manage her stress both in school and in her wushu classes. To help support these goals Leigh and I created weekly pro-social goals to help her develop friendships, manage her anxiety, and to support her social and emotional learning process. Secondary goals for the first year of treatment included coming up with strategies to help her minimize her reactions to being touched and decreasing her obsessive attachment to her imaginary social environment by encouraging her to develop relationships with her peers.

After the completion of the second year of therapy, Leigh had accomplished the majority of her treatment plan goals. Her overall mental health was improving and she was utilizing tools developed in the therapy and school settings to support her at school and in her wushu classes. The goals for the second year of treatment began with continuing to manage her anxiety and depression by utilizing the tools already created and establishing new ones as needed. Although Leigh’s behavior at school had significantly improved by this time, her behavior at home had declined, which led to her second major goal of managing her destructive behavior at home and coming up with replacement behaviors to support her sensory and emotional needs. Leigh was transitioning into the high school and her social expectations had increased. Therefore Leigh and I set a goal to extinguish talking about her imaginary social environment at school to help support pro-social interactions with her peers. A secondary goal for the year was to begin exploring Leigh’s sexual identity confusion in the hopes of cultivating a stronger sense of self-esteem and self love.
Leigh made an enormous amount of progress over the course of the second year. By the end of the second year, her depressive episodes were nearly gone, and her imaginary social environment was more of an afterthought. Her behavioral outbursts at home were gone and the social emotional need to bend and break things had been replaced with a number of different tools. She had made a few friends and her obsession with wushu spears had been replaced with equine vaulting and the equipment that came with it. Leigh had a pattern since she was six-years old of having obsessive attachments to a variety of inanimate objects, which lasted between two-three years; however, the spears were the first obsession that she personified, and her obsession on equine vaulting equipment in our third year of therapy together was not as socially awkward. The primary goals for the third year of treatment focused on managing the new obsession, continuing her exploration of self-acceptance, and supporting her process in developing more intimate connections with other people. The secondary goals were to begin to explore her anger around her adoption and work towards a better understanding of her own multiplicity.

Leigh’s Diagnosis

Axis I: 300.23 Social Phobia (Social Anxiety Disorder) R/O

296.90 Mood Disorder Not Otherwise Specified R/O

Axis II: 299.80 Asperger’s Disorder (2007)*

299.00 Autistic Disorder (Amended in 2010 Due to Asperger’s Disorder being eliminated from the next DSM)

Axis III: None

Axis IV: Adopted from China at nine months as one of 600 hundred babies in the orphanage; severe neglect due to circumstances.
The Therapy Journey

The first few months of therapy were spent building the therapeutic bond. The root of this bond was based on good communication, consistency, and weekly therapy goals. In the first few months a number of issues presented themselves. Leigh was infatuated with tai-chi and wushu spears. She felt culturally connected to the sport and spent the majority of her unstructured time at home engaged in creating an elaborate social environment. According to Leigh’s parents, she had had a number of obsessions that often lasted between two to three years. Her obsession at the beginning of treatment was particularly extensive and complex in nature. She saw herself as being married to her favorite spear, Jimmy. Her focus on the marriage had the effect of rendering her emotionally unavailable to other humans. Leigh had created an entire imaginary social world that was a place where she felt safe and seen. Unfortunately, the more she dove into her obsession, the more disconnected she became from her peers. Many of her stressors at school came from her wanting to talk about her wushu social environment and the subsequent rejection of her peers. This pattern continued her spiral downward toward further isolation.

In the third week of therapy, we completed an anxiety inventory where I was able to get a better look at what situations made her more anxious based on a 5-point scale. Social interaction was on the top of her list of stressors, along with flying, traveling, being touched, and being teased. Leigh had a hard time regulating her emotions. We
created an individualized 5-point anxiety scale with calming strategies to support her when she noticed herself feeling more anxious or agitated. Leigh was such a focused worker that she had a hard time taking a break when she needed one. Taking a break, then, became one of her weekly therapy goals. She eventually learned to allow herself to remove herself from the stressor. This was the first step in helping her manage her anxiety. In the sixth session, we created a plan for when she was feeling anxious in her tai-chi class. Prior to the class following our session, she talked with her instructor and they came up with a place where she could take a short break if she felt overwhelmed. The plan worked beautifully. We then created weekly goals to support her in taking breaks and advocating for herself. In the past, she would get so overwhelmed that she would quit. With these emotion regulation tools and calming strategies, there was a noticeable decline in her verbal outbursts, which then created an environment where she was able to be more successful.

The second major breakthrough with Leigh was giving her a therapeutic tool called a “brain dump” to manage her anxiety. She was given a jar of blue marbles, which represented good thoughts, and a jar of black marbles, which representing uncomfortable, angry, or anxious thoughts. In an empty jar that represented her brain, she was asked to add blue and black marbles that were congruent with the thoughts that were in her brain at a given time. We started with this task every session for the first few months so that I could get a baseline on her overall mental state. She would talk about the marbles as she went. This task seemed to clear her head and help her organize her thoughts so that she did not continue to feel flooded and overwhelmed. It also gave her an opportunity to problem-solve her conflicting thoughts and feelings. We would use an open chair method
of voice dialogue, so that she could embody the multiple sides of her conflicting thoughts.

Because Leigh was at a new school and needed a lot of support socially she found herself being targeted by more socially savvy individuals in her class. Her self-esteem was affected by their teasing and only further encouraged her to isolate herself from her peers. She was also in a classroom with 11 boys. Occasionally Leigh complained of not wanting to be female. I initially attributed it to being the only female in the class, but this continued to be an underlying theme over the next two years.

In early 2009, Leigh mentioned her desire to steal her father’s wushu weapons and bend them. She liked the idea of being mischievous and pushing boundaries. She also sought out the sensory input of exerting her power onto an inanimate object. Leigh liked the feeling of exerting her energy through trying to bend this wushu staff. When Leigh would get caught bending her father’s sword, she was given harsh consequences. She endured her father’s upset and was charged for the damages. Since she did not have a job, she had to work off her bill by doing undesirable housework. Those consequences made her want to modify her behavior. Leigh began tracking her impulses to bend the wushu staff. She marked any time she had an impulse to bend the spear. Over time we tracked certain patterns. If she had a bad day at school she would want to go bend the spears. Then her father began hiding his spears and staffs, which only reinforced the negative behavior by making it more of a game. Eventually, Leigh decided that the game was not worth it anymore, and when she had a bad day she would use one of her own spears to bend. Ultimately, her Dad decided to sell Leigh the staff she desired so that she could bend it as necessary and her behavior decreased significantly. During this time, her father
was quite sick as well. Her anxiety escalated with his illness, in part because of the drastic decrease in attention that she normally received from him. As Leigh’s dad’s health improved, they began spending more quality time together, and her overall affect improved significantly. She was unable to see this connection between her behavior and her father’s illness until she brought it up and we explored it nearly a year later.

The first major boundary I set with Leigh occurred eight months into therapy. By then, she and I had formed a solid therapeutic bond; she trusted me and we had had many successful breakthroughs in helping her manage her anxiety. She was transitioning into the high school as an eighth grader by choice and with that transition she was expected to modify her behavior to help her with her relationships with peers. Her lack of a filter around her imaginary social wushu world made her peers feel uncomfortable. She would talk about intimate occasions with her spears, including taking baths with her “husband,” and the boys in her class did not want anything to do with her. Leigh was considered a resistant social communicator, as defined by the Social Communication Scale, developed by Winner. This scale was used to give the professional staff some understanding of the level of social impairment that a student exhibited. A resistant social communicator simply meant that Leigh was resistant to modifying her behavior because she had difficulty taking into consideration the thoughts and perceptions of others. She understood that others had thoughts about her, but she had a hard time caring about those thoughts long enough to make any major changes. Up until that point, Leigh had made changes based on the fact that she had been really unhappy and deep down wanted to be accepted by others. We agreed that it would be more socially appropriate not to talk about Jimmy or the other personified spears in the school setting. She was more than welcome
to talk about her personified spears freely in the therapy setting, and I encouraged her to talk about her love for wushu as a sport.

Through our weekly social goals, Leigh had been working up to this transition. She had begun using small-talk topics with peers and started reading up on anime because her peers liked anime. She had come into numerous sessions frustrated with her peers because they did not understand her obsession. Her obsession over the course of the past eight months had gone from being fairly benign to quite intense. She cut and dyed her hair to match her wushu spears. She talked of taking romantic baths with them, and she was sleeping with them at night. Prior to this agreement she would address her spear as her husband to her peers and although she could not bring them to school; she would attend outside functions with her husband including some social engagements.

Leigh became quite upset with this initial boundary. On some level she understood that the boundary was set in her best interest, but she had a hard time with it.

She had two dreams that we worked with during this time. The first dream was:

The principal of the school and you [therapist] are looking for me in the school. I know it is the school but do not recognize the buildings. I realize that I brought “Jimmy” with me and I am afraid I am going to get caught. I am hiding under the desk with Jimmy and just as the principal and you walk in the door of the room I am hiding in, the dream ends.

The second dream was as follows:

This dream takes place in the principal’s office at the school. I am sitting in the office with Jimmy. The principal and you [therapist] walk in; the principal states, “Jimmy is not allowed at school, you are suspended, come back when you are ready to follow the rules.” You are sitting in the office agreeing with the principal.

Leigh had had these dreams over a three-night period, so when we met we wrote them down and began to dissect them.
Leigh felt initially that the dream was telling her that the principal and I were there to scare her, and she talked a great deal about feeling resistant to conforming to the boundary. I introduced the idea of Freud’s id, ego, and superego, where the id represents one’s instinctual desires, the ego attempts to negotiate these desires with reality, and the superego acts as one’s conscience. I suggested that maybe her id wanted to bring the spear to school and not conform to societal rules. We decided that the principal and I represented her superego. We were the part of her that was critical and rule bound. These dreams led to multiple discussions on the reasons for setting this boundary. We also discussed at length her fears that I was judging her. We talked a lot about the way in which her imaginary social environment served a function for her and how that purpose was safe in our therapy room. However, she understood that if she were going to be successful in the high school she had to find a way to bridge her interest with peers so that they would not be put off by her. We spent the summer preparing for this transition but talking about ways in which she could bring up her love for wushu and tai-chi to school without personifying her weapons to her peers. As one of her homework assignments, I assigned the movie, “Lars and the Real Girl.” his movie is about a socially awkward man named Lars who was going through a very tough time and decided to buy an anatomically correct blow-up doll. He named her Bianca and created a life with her in his small town. At the request of Lar’s psychologist, Lar’s brother and sister-in-law accepted her into their family in the hopes of helping Lar’s mental health. In the end, after a lot of self-discovery and support by the community, and especially through mutual attraction with a real girl, Lars was ready to let Bianca go and establish more healthy relationships with others. This movie was very evocative for Leigh. She commented on
how much Lars’s community supported him in his time of need. We also talked about ways in which she felt supported. We also talked about the differences between being pitied and being supported, and although the community supported Lars, they still had weird thoughts about him, and they thought he was going through a mental break down.

