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The DPsych Portfolio

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Psychotherapy with people with Asperger Syndrome; exploring ways to improve client and therapist well-being

Submitted in partial fulfilment of the requirement for the degree of Doctor of Psychology awarded by City University

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Table of Contents

Section A: Preface…….. 10

Acknowledgements……..... 13

Section B: The Research……..... 14

1. Abstract……..... 15
2. Abbreviations and Key Terms……. 17
3. Methodology…….. 18
4. Introduction…… 21
   - 4.1. Overview of the Research……..... 21
   - 4.2. Setting for the Research…….. 24
   - 4.3. The Evolving Epistemology……..... 25
5. Literature Review……. 27
   - 5.1. Definition: Historical Perspective …… 27
   - 5.2. The Wider Social Context……..... 30
   - 5.3. Mental Health …… 32
   - 5.4. Psychotherapy …….. 36
   - 5.5. Asperger Syndrome and Therapy…….. 41
     - 5.5.1. Therapist Preferences……..... 42
     - 5.5.2. Possible Characteristics of AS and the Interaction with Therapist Preferences and Therapeutic Assumptions.. 44
       - 5.5.2.1. Interpersonal and Social Functioning……..... 46
         - 5.5.2.1.1. Interpersonal and Social Functioning: Pragmatics…… 47

5.5.2.1.2. Interpersonal and Social Functioning: Beyond Language……..... 52
5.5.2.2. Psychological Mindedness……..... 57
5.5.2.3. Conceptual Complexity……..... 63
5.5.2.3.1. Conceptual Complexity: Weak Central Coherence……..... 63
5.5.2.3.2. Conceptual Complexity: Memory..... 68
5.5.2.3.3. Conceptual Complexity: Executive Functioning …….... 72
5.5.2.4. The Working Alliance……..... 75
5.5.2.5. Restricted and Repetitive Thought and Behaviour..... 76
5.5.3. Clinical Supervision…… 82
5.5.4. Preliminary Synthesis……... 84
5.5.5. Comparison Groups…….. 86
5.5.5.1. Comparison Groups: Borderline Personality Disorder..... 87
5.5.5.2. Comparison Groups: Depression…… 89
5.6. Aims of the Study…… 91
6. Method……..... 92
6.1. Research Design..……..... 92
6.2. Procedure…….. 95
6.2.1. Initial Stage…… 96
6.2.2. Interviews……... 96

6.2.3. Constructing the Pilot Questionnaire……. 101

6.2.4. Constructing the Final Questionnaire ……. 109

6.2.5. Layout of the Final Questionnaire…… 111

7. Results..…….. 116

7.1. The Initial Stage…….. 116

7.2. The Interviews……. 116

7.3. Constructing the Pilot Questionnaire……... 116

7.4. Analysing the Pilot Questionnaire ..…… 117

7.5. Analysing the Final Questionnaire……. 117

7.5.1. Reliability Analysis…….. 117

7.5.1.1. Participants who did not fulfil the Research Criteria…….. 117

7.5.1.2. Internal Check…….. 118

7.6. Refining and Exploring the Data……. 118

7.6.1. Validity and Reliability Analysis……. 118

7.7. Descriptive Analysis……... 122

7.7.1. Designation and Experience of Participants……. 122

7.7.2. Co-Morbid Concerns…….. 124

7.7.3. Model(s) Used……. 125

7.8. Analysis of the Factors…….. 125

7.8.1. Comparison Groups……... 125

7.8.1.1. Therapist Satisfaction across the Groups…. 128

7.8.1.2. Therapist Supervision across the Groups….. 129

7.8.2. Exploring the Factors within the Group AS……... 131

7.8.2.1. The Working Alliance……..... 132

7.8.2.2. Therapist Knowledge and Experience…..... 132

7.8.2.2.1. Therapist Knowledge…… 132

7.8.2.2.2. Therapist Experience…….. 132

7.8.3. Model(s)…….. 133

7.9. Preliminary Synthesis of the Analysis…… 135

8. Discussion…….. 137

8.1. The Journey through the Thesis and the Evolving

Epistemology..... 137

8.2. Results…… 144

8.2.1. Overview …… 144

8.2.2. The Working Alliance …… 144

8.2.3. Therapist Satisfaction and Supervision ……..... 147

8.3. Implication for Therapy with People with AS…… 149

8.4. Future Research.....…….. 151

8.5. Statement of Originality and Contribution……..... 153

8.6. Considerations…… 154

8.6.1. The Interview Sample……..... 154

8.6.2. Constructing the Attitude Statements……. 155

8.6.3. The Questionnaire…….. 158

8.6.4. Defining the Groups…… 163

8.6.5. Reflexivity……..... 164

8.7. Conclusion…….. 166

9. References …….. 169

10. Appendix…….. 194

Appendix 1. The Pilot Questionnaire……..... 194

Appendix 2. Invite Email……..... 201

Appendix 3. Further Information…….. 202

Appendix 4: Final Questionnaire…… 203

Appendix 5. Diagnostic Criteria for Asperger's Disorder: various measures…….…….. 226

Appendix 6. Diagnostic Criteria for Borderline Personality Disorder DSM-IV-TR…….. 228

Appendix 7. Diagnostic Criteria for Major Depressive Episode. DSM-IV-TR……..…. 229

Appendix 8. The Salient Utterances from the Interviews……..... 230

Appendix 9. Salient Utterances from the Interviews Placed within the Tentative Categories……..... 242

Appendix 10. Examples of Questionnaire Items Transformed from the Utterances taken from the Interviews..…….……. 245

Appendix 11. Examples of Questionnaire Items Transformed from the Literature…… 246

Appendix 12. Attitude Items within the Final Questionnaire by Tentative category…….. 247

Appendix 13. Wilcoxon Signed-Rank Post-Test…… 252

Section C: The Critical Literature Review…….. 253

11. The Construct of Perfectionism: Unidimensional and Unidimensional Models…..... 254

12. The Unidimensional Model of Perfectionism …….. 258

13. An Appraisal of the Unidimensional Model of Perfectionism ……... 261

14. Asperger Syndrome and Perfectionism …… 264

15. How Might the Unidimensional Model of Perfectionism Help Clinicians? 267

16. Conclusion……. 271

17. References …… 273

Section D: The Client Study ……. 282

18. Introduction …… 283

19. The Reason for the Referral…… 283

20. Sources of Information…… 283

21. Background Information …… 284

22. Formulation ……..…… 285

23. Therapeutic Model and Intervention…… 287

24. Progress…… 290

25. Summary and Recommendations…… 293

26. Appendix…….. 294

Appendix 1. …….. 294

27. References …….. 295

Table Index

- Figure 1. Scree Plot for the Exploratory Principal Component Analysis for the Fourteen Items……..... 119
- Table 1. Pattern Mattrix for the Exploratory Principal Component Analysis for the Fourteen Items for the Group AS..…….. 120
- Table 2. Interfactor Correlations for the Four Factors……. 121
- Table 3. Cronbach Alpha and Item-total Correlations for the Four Factors…..…… 122
- Figure 2. Graph to Show the Number of Participants by Job Title……. 123
- Table 4. Participant Experience in Number of Clients and Months……..... 124
- Table 5. Number of Respondents who Identified Specific Mental Health Problems in AS clients……..…. 124
- Table 6. Number of Participants using Particular Models in their Practice with the Three Client Groups……..... 125
- Table 7. Pattern Mattrix for the Items relating to the Factors Supervision and Satisfaction for the Groups Borderline Personality Disorder and Depression…….....…… 126
- Table 8. Cronbach Alpha and Item-total Correlations for the Factors Supervision and Satisfaction for the Group Borderline Personality Disorder…….....……. 127
- Table 9. Cronbach Alpha and Item-total Correlations for the Factors Supervision and Satisfaction for the Group Depression……..…….. 127
- Table 10. Summary Statistics for the Factor Satisfaction across the three Groups…..... 128
- Table 11. Exploring Differences among the three Groups Based on the Factor Satisfaction ……... 129
- Table 12. Summary Statistics for the Factor Supervision across the three Groups…..... 130
- Table 13. Exploring Differences among the three Groups Based on the Factor Supervision…….. 130
- Table 14. Summary Statistics for the Factor Working Alliance and Therapist Knowledge..... 131
- Table 15. Number of Participants using Particular Models in their Practice with Clients with AS……..…….. 133

- Table 16. Results for the Beck Youth Inventory at Start, Midway and End of Therapy..... 292

Section A: Preface

My journey into the field of Autism Spectrum Disorders began back some 20 years ago. Upon my first day within my first position working with children with autism at a special school I was instantly captivated. I was struck by a resounding difference in the ways in which these children behaved and interacted compared to all the other children I had met or worked with before. A fascination grew in me as I pursued a number of posts within the field working within various settings including: a lead role in a respite unit; an assistant psychologist post within a specialist counselling and assessment clinic; two trainee psychologist posts within a private hospital and within a specialist college; a number of posts working in adult as well as child and adolescent Tier 3 community teams. My present post as a Band 8a Counselling Psychologist, within three different services providing Tier 2, Tier 3 and Tier 4 support to children and adolescents, their families, carers and educators, has enabled me to broaden my experiences even further and refine my knowledge of Autism Spectrum Disorders.

Alongside these posts I have been involved in various research projects including applying Social Stories (e.g. Gray, 2004) to specific problem behaviour in people with autism; this was during my Diploma at Birmingham University. I found that this intervention significantly reduced the target problem behaviour, as well as increasing the quality of life and other socially valid dimensions in this adult with Asperger Syndrome. Following this research I explored the working alliance between therapists and their clients with Asperger Syndrome and clients without Asperger Syndrome.

Collectively, my research and work experiences have propelled my interests forward, culminating in the pursuit of the current Doctoral qualification. Within the Doctorate of Psychology I have attempted to communicate the experiences I have had that appear in line with my peers, as well as attempting to align the research to contemporary thinking within the academic world, with an emphasis on its application to clinical populations. This portfolio begins with the research on therapist experiences of providing therapy to people with Asperger Syndrome. Through the use of initial exploratory interviews and then a questionnaire the aim was to explore how therapists experience working with people with Asperger Syndrome. The thesis begins with an exploration of the epistemological position of the author before moving onto the introduction and literature review. The intention of the literature review was in order to highlight the core and associated features of Asperger Syndrome and other issues such as the quality of supervision that might influence therapy and the therapist

attitudes, revealing any possible tensions with the literature on therapist preferences and therapeutic assumptions.

As well as useful insights gained from the exploratory interviews themselves through content analysis, it was hoped that using the material from these interviews, as well as material taken from the literature review, a questionnaire could be constructed. Furthermore, it was hoped that following exploratory Principal Component Analysis of the data resulting from the attitude items held within the questionnaire, factors might emerge that may reveal more insight into the attitudes of therapists working with people with Asperger Syndrome. Finally, if factors were revealed it was hoped that relationships could be explored between these factors, as well as with other dimensions of the questionnaire such as therapist experience in terms of the number of clients worked with and the model(s) used, thus possibly highlighting further insights into therapists' attitudes. It was hoped that any insights gained from this exploratory study might lead to further future research and ultimately lead to improvements in the experiences of therapists working with this particular client group and encourage more therapists to embark on psychotherapeutic work with people with AS.

The third section of the portfolio explores the construct of perfectionism and attempts to ascertain whether it adds anything to our understanding of Asperger Syndrome and co-morbidity. It is hoped that this exploration will help to guide clinicians when supporting people with Asperger Syndrome who present with co-morbid mental health problems. The author attempted to achieve these aims by reviewing two competing models of perfectionism and a variety of mental health problems where perfectionism has been implicated, as well as reviewing particular treatment protocols and assessing whether they could be applied to psychotherapeutic work with people with AS.

Finally, the fourth part of the portfolio outlines a client report of a client with Asperger Syndrome, an eating disorder and features consistent with perfectionism as explored within the critical literature review. It was hoped that this client study might go some way in illustrating a typical adult with Asperger Syndrome in terms how the core and associated features of Asperger Syndrome and co-morbid psychopathology may influence the therapist and the possible considerations that might need to be taken when working with this population. It was hoped that this client report would add to the limited research literature in the area.

The overarching theme resonating throughout all of the aspects of this portfolio is working psychotherapeutically with people with Asperger Syndrome and exploring ways to improve client and therapist well-being as well as therapy efficacy.

Acknowledgements

I would like to extend my thanks to my supervisor Professor Dermot Bowler for supporting me throughout the four years of study; Dr. Silvio Aldrovandi for his advice and guidance; Annabel Scott for her inspiration and diligence, Anna Rodriguez for her understanding whilst I travelled this long and uneven road and finally, to my mother Susie, for inspiring a curiosity in me and developing a mentalising ability that has enabled me both the means to make a living but also as a route to carving out an identity, of which abnormal psychology and Autism Spectrum Disorders forms the core.

Section B: The Research

Research exploring therapists' attitudes to providing psychotherapy to people with Asperger Syndrome.

1. Abstract

It is well documented that people with Asperger Syndrome show a propensity to mental health problems (e.g. Tantam, 1988); one contributor possibly being difficulties with social interaction (Frith, 2004). People with Asperger Syndrome and mental health problems may therefore require support, one form being psychotherapy (e.g. Schopler & Mesibov, 1983). However, despite the possible need of this population and the recent drives towards improving access to psychological therapies to the wider population (Department of Health, 2010) there is relatively little literature on psychotherapeutic interventions for people with Asperger Syndrome (Weiss & Lunsky, 2010), which might possibly impact on the client and therapist. Furthermore, the author postulated that when people with Asperger Syndrome do access psychological therapy, the difficulties that contributed to them seeking therapy such as interpersonal difficulties may also impact on basic therapeutic assumptions and therapist preferences as outlined in the literature. Thus the overall premise of this current study derives from the way Asperger Syndrome is defined (however, provisionally) as a disorder of interpersonal functioning, this would lead to an expectation that doing therapy (an intrinsically interpersonally process) with those with Asperger Syndrome might negatively impact on basic therapeutic assumptions and therapist attitudes in some way.

In this study, therapists' attitudes to working psychotherapeutically with clients with Asperger Syndrome were explored. Following preliminary discussions with colleagues, interviews with five trainee psychologists and 129 completed questionnaires from therapists, a number of areas were revealed as potentially important to psychotherapists working with people with Asperger Syndrome. These areas were the quality of supervision, therapist satisfaction, the quality of the working alliance, therapist knowledge and experience, the model(s) used and co-morbid psychopathology and other co-morbid concerns.

Despite people with Asperger Syndrome being viewed from the dominate discourse as not necessarily contributing to the fulfilment of a number of therapist preferences and therapeutic assumptions as described within the literature, interviews and questionnaire, overall the sample in this study viewed clients with Asperger Syndrome as satisfying to work with and the therapists viewed the working alliance as good, supervision effective and satisfaction was not contingent on the use of the dominant cognitive behavioural therapy model.

Following correlational analysis, the quality of supervision, the amount of therapist knowledge and experience as well as the quality of the working alliance was significantly correlated with therapist satisfaction. It was proposed that the high ratings of satisfaction may be influenced by these factors as well as therapist characteristics and the wider social context which may view people with Asperger Syndrome in a positive light.

The overall message of this thesis goes some way in challenging the dominant "medical" discourse on Asperger Syndrome, a position that the author had somewhat originally embraced within this study. In challenging this paradigm this study may help to erode some of the myths and prejudices with regard working psychotherapeutically with people with Asperger Syndrome, including difficulties in forming a working alliance, thus leading some therapists to expect the work to be rather dissatisfying. This study may go some way in dispelling some of the "mystique" (Hare & Flood, 2001) with regard doing therapy with people with Asperger Syndrome that may leave some people with Asperger Syndrome at a loss when it comes to accessing psychological therapies

A number of criticisms were made of this research including the sampling, the construction of the attitude items, the questionnaire and more fundamentally, the epistemology which means the results should be taken as exploratory and provisional and to be confirmed by future replications.

2. Abbreviations and Key Terms

- AS will be used for Asperger Syndrome.
- The title “therapist” and “psychotherapist” will be used interchangeably to describe someone who is trained in and practices the treatment of psychological disorders and allied problems by psychological methods and “therapy” and “psychotherapy” will be used interchangeably to describe the practice of therapists and psychotherapists in the treatment of psychological disorders and allied problems (Coleman, 2009).
- The use of the term “statement” and “item” are used interchangeably to describe the attitude sentence which has been created from the utterances taken from the interviewees or from the literature for which the respondents rate their agreement or disagreement along a Likert scale.
- Within this study, an “attitude” is described as *“…a state of readiness, a tendency to respond in a certain manner when confronted with certain stimuli…Attitudes are reinforced by beliefs (the cognitive component) and often attract strong feeling (the emotional component) which may lead to particular behavioural intent (the action tendency component”* (Oppenheim, 1992, p.174-175).
- “Co-morbid psychopathology” and “co-morbid concerns” are terms the author has used to describe clinical problems that are in addition to and overlapping with the core disorder i.e. Asperger Syndrome.
- I will refer to myself throughout this thesis as either “author” or “researcher” depending on the context.

3. Methodology

The aim of this study was to explore therapists' attitudes to providing psychotherapy to people with AS through exploratory interview and questionnaire. Before the literature is reviewed and an attempt is made to describe in detail the research design and the specific methods employed, it will be important to initially explore the underpinning epistemological position and the specific paradigm from which the research was informed.

Epistemology can be described as the assumptions made about the researchers' broad world view and the nature of knowledge. An exploration of epistemology and how it is viewed within this study will be important as it will have direct implications on the type of theoretical perspective and how the data are collected; this should tie back into the aims of the study.

The author's epistemology evolved as the research progressed (this will be discussed within the discussion). The author's initial epistemology was consistent with *scientific realism* (Madill, Jordan & Shirley, 2000), a post-positivist epistemology (Sayer, 2000) that asserts that "…there is a truth, the world is largely knowable and just as it appears to be …" (Madill et al, 2000, p.3). Therefore, objectivity is viewed as possible and desirable. Within this epistemology it is assumed that reliable results, as long as they are not the product of systematic errors, tap phenomena which are reasonably independent of the researcher and the instruments of the research (Madill et al, 2000). Scientific realism accepts a degree of interpretation and metaphor in the findings of social research but it is argued that these are not desirable and that they should and can be eliminated. Scientific realism argues that one reality exists and it is the job of the researcher to uncover it, despite it being known imperfectly due to the researchers' limitations, moreover, the researchers subjective interpretations are viewed as a source of bias that needs to be and can be controlled for.

As a type of "soft" positivism (Sayer, 2000), scientific realism advocates the scientific method taken from positivist tradition. This approach is taken in order to search for significant relationships, established through *extensive* research methods whereby a large number of repeated observations are sort (Sayer, 2000). For example,

> *"One identifies a population and defines groups taxonomically, on the basis of shared attributes (for example, white women over 60; houses worth less than £50,000), and seeks quantitative relations among the variables"* (Sayer, 2000, p.20).

What is implicit in the scientific realism paradigm is the *successionist* viewpoint (Sayer, 2000), in that the researcher is looking for regularities between causes and their effects where generalisations can be made to other similar situations (Smith, 1998). To this end, the scientific realism paradigm advocates the positivist method. Although accepting fallibility in the positivist, objectivist method, these methods are viewed as the best methods in measuring "…true representations of the world…" (Madill et al, 2000, p.3) through establishing consensus, convergence and consistency within the research (Sayer, 2000), all qualities held in high regard within scientific realism. Furthermore, the intention is to find regularities and in doing so increase the confidence in the accuracy, objectivity and reliability of the research (Madill et al, 2000).

In this study positivist methods were used in a number of different ways. Within the initial interviews a coding system was created whereby categories emerged out of the data. In keeping with the scientific realism paradigm, the authors assumption was that there were "…categories in the data and [these] can be identified in an objective way by observers who know what they are looking for" (Madill et al, 2000, p.4). Furthermore, the positivist triangulation method of inter-rater reliability was employed, in order to help recognise reliable findings i.e. consistency of meaning (Madill et al, 2000). Later a questionnaire was constructed from the data emanating from the interviews and literature, another positivist method of enquiry that endorses categorisation and the search for regularities based on the assumption that the phenomena exists "out there, awaiting discover," and that the "…research is essentially a process of revealing or discovering pre-existing phenomena and the relationships between them" (Madill et al, 2000, p.4).

The scientific realism epistemology stands in contrast to *constructivism* and *critical realism*. In these paradigms the search for regularity, successionist linearity and convergence is rejected and replaced with the search for completeness (Sayer, 2000), the acknowledgement of phenomena embedded in a social and historical context, where experience is described within culturally defined discourse which only *intensive* research can reveal. Unlike the scientific realist paradigm, constructivists believe that there is no external reality independent of human consciousness, there are only

different sets of meanings and classifications which people attach to the world, therefore no position can be taken as everything is relative to its particular context thus ever changing (Silverman, 2000). Feyerabend (1978, cited in Robson, 2002) argues that "reality" can only be constructed using a conceptual system and since concepts are culturally determined, reality cannot be objective. Furthermore, the scientific realist notion of attempting to eliminate researcher interpretation as a form of bias is incompatible "…with the realisation that knowledge production involves an essential interconnection between researcher and researched" (Henwood & Pidgeon, 1994, p.231, cited in Madill et al, 2000). Within the constructivist paradigm the researcher is required to reflect upon their inevitable, unavoidable and essential contributions to what is being researched, in order to better understand the inner worlds of the participants and the co-creation of meaning. A number of other assumptions are also stressed within constructionism: that language plays a vital role as both the object of study and through which the world is constructed; that the meanings of people's experiences and their behaviours should be viewed in context; that these meanings produce working hypotheses rather than immutable empirical facts.

The constructivist paradigm is rejected and with it their view that there are no "truths out there," even about the physical world and that there is no stable or objective reality which exists that can be captured, measured and generalised, moreover, the belief that there is no reality outside conceptual systems generated by people is rejected (e.g. Trigg, 1989, cited in Robson, 2002). Unlike constructivists, it is believed that there is such a thing as a natural and social object which can be objectified, measured and generalised upon. Unlike constructivism, it is believed that there is an external reality independent of human consciousness and that a number of things can be agreed upon in the world. The scientific realist construct argues that science is required to create theories that represent the world as it stands in a given moment (Robson, 2002). Within my research an attempt has been made to unearth the attitudes that people share about certain features of the world, to explore them and try to establish if they say something about the current state of affairs for a particular population i.e. therapists who work psychotherapeutically with people with AS.

4. Introduction

4.1. Overview of the research

Tom is a tall, stocky 15-year-old. He is the older of two children; his father is a successful engineer and his mother is a secretary. He was born following…an uncomplicated pregnancy. Apart from a hernia repair in infancy, his medical history is unremarkable. Developmental milestones were within normal limits; Tom talked before he walked. He started nursery school at age 2½ years and already had unusual interests which were pursued to the exclusion of other activities. Over the years these interests have included stop signs, arrows, storm drains, and windmills, and more recently, have changed to clocks, mathematics, and computers. Tom was a self-taught reader by the age of 3 and was reading adult-level books by 4. In nursery he had poor peer relations, failed to listen to other children's comments, and was often oppositional and impulsive. At the same time he was aware of his social isolation…Despite precocious academic achievements he continued to have marked problems in social interaction and in the regulation of his behaviour. A clumsy and poorly coordinated child, Tom often seemed markedly odd outside home or school settings. In his preoccupations with clocks he might approach strangers and proceed to reset the person's watch without asking permission…Tom had no friends, very limited interpersonal skills, and signs of depression…Tom spoke in a monotone. His fascination with clocks pervaded all conversation. His poor social judgement was repeatedly observed, particularly in his description of interactions with peers. Nonverbal cues of social context e.g. gesture, facial grimaces, emphasis of voice and nonliteral communications, were limited…His very limited awareness of social conventions was illustrated by his one-sided conversational style, his tendency to belch and pass gas, and his use of graphic expletives with little apparent intention to shock his conversational partner…Tom had superior scores on verbal reasoning tasks, except for a task involving comprehension of social norms and conventions; although able to describe general social expectations, he was unable to translate this knowledge into

> *appropriate conduct…There was significant variability in Tom's speech-communication competence. His skills in the areas of single-word receptive and expressive vocabulary were excellent but far weaker when he had to cope with nonliteral and social language…In real situations with peers and adults, some of the nuances and subtleties that would occur in rapid succession in communication would be extremely difficult for him to detect, particularly if he had to appreciate someone else's point of view. Tom did not modify his language depending on context or cues; his pedantic and long-winded monologues suggest little appreciation of his conversational partner. Although his articulation was accurate, his prosody was significantly deficient...Thus while Tom is reported to have had early language skills well within normal limits, his current skills are unusual in a number of ways*" (Volkmar, Klin, Schultz, Bronen, Marans, Sparrow & Cohen, 1996, p. 119-120).

Most people, whether they are experienced mental health practitioners, researchers, academics or lay people, would be able to identify this as a description of a young person with AS. It is so easily recognisable because AS has had and continues to have widespread coverage in the media and stimulated much research in the clinical and academic world, leading to over 2000 studies and 100 books (Attwood, 2007); the setting up of dedicated journals on the topic, as well as numerous documentaries and films being made on the subject. AS has ignited the imagination of many people due to the unusual profile of both strengths and difficulties that often characterises this population, none so striking as the unusual ways in which they engage with other people.

The ways in which people with AS behave generally can be repetitive and restricted (e.g. South, Ozonoff & McMohan, 2005) but it is within the realms of social communication where those identified as having AS can stand out the greatest. Within this area the research clearly highlights specific difficulties such as with pragmatics (e.g. Verte, Geurts, Roeyers, Rosseel & Sergeantl, 2006) including with non-verbal communication (e.g. Koning & Magill-Evans, 2001) and with social skills generally (e.g. Knott, Dunlop & Mackay, 2006). These anomalies may impact on but also may result from a particular cognitive profile including difficulties with planning and switching-set (e.g. Landa & Goldberg, 2005), with memory (e.g. Bowler, Mathews & Gardiner, 1997; Bowler, Gardiner & Grice, 2000, 2003; Bowler, 2007; Bowler, Gardiner & Saavalainen,

2000), with the ways in which their experiences may be processed and integrated into meaningful wholes (Mottron, Burack, Stauder, & Robaey, 1999) and with their intersubjectivity of social experience, including difficulties with understanding their own and others' internal states such as emotions (e.g. Bauminger & Kasari, 2000; Baron-Cohen, Leslie & Frith, 1985), thoughts and desires (Baron-Cohen et al, 1985). These issues may compromise particular therapist preferences and therapeutic assumptions including clients to have intact interpersonal skills (Couture, Roberts, Penn, Cather, Otto & Goff, 2006), to be psychologically minded (Teasdale & Hill, 2004), to exhibit a degree of conceptual complexity (Davis, Cook, Jennings & Heck, 1977) and for a working alliance to be formed (Horvath & Greenberg, 1986, 1989).

A clearer definition of AS has only evolved over the last 20 years or so when there has been a concerted effort to define the disorder, particularly in order to try and differentiate it from other similar disorders such as Autism. Markers for AS are being established through brain studies (e.g. Hubert, Wicker, Monfardini & Deruelle, 2009), but most noticeably through identifying the specific phenotypes that characterise AS (e.g. The Diagnostic Statistical Manual IV- TR, American Psychiatric Association, 2000) in order to improve diagnosis but also better definition and description will hopefully result in improvements in the support they receive and improvements in the image of AS.

Improving the definition of AS and the support they receive is made ever more challenging by the realisation that the majority of people with AS may experience co-morbid psychopathology and other co-morbid concerns such as anxiety (e.g. klin, Volkmar & Sparrow, 2000), depression (e.g. Ghaziuddin, 2005) and problematic anger (e.g. Aston, 2003, cited in Paxton & Estay, 2007); the core features of AS and the features of mental health problems can overshadow one another (Tantam & Prestwood, 1999; Stewart, Barnard, Pearson, Hasan & O'Brien, 2006) creating difficulties for detection and intervention.

The research suggests that people with AS are more vulnerable to mental health problems than the general population (Tantam, 1988) and therefore suitable interventions are required. The relatively small evidence base for interventions for co-morbid mental health problems in people with AS points to the use of medication (e.g. Weiss & Lunsky, 2010) and psychotherapy, particularly cognitive behavioural therapy (e.g. Hare, 1997a). Although there is a small evidence base for the use of psychotherapy for this population there appears to be no research that the author is

aware of that explores therapists' experiences and attitudes to providing psychotherapy to people with AS; a potentially interesting area of research given the unusual profile of strengths and difficulties that characterise this population and the potential conflict with therapist preferences (e.g. Teasdale and Hill, 2004) and therapeutic assumption such as the ability to form a working alliance (Bertolino Bargmann, & Miller, 2011).

4.2. The Setting of the Research

In terms of the setting for the research this altered in relation to each stage.

The first stage took the form of informal discussions with peers, clinicians, academics and colleagues within a variety of settings including at the author's place of work, at conferences and at City University.

The second stage, the exploratory interviews took place at City University using trainee Counselling Psychologists thus employing a *judgement sample*. Five Counselling Psychologists in training were interviewed. The trainees were chosen based on the criteria that they had prior experience of providing psychotherapy to people with AS. The participants were recruited from the same Counselling Psychology course that the author attended. Contact was made to the potential interviewees through targeted verbal invitations to those that were known to have had prior experience of providing psychotherapy to people with AS; this was established through previous conversations with all students on the Counselling Psychology course. Moreover, all students were asked about their experiences and those that satisfied the research criteria where chosen for interview.

The third stage of the research was the questionnaire. The questionnaire was circulated to everyone on the United Kingdom Council for Psychotherapy professional directory during the pilot stage. The final questionnaire was then sent to everyone registered on the following professional directories: The British Psychological Society Counselling and Clinical Psychology directories; The British Association for Behavioural and Cognitive Psychotherapies directory; The British Association for Counsellors and Psychotherapist directory. An advert was also placed in the Psychologist magazine. The potential respondents were invited to participate with the web based questionnaire through the use of a standardised email.

4.3. The Evolving Epistemology

The reader should be made aware at this stage that the author's epistemological stance altered as the research progressed (this is discussed further within the discussion). The initial paradigm was *scientific realism,* a post-positivist successionist paradigm that looks for empirical regularity using positivist methods from which generalisations can be made (Robson, 2002). As the research unfolded, it was apparent that a *critical realist* paradigm fitted better with the author's personal values, profession and more broadly, the author's world view. On reflection, this construct would have also been better placed to capture the social, cultural and historical influences with regard the therapists attitudes leading to more fruitful findings as it would have been better able to capture the multi-layered, stratified context in relation to the phenomena being researched, including opportunity to reflect on the researcher's position and influence on the research. Defining the context in critical realism is crucial in understanding in detail what might have influenced the therapists' social constructions and also the researchers' interpretations of these in relation to the phenomena being researched. Initially although space for reflection was provided, the author did not value this detail of analysis and the researcher's interpretations were viewed as a form of bias needing controlling.

Critical realism replaces the search for consensus, notions used by scientific realism and other post-positivist traditions, with a valuing of diversity, novelty and completeness. The author's evolving epistemological stance is *generative*, it incorporates the social, cultural and historical perspective of the researched within an explanatory matrix. By the completion of the thesis, the author believed it would have been the most useful way to describe the data which incorporates mechanisms, outcomes and contexts. The altered epistemology would lead to a different set of methods of enquiry.

These issues are explored further within the discussion section. However, it is important to state that these issues have influenced the literature search in that despite the methodology section describing the authors original rather limited scientific realism paradigm, the literature review attempts to explore a richer broader research base to include critical realism research and other "weak" constructionist research, within which critical realism has been argued to belong (Sayer, 2000). Furthermore, the reader should also be warned that the literature review although including quite a bit of positivist research, the author also opening criticises it, which will appear to contradict

the author's methodology section as this was the author's original position. Furthermore, a range of research is explored, including positivist research, as in keeping with the evolving epistemology of the author, a range of research from different paradigms can be viewed as potentially beneficial, albeit, some research is better placed to produce more complete explanations (Sayer, 2000).

5. Literature Review

The intention of this literature review is to explore how therapists may experience providing psychotherapy to people with AS. The review will begin with a discussion of the history of AS, from tentative description to current day conceptualisation. The review will then explore the literature on mental health and other co-morbid concerns related to AS, in order to build a case for psychotherapy as one very important intervention. An attempt will then be made to explore how therapists may experience working with people with AS by linking a range of therapy and therapist assumptions, preferences and expectations with a range of different features that have been argued to characterise those with AS. This will be followed by a review of clinical supervision, viewed as a possible protective factor for some of the possible challenges faced by therapists. In the final sections of the literature review borderline personality disorder and depression will be explored as possible comparison groups before outlining the aims of the study.

5.1. Definition: Historical Perspective

What we have come to currently know as AS has had a long and contentious history to date and the definition continues to be controversial and ever evolving. This history began in 1944 when Dr Hans Asperger, a Viennese paediatrician, noticed similarities between some of the children he treated. It appeared to him there were particular behavioural differences in these children. These differences being: the ways in which they socialised, communicated, recognised and expressed emotions; the ways in which they talked about and engaged in particular topics and activities; their motor co-ordination and the ways in which they learnt and variations in their sensory experiences. Asperger believed that these features were pervasive and enduring, that these features had a neurological or genetic base and he differentiated these features from mental health problems such as schizophrenia, in keeping with this assertion, he named the disorder *Autistische Psychopathen im Kindesalter* (Attwood, 2007), translated as “autistic psychopathy” (Jordan, 1999) or more specifically, “autistic personality disorder” (Gillberg, 2002).