The first few months of high school were tough, but Leigh refrained from talking about her spears in the personified fashion. Leigh began to focus on observing what high school students enjoyed doing. She needed to find a way to bridge her interests with at least one peer in her class. She began developing an interest in anime. Anime is a style of animation that originated in Japan, and it has become very popular with teens. We came to the agreement that if she made a friend who she truly felt connected to we could discuss whether or not to broach the subject with them about her spears and how to do that. Leigh spent the entire year developing a friendship with a young man who was in the process of exploring his gender identity. Leigh was drawn to him because he was so comfortable expressing himself and they had anime in common. They had their ups and downs. Leigh was pretty reserved and rule oriented and her friend was less inclined to conform to the expectations of the classroom, but overall the unlikely pair got along quite well.

In February of that school year Leigh developed the mantra of “I want to be social.” She had gone to a series of school-based functions and she was not as anxious around her peers or social events any more. Shortly after that she joined an equine vaulting class in addition to her wuchu class, and she made a few more friends. The more community she created, the better she felt about herself. In therapy, the conversation shifted from her imaginary dramas with her wushu spears to real, social interactions with
her peers. Leigh was beginning to not need her imaginary social environment to feel accepted.

In April of 2010, Leigh had nearly completed her first year of high school, and I missed our first session. I was out sick that day but that information did not get transmitted to the high school. I had missed sessions in the past for meetings, but she had always known about them ahead of time, and we had rescheduled. Leigh was extremely upset that I had missed our session. My absence and the lack of communication had triggered her imaginal structure that felt young and abandoned. When I returned two days later, I came into the high school to find her, to check in with her and to reschedule. She yelled, “You no-showed on me; I am going to tell my mother that you no-showed.” At this point I rescheduled my time and we had an emergency meeting. I started with, “I see that you are really upset with me, I did not mean to miss our session, but I was out sick. I did not get to see any of my clients in the last two days. I am sorry that nobody told you that I was out sick.” I reassured her that she was very important to me and that I would never intentionally not show up for her.” Leigh cried a lot this session. We talked about how it felt to be forgotten and that it was not my intention to make her feel that way. We talked extensively about how threatening me that she would tell her Mother was not going to change the situation and that it was enough for her to say, “I was worried and felt forgotten when you did not show up.” Although this emergency session was stressful, it reassured Leigh that regardless of her struggles to attach to people, we had an attachment and our attachment could handle disappointment, anger, and rejection.

With the transition from her socially anxious self to a more socially confident individual, Leigh changed a lot. She began to care more about what people thought about
her. She was more apt to socialize with her peers during breaks at school. In an effort to try to connect with her peers, she had begun to become interested in equine vaulting and anime. Consequently, she was able to converse about both of these topics with ease with her peers. As time went by, she slowly transitioned into a new obsession. She turned her focus to equine vaulting equipment. Jimmy and her spears had become more of an afterthought although she still competed with Jimmy in her wushu competitions.

In the spring of 2011, Leigh told me that she was no longer married to Jimmy. She had found a young man at her vaulting class whom she was interested in. While this relationship was short lived, it truly pushed Leigh into considering what a friendship with a living being was. Leigh claimed she was a flexible thinker, but at the core of social thinking is the idea that a reciprocal relationship hinges on the ability to take into consideration what other people think about what one does and then modify one’s behavior accordingly. Leigh was resistant to modifying her behavior and avoided thinking about what people might be thinking about her. When one is creating a friendship that is not supported in the school environment, one generally expects to make use of phone calls to learn more about each other. Leigh did not like to use the phone. She was able to talk about horses with this young man, but she did not take much initiative to learn more about him. Nevertheless, this was a good step for Leigh. Even though it was short-lived, it was great for her self-esteem, and it pushed her to want to connect with another human being outside of school.

Leigh struggled with her self-esteem. This had always been present but it became a bigger issue the more social she became. She was uncomfortable with the way she looked, refused to allow her picture to be taken and was generally unhappy in her own
skin. Her therapy evolved significantly over this two-year period. However, since the break up with this young man, Leigh regressed further into her new obsession. She had a collection of equine vaulting equipment that she bought from a number of different vendors. She wrapped up in the horse equipment and slept in the horse equipment. Often her behavior translated into early developmental imagination-based play. She pretended she was the horse and was completely enamored by the vaulters. Because she was such a sensory-based individual, much of her experience involved dressing up. This can be attributed to early childhood attachment deprivation. Unfortunately, it became a problem when she dressed up and left the house or talked about her behaviors at school. On a basic level, she understood that other people found what she did with the horse equipment to be weird. Understanding this was in itself a big step for her. However, she was constantly torn between whether or not she cared what they thought. The part of her that wanted to be accepted socially was battling with the side of her that wanted to retreat into her inner world. Finding a balance was extraordinarily difficult for Leigh.

At the time of this writing, Leigh has set goals for herself to work on perspective taking and making a positive impression on others. Impression making was broken down into three sections, which included

1. What you do,
2. What you say, and
3. How you look.

Leigh had made progress with the first two, but as of this writing, we are still working on the “How you look,” piece. I learned from talking to her parents that Leigh is intelligent enough to graduate high school and go to college. She is hard working and dedicated to
her studies. I know that socially, however, college will be very difficult. Leigh aspires to be a chef or a surgeon. However, I know that she would not get past the front door for a job interview in some of the outfits she wears.

Although she wore only Asian silk outfits when we began our work together, as the therapy progressed she drastically altered her appearance. She began to wear her hair short and spiky, and she often dyed it red. She wore an eclectic mix of clothes that were often mismatched or oversized for her frame. She claimed she had logical methods for her dress; for example, she did not like to have wet pants, so on rainy days she would wear her horse riding boots with a pair of oversized shorts and her purple dragon jacket. She had a bright orange ski cap that she wore occasionally when her ears were cold. This transition made her appear more androgynous. Although she claimed that she had practical reasons to wear what she wore, social norms are not based in logic. She called her proclivity for dressing this way her “sore thumb style.” Only recently, in the course of our work had she become more focused on her appearance and she began to be more mindful of the impression that she makes on others by her choice of dress.

Over the two and a half years of the course of this case study, Leigh made amazing progress, even with her resistance to change. She had a safe place to express herself and worked hard to make positive changes in her life. When she was really stuck, we did art, and she found clarity in the process. Art was a wonderful outlet for Leigh. When she was frustrated, we painted, and often times through her art she would find resolution to the inner conflict that she was feeling. One of the horses that she was working with died and she made a fitting and breathtaking tribute to her love for that horse. It was quite a cathartic experience for her. If she was sad, she would write and she
found comfort in the writing. In total, Leigh created a number of mechanisms that were serving her successfully and she would establish more. Leigh was continuing to grow as an individual and her rigid nature was slowly beginning to show some flexibility, to the point where she was starting to at least consider, and sometimes implement, alternative courses of action.

**Legal and Ethical Issues**

There were very few legal and ethical issues that I came across treating Leigh. Managing the balance between her being a minor and holding confidentiality was a minor challenge in the beginning. However, her parents were very supportive of her process. I was very lucky that Leigh had a wonderful relationship with her mother, and as long as I let her know that I was going to check in with her mother, she was content. Leigh’s mother and I had a phone conversation every other month, more often if the need arose.

**Outcomes**

Leigh made amazing changes over the last two and a half years. She went from being an extremely anxious and depressed young lady, to an emotionally stable young individual. She created tools to support herself when she was feeling anxious or depressed and she used them. At the end of these two and a half years she rarely brought up her feelings of anxiety and depression. She had progressed from being a very isolated teen who shied away from all contact with other people to showing interest in others and a desire to make connections with others. She began to initiate conversations and made a few school friends. Her obsessions were still prevalent but they were serving a purpose
for her. She was working with them so that they did not inhibit the connections she was making with others. Her self-esteem was an area of concern that we were still hoping to improve as she was beginning to explore her sexual identity further. Leigh was beginning to mature; she had become a beautiful young lady who at the time of this writing is in the middle of puberty. As she grapples with this awkward stage, I know there will be stumbling blocks, but I also feel assured that she will make it through; she now has a support system in place to help her. I am not the only one who has seen amazing changes in Leigh. She sees these changes in herself, and she is quite proud of herself and what she was able to achieve at such a critical time in her life.
CHAPTER 4

LEARNINGS

Key Concept and Major Principles

My client was originally diagnosed with Asperger’s disorder, more commonly referred to as Asperger’s syndrome. As mentioned earlier, due to the evolution of diagnostics, Asperger’s syndrome is in the process of being discontinued in the *DSM-V*. In light of this transition, my client was diagnosed with Autistic disorder, more commonly referred to as ASD a year ago. According to the *DSM-IV-TR*, the primary differences in these two diagnoses are that the people diagnosed with Asperger’s syndrome do not exhibit early learning delays in language or cognition.\(^1\) People who are diagnosed with Asperger’s syndrome and people diagnosed with ASD both display impairments to varied degrees in social interaction, communication, and perspective taking. They also have a tendency toward restricted, repetitive patterns of behavior, special interests, and activities. Some people with these diagnoses also demonstrate sensory integration dysfunction and oftentimes struggle with components of language, including nonliteral language, making inferences, and problem solving.\(^2\) My client, Leigh, demonstrated a wide range of deficits as evidenced by her Triennial review, which can be seen in Appendix 2.

While the *DSM-IV* gives a basis of understanding the challenges Leigh struggled with, I also used the Social Communication Scale developed by Winner to help support treatment with all of my clients including Leigh. According to this scale, Leigh fell under
the category of resistant social communicator. Individuals in this particular category tend to resist the desire to blend in with the group. They are often quite insistent and argumentative. These individuals have a hard time making the connection that their behavior the day before affects how people treat them the next day. Resistant social communicators in general present with anxiety, and often depression, that can manifest as angry outbursts.³

Once I found where Leigh landed on the Social Communication Scale I was able to use our treatment time to develop her ILAUGH profile. The ILAUGH model was developed by Winner as well, and is an acronym for the different areas that contribute to the student’s overall social cognitive strengths and deficits. It also incorporates how these areas affect the students’ day-to-day functioning at home and at school and identifies areas of need.⁴

“"I” stands for initiation of communication or action: this area helps assess the extent to which the student initiates interactions with peers, how successful the student is with these interactions, and whether this is an area of need. It is important also to determine whether or not students advocate for themselves when they need help.⁵

“L” stands for listening with eyes and brain. This pertains to whether the student observes others and looks for social cues. On a basic level, it is important to assess whether the individual makes eye contact and maintains attention in the classroom. On a more advanced level, one assesses whether the student tracks eye gaze and uses that information to pick up important context clues, such as how somebody might be feeling.⁶

“A” stands for abstract and understanding inferences, and this area is concerned with the degree to which the student infers meaning in people’s language and actions.
Similarly, it is important to consider whether the student understands abstract language and the tone it is presented in, which includes idioms, colloquialisms, sarcasm and slang.\(^7\)

“U” stands for understanding perspective. This area is used to assess whether or not the student incorporates other peoples’ perspectives to help them regulate their social relationships. On a basic level, that would include the ability to share space effectively. On a more advanced level, this section is looking for problem-solving skills. For example, one must try to determine whether the student takes into consideration how somebody else might feel in a given situation and integrate that information prior to coming up with a solution.\(^8\)

“G” stands for gestalt processing/understanding the big picture. This section is used to assess whether or not the student can see the bigger picture. It assesses whether students are able to stay on topic in conversation and whether their language is tangential. It covers the degree to which a student looks at a social situation and picks out the important pieces, and the degree to which they are distracted by unimportant details.\(^9\)

“H” represents humor and human relatedness. This area assesses whether the student is able to relate to peers through humor. One must determine whether students can maintain or modify their humor based on their audience.\(^10\) Based on the ILAUGH model, Leigh had many areas of need; however this is a common occurrence for children with ASD. The ILAUGH model is a comprehensive look at the student’s social strengths and deficits, which are then translated into treatment goals.