It was not until 1981 that AS, as a term, was first used by Lorna Wing. Then in 1991 Frith (1991a) first translated Asperger’s seminal paper into English (cited in Jordan, 1999). The lag between Asperger’s and Wing’s use of the term AS prompted numerous authors to retrospectively identify research on other disorders where participants could

have been diagnosed with AS (Ssucherewa, 1926; Gillberg, 1996; Wolf, 1996; Wolf & Chick, 1980 cited in Ghaziuddin, 2005), suggesting that AS had always existed as a separate disorder even before Asperger's seminal paper.

By improving the definition of AS, Wing (1981) and Frith (1991a, cited in Jordan, 1999) began a process which would ultimately improve our understanding and the support provided to people with this disorder. In the late 1980's a consensus for a definition begun to develop with contributions from Burd and Kerbeshian (1987, cited Jordan, 1999), Tantam (1988), Szatmari et al (1989, cited in Gillberg, 2002) and Gillberg and Gillberg (1989, cited in Gillberg 2002). In 1993 and 1994, within the most widely used diagnostic manuals: the International Classification of Diseases and Disorders – 10 (World Health Organisation, 1993) and the Diagnostic Statistical Manual IV (American Psychiatric Association, 1994) respectively, AS, or rather Asperger Disorder was recognised and classified as a separate disorder.

From the loose working definitions that had been provided by a number of clinicians (Jordan, 1999) came a clearer set of quantifiable indicators to AS. However, despite this relative clarity, the agreement on diagnostic definition is still evolving. One measure of this is that there are currently a variety of diagnostic systems that are being used in the scientific study of AS (Gillberg, 2002), each being criticised for numerous reasons one of which is the use of slightly different criteria. For example, the International Classification of Diseases and Disorders -10 (World Health Organisation, 1993) and the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000) have been heavily criticised for using slightly different criteria from each other (Attwood, 2007; Jordan, 1999) and for using indicators that are at best unclear and misleading and open to interpretation and at worst inaccurate for differential diagnosis thus, subject to validity and reliability problems (Attwood, 2007; Bowler, 2007).

One main reason for the delay in the immergence of a clearer definition of AS and the criticisms for the current diagnostic systems is because of the continued debate between researchers and clinicians regarding AS's differentiation from other psychiatric, neurodevelopmental and language disorders, such as Attention Deficit Hyperactivity Disorder (e.g. Asherson, 2009), Rett's Disorder (Rett, 1966, cited in Jordan, 1999), Non-Verbal Learning Disability (e.g. Cohen & Volkma, 1997), William's Syndrome (e.g. Cohen & Volkma, 1997), Autistic Disorder (Howlin, 2003; Attwood, 2007), Deficits of Attention, Motor Control and Perception (Gillberg & Rasmussen, 1992, cited in Jordan, 1999), Pervasive Developmental Disorders-Not Otherwise

Stated, Schizoid Personality Disorder (Wolff, 1995, cited in Bowler, 2007) and Semantic Pragmatic Disorder (Rapin & Allen, 1983, cited in Jordan, 1999). Furthermore, one of the major contentions in understanding and defining AS has been in trying to unpick it from disorders that share all of the main underlying fundamental characteristics within the areas of social relating, communication and imagination/inflexibility (Gillberg, 2002), for which the terms Autism Spectrum Disorder (Wing, 1996, cited in Jordan, 1999) and Pervasive Developmental Disorder (e.g. American Psychiatric Association, 2000) have been used synonymously to describe this relationship. The majority of the research exploring this particular contention has debated the differences between those diagnosed with AS and those diagnosed with Autistic Disorder, particularly those where the intellectual quotient is within the normal range, named "Cognitively Able" (Klin et al, 2002b cited in Gaus, 2007) or more widely termed "High Functioning Autism" (DeMyer, Hingtgen & Jackson, 1981). For example, research has not revealed convincing findings that there are any qualitative differences in the behaviour profiles (Dissanayake, 2004, cited in Attwood, 2007) such as communication ability (Verte et al, 2006), few differences in social interaction (Macintosh & Dissanayake, 2006), circumscribed interests (South, Ozonoff & McMahon, 2005), repetitive behaviours (Cuccaro, Nations, Brinkley, Abramson, Wright, Hall, Gilbert & Pericak-Vance, 2007) or quantitative differences in the cognitive profiles (e.g. Manjiviona & Prior, 1999) comparing those diagnosed with High-Functioning Autism with those diagnosed with AS, moreover, there is a lack of any substantial difference between the two diagnostic groups (Howlin, 2003) and that any distinctions that are found "wane across all symptom domains" as those with High-Functioning Autism and AS mature (South et al, 2005; Howlin, 2003). Therefore, High-Functioning Autism and AS should not be treated as distinct categories (Ghaziuddin, 2005) but perhaps just rather in relation to severity of symptoms under the autism spectrum concept (Verte et al, 2006). For these reasons, research on both High-Functioning Autism and AS will be used within this literature review as relevant to this study.

Despite some remaining contention about the definition, conceptualisation and the specific features required for the diagnosis of AS, agreement does appear to exist regarding the broad core characteristics of AS, with an acknowledgement that some of these are shared with other disorders, sometimes so closely that differentiation is difficult and that the expression of these core features can vary between each individual identified as having AS but within parameters. With that in mind, AS has been defined as a developmental disorder characterised by a particular profile of

psychological, cognitive and behavioural characteristics that have a biological basis (Attwood, 2007); diagnosis is made at the behavioural level. Within the International Classification of Diseases and Disorders -10 (World Health Organisation, 1993) and the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000) systems diagnosis is indicated where there is qualitative impairments in social interaction, restricted, repetitive and stereotyped patterns of behaviour, interests and activities, with no clinically significant delay in language or cognitive development. The additional feature of clinically significant impairment of functioning in work, social or other important areas of life is also required in the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000). The Gillberg (1991, cited in Gillberg, 2002) definition, includes motor co-ordination problems, whereas the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000) does not state this as defining and the International Classification of Diseases and Disorders – 10 (World Health Organisation, 1993) mentions it as a non-diagnostic feature. Gillberg's (1991) system also states that there are unusual language qualities but there may not be a language delay (cited in Gillberg, 2002).

Therefore, a relatively clearer definition of AS now appears to exist. This definition will not only be influenced by increased understanding based on future scientific enquiry but also through "folklore" influenced by the social model of disability thus leading to a more refined, accurate and helpful conceptualisation. For example, it is predicted that within the new Diagnostic Statistical Manual, AS will no longer exist as a diagnosis, instead being subsumed into the wider definition of Autism Spectrum Disorders. This has implications. For example, AS can be viewed by some clinicians and arguably the wider society as a more favourable diagnosis and less stigmatising compared to other Autism Spectrum Disorders due, for example, with its association with superior intellect (Frith, 2004; Mayes & Calhoun, 2008). Therefore, before we turn to exploring mental health in AS, the use of psychotherapy as a possible intervention and the interaction between the features that characterise this condition and therapy and therapist assumptions, preferences and expectations, a short exploration will be made on the social model of AS and the possible impact on the definition of AS and therapist attitudes.

5.2. The Wider Social Context

It would seem that are a number of positive shifts are appearing to be seen in the field of Autism Spectrum Disorder's generally and AS specifically. These shifts may be

important as the therapeutic process is inevitably affected by the biases and values of therapists (Lopez, 1989; Murray & Abramson, 1983, cited in Garnets, Hancock, Cochran, Goodchilds & Peplau, 1991) and the extent to which therapists' feel comfortable with their clients (Gunderson, 1978, cited in Bland & Rossen, 2005). These shifts are specific attempts to provide a more favourable image of the syndrome through descriptions of common characteristics as *differences* rather than *deficits* (e.g. Jordan, 1999) with well-known figures within the field of Autism Spectrum Disorders coining those without this syndrome *neurotypics* (e.g. Gillberg, 2002), suggesting difference as a positive attribute. Furthermore, some people have changed the title Autism Spectrum Disorders to Autism Spectrum Conditions in order to reflect a more adaptive perspective, as Asperger said himself "Not everything that steps out of line, thus `abnormal' must necessarily be `inferior.'" (1938, cited in Attwood, 2007). Furthermore, according to Frith (2004) Asperger alluded to several of his cases having high originality of thought and verbal expression, supporting Craig and Baron-Cohen (2000, cited in Frith, 2004) who argue that children with AS can be extremely creative. Gillberg (2002) argues that

> *"People with AS-with their lack of flexibility and, often, stunning egocentricity-have major problems coping with 'normal' life. At the same time, many are 'free thinkers' and may be scientifically or aesthetically highly skilled people. 'Asperger people' (as they sometimes like to refer to themselves) are fascinating and, possibly, specifically valuable for the development of the human species. Their difficulties and strengths shed light on the development and minds of other, 'neurotypical'…people* (p.4)*.*

Furthermore, many authors, clinicians and researchers have retrospectively identified a number of high profile and respected people from history such as Einstein (Fitzgerald, 2000) that could have been diagnosed with AS, a product of refined definition and conceptualisation within a historical context which may help to enable a more positive reframing of the syndrome. These famous figures are associated with achievements relating to a focus on objects rather than people (Baron-Cohen, 2002b) thus highlighting the adaptive skills of people with AS and difference rather than disability (Baron-Cohen, 2002b). Attwood and Gray (1999) outline criteria for what they call discovery rather than diagnosis of people with AS, in their attempt to highlight the strengths and talents rather than deficits of people with AS.

Thus a social model is outlined that appears to compete with the medical model in that AS can be viewed as a personality variant and only a disability secondary to the barriers society creates and maintains, therefore, according to this construct, if the barriers are eroded so too is the disability (Oliver, 2004, cited Elliman, 2011). The social model is compelling in identifying the strengths of people with AS and placing responsibility on society to dismantle barriers where they exist. However, this model neglects the actual impairment such as possible extreme sensory sensitivities (Elliman, 2011) that can, alongside prejudice and social barriers, lead to difficulties in the person. Therefore, despite the beliefs of some social constructionists, the shifts from a more negative to a more positive attitude towards AS and emphasis on strengths and abilities, it is a widely held view that people with AS remain impaired in a number of ways, all of which might influence the attitudes of therapists working with them within a therapeutic context. Nevertheless, even if the characteristics that have been used to define people with AS can be construed as strengths they may still impact on therapists and therapy, the possibilities of which may need to be considered by the therapist; potentially impacting on their expectations and preferences. The social model is not dismissed but embraced alongside the medical model to form a more complete view on what can influence therapist attitudes; this is a dynamic and stratified position to take and in keeping with the emerging epistemology of the author, that being critical realism.

With this in mind, we now turn to exploring mental health and AS as a way to justify the use of psychotherapy for some people with AS. This will be followed by an exploration of psychotherapy as a possible intervention and the possible implications for therapists' attitudes when considering the range of features that those with AS may bring to therapy.

5.3. Mental Health

> *"…if intuitive mentalising failure makes it hard to predict and interpret other people's behaviour, then the social world cannot be the source of pleasure that it can be for ordinary people. Especially if there is a desire to be part of the social world, as frequently expressed by people with AS, unexplained failure of social interactions may well create or intensify feelings of depression. The inability to cope with the non-routine aspects of everyday life due to executive functioning problems may also contribute to high anxiety and depression"* (Frith, 2004, p. 682).

Detecting and diagnosing mental health problems in those with AS may be very difficult for a number of reasons: there are relatively few professionals who are specialised enough to detect co-morbidity in those with AS; the current classification systems make diagnosis difficult; there are very few standardised instruments for aiding detection of mental health problems in people with AS; the features of AS can be confused with and therefore overshadow mental health problems (Tantam & Prestwood, 1999; Stewart et al, 2006). This may be why there is relatively little research on co-morbid psychopathology with AS. Based mainly on both a range of clinical experiences of experts in the field and research using predominately clinic based samples it would seem that people with AS do show a propensity to mental health problems (Tantam, 1988), such as anxiety and depression, in children (Klin et al, 2000) and in late adolescence and early adult life (Tantam & Prestwood, 1999). Some people with AS may be more susceptible to co-morbid psychopathology because of genetic association (Tantam, 2000) or via difficulties with social perception, understanding and experience (Meyer, Mundy, Hecke, & Durocher, 2006) and the impact of secondary disability where they may be marginalised due to prejudice. Hurtig, Kuusikko, Mattila, Haapsamo, Ebeling, Jussila, Joskitt, Pauls and Moilanen (2009) found, using both clinical and community based samples based on informant reports, that children and adolescents with High-Functioning Autism showed more psychiatric symptoms such as being withdrawn, anxious and depressed compared to the comparison group. Reflecting the difficulties with diagnostic overshadowing, the main limitation of this study and similar research is in using criteria for satisfying psychiatric diagnosis that overlap with the core features of Autism Spectrum Disorders, therefore differentiating the two is rather difficult. The number of participants was also rather small (n=47) and the sample may not reflect the wider population of people with AS given for example, that it used some clinic based samples.

Asperger and Kanner themselves both described co-morbid features consistent with contemporary diagnostic categories relating to such things as anxiety disorders (Ghaziuddin, 2005). Furthermore, it has been argued that the more able the individual is with an Autism Spectrum Disorder the more likely they may be to experience anxiety and/or depression as they become more aware and thus distressed by their difficulties, as they want to socialise but find it difficult (Hare, 2001). However, this assertion may not be warranted given that it might simply be too difficult to detect mental health problems co-morbid to an Autism Spectrum Disorder in those lower functioning

individuals, due to communication difficulties for example, also mental health problems in this group might manifest differently to the higher functioning group.

Ghaziuddin, Weidmer-Mikhail and Ghaziuddin (1998) found in their study that 65% of the sample of people with AS had a co-morbid concern, the most common being depression and Attention Deficit Hyperactivity Disorder. Muller, Schuler and Yates (2008) found that individuals with an Autism Spectrum Disorder, including AS, reported within a semi-structured interview, social isolation, a longing for greater intimacy and difficulties with social interactions and communication.

In a study by Bauminger and Kasari (2000) they found that children with High-Functioning Autism reported greater loneliness than the developmentally typical comparison group, less friends (concurring with Hurtig et al's, 2009 research) and less satisfaction with their friendships. However, the descriptions used by those with an Autism Spectrum Disorder of these things appeared qualitatively different to those without an Autism Spectrum Disorder and therefore one cannot generalise in terms of what it means for them. Other criticisms of this study include using techniques that are susceptible to bias including prestige bias (Robson, 2002) leading to possible unreliability, shown possibly in the disparity between ratings produced by the parent compared to the person with an Autism Spectrum Disorder. Furthermore, this study did not screen for co-morbidity such as depression, which is often associated with social isolation (Antony & Barlow, 2002) and has been argued to compound the problems associated with AS (Frith, 2004).

Mirroring the general population, one of the most common mental health concerns in those with AS may be depression (Ghaziuddin, 2005; Tantam, 1988, 1991). Rates in the general population have been argued to be between 2% and 3% in males and 5% to 9% in females (American Psychiatric Association, 1994) whereas rates of depression for people with an Autism Spectrum Disorder can range from between 4% and 38% (Lainhart, 1999, cited in Stewart et al, 2006), however, the prevalence may be as high as 52% (Ghaziuddin et al, 1998). There is also evidence to suggest an association between bipolar affective disorder and AS (DeLong & Nohria, 1994, cited in Tantam, 2000). The awareness of those with AS about their differences compared to the general population (Hedley & Young, 2006), their desire to socialise but experiencing difficulties leading to ridicule, rejection and exclusion (Attwood, 1998, cited in Hedley & Young, 2006) and the lack of protective factors such as satisfactory friendships (Bauminger & Kasari, 2000) and supportive social networks (Renty &

Roeyers, 2006) may be important factors in maintaining poor quality of life and the development and maintenance of depression in some people with AS. In a phenomenological study by Punshon, Skirrow and Murphy (2009) they found that an important theme in the discussions with 10 participants with AS was feelings of isolation when growing up and prior to their diagnosis of AS; with the diagnosis of AS came a sense of "fitting" in with others who also had a diagnosis of AS (p.277). This study also identified misunderstanding, misdiagnosis and inappropriate interventions as maintaining feelings of alienation in the participants, contributing to their anxiety, depression and self-harm (Punshon et al, 2009); with diagnosis came a sense of normalisation of their difficulties and a sense of exoneration "…from being blamed" for previous problems (p.277).

In terms of anxiety, those with an Autism Spectrum Disorder may also be overly represented (Simonoff, Pickles, Charman, Chandler, Loucas & Baird, 2008; Gillott, Furniss, & Walter, 2001), where anxiety may be an almost universal feature of AS (Tantam, 2000). This is not unexpected given the difficulties they might experience with every day coping (Ruberman, 2002) and confusing social interactions. In Muris, Steerneman, Merckelbach, Holdrinet and Meesters' (1998) meta-analysis they found that 84.1% of children with a Pervasive Developmental Disorder met the full criteria of at least one anxiety disorder. Attwood (1998) states that many young adults with AS report intense feelings of anxiety, an anxiety that may reach a level where treatment is required. Anxiety can be very pervasive and there is evidence that it can predispose to other psychiatric disorders such as depression (Hirschfed et al, 1989; Kendler et al, 1993, cited in Stewart et al, 2006). One anxiety disorder particularly difficult to differentially diagnose is obsessive compulsive disorder due to the similarity with the core diagnostic features of AS. Compulsions may be common in AS but obsessional, egodystonic thoughts may not be (Ghaziuddin, 2005), although it may hard to establish egodystonic symptoms in some people with an Autism Spectrum Disorder (Reaven & Hepburn, 2003). Obsessive compulsive disorder does appear to coincide with AS and may be more common in this population (Kerbeshian & Burd, 1986, cited in Tantam, 2000), although there is very little literature examining the relationship between the two (Thomsen, 1999). Szatmari, Bremner and Nagy (1989) studied a group of 24 children. They discovered that 8% of the children with AS and 10% of the children with High-Functioning Autism were diagnosed with obsessive compulsive disorder, this compared to 5% of the control group of children without an Autism Spectrum Disorder but who were experiencing social difficulties. However, this research assumes that the

diagnosis of co-morbidities was accurate which might be difficult given the difficulties in identifying co-morbidity in those with AS described earlier.

Problematic anger has also been identified in people with an Autism Spectrum Disorder, including people with High-Functioning Autism and AS. Aston (2003) studied couples and found that 75% of female partners with AS had been violent towards their partners and 40% of men with AS had been violent towards their partners (cited in Paxton & Estay, 2007). The effects of problematic anger can be significant and can benefit from being targeted within psychotherapy using, for example, a modified cognitive behavioural therapy approach (Kellner & Tutin, 1995).

The limited research suggests that mental health problems have been shown to be very common in those with AS. However, these studies have a number of shared limitations as they are predominately based on anecdotal evidence, small samples and often from clinical populations therefore may not reflect the wider population of people with AS. However, as therapists are likely to see people with AS who have additional difficulties in clinical settings this research may help the therapist understand the types of problems they might encounter. The major mental health problems that some of those with AS might be susceptible to share some common symptomatology, which could be argued to further exacerbate the features of AS; these might influence psychotherapy and therapist attitude. For example, low self-esteem, inflexibility and polarised thinking are common features across many mental health problems (Butler, Fennell & Hackmann, 2008). Furthermore, some people with AS may be receiving the wrong types of interventions for mental health problems (Ryan, 1992), which may exacerbate their difficulties (Tantam, 1991; Punshon et al, 2009). Hare (1997a) concludes that those with AS can disproportionately experience mental health problems and that therefore there is a need to develop effective interventions such as psychotherapy for this client group. An exploration will now be made of psychotherapy as one type of intervention as it is applied to people with AS before exploring in more detail the literature on therapist attitudes and preferences in general before turning to how these might relate to therapy with clients who have AS specifically.

5.4. Psychotherapy

> *Psychotherapy is an efficacious approach for the amelioration of psychological distress and improvement of functioning* (Bertolino et al, 2011, p.4).

Following a review of the published research including reflecting on Steward et al's (2006) extensive review, it would appear that medication is the method of choice when treating mental health problems in those with AS, moreover, there is relatively little reported research on the use of psychotherapeutic interventions (Weiss & Lunsky, 2010) over and above simple behavioural modes which may neglect the emotional and cognitive aspects of the person with AS (Paxton & Estay, 2007; Hare & Paine, 1997). It would appear that when cognitive and emotional aspects are targeted then the mode is often social skills groups (e.g. Attwood, 2007; Howlin & Yates, 1999) and these appear to target issues in a rather circumscribed manner such as targeting theory of mind abilities (Weiss & Lunsky, 2010) and therefore might not reflect the complexity of the problems experienced by some people with AS and the complexity of "real-life" settings in which these skills are meant to be carried over to.

There is very limited research into psychotherapy and AS, this is despite the possible steady increase in psychiatric disorders over the last 20 years (Ghaziuddin, 2005), recent department of health drives to improve the access people have to evidence based psychological therapies (Department of Health, 2010) and the clear consensus that this population is particularly vulnerable to mental health problems (e.g. Tantam, 1988) and therefore the seeking of psychotherapy as a possible remedy. For the generally population psychotherapy has been argued to be extremely effective in terms of increasing functioning and decreasing the symptoms of mental health, the need for medication and the cost of health care provision (Chiles et al, 1999; Kraft et al, 2006, cited in Bertolino al, 2011). In terms of Autism Spectrum Disorders, there is a small body of clinical and anecdotal evidence which seems to show that counselling can be particularly helpful for some people diagnosed with AS.

Based on review and meta-analysis Schopler and Mesibov (1983) argue that counselling can be valuable for both adolescents and adults with an Autism Spectrum Disorder. They argue that the 1:1 therapeutic relationship can provide the structure, guidance, information and support they may need to function more effectively. Bromfield (2000) discusses psychoanalysis and through meta-analysis concludes that it is very relevant with at least milder forms of Autism. Stoddart (1999) demonstrated through a descriptive analysis of three case studies that individual and family therapy can be very effective for those with AS. This was based on information provided by the family and the clients and was demonstrated by reductions in family conflict and medication, increases in quality of life in terms of greater community participation and broadening of interests and aspirations and decreases of anxiety and depression in the

client. However, there are a number of significant concerns with this research in terms of methodology. There was no clear model applied within the therapy, the therapist appeared to simply switch between a number of different but compatible models according to the presenting issue in each session. Furthermore, there was no measure of any of the co-morbid concerns targeted; this had implications in terms of the ways in which change was measured. Finally, in addition to the psychotherapy, a number of other interventions were simultaneously being applied including social skills groups and medication; it will be hard to ascertain the differential merits of each.

The limited research that does exist appears to support the use of psychotherapy for those with AS where the most thoroughly researched and evidenced studies come from the use of cognitive behavioural therapy (e.g. Hare, 1997a; Kellner & Tutin, 1995). Cognitive behavioural therapy has been argued to create positive effects that can become habitual over time and can lead to long lasting effects (Glasman, Finlay & Brock, 2004). Cognitive behavioural therapy has been found to be effective in helping people with depression both from the general population (e.g. Beck, 1995) and for those with AS (e.g. Hare, 1997a; Paxton & Estay, 2007).

Hare and Paine (1997) illustrate the effective use of cognitive behavioural therapy through a client study of a client who presented with a potentially dangerous sexual offending behaviour over four sessions. In another study, Hare (1997a) showed that through the use of 15 sessions of cognitive behavioural therapy a client with severe depression and self-injurious behaviour improved as demonstrated by lower scores on the Beck Depression Inventory (Beck, Steer & Brown,1996) towards the end of therapy, from a score of 29 to 13, thus the client went from moderately to mildly depressed, where scores below 9 indicate no depression. Lord (1995) demonstrated a successful intervention with regard obsessive symptoms in an adolescent male using cognitive behavioural therapy (cited in Reaven & Hepburn, 2003) and Reaven and Hepburn (2003) illustrated marked improvement in a 7 year old child with AS who was experiencing difficulties with obsessive compulsive disorder, using an adapted cognitive behavioural therapy approach designed for children. Finally, Cardaciotto and Herbert (2004) showed through another single client study the effective use of a 14 week course of cognitive behavioural therapy in reducing social anxiety and depression, in addition to increasing social skills such as appropriate use of eye contact. One of the benefits of client studies is the level of detail that can obtained, however, these studies did not capitalise on this potentially intensive research method due to the impinging paradigm. In addition, as these were all single client studies the

results may be difficult to generalise to the wider population of individuals with an Autism Spectrum Disorder. In addition, the research did not distinguish between the various different contributions to the improvement from such things as the particular characteristics of the clients, the therapists, the working alliance, the protective characteristics of the systems around them such as the families and the influence of other interventions also applied at the time such as medication.

Some researchers have attempted to overcome some of the limitations identified in the single client studies through randomised controlled trials. In four different randomised control trials it was found that cognitive behavioural therapy was more effective than waiting list for children with either High-Functioning Autism or AS and anxiety (Sofronoff, Attwood, Hinton & Levin, 2007; Wood, Drahota, Sze, Van Dyke, Decker, Fujji, Bahng, Renno, Hwang & Spiker, 2009; Chalfant, Rapee & Carroll, 2006) and with problematic anger (Sofronoff et al, 2007). However, it may be difficult to generalise this post-positivist research that used cohorts selected on the basis of "pure" forms of AS to the wider heterogeneous AS population. In another study, it was found, in what the authors claim may be the only piece of research into group cognitive behavioural therapy targeting clients with AS and mood and anxiety disorders, that gains were made with all three of the clients in this study, however, gains were difficult to maintain (Weiss & Lunsky, 2010). However, there were only three people in this group, with extremely different backgrounds and despite them all having an anxiety and mood disorder, as the authors claim, these had very different etiologies and presentations. Furthermore, it is difficult to ascertain which things (and to what degree) actually influenced the alleviation of their distress over the course of therapy as very few measures were taken including no self-esteem measure which is surprising given its transdiagnostic association (Butler et al, 2008) and known to be the only thing that often improves with group work for people with an Autism Spectrum Disorder (Howlin & Yates, 1999).

Cognitive behavioural therapy has been shown to be effective for people with an Autism Spectrum Disorder by targeting the distorted thinking and avoidance that can precipitate and maintain mental health problems such as anxiety and depression. It is clear that the repetitive, "scientific" logical, concrete and explicit approach to cognitive behavioural therapy including agenda setting and explicit homework tasks can appeal to some of those with AS, found for example, in the participants in Weiss and Lunsky's (2010) study. However, despite the possible benefits of this model and other models adaptations may still need to be made (e.g. Kellner & Tutin, 1995). For example,

providing the client visual aids such as drawings, diagrams and written notes can be helpful (Fullerton & Coyne, 1999; Gray, 1998), as with other clients, as well as explicit, direct directions or rules for intervention (Reaven & Hepburn, 2003), in order to enhance attention, retention, organisation, understanding and generalisation of information and learning (Fullerton & Coyne, 1999). The therapist may need to teach memory strategies (Bebko & Ricciuti, 2000) and provide plenty of time for the person with AS to process information, as this may be slower than typical individuals particularly when dealing with emotionally laden information (e.g. Kaland, Moller-Nielsen, Callesen, Mortensen, Gottlieb & Smith, 2002), such as dealing with "hot" cognitions and conducting cognitive restructuring as found in Weiss and Lunsky's (2010) research. These adaptations may not only leave some therapists feeling confused and overwhelmed but also adrift from what they know of what it means to be a therapist (Paxton & Estay, 2007). For example, Paxton and Estay (2007) argue that sometimes in the psychotherapy the sessions they provided felt more like "lessons" than "counselling," as there may be a lot of information sharing; this may not be what the psychotherapist expects, desires or feels satisfied with.

Furthermore, therapists will also need to know that some people with AS, despite their obvious difficulties, may not recognise that they have concerns that need targeting. For example, Koning and Magill-Evans (2001) found that the majority of a group with AS perceived their difficulties as less severe than did their parents and teachers, thus they may not seek help when needed or dismiss it when offered. Knott et al (2006) also found that about half of the 19 children and adolescents with an Autism Spectrum Disorder in their research under-reported the severity of their difficulties compared to their parents. Frith (2004) points out the irony that the cognitive strengths seen in AS can disguise the social difficulties and lead to less willingness to acknowledge areas of need and seek support. Therefore, it may not be the persons idea to attend therapy (Paxton & Estay, 2007) and they may not accept personal responsibility for change (Weiss & Lunsky, 2010), all issues which may influence some therapist's expectations of the usual therapeutic relationship, the working alliance and ultimately their attitude to providing therapy to this population.

All the issues described may leave the inexperienced therapist feeling frustrated (Paxton & Estay, 2007) and given that empathy may not be reciprocated (Hare, 1997b) the therapist may feel alone in this struggle. Working psychotherapeutically with people with AS, including adapting the model used to fit the particular needs of the client, may require a thorough but flexible understanding of this disorder and how it

may manifest in the individual, as it is a heterogeneous disorder, alongside other characteristics, how it may overlap and interact with co-morbid concerns and influence the therapeutic relationship and outcome. AS is a complex heterogeneous disorder which has been characterised by a potentially unusual interpersonal style, various co-morbid concerns and a lack of a solid evidence base for working psychotherapeutically; some therapists may feel excited and others daunted by this; working with people with AS may run counter to the therapist's preferences. An exploration of what the therapist may experience when working psychotherapeutically with this population will now be undertaken. This will be done by reviewing the literature on a range of common features that have been shown to be associated with AS alongside the possible impact of these on the therapist and in relation to basic therapeutic assumptions as well as therapist preferences. This will be followed by an exploration of clinical supervision as a possible resource to support therapists in the task of providing therapy to people with AS before describing the comparison groups and the aims of the study.

5.5. Asperger Syndrome and Therapy

> *"What I knew about psychoanalytic and other personality theories, psychodynamics, unconscious motivation, subtle "understood" meanings was not helping me to understand these people's minds or their experiences. They could seem self-centred, detached, uncaring, or even hurtful...They seemed odd to others, and others often seemed odd to them… In understanding the minds of these children, I was often the clueless one…"* (Jacobsen, 2004, p. 570).

Working psychotherapeutically

> *"…with people with AS can be very difficult as many of our unconscious expectations about relationships, including professional ones, are often violated. This is in addition to the more obvious difficulties in speech and non-verbal communication"* (Hare, 1997b, p.8).

There appears to be no research that the author is aware of that directly explores therapist attitudes and preferences in relation to working with people with AS. It is therefore the intention of the author to explore the various different features that are associated with AS and how they may interact with therapist preferences and therapeutic assumptions. These features may manifest in a variety of ways in clients

with AS, which may impact on and influence the psychotherapeutic relationship, the ways in which psychotherapy is conducted and therefore therapist attitude as they may conflict with therapist preferences. However, before an exploration of the features that describe AS is conducted and their possible impact on therapist attitudes, an exploration of therapist preferences will be undertaken, which might help to provide some parameters to the subsequent exploration.

5.5.1 Therapist Preferences

In terms of both client and therapist preferences, engagement/interaction and therapeutic outcome within general mental health, there appears to be a number of influences. The degree to which a client and therapist match or are similar on a number of different dimensions appear to be important such as age, values, biases, preferences (e.g. Atkinson & Schein, 1986; Beck, 1988; Beutler et al, 1994; Jones et al, 1997; cited in Teasdale & Hill, 2004; Lopez, 1989; Murray & Abramson, 1983, cited in Garnets et al, 1991; Marshall, Seran, Fernandez, Mulloy & Thirtom, 2003; Teasdale & Hill, 2004) and interpersonal factors (Couture et al, 2006). It appears that the ability to form a working alliance between client and therapist is also important for both clients and therapists and for good therapy outcome (Martin et al, 2000 cited in Busseri & Tyler, 2003; Horvath & Symonds, 1991; Bertolino et al, 2011) and that in turn the quality of the working alliance is dependent on the interpersonal functioning of the client, in that the therapeutic alliance can be negatively influenced by client hostility, “detachment” (Hersoug et al, 2002; Kivlingham et al, 1998; Saunders, 2001, cited in Couture et al, 2006), social functioning and “autistic preoccupation” (Couture et al, 2006), relating to a restricted and repetitive thought and behaviour pattern; these may not be mediated by client symptoms (Gibbons et al, 2003; Hersoug et al, 2002; Marmar et al, 1989; Moras & Strupp, 1982; Saunders, 2001; cited in Couture et al, 2006). Research also suggests that therapists may also prefer clients who are logically minded (Davis et al, 1977), desire a relationship and view themselves as responsible for counselling (Heine & Trosman, 1960, cited in Davis et al, 1977). Client characteristics are not only important in relation to therapist preferences and the establishing of the working alliance but also viewed as the most important therapeutic factor in positive therapy outcome including the client’s level of premorbid functioning, the quality of their participation in therapy, their social support system and their personal motivations (Bertolino et al, 2011). As positive therapy outcome is important for therapist satisfaction, these characteristics are viewed as crucial.

In a rare study by Teasdale and Hill (2004) they found using 132 counselling psychology trainees via a web-based survey that the trainees preferred clients who are psychologically minded, defined by Teasdale and Hill (2004) as a client "…who wants to talk about him or herself and has a desire and ability to gain insight into their problems and concerns," a view echoed by Davis et al (1977) who have argued that therapists prefer clients who have a need to relate to others. Conte et al (1996) defines psychological mindedness as "a willingness to try to understand self and others, a belief in the benefits of discussing one's problems, openness to new ideas, and access to one's feelings" (cited in Beital, Cecero & Ferrer, 2004). Farber (1985) defines psychological mindedness as "…a trait which has at its core the disposition to reflect upon the meaning and motivations of behaviour, thoughts, and feelings in oneself and others," (p.170) which is regarded as an important quality in clients as well as therapists (Farber, 1985). Teasdale and Hill's (2004) research also suggested that therapists may prefer clients who have intact interpersonal skills (Teasdale & Hill, 2004), which has already been suggested may mediate the working alliance (Couture et al, 2006) and might also be influenced or underpinned by the client's level of psychological mindedness (Faber, 1985).

Very closely linked to the concept of psychological mindedness is the assertion that therapists may also prefer clients who exhibit a degree of conceptual complexity (Davis, et al, 1977). Teasdale and Hill (2004) describe the person with conceptual complexity as:

> *"…a person who processes interpersonal stimuli through a highly abstract system that uses and combines a number of dimensions in processing information. In contrast, someone with a low level of conceptual complexity processes interpersonal stimuli in a unidimensional and unintegrated fashion"* (p. 32).

It could be argued that both the concept of psychological mindedness and the construct of conceptual complexity are inextricably connected based on this description.

Teasdale and Hill's (2004) survey is criticised for a number of reasons. Firstly, the authors point out that trainees were surveyed and as trainees they may change their preferences of client characteristics as they experience a wider range of clients, thus experience may influence preference and therefore these findings may not be able be

applied to more experienced therapists. Secondly, only single items were used to measure the various therapist attitudes, which is not good practice (Thurstone, 1947, cited Lam & Adam, 2007; Wanous & Reichers, 1997). Furthermore, these items were not subjected to rigorous research in terms of whether the therapists understood the items and whether they measured what they purported to measure. Finally, the survey only attracted 35% of trainee therapists contacted via various courses, those that responded may have come from a very different population compared to the people who did not e.g. the latter group may prefer clients who are not psychologically minded. Finally, as with other extensive research, this research may have been improved if it had employed more intensive methods where the context could have been reflected upon to include the cultural, social and historical influences on the therapists' accounts and the researcher's interpretations of these, resulting in a more dynamic account, possibly leading to greater explanation and interpretation of meaning (Sayer, 2000).

An exploration will now be undertaken of the literature that describes the possible features that have been argued to define AS and the possible conflict with therapist preferences and therapeutic assumptions, as described above, including a need for a client to have a degree of interpersonal and social functioning, to be logically and psychological minded, to have a degree of conceptual complexity, with an absence of restricted and repetitive thought and behaviour patterns in order to facilitate the working alliance, the forming of which is an important therapeutic assumption and a possible therapist preference.

5.5.2. Possible Characteristics of Asperger Syndrome and the Interaction with Therapist Preferences and Therapeutic Assumptions.

The therapist encountering a client with AS may observe that despite the client appearing to have no obvious difficulties relating to linguistics they may experience difficulties generating relevant ideas in conversation, they may lack flexibility of thought and behaviour (Bishop & Norbury, 2005), possibly presenting with a rather ridged, polarised (Reaven & Hepburn 2003; Weiss & Lunsky, 2101), perfectionistic (Paxton & Estay, 2007; Hare, 2005; Gillberg, 2002) and dichotomous thinking style (Hare, 2005), meaning the interaction may be dominated by circumscribed topics (South et al, 2005). The client with AS may focus on the detail in session unless prompted otherwise (Jolliffe & Baron-Cohen, 2001), rather than global themes across the session or sessions and experience difficulties with smoothly shifting from one topic or theme to another (e.g. Landa & Goldberg, 2005), which may translate into problems with

conversation cohesion and fluency (Adams, Green, Gilchrist & Cox, 2002; Attwood, 2007; Fine, Bartolucci, Szatmari & Ginsberg, 1994). These issues, combined with potential difficulties in monitoring their recipient's needs (Fine et al, 1994; Ghaziuddin & Gerstein, 1996) and difficulties with jointly attending to material in session, might lead to difficulties with establishing a working alliance and lead to possible breakdowns, which may be particularly evident with emotional discourse (Adams et al, 2002), which is often the target of psychotherapy. Furthermore, the clinician may be misled into believing that the client with AS with whom they are working, who may show for example a good grasp of language at the mechanical level, may also have a proportionately good understanding of the emotional and social interchange at a conceptual level, but in reality may be suffering behind a somewhat superficial veneer, having possibly camouflaged their deficits with compensatory mechanisms such as logic and rote learning (Frith, 2004). Although a client with logical thought may be satisfying for some therapists to work with (Davis et al, 1977), the difficulties that some clients with AS may have with psychological mindedness and conceptual complexity may leave other therapists feeling dissatisfied, possibly further compounded by the client inadvertently or purposefully masking these difficulties, in that the clients possible difficulties in receiving, storing and processing interpersonal information in highly abstract and multidimensional ways may go undetected (Davis et al, 1977) until breakdowns emerge; "The appearance of normality is deceptive…and breaks down when novel or stressful situations arise" (Frith, 2004, p. 683). Furthermore, the unsuccessful masking of difficulties could potentially lead to further difficulties in the individual (Punshon et al, 2009) and thus a viscous cycle may ensue as difficulties become more pronounced and eventually entrenched.

Therapists attitudes may also be influenced by the lack of research into psychotherapeutic approaches to mental health problems in those with AS. What research there is on psychotherapy and the various characteristics that have been argued to define AS can be confusing and contradictory which may unsettle the clinician. Certainly Bertolino et al (2011) argues that it is important for therapists to feel confident in the therapy and the model applied as a means of positive change. People with AS can be easily misunderstood by professionals who are unaware of the potential characteristics of AS (Attwood, 1998; Shuttleworth, 1999 cited in Paxton & Estay, 2007) leading to possible problems not only being experienced by the therapist, the target of this thesis, but also by the client with AS, their partner and/or family. For example, it was reported by Aston (2003) that approximately 40% of couples where at

least one member had AS, were dissatisfied with previous psychotherapy (cited in Paxton & Estay, 2007). The therapist will need to acknowledge both the possible cognitive differences that characterise this disorder but also the possible cognitive distortions that characterise mental health problems, a complex endeavour that requires experience, where this is lacking therapist effectiveness may be compromised and burnout more likely (Lambert, 1989).

Apart from being logically minded, all the characteristics of AS described above may challenge the therapists desire for a client to have a degree of interpersonal and social functioning, to be psychological minded and have conceptual complexity. In terms of therapeutic assumptions, one essential assumption may be challenged in terms of forming a working alliance, influenced by several possible characteristics that the client may bring to the therapy including their possible difficulties with social functioning, "autistic preoccupation" or restricted and repetitive thought and behaviour patterns (Couture et al, 2006). The lack of a solid and robust evidence base and the potential lack of knowledge the therapist has may also influence their attitude to providing psychotherapy to people with AS. For example, Bertolino et al (2011) argues that for the therapist "…positive expectations, faith in the therapy as a practice and a belief in (allegiance to) the approach and methods utilized" is important, particularly for a positive outcome to therapy. Furthermore, a lack of focus in therapy, possibly due to a lack of therapist knowledge, predicts negative therapeutic outcome (Bertolino et al, 2011)

A detailed exploration of the research exploring the possible features of AS that relate to the areas of therapist preferences and therapeutic assumptions explored above will now be undertaken to unearth the possible impact on therapist attitudes, beginning with interpersonal and social functioning.

5.5.2.1. Interpersonal and Social Functioning

It is a commonly held view that an essential feature of AS is a qualitative impairment in social interaction, which includes the lack of social and emotional reciprocity and impairments in the use of non-verbal communication with which to regulate social interaction; this is reflected across all diagnostic classification systems:

> *"The nature of these children is revealed most clearly in their behaviour towards other people. Indeed their behaviour in the social group is the clearest sign of their disorder"* (Asperger, 1944, cited in Attwood, 2007).

Social reciprocity requires a number of skills and for these skills to be integrated otherwise difficulties within the social interaction may be more likely; problems here may challenge therapist preferences (Teasdale & Hill, 2004; Couture et al, 2006). In order to successfully engage with another person a number of skills are required including pragmatic abilities, which is the use of verbal and non-verbal communication in context. In order to use this skill and effectively socially interact the person must understand the social-context which would include the perceived needs of the conversation partner in order to guide the interaction. The person must engage flexibility with their conversation partner on multiple levels including mental state and emotional recognition, utilising social cognition skills in order to help them understand the internal states of others within the particular social-context. Difficulties in all these areas have been identified in those with AS. We begin by reviewing the research on pragmatics before turning to a broader and deeper exploration of interpersonal and social functioning.

5.5.2.1.1. Interpersonal and Social Functioning: Pragmatics

Research appears to have shown that despite children with AS showing adequate expressive language ability by the age of 3 years (Szatmari, 1998, cited in Verte et al, 2006), this can often be limited to the more mechanical, formal aspects of language expression such as syntax (Fine et al, 1994). Despite these language abilities some people with AS are known to experience possible difficulties generating relevant ideas in conversation (Bishop & Norbury, 2005), they may lack flexibility (Attwood, 2007) translating into possible problems with conversation fluency, where interchanges can be full of abrupt changes of topic and tangential responses (Fine et al, 1994). It is within the social use of language where context and the listeners needs are considered that those with AS may experience difficulties, referred to as pragmatics (Verte et al, 2006; Adams et al, 2002). Pragmatics is fundamental in social discourse and thus to a therapeutic interchange, it includes such things as topic management, initiating and maintaining conversation, turn taking, repairing breakdowns in interactions when they occur and shifting conversation smoothly when required, all these may be problematic in those with High-Functioning Autism (Fine at al, 1994). All these features have obvious implications on a therapeutic encounter and therapist preferences where language mediates the interchange.

Pragmatics also incorporates prosody, an aspect of speech which is used to convey a particular social reality. Prosody is also viewed as a possible area of difficulty for some

of those higher functioning individuals with an Autism Spectrum Disorder and in particular those with AS (Koning & Magill-Evans, 2001). The areas within prosody that may appear particularly problematic are with resonance, phrasing and stress (Rhea, Augustyn, Klin & Volkmar. 2005) giving a possible impression of a voice melody that is full of unusual pitches and rhythm (Fine et al, 1991; cited in Attwood, 2007; Shriberg et al, 2001; cited in Frith, 2004) which given prosody is a way to communicate meaning this may leave the therapist unsettled and uncertain about what is being communicated.

In Verte et al's (2006) research it was found that 70% of children in the sample with AS, compared to 0% of the comparison group experienced pragmatic problems based on parent scores on the Children's Communication Checklist. In another study, also using the Children's Communication Checklist, Bishop and Baird (2001) found that pragmatic ability, based on scores from both parent and professional ratings, was worse in children with AS compared to those with a specific learning disability; these differences were not explicable in terms of chronological age or intellectual functioning. However, within both these studies there was substantial disagreement between the parent ratings and the teacher ratings and thus detecting pragmatic difficulties in people with an AS in these studies does not appear particularly reliable. Furthermore, these studies and the instrument employed, neglect the influence of the context in which these pragmatic difficulties occur or are being rated. Both these studies and the Children's Childhood Checklist as an instrument to measure pragmatics within them, do not appear to acknowledge the interdependency of pragmatic functioning i.e. the extent to which the conversational partner helps regulate, or not, pragmatic functioning, moreover, there is no reference made to the collaborative nature of conversation, the impact of the context when rating pragmatic ability i.e. the research does not appear to acknowledge "…both sides of the social equation…" (Attwood & Gray, 1999). Therefore, one wonders how this research translates to "real-life" settings such as encounters with a therapist. By definition pragmatics involves a context and within this context are conversational partners, pragmatic difficulties occur between people and when the context is not explored it leaves the reader wondering how to extrapolate the findings and in particular to the therapeutic setting. These criticisms are multiplied when also considering the substantial difficulties with informant ratings of behaviour, which this measure is dependent on, particularly as the Children's Communication Checklist has not been validated to people with AS, to parents and there was no detailed account of how it was translated into Dutch for the Verte et al's (2006) study,

thus ironically for this particular study, possibly leading to pragmatic problems with the use of the measure.

Adams et al (2002) in their study appear to acknowledge, at least in part, the context in which conversation occurs. They showed that the participants between the ages of 11 and 19 years with AS experienced significantly more pragmatic problems, particularly in relation to emotional discourse compared to the more “neutral” everyday discourse, than the matched group with conduct disorder (Adams et al, 2002). The study systematically analysed the utterances of both participant and the conversation partner (a Clinical Psychologist) from a set of conversations taken from the Autism Diagnostic Observational Schedule (Lord et al, 1989, cited in Adams et al, 2002). Using discourse analysis they provided a detailed analysis that was interactional, reflecting on the influence of both people within the interaction on the conversation, thus the context in which an utterance occurred including what had come before in the conversation when analysing conversation portions was incorporated into the analysis. However, the extent to which these findings can be generalised to other settings including complex “real-life” settings is questioned particularly given that people with AS can often benefit from very closed and controlled situations like this for reasons such as reducing complexity and providing cueing (Blackshaw, Kinderman, Hare & Hatton, 2001). However, these findings may translate better to the therapeutic situation compared to “real-life” settings given that therapy is often conducted on a one to one basis, within a consistent and calm setting and following a particular framework or model, therefore therapist preferences may be challenged if clients find emotional discourse difficult, often the essence of therapy. However, more could have been learned if this research had analysed in greater detail the discourse between researchers and participants perhaps using qualitative methods to pick up on all the lost nuances of the interaction providing more depth and breadth to the research thus helping a therapist who may read this research know how to support their client in therapy.

Fine et al (1994) found, also using a discourse analysis, that those with AS experienced poor conversational style such as a difficulty in monitoring their listeners needs and a lack of referring to previous aspects of the conversation to provide cohesion and aid reciprocal interaction. However, this research was conducted before clear consensus on diagnosis of AS had been established, using rather vague criteria based on Wing (1981), therefore there may have been some validity problems in forming the AS group; this also has implications on generalising these findings to the people defined as having AS using current definition. The analysis appears detailed in

that it explored the conversation style and fluency as it unravelled rather than analysing isolated communication acts but still only from the perspective of the participant. Furthermore, the quality of the communication and other characteristics of the blind researcher that held the conversations with the participants was not explored, therefore it is unclear how much this may have influenced the interaction; again this appears to be a lack of appreciation of the context. The same conversation partner was used throughout the research with all participants, those with Autism, AS and matched controls, therefore the results found could have been influenced by some of the features of this researcher including their ability to repair breakdowns when they occurred with particular clients. Furthermore, the conversation partner could have had a preference for people who do not share characteristics that are common to people with AS (Teasdale & Hill, 2004). Both these things could have affected the quality of the conversation partners input to the conversation and as only the quality of the participants input to the conversation was measured, this left a huge gap in the research in terms of understanding how the conversation broke down and how this research might relate to therapy and therapist preferences. However, considerations may be gleaned from this research in that therapist's facing clients with potential difficulties with monitoring the therapist's needs and a lack of referring to previous aspects of therapy either within or between sessions may leave the therapist feeling their preferences have been compromised in some way.

Another feature of pragmatics which can be viewed as problematic in some of those with AS is the pedantic use of speech (Wing, 1981), where the speech can be viewed as overly formal and pretentious (Ghaziuddin et al, 2000; Kerbeshian, 1990, cited in Attwood, 2007; Ghaziuddin & Gerstein, 1996). Pedantic speech is:

> *"…speech in which the speaker conveys more information than the topic and goals of the conversation demands, violating expectations of relevancy and quantity; sentence structure may have the formality, and vocabulary display the erudition expected of written language. Conversational turns resemble rehearsed monologues rather than contributions to a jointly managed dialogue. Articulation may be precise and intonation formal"* (Ghaziuddin & Gerstein, 1996, p. 589).

Ghaziuddin and Gerstein (1996) found that 76% of participants with AS, compared to 31% of those with High-Functioning Autism were categorised as being pedantic, this was based on a definition and a rating scale developed for this particular study which

had not be validated therefore it is yet to be established if this measure is valid and reliable. Criticisms include the results possibly being due to factors over and above what was being measured, for example, being pedantic or exhibiting pragmatic difficulties could be more apparent in certain social contexts, perhaps the context in which this research was conducted was not conducive to people with AS. Furthermore, a related issue is that an influence to pragmatic ability could have been anxiety, known to be very common in people with AS (Attwood, 1998) but not something that was screened for in this research.

The features described within the area of pragmatics enables a cohesive discourse with a conversation partner such as with a therapist. Certainly, many have argued that some people with AS can experience difficulties providing an organised and coherent framework to narratives (Abele & Grenier, 2005, cited in Attwood, 2007). In Fine et al's (1994) research they found that participants with AS made more unclear references during ten minutes of discourse about common topics relating to school, family and hobbies, compared to the matched comparison group. Furthermore, the higher functioning group made less reference to the previous stretch of the conversation and more to aspects of the physical environment, thus the authors stated that it was difficult to build a reciprocal conversation and led to breakdowns. This has clear links to the therapeutic interchange and may link to possible preferences of the therapist for a client with intact interpersonal skills (Teasdale & Hill, 2004). However, there are criticisms of this research. Despite good procedure in relation to using a blind conversation partner and coder, no reference was made to how the conversation partner managed any breakdowns and variability may have occurred in the experimenters' responses, extrapolated to the therapy session, perhaps breakdowns, if they occur, could be helped through therapist knowledge and support.

The exploration of the possible pragmatic difficulties in those with AS was to highlight the ways in which some of those diagnosed with AS may experience difficulties with social discourse, but perhaps only in certain settings and contexts. Looking more broadly and beyond language, it has been argued that people with AS can suffer other difficulties that relate to social and interpersonal functioning which might challenge both them and their conversation partner which could be extrapolated to the therapeutic relationship and to therapist preferences.

It is argued that social interaction requires the ability to engage with another person on multiple levels such as at the emotional level and therefore much broader and deeper

than at the level of just language, after all AS is not a language disorder. People with AS have also been argued to experience other problems such as using and interpreting other forms of communication, over and above the verbal modality, when regulating interactions such as with nonverbal communication including tone of voice, gesture, eye gaze, facial expression and posture (Kerbeshian et al, 1990, cited Attwood, 2007). Furthermore, social interaction has been defined as a reciprocal process in which one person effectively initiates and responds to the social stimuli exhibited by others (Shores, 1987, cited in Bauminger, 2002). Therefore, to establish what it might be like to provide therapy to someone with AS and to discover more about the interpersonal and social functioning of those with AS and thus whether this is an area which might challenge therapist preferences (e.g. Teasdale & Hill, 2004) an exploration at a deeper level is required, beyond language looking at broader entities and at the essence of interpersonal and social functioning.

5.5.2.1.2. Interpersonal and Social Functioning: Beyond Language

Koning and Magill-Evans (2001) conducted comprehensive research exploring cooperation, self-control, responsibility, empathy and assertion using the Child and Adolescent Social Perception Measure and the Social Skills Rating System and language skills using the Clinical Evaluation of Language Fundamentals-Revised measure. In this research they compared twenty-one adolescent boys with a diagnosis of AS with an age, gender and verbal IQ matched comparison group. They found that the group with AS experienced significant deficits of social skills including cooperation, self-control, responsibility, empathy and assertion and group differences in social perception skills specifically. Furthermore, the group with AS found it relatively more difficult to deal with a number of simultaneous non-verbal social cues: voice tone, facial expression, body posture and situational cues, rather concentrating disproportionately on facial cues, thus possibly restricting their social sense making; this the authors believe would hinder their ability to understand complex interactions such as understanding sarcasm. Relative to the comparison group, receptive language was also problematic in some of the adolescents with AS, thus non-verbal and verbal interpretation would be problematic. Despite the thorough nature of this research there were a number of concerns. Firstly, verbal IQ was measured but not performance IQ, given that deductive non-verbal reasoning was a huge component in many of the tests within this study, this was rather surprising, moreover, non-verbal reasoning might have been a confound. Secondly, within the Child and Adolescent Social Perception measure, the verbal modality was withdrawn (by turning the sound down on the video

recording depicting the social event), it is unclear whether this would have disadvantaged the AS group. Thirdly, there were differences found between parent, teacher and the ratings of the participants within the AS group, this disparity was not found within the comparison group using the Social Skills Rating System. This may suggest that this measure is not particularly reliable or valid for people with AS, it might be, for example, that for people with AS different criteria apply. For example, people with AS in this study rated their social skills as relatively good, compared to the teacher and parent ratings, they also rated themselves as having significantly fewer friends than the comparison group, it is possible that the researchers are applying standards of quality of life, for example, that simply do not apply to people with AS. For example, it has been shown that mothers' ratings of the quality of friendship are qualitatively different to people with an Autism Spectrum Disorder (Bauminger & Kasari, 2000). Finally, the extent to which these results measuring specific features in "laboratory" situations can be extrapolated to multidimensional abilities such as empathy and to "real-life" settings needs to be established. However, the anomalies described in this research, if they emerge in the therapy setting, may leave the therapist believing their preferences have been compromised, such as with a need for a client to have intact interpersonal and social functioning (Teasdale & Hill, 2004).

Knott et al (2006) found in 19 children and adolescents with an Autism Spectrum Disorder, significant difficulties with social skills such as verbal conversation skills, non-verbal communication, social and emotional reciprocity. They also found, similar to Koning and Magill-Evans's (2001) research, significant difficulties with social "competence," defined as the outcome of such social skills such as successful social interaction leading to such things as friendships. There were many problems with this research: the study defined social competence as the number of friends, this may not be valid as argued in relation to Koning and Magill-Evan's (2001) research; the study used self-report questionnaires which had not been validated to those with an Autism Spectrum Disorder; there was no confirmation of exact diagnosis and despite the authors stating that there were a few participants with AS it is unclear the exact number and how they performed compared to the other populations within the sample. Furthermore, there was an absence of neurodevelopmental information and finally there were no details about co-morbid psychopathology such as anxiety (e.g. Tantam, 2000), therefore it is difficult to pinpoint the reasons for the results and the dynamic processes involved.

Despite some of the difficulties with some of the research including a lack of acknowledgment of the context in which difficulties may arise and are measured, there appears to be some evidence that some people with AS may experience some difficulties with social interaction, particularly emotionally laden interactions. When the areas explored above are problematic in the client then the impact on the therapy and the therapist attitude may be significant. Possible difficulties in these areas may lead some therapists to believe that their preferences have been compromised, perhaps perceiving their clients with AS as odd, arrogant and omnipotent (Paxton & Estay, 2007; Attwood, 2004), with the possible lack of emotional resonance being perceived by some therapists as rather "cold" (Tantam, 1991; Frith, 2004). For example, it has been found that due to differences in social interactional style some children with AS have been described as irritating and intrusive by peers and silly, immature, uncooperative and rude by teachers (Church, Alisanski & Amanullah, 2000), this may well also emerge in the psychotherapy setting with certain therapist, client dyads. This has clear links to the research explored earlier on therapist preferences in that some therapists may not only prefer clients who have intact interpersonal skills (Teasdale & Hill, 2004) but they may also want to work with clients who want to form a relationship and are not "hostile" in session (Hersoug et al, 2002 cited in Couture et al, 2006), which Paxton and Estay (2007) and Attwood (2004) argue may be a possibility when working with clients who have AS.

The literature appears to support the view that those with AS have some difficulties in interpersonal and social functioning, including engaging in emotional discourse (Adams et al, 2002), often the focus of therapy and thus therapist preferences may be compromised. There is other research that may provide further insight into some of the reasons for the difficulties in this area, specifically exploring emotion recognition and reciprocation. Davies et al (1994) found that children with AS scored significantly worse than a matched comparison group in their recognition of emotions from facial expression (cited in Koning & Magill-Evans, 2001). However, it has been found that the majority of those with AS do not appear to have problems with understanding and using simple emotions such as happiness and sadness but rather appear to have difficulties with understanding complex emotions (Frith, 2004). Many researchers have shown that those with High-Functioning Autism find it difficult to understand and predict the causes for complex emotions such as embarrassment, empathy, surprise and pride (Buitelaar et al, 1999; Capps et al, 1992; Jaedicke et al, 1994; cited in Bauminger, 2002; Bauminger & Kasari, 2000) but can understand simple emotions as well as the

matched developmentally typical comparison group (Adolphs et al, 2001; Robel et al, 2004, cited in Hubert et al, 2009).

As with language ability, emotion understanding may be problematic for some of those with AS when what is required goes beyond relatively simple and mechanical understanding of emotion. Problems may occur when understanding the emotion requires acknowledgment, understanding and integration of the social-context in order to understand and create social meaning (Buitelaar et al, 1999, cited in Bauminger, 2002), certainly complex emotions such as sarcasm will require such recognition and integration of context, including emotions and mental states. Frith (2004) argues through Baron-Cohen and his colleagues that the lack of empathising is due to an excess of systematising, which is a particular engagement with the physical world (Baron-Cohen et al, 2003, cited in Frith, 2004). To support this, Lawson, Baron-Cohen and Wheelwright (2004) found that empathising was lowest in males with AS, compared to males and females without AS, where the females were the best at empathising. Females scored the worst at systemising, compared to the males with and without AS (Lawson et at, 2004). This potential lack of emotional resonance with others, Tantam (1991, cited in Frith, 2004) believes can be perceived as callous by others including the therapist providing therapy, this may infringe on therapist preferences (Hersoug et al, 2002 cited in Couture et al, 2006).

It has been argued so far that successful social discourse and more generally, social reciprocity or interpersonal and social functioning incorporates a range of abilities, including pragmatic skills and understanding the social meaning conveyed in nonverbal communication, such as facial expression, it requires emotion and mental state understanding which includes the recognition and integration of the social-context in which the interaction occurs, all of which is used to guide the social interaction. These multidimensional cognitive abilities, which are vital for effective interpersonal and social functioning, have collectively been called s*ocial cognition:*

> *"Social cognition includes the…ability to spontaneously read and correctly interpret verbal and nonverbal social and emotional cues; the ability to recognize central and peripheral social and emotional information; the knowledge of different social behaviors and their consequences in diverse social tasks (e.g. how to initiate a conversation, how to negotiate needs, how to make a group entry); and the ability to make adequate attribution about another person's mental state…"* (Crick & Dodge, 1994, cited in Bauminger, 2002, p. 284).

As described in this quote, social cognition includes mental state and emotion recognition, understanding and reciprocation, difficulties here may affect a range of social skills needed for social reciprocity including understanding and using verbal and non-verbal communication as described earlier, but also cooperation and more complex abilities such as empathy. Social cognition is synonymous with a very famous concept within the field of Autism Spectrum Disorders called Theory of Mind (Baron-Cohen et al, 1985). Theory of Mind, as described by Baron-Cohen et al (1985), is the ability to infer and reflect upon one's own and others' full range of mental states (first order Theory of Mind being the ability to reflect on others' thoughts, whilst second order Theory of Mind is the ability to reflect on others' thoughts about others' thoughts and so on), which include beliefs, desires, intentions and emotions thus enabling an individual to predict the actions of others and to respond accordingly.

Difficulties with social cognition and Theory of Mind may impact not only on the therapist preference for a client to have intact interpersonal functioning but also the preference for a client to be psychologically minded (Teasdale & Hill, 2004), a fundamental characteristic that could be argued to underpin interpersonal and social functioning. There are striking similarities between the construct of social cognition, Theory of Mind and psychological mindedness, as proposed by Baron Cohen et al (1985) and Faber (1985) respectively and the notion of psychological mindedness as a therapist preference as argued by Teasdale and Hill (2004). Faber (1985) describes psychological mindedness as the ability to "…reflect upon the meaning and motivations of behaviour, thoughts, and feelings in oneself and others," (p.170) which is regarded as an important quality in clients.

An exploration of the literature that appears related to the construct of psychological mindedness will now be undertaken in order to ascertain whether clients with AS could possibly challenge this important client attribute (Faber, 1985) in relation to therapist

preferences (Teasdale & Hill, 2004). This exploration will include the literature on Theory of Mind and social cognition as synonymous with the construct of psychological mindedness.

5.5.2.2. Psychological Mindedness

In keeping with Baron-Cohen et al's (1985) assertions as outlined above, Kaland et al's (2002) research found that children and adolescents with High-Functioning Autism and AS experience difficulties attributing mental states in context, were more likely to attribute physical states to mental state scenarios and were more likely to interpret behaviour and language literally, but had significantly fewer difficulties inferring physical states. This is consistent with the research by Fine et al (1994) described earlier when discussing possible pragmatic abilities in some of those with AS. Baron-Cohen and his colleagues have shown using the Reading the Mind in the Eyes test (Baron-Cohen et al, 2001, cited in Rutherford, Baron-Cohen & Wheelwright, 2002) and the Reading the Mind in the Voice test (Rutherford et al, 2002), that those with High-Functioning Autism and AS do experience deficits in inferring mental states in others. Losh and Capps (2003) found that most participants with High-Functioning Autism and AS passed a second order Theory of Mind task (the task was taken from Perner & Wimmer, 1985, cited in Losh & Capps, 2003) but were impaired on a more advanced Theory of Mind task (the task was taken from Happé, 1994, cited in Losh & Capps, 2003) and a range of emotional understanding tasks, including experiencing difficulties in defining the emotions and providing fewer explanations for the characters' internal states within the Mayer story book narrative (1969, cited in Losh & Capps, 2003) and using less causal explanations for their own personal narratives compared to typically developing children.

It has been argued that possible difficulties with mental state understanding is shown through difficulties people with an Autism Spectrum Disorder have with understanding sarcasm, metaphor, figures of speech, humour (Baron-Cohen, 1997a; Happé, 1994; Kaland et al, 2002, cited in Bowler, 2007; Martin & McDonald, 2004) and other indirect communication (Happé, 1994, cited in Landa & Goldberg, 2005). Furthermore, Hill, Berthoz and Frith (2004) found in their research that those with AS found it more difficult, compared to the IQ and age matched comparison group, to identify and describe their own feelings and were less interested to know about the psychological motives behind actions. In Hare and Flood's (2001) research, they found that those with AS, compared to the non-matched comparison group, produced significantly fewer

mental state terms when describing social pictures, within the Projective Imagination Test. However, in this latter research it was not made explicit that mental states were required, therefore those with AS may not have known that these were required, this is discussed later in terms of orientating the person with AS through prompting and cueing, which can often lead to enhanced skill utilisation.

The few pieces of research that found intact mentalising skills in those with AS has been heavily criticised for a number of reasons including that the measures they used were not advanced or subtle enough to detect deficits and for not emulating "real-life" situations therefore not measuring what they purport to measure as related to "every-day" settings. Furthermore, they often focus on single modalities such as the visual (e.g. Reading the Mind in the Eyes task) or auditory (e.g. Reading the Mind in the Voice task) when assessing mentalising which although revealing interesting results, these tasks may produce limited findings as they simply do not match-up to "real-life" encounters such as with a therapist.

Some research which has been argued to be particularly naturalist is by Ponnet, Roeyers, Buysse, De Clercq and Van Der Heyden (2004) and also by Beaumont and Newcombe (2006). Ponnet et al (2004) found that participants with AS were as able as the developmentally typical matched comparison group in passing "static" Theory of Mind tasks such as the Reading the Mind in the Eyes task (Baron Cohen et al, 1997, cited in Ponnet et al, 2004) and the Strange Stories task (Happé, 1994, cited in Ponnet et al, 2004), but were significantly worse on more naturalistic and thus complex, multimodal Theory of Mind tasks. Beaumont and Newcombe (2006) also found, in their research using what they argue to be naturalistic Theory of Mind tasks (e.g. multimodal), that those with High-Functioning Autism and AS provided significantly fewer correct mental state answers to questions about a commercial they had seen and fewer explanations for characters' mental states in a narrative task describing the events depicted in pictures from the Thematic Apperception Test, compared to the matched comparison group; this latter finding appears consistent with Klin's (2000) and Tager-Flusberg's (1995) research (cited in Beaumont & Newcome, 2006). Dahlgren and Sandberg (2008) found in there study of 30 children with an Autism Spectrum Disorder, 17 of which had AS, that referential communication, a relatively complex and arguably naturalistic task in which something has to be described in a way that others will understand (in this research describing one picture card amongst many, successfully done by concentrating on differential features), was problematic for those with an Autism Spectrum Disorder, compared to the developmentally typical age

matched comparison group. Referential communication was associated with Theory of Mind ability, measured using the Theory of Mind tests by Baron-Cohen (Baron-Cohen et al, 1985 and Baron-Cohen et al, 1989).