I also assessed the extent to which Leigh had the ability to understand others states of mind, which is defined in the principle, theory of mind (ToM).\(^11\) This is the ability to infer that other people have thoughts, beliefs, desires, and intentions separate
from one’s own. People who have ToM then use this information to interpret what others’ say, predict what they might do next, and make some sense of their actions and behaviors. This task is extremely difficult for children with social deficits. The concept of ToM is at the root of the ILAUGH model and is pulled apart into many different categories so that clinicians can use the information to pinpoint the areas of need within a diagnostic population that is quite diverse.

Due to being left for nine months in a severely overcrowded orphanage, Leigh struggled to make attachments. Attachment theory was critical to an understanding of Leigh’s challenges. John Bowlby developed his attachment theory based on three primary principles:

a. The primary status and biological function of intimate emotional bonds between individuals, the making and maintaining of which are postulated to be controlled by cybernetic systems situated within the central nervous system, utilizing working models of self and attachment figure in relationship with each other.

b. The powerful influence on a child’s development of the way he was treated by his parents especially his mother, and…

c. That present knowledge of infant and child development requires that a theory of developmental pathways should replace theories that invoke specific phases of development in which it is held a person may become fixated and/or to which he may regress.3

Similar to working with many other children who had ASD, it was important to work with Leigh’s multiplicity. According to Aftab Omar, multiplicity is defined as “to have many selves.”13 Accordingly, the concepts and principles developed by Omer’s work constituted a large contributing factor to my ability to think and work with Leigh. The next layer of work was to identify which lens she was operating from, or, according to Omer, which imaginal structure was activated while affected.14 Leigh, like many
children with ASD, was torn between wanting to conform to social norms to help mitigate her anxiety but also wanted to feel supported for who she was as an individual. Consequently, a large part of the therapeutic process was breaking down the social norms into smaller pieces that then could then be integrated. This process was then followed by helping Leigh feel she embodied her own autonomy. Omer stated that with autonomy comes responsibility and with that responsibility comes freedom.\textsuperscript{14} As of this writing, my client will be 18 in less than three years, and my ultimate goal for her is for her to feel grounded in a sense of autonomy so that she will enter the world with the internal supports and ideally the external supports she needs to be successful.

\textbf{What Happened}

Leigh was my second client. I began seeing her shortly after ending with my first client, with whom I had been working in the classroom for years. I was anxious, as I did not have a relationship with Leigh prior to beginning therapy. She was a new student who was very rigid and presented with a lot of anxiety and depression. Leigh had a hard time taking into account the perspectives of others, which fueled her argument toward not wanting to be social. Moreover, she struggled to understand how she affected the people around her and how those impressions then impacted her interpersonal relationships. At the time, she much preferred to engage in her made up world of her wushu spears.

In our first session, she clearly stated that she had tried multiple therapists and she had not liked any of them. I remember being fascinated by her. She was so strong willed and she was indifferent toward me, which was a fairly new experience for me. Most of the time, students tended to gravitate toward me, but she was not so easily intrigued.
Anytime I had an agenda it was quickly rejected. She needed me to follow her lead. This was also new to me. I always had a plan for every situation I was in, which speaks to one of my primary imaginal structures.

After about two months of listening to how upset and terrible she felt about being unsuccessful, I asked her if she wanted things to change. We talked a lot about what she wanted to change because her ideas of what needed to change and my ideas were different. For example, she felt that the other students needed to be more understanding; she wanted them to just accept her for who she was and, on top of everything, she thought they should want to talk to her about her swords. Leigh did not understand that friendship was a two-way street and that her erratic rants and behaviors made a negative impression on her peers. We started making weekly social goals and anxiety goals, to target the two main areas that were affecting her the most. The social goals started with having her observe her peers, what they liked to do, and what they were interested in. The anxiety goals began with using the 5-point anxiety scale so she could begin to regulate her emotions by and taking more frequent breaks when she her anxiety was high. The focus here was to teach her to leave the situation rather than to react in front of her peers so that she could give them a more positive impression of her. She did not necessarily have the capacity at the time to have a friendship, but she wanted to be accepted by her peers and these goals helped with that desire. Once she was in a place to go a little deeper with her therapy, we started with some imagination-based practices, art therapy, and dream work. Once she felt confident in our relationship, we moved further into exploring her attachments and her progression toward wanting to make connections with others. I discovered that there seems to be a misconception that
children with ASD have attachment difficulties based on the nature of the diagnosis. I found this to be completely untrue. Leigh’s attachment difficulties were due to the nine-month gap of inconsistent contact with a primary caregiver early on. Because Leigh’s resistance to touch was circumstantial and not consistent with sensory integration tactile defensiveness, I believed it was psychosomatic due to the anxiety she experienced around not having a reliable primary caregiver for her first nine months.

When Leigh felt conflicted, she often opted to paint. Her art is highlighted in Appendix 3. Through painting, Leigh was able to show how great her reflective capacity and intuitive nature were. She often would talk about her process and reflect on how the images came to life on the paper. Her artist embodied intuitive clarity but she only was willing to tap into it occasionally. This was highlighted in a painting she did when she was mourning the loss of her horse. She rode the same horse every week for months, and unexpectedly, it had to be put down. She did not have a chance to say goodbye. Her painting, and eventually her narrative on this process, helped her get in touch with her anger and her grief around this loss.

The predominant part of participating in Leigh’s initiatory journey was supporting her in exploring her unique passionate nature and how she has adapted to connect with the world around her. Leigh continued to work on who she was and who she wanted to be throughout the therapeutic process. Helping her to identify the many aspects of her multiplicity was at the root of many of our therapy sessions. Leigh would often choose to dress up as a way of expressing different aspects of her multiplicity. Leigh would create costumes that coincided with the different parts of herself she was "trying on." For example, one day she would dress in an oversized polo shirt and baggy shorts to express
a more masculine look. Another day she would dress up in a homemade dress that she created to mimic the champion horse vaulters. On rare occasions, she would wear her Asian silk outfits. Her fashion style was often indicative of the part of her that she wanted to express to the world that day. She was trying on these different parts of herself to see where she felt the most comfortable. In the end, all she wanted was to be accepted and loved without losing herself in the process.

**My Imaginal Structures**

**How I was Affected**

In looking back over the course of the last three years, I realized that I have always had very conflicting reactions toward Leigh, which were directly related to my own imaginal structures. The therapy sessions progressively become more complex. In the beginning it was crisis management; I had more of an illusion of control over the course of the therapy sessions. She would come in with an upsetting incident with a peer, whether it was being teased or somebody touching her accidentally, and we found ways to support her in managing it. When she felt rejected or anxious, she would often dive into the luminal space of her imaginary world, and I was able to be a supportive passenger through that process. In that space, she would talk about her romantic interludes with her “husband” Jimmy, the wushu spear, and the in-depth relationships of the other 28 spears that made up her imaginary social environment. She was completely consumed by these spears. According to her parents, Leigh had a new obsession every two to three years. When we started therapy and throughout the first two years, she was consumed by her wushu and tai chi swords and spears. In the later part of our therapy
together, her obsession transitioned slowly to the horse equipment. The social goals that we set up each week for the first couple of years grounded the therapy by providing structure outside of her obsessions.

In the last year and a half, our time together for therapy increased, which opened a window for more exploration. Leigh affected me more than any other client I have had so far. I found that I often had resistance to our sessions because my entire world stopped. Every session was like going down a new rabbit hole, and it triggered my need to be in control. Sometimes I understood the progression of what was going on, and other times I felt that her stream of consciousness was so chaotic that I had no idea what she was talking about. However, in the most chaotic of moments, she made meaning out of the chaos. One of the most valuable learnings over the course of the therapeutic relationship was the importance of being present without an agenda. My agendas would cloud the therapeutic process and were often fueled by the concerns of her parents and my feelings of being accountable for the growth that both her parents and her academic community wanted to see in Leigh. When we would have sessions where Leigh would be spiraling around an obsession, I would feel anxious because I sensed that she was stuck. For example, Leigh thought that two people in Germany who she had bought some of her horse equipment from over the Internet were her friends. She had intimate feelings for one of them. Once the transaction had been made, she was devastated by the fact that these individuals did not continue to maintain correspondence with her. She would spend 40 minutes of our session perseverating on this made-up relationship with these people who she believed were more than merely business relationships. She would also make references to anime characters and Grey’s Anatomy characters, expecting me to make the
connections on how they connected to her on a personal level. She created the relationship in her mind. She showed me every email. Although the process was at times frustrating, she eventually began to walk me through her thought process. When I was present for those sessions and not caught up is my own judgment, we often found monumental moments of clarity and she would move on.

Leigh was on a transformative journey toward self-discovery and self-love. Her initiatory process drove the therapy. My biggest struggle in this process was to find a suitable ending point for the purposes of this case study. Leigh’s journey was not complete and although I was at the end of my study, our work together was continuing. Throughout our journey, I was intrigued and inspired by her resistance to compromise her unique nature to conform to societal norms. Part of her process, and a partial focus of the therapy, was to prepare Leigh to be a semi-independent member of society. The way in which her brain works makes it difficult for her to innately understand the social nuances that drive our society. My job has been to support her path toward understanding, self-reflection, and finding a balance between conformity and individuality.

**My Imaginal Structures**

Many of my imaginal structures were present in Leigh’s therapy sessions. My need to control the sessions by having an agenda was a predominant imaginal structure. I wanted to be prepared so that our short amount of time was effective. Our initial individual sessions were only a half hour long, which never felt long enough to get anywhere. However, looking back, that was the amount of time that she could handle.
She needed to attach slowly and be able to build that relationship in short, gradual steps. I do not think she could have handled a 50-minute individual session initially.

My imaginal structure, which needed to control the therapy session works hand-in-hand with my structure to fix things. This structure was fueled by my anxiety and insecurities that revolved around “fixing” Leigh or helping Leigh “fix” her problems. I felt a certain amount of pressure from her teachers and her family to help her to be more socially successful in the classroom. In looking back to that time, Leigh was just trying to get through each moment without coming unglued. My “fix-it” structure was motivated by a wealth of tools that I wanted to use. I eventually realized that the best tools came in the moment when the situation presented itself and the therapeutic tools were created organically.

The Client’s Imaginal Structure

Unlike some of my other clients that truly liked trying out new tools, Leigh’s inclination toward most strategies that were not created collaboratively was “no.” Leigh’s “no” imaginal structure often clashed with my “I have an agenda” imaginal structure, which, in essence, was how both our control-based imaginal structures manifested.