Overall, the research appears to show that some of those with High-Functioning Autism and AS have some mentalising abilities but experience difficulties with multidimensional, fluid, complex naturalistic tasks that emulate "real-life" settings which could lead to difficulties in conveying information to others, supporting earlier discussions on language and social and emotional reciprocity; this points to possible difficulties with psychological mindedness in people with AS as conceptualised by Teasdale and Hill (2004), Faber (1985) and Beital et al (2004).

The difficulties in utilising mentalising capacities in "real-life" settings (and the tasks that purport to emulate them) may be due to the complexity of real-world situations (Klin et al, 2003, cited in Frith, 2004) and that true social situations are unstructured, in contrast to laboratory settings where these abilities are usually taught and tested, using explicit tasks (Beaumont & Newcombe, 2006). It could be argued that the reason for the lack of skill utilisation in "real-life" settings might be because those with AS might not know when to use them, something Gresham (1997) calls a *social skill performance deficit* rather than a *social skill acquisition deficit* (cited in Spencer, 2003). Blackshaw et al (2001) showed that those with AS produced more mental state terms to describe social pictures when cued, using the Projective Imagination Test, such that the scores did not differ significantly from the non-matched comparison group, whereas when uncued, possibly reflecting "real-life" situations, they did differ significantly. In Losh and Capps's (2003) research the personal narratives provided by those with High-Functioning Autism and AS were generally comparable to the developmentally typical comparison group, but only with a high degree of researcher guidance. Finally, in Kaland et al's (2002) research participants required significantly more prompts than the developmentally typical comparison group, when attempting to solve mental state tasks. Therefore, it may be that in social situations Theory of Mind abilities are not being utilised as the situations may lack the cues that may be important in recognition and recall. What is important here is that the research suggests that when supported some people with AS appear more able to use their skills to fit the expectations of the task and thus the social context appears extremely important in skill utilisation and measurement.

A different but related reason for the lack of utilising mentalising abilities in naturalistic tasks and "real-life" settings, might be that some of those with AS become cognitively overloaded, after all "real-life" settings require a range of abilities over and above complex mind-reading and the person is involved in a dynamic interaction and not simply the static perceiver. Some of those with AS may become cognitively overloaded due to the qualitatively different way in which they are processing social information. It is argued that some of those with AS who do exhibit mentalising abilities may be doing this by providing logical interpretations, thus not necessarily exhibiting an "intuitive mentalising ability" (Frith, 2004, p.678), something Fonagy (2008) calls "gut," or "implicit mentalising" ability. The assertion is that those higher-functioning individuals with an Autism Spectrum Disorder maybe processing affective and social material and passing relatively simple and discrete Theory of Mind tasks through compensatory strategies (Happé & Frith, 1995, cited in Jordan, 1999; Rutherford et al, 2002), perhaps through logic and intellect (Kasari et al, 2001; Sigman & Ruskin, 1999; cited in Bauminger, 2002; Hermelin & O'Connor, 1985; Sacks, 1995), rather than through intuitive mentalising. This notion links to Faber's (1985) distinguishing of two types of psychological mindedness: the intellectual knowing which is logical and linear psychological knowledge and is "…essentially uninfused with a personal 'feeling' component," and the second type, which is "infused" with "feeling," where the essence is experiential, where one's own and others internal states are "felt," rather than simply intellectualised and described. This distinction fits well with both Fongay (2008) and the research on psychological mindedness or Theory of Mind abilities described above.

In terms of cognitive overload and different types of mentalising, it is a well held view that those with AS, compared to people with autism, engage in relatively more complex social and emotional interactions by utilising their relatively higher cognitive abilities (Kasari et al, 2001; Sigman & Ruskin, 1999, cited in Bauminger, 2002; Hermelin & O'Connor, 1985; Sacks, 1995), thus suggesting that they are compensating for deficits. Thus, the complexity of naturalistic Theory of Mind tasks and "real-life" settings may interfere with comprehension, decision and action (Bowler et al, 2005), such as those related to mentalising. Bowler et al (2005) argues for an information processing deficit which effects the way in which people with AS are able to consider all the contingent elements within a task, rather than a failure in "…a mechanism specific to the understanding of mental states…" (Bowler et al, 2005, p.270). It has been shown in research that when mentalising skills are called upon (and other cognitive tasks such as divided attention e.g. Bogte, Flamma, Van Der Meere & Van Engeland, 2009), some

of those with High-Functioning Autism and AS appear to show increases in processing time (e.g. Kaland et al, 2002; Ponnet et al, 2004) thus appearing to support the notion that they are becoming overloaded by having to use more explicit, mechanical and cognitive routes to overcome intuitive mentalising deficits. This has links to the findings made by Blackshaw et al, (2001), in that cueing may act to simplify things.

The potential difficulties that some clients with AS may have with regard to inferring one's own and another's mental states when needed in a complex setting, including thoughts and feelings and what led up to them, might influence the psychotherapeutic encounter not only in terms of the fluency of discourse such as the quality, quantity, relevance and clarity i.e. pragmatics but also as the client with AS may not share important information with the therapist or may become disgruntled when questioned on what the client assumes the therapist already knows (Hare, 1997b). The potential difficulties the client may have with psychological mindedness has direct links to therapist preferences (Teasdale & Hill, 2004).

An overview of the literature on Theory of Mind, psychological mindedness and mentalising shows mixed findings. However, generally the findings from the research explored appears to show that some of those with High-Functioning Autism and AS do appear to do better when using unidimensional "static" tasks that are structured, cued within a laboratory setting in contrast to unstructured, multidimensional, relatively complex naturalistic tasks that are argued to emulate the uncued and unstructured "real-life" settings. However, from an evolutionary perspective, it could be argued that the differences found in some of those with a AS compared to other populations in terms of mentalising capacities, possibly due to differing neurobiology and developmental trajectories (Hobson, 2002) is perhaps because for those with AS mentalising, as it is quantitatively and qualitatively conceptualised by other populations, is not required. The differences in which some of those with AS think, feel and behave, may stand them apart from others, something that may define them as potential leaders (Tantam, 2011) and features which may be "…valuable for the development of the human species" (Gillberg, 2002); a perspective that has helped some with AS feel their diagnosis is an advantage over other non-AS people (Punshon et al, 2009). Therefore, measuring a "neurotypical" construct in those that are not "neurotypical" and perhaps do not desire to be and where the difficulties can be viewed as differences thus possibly serving biological purposes, might be inappropriate. However, despite the various criticisms of the research, the exploration within this section was a pragmatic one, to illuminate some of the issues that might be encountered by the therapist when

working with people with AS whether viewed as a difference or deficit, therefore, in that respect the research is very useful.

In keeping with this pragmatic perspective, the differences argued to exist between some of those with AS and other populations with regard to inferring one's own or another's internal states when needed, might impact on the therapeutic engagement. This potential impact might occur whether or not the "problem" is viewed as residing within the person with AS (medical model) or between them and their therapist (social/contextual) and therefore may need to be acknowledged within the therapeutic relationship. The implications of differences with internal state identification and exploration between some of those with AS and their therapists may be serious, as this is viewed as an integral component of many psychotherapies including cognitive behavioural therapy (Butler et al, 2008). Even when mentalising abilities and referential communication appear to be intact in the way that the therapist might desire (from a "neurotypical" perspective for example) perhaps through therapist intervention (e.g. cueing or reducing cognitive overload in session), the possible lack of generalisability may be problematic for specific aspects of therapy such as psychoeducation, an important component of many therapies including cognitive behavioural therapy (Butler et al, 2008); this is where skills may not transfer to other settings where problems are experienced, this may influence therapy efficacy and thus therapist attitude. Furthermore, the therapist may not desire a client who requires adaptation to sessions in order to compensate for their possible difficulties with cognitive overload for example. Certainly, the research would suggest that therapists prefer clients who have a degree of conceptual complexity which is an ability in the client to process interpersonal stimuli by integrating multidimensional information (Teasdale & Hill, 2004). There have been a number of pieces of research explored so far that have shown that people with AS may do better with unidimensional interpersonal processing at the expense of multidimensional interpersonal processing; for example, this was highlighted in the research on emotion recognition (e.g. Bauminger & Kasari, 2000; Hubert et al, 2009; Koning & Magill-Evans, 2001). The concept of conceptual complexity, as proposed by Teasdale and Hill (2004), could be viewed as a broad fundamental capacity that underpins social functioning and psychological mindedness. Given this is an important therapist preference and an important and fundamental skill, an exploration will now be provided of the research that may help to ascertain the possible degree of conceptual complexity in the client with AS and thus to what extent this therapist preference may be satisfied or not.

5.5.2.3. Conceptual Complexity

There are various well established cognitive models that have used to describe in detail some of the cognitive skills of those with AS as related to social interaction, social functioning and to other non-social domains. These models have often been put forward as possible explanations for the various interpersonal difficulties that people with an Autism Spectrum Disorder may experience, as well as other difficulties and anomalies that are non-social. One cognitive theory has already been explored called the Theory of Mind (Baron-Cohen et al, 1985), this model pointed to the possibility of difficulties in people with AS with regard interpersonal and social functioning and psychological mindedness emanating from a problem with social cognition. The discussion of this model also proposed that the difficulties with interpersonal and social functioning might not be due to mentalising per se but instead might be due to an information processing difficulty which might interfere with the person's ability to consider all the contingent elements in a task, social or otherwise (Bowler et al, 2005), moreover, the difficulties with mentalising may be due to a difficulty with conceptual complexity.

Two other cognitive models will now be explored that go beyond social cognition and may help to illuminate potential difficulties in the client with AS with regard conceptual complexity, these models are *Weak Central Coherence* (Frith, 1989) and *Executive Functioning* (Ozonoff, Pennington & Rodgers, 1991). The exploration of these models will sit either side of an exploration of a particular cognitive ability, that being memory, in order to further emphasise the possible tensions that may arise with regard working with clients with AS and the therapist's preference for clients to be able to process and combine multiple interpersonal stimuli using a highly abstract system (Teasdale & Hill, 2004).

5.5.2.3.1. Conceptual Complexity: Weak Central Coherence

This theory describes the ability to pull together diverse pieces of information in context in order to construct a "global meaning" or "gist" of that particular situation (Frith, 1989). Frith (1989) argues that people with an Autism Spectrum Disorder have a weak or missing search for meaning. This theory concentrates on both peaks and impairments of performance. Theory of Mind requires the ability to take a global view and to integrate multiple perspectives, which suggests Theory of Mind may develop out of central coherence (Jarrold et al, 2000, cited in Martin & McDonald, 2004).

Many have argued, such as Shah and Frith (1983, cited in Jordan, 1999) that evidence for the tendency in those with an Autism Spectrum Disorder to concentrate on detail at the expense of higher order integrating, into meaningful wholes, comes from their superior ability to process unconnected stimuli shown in their performance on the Embedded Figure Test and the Block Design component of the Wechsler intelligence battery; these tasks require the participant to resist seeing the whole in favour of local elements (Rodgers, 2000). Rinehart et al (2000, cited in Martin & McDonald, 2004) argue that some of those with AS are drawn to local information at the expense of processing accuracy at the global level, shown in the Local Global Processing Task, whereby greater interference was caused by the type or similarity of the "local" letters that make up the larger "global" letter. Martin and McDonald (2004) found in their research, comparing fourteen participants with AS to an age and Verbally IQ matched comparison group, that those with AS showed a local bias to solving visuo-spatial puzzles and did not utilise context or meaning to facilitate this process; difficulties generating inferences about others' mental states was also shown. Jolliffe and Baron-Cohen (2001) found that those with High-Functioning Autism and those with AS experienced significantly more difficulties than the developmentally typical matched comparison group in a visuoconceptual integration task in which participants had to piece together jigsaws depicting objects and also identify what the object was from only one piece of the jigsaw.

In terms of narration, an area explored earlier, it has been argued that, qualitatively, some of those with an Autism Spectrum Disorder, including the high-functioning group, can appear disorganised (Loveland et al, 1990, cited in Beaumont & Newcombe, 2006), incoherent (Klin, 2000, cited in Beaumont & Newcombe, 2006) and quantitatively there may be a distinct lack of causal connections between story elements (Losh & Capps, 2003), all argued to demonstrate possible difficulties with cohesion, integration and incorporating context. Finally, the model does appear to provide some clue to the reasons why some people with High-Functioning Autism and AS may experience difficulties with social and emotional reciprocity discussed earlier. For example, Koning and Magill-Evans (2001) found in their research discussed earlier, that the group with AS found it relatively more difficult to integrate voice tone, facial expression, body posture and situational cues, rather concentrating disproportionately on the specific detail of facial cues, this may demonstrate a Weak Central Coherence and difficulties integrating and dealing with multiple dimensions, as conceptualised by the notion of conceptual complexity (Teasdale & Hill, 2004). As illustrated earlier,

emotion understanding may be problematic for some of those with AS when what is required goes beyond relatively simple and mechanical understanding of emotion based on relating simple aspects such as specific and isolated behavioural cues such as facial features; problems may occur when understanding the emotion requires acknowledgment, understanding and integration of the social-context in order to understand and create social meaning (Buitelaar et al, 1999, cited in Bauminger, 2002), these are aspects of central coherence and appear directly related to the construct of conceptual complexity as proposed by Teasdale and Hill (2004).

However, as with the Theory of Mind assertion, there appears to be as much research highlighting Weak Central Coherence as there is highlighting intact central coherence in those with an Autism Spectrum Disorder. Rodger (2000) found that those with AS were no better at the Embedded Figure Test and Block Design Task compared to the developmentally typical matched comparison group. Martin and McDonald's (2004) research found that those with AS could recall meaningful word lists more easily than random word lists, suggesting the utilising of a categorising strategy, a result showing a possible intact central coherence. Those with AS also showed similar results to the comparison group, when completing a "random puzzle," showing no superiority of processing of non-meaningful material.

The reason for the mixed findings could have been due to a number of fundamental criticisms of the research explored. In Rodgers (2000) and Martin and McDonald 's (2004) research the samples recruited were very small thus the results may have been due to confounding variables relating to the restricted sample. Furthermore, in Rodgers (2004) research neither co-morbidity nor verbal or performance IQ was screened for and in Martin and McDonald 's (2004) research they only screened for verbal IQ. This is surprising given some of the performance IQ subtests within the Wechsler measures (e.g. Block Design) are argued to measure the very cognitive skills that these studies were assessing i.e. Weakness of Central Coherence. Therefore, non-verbal IQ was not controlled for. Likewise, just as it is important to screen for cognitive skills and co-morbidity in the sample so that clarity is increased regarding the mechanisms involved in the explanatory matrix, to use realist terminology, having a sample without such features may lead to difficulties with regard generalising. Joliffe and Baron-Cohen's (2001) research produced some interesting and useful results, however, it will need to be established how much these results can be generalised to the typical population of people with AS who may have a range of additional common features including possible co-morbidity such anxiety, features that this research controlled for.

Furthermore, it could be that the profile or pattern of abilities and deficits seen in Joliffe and Baron-Cohen's (2001) study change when co-morbidity is added into the mix, creating a pattern which cannot be understood simply in terms of two or more disorders coming together i.e. it might be unclear how say anxiety and AS mix and lead to a particular cognitive or behavioural profile, a profile that cannot be extrapolated merely from studying AS and anxiety separately. The research explored has been invaluable in our understanding of Autism Spectrum Disorders, however, it may be difficult to generalise the findings from these studies, studies which use specific, discrete and circumscribed tasks in a laboratory setting to dynamic and complex social settings; further research would need to establish this. Finally, what is common throughout the research is a lack of exploration of the processes that the person with AS goes through when attempting to generate solutions to the tasks to which they have been subjected, so the reader is left wondering how and why. What may enhance the research is an exploration of the participant's experiences of the research, exploring the process that they went through, for example, exploring how they understood the task(s) and what helped and hindered them.

In order to reconcile the mixed results researchers have argued that those with an Autism Spectrum Disorder can process at both local and global levels but modulate differently to those without an Autism Spectrum Disorder (Mottron et al, 1999) and that the default for those with an Autism Spectrum Disorder is to process at the level of detail, unless prompted otherwise (Jolliffe & Baron-Cohen, 2001), thus pointing to the importance of understanding the processes involved in skill utilisation and the context in which they occur. They argue that as long as the task is relatively simple, they are primed to use the skill and given enough time, those with an Autism Spectrum Disorder can process and integrate in context (Jolliffe & Baron-Cohen, 2001), reflecting similar conclusions to the research on Theory of Mind abilities and supporting the need to reflect on the social context when assessing skills and potential deficits. For example, in the research on face processing, it has been shown that high-functioning older individuals with an Autism Spectrum Disorder do appear to have a preference for specific features, particularly the mouth area, but can process faces holistically, however, global processing may fail in relatively demanding situations such as in "every-day" naturalistic contexts (Bowler, 2007), possibly due to complexity and/or due to the uncued nature of these situations. In support of this argument Jolliffe and Baron-Cohen (2001) assert that the participants with High-Functioning Autism and AS in their research, compared to the developmental typical comparison group, were impaired in

central coherence but that "…despite this impairment, the performance…was one of inefficiency rather than inability. They were not unable to integrate visual elements, just significantly less proficient at doing so" (Jolliffe & Baron-Cohen, 2001, p. 211). Lopez and Leekam (2003) also found that children with High-Functioning Autism could use contextual information in order to enhance their recognition and memory for stimuli, as long as this was at the single item level, they did relatively worse than the developmentally typical matched comparison group when multiple items required integration (cited in Beaumont & Newcombe, 2006). Beaumont and Newcombe (2006) support this assertion in their research, finding that those with High-Functioning Autism and AS were able to correctly answer as many central coherence questions as the developmentally typical comparison group, when the task was kept simple and structured. They were able to provide integrated explanations for narrative events related to non-mental-state phenomena of characters within the Thematic Apperception Test, although again, clear and explicit instructions were provided, in this case on how to structure the narrative. Martin and McDonald (2004) noted that a long period was given in the word list activity and priming or preparation was provided in the random puzzle, thus "…allowing them to overcome their natural tendency to focus on the local details and also absorb the global information" (p. 324).

Whether the view is that the person with AS may have an extreme analytic or the gestalt cognitive preference or difficulties in modulating the two under certain conditions, the possible processing differences highlighted here can be seen to be an important consideration when conducting therapy with someone with AS. The Weakness of Central Coherence model, despite the misleading title, defines a range of cognitive abilities including strengths. The therapist might need to acknowledge these and consider if sessions need to be relatively simplistic, cued and structured. The client with AS, without the right support, may concentrate on local information, missing the essence or meaning within or between sessions or it may instead be that the individual will not dissemble relevant material from the overall theme of a session or number of sessions unless primed to do so; they may not know that this is required of them. Possible communication difficulties between people with AS and others have also been highlighted within this theory, problems that may impinge on fluent discourse with the therapist if not considered. These anomalies may influence the collaborative relationship and the working towards mutual goals and tasks, important in a healthy working alliance (Horvath & Greenberg, 1986, 1989) and thus may influence the therapist attitude. In order to deal with these differences the therapist might need to

consider reducing the complexity of the session, the therapist may need to work on concrete and specific symptoms rather than “big issues” (Hare, 1997b) which might be too complex. This may highlight the possible compromising of the therapist’s preference for clients to have a degree of conceptual complexity, which, as already described, is the assertion that some therapists prefer clients who receive, store and process information in highly abstract and multidimensional ways rather than in unidimentional, unintegrated and concrete ways (Teasdale & Hill, 2004).

The atypical attentional features described above, which may only be a difficulty in certain contexts and a strength in others (e.g. Attwood & Gray, 1999), might not only have a pervasive effect on social and non-social sense making in the moment, due to the possible lack of integration of context, for example, but this tendency for local processing, which has the potential to increase the understanding of certain tasks but also has the potential to restrict and constrain the person in others, may then also lead to on-going problems with learning and memory, thus further influencing future social interchanges. Memory has only very briefly been touched upon within the Weak Central Coherence account. Exploration will now be made into further memory function in those with High-Functioning Autism and AS, an area which is argued to influence psychotherapy both directly and indirectly and may help to highlight tensions between working with clients with AS and a possible preference in the therapist to work with clients who have a degree of conceptual complexity (Teasdale & Hill, 2004).

5.5.2.3.2. Conceptual Complexity: Memory

The area of memory is somewhat neglected in AS, however, there are a few pieces of research that directly investigate memory in this population. Overall, the research suggests that those more able individuals with an Autism Spectrum Disorder experience an uneven profile of strengths and possible difficulties or certainly differences within the realm of memory, particularly when not supported by the situation such as through guides and prompts (e.g. Bowler et al 2000); this reflects the previous research explored with regard mentalising and central coherence and points to possible difficulties simultaneously processing multidimensions and complexity thus highlighting possible breaches to therapist preferences (Teasdale & Hill, 2004). In particular the areas of difference appear to be with episodic (e.g. Bowler et al, 2000) and semantic memory (Hermelin & O’Connor, 1970, cited in Bowler, 2007).

In Toichi and Kamio’s (2003) study they showed that people with High-Functioning Autism or those with mild learning disability did not show levels-of-processing effect

(the idea that semantic processing of verbal material facilitates long term memory and compared to more 'shallow' phonological or perceptual processing), therefore according to this research, some people with an Autism Spectrum Disorder appear to process at a more superficial or shallow level, not processing the deeper semantic similarities of cues. Bowler, Matthews and Gardiner (1997) found that participants with AS remember in a similar way to individuals with autism demonstrated by their failure to use category information to aid their free recall. Minshew and Goldstein (2001) echo Bowler et al's (1997) findings through the memory testing of 52 High-Functioning adolescents and young adults with Autism and 40 people within the matched comparison group. Minshew and Goldstein (2001) argue that the memory problems in this population, including semantic and long term memory were due to poor utilisation of organisational strategies, shown in problems the participants had with increasingly complex tasks.

Overall, the research on memory, as with the other areas reviewed so far, add substantially to our knowledge and understanding of AS and in particular whether therapists may have their preference for a client to process complex multidimensional information infringed upon when working with this client group. However, despite what can be gained from this type of research there are obvious limitations which many of the researchers point out themselves. Overall, it would appear there is variability in the quality of the research explored so far, in that some researchers are able to provide good quality data (e.g. Bowler, Matthews & Gardiner's, 1997) but also accept the limitations of it such as difficulties in establishing how the results might generalise to "real-life" complex settings. Other researchers simply do not appear to acknowledge the multifaceted, dynamic, generative, interdependent and complex nature of the various skills involved in their research tasks.

There has been some research that has gone some way in linking memory with other areas of difficulty for people with AS and which have a more naturalist flavour, exploring "every-day" social interaction and communication abilities. Ponnet et al (2004) found that participants with AS were less accurate than the developmentally typical comparison group in inferring internal states based on past memory of a naturalist mind-reading task, whereas there were no differences when past memory was not involved; this has obvious links to the Theory of Mind research and points to memory problems as an influence to mentalising. However, this more naturalistic research can still be criticised for being rather artificial as the task involved participants viewing videotapes of social interactions and then them writing down mind-reading

aspects of the actors such as thoughts. As the researchers themselves point out, “real-life” settings require people to be both “perceivers and targets” of mind-reading (p.262). Furthermore, “real-life” settings incorporate a range of other abilities that were not measured in this research such as more global cognitive skills such as executive functioning and unlike “real-life” situations the participants in this research had as much time as they required to “mind-read”. Finally, there were very few participants in this research and co-morbid concerns were not screened for thus possible errors where not explored and generalising might be difficult.

Dahlgren and Sandberg (2008) conducted a study that similarly attempted to link memory with other areas of potential concern for people with AS, areas which appear related to “every-day” functioning i.e. referential communication and therefore appears to have good face validity. Dahlgren and Sandberg (2008) found that 30 children with an Autism Spectrum Disorder, 17 of whom had AS, experienced more intrusions in the free recall exercise, within their research on referential communication, compared to the comparison group. Dahlgren and Sandberg (2008) argue that this difficulty could lead to a communication breakdown in “real-life” settings when these memory difficulties intertwine with difficulties in describing experience, which this research also found. However, the children in this study with an Autism Spectrum Disorder had significantly lower full-scale IQ’s than the comparison group therefore the results could have been at least partially due to a more global cognitive difficulty rather than an Autism Spectrum Disorder specific issue.

In contrast to these studies which found difficulties with memory, there are a range of studies that have found intact memory function and even strengths for people with an Autism Spectrum Disorder. Bowler et al (2000) showed that those with AS appeared to understand the semantic relationships between words illustrated by the typical phenomenon of ‘intrusion errors,’ where participants falsely recall words from one list that actually belong to another which had been previously learnt. However, Bowler et al (2000) argue that the participants relied more heavily on noetic as opposed to autonoetic awareness; they asserted that this might mean that they experienced difficulties with episodic memory which is required for goal-directed behaviour. Language and verbal IQ was assessed but co-morbidity was not assessed for and given that anxiety, for example, is very likely in people with AS (e.g. Tantam, 2000) and that anxiety and the medication to treat it can effect cognitive skills (e.g. Bogte et al, 2009), co-morbid psychopathology might have significantly influenced the findings. Similarly, Martin and McDonald’s (2004) research showed that those with AS were

found to recall meaningful word lists more easily than random word lists and comparable to the matched verbal IQ and age comparison group and therefore those with AS do appear to show some use of meaning within recall, thus at least a partially intact semantic memory system. The research also suggests that people with AS do much better when they are provided with prompts or cues by the environment. In relation to this latter point, Bowler, Gardiner and Berthollier (2004) found that participants with AS provided significantly less context when recalling an event than the developmentally typical comparison group, unless prompted to do so. When those with AS do recall personal experiences, which is possible when cued (Boucher & Lewis, 1989, cited in Jordan, 1999) the account appears qualitatively similar to typical individuals (Bowler, 2007). Similarly, Losh and Capps (2003) found that participants with High-Functioning Autism and AS, with prompts from the researchers, were as able as the developmentally typical comparison group to provide thematically integrated and elaborated narratives about personal past experiences. This suggests that if the therapist is able to provide cueing, prompts and perhaps to simplify the therapy session then clients with AS can simultaneously integrate interpersonal stimuli as suggested to be a preference for therapists (Teasdale & Hills, 2004).

The use of prompts and cues to possibly decrease the cognitive overload or guide the person with AS in the direction required of the situation, integrates the research on the range of cognitive skills explored so far in all of the sections. The various “laboratory” based research explored above, although not necessarily establishing how the findings may relate to “real-life” settings, has been invaluable in highlighting the benefits of cueing and supporting the person with AS to increase their potential and perhaps compensating for some difficulties they may have specifically with interpersonal functioning, and more broadly with psychological mindedness and with conceptual complexity. Therefore, again, exploring the context is very important in understanding the explanatory matrix in which processes occur and where skills are learned and utilised, in this section, in relation to memory. It would seem that when some of those with High-Functioning Autism are guided by the researchers such as by orientating them to the semantic aspects of words, then they do appear to show enhanced free recall (Mottron, Morasse & Belleville, 2001) in terms of semantic and episodic memory (Boucher & Lewis, 1989, cited in Jordan, 1999). In other words, the research suggests, people with AS appear to do a lot better when provided with cues and prompts.

The literature on memory, suggests that some people with AS can experience both episodic and semantic difficulties in uncued, complex situations which may translate to

the psychotherapy setting. For example, therapists might need to acknowledge that without support their clients with AS may experience difficulties recalling detailed past personal experiences, recalling past events being an important aspect of the majority of models of psychotherapy, however, with the right support they may do very well. It is uncertain whether this level of support conflicts with some therapist's preferences and with the construct of conceptual complexity as proposed by Davis et al (1977) and further elaborated upon by Teasdale and Hill (2004).

Memory has been linked to the two cognitive theories explored so far: Weak Central Coherence and Theory of Mind (e.g. Bowler, 2007; Ponnet et al, 2004). However, there is another theory that has also been linked to memory and which may help to explore further whether the preference for some therapists to have a client who exhibits a degree of conceptual complexity may be challenged and may also help to highlight other therapist attitudes to working with people with AS. This theory provides additional information about the possible characteristics of those with AS in its attempts to explain this complex disorder and in so doing provides some recognition of the complexity and interdependency of particular cognitive skills which some other theories and researchers neglect. This theory asserts that the features seen in Autism Spectrum Disorders are secondary to difficulties with a diverse range of higher level cognitive skills, coordinated by executive functioning, therefore this model may help to highlight any conflicts or tensions the therapist may have when working with clients with AS and their possible preference for them to have a degree of cognitive complexity.

5.5.2.3.3. Conceptual Complexity: Executive Functioning

Ozonoff et al (1991) put forward an argument that the fundamental difficulties associated with an Autism Spectrum Disorder are down to problems with e*xecutive functioning*. It is argued that the frontal lobes mediate executive functions which are those processes concerned with planning, switching-set, set-maintenance and flexibility of thought and action, inhibition and attention disengagement. All these processes allow the individual to disengage from the external world, instead guiding behaviour through mental models and internal representations (Jordan, 1999). These complex features have been argued by a number of authors to have implications on communication functioning and general social skills, as for example, social interaction requires a disengagement from a particular perspective thus implicated in first and second order Theory of Mind abilities (Martin & McDonald, 2004). Furthermore, difficulties with inhibition of impulses may adversely affect social interactions as would

difficulties with cognitive shifting and flexibility of thought (e.g. Landa & Goldberg, 2005), skills required to meet variable social demands and in order to infer conversation partner communication acts. For example, in order to pass the Reading the Mind in the Voice task (Rutherford et al, 2002) one must be able to selectively attend and sustain this attention, whilst controlling impulses. Failure of this task in itself does not mean Theory of Mind deficits or put another way, Theory of Mind and other higher level skills require a number of basic assumptions to be met, attention being crucial.

As with the Theory of Mind argument and Weak Central Coherence, there is a plethora of mixed findings regarding the range of higher order cognitive abilities in those with High-Functioning Autism and AS. Rinehart, Bradshaw, Moss, Brereton and Tonge (2001) built on their previous research using the Hierarchical Local Global Processing Task. In this research participants had to switch from local (small numbers within larger numbers) to global (larger numbers made up of smaller numbers) processing, they found that those with AS did not show a deficit in shifting attentional set challenging the executive functioning argument and its assertion that it underpins the social/cognitive deficits that characterises Autism Spectrum Disorder's (e.g. Berger et al, 1993; Courchesne et al, 1994a; 1994b, cited in Rinehart et al, 2001; Lander & Goldberg, 2005). However, the number of participants were very low (n=12) and with it the confidence in generalising to the wider population.

Bogte et al (2009) found that those participants with Autism and High-Functioning Autism did not show divided attention deficits, argued to be an aspect of executive functioning, compared to the developmentally typical comparison group. However, they were much slower than the control group, possibly supporting previous research on complexity, cognitive overload and processing time (e.g. Kaland et al, 2002). These results are in contrast to other research that shows limited divided attention capacity in some of those with High-Functioning Autism (Althaus et al, 1996; Swab-Barneveld, 1998, cited in Bogte et al, 2009). In both Bogte et al's (2009) and Rinehart et al's (2001) studies where specific skills are measured, it is rather difficult to claim that one component e.g. shifting-set or divided attention, out of a wider set of cognitive skills i.e. executive functioning as described at the beginning of this section, can be isolated in such an artificial way. Nyden, Gillberg, Hjelmquist and Heiman (1999) attempt to deal with this criticism by assessing a wide range of cognitive skills related to executive functioning. In their research, those with AS showed deficits in a range of tasks purported to assess executive functioning: speed, attention, inhibition, focus-execute

and working memory but did not show difficulties with switching-set using the Wisconsin Card Sorting Task (Grant & Berg, 1948, cited in Nyden et al, 1999); it is a significant oversight that the authors did not explore why those with AS scored within the normal range on this well-known measure of executive functioning which incorporates a range of the other skills measured in this research. In Landa and Goldberg's (2005) research they found that those with High-Functioning Autism experienced both difficulties and strengths in a number of executive functioning tasks within the Cambridge Neuropsychological Test Automated Battery (Cambridge Cognition, 1996, cited in Landa & Goldberg, 2005). They experienced difficulties with planning and spatial working memory, possibly due to perseveration and they did better than the developmentally typical matched comparison group within the extra-dimensional flexibility/set shifting component (conceptual shifting) and experienced relative difficulties within the intra-dimensional flexibility/set shifting component (perceptual shifting), the latter, according to the authors should be the easier component; the authors do not provide a clear and convincing explanation for this unusual outcome. Furthermore, it may be difficult to establish if any results based on a specific skills tested in a closed and controlled system where attentional problems are reduced for example (e.g. Hinshaw, 1994), can be generalised to "real-life" complex settings where these skills will be required simultaneously with other skills, some of which are interdependent; research findings are most useful when they can be applied to "every-day" situations and clinical issues.

Despite criticisms, the research described above may help identity some considerations when working psychotherapeutically with this population, including the impact on therapist attitude. Considerations include the possibility that some of those with High-Functioning Autism and AS may not have difficulties with inhibition and divided attention in controlled settings, but might show difficulties with perseveration (Landa & Goldberg, 2005), working memory and planning (Landa & Goldberg, 2005) in controlled settings, which Bowler (2005) argues may be due to problems with disengagement from the "here-and-now," and generating "if-then" type courses of action; there are mixed findings for their ability to shift-set (Landa & Goldberg, 2005; Rinehart et al, 2001; Nyden et al, 1999). These assertions might generalise to "real-life" settings where more problems may be faced, particularly as real-world settings will inevitably be more complex and uncued.