In one of our later sessions roughly three years into the therapy process, Leigh started the session with, “Sometimes I feel like I have multiple personality disorder.” The rest of that session was spent talking about all her different “personalities.” She was a very complex individual who had a lot of reflexive capacity. Although this conversation only scratched the surface of her imaginal structures, it began the process of awareness concerning the complexity of her personality. Leigh often would express her different
“personalities” by dressing up as individuals who embodied certain aspect of those personalities that she admired. On some days she would dress up as famous anime characters or famous horse vaulting champions. These occasions often occurred if she had a presentation in class or when she was going out in the community. Unfortunately, most people had no idea what the context was for her choice in costumes. Although not a socially good choice at times, especially when she was out in public, I believe it helped ground her in expressing herself in different ways.

Many of Leigh’s imaginal structures were developed as coping strategies due to the nine-month attachment deprivation. She had a very hard time trusting anybody, and even after years of working with her, we went through periods of time where she tested the attachment to see if I was going to reject or abandon her. This imaginal structure was very young. In one incident, I had missed a session due to illness and the message did not get communicated to Leigh. When I returned to work and approached her she was very upset and stated, “I am going to tell my Mom, that you missed our session.” Her response to my absence revealed a very young child structure that came out when she was feeling vulnerable.

Leigh’s most common imaginal structure was her “I need to be in control to feel safe” structure. She was the most successful when her day was structured and she was focused on academics. When there was too much free time it left a lot of room for unexpected social interactions, which triggered her anxiety. When her anxiety was escalated, this control structure presented itself, and she often acted out. Leigh’s low-level manifestation of control structure was often refusing to try new things, isolating herself, or refusing to talk about topics that might have created uncomfortable feelings,
such as transitioning to adulthood or sex education. For Leigh, the idea of graduating high school was terrifying and it became difficult for her to manage that anxiety. Leigh would talk about it in the therapy sessions if I approached it as a requirement for her classes. She would prefer to talk about it with me than the transition specialist, but she still often needed a lot of breaks. When Leigh’s dad was very sick, Leigh felt completely out of control. The high level presentation of this imaginal structure was to damage his wushu weapons and try to bend them around her body.

Leigh had an imaginal structure that did not allow her to acknowledge that she felt anger toward me. She denied having feelings of anger toward me, even though we had many evocative conversations that led her to be visibly frustrated with me. The only way she felt comfortable expressing her anger at me was in dream form. She would bring in dreams which depicted situations in which she was frustrated with me. For example, I was asked by her school team and her parents to address her erratic choice in clothing. I delicately made a point that what she wore made her diagnosable. I told her that people have thoughts, such as, “What’s up with that person?” This of course put Leigh on the defensive, but it evoked a needed conversation. In our next session, she brought in the following dream: “I had a dream that I slapped you across the face. You were so shocked.” When we analyzed the dream, she was able to express that she was angry with me in the dream. We had many discussions about what it meant to be angry with someone and know that they would not disappear because of the anger. This “I can’t show people that I am angry because they will reject me” structure that Leigh developed was because she was so afraid of being abandoned by the people she felt closest to.
New Learnings About My Imaginal Structures

Through this process I have learned that having an agenda for therapy is not always what the client needs in the moment. I had an agenda because it made me feel like I had some sense of control of the therapy session, and it made me feel like I was doing my job. In many cases, my agenda was inhibiting me from being present in the moment, which restricted my ability to meet my client in a constructive place.

There was a period of time where I was seeing Leigh after school and our sessions inhibited me from being part of a clinical meeting that I felt I needed to be a part of. In the mind of the clinic director it was more important for me to see Leigh and generate revenue than to be at the clinical meetings every other week. As a result, our therapy suffered. I was not present mentally, and on some level Leigh knew I was mentally gone because she would spiral further into her obsessions. I could not follow her so she would continue to perseverate on the same obsession. I only realized this pattern after looking over the notes. I switched our sessions to a time that did not conflict with my meetings, and we did not get stuck like that again. I realized that the therapy was stagnating because I was not mentally present and she was dissociating to a place where she would rather be.

In hindsight, Leigh’s growing ability to manage her anxiety provided a vehicle for me to work on managing my own anxiety. Leigh’s progression toward attachment allowed her to feel safe in the therapy setting and it allowed me to put my agendas and my “fix it” imaginal structures aside so that I could be present for her in the moment.
Primary Myth

The primary myth for this case is best illustrated in Jean Houston’s exploration of the epic self-love story of Psyche and Eros. According to Houston, “The story of Psyche and Eros gives us a travail of a younger, more unconscious love, and describes the labors the soul performs in its harrowing path to consciousness—the path of gaining inner allies and growing resources until one is ready for the Divine Beloved within.” 15 This initiatory tale depicts the soul’s transformation from a wounded child to the embodied feminine spirit.

Psyche was a beauty so great that people came from all over to admire her; this left her feeling disconnected from others, as she was put on display for the world to watch from a distance. Houston wrote, “Although everyone adores Psyche, no one will marry her because there is a quality of ‘too muchness’ about her. . .She grows more and more lonely, coming to hate the loveliness that charmed so many nations.” 16 In similar fashion, Leigh was unable to make connections to the world around her. She was watched and put on display but was unable to make connections with her peers due to the way in which she moved through the world. Her peers did not understand her, and the adults around her let her be who she wanted to be, but her way of being isolated her from her peer group, and ultimately left her feeling lonely. She was too much. Because ASD is primarily a social learning disability, Leigh did not understand how to make connections to others. Her ability to relate was compromised, which was often difficult for others to understand because on the outside she presented as a neurotypical child. This difference, the social learning disability, isolated her. She did not play the way others played. She did not talk about the same things as other little girls, and over the years the social divide
became overwhelming. Then Leigh created her own environment where she would not be rejected, and she began to retreat entirely.

Returning to the myth, nobody wanted to marry Psyche. After quite a long time of being passed over for a husband, Psyche’s father became impatient. Psyche’s father went to the oracle of Apollo and asked him to send Psyche a husband. Psyche’s father returned with horrible news: she was to dress in mourning and be left on a mountaintop to marry a terrible monster. Unknown to Psyche, this punishment was because of Aphrodite’s jealousy. Psyche was so beautiful that people were forgetting to worship Aphrodite, which made Aphrodite angry. She convinced her son Eros to make Psyche fall in love with the most vile creature that he could find. Unfortunately for Aphrodite, Eros took one look at Psyche and fell madly in love with her. He took her to a magical place where they could be together.17 Houston writes:

> It is an unpeopled place, yet everything is attended to by invisible servants. Psyche is forbidden to see her lover; she must know him only in the dark. . .Thus Eros, as the intermediary between worlds, must create the world-in-between, providing sacred time and space to do the work of love and transformation. He has created a chrysalis from which a butterfly may emerge.18

This is the point in the story where Leigh and I began therapy. She had been rejected and abandoned. She had given up on being present. Leigh created a magical “unpeopled” place. She had a lover who, similar to Eros, could only provide a fraction of what someone truly needs in a balanced, loving relationship. Leigh created someone to love her and accept her on her own terms, and for a while this worked for her. That someone was her personified spear “Jimmy.” It protected and supported her fragile psyche that had taken so much rejection. For Leigh, rejection and abandonment started with her birth mother and continued throughout her childhood by her peers.
Houston goes on to explain, “Without Psyche having been in this magical no-
place for a while, she would never have had the erotic quickening by love to enable her to
go out and do the impossible, awesome, and awful tasks to which she is later assigned.”

In an honest un-sugar-coated world, this might be akin to saying, “I am going to my
imaginal place where I get nurtured, seeded, and fed so that I can then go out and do my
work in the world.” Leigh needed this same place where she was nurtured, seeded, and
fed so that when she was ready she could return to the world and brave its many
obstacles. For both Leigh and Psyche, this magical no-place provided love and
acceptance for a short, but blissful, amount of time. Similar to Psyche, if Leigh had
chosen to stay in her magical place where she was married to a wushu spear, it would
have led to much more severe mental health issues and she would not have grown into
the amazing individual that she is today.

Psyche became lonely. Against the recommendation of her lover, she invited her
sisters to come spend time with her. Her sisters were so jealous that they convinced her to
light a lamp and slay her monstrous lover. Bringing light to a situation that is otherwise
set in the dark cultivates change. Although change is scary and often undesired, it is part
of the transformative process and thus an integral part of the development of the soul.

Leigh’s lamp illuminated the realization that she could not live in her magical
world forever and that the outside world would not accept her magical world. Like
Psyche, she could not continue in the darkness. When Leigh moved to the high school,
she made a commitment to herself to contain her magical place at home and in the
therapy setting. It was too precious a place to be subjected to the ridicule of others. With
this change there was a loss. There was longing for the integration of her magical world and her real world.

As Psyche approached Eros in the night with a lamp and unsheathed knife she saw that he was actually a handsome young man and not a monster at all. The knife is a poignant symbol in the Psyche and Eros myth. In an excerpt from an article written by Elizabeth Nelson, that focuses solely on the symbolism of Psyche’s knife, she states:

“Those who are experienced in battle know that any naked blade is a threat, which is why opponents attend with particular solemnity to the unsheathing of their weapons. It is a ritual that signals the beginning of the conflict, no matter what ensues or how the conflict is resolved.”

At this point in the myth Psyche was on the precipice of change, and deep down she knew that there was a strong likelihood that her life would change forever. Nelson goes on to explain, “The idea of Psyche wielding the knife disturbs the assumption that the soul is tender and vulnerable without a shred of ruthlessness, autonomy, or purpose. But as Eros and Psyche dramatizes, the soul obeys its own inexorable drive toward wholeness with or without the ego’s consent.”

In reference to the symbolism of the knife, I find it interesting that my client also chose a weapon. Similar to a knife, Leigh’s partner was a wushu spear. It stands to reason that this masculine symbol that encompassed her magical environment was part of her process toward integrating the masculine and feminine. On some level, perhaps, she felt armed and protected against the outside world when she was with her wushu spears. In her magical world, these weapons represented love, connection, and safety from a world that in her mind did not provide a place for her.
Returning to the myth, Eros woke up to burning oil dripping upon his body as his lover was breaking the cardinal rule. She was a mere mortal and therefore not allowed to look upon a god. Eros flew out the window, leaving a love-stricken Psyche alone and devastated. She searched and searched for her lost love Eros. She tirelessly asked the gods for help, but the gods refused to help Psyche for fear of incurring the wrath of Aphrodite. Psyche even attempted to drown herself in the stream, and the stream refused to support her and tossed her back onto the shore.23

During her first summer, Leigh found herself in a similar circumstance. She had separation anxiety and suicidal thoughts on a couple of occasions when she was forced to go on a plane and was unable to bring her spears. She was devastated by the idea that she would be alone. Eventually, some accommodations were made that helped those transitions. For Leigh, the idea of being so far away from her safe place was acutely distressing. Often people with ASD struggle with changes in their routine; Leigh would become unraveled.