The executive functioning theory describes some of things that therapists might need to consider when working with people with AS. For example, joint attention is necessary

for the interpersonal relationship to be established and problems to be mutually explored, whilst spontaneous behaviour may be affected, meaning the possible need for some cueing during therapy (Jordan, 1999), these issues may infringe on the therapist's preference for their clients to have a degree of conceptual complexity, to be psychologically minded and have intact interpersonal skills.

When the areas described in the literature review so far are problematic then breakdowns in interaction may begin to appear thus potentially impacting on an important therapeutic assumption, the working alliance, viewed as an essential component of therapy irrespective of model or therapy duration (e.g. Martin et al, 2000 cited in Busseri & Tyler, 2003; Horvath & Symonds, 1991). Therapeutic alliance has been argued to be negatively influenced by client social functioning (Couture et al, 2006), viewed as potentially problematic for those with AS, based on the literature review so far.

The working alliance will now be explored. Following that, restricted and repetitive thought and behaviour patterns will be explored as linked to "autistic preoccupation," argued to impact on the building of a collaborative relationship (Couture et al, 2006). Finally, an exploration of clinical supervision as a possible resource for therapists will be provided followed by a short discussion of the comparison groups before moving on to the aims of the study.

5.5.2.4. The Working Alliance

> *The therapeutic alliance refers to the quality and strength of the collaborative relationship between the client and therapist* (Norcross, 2010, cited in Bertolino et al, 2011, p.15).

The working alliance has been argued to be comprised of an agreement of tasks and goals within therapy and the quality of the bond between therapist and client (Bordin, 1975). There are well over 1100 separate studies that document the importance of the working alliance (Bertolino et al, 2011) but the author is aware of none that explores the working alliance with people with AS. In therapy, some therapists may experience difficulties with building rapport and building a working alliance with some of those with AS as a shared understanding of the relationship may not be present (Hare, 1997b). For example, it was found in a study by Bishop and Baird (2001) that rapport was worse in those with AS based on parental ratings on the Children's Communication Checklist, than those with Attention Deficit Hyperactivity Disorder and Specific

Language Disability and Pervasive Developmental Disorders-Not Otherwise Stated; these differences were not explicable in terms of age or intellectual functioning.

In another study it was found that the working alliance for therapists working with clients with AS, as measured by the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989), was significantly worse than the working alliance for therapists working with those without AS (Chalk, 2005, unpublished). Finally, Weiss and Lunsky (2010) found that clients with AS and mental health problems expressed difficulties with alliance potential as measured by the Suitability for Short-Term Cognitive Therapy Interview (Safran et al, 1990; Safran et al, 1993, cited in Weiss & Lunsky, 2010). This is important as it is a very well established view that it is the therapeutic relationship, more than any other factor, such as therapeutic orientation, which is significant in the effectiveness of psychotherapy (e.g. Dryden, 1994; Gelso & Carter, 1985; Luborsky et al, 1983; O'Malley et al, 1983; Bergin & Lambert, 1978; Hill, 1989, cited in Clarkson, 2003). Horvath and Greenberg (1989) argue that efficacy of psychotherapy lies in the quality of the working alliance. Rush (1986) describes the necessity of the working alliance in facilitating "…the application of therapeutic techniques and constructive changes in the behavioural, emotional and cognitive patterns" (p.59).

As stated, the ability to form a working alliance between the therapist and their clients has been argued to be influenced by the clients social functioning, but may also be influenced by what Couture et al (2006) calls "autistic preoccupation" roughly translated as a preoccupation with particular themes, which may be related to a restricted pattern of thinking and behaviour, an area which is part of the diagnosis for AS (American Psychiatric Association, 1994). An exploration of this area will now be undertaken in order to ascertain whether there is a potential for this feature to be a challenge for therapists working with this particular population.

5.5.2.5. Restricted and Repetitive Thought and Behaviour

The second major diagnostic criteria for AS, the first being social interaction/reciprocity which has already been discussed, is inflexibility expressed through restricted and repetitive behaviours. Within the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000), International Classification of Diseases and Disorders - 10 (World Health Organisation, 1993) and Gillberg's (1991, cited in Frith, 2004) classification system this particular area is described as an unusually intense, all encompassing, repetitive preoccupation with a narrow range of interests, behaviours

and activities and inflexibility in the adherence to particular routines, such that there is an interference with daily functioning.

> *"…anecdotes suggest that difficulties tend to arise from the fact that people with AS see situations in fixed and absolute terms, rather than relative to context...They appear to find it hard to override routine responses. They are well known for being rigid and tend to take any change of plan or routine very badly. They crave sameness just like individuals with other forms of autism, and they thrive if there is clear structure in the environment and they need external prompts to carry out infrequent and unusual tasks… they often need someone to remind them when they should do something that they intended to do, and to tell them what the appropriate action should be in slightly unexpected situations"* (Gillberg, 1991, p. 680, cited in Frith, 2004).

This domain has generally been neglected within the research on Autism Spectrum Disorders (South et al, 2005); research appears to be heavily biased towards the areas defined by social interaction and communication. This may be due to the general consensus that the repetitive and restricted behaviour component to this syndrome is not viewed as central compared to the social interaction/reciprocity domain (Shattuck, Seltzer, Greenberg, Orsmond, Bolt, Kring, Lounds & Lord, 2007). Despite the lack of research, restricted and repetitive behaviours may be a core feature of AS and while there is separation with social interaction/reciprocity within the research, restricted repetitive behaviours should not be viewed as distinct and disconnected from the other main core diagnostic features. This domain has also been linked to associated features such as sensory abnormalities (e.g. Chen, Rodgers, & McConachie, 2009). The research on language, social and emotional reciprocity and on the need for cueing all relate clearly to this domain and echo aspects of the quote above.

Repetitive and restricted behaviours can have a significant impact on daily functioning, including social interaction. For example, many researchers and authors argue that the circumscribed interests in those identified as having High-Functioning Autism and AS can be exhibited with such intensity, duration and frequency that they can negatively interfere with school, home and social interactions (South et al, 2005). The special interests and all-encompassing topics can dominate conversations and may irritate conversation partners, who may not share these interests and lead to rejection (South et al, 2005). Frith (2004) implicitly illustrates how inflexibility and repetition resonates

within the social interactions of those with AS and therefore it can be seen why Couture et al (2006) argues how the absence of this feature might be an important therapist preference; thus restricted and repetitive behaviour may be an area worthy of exploration in terms of the possible impact on therapist attitudes.

Following from Turner's (1999, cited South et al, 2005) research, the little research that does exist in this area usually splits restricted and repetitive behaviours into lower-order (e.g. hand flapping) and higher-order (e.g. circumscribed interests). Militerni et al (2002) studied whether age has a relationship with repetitive behaviours finding that older children with an Autism Spectrum Disorder were more likely to exhibit complex higher-order repetitive behaviours than the younger cohort who exhibited more sensory and motor lower-order repetitive behaviours (cited in Esbensen, Seltzer, Lam & Bodfish's, 2009). South et al (2005) found in their research using the Repetitive Behaviour Interview (Turner, 1991, cited in South et al, 2005) and the Yale Special Interests Interview (South et al, 1999, cited in South et al, 2005) that all forms of repetitive behaviours, lower-order and higher-order were exhibited in both participants with High-Functioning Autism and those with AS. Esbensen et al's, (2009) research supported South et al's (2005) findings when they observed, using the Repetitive Behavior Scale – Revised (Bodfish et al, 2000, cited in Esbensen et al, 2009), that all of the subtypes of repetitive behaviours (both lower and higher order) were exhibited by the whole sample of individuals (n=712) whom had a diagnosis of an Autism Spectrum Disorder, including AS, irrespective of age and ability, but that repetitive behaviours appeared to decrease with age.

In another study also using the Repetitive Behaviour Scale-Revised, Lam and Aman (2007) also found age related differences in the restricted and repetitive behaviours of those with High-Functioning Autism and AS. Lam and Aman (2007) found a more heterogeneous pattern of repetitive behaviours, finding that stereotyped behaviours and restricted interests were less frequent in older individuals with an Autism Spectrum Disorder, whereas ritualistic/sameness was more frequent among the older individuals. Finally, in Bishop, Richler and Lord's (2006) research, age and Intellectual functioning appeared to significantly interact with the prevalence of repetitive behaviours. In their research, all the children in their sample aged between 15 months and 12 years with an Autism Spectrum Disorder, 2 of which had AS and 268 had a Pervasive Developmental Disorder-Not Otherwise Stated, exhibited all categories of repetitive behaviours, lower-order and higher-order, as measured by the Autistic Diagnostic Interview-Revised (Lord et al, 1994, cited in Bishop et al, 2006). Nonverbal IQ

appeared to be positively associated with higher-order repetitive behaviours such as circumscribed interests and negatively associated with lower-order repetitive behaviour such as hand flapping in older children. Despite some subtype discrepancies, the research suggests a reduction in severity and frequency of the majority of repetitive behaviours with age, with the exception of circumscribed interests.

The above research shares a number of criticisms. They use a variety of sources for the information on the people with Autism Spectrum Disorders such as different ways to assess intellectual functioning. The majority of the measures have not been validated to people with AS such as the Repetitive Behavior Scale – Revised which makes extrapolations and comparisons difficult. In Lam and Aman's (2007) research the questionnaire used provided rather spurious information on the characteristics of those with an Autism Spectrum Disorder. For example, the questionnaire categorised the Autism Spectrum Disorders as mild, moderate or severe, thus reflecting a crude continuum approach rather than the established dynamic spectrum concept to Autism Spectrum Disorder. Questionnaires have also been criticised for being susceptible to a number biases including the requirement of a basic level of literacy. The research that measured differences in repetitive and restricted behaviours by age were not longitudinal and thus used separate individuals to produce life span patterns, thus symptom change could be due to cohort differences not developmental trajectory. Finally, parent self-reports were used throughout the research, thus as Esbensen et al (2009) argues, the decrease in repetitive behaviours with age may be due to parents becoming more tolerant over time thus not a reduction in real terms at all.

Notwithstanding the various criticisms of the above research, it would appear, as with all the core features of Autism Spectrum Disorder's, repetitive and restricted behaviours may impact on social interaction, however, the features may abate with age (Fecteau et al, 2003; Mawhood et al, 2000; Seltzer et al, 2003; Shattuck et al, 2007, cited in Esbensen et al, 2009) but may not disappear, by definition, Autism Spectrum Disorders are life-long conditions. The impact of repetitive behaviours has been relatively better researched in Autism (e.g. Gordon, 2000; Pierce & Courchesne, 2001, cited in Lam & Aman, 2007) than in AS. Despite the huge amount of descriptive information provided by many respected authors on repetitive behaviours and AS, these appear to be mainly descriptions based predominately on clinical experiences rather than rigorous scientific research (Attwood, 1998, 2007; Gillberg, 2002). The little research that does exist within this area with regard those with AS, suggests that repetitive behaviours and rigidity might have a significant effects on interpersonal

relationships. In South et al's (2005) research, they found, based on verbal reports within the Repetitive Behaviour Interview and the interference subscale within the Yale Special Interests Interview, that repetitive behaviours appeared to substantially interfere with individual and family and social relationships generally (South et al, 2005), this South et al (2005) argues is consistent with Bashe and Kirby's (2001) assertions and reflects Klin and Volkmar's (2000) client study of a 15 year old with AS. As psychotherapy is an interpersonal endeavour, restrictedness and repetitiveness may have an equally significant effect on therapist attitude although it needs to be acknowledged, once again, these assertions neglect to explore the social context in which these issues are exhibited, therefore for one person repetitive and restricted behaviours may be a problem, for another it may serve an important function and for the receiver it may be viewed as fascinating (Gillberg, 2002) or easily managed in session, particularly for the experienced clinician.

Restricted and repetitive behaviours, or inflexibility as some authors and researchers name this domain (e.g. Jordan, 1999, possibly echoing the underpinning cognitive style), can be seen to resonate in all three cognitive theories described so far, highlighting a possible link between cognitive style, inflexibility and repetitiveness (e.g. Chen et al, 2009; Mosconi, Kay, D'Cruz, Seidenfeld, Guter, Standford & Sweeney, 2009). For example, in terms of Theory of Mind this feature may be linked to the difficulty in disengaging from one's own perspective in order to engage in another's. Within executive functioning, this feature may be highlighted in the possible difficulties with shifting set and finally, in relation to Weak Central Coherence, this feature may be shown in the possible difficulties in modulating between the extreme analytic and the gestalt view point, or in the over focus on detail. All these things could be argued to be examples of or manifestations of inflexibility, repetitiveness and restrictedness.

It will be important for therapists to acknowledge a possible cognitive and behavioural inflexibility leading to sessions possibly being dominated by particular repetitive topics, difficulties shifting thinking patterns and learning in session may not generalise (Hare, 1997b; Paxton & Estay, 2007). The thinking style of some of those with AS may echo some of the thinking styles of people without AS who have a mental health problem (Hare, 1997b), where cognitions may be polarised, rigid (Reaven & Hepburn, 2003; Weiss & Lunsky, 2010) and dichotomous (Hare, 2005):

> *"People with ASD tend to think in polarities, black and white. They like firm answers and consistent routines, where things are the same and do not change unpredictably. They like rules that are consistent, and will follow these rules, expecting everyone else to also follow the same rules. People on the spectrum tend to be rule bound, which means that their behaviour is governed by rules. They may get stuck on the rule and may have difficulty coping with the exception to the rule*" (Paxton & Estay, 2007, p. 74).

A related concept to inflexibility, which is well established within particular specialisms within the field of psychotherapy, is the concept of perfectionism, argued by some to be a possibility for those with AS (Paxton & Estay, 2007; Hare, 2005; Gillberg, 2002). Indeed, the various cognitive styles that researchers and authors have attributed to some people with AS are consistent with other researchers definition of perfectionism (e.g. Shafran & Mansell, 2001), a term which includes rigidity, inflexibility and dichotomy of thought (Egan, Piek, Dych & Rees, 2007). Perfection and these specific cognitive features have been found to be linked to a number of mental health problems such as anxiety disorders (e.g. Rheaume, Freeston, Ladouceur, Bouchard, Gallant, Talbot, & Vallieres 2000) including obsessive compulsive disorder (e.g. Veale & Willson, 2005), eating disorders (e.g. Shafran, Lee & Fairburn, 2004) and depression (e.g. Alden, Bieling & Wallace, 1994). Perfectionism has been linked to difficulties with establishing the therapeutic alliance (e.g. Hewitt et al, 2003; Shafran et al, 2002) in that difficulties in alliance formation may be due to the lack of contribution by the perfectionistic clients to the therapeutic alliance (Dunkley, Blamkstein, Masheb & Grilo, 2006). However, perfectionism can be positive and has been linked to success (Kobori & Tanno, 2005).

Apart from being logically minded, all the characteristics of AS described so far may challenge the therapists desire for a client to have a degree of interpersonal and social functioning, to be psychological minded and be able to engage in conceptual complexity, with an absence of "autistic preoccupation" or restricted and repetitive thought and behaviour patterns, making the establishment of a working alliance between client and therapist less likely (Couture et al, 2006); this is an important therapeutic assumption. All the issues described so far may leave the therapist, particularly the inexperienced therapist, feeling frustrated (Paxton & Estay, 2007) and given that empathy may not be reciprocated (Hare, 1997b) the therapist may feel alone in this struggle. One area of important support is clinical supervision, which is generally

viewed as an essential competent of clinical practice and continued professional development for practicing and registered therapists (e.g. British Association of Counselling and Psychotherapy), including psychologists (e.g. the British Psychological Society). A brief overview will now be provided of this important resource, which may influence therapist attitudes to working with people with AS.

5.5.3. Clinical Supervision

Clinical supervision is recognised as important in the delivery of effective clinical services (Butterworth & Woods, 1999) as it provides an important mechanism to support and develop staff (Pretorius, 2006). The British Psychological Society states clearly that:

> "*Supervision/consultative support is a contractual relationship between practitioners for the purpose of supporting, evaluating and developing professional practice. There is an ethical requirement for every practitioner to have regular supervision of consultative support from a suitably qualified professional…*." (British Psychological Society, Division of Counselling Psychology, 1998, p.6).

Wheeler and Richard (2007) found from their extensive meta-analysis of studies on clinical supervision, that supervision is essential in providing opportunity to gain confidence, to increase self-awareness and self-efficacy, to develop skills, receive general support and to ultimately positively influence client outcome. Given that therapists "…routinely fail to identify clients who are not progressing, deteriorating and at most risk of drop out and negative outcome…" (Hannan, Lambert, Harmon, Nielson, Smart & Shimokawa, 2005) supervision may be a way to help educate therapists to notice the signs of decline and to intervene accordingly (Bertolino et al, 2011).

Carroll (1996) argues that the purpose of clinical supervision is to support, educate and evaluate (cited in Townend, Lannetta & Freeston, 2002). Gilbert and Evans (2000) argue that clinical supervision is about spending time with a more "seasoned" and experienced practitioner where wisdom and expertise is shared (cited in Townend et al, 2002). Others emphasise the working alliance between the supervisor and supervisee as crucial aspects of clinical supervision (e.g. Bambling, King, Raue, Schweitzer & Lambert, 2006). Townend et al (2002) argue that generally there is an agreement in the literature that supervision in clinical practice is a learning process in terms of attitude refinement, knowledge attainment and skills development.

The things that all the reviews and articles have in common in the area of supervision is the assertion that one major component of clinical supervision, particularly cognitive behavioural therapy supervision, is the dissemination of best practice, the transferring of information about the theoretical and technical aspects of practice and the practical application to therapy (Perris, 1993, cited in Pretorius, 2006). In terms of cognitive behavioural therapy supervision, it is argued that opportunity should be given to discuss the emotions and cognitions of the clients, to help the supervisee develop case formulations, to consider treatment and technique options as well as discussing obstacles to these (Pretorius, 2006). With this mind, the supervisor needs to be experienced not only in the model but also the client group with which the supervisee is working. Given the relative lack of knowledge and expertise in the area of AS, as already explored, clinical supervision may not be as supportive as is necessary thus creating another source of challenge for the already potentially challenged therapist; "Poorly trained, poorly supervised and badly managed therapists are at best ineffectual and at worst dangerous" (p. 1, Holland, 2006, cited in James, Milne, Marie-Blackburn & Armstrong, 2006).

A number of studies have been conducted that have explored clinical supervision. In a survey of clinical supervision conducted by Townend et al (2002) it was found that of the 170 respondents the majority were very satisfied with the clinical supervision they received. However, Townend et al (2002) argue that this may be as much to do with the quality of supervision as the low expectations of the supervisees. The questionnaire was designed for this survey and given there was no information on how items and pools of items within the questionnaire were specifically constructed there is no way of establishing how valid the measure of satisfaction was, for example.

Schaivone and Jessell (1988) found that perceptions of supervisor "expertness" was viewed as more favourable than more "inexperienced" supervisors in 86 masters level counselling education students. Gabbay, Kiemle and Maguire's (1999) survey of clinical psychologists found that of the 120 respondents, 42% were dissatisfied with their current clinical supervision provision and 40% wanted improvement. The respondents stated that the most satisfying aspects of supervision were the supportive elements such as reflection; a lot of emphasis was placed on trust and respect in the relationship and "sharing difficult/sensitive issues" and being "held" by the supervisor (p.408). Both these surveys are rather old and things have changed a lot in terms of supervision expectations following developments in the NHS such as following the

establishment of clinical governance. In addition, these studies provide no detail about how the questionnaires were developed and validated, including how the items/questions or groups of items/questions were constructed to measure particular facets or whether they did indeed measure what they expected to measure. Furthermore, despite the qualitative information being interesting and appearing to support the quantitative information, there appeared to be no rigor in how the qualitative information was analysed, the authors could have simply cherry-picked the extracts that appeared to support their argument.

In a more modern and rigorous survey using a number of validated measures Hyrkas (2005) found that the quality of clinical supervision related to job satisfaction and burnout for mental health and psychiatric health care professionals, moreover, that ineffective supervision was related to job dissatisfaction. This research appears very thorough but as the sample came from Finnish mental health settings it may be difficult to extend the assertions posed in the survey to other countries with varying cultural contexts including possibly differing expectations about supervision provision. Despite the limitations of the research explored above, the findings asserted within them appear to provide a good summary of the extensive research that exists on clinical supervision. The research appears to point to the importance of clinical supervision for therapists but this is only satisfying to supervisees when the supervision is regular, supportive and delivered in an expert and professional way by an experienced supervisor.

5.5.4. Preliminary Synthesis

The majority of the research explored above, although invaluable in helping to understand AS, appears to share a number of possible limitations. These limitations include the neglect of the stratified nature of “real-life” social settings and thus the processes involved in social encounters where skills are utilised, which the research attempts to generalise to. This includes the dynamic social interaction between the person with AS with others and the personal meanings that those studied have about them, which may act as important mechanisms within the explanatory matrix or an important outcome; this points to intensive rather than extensive research methods. Despite this, the research explored above has been helpful in demonstrating that people with AS are heterogeneous, presenting in a variety of ways but within particular parameters. People with AS can present differently according to a number of things

including co-morbidity and the context such as how the social partner interacts with them (e.g. cueing skills) and the wider social context e.g. according to a set of potential prejudices that the therapist may have. However, there may be things that are common to people with AS. Despite the limitations, a number of things can be gleaned from the research above that could, from a pragmatic perspective, lead to a number of therapist considerations in order to enhance theirs and their clients' experiences of therapy, if deemed appropriate. The research might also point to a number of things that could influence therapist attitudes.

Despite the limitations of the research, the research has been useful in highlighting that some of those with AS show a possible disparity between vocabulary and syntax within the normal range and a sometimes over pedantic expressive communication style, with possible difficulties with pragmatic skills specifically and pervasive difficulties with social and emotional understanding and reciprocity generally. Three major theories have been explored in order to provide additional insight into these anomalies, to broaden the exploration beyond behavioural manifestations and to reveal some of the cognitive abilities that may underpin them. It was argued that people with AS may show a profile of strengths and difficulties in a number of different psychological and cognitive domains and processes, some specific, some more global entities, some related to lower order and others related to higher order information processing skills, but all appearing implicated in influencing interpersonal relatedness. Finally, repetitive and restricted behaviours were outlined in relation to theory and influence on social engagement and learning style.

Whilst reviewing therapist preferences and basic therapeutic assumptions and comparing them to the features of AS from the literature review then there is a distinct possibility that some therapist's preferences and some basic therapeutic assumptions may be challenged when working with this population including the need for intact social functioning, psychological mindedness, conceptual complexity and the ability to form a working alliance. The client group the therapist is working with can be viewed as a facet of job satisfaction and job satisfaction has been linked to both physical and psychological health (Faragher, Cass & Cooper, 2005), turnover, absenteeism (Ivancevich & Matterson, 1980; Maslach, 1982, cited in Ross, Altamier & Russell, 1989) intent to stay in a job (Kosmoski & Calkin, 1986), burnout (Faragher et al, 2005) and the quality of patient care (Grol, Mokkink, Smits, Van Eljk, Beek, Mesker & Mesker-Niesten, 1985), those particularly susceptible are in jobs involving the care of others (Maslach & Jackson, 1981, cited in Ross et al, 1989) of which counselling is one

(Farber, 1983, cited in Ross et al, 1989). Therefore, it is a distinct possibility that some therapists may experience dissatisfaction when working with people with AS which could lead to negative consequences for both the therapist and the client. However, it might also be that some therapists will be satisfied with working with people with AS, particularly when reflecting on the positive aspects identified within the literature review, however, according to the therapist preferences explored this appears unlikely.

The intention of the broad and comprehensive exploration has been to highlight the possible influences client characteristics relating to AS might have on psychotherapy and therapist attitude, particularly when comparing these characteristics to therapist preferences and therapeutic assumptions. The intention of this research was to explore therapist attitudes including satisfaction through interview and questionnaire. However, in order to be sure that therapist ratings within the questionnaire reflects their work with people with AS and not therapy per se or complex clients per se comparison groups will be required. Therefore, borderline personality disorder and depression were chosen as comparison groups. An exploration of these disorders will now be made but it will be kept brief as these are groups that were chosen simply as a way to further validate therapists' ratings on the questionnaire. The reasons for these groups being chosen as comparisons groups will now be discussed starting with borderline personality disorder, then depression before explicitly stating the aims of the study.

5.5.5. Comparison Groups

The intention of the descriptions provided below on both borderline personality disorder and depression are in order to describe the defining or shared characteristics of these disorders, the characteristics that appear to cluster in some way and help to differentiate them from other disorders. However, it is acknowledged that like AS, these are heterogeneous groups with differing developmental trajectories and where co-morbidity is frequent. It is recognised that absolute clarity may be required by particular types of clinician and/or researcher from particular paradigms such as the positivist paradigm where classification is important to ensure that a relatively homogeneous group of participants are selected for the research, for example, in order to diminish extraneous sources of variance (Butler et al, 2008). For most psychologists however, such rigidity may not be viewed as possible or as important. The author advocates a pragmatic position embracing specificity and a transdiagnostic perspective (Butler et al, 2008) where AS, borderline personality disorder and depression can be differentiated from other similar disorders in terms of a pattern of phenotypes for

example, but at the same time acknowledging that some of the features that define them may also be shared with other disorders and the person may manifest them in different ways but within parameters. This perspective acknowledges the heterogeneity of a population that may share particular clustering characteristics within specific parameters but who may manifest these in different and individual ways according to different developmental trajectories or set of circumstances and may exist alongside co-morbid conditions and other characteristics in relation to individual differences. It is also acknowledged that the person with AS may be defined and experienced differently by others according to a fluctuation in social, cultural and historical context. This is a flexible perspective that clinicians would recognise as *case conceptualisation* or *case formulation* (Butler et al, 2008; Gaus, 2007) viewed as paramount for effective and ethical working. This approach would support the clinician in intervening by helping them select the appropriate intervention. With that in mind the author will attempt to firstly describe borderline personality disorder and then depression before moving onto the aims of the study.

5.5.5.1. Comparison Group: Borderline Personality Disorder

Borderline personality disorder appears to be the most common personality disorder (Lawson, 2000, cited in Fazio-Griffith & Curry, 2009), affecting up to one in thirty-three women (Mayo Clinic, 2006). Borderline personality disorder has been characterised by a pervasive pattern of instability of interpersonal relationships, self-image and mood and impulsive behaviour (The National Institute for Clinical Excellence, 2009; American Psychiatric Association, 2000, please see Appendix 6). Furthermore,

> *"…there is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide. Its course is variable and although many people recover over time, some people may continue to experience social and interpersonal difficulties"* (National Institute for Clinical Excellence, 2009, p.3).

The disorder may significantly affect the life of the person and those closest to them by straining relationships, causing instability in employment, interfering with social activities and fostering a negative self-image and self-worth (Mayor Clinic, 2006).

The intervention of choice for people with borderline personality disorder appears to be psychotherapy (Mayor Clinic, 2006) such as dialectic behavioural therapy (Linehan, 1993). In relation to therapist experiences most mental health staffs describe clients with borderline personality disorder as amongst the most challenging clients that they encounter (Cleary, Siegfried & Walter, 2002, cited in Bland & Rossen, 2005). The majority of the literature points to the relationship being the most significant aspect of challenge with clients with borderline personality disorder

> *"The client with borderline personality is not capable of establishing a relationship with the therapist, which can be considered the most significant part of the therapy process"* (Glickauf-Hughes, 1997, cited in Fazio-Griffiths & Curry, 2009, p. 106).

Clients with borderline personality disorder have been associated with poor working alliance (Glickauf-Hughes, 1997, cited in Fazio-Griffith & Curry, 2009; Ward, 2004) possibly due to the characteristic vacillating interpersonal style and "splitting" (Gunderson, 1984. Piccinino, 1990, cited in Bland & Rossen, 2005) and the impression this gives to the mental health professional that this is a malicious manipulation (Bland & Rossen, 2005) that may leave the therapist feeling like a failure (Frazer & Gallop, 1993; Greene & Ugarriza, 1995; O'Brien, 1998, cited in Bland & Rossen, 2005) and thus possibly reducing therapist satisfaction.

The extensive literature on borderline personality disorder suggests that the possible difficulties with interpersonal functioning, emotion identification and regulation (Ebner-Priemer et al, 2007, cited in Fazio-Griffith & Curry, 2009; Linehan, 1993) may be at the heart of this disorder leading to a possible strain on the mental health professional (Bland & Rossen, 2005). Fazio-Griffith and Curry (2009) found in their research of trainee counsellors that a majority of those interviewed experienced increasing frustration with these clients which is not surprising given that some of these clients are thought of by others as being volatile, manipulative, impulsive and self-destructive, thus leading to possible problems with the therapeutic process including the therapeutic alliance (Glickauf-Hughes, 1997, cited in Fazio-Griffith & Curry, 2009).

To compound things further, supervisors may not be experienced or equipped to support therapists with these clients (Fazio-Griffith & Curry, 2009), as supervisors may not have been taught to deal with specific client characteristics (Borders et al, 1995; Holloway, 1995, cited in Fazio-Griffith & Curry, 2009) and where the difficult relationship the supervisee might have with their client may be played out as a "parallel process" between the therapist and their supervisor (Glickauf-Hughes, 1997, cited in Fazio-Griffith & Curry, 2009).

Borderline personality disorder was chosen as a comparison group as despite etiological differences it is viewed as similar to AS in that both disorders are viewed as enduring, pervasive and complex conditions whose main features are essentially interpersonal and emotional (American Psychiatric Association, 2000; Linehan, 1993) which can possibly lead to some therapists struggling with building and maintaining a therapeutic rapport (e.g. Bender, 2005) but where there are differences in that with borderline personality disorder there is a relatively extensive evidence base for effective clinical treatment (e.g. Linehan et al, 1991; Linehan 1993) and where there may be fewer pragmatic difficulties (Tantam, 1986, 1988, cited in Ghaziuddin & Gerstein, 1996).

5.5.5.2 Comparison Group: Depression

Depression may be one of the most common disorders encountered by mental health professionals (Zheng et al, 1997, cited in Antony & Barlow, 2002), so much so that it has been labelled the "common cold" of psychopathology (Gilbert, 1992). Diagnosis is made based on a cluster of symptoms that persist for weeks, months or even years. Central to this mood disorder is significant cognitive, emotional, behavioural, somatic and social impairments (American Psychiatric Association, 1994). According to the Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000), major depression is characterised by depressed mood or markedly diminished interest or pleasure in most activities (please see Appendix 7). Additional symptoms include: suicidal ideation or suicidal attempts, feelings of worthlessness or excessive guilt, agitation or psychomotor retardation, hypomania or insomnia, impaired concentration, weight gain or loss, indecisiveness or difficulty thinking, loss of energy or fatigue (Antony & Barlow, 2002). The course of major depression may be chronic and recurrent, with between 50% and 85% of depressed clients experiencing multiple subsequent episodes (Coyne et al, 1999, cited in Antony & Barlow, 2002).

Recognised interventions for depression include medication and psychological approaches including psychosocial support and psychotherapy. It has been argued that one of the major developments in the treatment of depression has been the emergence of cognitive behavioural therapy (Antony & Barlow, 2002); there are many books and journals on the effective use of cognitive behavioural therapy with depression either in combination with medication or on its own (Williams, 1997, cited in Barlow, 2001). This disorder stands in stark contrast to AS as being a disorder which has been thoroughly researched, with recognised and often effective treatment protocols (e.g. The National Institute for Clinical Excellence guidelines, 2009) and a disorder which will be familiar to most practitioners (Zheng et al, 1997, cited in Antony & Barlow, 2002). It does not appear to be associated with the same enduring and pervasive interpersonal difficulties that characterise the core features of either AS or borderline personality disorder and therefore is not viewed as complex.

This literature review has attempted to provide a comprehensive account of AS in terms of the features that may influence therapist attitudes to working with this client group. The review began with a discussion of the history of AS. An overview of research regarding the possible core characteristics that define this disorder as well as associated features was provided within the context of the possible influence these features might have on psychotherapy and therapist attitude, using the literature on therapist preferences and therapeutic assumptions are a guide. This was followed by an exploration of another important area that might influence therapist attitudes to working with this population, the quality of clinical supervision. In the final section of the literature review borderline personality disorder and depression were explored as possible comparison groups. It is hoped that through this literature review the intentions and aims of this study have emerged, it will now be important to explicitly state them.

5.6. Aims of the Study

- To explore therapists' experiences of providing psychotherapy to people with AS through interview and then questionnaire. If factors are revealed following exploratory Principal Component Analysis then the following five hypotheses will be tested:
    - 1. Therapist preferences will not be met.
    - 2. The working alliance will be poor.
    - 3. Therapist satisfaction will be poor.
    - 4. Supervision will be poor.
    - 5. The quality of the working alliance will be positively correlated to therapist satisfaction.
    - 6. Therapist experience will be positively correlated to therapist satisfaction.