In the myth, according to Houston, “The four tasks that Aphrodite will set before the young woman serve as a series of initiations leading to deepening structures of consciousness.”24 The first overwhelming task that was assigned to Psyche was to sort a huge pile of seeds. She became so overwhelmed by the task that she gave up, which provided an opportunity for support from another source. The army ants, one by one, sorted the seeds in the requested amount of time.25 Houston states, “This accomplishment reminds us of our own innate capacity to select, sift, correlate, and evaluate.”26 Leigh’s first big task after committing to separating from her magical world at school was to begin selecting peers that she felt she could possibly have something in
common with. This was a daunting task, and she had a lot of resistance to it. Her initial job was to observe. In the therapy sessions, we set goals for her to observe particular people in her class that she had positive or neutral thoughts about. Her job was to find out, what did these teenagers do? She was to think about what she found interesting about the things that they did. She was to ask herself whether there was anybody in the class who she could see herself getting to know. Her task was to build a hypothetical bridge between her and a peer. After some soul-searching, the first bridge she built was with anime, which is a type Japanese television animation. She began researching anime and bought books on anime so that she would have something to talk about with a peer that she seemed intrigued by. Over the course of a year, she cultivated a friendship with a young man in her class. They would talk about anime and they liked to dance during their down time at school. Although they were an unlikely pair, she had created a bridge to the real world.

In the myth, Aphrodite was astonished and furious that Psyche accomplished the first challenge. The first challenge was not enough for Aphrodite, so Psyche was given a second challenge to prove that she was worthy. In the second challenge, Psyche was to collect golden fleece from dangerous “frenzied” sheep who killed anyone who crossed their path. In Psyche’s utter despair she received help from a singing reed. She was advised to wait until nightfall when the sheep were asleep so that she could collect the golden fleece that had been left on the bushes from the sheep who had brushed against them throughout the day. According to Houston, “The reed rising from the waters of the depth represents the wisdom of growth, with its sense of appropriate timing. . . . The
reeded self knows that everything is possible, but that it is possible by the practice of paradox, intuitive knowing, and indirection.” 29

Leigh’s second challenge was to expand her access to social opportunities. She had recently stopped her wushu practice and needed another outlet through which to express herself. She liked to dance but she could not handle the intimacy dancing with other people demanded. She liked to sew, but she did not have the ego strength to accept feedback from someone she did not trust. After months of searching, she decided to try therapeutic horseback riding. This challenge was an opportunity for her to indirectly be in contact with others while being intimately connected to a much safer soul, the horse. For children with social learning challenges, it is often easier to connect with animals because they provide unconditional acceptance. She fell in love with her horse, and through this love she began to work on making connections with others. Similar to Psyche, in the myth she was able to intuitively meet this challenge by approaching it indirectly. Leigh felt safe with horses, and when she was there with them she had her safety net to support her social growth.

Psyche returned to Aphrodite with the golden fleece in hand. Aphrodite, frustrated by the continued success of this mortal being, gave Psyche a third challenge to obtain the “waters of life.” Psyche was given a crystal vial, and her task was to fill it with the water that fed the current of the underworld. This stream was surrounded by dangerous peaks, which were nearly impossible to climb and were guarded by dragons.” 30 These dragons represent the recurrent and universal mythic demand that the young girl face the dragon. Houston continues, “They are the keepers of the threshold, chthonic guardians of the secrets of life who stop you if you are unprepared.” 31 For Leigh, this task was
represented when she confronted our attachment. When I was out sick, I missed our session, and when she was not made aware of my absence, she was furious. She could have just stuffed her feelings of rejection and abandonment, but she did not. She felt strong enough in our relationship that she could get upset with me and know that I was not going to leave her. This was a huge threshold that she crossed in our relationship, and we worked with these feelings for many weeks. This incident would occasionally come up throughout our work together, although it was reflected upon later as a huge milestone in her personal growth. She had confronted her feelings of abandonment, which was her biggest dragon. For Psyche, Zeus sent an eagle to help her accomplish her task. Houston elaborates, “If this myth teaches us nothing else, it shows that help is always present.”

Leigh also came to realize this. She realized that regardless of how frustrating some of our interactions have been for her, that I was there for her as a trusted helper and confidante. For a long time I truly believed Leigh felt she was on her own and that there was nobody out there to help her recreate a more positive social experience. That has since changed.

At the time of this writing, Leigh has continued to work on this part of the myth. She successfully completed three challenges and is on the precipice of using the tools that she has integrated to meet her next challenge. At this point in the myth, Psyche was “moving more and more toward the integration of the masculine and feminine powers and the understanding within her.” Psyche’s last and final challenge was to take a journey into the underworld and acquire a jar of beauty ointment from Persephone. She was given direct instructions on how to complete this task. She has to avoid many distractions and remain disciplined on her journey. Leigh’s challenges will extend over
the course of the next three years. She must remain disciplined and complete high school. She needs to not shy away from the discomforts of change and explore what options she will have as a young adult. Through all this, Leigh must continue on her path toward self-love, autonomy, and acceptance.

**Personal and Professional Development**

It has been extremely rewarding to work with my client as long as I have. To see her personal growth over such a long span of time puts in perspective how much an individual can change. As a therapist, I have grown significantly due to our time together. Through personal reflection, one of the most poignant lessons I have learned is how much my energy and presence affects the space. As I mentioned, there was a time when our sessions were conflicting with an important meeting on a regular basis and I was not mentally present for those sessions. Looking over the notes, it became obvious to me how little we accomplished during that short time in those sessions. She would often spiral down into her own obsessions and we would spend weeks and weeks going over the same material because I was not fully present. The more she spiraled down, the more irritated I would become because I felt I was wasting my time. In essence, I was not giving her the attention she needed to feel safe enough to move through her process. Once I changed the time and day that I saw her, we got back on track. It made a world of difference.

As a therapist, I learned to let go of my agenda. Leigh brought into the space what she needed to bring and my job was to create a safe environment where she could grow on her terms. There have been times where I have had to set certain boundaries around
her behavior, to help support her social growth. For example, as a prerequisite for moving her to the high school as an eighth grader, the expectation was that she did not talk about her personified spears. She could talk about her participation in her wushu practice but not that she was married to a spear. She had already severely hindered her reputation in the middle school and had been teased regularly by her peers about her relationship with her spear. This boundary was set to help her be more socially successful. It was very difficult for her at first, but in the end she was more successful socially and was able to make connections where she had been unable to in the past.

Ultimately, the aspect that supported my professional development the most was her willingness to try all different kinds of therapeutic techniques. We tried all different types of imagination-based therapy including art therapy, narrative therapy, dream therapy, imagination based triads, and social cognitive behavioral therapy. She was quite open to what was present in the room and her willingness to participate as well as give me feedback was an invaluable gift, especially as I was a new therapist.

**Applying Imaginal Approaches to Psychotherapy**

There has not been a lot of research that I have found on applying imaginal approaches in therapy with children on the Autism spectrum. However, using imaginal approaches offered an invaluable strategy to support the therapeutic process when addressing anxiety and depression with many of my clients, including Leigh. Because ASD is a disorder that has varied degrees of severity, there is a certain amount of self-reflective capacity necessary to work with imaginal approaches. With support, she was able to benefit from a variety of different approaches. Leigh was in the process of
cultivating an inner support system where she was learning to love who she was as an individual. She was also working on finding a balance between the social obstacles that are inherent with ASD and finding her individuality.

These imaginal approaches provided a gateway to cultivating attachment. In the therapy setting, Leigh was able to express her individuality and be seen. She also knew that what we did in the therapy session was unique. I would often introduce a new technique with the question, “Are you up for exploring something new?” She gravitated to this because she knew that it was something new for both of us and therefore it made the process special. Overall, these imaginal approaches have been at the core of my exploring the passionate nature of this individual soul and therefore have been precious to the process.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

The clinical case study process has been invaluable to my growth as a professional. Although the case study was based on therapy sessions over the course of a two and half year span of time, the therapeutic process continued on. As an intern therapist, I felt I had been blessed to have had so much time to explore with my client her challenges and desires. In today’s society many people commit to therapy for short periods of time, and I was lucky enough to have a client whose family was invested in our process. Occasionally, my client and I would reflect back over the course of her treatment journey and it was amazing to see how many capacities she had cultivated and how many obstacles she had overcome; these were remarkable even in a two and a half year period. To see that progression and then to document the experience was an amazing journey for me.

Through the writing process, I was able to reflect upon the journey in such depth that I was finally able to see how much this work with Leigh influenced who I am as a therapist. I know that cases like Leigh’s are rare, not only because of the intense content of our journey, but also the length of time that has been allotted for this journey. Through the writing process, I was able to reflect upon moments of success, where my client was able to stand at an initiatory juncture and mindfully engage in the process. Conversely, I was also able to see the many places where I missed my client or was too
caught up in my imaginal structures to meet her where she needed me to be. However, I was also able to repair those moments and that often made the therapeutic bond stronger.

During the therapy process, I was able to try many types of strategies, although not all of them were met with success. Subsequently, she and I developed an eclectic tool-box of strategies that worked not only for her but for many of my clients. Because children with ASD often have a hard time creating pictures in their mind, we used many visual strategies to help support the therapy process.

On a personal level, the clinical case study process has tested my ability to stay committed and focused on what seemed to be a never-ending process. The extent of effort and time that has been put forth for this process to be successful has helped me cultivate a strong sense of determination and ultimately an astonishing sense of accomplishment. I have always struggled with writing and have a multiplicity of inner critics, which made this process even more difficult. This clinical case study has helped me develop a more realistic understanding of my writing ability. The process of completing the Literature Review expanded my ability to synthesize an extensive amount of information, and with that information I was able see the places where the research on ASD could be further expanded. The Progression of Treatment required that I take a closer look at all of the steps that had been taken throughout the therapeutic process. It was difficult to pick and choose from so many memorable moments. The process of completing the Learnings chapter provided an opportunity to explore the Progression of Treatment through a mythic lens, and this, while challenging, helped validate the journey that my client and I took.
Lastly, this process has reinforced my decision to become a therapist. I truly enjoy working with children, especially children on the ASD. In Leigh’s case, there were many factors that contributed and informed the therapeutic process outside of the social learning challenges that are associated with ASD. With ASD becoming a more common diagnosis, I am excited to continue researching and developing new therapeutic techniques that support the social learning process.

**Impact of the Learnings on My Understanding of the Topic**

The learnings that I discovered throughout the clinical case process have changed my understanding of the topic in a number of different ways. Initially, I understood my client solely through the social learning lens. My initial thought was that her anxiety and depression were exclusively due to her inability to connect socially with others. One of my biggest learnings was how to differentiate between the two factors that made it difficult to form relationships: her impaired social abilities due to her ASD and her attachment difficulties.

I initially read a significant amount of literature by Winner, which addressed the importance of breaking down social skills into clear and concise steps. Winner provided a number of strategies that helped to break down the steps of cultivating a friendship. She provided concrete, practical tools to help identify what to look for and how to make the necessary social connections.¹ Leigh needed so much more than this initial social understanding. As we dove further into the process, I began to do more research on attachment. In, *A Secure Base*, Bowlby writes about five therapeutic tasks that support the process of attachment. In looking back over the progression of treatment and the
learning chapters, I can see how invaluable the first two tasks were to the therapy process. At the end of the time frame of this study, the remaining three tasks were yet to come. The first task was to provide a secure base in the therapy setting from which Leigh could explore her struggles. Leigh needed a safe place to feel accepted. She had mentioned that previous therapists had made her play. According to her mother, Leigh was never interested in typical play and had no desire to make connections through play. Leigh’s resistance of cooperative play was analogous to most of the literature surrounding working with children on the Autism spectrum. Moreover, this reinforced my secondary learning, which was the importance of following the lead of client, even if it was contrary to research supporting the diagnosis.

Bowlby’s second step of, cultivating attachment, as applied to Leigh, was to assist her in exploring the ways in which she chose to engage in relationships with significant figures in her life. The next step was to explore what the social, emotional, and behavioral expectations were around those relationships. In Leigh’s sessions, we often talked about her relationship to her mother and father as well as her relationship to her personified spears. The common link between all of these relationships was safety. The relationships were safe because she felt emotionally met and she relied heavily on them. Her initial forays into forming relationships with real friends were not always successful. When Leigh made her first peer friendship after a lot of work on her part, she then became quite controlling. This person was so precious to her that she became overbearing and did not take into consideration how her actions affected the relationship. Leigh’s social learning deficits included struggles with understanding the perspectives of others; these, combined with her difficulties around attachment, in addition to the social learning
challenges of her new friend, posed a number of obstacles in their friendship. Although the relationship did not last, it was crucial in her development toward making connections outside her family unit.

Although Leigh’s needs were not sufficiently met in the first nine months, her adoptive parents were wonderfully supportive and very patient about her progress. Because Leigh was an only child and had spent most of her childhood choosing to engage with adults, she had less of a desire to make connections with her peers. The adults in her life were accepting and tolerant, if not overindulgent, of her social idiosyncrasies. This can be seen in her family allowing her to wear her home-made costumes out to dinner or allowing her to bring her “husband” to her synagogue. When parenting children with social challenges, there is a fine line between meeting these children where need to be met and giving them feedback to help them to be mindful of the impression they are making. More often than not, most children after a certain age take feedback better from trusted adults and peers rather than their parents.

Overall, my initial understanding of my client has changed significantly since the exploration of the Learnings chapter. The process of truly reflecting on what was present in the therapy encounter and then exploring the different wounds that built the foundation with which Leigh moved through the world was an amazing journey.

**Mythic Implications of the Learnings**

Both ritualizing and mythologizing were important approaches to understanding the depth of the therapeutic process with Leigh. Aftab Omer expressed that, “Ritualizing is the process where the soul promotes experience and mythologizing is the process by
which the soul makes meaning.” Early on in my work with Leigh, I asked her and her family to watch the movie, *Lars and The Real Girl*. The movie was about a socially awkward young man named Lars who was going through a psychologically very difficult time and decided to buy an anatomically correct blow-up doll. He named her Bianca and created a life with her in his small town. At the request of Lar’s psychologist, Lar’s brother and sister-in-law accepted her into their family in the hopes of helping Lars’ better manage his psychological crisis. In the end, after much self-discovery and support by the community, in addition to meeting a real girl he was interested in, Lars was ready to let Bianca go and establish more healthy relationships with people around him. This was our first story from which we drew parallels to approach Leigh’s circumstances and challenges. Leigh and I had many discussions about how this story related to her obsession with her personified spear “Jimmy.” In the film, Lars was accepted in the community around him, but he was also pitied. Leigh needed to understand that she was in charge of the impression she was making on her peers. At this point in time, she needed to make a decision about what kinds of thoughts she wanted people to have about her. Part of this process for her was working on taking accountability for her actions and learning to move through the world with mindfulness and intention. Through this process, Leigh made the decision to be more accountable for her actions; however, the goal of being more mindful brought a whole slew of other challenges, including the emergence of a more prominent inner critic.

As I continued working with Leigh, I was drawn to the myths about Artemis. When I thought about Leigh, I saw her as a lone warrior, content to be in the woods alone with her nymphs and woodland animals. Social interactions made her so anxious that she
preferred to be with her spears, away from the world. Leigh started our process as Artemis and then she changed her myth. There began to be more complexity to her story than simply her being a lone warrior. Leigh, the lone warrior, was on an initiatory path with many challenges to overcome, which then diverted the myth from Artemis to Psyche and Eros. The theme of initiation contained in the myth of Psyche and Eros became more central to her transformation.

I chose the myth of Psyche and Eros to help make meaning of the therapeutic process with Leigh. Leigh was on a transformational journey to find self-love. Both Leigh and Psyche conquered a number of obstacles along their initiatory path. They were given tasks to support their transformations and they accepted them. Similar to Psyche, Leigh felt isolated. Leigh’s isolation stemmed from her social anxiety, and her attachment struggles. I used this myth to take a deeper look at Leigh’s phenomenal journey toward engaging in the world around her.

Both of these stories were integral parts of the learning process. In reflecting upon these stories and how they played out in the therapy sessions, I was able to more fully understand the complexity of my client. Not only was I able to make meaning with some of these stories, so was she. Being a teenager is difficult enough, but it can be excruciating to have to endure this process while not understanding the social nuances needed to support this transition into adulthood.

**Significance of the Learnings**

The most significant learning that came from this process was the understanding that imagination-based practices are successful with the Autism population. An eclectic
use of imagination-based strategies, in addition to the more traditional methods, such as social cognitive therapy and cognitive behavioral therapies, were important to the therapeutic process with Leigh. I truly believe that if I had only used social cognitive therapy and cognitive behavioral therapy with Leigh, we would not have built the container necessary to work with her attachment struggles or her social anxiety. Leigh’s expression through art, voice dialogue strategies, narratives, and dreams set the stage for a deeper, more expressive connection. My learnings supported the belief that children with ASD can cultivate capacities through transformative practices.

The Application of Imaginal Psychology to Psychotherapy

In reflecting upon this process through an imaginal lens, the crux of Leigh’s struggles were related to her difficulty in effectively engaging the peer principle. Aftab Omer developed the theory of four modes of experiencing, which include the mother principle, the father principle, the peer principle, and the collaboration and integration of all three. The peer principle was founded on the ability to create intimate connections with others. When intimate connections are made, then the peer within us is capable of trivializing differences with the common goal of finding community. This posed the question of how do people with Autism cultivate these capacities? The social deficits inherently associated with ASD made true intimacy on a collaborative level significantly more difficult for Leigh, as it does for many of these individuals. Applying imaginal psychology in psychotherapy with this population would be invaluable to the sustainability of communities that support these individuals.
There are many ways in which imaginal psychology can be put into practice with this population. Providing that the individual has some reflective capacity, it is important to integrate experiences that transform. Using forms that include the inner friend and the inner critic were essential to the accountability process in Leigh’s therapy. Once Leigh truly embraced this idea of wanting to be social, we created a form that allowed her to express the two conflicting aspects of her nature. On one hand she would want to be free to wear her horse equipment to school and on the other hand she was worried that people would think poorly of her. This form created an opportunity for her to express herself and problem-solve a situation that was fueled by conflicting impulses.

The application of imaginal psychology in psychotherapy ultimately provides an opportunity to explore the deeper recesses of the human experience. It provides an outlet for clients to express and, if necessary, recreate their story with a sense of purpose and conviction. Through the imagination-based practices, clients, including those who struggle with Autism, can be successful in cultivating the necessary capacities to live a more soulful life.

**Bridging Imaginal Psychology**

Imagination-based practices are common when working with children with Autism. Children have an innate desire to not only express but to make meaning of their experiences. Most of the bridging that is necessary in working with this population is with the parents. Hopefully, as research continues to evolve, there will be more studies done on children with Autism and imaginal psychology. In my experience, the parents that I have worked with want to see their child find some relief from their anxiety.
Imaginal psychology provides the structure to build the capacities necessary to manage their anxiety. Imaginal psychology includes an eclectic mixture of theories and tools, not all of which are designed for working with children; however, many of them can be adapted to support the therapeutic process of children and adolescents. Imaginal psychology focuses on the use of the imagination to make meaning; therefore techniques that can be incorporated include art, dream work, narrative, expression, drama, and play, which are all essential to cultivating experience.

**Areas for future Research**

There has been a significant amount of research on Autism and developing strategies to support the social learning process. There have also been a number of books developed with strategies to help with social anxiety and anger. Autism has essentially become an epidemic, and researchers have yet to determine its etiology. However, more and more studies are being conducted to support the social and emotional development of these individuals. There are a number of areas that would be interesting to research.

One fruitful direction might be to research the ability to integrate shame in relationship to Winner’s social communication profile. Winner’s profile currently has eight different levels, including severely challenged social communicator, challenged social communicator, emerging social communicator, resistant social communicator, nuance challenged social communicator, weak interactive social communicator, socially anxious social communicator, and the neurotypical social communicator. According to Aftab Omer, for shame to become transmuted into autonomy, rituals of accountability are necessary. I am curious about where on the social communication profile shame could
be added and at what level children are capable of integrating shame. It would be interesting to identify the origins of the reflective capacities necessary to integrate shame. The process of accountability needs some level of perspective-taking and understanding the affect of shame also takes a level of social understanding. Ultimately, the question remains, does shame manifest in children with Autism and at what level of social function is the ability to transmute shame into autonomy possible?

I am also interested in researching empathy and how empathy manifests in children with ASD. To empathize with another being, it is necessary to first integrate the information contained in a given situation and then allow oneself to be affected by someone else’s experience by relating it to one’s own. This task requires a high level of perspective-taking. In some ways, empathy is even more difficult because people who are able to empathize do not directly connect with another individual through experience, but have the capacity to imagine how they might feel if subjected to that experience. It is easier to appear to be empathizing with an experience then to actually go through the emotional experience to make that intimate connection. I think it would be a worthwhile study to explore how empathy would manifest on the social communication profile. Research might be able to answer whether empathy became evident at a particular level or whether empathy is able to be assessed on a case-by-case basis. Research might reveal whether or not it can be cultivated through experience in cases where it is not innately demonstrated.

I would also like to look further into the relationship between Autism, attachment and sensory dysfunction. There is a particular group of children often on the Autism spectrum who early on in life struggle to regulate their sensory input. This often
manifests in the inability of the mother to soothe her infant. These children are often averse to touch, which makes for a very stressful home environment. I am curious to know how this affects the bonding process with the mother and therefore affects attachment.

Autism spectrum disorder has been the focal point of many new research studies because it so prominent in our culture. Over the next decade, this diagnosis will be teased apart into clear-cut categories based on social functioning and behavior, which will then fall more specifically under the umbrella of ASD. With these more defined categories, new therapeutic techniques will be developed to support the social and emotional growth of these children. My hope is that imaginal psychology will be incorporated into some of these research studies as a basis for psychotherapy.
APPENDIX 1

INFORMED CONSENT FORM

To the Parents of __________________:

Your child, ______________, is invited to be the Subject of the Clinical Case Study I am writing, on Asperger’s Syndrome. The study’s purpose is to better understand the therapeutic process used in working with individuals with Asperger’s Syndrome in relationship to attachment and social cognition.

For the protection of you and your child’s privacy, all of my notes will be kept confidential and your identities will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, may however be useful to people who work with, live with, or have been diagnosed with Asperger’s Syndrome.

The Clinical Case Study does not directly require your own or your child’s involvement. However, it is possible that you and/or your child simply knowing that she is a subject of the study could affect her in ways which could potentially distract her from the primary focus in the therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to allow ______________ to be the subject of this Clinical Case study, you may withdraw your consent and discontinue you and your child’s participation at any time and for any reason. Please note as well that I may need to terminate your child being the subject of the study at any point and for any reason. I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or may contact the Academic Services Coordinator at Meridian University, 47 Sixth Street, Petaluma, Ca 94952, telephone: (707) 765-1836.