6. Method

Following on from the overview of the literature which followed an exploration of the author's theoretical perspective it will now be important to outline the practical aspect of the research design within the parameters of the scientific realist paradigm, this will go from a broad to a specific description. The scientific realist construct provides a clear way in which general philosophical ideas and principles can be applied to the specific practical task of research design. Pawson and Tilley (1997) point out that in most social research there is always initial speculation, however, pre-research insights can be gained by sourcing similar research, by building on established ideas and by discussing the proposal with those knowledgably about the research area. Once some ideas are shaped then further exploration may help to reveal more about the research and the ways in which measurement can be applied (Pawson & Tilley, 1997). The next step is what Oppenheim (1992) calls "working on in detail," which is where the research methods or designs can be employed.

6.1. Research Design

At the time it was believed that the *self-completion questionnaire* was the best research method to achieve the desired outcome by the author i.e. to explore anonymously a range of therapist views from a wide range of therapists. However, other methods were considered and ultimately rejected based on all of their individual merits and their application to this study within the original epistemology.

Focus group, face-to-face interview and also *telephone interview* were rejected on the basis of two very important aspects of this research: the need for a respondent's information to be kept anonymous due to the nature of the research questions (discussed later) and in order to reduce *prestige bias.* In general, questionnaires have a number of benefits: they are low cost, easy to process, they avoid interview bias and they can potentially reach more people and a larger geographical area can be covered to reach a broad range of attitudes (Czaja & Blair, 1996; Robson, 2002). However, self-completion questionnaires also have a number of limitations such as the potential for a low response rate, being unsuitable for people with poor literacy, those with physical disabilities and for those for who English is not their first language (Czaja & Blair, 1996; Robson, 2002). However, despite the difficulties with possible *sampling frame bias, low response rates* and the inability to control the *response situation* (Czaja & Blair, 1996; Robson, 2002), making the questionnaire web based might have helped

to reconcile the potential for other problems with self-completion questionnaires such as the question order effects (Dillman, 2000; Czaja & Blair, 1996; Robson, 2002), as this could be standardised by ensuing that respondents could not move around the questionnaire as they wished thus creating potential bias. It is also acknowledged that questionnaires can produce different answers to questions compared to interviews (Dillman, 2000); this is explored further within the discussion.

Grounded theory was considered as a possible method of enquiry. Developed by Glaser and Strauss (1967), grounded theory is an approach in which theories arise from the data, through constant interaction with the data, in a discovery-orientated fashion. This sits comfortably with scientific realism, like scientific realism, grounded theory asserts that "…the phenomenon exist 'out there' awaiting discovery…" (Rennie, 1996, p. 22, cited in Madill et al, 2000). The first two of the three stages in the process of grounded theory in some way reflects the way in which this study was conducted; the first two stages associated with exploration and description of the phenomena, the third stage associated with theory generation (Robson, 2002). In keeping with grounded theory, this study followed a systematic approach to coding by both the researcher and the additional researcher through the categorising of the interview material. Then, in the latter part of the research, the research intended to discover links or relationships between categories through the data analysis. Furthermore, in order to have some confidence in the results, a triangulation analysis was conducted comparing qualitative and quantitative material and comparing multiple researchers and exploring inter-rater reliability. One aspect of the comparison of the researchers coding took the form of comparing the categories that the researchers proposed and looking for thematic convergence (Madill et al, 2000). Where any differences occurred, of which there were very few (less than 8% disparity), discussions allowed an integration to form categories that were thematically similar (Madill et al, 2000), however, these remained tentative throughout the research up until the exploratory Principal Component Analysis. Despite a number of similarities between this study and the method of grounded theory, one important assumption was possibly violated and therefore grounded theory was not taken up, in that the researcher did have a sense of the topic, however restricted in depth and breadth, whereas in grounded theory the theory should be grounded in the data.

Interpretative Phenomenological Analysis was considered as a possible alternative research method to the questionnaire. In a number of ways Interpretative Phenomenological Analysis was viewed by the author as a viable option and sound

alternative to the questionnaire design employed. Interpretative Phenomenological Analysis may have been able to explore, through the use of in-depth interview for example, a therapist's personal perception or account of providing therapy to people with AS. This may have led to a detailed analysis of the therapist's particular account which could have been compared with other therapist's accounts; an idiographic approach that may have led to some interesting findings. However, Interpretative Phenomenological Analysis was rejected at it was incompatible with the author's initial scientific realist epistemology and method of enquiry. The author wanted to gather attitudes from a wide range of therapists with which group comparison could be made, in terms of experience, professional background, knowledge and therapeutic orientation, whereas Interpretative Phenomenological Analysis usually explores a relatively small number of cases (Smith, Flowers & Larkin, 2009) i.e. is more intensive (Sayer, 2000). The intention of this study was to explore the convergence of therapists from multiple backgrounds within the scientific realist paradigm. Furthermore, Interpretative Phenomenological Analysis was rejected as the author's view that it is possible to fix experience in terms of predefined categories, however tentative, incomplete or context dependent these may be conflicts with Interpretative Phenomenological Analysis (Smith et al, 2009). However, the author recognises that these categories will not necessarily provide a complete account of the participants experiences in relation to the phenomenon explored, in this study this was in relation to their experiences of providing therapy to people with AS.

Before exploring the more specific issues relating to the specific questionnaire and the procedure within this study an exploration of issues relating to the design of the questionnaire will now be undertaken.

There is a rich and extensive source of literature on questionnaire design. Oppenheim (1992) is well known within the realms of questionnaire design and proposes a number of stages which appear to fit very well within the realist paradigm and Pawson and Tilley's (1997) stages of research described earlier. 1) Gather insights about the research area by reviewing the relevant literature and through informal discussions with colleagues who may have a background in the area of interest. 2) These explorations should lead to a preliminary conceptualisation of the study. 3) From conceptualisation should come the defining of the research aim(s). The aims(s) should go from a general to a specific description thus leading to them being operationalised. This should lead to a statement of the possible mechanisms, that might be measured and in what contexts the measurement should take place. For each possible mechanism a set of questions,

scales and indicators will need to be formulated. 4) Once this has been done the questionnaire needs to be designed. 5) The sample which will be targeted then needs to be described. 6) Then the actual field work is conducted including pilot work in order to refine the measure and then finally administering the final questionnaire. 7) The data are then processed and analysed. 8) The research is then written up. This process outlines the stages that were undertaken within this study, the stages will now be described.

6.2. Procedure

6.2.1. Initial Stage

The first stage, after receiving ethical/University approval for the research from City University, was to review the relevant literature and hold informal discussions or *informal interviews* (Robson, 2002) with colleagues and specialists in the area as an exploratory exercise. This appears consistent with what Robson (2002) calls the *situational analysis,* by initially identifying the important aspects of the research early on interview guides can be generated to use within the more formal interviews to take place later within this study.

In terms of the literature searches, a number of key texts, books, journals and articles that appeared relevant to this area of interest were identified and explored. The literature searches occurred throughout the research and at every stage, at this initial stage of the research as well as following each interview and the pilot questionnaire as more material was generated from these sources. When conducting general internet literature searches a number of key words and phrases were used to identify relevant literature and research. The literature searches used the word AS in combination with additional key words (i.e. AS and…): diagnosis; history; flexibility; rigidity; restricted and repetitive behaviour; pragmatics; communication; social skills; memory; Theory of Mind; Weakness of Central Coherence; executive functioning; counselling; therapy; psychotherapy; cognitive behavioural therapy; mental health; anxiety; depression; therapists' experiences of working with; therapeutic alliance; working alliance; supervision; satisfaction. In addition, searches were done on borderline personality disorder and also depression, in conjunction with key words (i.e. borderline personality disorder and…/depression and…): therapeutic alliance; working alliance; therapy; cognitive behavioural therapy; supervision; satisfaction. Finally, searches were done on topics not relating specifically to AS, borderline personality disorder or depression, these were: satisfaction; job satisfaction; therapeutic alliance; working alliance;

cognitive behavioural therapy; therapist preferences. The databases and search engines utilised were: Google Scholar; Google; Athens; City University library catalogue; University of London Senate House library catalogue. Once general searches were performed more targeted searches were done on specific journals such as *Autism, The International Journal of Research and Practice*, the *Journal of Autism and Developmental Disorders*, and *Research in Developmental Disorders* as well as citation searches using Google Scholar and websites including The Department of Health.

6.2.2. Interviews

The information that was gathered from the discussions and literature searches were used to construct broad and tentative *hidden agendas* (Oppenheim, 1992) which, if required, could be used to gently guide the second stage, that being the individual formal interviews of therapists with experience of providing therapy to people with AS. The broad themes orientated around exploring therapists' experiences of providing psychotherapy to people with AS including alliance formation, possible differences with other client groups, interpersonal features and the possible influence on therapy.

The interviews were exploratory, that is, the use of interviews within this study was

> *"…essentially heuristic: to develop ideas and research hypothesis rather than to gather facts and statistics. It is concerned with trying to understand how ordinary people think and feel about the topic of concern to the research"* (Oppenheim, 1992, p.67).

Exploratory interviews allow new dimensions of study to be revealed, they can reveal differences between individuals and therefore groups and can produce a source of attitudinal and perceptual expression which can be converted and used within the questionnaire (Oppenheim, 1992). Thus "…interviews help in the formulation of the research problem, in the articulation of dimensions…and in the details of instrument building" (Oppenheim, 1992, p.68). The use of *depth interviews* were used rather than *structure*d or even *semi-structured* interviews where there are fixed, pre-determined questions. The depth interview allows the respondents to freely verbalise their attitudes thus hopefully produce "…rich and illuminating material…" (Robson, 2002, p.273). The respondents should only be guided by the interviewers general area of interest within

the parameters of the hidden agendas, thus this type of interview can be argued to be much more informant than interviewer led (Powney & Watts, 1987), in that the *unstructured* nature of this type of interview, through a *non-directive approach,* allows the respondent to explore their issues unhampered (Merton, Fiske & Kendall, 1956). Once the questionnaire is built then it can be used to explore further the dimensions elicited within the interviews and dimensions taken from relevant research and the discussions with colleagues.

It was acknowledged that the depth type of interview can be susceptible to a number of biases therefore a number of important things were acknowledged within the original epistemology before interviewing in order that the research was ethical and that the information gained was of the highest quality: was reliable, valid, as unbiased as possible and created enough information and detail to help in the construction of the questionnaire. This began with attempting to choose the appropriate *sample frame* for the interviews. The interview aspect to this study employed a *judgement sample* i.e. a small sample that seemed typical of the target population. Five Counselling Psychologists in training were interviewed whom all had varying degrees of experience of providing therapy to people with AS (the criterion was that they had to have had at least one encounter of providing formal therapy to someone with AS). It was acknowledged that these were trainees and therefore would not necessarily exactly match the target population, most of which would be relatively experienced qualified psychotherapists (although some may be trainees), this might lead to a potential source of error; this is explored further within the discussion.

The participants were recruited from the same Counselling Psychology course that the researcher attended. Contact was made to the potential interviewees through targeted verbal invitations to those that were known to have had prior experience of providing therapy to people with AS; this was established through previous conversations with all students on the Counselling Psychology course. Moreover, all students were asked about their experiences, those that satisfied the research criterion were chosen for interview.

At the beginning of the interview a general overview of the research intention was provided (Oppenheim, 1992). The therapists were all told that the intention of the interview was in order to explore their experiences of providing therapy to people with AS in a very general sense. The participants were told that the interview session would last at least twenty minutes, it would be recorded and that although transcripts would

be produced the sessions were strictly confidential in that no identifying information would be used (Lofland & Lofland, 1995). It was made clear that this was an informal and unstructured exercise and therefore they could ask questions throughout the interview if they wanted (Lofland & Lofland, 1995). They were also told that if they wanted, the research findings could be forwarded to them once the research was completed.

Prior to the interviews and throughout the interviews it was carefully considered that interviews can be a complex interpersonal endeavour and can create an imbalance of power which may influence people's ability to give honest and candid answers, especially relating to perceived inadequacies (Morton-Williams, 1993). Furthermore, within this study the researcher had a special relationship with the interviewees in that they were peers on the same course. This may have led to a number of biases including the nature of interviewees' disclosures. As the researcher knew the interviewees they may have felt it was difficult to be honest and give the required depth and breadth required particularly in relation to material relating to perceived ability, performance and adequacies relating to their work with clients with AS. The respondents may have also felt obliged to participate; this is an ethical consideration. Conversely interviewees may have felt flattered to be asked to participate which may have possibly lead to over-talking and over-describing very personal issues. These issues are explored further within the discussion.

An attempt to tackle these issues and reconcile the potential biasing was made prior to the interviews. As a psychologist trained in providing therapy, it was believed that a number of general principles and specific techniques could be transferred from that training and experience and applied to these interviews in order to facilitate the process of effective information gathering. Clearly, good interpersonal skills are likely to be very important. Above all, it was believed that it would be vital to put the interviewees at ease as it was necessary to allow the interviewees to have the scope to explore as they wanted. Through this non-directive style it was hoped that the interviewees would be given opportunity to explore their experiences freely. Merton et al (1990) describe the value of non-directive interviewing as a way to give the "…interviewee an opportunity to express himself about matters of central significance to him rather than those presumed to be important by the interviewer" (p.13).

Merton et at (1990) recognises the work of Carl Rogers and Roethlisberger in facilitating the recognition and value of non-directive interviewing. In this regard an

attempt was made to utilise Rogerian psychotherapeutic techniques (for which the author has a professional qualification) to facilitate the interviews. Good active listening skills were employed, trying to demonstrate acceptance of the interviewees in order to allow them to communicate an open and honest account. Being encouraging and non-judgemental was vital as was the need to use probes but with minimal intrusion, trying not lead, having a neutral presence and always maintaining a natural 'rhythm' with the person in order to help them speak openly and honestly and to help them self-explore until clarity is established in relation to their particular experiences (Merton et al, 1990). It would be important to not direct the interviewee as this is incompatible with unanticipated responses (Merton et al, 1990), which in turn is incompatible with this aspect of the research.

Probes were used very occasionally within the interviews. These probes were shaped by the hidden agenda orientating around exploring therapists' experiences of providing psychotherapy to people with AS, specifically exploring any possible differences with regard other client groups the therapists had worked with, issues relating to alliance formation and the interpersonal features of clients with AS and the possible influence on therapy. The interviewees very much led the interview; however, the interviewer could use the guide throughout the interview, probing in a number of ways, but always grounded in the participants' discourse. Probes were employed as unobtrusively as possible. When probes were used they remained very subtle such as repeating back aspects of the persons utterance, using *minimal encourages* (e.g. Mearns & Thorne, 1988) such as "mmmhmm…" or asking "can you say anything more about that?" When probes in the form of questions or statement were used it was important that they were general and open-ended, as short as possible and avoided jargon (Robson, 2002). It was very important to make sure that the probes were projective so as to minimise leading and therefore biasing. Above all when considering the general atmosphere of the interviews and the use of probes, the interviewer's style was gentle and without unsettling the process from which reliable insights into the interviewees attitudes could be revealed. It was important to try and just guide the interviewees to follow up on words, sentences or statements through "mirroring," summaries and reflection or minimal encourages rather than in a rather artificial way ask standardised questions. Loftland & Loftland (1995) emphasise the importance of this guide:

> *"…a guide is not a tightly structured set of questions to be asked verbatim as written, accompanied by an associated range of preworded likely answers. Rather, it is a list of things to be sure to ask about when talking to the person being interviewed…You want interviewees to speak freely in their own terms about a set of concerns you bring to the interaction, plus whatever else they might introduce"* (p.85).

In addition to the occasional probe, at the beginning of the interviews specific standardised fact based questions were asked e.g. the number of clients with AS they had worked with. They were kept at the beginning in order to not unsettle the "flow" of the interview once it got started. Whenever these questions were asked then it was important that they were clear, not too vague, not too intimate or abstract, not too narrow or wide in cope, that colloquial or technical words were avoided and that they were not too long or short (Oppenheim, 1992). The specific questions asked to all interviewees were related to their background within therapy and their specific experience of providing therapy to people with AS. The actual questions were: "How much experience do you have in providing therapy?" and "What experience have you had with providing therapy to people with AS?" It is acknowledged that these questions may have impacted on "setting the scene," the all-important context for the realist paradigm and the way in which the participants interpreted the research and the role of interviewer, possibly as expert provoking a tendency to produce a positive response set and thus causing a potential *prestige bias* (Robson, 2002). However, the transcripts do not appear to endorse this position, moreover, consistently the interviewees appeared to provide a balanced appraisal of their work, often reflecting on both their strengths and difficulties.

In terms of the physical environment, the interview room was familiar to the interviewees. The room was comfortable, private with no interruptions, there were no physical barriers between the researcher and the participant, the recording equipment was nearby but not intrusive, the lighting was mild and the general atmosphere was relaxed and unhurried.

As a final point it was acknowledged that the nature of therapy can bring up difficult emotions in therapists which the interview may trigger, therefore it was acknowledged that some participants may require support and possible supervision following the

interview session; it was made clear that an appropriate individual or service would be explored with the participants if this was required.

6.2.3. Constructing the Pilot Questionnaire

There were a total of five interviews conducted. Following the interviews, the third stage was to go through the transcripts and extract the utterances that appeared consistent between participants and/or with the literature and/or with the discussions (please see Appendix 8). In order to minimise biasing, a second person, who had a psychology degree also did this. This process took the form of a *coding* system whereby responses were placed into tentative categories defined and "…driven by the nature of the responses and the themes and dimensions they suggest[ed]…the purpose of the survey in general and of [the research]…question in particular" (Robson, 2002, p.258). By classifying responses in terms of shared content or themes the data could be reduced and turned into closed items in the form of attitude statements to use within the questionnaire. Inevitably information can be lost in this process (considerations with regard this issue is explored within the discussion). This process describes a content analysis whereby units of information either at the level of word, sentence or paragraph are sorted into categories based on shared themes. These attitude statements taken from the interviews were added to items taken from the research literature in order to construct a "pool of items" around the apparent and tentative themes. The tentative themes or categories changed throughout this process as more was learned from the data and the literature. The first stage of reviewing the literature created some hidden agenda's for the interviews (these could be viewed as the beginnings of the tentative categories), these orientated around therapists' experiences of providing psychotherapy to people with AS, specifically around possible differences with regard other client groups the therapists had worked with, issues relating to alliance formation and the interpersonal features of clients with AS and the possible influence on therapy. During the process of content analysing the interviews, the categories evolved and eventually some agreement formed around these tentative themes, which could then be piloted and later analysed through exploratory Principal Component Analysis thus possibly changing them again. The reason for an exploratory rather than confirmatory analysis was because the item assignment to each potential factor was purely speculative and conceptually driven (e.g. Lam & Aman, 2006). The tentative themes following content analysis were:

1. Working alliance: attitude statements relating to the forming of a collaborative relationship.

2. Therapist preferences: attitude items relating to the whether the client is psychological minded, is logically minded and has a degree of conceptual complexity; whether the client takes responsibility for making changes and attitude statements relating to ease of therapeutic change and barriers.

3. Therapist knowledge: attitude statements relating to perceptions the therapists have about whether they have the required knowledge to do the job, their effectiveness and their own confidence in their ability.

4. The quality of supervision: attitude statements relating to being provided the appropriate quality of supervision.

5. Therapist satisfaction: attitude statements relating to whether the therapy was fulfilling, matched expectations, was liked and whether it was stimulating.

As stated above, each tentative dimension was made up of items taken from the interviews and from the literature. The items that were used within the tentative theme working alliance were taken from the interviews and added to items adapted from the Working Alliance Inventory, Short Form, therapist version (Busseri & Tyler, 2003), which itself was adapted from the original Working Alliance Inventory (Horvath & Greenberg, 1986, 1989). The Working Alliance Inventory, Short Form, therapist version is made up of twelve items, four for each of the three dimensions purporting to tap the therapeutic alliance (Bordin, 1975): *tasks, bonds and goals.* This measure purports to be able to be used across therapeutic orientations. There are numerous measures of therapeutic alliance but the Working Alliance Inventory is argued to be the best researched (Busseri & Tyler, 2003). Adaptations were made to the items in the Working Alliance Inventory, Short Form, therapist version in order to allow therapists to provide a retrospective account of the alliance formation with all their clients who had AS, this is because the author is unaware of any alliance formation measures that are retrospective. Later exploratory Principal Component Analysis would determine if a working alliance factor exists and which items cluster to form it, which may include items from the other proposed dimensions.

In relation to attempting to explore therapist satisfaction within the questionnaire, as with the working alliance and all the other dimensions, items were taken from the initial

interviews and also taken from the literature; later exploratory Principal Component Analysis of the questionnaire would determine if a therapist satisfaction factor exists and which items cluster to form it. Job satisfaction, according to Faragher et al (2005) following their extensive meta-analysis, has been measured either by using single item global measures or composite measures that tap various job components. A global or composite scale to tap satisfaction is not indicated in this study because only a measure of a single facet of job satisfaction was required i.e. satisfaction with working with people with AS. No standardised retrospective measure of satisfaction was found during the literature search that could measure this facet, therefore a measure was constructed using attitude items taken from the initial interviews and the research literature including the work on single item satisfaction measures (Wanous & Reichers, 1997; Nagy, 2002). The literature on single item satisfaction measures suggests that as long as the construct being measured is unambiguous to the respondent or sufficiently narrow then single item measures of satisfaction are sufficient (Sackett & Larson, 1990, cited in Wanous & Reichers, 1997). Wanous and Reichers (1997) argue that:

> *"…if neither the research question nor the research situation suggest the use of a single-item job satisfaction measure, then choosing a well constructed scale makes sense. However, if the use of a single item is indicated, researchers may do so in the knowledge that they can be acceptable"* (p. 250-251).

Following email correspondence with Beehr (2006), a researcher in satisfaction scales, it was decided that a more reliable measure of satisfaction would be to extend the one item measure to a three item measure and to add this to the pool of items taken from the interviews that were believed to relate to satisfaction which could then be later subjected to an exploratory Principal Component Analysis with all the other items within the other tentative dimensions. Ideally several items should be used when measuring an attitude, as internal consistency can be checked when multiple items are used (Wanous & Reichers, 1997). The use of multiple items was used for all the proposed dimensions in this study in order to provide a more valid and reliable measure of respondents attitudes. This came out of the assertion that attitudes are relatively hard to elicit. They are

> *"…often complex and multidimensional and appear prone to the effects of question wording and sequence. These problems point to the use of multiple questions related to the belief or attitude…"* (Robson, 2002, p.272).

Furthermore, the reason for sets of items is based on the assumption that:

> *"…there is such a thing as a "true" attitude, which is also relatively stable, just as in the case of factual questions there are "true" facts or events. However, since an attitude score is more complex than, say, a respondent's method of travelling to work, it is unlikely that a single question will reflect it adequately. Also, the chances are that too much will be dependent on the actual question form and wording, on context, emphasis and mood of the moment, so that the results will be a compound of the (relatively stable) attitude and of these other (momentary) determinants – hence poor reliability of the single-attitude questions. By using SETS of questions, provided they all relate to the same attitude, we maximise the more stable components while reducing the instability due to particular items, emphasis, mood changes and so on"* (Oppenheim, 1992, p.147).

In relation to the satisfaction dimension, Beehr (2006) suggested using the following three items for a global satisfaction measure:

- *All in all I am satisfied with my job.*
- *In general, I don't like my job. (reverse scored)*
- *In general, I like working here.*

This was adapted to the following facet satisfaction scale:

- *All in all I am satisfied with my work with these clients*
- *In general, I do not like working with these clients (reverse scored)*
- *In general, I like the work with these clients*

In terms of transforming the utterances taken from interviews and the information taken from the research into questionnaire items this was performed according to Oppenheim (1992), de Vaus (1991), Dillman (2000, 2009) and Robson (2002). It was important to use language that respondents understood and recognised, to restrict the item length

below twenty words, to avoid double barrelled items, to avoid proverbs, double negatives, acronyms, abbreviations, leading items, to use simple words and phrases and not to over tax the respondents cognitive and memory ability.

An attitude statement is a single sentence that expresses a belief, point of view, a preference, a judgement, a position or an emotion (Oppenheim (1992). Oppenheim (1992) argues that the attitude statements should be meaningful, interesting and exciting to participants. In writing these statements, Oppenheim (1992) argues that they should not be written in a stilted and rational way but rather contentious utterances from the interviews should be selected, utilising phrases relating to emotions such as hopes, dreams and fears. Items should be clear personalised statements of feelings, whilst avoiding colloquialisms, acronyms, proverbs, double-negatives and double-barrelled statements (Oppenheim, 1992). For example, the following utterance "…the client didn't really want to come to therapy…" was taken from an interview transcript and converted into the following (reversed) attitude item: "These clients are usually happy to come to therapy" (please see Appendix 10 for more examples).

In total 52 attitude items were created from the research and from the interviews. Polarised opposites were created from these in order that a balance of positively and negatively worded items could be piloted for reliability reasons. Furthermore, both positively and negatively worded item pairs were used in order to test which type, either the negatively or positively worded item would be favoured by the participants through this pilot stage. This created 105 attitude statements of both negatively and positively worded item pairs. These items were used for the fourth stage, constructing the pilot questionnaire.

The advantages of constructing a questionnaire from the transcripts taken from the interviews are that the salient themes taken from therapists themselves will be targeted and further explored. Furthermore, using the words and sentence structure uttered by the interviewees may help those participants completing the pilot questionnaire as it will use language that they may recognise (Oppenheim, 1992). It is important to use statements and questions that the respondents will understand, with little ambiguity in order to get a valid measure of respondents' thinking, feeling and doing; this is an issue of *internal validity*, without this reassurance the questionnaire will not be measuring what it was intended to measure (Robson, 2002).

In order for participants to score their agreement or disagreement to the items held within the pilot questionnaire a five point Likert scale was used, creating a closed-

ended, ordered category system (Dillman, 2000). A number of things were considered when employing a Likert scale within this study. Firstly it was important that the core assumptions of the use of *fixed-alternative* responses were satisfied, in that they needed to be "…accurate, exhaustive, mutually exclusive and on a single dimension" (Robson, 2002, p.244). The typical Likert configuration was used in order to satisfy this requirement, thus the categories used were: "strongly agree," "agree," "uncertain/unsure," "disagree," "strongly agree." Another consideration was the importance of having very few neutral items as it needs to be clear whether the items are positive or negative in order to score them properly, this was done during item construction. The logistics of Likert scaling is that a score is elicited from one to five or five to one depending on whether the item is positive or negative. They are then added in order to provide a range. It was important to decide whether a high score corresponded to a positive or a negative attitude; in this study a high score corresponded to a relatively positive attitude. An equation was performed on the raw score in order to reverse the negative items so that consistency is retained i.e. that a high score is consistent with a relatively favourable attitude and a low score relatively unfavourable. With this in place, once each respondents score is added it can be seen how their score relates to the maximum and minimum score possible.

Oppenheim (1992) argues that there are three main criticisms of the Likert scale. Firstly, that Likert scaling makes no commitment to equal appearing intervals; however, Oppenheim (1992) argues that uni-dimentionality is often achieved when using the method of internal-consistency, a method employed in this study (discussed later). Secondly, Likert scaling lacks *reproducibility.* The argument here is that the same total score can be achieved in a number of different ways thus two respondents sharing the same scores could have achieved them in totally different ways, thus having different meanings. However, it could be argued that if all the items have gone through rigorous research including sharing their origins as spontaneous statements expressed by interviewees or taken from the literature and that they have been subjected to internal consistency analysis, piloted and found to measure the same underlying construct, therefore it does not matter too much how the total figure is arrived at; this is what was done within this study.

The third criticism of Likert scaling is that there will be uncertainty in terms of where the midpoint or neutral point between positive and negative attitudes is. As Oppenheim (1992) argues, respondents may be checking the midpoint as a statement of lack of knowledge or uncertainty, a phenomenon Oppenheim (1992) calls "lukewarm," as

Oppenheim (1992) continues to argue, this score might also be the outcome or balancing out of both strong positive and strong negative responses. This said, Oppenheim (1992) asserts that Likert scales are usually a very reliable way to achieve the ordering of people according to attitude and they provide a more precise way of pinpointing attitude than mere agree/disagree measurements.

The process of pilot work would create an opportunity to test the *face validity* of the questionnaire specifically and the research generally. The participants were not only invited to complete the questionnaire but also to comment on such things as the clearness of presentation, the wording of the items and the instructions and other aesthetic components. Very helpful comments came back from a number of participants which led to further refinement of the questionnaire, discussed later in this section. Finally, piloting also enabled the testing of the logistical and technical aspects of the research (Dillman, 2009). For example, it was important to test whether respondents experienced any difficulties with completing the questionnaire, to establish how long it took most participants to complete it, how many people responded and how long it took to analyse it. Pilot work would also provide an opportunity to prune any redundant items through a reliability analysis looking at the internal consistency.

In terms of the sample, every member of the United Kingdom Council for Psychotherapy directory was sent the pilot questionnaire; this was a total of 6973 people. It was anticipated that this sample might be representative of therapists in general and of therapists who might work with people with AS, borderline personality disorder and depression; it was also believed that the psychotherapists within this directory were a very close match to the directories within the professional bodies that would be targeted using the final questionnaire. This is an issue of *external validity;* it is concerned with the necessary attribute of *generalisability* (Robson, 2002), important within the authors original epistemology.

The questionnaire was web based which enabled a relatively easy and efficient way to contact a large number of participants. It also enabled the research to be anonymous. Questionnaires have been argued to elicit much more honesty than other forms of survey such as interviews (Dillman, 2000) and with the additional guarantee of anonymity, hopefully this would be enhanced further by reducing the *prestige bias* (Robson, 2002). However, only those therapists who were registered with these directories, with up to date email addresses, with access to their emails and the internet, who were confident and competent with using a personal computer and the

internet would be able to respond therefore creating potential biases. Furthermore, any difficulties that may arise as the participants complete the questionnaire would not necessarily be brought to the attention of the researcher and thus the person may just fail to complete it or a *measurement error* may be created (Dillman, 2000, 2009). However, participants were invited to email the researcher if required and some respondents took this up when problems arose.

The questionnaire within this study was also quite lengthy and could take up to twenty minutes to complete; this might put off certain people (this point is explored within the discussion section). Finally, only those with certain views may complete it. Certain types of therapists may avoid completing it such as those who are indifferent or ambivalent to the research question or those who may not have strong enough views to motivate them to complete such a lengthy questionnaire thus those with more favourable or relatively neutral and balanced attitudes for example may not see the value of the research. The argument here is that there may be a difference between responders and non-responders in terms of their attitudes. Face-to-face interviews may have increased response rates but the need to keep the respondents reports anonymous made this method undesirable. Multimodal approaches such as a mail out to complement the internet survey may have been helpful (Dillman, 2000, 2009). However, potential problems here include it being impossible to know which of the sample that were sent the internet survey did not complete it in order to send out the mail version, this is because the survey is anonymous (all these issues are explored further in the discussion).

In order to increase the response rate a number of strategies were utilised. A small financial incentive was offered (Dillman, 2000) of a £2 lunch voucher. In addition, a lot of effort was put into creating a good professional appearance, the topic appeared to be contemporary and may be generally quite relevant to the respondents approached (Dillman, 2000) and if the participants are proficient in using the computer then it is relatively easy to complete and return it.

A standardised invitation email or cover letter was compiled (please see Appendix 2) following thorough vetting for ethical considerations using the City University Psychology ethics protocol by the City University Department of Psychology Research Ethics Committee. An attempt was made to pitch this email at the level of the respondents using language they would understand (Dillman, 2000). This email enabled the communication of confidentiality and outlined the statement of intent. This

was viewed as very important as it may help to make sure that respondents are orientated. Without this statement of intent this may lead to ethical problems as the respondents might not be clear about what they are required to do and what they are consenting to. Leaving out the statement of intent may also lead to methodological problems, as Oppenheim (1992) argues, if respondents are left to decide what the research intent is, they will have to guess and therefore there is the potential that the respondents may all guess differently; these differing “frames of reference” could lead to an erroneous effect as diverging scores should only be due to the research question (Oppenheim, 1992). The respondents were also offered more information following the completion of the questionnaire (please see Appendix 3).

6.2.4. Constructing the Final Questionnaire

The fifth stage took place following the completion of 115 pilot questionnaires by the participants within the United Kingdom Council for Psychotherapy directory. It would not be possible to know whether this sample size was significantly negatively impacted by non-response as the total population is unknown i.e. therapists who have worked with clients with AS, borderline personality disorder and depression (this is explored later within the discussion). The pilot work led to a number of changes to create the final questionnaire. These changes (discussed later) were based on feedback from the participants about the quality of the items, internal consistency analysis and pruning by the researcher based on review.

Following the pilot stage it was clear that a number of other areas could be usefully added to the final questionnaire. Within the final questionnaire the client’s co-morbid psychopathology and other co-morbid concerns were asked about in order to establish if this matched the literature and in order to help gain insights into the kinds of additional problems people with AS are presenting with and what therapists might face in therapy. Participants were also asked what model(s) they used within therapy with people with AS. The reason for this was because the interviewees in the initial interviews spoke about finding some models difficult to use with people with AS and also as the majority of research on working psychotherapeutically with this population advocates cognitive behavioural therapy (e.g. Hare, 1997a) and therefore it would be interesting to discover what proportion of the participants used cognitive behavioural therapy and whether there are any differences in attitudes compared to those that do not use cognitive behavioural therapy. In addition, therapists experience in terms of the number of months in practice and number of clients worked with was also asked

about to establish if experience has a relationship to therapist attitude. The use of the words “approximately” and “usually” were used in order to help ascertain experience in months, as specific numbers may be harder to remember for respondents (Dillman, 2000). Furthermore, to help reduce biasing effects that can result from offering response categories a blank space was provided at the end of these questions (Rockwood, Sangster & Dillman, 1997, cited in Dillman, 2000), the space provided was limitless.