I, ____________________________, and

I, ____________________________, understand and consent to let my child be the subject of the Clinical Case Study written by Beth Curtin, on the topic of Asperger’s Syndrome. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study, which will also refer to other significant people in my child’s life, particularly myself, as her parent. I have had this study explained to me by Beth Curtin. Any questions of mine about the Clinical Case Study have been answered, and I have received a copy
of the Informed Consent form. The participation of my daughter is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my child’s clinical case history, as well as for disclosure of all other information about her including, but not limited to, information which may be considered private or confidential. I understand that Beth Curtin will not disclose my child’s name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Beth Curtin and Meridian University (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use, and disclosure of my clinical case history and all the information concerning me including, but not limited to information which may be considered private and confidential. Meridian University assumes no responsibility for any psychological injury that may result from this study. The Terms and provisions of this consent shall be binding upon heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this_______ day of __________,20_____, at
______________________.
______________________.

By:________________________________
______________________________

Parent’s Signature

______________________________

Parent’s Signature

Print (both) Parent’s name legibly and clearly on this line

Thank-you for your time and consideration,
Beth E. C. Curtin, MA
Social Cognition Specialist/ Anger and Anxiety Management
Psy. D Student at Meridian University

Please feel free to contact me with any questions at
(707) 546-7834
APPENDIX 2

SOCIAL COGNITION ASSESSMENT

Student’s Name: Leigh XXX
Date of Birth: 08/5/1995
Date of Report: 5/10/2010
Age at Evaluation: 14 years 7 months
Home District/School: XXX/XXX
Dates of Evaluation: 3/15/10, 3/18/10, 3/29/10,
Grade/Teacher: 8th / XXX High School
Evaluater: Beth E. C. Curtin, MA,
Social Cognition Specialist

Dear Parent/Guardian: The following summarizes the assessments conducted by the above named specialist with your son/daughter. Included in this report is information that may assist in making appropriate educational recommendations. The components of this report meet the requirements of the Educational Code, Section 56327. The Individualized Education Program (IEP) meeting is held to discuss the assessment results; however, if you should have questions about this report, do not hesitate to contact the evaluator. This report is made a part of your child’s school records, and you may request a copy through the school’s administrator.

REASON FOR REFERRAL: This assessment was completed as a part of Leigh’s Triennial review to assist the IEP team in updating present levels of performance and determining areas of need.

BACKGROUND INFORMATION: Leigh is a 14 year old female who is eligible for special education services with a primary disability of Autism Spectrum Disorder. She has been attending the XXX School since August 25, 2008.

Current Social Goals and Progress toward them:
Goal #5 - By 4/2010, in the school setting, Leigh will note non-verbal body language and infer if her listening partner is interested or not interested and modify her behavior accordingly in 3 opportunities in a week as measured by data collection and staff observation. Moderate Progress: In the therapy setting she is able to complete this task with a moderate amount of prompting and is able to notice more obvious clues such as turning away from her mid conversation or looking overtly bored. According to the data presented by the high school she is successfully completing this task on average once a week.

Goal #6- By 4/2010, in the therapy setting, when given situations that Leigh has not directly experienced, she will use her imagination to determine how that person would likely feel and act, and what they might say in that particular situation in 4/5 opportunities. Goal Met: in simple situations without the use of visuals she was able to meet this goal in 80% of opportunities.
ASSESSMENT RESULTS:

Assessments Administered:
Leigh’s social cognition skills were assessed for this report through informal interaction, participation in informal assessment tasks, discussions with teachers and observation with his peers throughout the school day. The following formal tests were utilized:

- Test of Problem Solving 2(TOPS2-A)-Adolescent
- Social Language Development Test- Adolescent

Testing Behavior: Leigh was assessed over 4 sessions. She was cooperative and compliant throughout all of the testing sessions. Her maximum testing duration was between 35-50 minutes.

Formal Testing:
The TOPS2-A is standardized for students 12 years through 17 years 11 months. The TOPS2-A evaluates the critical thinking skills of Making Inferences, Determining Solutions, Interpreting Perspectives, Problem Solving, and transferring insights. The TOPS2-A requires the student to listen and read along with a passage and then answer some questions.

<table>
<thead>
<tr>
<th>Age Equivalency</th>
<th>Making Inferences</th>
<th>Determining Solutions</th>
<th>Problem Solving</th>
<th>Interpreting Perspectives</th>
<th>Transferring Insights</th>
<th>Total Test</th>
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<tr>
<td>14-9</td>
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<tr>
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*A Standard Score of 85-115 is considered within average range. Leigh’s total score was considered in the low-average range, with some relative weaknesses in problem solving, and transferring Insights. Leigh’s relative strengths were in the areas of making inferences and interpreting perspectives. The design of this test allows an infinite amount of time to answer and does not require the student to give a short concise response. However, Leigh very rarely took more than a few seconds to come up with her answer and when prompted with, “can you tell me more?” she almost always responded with “no.”

Leigh’s strength was in interpreting social language. This part of the social language test had a lot to do with demonstrating and understanding the meanings of gestures, tone, posture, and figurative language. Many of these skills were addressed in her social group while addressing her goals.

Leigh overall had a much harder time with the Social Language Test than the TOPS2-A. The Making Inferences section in the Social Language Developments Test was administered by photo. She was asked to interpret the photo and make a smart guess as to what the person might be thinking based on their facial expression and the clues in the picture. This is definitely an area of need for Leigh and will be recommended as a goal for next year. The questions that were asked in the Problem Solving section were typical teenage problems that do not have easy solutions. I got the impression that Leigh had not been exposed to many of these issues and therefore her world knowledge was limited. For example: You and your friend both work at an ice cream shop. You both want to go to a concert on Friday evening. The problem is, your boss says one of you needs to work that night. What would be a good way to solve this problem? Why is that a good solution? Leigh response was: “Try and rearrange the concert for a different day. Don’t make your boss mad. Don’t lose your job.”

Many of Leigh’s responses in this section were on the right path but were too vague. As Leigh continues to expand her social networks, be exposed to more teenage experiences and attend the social groups, my hope is that she will be more successful in this area. In the Social Interaction section, Leigh was asked to respond to a number of socially sensitive situations, where tact and social finesse were required. Leigh understood the situations, however she was very blunt which in a real life situation would put off her conversational partner. For example: Lindsey, the chatterbox, corners you when no one else is around and you want to end the conversation what do you do? Leigh’s response: “Would you make your next few words short. I really gotta go!” Although Leigh got her point across, I was looking for more of a social fake so that “Lindsey” would continue to have good thoughts.

Lastly Interpreting Ironic Statements, in this section Leigh was asked to listen to a CD where the speaker stated a passage that used an idiom. The tone and context in which she said the idiom was sarcastic and Leigh recognized the idiom but did not understand the context of the Sarcasm in the passage. So the meaning that the test was looking for was

<table>
<thead>
<tr>
<th></th>
<th>Making Inferences</th>
<th>Interpreting Social Language</th>
<th>Problem Solving</th>
<th>Social Interaction</th>
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</tbody>
</table>

*A Standard Score of 85-115 is considered within the average range. *(BN) = Below Norms.
the interpretation of the sarcasm in relationship to the idiom. This is a complex social skill and will hopefully be addressed in the social group.

**Informal Social Pragmatic Assessment**

Social cognition is an area that is difficult to assess through traditional standardized assessment procedures, therefore, a number of informal tasks developed by Michelle Garcia Winner were presented to Leigh to aid in assessing her social cognitive knowledge and skills.

- **Eye contact and proximity:** Leigh made very limited eye contact throughout the testing sessions. This behavior suggests that Leigh does not have an understanding that eyes convey information about the thoughts and emotions of others. When in seated situations in the classroom and the therapy setting, Leigh will often sit quietly and will make eye contact often and is easily redirected if distracted. She seems to process information visually and is inclined to check in visually, if there is a particular task at hand that she needs to attend to. While walking with Leigh, she often will walk a head of me and occasionally needs prompts to maintain proximity. It has been observed on a number of occasions that if she goes through the door first she will rarely hold the door for the person behind her unless engaged in conversation or prompted or in a large group. This indicates that Leigh is not always aware of her surroundings. When prompted after closing the door on the occupational therapist she said, “Well I don’t have eyes in the back of my head.” The O.T. patiently reminded her that part of being a social thinker is to aware of who you are walking with and how you affect them.

In the testing session Leigh was given a quick “Thinking with your Eyes” test where she was asked to look at my eyes and track what I was looking at and then make a “Smart Guess” as to what I was thinking about. Leigh was able to read my eye gaze with 100% accuracy and given the correct information make a guess as to what I was thinking about with 100% accuracy. Leigh is able to infer in simple situations such as tracking eye gaze but struggles to understand not only her affect on others but more complex inferences that include emotions and body language.

- **Personal Information and Self Advocacy:** Leigh was asked to fill out a form that needed her name, the date, and some personal information (birth date, address, etc.). We ask the students to fill out this page to determine, first of all, if they know the information, and second if they know how to ask for help when they need it. Leigh’s handwriting was large for her age, but legible. The process of writing seems to be labor intensive for her even though she does it without complaint in the therapy setting. She was able to fill out all of the information necessary and asked what the date was very appropriately. In this situation her self-advocacy skills are appropriate. In the therapy setting and class setting occasionally when she feels slighted, anxious or disappointed she will attempt to manipulate by threatening to talk to her Mom or in the school setting demand that the staff talk to “Her Therapist” which is myself. My hope this year to give her some tools to talk to people about how she is affected rather than threaten them
because ultimately this strategy is off putting and won’t serve her socially in the school or future work environment.

- **Double Interview**: Leigh participated in a “double interview” with this evaluator. I began by interviewing Leigh.

Leigh was asked nine different questions. She answered all of the questions with thoughtful concise responses. There were no off topic comments nor monologues. She did a wonderful job on this part. Notable responses:

- What are your hobbies? Leigh stated, “Dancing and sleeping, vaulting and mowing lawns.
- Who are your friends? Leigh paused and responded, “Bob… somewhat Max, Linda and Heather”
- What are good things about school? Leigh said, “THERAPY, I love therapy. It is a safe environment.”
- If your mom had a day to herself, when she did not have to focus on being a mom, what would she do?
  Leigh responded with, “She would work on her labyrinth and do art and analyze dreams.
- If your dad had a day to himself, when he did not have to focus on being a dad, what would he do on that day? Leigh said, “He would work outside in the garden.”

I was impressed with her ability to have and maintain a conversation. This was definitely a strength of hers in the testing process. Her understanding of the extent and level of her friendships implied social insight. Her relationship with those individuals have been rocky over the year and by her response it let me know that she was aware that those relationships were not as smooth as one would like. The questions about what Mom or dad would do in their free time are given to test perspective taking skills. It is common for individuals with social deficits to be unable to grasp the bigger picture when it comes to understanding the thoughts of other people. However, based on her response she seems to grasp that her parents have hobbies and interests that do not directly revolve around her which implies a level of perspective taking.

The Second part of the Interview, Leigh was asked to make a “smart guess” as to who and what was going on in three pictures. Two of the three pictures were framed and taken from my desk in front of her. The third was removed from my bulletin board. The first picture was of me (the interviewer) on my wedding day with my family. Leigh was able to state that it was me in the picture and that I was getting married. When asked about making a smart guess about the other people in the picture she guessed that it was my husband and my sister and parents. She was able to mentally note the age differences and made a great guess. The next two pictures were similar, Leigh was able to identify what the people were doing in the pictures and that I was in them. The third pictures was of me and my sister in Ireland and before she made her guess she asked if I had a sister.
My guess is that she was deciding whether the other person was my sister or a friend. Once she got that information she said, “You and your sister on vacation.” Leigh did a great job on this section of the double interview.

For the third section of the double interview, Leigh was asked to come up with six questions to ask me. She asked:

- “Who do you live with?” I said, My husband, Ian and my two dogs.
- “What is your full name and title?” – I said, Beth Erin Cain Curtin, and I have a Master’s in Psychology, I am a Social Cognition Specialist at XXX and I am currently a Doctorate student at Meridian University. (Because I see Leigh not only for Social Cognition but for Anger and Anxiety Management she has asked me on a number of occasions about my title is.)
- “Do you have any pets?” I said, Yes, I have two dogs”
- “What is your favorite Movie?” I said “League of their Own”
- “What are your hobbies?” – Art, gardening, swimming and hiking
- “What is your favorite sport”- Soccer

Leigh and I have worked together for quite a while know and this was the first time outside the group setting where she had to come up with questions on her own. Other than the occasional questions where I was sure she already knew the answer she did quite well. There were no uncomfortable pauses and she was appeared to be attending to the answer that I gave. She did not use follow-up questions but I have heard her utilize that strategy with her peers in the therapy group. Social curiosity is difficult to teach, but certainly can be addressed and improved upon over time. Leigh has a limited window of interests which I was directly avoiding to see if she would attempt to learn more information. Had I mentioned that talking about dreams was one my hobbies, medical shows or horseback riding she would have been able and has in the past been able to ask a number of follow-up questions. Unfortunately it is still important to ask follow-up questions regardless of a preferred interest, because it ultimately helps you learn more about your conversational partner and it give others positive thoughts. This is an immerging skill for Leigh and we will continue to work with it in her social group.

- Social Sequences: Leigh was presented with two eight-picture sequences. Socially themed sequences are about other people’s experiences and how people relate to each other socially. This task also sheds some light on the student’s basic ability to arrange items in logical flow. Difficulty with this task indicates potential difficulty with a student’s ability to explore information as it relates to a larger whole. Leigh missed three cards on the first sequence and got the second sequence correct. She was able to put the cards in order independently the second time around. Most students that I work with place their cards in order from left to right. Leigh placed them in order from top to bottom.
The first sequence was about two children and their mothers meeting up at the park. At the end of their play date they trade wheels. The boy goes home with his friend’s scooter and the girl goes home her friend’s bike. Once the three cards were arranged appropriately Leigh had a pretty good sense of the sequence although she titled it, “My little friend.” The title of a story is intended to focus on the main event or purpose and in this sequence it was definitely the trade. Normally, we only do one sequence but I wanted to give Leigh another opportunity to see if this is something that I needed to directly address with a goal. The second sequence was about a brother and sister baking a cake for their mother. She got all of the cards in correct order, was able to note the most of the visual clues and titled the sequence “Birthday party.” She did very well on the second sequence.

• Social Scenario Pictures: Leigh was presented with five different social scenario photos that represent some form of social interaction or display of specific emotion. For each photo, Jake was asked to explain what was going on in the picture and how the people felt. For this task we are trying to determine if the student is able to:
  1. Accurately determine the overall social theme in the picture
  2. Appropriately label the environmental context of the picture
  3. Identify the emotions of the subjects in the photo

Leigh was able to accurately label three of the five pictures. Her emotional vocabulary and emotion recognition skills are fairly good, but her ability to understand the bigger picture in the picture is pretty limited. She struggles to make a smart guess as to what they might be thinking based on what they are feeling. One of the more telling pictures is of a boy that is putting salt in the sugar bowl behind his sisters back with the intention of her being mislead and spoiling her breakfast. This card tests one’s ability to identify motive as well as “Theory of mind” which is the ability to understand the big picture. Leigh was able to identify that the boy was putting salt in the sugar bowl but not his intention of tricking his sister. The other card Leigh missed was of a Mom leaving her child with a babysitter. Leigh missed the age difference and did not notice the clue that the woman was leaving. This is probably Leigh’s biggest area of need. She was able to identify the other three cards fairly well but she seemed uncertain. This deficit was also highlighted in the Social Language Test. If she is unable to understand the bigger picture in a given social situation it is directly going to lead to perspective taking impairments which probably contributes to social anxiety.

The ILAUGH model is a framework developed by Michelle Garcia Winner to help further explain social cognition and how it impacts students across their social experiences as well as their academic day. Based on the above testing and observation information, Leigh’s profile is reviewed below:

I= Initiation of Language: This is the ability to initiate socialization or activities that are not routine or requests for help across the day. Based on the testing and observation,
Leigh is a very routine-based individual. She is starting to initiate interactions with her peers but struggles to interpret non-verbal body language, motive, and intent. In the school environment, she prefers one-on-one attention and seeks help regularly from staff. Leigh is a very rigid thinker and is quick to shut out uncomfortable topics. She does not like to problem solve situations with staff, but when pressed in the therapy setting, she will attempt. Leigh seems too see people as good or bad and will identify them as such based on their interactions with her without any accountability on her part. However, her conversation skills have improved significantly over the last year and she has a desire to make connections with others.

**L=Listening with your eyes and brain:** This speaks to the student’s ability to process the information in his environment. Leigh is a very hard worker. There are very few academic subjects that she is resistant to working on. She does prefer science to most others. She has some hesitation around art due to frustrations with fine motor deficits. Leigh uses his eyes and ears to learn and retain information. He makes some eye contact and is able to pay attention. She is currently in a social group once a week and is seen independently for anger and anxiety management. She is easily frustrated in the social group, but participates to the best of her ability.

**A=Abstract and Inferential Language:** Students are constantly required to “take what they know and make a guess” in classrooms and in social relationships. Making inferences becomes an important part of peer relationships when the peer group becomes more “savvy and sophisticated” in their interactions. Leigh has taught herself a number of idioms and uses them regularly, however, in the Social Language test and based on observation, she has a difficult time inferring tone and sarcasm. On the TOPS2-A Leigh tested in the 58% in Making Inferences and on the Social Language Development Test she tested in the 1% in making inferences. The biggest difference between these two tests is how they are presented. Leigh is much better in hypothetical situations that are given orally. She really struggles with making inferences based on a picture. Unfortunately, most social inferences are noted visually and are not broken down into a scenario. This is an area of need for Leigh.

**U=Understanding Perspective Taking:** This describes the student’s ability to consider the needs, thoughts, motives, and emotions of other people with whom the student communicates or associates, while also considering her own. It also includes acknowledging the presence, thoughts and intention of others in the environment, even if the student is not directly communicating with those people. In hypothetical situations Leigh can identify some of the motives and intentions of others. Once again, she scored in the 53% on the TOPS2-A which is within the normal range. On the Social Language Development Test, she scored in the 9th percentile and in the 2nd percentile. In real life situations, if she has encountered the situation before, she is able to make a smart guess as to what she could do, but overall, she has hard time understanding the perspectives of others in real life time. Problem Solving is certainly a skill that is directly connected to perspective taking. On both the TOPS2-A and the Social Language Development test this area was a relative weakness. Based on observation, Leigh will engage with her peers and not pick up on the fact that he/she is not interested in talking at length about what Leigh
wants to talk about. Leigh seems to want to make friends but is resistant to making personal changes that might help her achieve that goal. Leigh genuinely is a sweet natured individual but is very guarded toward people. This is common in students who have had difficult times making connections with others.

**G=Getting the Big Picture/Gestalt:** This describes the student’s ability to understand how facts link together into larger concepts, as well as his overall awareness of contextual clues provided in different environments. Reading comprehension, written expression, completing math word problems, as well as social relationships all require a student to form a larger concept from the facts presented. In social relationships, underlying concepts are threaded through conversational language or even the desire or lack of desire to be with another person. Leigh was able to successfully complete an 8-card sequence and get the main theme of one of them. Leigh seems to understand simple social situations. She gets how the world works under simple circumstances. She is good at logically answering questions and understands basic comprehension of stories. Leigh struggles with complex social situations. As mentioned above, tone, motive, and subtle non-verbal body language are difficult for her to interpret. In the therapy setting we practice having conversations where one party might be demonstrating non-verbal messages and the other is supposed to use that information to modify his/her behavior. In this context with support she can do it. In the classroom, based on teacher observation and data collection she is not translating this skill on a regular basis. When we watch social based video clips as long as the actions are overt she successfully contributes to the discussions, she does not pick up on all the clues but she gets some of them. Hopefully she will create a safe community for herself to be able to analyze social situations in. That is a big part of having close friendships. We will continue to work on these concepts this year.

**H=Humor and Human Relatedness:** This describes the student’s overall ability to successfully interact with his peers as well as his teachers, and others. Leigh has slowly began to modify the way she relates with her peers. When engaged in a conversation of a mutual topic she is able to relate and use some humor. When in a good space she is a very friendly upbeat individual. She has specific interests and prefers to talk about these topics with people who share that interest. She has made progress in this area, in that she is more mindful about who she monologues with and finds people who have similar interests to talk to. Leigh will social fake on occasion to maintain a conversation but only if she really likes the person. Leigh has an unusual sense of humor that often leaves people who do not know her wondering what she is talking about.

**Impressions and Recommendations:**
Leigh is a likeable young individual who is hard working, has a wonderful creative ability and a desire to do well in school. Informal and formal testing, observations, and teacher reports all indicate some significant areas of social impairment. Social Success hinges on the ability to understand others perspectives, make inferences, demonstrate conversation skills, problem solve and self advocate. Based on Michelle Garcia Winner’s “3 Levels of Perspective Taking”, Leigh appears to demonstrate characteristics of the second level of perspective taking which is called, “Emerging Perspective Taker.”
Which simply means that Leigh is capable, but struggles to, interpret social situations. Students at this “EPT” level have difficulties in perspective taking, abstract language and problem solving. These individuals are often seen as quirky and have a desire to interact with others. All of these social nuances can be worked and improved upon with help. Although this may seem simple it takes a lot of practice to work on these skills which often come as second nature to those who are socially savvy. Since Leigh seems to enjoy coming to Social Groups and is a quick learner, it is likely that she will continue to make progress socially. Visually assessing social situations seems to be at the root of Leigh’s deficits. This inhibits her perspective taking, her ability to problem solve successfully and her social understanding of the bigger picture. Part of the task will be to continue to broaden her world knowledge through more complex social scenarios and provide her problem solving tools to help her be more successful. In addition to the social program at XXX, the academic curriculum focuses on teaching and reinforcing social cognition skills throughout the day. It is felt that Leigh’s social needs can be met both in the class and therapy environment. If there are any further questions, please don’t hesitate to contact Beth E. C. Curtin, Social Cognition Specialist at XXX-XXXX.

Beth E. C. Curtin, MA
Social Cognition Specialist
Anger and Anxiety Management
APPENDIX 3

LEIGH’S PAINTING

In loving Memory of Leigh’s Horse
NOTES

Chapter 1


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## Chapter 3


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