All these additional areas used specific questions, rather than attitude items and therefore the responders should experience relative ease in answering them as they should have an “accurate, ready-made answer” (Dillman, 2000, p.35). Due to the relative simplicity of the additional dimensions discussed above and the belief that question structure and wording for these aspects are relatively less important than opinion type items at the beginning of the questionnaire (Dillman, 2000), they were only piloted on one participant, a qualified Clinical Psychologist; through discussion with this participant some refinement of the dimensions was enabled.

The final questionnaire was made up of 4 sections utilising questions that elicited facts, attitude scales, projective techniques and rating scales (please see Appendix 4 for the final questionnaire). The layout of the questionnaire, question order and how each section fitted with each other section was considered. Dillman (2000, 2009) argues that a well presented questionnaire is associated with increased response rates and the reduction of measurement error; an attractive, user friendly questionnaire is much more inviting to the respondent and increases attentiveness to detail (Dimman et al, 1991, cited in Dillman, 2000). As well as considering the visual elements to the questionnaire relating to such things as the location of each section, spacing, shape, size, brightness and colour of the visuals, their simplicity, regularity, symmetry and the figure-ground format (Dillman, 2000, 2009) the wider context of each question and section was also considered. In order to illustrate this latter point, Dillman (2000) argues that

> *"…it is important to recognise early on that a questionnaire cannot be viewed a compilation of completely independent questions that have no effects on one another. Not only must each question be evaluated on the basis of its individual content, but also with regard to the larger context that often adds or subtracts meaning…we should not be surprised that respondents identify the questions as related to one another and adjust their answers to the second question based on answers to the first one"* (p.91).

The use of a web based questionnaire enabled this latter point to be reconciled, relating to the confounding error of *order effects*. Order effects were avoided by using separate pages for each section and also not allowing the participants to scroll back (Dillman, 2009). It was hoped that the latter strategy would avoid participants "….carrying the context and memory of previous questions across screens" (Dillman, 2009, p. 165); a phenomena whereby previous questions and their responses can influence future question meaning and their response. In addition to having separate pages for each section and not allowing respondents to scroll back, the attitude items and the position of the three columns relating to the three groups, namely, AS, borderline personality disorder and depression were randomised. This technique may help any confounding problems relating to such phenomenon as order effects as well as the *halo effect,* problems relating to *central tendency* or *the primacy* and *recency effects* (Dillman, 2009).

6.2.5. Layout of the Final Questionnaire

The first section of the questionnaire provided a statement of background in order to orient the responder. Enough information was given in order for them to make an informed decision about consent to participate but still broad enough so as not to bias their responses. Following this statement there were three statements relating to consent which the participant had to "check" if they agreed and in order for them to proceed with the study. However, it was stated that they could still terminate the study at any time.

The second section of the questionnaire held a list of 65 attitude statements. The original number was 105. This was reduced to 65 following the pruning of 56 items, the rewording of 1 item and the addition of 16 items from the literature. An item was pruned for one of three reasons: if it was viewed as awkward or confusing following feedback from the participants within the pilot stage or following review by the author; if it failed

the Cronbach Alpha reliability analysis (please see page 98 for a description of the criteria for this analysis) and as both negatively and positively worded item pairs for all attitude statements were not required within the final questionnaire. However, with regard this latter point, not all the polarised opposite items in each item pair was deleted because the final questionnaire required the inclusion of an *internal check* to enhance reliability. This was achieved by retaining five of the item pairs; these could be analysed later for consistency. The item pairs were:

- *All in all it is easy to be hopeful with these clients*
- *Generally it is hard to be optimistic with these clients*

- *In general, I do not like working with these clients*
- *In general, I like the work with these clients*

- *I often struggle to know what to do in therapy with these clients*
- *I often know what to do in therapy with these clients*

- *It is generally difficult to form a working alliance with these clients*
- *Forming a working alliance is generally straightforward with these clients*

- *Generally my supervisor gives me the support I need with these clients*
- *Generally my supervisor does not give me the support I need with these clients*

Only five item pairs were required to check reliability, therefore for all item pairs from the original list within the pilot questionnaire, accept the item pairs retained for reliability checks, only either the negatively or the positively phrased item within the pair was retained. To aid reliability a balance between positively and negatively worded items were strived for thus thirty four statements that were positive and thirty one that were negative were retained. The choice of whether the item retained would be the positively or the negatively worded item of the pair was based on two things: 1) the origin of the item i.e. whether the origin of the item had a negative or positive slant taken from the literature or from the interviews, or 2) whether it would be clearer to the respondents either negatively or positively worded, this was based on piloting and author review.

For each attitude statement/item the participant's scored their agreement or disagreement using a typical five point Likert scale. These items made up several proposed and tentative themes as discussed earlier (an exploratory Principal

Component Analysis would be conducted on the data from the questionnaire to see which factors would actually emerge from the data, therefore these proposed themes were tentative at this stage): working alliance; therapist preferences; therapist knowledge; quality of supervision and therapist satisfaction.

The third section held details about the therapists' experience in terms of the amount of time in practice and the number of clients they had worked with within the three groups. This section also held details about the model(s) they used. Oppenheim (1992) states that participants are put at ease when these types of general details are asked later on in the questionnaire, moreover, putting these things too early could put them off. This section also asked about the client co-morbid psychopathology and other co-morbid concerns.

The final questionnaire was sent to everyone on the British Psychological Society Clinical and Counselling Psychology directory (1408 and 823 people respectively), the British Association for Behavioural and Cognitive Psychotherapies directory (731 people) and the British Association for Counsellors and Psychotherapist directory (10400 people); in total there was 13362 questionnaires circulated. It was believed that the therapists within these directories were a representative sample of the total population i.e. therapists with experience of providing therapy to people with AS, borderline personality disorder and to people with depression. Every therapist on these directories was targeted as those with the specific experience required for the inclusion criteria could not be identified with which to create a sample frame. An advert was also placed in the Psychologist magazine to reach those not on these directories.

It is also important within the positivist paradigm to get a reasonable size sample size not only for reasons of representation and generalisability by also so that the Principal Component Analysis correlations will be accurate and therefore the pattern to come out stable enough. Therefore, a priori calculation/estimation was conducted on the basis of discussions with my supervisors. It is protocol to have at least 10 participants per variable to get the required stability and given that there were 65 variables put through the exploratory Principal Component Analysis this means that at least 650 participants were required. .

It was also acknowledged that the uptake of this study would be severely limited due to the constraining inclusion criteria of the questionnaire i.e. that therapists were required to have provided therapy to all three of the populations: AS, borderline personality disorder and depression. Furthermore, it was also acknowledged that the sample may

have been skewed due to issues discussed earlier in relation to the design such as the way in which the participants were approached e.g. using the internet and magazine.

In total 163 people completed the questionnaire (this low response rate is explored within the discussion). The quantitative data generated from the questionnaire was scrutinised in a number of ways: by reviewing the quality of the data; by reviewing whether all the assumptions had been met i.e. that all participants had worked with all three populations (defined by whether they checked the relevant boxes on the questionnaire to indicate that they had worked with all three populations); by analysing reliability through analysing any discrepancy between the four reversed item pairs; through validity analysis using an exploratory Principal Component Analysis and through an internal consistency analysis (Cronbach's Alpha). The exploratory Principal Component Analysis was extremely important to the research as it would allow an exploration of the attitude items, to establish if they "hung" together or clustered in some meaningful way, thus revealing any latent, unobserved variables or factors (Stapleton, 1997). This process may also prune any redundant items and also test the construct validity, checking that the items measured what they were intended to measure i.e. therapist attitudes. Finally, if the exploratory Principal Component Analysis was successful in revealing any factors then these could be used to explore any relationships these factors might have with each other, as well as with the other aspects of the questionnaire, to reveal further insights.

In terms of the exploratory Principal Component Analysis selection and allocation of an item to a factor, this was based on: 1) reviewing the scree plot (Cattell, 1966, cited Field, 2005); 2) the item loaded >.35 on that particular factor (e.g. Lam & Adam, 2007); 3) eigenvalues above 1.0; 4) have at least 3 items making up the factor (Thurstone, 1947, cited Lam & Adam, 2007); 5) if a complex structure is revealed (i.e. an item loads on more than one proposed factor) then the item is retained for the factor it best fits according to the underlying construct (Rawson, 2012). The oblique rotation, *Direct Oblimin* was used as this technique is useful when measuring human traits that are likely to correlate; this technique presents estimates of correlations among common factors (e.g. Lam & Adam, 2007; Field, 2005). Following the exploratory Principal Component Analysis the Cronbach analysis was performed on each factor separately, the criteria for rejection of a particular item through the Cronbach's Alpha was: 1) were an item had a negative value; 2) had a value <.3 within *Corrected Item-Total Correlation*; 3) when deleted would increase Cronbach's Alpha. Finally, following Cronbach analysis, exploratory Principal Component Analysis was then performed

again to establish if the items still loaded as they did prior to the Cronbach Analysis; the cycle continued until all criteria were satisfied and no more items could be removed.

This whole process is called *attitude scaling* (e.g. Oppenheim, 1992), whereby a larger number of items from interviews, research and one's own experiences is scaled through item analysis. The result is a number of attitude scales

> *"Attitude scales are relatively overt measuring instruments designed to be used in surveys...Their chief function is to divide people roughly into a number of broad groups with respect to a particular attitude, and to allow us to study the ways in which such an attitude relates to other variables in our survey"* (Oppenheim, 1992, p.187).

7. Results

7.1. The Initial Stage

This initial stage of discussions with colleagues and reviewing the literature revealed a number of broad areas which were chosen to tentatively guide the interviews; this was the qualitative phase of the research. The themes related to possible aspects of therapy with people with AS such as possible differences with regard other client groups the therapists had worked with, issues relating to alliance formation and the interpersonal features of clients with AS and the possible influence on therapy.

7.2. The Interviews

There were a total of five interviews conducted with Counselling Psychologists in training who had a background in providing therapy to people with AS. The interviews lasted 30 minutes and were recorded and later transcribed. The utterances that appeared salient and appeared to fit consistent themes between participants and/or with the literature and/or with the discussions with colleagues were retained. In order to minimise bias, a second person who had a background in psychology also did this; concordance was equated at 92% (please see Appendix 9 for the interview utterances placed within the tentative categories/themes).

7.3. Constructing the Pilot Questionnaire

Once the participants' utterances from the interviews were transcribed they were transformed into closed attitude statements to use within the pilot questionnaire (please see Appendix 10). The attitude statements taken from the interviews were then added to attitude statements created from the research literature (please see Appendix 11 for some examples) in order to construct a pool of items around the tentative themes or categories (please see Appendix 12 for all the items within each tentative category and their sources). For each attitude statement/item the participant's scored their agreement/disagreement using a typical five point Likert scale (please see Appendix 1 for the pilot questionnaire).

7.4. Analysing the Pilot Questionnaire

A total of 115 completed pilot questionnaires were returned from a total of 6973 sent out. These were analysed in order to refine the item pool for the final questionnaire. In terms of reliability, an item was removed if it was viewed as confusing following feedback from the participants or following its review by the author. Items were also removed based on Cronbach's Alpha reliability analysis and because polarised opposites of every item was not required for the final questionnaire. Following this process the total item pool was reduced from 105 to 65 following the pruning of 56 items, the rewording of 1 item and the addition of 16 more items taken from further literature searches.

7.5. Analysing the Final Questionnaire

7.5.1. Reliability Analysis

In terms of the final questionnaire, there were a total of 163 completed questionnaires out of a total of 13362 questionnaires circulated. First a reliability analysis was conducted on the data set in two ways: removing participants who did not fulfil the criteria for the research despite them completing the questionnaire and following the internal check.

7.5.1.1. Participants who did not fulfil the Research Criteria

Participants were removed who had indicated that they had had no clients, either past or present that had either AS, borderline personality disorder or depression. It was acknowledged that despite participants being given clear and repetitive instructions that they must have had experience of working with all three populations, some participants may not have read these instructions carefully enough or thoroughly enough, or may not have understood them completely and gone ahead and completed the questionnaire regardless. Therefore, any participants stating that they had experience of "0" clients with AS, borderline personality disorder or depression, asked within the second section of the questionnaire, were removed, as their results could not be considered reliable and/or valid. 18 participants were removed on that basis leaving a total of 145 completed questionnaires.

7.5.1.2. Internal Check

The second way in which the reliability of the participants was analysed was to perform the internal check. Any participants that were viewed as unreliable would be deleted as the data they produced could not be sufficiently trusted. This was done by calculating the discrepancy between five pairs of attitude statements across the 3 conditions (therefore, a total of 12), each pair constituting both a positive and negative pitching of that attitude. If a participant achieved more than 2 Likert points difference on any item pair comparison or more than 1 Likert point difference on all of the item pair comparisons then they were rejected. 16 participants were rejected on that basis, leaving 129.

7.6. Refining and Exploring the Data

7.6.1. Validity and Reliability Analysis

Exploratory Principal Component Analysis and Cronbach Alpha reliability analysis was performed on the data set produced by the attitude items from the final questionnaire using the criteria set out in the procedures. The procedure was to perform waves of exploratory Principal Component Analysis followed by Cronbach Alpha on each factor revealed separately (Field, 2005). This process reduces the overall number of items and factors. The first exploratory Principal Component Analysis revealed twenty possible factors from the items for AS. However, following several waves of analysis four factors incorporating fourteen items were revealed for the group AS, these were named: therapist satisfaction; the quality of supervision; working alliance; therapist knowledge; the scree plot appeared to support this factor solution (please see Figure 1 for the scree plot and Table 1 for the factor solution). As one of the items clustered on both Factor 1 and Factor 4, thus revealing a complex structure for these factors (please see Figure 1), a choice to use this item for Factor 1 and not Factor 2 was made for conceptual reasons, as it appeared to fit much better with the construct relating to satisfaction (Factor 1) than therapist knowledge (Factor 4).

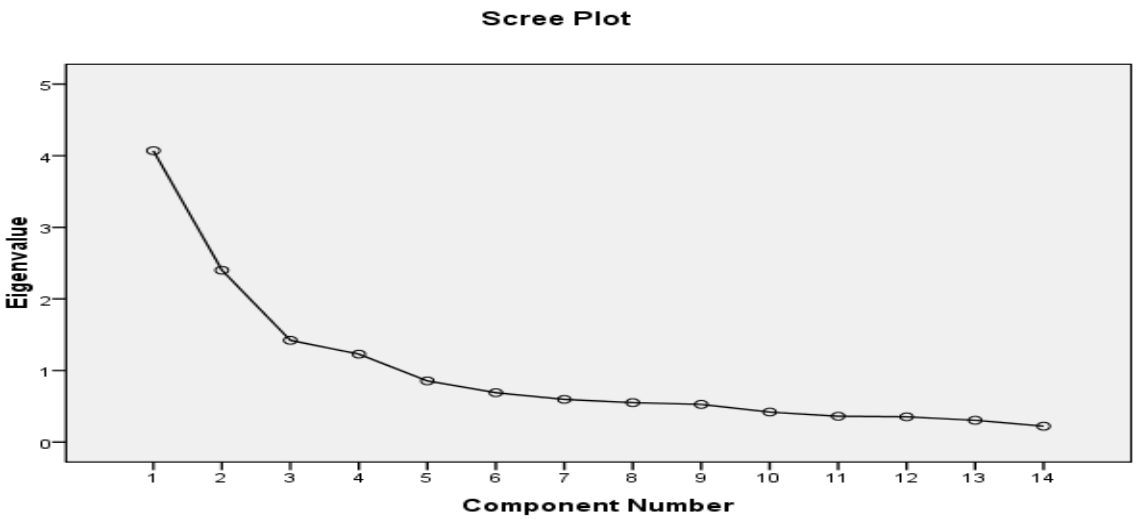

Figure 1. Scree Plot for the Exploratory Principal Component Analysis for the Fourteen Items.

Item	Factor 1	Factor 2	Factor 3	Factor 4
In general, I do not like working with these clients	.715			
I have often thought that working with this client group is not right for me	.478			.547
In general, I like the work with these clients	.875			
Generally my supervisor gives me the support I need with these clients		.846		
Generally my supervisor does not give me the support I need with these clients		.895		
Supervision is usually not very helpful in my work with these clients		.850		
These clients are usually happy to come to therapy			.833	
These clients often believe that the way we have worked with their problem(s) was correct			.581	
These clients and I usually agree on what is important to work on in therapy			.641	
Generally these clients and I can build a good understanding together of the kind of changes that would be good for my client			.753	
I often feel frustrated when working with these clients				.557
I often feel confused when providing therapy to these clients				.898
I often feel out of my depth whilst providing therapy to these clients				.756
I often struggle to know what to do in therapy with these clients				.738

Table 1. Pattern Mattrix for the Exploratory Principal Component Analysis for the Fourteen Items for the Group AS.

In terms of the factor relating to the working alliance, the items that clustered to form that factor appeared consistent with Bordin's (1975) model of the working alliance. The first two items were adapted from and relate to the dimension *task*, the third adapted from and relates to the dimension *goal* and the final item was taken from the interviews and appears to correspond to Bordin's (1975) dimension *bond*:

- These clients and I usually agree on what is important to work on in therapy
- These clients often believe that the way we have worked with their problem(s) was correct
- Generally these clients and I can build a good understanding together of the kind of changes that would be good for my client
- These clients are usually happy to come to therapy

The proposed tentative factor therapist preferences, was not revealed through the exploratory Principal Component Analysis and therefore could not be used for later analysis. Collectively, the four factors accounted for 65% of the variance. Table 2 shows the correlations amongst the factors, the highest being between therapist knowledge (factor 1) and satisfaction (factor 4); this would suggest that the correct rotation was chosen (Field, 2005).

Factor	Therapist Knowledge	Supervision	Working Alliance	Satisfaction
Therapist Knowledge	1	.171	.279	.314
Supervision	.171	1	-.081	.111
Working Alliance	.279	-.081	1	.160
Satisfaction	.314	.111	.160	1

Table 2. Interfactor Correlations for the Four Factors

Table 3 shows the Cronbach Alpha reliability analysis output relating to the fourteen items in relation to the four factors for the group AS.

Factor	Alpha	Item	Item-total correlation
Satisfaction	.786	In general, I do not like working with these clients	.675
		I have often thought that working with this client group is not right for me	.597
		In general, I like the work with these clients	.613
Supervision	.833	Generally my supervisor gives me the support I need with these clients	.687
		Generally my supervisor does not give me the support I need with these clients	.708
		Supervision is usually not very helpful in my work with these clients	.685
Working Alliance	.706	These clients are usually happy to come to therapy	.549
		These clients and I usually agree on what is important to work on in therapy	.451
		Generally these clients and I can build a good understanding together of the kind of changes that would be good for my client	.491
		These clients often believe that the way we have worked with their problem(s) was correct	.477
Therapist Knowledge	.758	I often feel frustrated when working with these clients	.472
		I often feel confused when providing therapy to these clients	.630
		I often feel out of my depth whilst providing therapy to these clients	.530
		I often struggle to know what to do in therapy with these clients	.601

Table 3. Cronbach Alpha and Item-total Correlations for the Four Factors

7.7. Descriptive Analysis

7.7.1. Designation and Experience of Participants

The majority of the respondents defined themselves as Psychologists (n=65) making up almost 50% of the sample. In addition, there were 55 respondents who defined themselves as Counsellors/Psychotherapists, 3 respondents defined themselves as Cognitive Behavioural Therapists, 1 defined themself as a Psychologist in training, 1 defined themself as a Psychiatrist and 4 respondents could not be defined within these categories (please see Figure 2.).

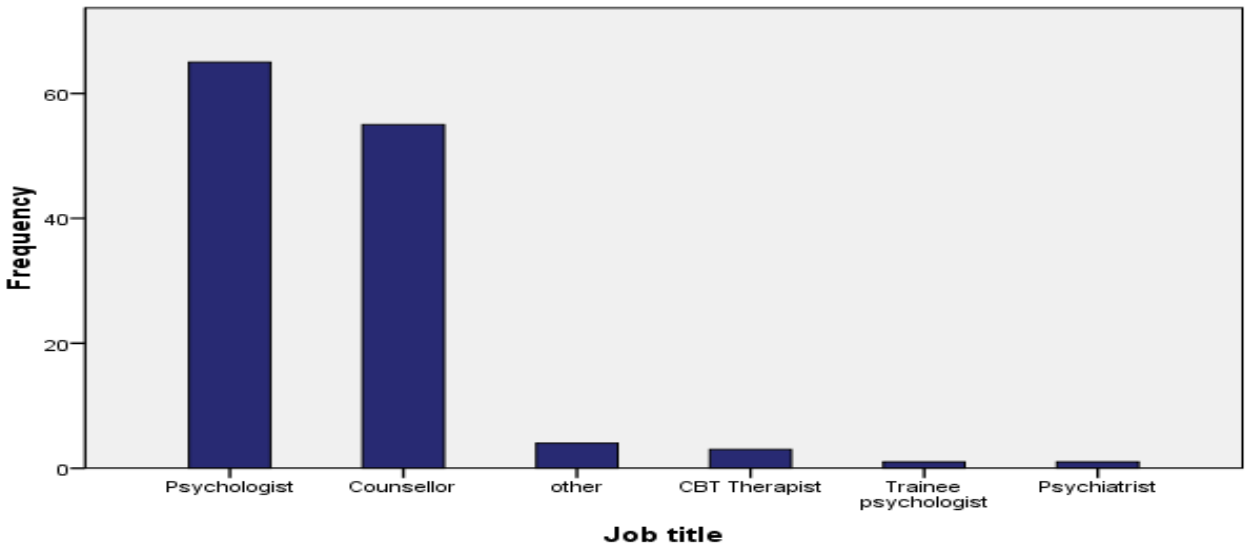

Figure 2. Graph to Show the Number of Participants by Job Title

In terms of experience, this was measured in months and number of clients (please see Table 4). Within the number of clients worked with section, seven participants gave an unusually high number of clients (e.g. 10000) thus this was treated as an error and therefore missing data. In addition, within the length of time worked section, five participants gave an unusually high length of time worked (e.g. 2400 months) thus this was also treated as an error and therefore missing data. On average the number of months of experience with clients with AS was 60, 24 months for borderline personality disorder and 120 months in relation to depression. In terms of number of clients, it was found that on average participants had experience of providing therapy to 3 clients with AS, 5 with borderline personality disorder and 50 clients with depression. The mode was used in all cases due to a number of outliers.

	Number of clients with AS worked with	Number of clients with Borderline Personality worked with	Number of clients with depression worked with	Number of months worked with clients with AS	Number of months worked with clients with Borderline Personality	Number of months worked with clients with Depression
Valid	122	122	122	124	124	124
Missing	7	7	7	5	5	5
Mode	3	5	50	60*	24*	120*
Minimum	1	0	2	1	4	2
Maximum	600	300	650	360	480	480

* Multiple modes exist. The smallest value is shown.

Table 4. Participant Experience in Number of Clients and Months

7.7.2. Co-Morbid Concerns

Participants recorded which co-morbid concerns their clients with AS had presented with. The most common was anxiety, depression, obsessive compulsive disorder and problematic anger (please see Table 5). The least common was body dysmorphia, post-traumatic stress disorder and simple phobia.

Co-Morbid Concerns	Number of Respondents
Anxiety	81
Obsessive Compulsive Disorder	82
Body Dysmorphia	25
Agoraphobia	26
Couple Distress	35
Problematic Anger	84
Eating Disorder	33
Panic Disorder	43
Simple Phobia	23
Drug and Alcohol	29
Sexual Dysfunction	29
Depression	81
Psychosis	30
Attention Deficit Hyperactivity Disorder	50
Post Traumatic Stress Disorder	20

Table 5. Number of Respondents who Identified Specific Mental Health Problems in AS clients

7.7.3. Model(s) Used

Participants recorded which model(s) they used with their clients with AS, with borderline personality disorder and with depression (please see Table 6). The most common model used across all three client groups was cognitive behavioural therapy. In relation to AS, the least used models were cognitive analytic therapy and dialectic behavioural therapy. In addition, a number of participants used the qualitative section, the majority of whom stated that they used an integrative approach to providing therapy to clients with AS.

	CBT	Systemic	Person Centred	Narrative	Psycho-dynamic	Solution Focused	Personal Construct	CAT	Inter-personal	DBT
AS	92	45	40	22	29	42	12	8	20	9
BPD	60	41	39	24	46	38	13	19	26	26
D	89	37	43	32	41	53	10	14	22	7

Table 6. Number of Participants using Particular Models in their Practice with the Three Client Groups

7.8. Analysis of the Factors

7.8.1. Comparison Groups

In order to increase the confidence in therapist ratings and to help insure that the ratings of therapists resulted from working with people with AS and did not merely reflect providing therapy per se or to providing therapy to complex groups per se, comparison groups were used comparing two of the factors: therapist satisfaction and the quality of supervision. These factors were revealed through Principal Component Analysis for the groups borderline personality disorder and depression (please see Table 7); the two factors accounted for 77% and 73% of the variance for the groups borderline personality disorder and depression respectively. A Cronbach Alpha was also conducted to check the reliability (please see Table 8 and Table 9).

Item	Supervision: Borderline Personality	Satisfaction: Borderline Personality	Supervision: Depression	Satisfaction: Depression
Generally my supervisor gives me the support I need with these clients	.876		.873	
Generally my supervisor does not give me the support I need with these clients	.921		.826	
Supervision is usually not very helpful in my work with these clients	.833		.795	
In general, I do not like working with these clients		.895		-.775
I have often thought that working with this client group is not right for me		.853		-.861
In general, I like the work with these clients		.903		-.887

Table 7. Pattern Mattrix for the Items relating to the Factors Supervision and Satisfaction for the Groups Borderline Personality Disorder and Depression

Borderline Personality Disorder			
Factor	Alpha	Item	Item-total correlation
Satisfaction	.859	In general, I do not like working with these clients	.777
		I have often thought that working with this client group is not right for me	.701
		In general, I like the work with these clients	.731
Supervision	.849	Generally my supervisor gives me the support I need with these clients	.710
		Generally my supervisor does not give me the support I need with these clients	.773
		Supervision is usually not very helpful in my work with these clients	.685

Table 8. Cronbach Alpha and Item-total Correlations for the Factors Supervision and Satisfaction for the Group Borderline Personality Disorder

Depression			
Factor	Alpha	Item	Item-total correlation
Satisfaction	.822	In general, I do not like working with these clients	.727
		I have often thought that working with this client group is not right for me	.685
		In general, I like the work with these clients	.628
Supervision	.789	Generally my supervisor gives me the support I need with these clients	.621
		Generally my supervisor does not give me the support I need with these clients	.623
		Supervision is usually not very helpful in my work with these clients	.648

Table 9. Cronbach Alpha and Item-total Correlations for the Factors Supervision and Satisfaction for the Group Depression

7.8.1.1. Therapist Satisfaction across the Groups

Firstly, normal distribution was investigated for satisfaction for all the three groups. The data in all three groups were found to be significantly non-normal using Kolmogorov-Smirnov and Shapiro-Wilk test for normality for AS ($D(129)=0.16$, $p<.05$), for borderline personality disorder ($D(129)=0.13$, $p<.05$) and for depression ($D(129)=0.17$, $p<.05$). Therefore, non-parametric tests were applied. Please see Table 10 for summary statistics for the factor satisfaction across all three groups.

	Satisfaction: AS	Satisfaction: Borderline Personality	Satisfaction: Depression
Valid	129	129	129
Missing	0	0	0
Mean	11	10	11
Std. Deviation	3	3	3
Skewness	-.677	-.367	-.688
Kurtosis	-.273	-.763	-.299
Minimum	3	3	4
Maximum	15	15	15

Table 10. Summary Statistics for the Factor Satisfaction across the three Groups

In terms of satisfaction, 70% of participants rated satisfaction high whilst providing therapy to clients with AS, 62% of participants rated satisfaction high whilst providing therapy to clients with borderline personality disorder and 74% of participants rated satisfaction high whilst providing therapy to clients with depression.

To establish if there were any differences among the three groups based on the factor satisfaction a Friedman analysis was conducted (please see Table 11): ($X2$ = (127) = 5.8, p=.52).

Group	Mean Rank
Asperger Syndrome	2.03
Borderline Personality Disorder	1.86
Depression	2.11

Table 11. Exploring Differences among the three Groups Based on the Factor Satisfaction

A Wilcoxon Signed-Rank post-test was then conducted to follow up these findings. A *Bonferroni Correction* was applied and so all effects are reported at .0167. It was found that there was a significant difference comparing satisfaction between depression (*Mdn* = 12) and borderline personality disorder (*Mdn* = 11) (z=-2.045, p=.008, effect size r=-.21). Furthermore, 52 (44%) therapists out of 129 scored higher rates of satisfaction for depression compared to the borderline personality disorder group (46 tied, please see Appendix 13). Therefore, it was found that working with borderline personality disorder is significantly less satisfying than working with clients who have depression. However, the effect size was small. There was no significant difference found comparing satisfaction between AS (*Mdn* = 12) and borderline personality disorder (z=--1.542, p=.123) and AS and depression (z=-.991, p=.322).

7.8.1.2. Therapist Supervision across the Groups

Firstly, data in all three groups were found to be significantly non-normal using Kolmogorov-Smirnov and Shapiro-Wilk test for normality for AS (D(129)=0.14, p<.05), for borderline personality disorder (D(129)=0.17, p<.05) and for depression (D(129)=0.16, p<.05); non-parametric tests were applied.

In terms of supervision, 71% of participants rated the quality of supervision high whilst providing therapy to those with AS, 77% rated the quality of supervision high whilst providing therapy to those with borderline personality disorder and 79% of participants rated the quality of supervision high whilst providing therapy to those with depression (please see Table 12 for summary statistics).

	Supervision: AS	Supervision: Borderline Personality	Supervision: Depression
Valid	129	129	129
Missing	0	0	0
Mean	11	12	12
Std. Deviation	3	3	3
Skewness	-.645	-.760	-.928
Kurtosis	-.450	-.411	.246
Minimum	3	4	3
Maximum	15	15	15

Table 12. Summary Statistics for the Factor Supervision across the three Groups

A Friedman analysis was conducted (please see Table 13): ($X2$ = (127) = 17.0, p=<.001).

Group	Mean Rank
Asperger Syndrome	1.81
Borderline Personality Disorder	2.05
Depression	2.15

Table 13. Exploring Differences among the three Groups Based on the Factor Supervision

A Wilcoxon Signed-Rank post-test was then conducted. A Bonferroni correction was applied and so all effects are reported at .0167. Consistent with the Friedman, it was found that there was a significant difference with regard the quality of supervision between AS (*Mdn* = 12) and borderline personality disorder (*Mdn* = 13, z=-3.077, *p*=.001 *r*=-.27) and between AS and depression (*Mdn* = 13, z=-3.715, *p*=.000, *r* =-.33). Furthermore, 37 participants (28%) out of 129 scored higher for the borderline

personality disorder group when compared with the AS group (77 tied) and 46 (35%) out of 129 scored higher for the depression group when compared to the AS group (65 tied) with regard the quality of supervision. These results suggest that the quality of supervision is viewed as significantly worse whilst providing therapy to clients with AS compared to when providing therapy to clients with borderline personality disorder and to clients with depression. These results suggest that the therapists experienced a different quality of supervision according to the group they worked with. This suggests that the therapist ratings are related to the group they are working with rather than therapy *per se* or complex clients *per se*, moreover, in terms of validity, it appears therapists do share a view of what AS is, that it is different and distinct from the other groups and therefore this important assumption may be satisfied, giving some confidence in therapist ratings across all areas of exploration.

7.8.2. Exploring the Factors within the Group AS

Next an exploration was conducted on the factors working alliance and therapist knowledge within the group AS. Please see Table 14 for summary statistics on these factors.

	Working Alliance	Therapist Knowledge
Valid	129	129
Missing	0	0
Mean	13	12
Std. Deviation	3	3
Skewness	-.680	-.290
Kurtosis	.447	-.384
Minimum	4	4
Maximum	19	19

Table 14. Summary Statistics for the Factor Working Alliance and Therapist Knowledge

7.8.2.1. The Working Alliance

In terms of the quality of the working alliance, 62% of participants rated the quality of the working alliance as good and 26% rated the working alliance as poor whilst providing therapy to those with AS.

Correlations were performed between the factor working alliance and satisfaction using Spearman's Rho. The results show that there was a positive significant correlation between the working alliance and satisfaction rs (127) = .311 *p*=<.001. There was no significant correlation found between the working alliance and the quality of supervision rs (127) = -.031 *p*=.729.

7.8.2.2. Therapist Knowledge and Experience

Therapist knowledge was measured by the factor therapist knowledge. Experience was measured in terms of the length of time in practice and the number of clients with AS that the therapist had worked with.

7.8.2.2.1 Therapist Knowledge

In terms of therapist knowledge, 48% of participants rated their knowledge as good and 41% of participants rated their knowledge as poor in relation to therapy with people with AS. Correlations were performed between the factor therapist knowledge and satisfaction using Spearman's Rho. The results show that there was a significant positive relationship between therapists knowledge and satisfaction rs (127) = .505 *p*=<.001. Therapist knowledge was also positively correlated with the working alliance rs (127) = .375 *p*=<.001.

7.8.2.2.2 Therapist Experience

Experience in terms of the length of time in practice and the number of clients worked with was correlated with satisfaction using Spearman's Rho; a total of two tests were performed therefore a Bonferroni correction was applied and all effects are reported at .025.

It was found that there was a significant positive correlation between the number of AS clients and satisfaction with regard this client group (rs (120) = .224 *p*=.006). It was

also found that there was no significant correlation between the length of time that the participants had worked with clients who had AS and satisfaction with this client group (rs (122) = .088 *p*=.165).

7.8.3. Model(s).

Participants were asked which model(s) they used in their therapy with clients with AS (please see Table 15). In total, 92 participants (71%) out of the 129 participants stated that they used cognitive behavioural therapy in their practice with those with AS and 37 participants indicated that they did not use cognitive behavioural therapy in their work with people with AS.

Model	Number of participants	Percentage of the sample
Systemic	45	35%
Person Centred	40	31%
Narrative	22	17%
Psychodynamic	29	23%
Solution Focused	42	33%
Personal Construct Psychotherapy	12	9%
Cognitive Analytic Therapy	8	6%
Interpersonal	20	16%
Dialectic Behaviour Therapy	9	7%
Cognitive Behavioural Therapy	92	71%
Other	38	29%

Table 15. Number of Participants using Particular Models in their Practice with Clients with AS.

Some respondents also provided qualitative information about the model(s) they used with people with AS; these statements appeared to support the interviews and the research literature, some examples are provided below alongside thematically similar utterances taken from the interviews:

> *"AS clients appear to benefit from cognitive behavioural therapy the most. They appear to understand the structure"* (questionnaire).

> *"Written summaries are often useful for people with AS"* (questionnaire).

"Schema work not helpful" (questionnaire).

"Although people with AS tend to think more often in visual/imagery based ways I have found it difficult working with these images" (questionnaire).

"…I write everything down…everything is done very visually…" (interviews, person 1).

"…I know that I couldn't get far with a lot of interpretation because she wasn't going to be able to think abstractly about things…" (interviews, person 2).

"…there is a requirement that one is more directive otherwise you are going to be there, not just all day but all year…" (interviews, person 3).

"…I was adapting the model for the needs of the client, for the need of her…" (interviews, person 3).

"…really wasn't able to work with the unconscious, she had no concept of free association…It was quite a struggle working psychodynamically but I felt she could benefit from counselling" (interviews, person 4).

Comparisons were made, between participants who identified themselves as using cognitive behavioural therapy and those that identified themselves as not using cognitive behavioural therapy in therapy with people with AS, with regard the factors therapist satisfaction, the quality of supervision and the working alliance.

The data were found to be significantly non-normal using Kolmogorov-Smirnov and Shapiro-Wilk test for normality: (D (92) = 0.163, p<.05 for satisfaction in the "cognitive behavioural therapy" group; D (37) = 0.20, p<.05 for satisfaction in the "non-cognitive behavioural therapy" group, D (92) = 0.14, p<.05 for supervision in the "cognitive behavioural therapy" group and finally, D (37) = 0.18, p<.05 for supervision in the "non-cognitive behavioural therapy" group) therefore a Wilcoxon Rank-Sum test was conducted. It was found that there was no significant difference in the scores on the two factors: therapist satisfaction and the quality of supervision between those that identified themselves as using cognitive behavioural therapy compared to those that did not (**satisfaction:** Ws =2288.000, *ns, r*=-0.06 *MDN*= 12 for the "non-cognitive

behavioural therapy" group and *MDN* = 12 for the "cognitive behavioural therapy" group and **supervision:** Ws =5856.000, *ns*, *r*=-0.05 *MDN* = 12 for the "non-cognitive behavioural therapy" group and *MDN* = 12 for the "cognitive behaviour therapy" group).

To further support this view of the closeness of fit between the two groups (i.e. those that use cognitive behavioural therapy with clients with AS and those that do not use cognitive behavioural therapy with clients with AS), the percentage of participants achieving a score consistent with a positive perspective on the factor satisfaction within the "non-cognitive behavioural therapy" AS group was 70%, within the "cognitive behavioural therapy" group it was also 70%. The suggestion is that the use of cognitive behavioural therapy as either the sole model or in combination with other models when providing therapy to clients with AS does not appear to influence therapist satisfaction.

It was also found using a Wilcoxon Rank-Sum test that there was no significant difference between the working alliance and the model used (Ws =2187.000, *ns, r*=-0.06 *MDN* = 13 for the "non-cognitive behavioural therapy" group and *MDN* = 14 for the "cognitive behavioural therapy" group) this appears to fit the literature on working alliance.

7.9. Preliminary Synthesis of the Analysis

Following preliminary discussions with colleagues, interviews with five trainee psychologists and questionnaires from 129 therapists, a number of areas were revealed as potentially important to psychotherapists working with people with AS. These areas were associated with the quality of supervision, therapist satisfaction, the quality of the working alliance, therapist knowledge and experience, the model used and co-morbid psychopathology and other co-morbid concerns.

Following analysis, the quality of supervision, the amount of knowledge and experience as well as the quality of the working alliance appears to be associated with therapist satisfaction but not the model used. Furthermore, there was no relationship found between the working alliance and both the quality of supervision or the model used. There were significant differences found in the ratings of the quality of supervision comparing the group AS with the other two comparison groups, suggesting that therapist ratings might be valid and might not be a reflection of providing therapy per se or to complex groups per se.

Overall, the sample in this study viewed clients with AS as satisfying to work with despite this population possibly being viewed as not necessarily fulfilling a number of therapist preferences as described within the literature review, the initial interviews and within the qualitative aspects of the questionnaire (this factor was not revealed through exploratory Principal Component Analysis and therefore no analysis could be done using this dimension). The relatively high ratings of overall satisfaction for this group may be due to the relatively favourable ratings on the factors: therapist knowledge, the quality of supervision and the quality of the working alliance. However, high ratings of satisfaction may also be due to things over and above these dimensions that were not measured in this study, such as therapist characteristics and the wider social context which may view people with AS in a positive light. However, before any firm conclusions are made these results need to be explored and scrutinised through the discussion section.

8. Discussion

This section will begin by describing how the epistemology altered as the thesis progressed. It is hoped that this will provide a background or context with which the results can then be explored, including what the results might mean to therapists and people with AS and highlight areas of possible future research. The final part of the discussion will specifically critique the methods employed within this study.

8.1. The Journey through the Thesis and the Evolving Epistemology.

Retrospectively, the author took what he thought was a straightforward position within the scientific realist paradigm, from that position making what the author thought were clear hypotheses about what AS may mean to therapists who encounter them in therapy. However, this was contrasted by the author's final epistemology and following the results there was an evidencing of a very different experience for therapists when working with clients with AS, one of possibility and optimism.

The overall message of this thesis goes some way in challenging the dominant "medical" discourse on AS, a position that the author had somewhat originally embraced within this study. In challenging this paradigm this study may help to erode some of the myths and prejudices with regard working psychotherapeutically with people with AS, perhaps even dispelling some of the "mystique" (Hare & Flood, 2001) that may leave some people with AS at a loss when it comes to accessing psychological therapies, whilst leaving therapists who have not discovered the possible pleasure of providing therapy to people with AS also at a potential loss.

The results of this thesis highlight the original rather limited world view of the author and the equally rather limited original narrative held about people with AS, albeit tentative and evolving throughout. On reflection, the original epistemology, from which the methods arose, was stifling both for the author and for the research. However, from the original limited epistemology and methods arose some surprising and interesting results and highlighted what could be achieved if a different set of methods were applied. Different methods might have helped to provide the opportunity, where this study failed, to explore the cultural and historical background of the therapists, instead this study reduced opportunity through data shrinking analysis**.**

Initially the author took the dominate discourse of AS, applying the thinking and methods of the "masculine," context-independent positivist epistemology (Sayer, 2000,

p.51), as argued by the reductionist assertions of those from this tradition e.g. AS in some way is a manifestation of the "extreme male brain" or "hyper-masculinisation" (Baron-Cohen, 2002a). Furthermore, the author's changing epistemology also revealed how the research may have reflected the dominant discourse of "strong" cultural essentialism, in that there may have been an initial belief that there are fixed essential characteristics that group people diagnosed with AS together such as difficulties with interpersonal skills that lead directly to poor working alliance and that these would be regularly encountered in psychotherapy leading to reduced satisfaction in the therapist; a view that there is a "…one-to-one relationship between a single biological essence and a single kind of behaviour, without any social mediation or construction…" (Sayer, 2000, p.99) This highlights another tension in light of the changing epistemology, that the research was effectively deterministic based on the essential criteria explored in the literature search mostly from a dominate reductionist paradigm. In terms of epistemology, the author was

> "…*led away from a* [critical] *realist approach by the hegemony of positivist methodology, with its disregard of problems of conceptualization and abstraction and its successionist theory of causation…"* (Sayer, 2000, p.27).

This is not to say the author does not believe that there are shared essential characteristics or properties of people with AS, to do this would disregard everything from the research base and to deny potential need. The author does not take a "hard" essentialism or "strong" social constructionism position, instead the author now takes a "moderate" essentialism and "weak" social constructionism perspective, consistent with a critical realist perspective (Sayer, 2000). The author believes that AS exists as a phenomenon beyond social constructs, that there are things common to people with AS, but AS is understood via social constructs and discourses. "Hard" social constructionism would assert that AS is wholly and completely socially constructed and does not exist beyond social constructions; to the author this position would deny the possibility of actual impairments and need such as those linked to extreme sensory experiences (Elliman, 2011) but these biological processes, in terms of sensory need for example, are mediated by social processes,

> *"…those who wish to argue that the body has certain essential properties, or at least causal powers, do not need to suppose that this entails a one-to-one relationship between a single biological essence and a single kind of behaviour, without any social mediation or construction. We have many biological powers, they can be activated and mediated in a vast number of ways, and hence the range of sexualities and other activities of which people are capable is wide, but like any social constructions, behaviours draw partly upon non-social materials, including the body, and are constrained and enabled by their properties"* (Sayer, 2000, p.99).

As the research unfolded, it was apparent that a critical realist paradigm was better placed; upon reflection this paradigm was more consistent with the author's personal values, profession and more broadly, the author's world view. Critical realists would reject the assertion that the world and the things that make it up are nothing more than discourse but instead they would argue that the discourse, at least in part, is dealing with something "real" (Sayer, 2000). Originally as a researcher practicing within the scientific realism paradigm, it was argued that

> *"…there is a truth, the world is largely knowable and just as it appears to be, and that the scientific method, although fallible, can measure true representations of the world…"* (Bunge, 1993, p. 231, cited in Madill et al, 2000).

However, five years on and at the point of completion of a doctoral thesis the author now takes the critical realism perspective and argues that "…the way we perceive facts, particularly in the social realm, depends partly upon our belief and expectations" (Bunge, 1993, p. 231, cited in Madill et al, 2000). Thus critical realism is consistent with "weak" social constructionism in the inherent subjectivity in the production of knowledge, but unlike "strong" relativism, critical realism is a position that asserts that there is a reality independent of human consciousness, there are objective objects beyond human consciousness, but they come to be known through discourse and are therefore socially constructed and value-laden, "There is no contradiction involved in accepting both that there is a world existing independently of our thoughts and that we can only know what it is like from within discourse" (p41, Sayer, 2000);

> *"Non-realists reject objectivity: from the correct point that the objective properties of something can't be known independently or our ('subjective') thoughts about them, they wrongly conclude from this that they can only exist if they are thought about"* (Sayer, 2000, p.60).

Critical realism accepts that knowledge is fallible as it is embedded in a complex dynamic fluctuating social system "…no philosophy of science can promise 'royal road to truth' and critical realism is no exception" (Sayer, 2000, p.17). Critical realism is not attempting to find positivist universal laws from empirical regularities but instead critical realism attempts to discover a level of knowledge that is "adequate" in a practical sense (Sayer, 2000, p.41); a pragmatic position in terms of finding something useful in the research that can help progress our knowledge. Within the critical realism paradigm, it is believed that there is a "truth" out there to be discovered but it can only be known "adequately" at best due to the fluctuating social, cultural and historical context in which the object of research is embedded. Critical realist explanations appreciate how a particular phenomenon is embedded in a wide range of social processes and thus any social explanation is required to acknowledge the "stratified nature of social reality" (Pawson & Tilley, 1997, p.64). This contrasts with "hard" relativism which asserts that all things are generated through co-constructions, there is no "truths" to be captured, not even adequately. The critical realism notion of adequate knowledge or *practical adequacy* as coined by Sayer (2000) and the assertion, in contrast to social constructionism, that some explanations are more valid than others, is described within the following example:

> *"…Ronald Reagan once tried to challenge the social construction of 'battered women' by calling them 'runaway wives.' The only way the latter social construction can be challenged is by defending the* [critical] *realism, objectivity or practical adequacy of the first social construction, they really were battered"* (Sayer, 2000, p.92).

The dynamic theoretical perspective of critical realism requires equally dynamic methods of enquiry. If one acknowledges the context, which would include the cultural, social and historical influences on the therapists' accounts and the researcher's interpretations of these accounts, this points to intensive research methods. This study was not intensive, it was extensive, nor was it dynamic enough to capture the multi-layered, stratified context in relation to the phenomena being researched, including adequate space to reflect on the researcher's position and the possible influence on

the research. Defining the context in critical realism is crucial in understanding what might have influenced the therapists' social constructions in relation to the phenomena being researched and the interpretations of the researcher. Unlike the original scientific realism paradigm, the author now argues that the researcher's position should not be viewed as another source of bias that needs to be controlled but instead made transparent as this position inevitably guides the research frame and process, "Reflexivity is conducive…to objectivity in the sense of developing true or practically adequate accounts" (Sayer, 2000, p.61).

The critical realism paradigm accepts that the researcher interprets and constructs, alongside the participants, but these constructs do not necessarily intertwine with the participants in the moment, this enmeshment between researcher and the researched being an essential feature of social constructionism and relativism is not embraced by critical realism (Sayer, 2000). Unlike relativism, the author does not assume that there is always co-creation or co-construction, a more robust and resilient position is argued for in terms of the attitudes held by the therapists'. Whilst the author believes that intertwining between the researcher and the researched can exist, the two can be distinguished. Sayer (2000) uses the following example to argue against the notion of there always being a co-construction of social reality, using political discourse as the example:

> *"In studying contemporary political discourse I may use the same concepts as politicians, etc., but that does not mean that the political discourse is a product of my analysis. The political discourse exists as it is regardless of whether I study it and whether I think of it. Even if the researcher spends years researching some social phenomenon, interpreting it in various ways, s/he may still have no discernible influence on its objects of study. Certainly some social theories can be influential – usually when they provide a social technology or latch onto and articulate some important but previously unarticulated structure of feeling in the wider society – but let's not kid ourselves: much of the time social scientists' work only influences a handful of peers…Social structures and practices are concept-dependent, but they are usually most dependent on concepts of actors in the past, not today, and not necessarily those of today's social researchers"* (Archer, 1995, cited in Sayer, 2000, p.34).

As argued, in terms of the methods of enquiry, a critical realist epistemology would argue for a different, more dynamic set of methods to those used in this study and unlike positivism and relativism, is compatible with and endorses a relatively wide range of research methods (Robson, 2002). For example, the questionnaire, the main method of enquiry in this study, would not be consistent with the critical realism paradigm. Firstly, questionnaires are constructed through reductionist, homogenising techniques; critical realism rejects categorising as it can fracture the data, it separates statements from the context which can lose valued complexity. Furthermore, this method is rigid, whereas flexibility is required within the critical realism paradigm "Because events are not pre-determined before they happen but depend on contingent conditions, the future is open – things could go in many different ways" (Sayer, 2000, p.15). Questionnaires are also successionist as questionnaires attempt to establish regulatory. Regularity is rejected by critical realism as the same mechanism can cause different outcomes according to varying contexts (Sayer, 2000), instead an explanatory matrix is required that incorporates the context,

> *"There is more to the world… than patterns of events. It has ontological depth: events arise from workings of mechanisms which derive from the structures of objects, and they take place within geo-historical contexts. This contrasts with approaches which treat the world as if it were no more than patterns of events, to be registered by recording punctiform data regarding 'variables' and looking for regularities among them…social scientists are not only dealing with systems that are open but ones in which there are many interacting structures and mechanisms. This creates the risk of attributing one mechanism (and its structure) effects which are actually due to another"* (Sayer, 2000, p15-16).

Critical realism does not advocate regulatory as this assumes closed systems, measuring cause and affect thus successionist, this is more in line with the author's original position. Initially, within the scientific realism paradigm the author was searching for regularities between therapist ratings such as ratings of working alliance and satisfaction for example. This method assumed a closed and stable system.

The shift of epistemology for this study would raise the analysis from that of possible classification (although this study never achieved any more than the status of exploration) to that of explanation, involving illumination of ambiguity (Smith, 1995,

cited in Madill et al, 2000). After all, “Meaning has to be understood, it cannot be measured or counted, and hence there is always an interpretative or hermeneutic element in social science” (Sayer, 2000, p.17). The author’s original epistemology and method of enquiry was limiting and did not go beyond simply describing the data such as measuring the number of therapists who were satisfied for example. The critical realism paradigm embraces a more complete account by exploring therapists’ experiences beyond the reductionist, homogenising, consensus driven parameters set by the coding system within the interviews and the Principal Component Analysis within the questionnaire.

The author’s new epistemological stance is generative, it incorporates the social, cultural and historical perspective within an explanatory matrix. It is the most useful way to describe the data which incorporates mechanisms, outcomes and contexts. The author embraces the critical realism paradigm as a richer and more satisfying paradigm and one that sits more comfortably with the author’s professional identity as a Counselling Psychologist.

When criticising the original paradigm and methods employed, this is not to reject the value of the authors’ research. Within the critical realism paradigm, the author is able to take a pragmatic position and find value in the results of post-positivist research, albeit, only partial explanations can be gleaned (Sayer, 2000). With that in mind, the author will now explore the results, focusing on the salient and important, attempting to explain the outcomes and to explore what the results might mean for therapists working with people with AS in a psychotherapeutic setting. Where possible a critical realism perspective will be provided. Following this a critique of the methods employed will be conducted.

8.2. Results

8.2.1. Overview

The following hypotheses were explored within the research:

- 1. Therapist preferences will not be met.
- 2. The working alliance will be poor.
- 3. Therapist satisfaction will be poor.
- 4. Supervision will be poor
- 5. The quality of the working alliance will be positively correlated to therapist satisfaction.
- 6. Therapist knowledge and experience will be positively correlated to therapist satisfaction.

The factor relating to therapist preferences was not revealed through Principal Component Analysis and therefore this dimension could not be explored any further. In relation to working with people with AS the working alliance was found to be good (please see section 7.8.2.1. within the results section), satisfaction was found to be high (please refer to section 7.8.1.1 within the results section) and the quality of supervision was found to be good (please see section 7.8.1.2. within the results section). The working alliance was found to be positively correlated to satisfaction and knowledge. Therapist knowledge and experience was positively correlated to satisfaction in relation to working with people with AS. A more thorough exploration of the results will now be conducted.

8.2.2. The Working Alliance

It was found that 62% of therapists in this study rated the quality of the working alliance as good whilst providing therapy to those with AS (please see section 7.8.2.1. within the results). This is a very positive outcome as the quality of the working alliance above any other factor, including therapeutic orientation, has been shown to be the most important aspect of therapy (Clarkson, 2003). For example, the strength of the working alliance has been shown to be associated with therapy outcome (e.g. Horvath & Symonds, 1991; Bertolino et al, 2011). Horvath and Symonds (1991) have shown a

moderate association between good working alliance and positive therapy outcome and Busseri and Tyler (2003) argue that Martin et al (2000), in their meta-analysis, found an average effect size of .24 for this relationship.

The literature suggests that the working alliance is important irrespective of the length of therapy or the model applied (e.g. Horvath & Luborsky, 1993). Similarly, this study found that the working alliance is independent of the therapists' theoretical orientation (please see section 7.8.3. in the results). Bordin (1979) provides a transtheoretical perspective on the working alliance suggesting that different therapy models share three fundamental elements that correspond with working alliance formation, these are *tasks, bonds* and *goals.* Consistent with the research, these three elements were revealed as important within this study, following Principal Component Analysis.

Therapist characteristics appear to be important in the formation of the working alliance. For example, the degree to which the therapist is similar to and matches their clients may be important (e.g. Atkinson & Schein, 1986, cited in Teasdale & Hill, 2004). The literature has also shown that more experienced and knowledgeable therapists are better at facilitating collaboration (Baldwin et al, 2007, cited in Bertolino et al, 2011; Horvath & Luborsky, 1993; Davenport & Ratliff, 2001). Supporting this assertion, this study found that the working alliance was associated with therapist knowledge (please see section 7.8.2.2.1 within the results).

In a number of studies it has been shown that it is the client's perception of the therapist characteristics that are most crucial for alliance formation. For example, client's perceptions of the therapist's empathetic ability, rather than therapist behaviour, led to the most robust correlational outcome (Horvath & Luborsky, 1993). Dryden (1984) argues that the psychotherapist must have face validity or "communicator credibility" (p.249), which is concerned with the tendency of some clients to associate effective and reliable psychotherapy with certain characteristics (cited in Clarkson, 2003).

In terms of the perception of the client towards the therapist's capacity such as their empathic ability when considering the development of the working alliance, Rush (1986) argues that this perception can be influenced by client characteristics such as the way in which the client processes and organises information. It is possible then that any differences and impairments in memory, concentration and abstraction in the

client, as reported in the literature for people with AS, might possibly affect the interpretation and experience that the client has of the therapist, which in turn may affect the quality of the working alliance. Furthermore, client characteristics have been argued to not only effect the perception the client has of therapist's capacities and capabilities such as empathic ability (Horvath & Luborsky, 1993) but also client characteristics may influence their own contribution to the development and maintenance of the working alliance. For example, Marmar et al (1988, cited in Horvath & Luborsky, 1993) found that client intrapersonal factors (e.g. client motivations) and Moras and Strupp (1982, cited in Horvath & Luborsky, 1993) found that interpersonal factors (e.g. difficulties forming social relationships) appear to have significant effects on the quality of the alliance.

Given that the majority of the literature states that client characteristics appear fundamental when considering the establishment of a working alliance, it was postulated by the author that forming a working alliance with a person with AS could be difficult due to the differences some clients with AS may have in processing, memory and abstraction as well as more directly related characteristics such as interpersonal difficulties and rapport building (Bishop & Baird, 2001). However, interestingly, despite these differences and potential difficulties, the majority of therapists in this study rated the working alliance as good. This is in stark contrast to one rather limited study by Chalk (2003, unpublished) who found that the working alliance was significantly worse when working with clients with AS compared to clients without AS, from the therapist's perspective.

It might be that the therapists in this study are in some way supporting their clients who have AS in a range of ways including in relation to forming a working alliance, clients who may have difficulties with interpersonal functioning and difficulties in other areas linked to alliance formation. The literature consistently suggests that people with AS have got at least the rudimentary skills necessary for social interaction and alliance formation such as skills relating to Theory of Mind (e.g. Blackshaw et al, 2001), but often only when supported through environmental cueing (e.g. Blackshaw et al, 2001), simplifying the interaction and reducing the complexity of the situation (e.g. Bowler et al, 2005). It might be that the calm, structured and supportive environment often characteristic of a psychotherapeutic setting, in addition to a knowledgeable therapist, might in some way help to enable people with AS to utilise the skills they have in order

to form a good working alliance, certainly, the therapists in this study rated their knowledge as good (please see section 7.8.2.2.1 within the results).

8.2.3. Therapist Satisfaction and Supervision

Therapist satisfaction was high across all three groups (please refer to section 7.8.1.1 within the results). This is important as therapist satisfaction has been linked to both physical and psychological health in the therapist (Faragher et al, 2005) and the quality of client care (Grol et al, 1985). Despite the evidence base suggesting otherwise, satisfaction was not influenced by the therapeutic model, moreover, therapists do not need to use cognitive behavioural therapy to feel satisfied despite this model being viewed as the dominant and most effective when working with people with AS (e.g. Hare, 1997a).

The reason for high satisfaction as reported by the therapists in this study may have been for a number of reasons. Clients with AS may satisfy particular therapist preferences. For example, perhaps clients with AS are viewed as logically minded by the therapists in this study; this client characteristic has been argued to be a preference for some therapists (McMahon, 1964, cited in Davis et al, 1977) and a feature that has been associated with AS (Kasari et al, 2001; Sigman & Ruskin, 1999; cited in Bauminger, 2002; Hermelin & O'Connor, 1985; Sacks, 1995). Therapist satisfaction may have also been influenced by the quality of the working alliance, shown to be high in this study, as already described.

Therapist satisfaction may have been influenced by things over and beyond client characteristics and the working alliance given that it was found that therapist satisfaction was high across all three groups. For example, the quality of supervision was found to be good in this study and was positively correlated with satisfaction (please see section 7.8.1.2. within the results section). In this study, 71% of therapists rated the quality of supervision as good in relation to therapy with people with AS. The quality of supervision has been shown to be associated with therapist satisfaction in other studies (e.g. Hyrkas, 2005). The quality of supervision has been linked to supervisor style, perspectives and roles (Bernard & Goodyear, 2004; Friedlander & Ward, 1984; Ladany, Walker & Melincoff, 2001, cited in Fernando & Hulse-Killacky, 2005) which can increase satisfaction in the supervision (Heppner & Roehlke, 1984, cited in Fernando & Hulse-Killacky, 2005), self-efficacy (Cashwell & Dooley, 2001, cited

in Fernando & Hulse-Killacky, 2005) and confidence (Heppner & Roehlke, 1984, cited in Fernando & Hulse-Killacky, 2005) in the supervisee which in turn could influence supervisees satisfaction in the therapy they provide. Certainly satisfaction in the supervision has been linked to job satisfaction (Hyrkas (2005). When the supervisor matches their style of supervision to the needs of the supervisee, in relation to the specific client group, supervisees rate supervision more highly (Fernando & Hulse-Killacky, 2005); these aspects may have formed part of the clinical supervision of the therapists who rated the quality of supervision and satisfaction as high in this study.

It has been argued that there is often an absence with regard to specific client characteristics in the training of supervisors (Borders et al, 1995; Holloway, 1995, cited in Fazio-Griffith & Curry, 2009). For example, it has been found by Fazio-Griffiths and Curry (2009), in a small study using grounded theory, that four of the six supervisor participants felt that knowledge of borderline personality disorder was important for effective supervision in their work with people with borderline personality disorder. The high ratings with regard the quality of supervision in this study may reflect supervisor knowledge of clients with AS. It has been argued that there are a number of recognised effective interventions which can promote positive growth and change in clients with AS (Attwood, 2007). As supervision is one way to disseminate expertise and that the quality of supervision has been associated with therapist knowledge in this study; perhaps the supervisors of the satisfied therapists in this study had been trained in both working with people with AS and the supervision of therapists working with this client group, particularly with regard specific characteristics.

Therapist satisfaction may have also been influenced by therapist characteristics. In this study, therapist knowledge and therapist experience with regard psychotherapeutic work with people with AS was positively correlated to therapist satisfaction; the majority of therapists rated their knowledge as good (please see section 7.8.2.2.1 and section 7.8.2.2.2 within the results). It was proposed following the literature review that the lack of a broad and extensive evidence base for working psychotherapeutically with people with AS would influence therapist satisfaction. However, this study found that the kinds of concerns that clients with AS bring to therapy are those identified in the literature, albeit the limited literature; the concerns are also common across many populations: anxiety, depression, obsessive compulsive disorder and problematic anger (please see Table 5). This may have contributed to therapist satisfaction as

therapists might be more confident as they may recognise the concerns that their clients bring to therapy.

8.3. Implications for Therapy with People with AS

Overall these results challenge the prevalent discourse with regard AS. It is positive that despite the possible challenges with regard psychotherapeutic work with people with AS and the possible conflict with regard a range of therapist preferences, as extrapolated from the literature, overall therapists appear to be satisfied when working with people with AS and believe they are able to form a good working alliance, and both satisfaction and the working alliance is not contingent on using the dominant cognitive behavioural model.

These findings are particularly interesting in light of the research on therapist preferences for particular client characteristics and basic therapeutic assumptions such as the need for clients to have intact interpersonal skills (Couture et al, 2006), to be psychologically minded (Teasdale & Hill, 2004), to exhibit a degree of conceptual complexity (Davis et al, 1977), for clients to view themselves as responsible for counselling (Heine & Trosman, 1960, cited in Davis et al, 1977) and for clients to be able to form a working alliance. These areas were all viewed by the author as potential problem areas for people with AS following the literature review and interviews. For example, several interviewees identified areas of potential conflict in their work with clients who have AS that appeared to relate directly to Davis et al's (1997) notion of conceptual complexity, yet overall, the therapists from the study were very satisfied when providing therapy to people with AS:

> *"I find people with Asperger's very concrete…whereas if you take the students that I work with at university they are very abstract…so it is a very different level of conversation…there is no abstractness"* (person 1).

> *"I had to offer many explanations because at some point she didn't have the insight, I mean she was very intelligent, she could understand but on the social interaction of things she didn't have an explicit understanding so I had to be more explicit as to what was happening"* (person 2).

> *"Very rigid…very concrete…it left me feeling actually quite frustrated"* (person 4).

Within the critical realism construct some of the possible reasons for the results of this study can be explored further and beyond the data produced by the positivist methods of enquiry applied within this study. Within the critical realism paradigm one acknowledges the context, which would include the cultural, social and historical influences on the therapists' accounts and on the researcher's interpretations of these accounts. Critical realism embraces the multi-layered, stratified context in relation to the phenomena being researched. Defining the context in critical realism is crucial in understanding what might have influenced the therapists' social constructions in relation to the phenomena being researched. From a critical realism perspective the broader views of therapists and how these may be played out in their work with people with AS including the values they hold as therapists would be important. For example, what are the possible influences of government policy relating to equality and diversity (e.g. Equality Act, 2010) and more specifically what are the possible influences of the shifts in the attitudes of society towards AS, helped along by authors and researchers concentrating not only on impairments but also highlighting differences and strengths? For example, people with AS have been argued to not only have superior strengths within particular intellectual abilities (Bowler, 2007) and highly skilled in such areas as science (Gillberg, 2002), they are also often argued to be very creative and original in thought and expression (Frith, 2004), they may be viewed as "fascinating" and "…specifically valuable for the development of the human species" (Gillberg, 2002, p.4). The differences in which some of those with AS think, feel and behave, may stand them apart from others, something that may define them as potential leaders (Tantam, 2011). Gillberg (2002) argues that although people with AS may have many of the difficulties highlighted within the literature search such as inflexibility, at the same time

> *"…many are 'free thinkers' and may be scientifically or aesthetically highly skilled people…'Asperger people'…are fascinating… Their difficulties and strengths shed light on the development and minds of other, 'neurotypical'…people* (p.4).

Certainly one interviewee appeared to very much value the differences that those with AS can bring to therapy

> *"…it was interesting. And I was fascinated...her recall of certain dates and times. It was absolutely amazing…"* (person 4).

This apparent shift in societal views of AS may be very important as the therapeutic process is inevitably affected by the biases and values of therapists (Lopez, 1989; Murray & Abramson, 1983, cited in Garnets et al, 1991) and the extent to which therapists feel comfortable with their clients (Gunderson, 1978, cited in Bland & Rossen, 2005). This positive shift in societal views towards people with AS and the increasing knowledge and value of their strengths as well as their needs might help to understand some of the reasons why it was found in this study that there are a number of significant positives to working psychotherapeutically with people with AS. This wider social context is very important and may have significantly influenced the ratings therapists gave in relation to AS, this might explain some of the reasons why despite the possible challenges that face therapists as reported in the literature review and the interviews when working with this group of people, therapists still find doing therapy with people with AS interesting and satisfying. It is hoped that this study may add to the positive re-framing of AS and might go some way in promoting psychotherapeutic work with people with AS as a real possibility and one full of potential. One area of important potential, as identified in this study, being the establishing of a good working alliance, viewed as a fundamental characteristic of good outcome in therapy and one that has been shown to be more than possible in this study; this possibility may be one important contributor to therapist satisfaction.

8.4. Future Research

This study may not only help to illuminate some important positives to providing therapy to people with AS but it might also help to develop future research projects. In that regard, the author would advocate intensive research methods in an attempt to reveal adequate truths about doing therapy with people with AS. The aim of intensive research would be to explore this multi-layered, stratified phenomenon and the social, historical and cultural context in which it is embedded. Certainly, using this method of enquiry, within this epistemology, a number of things could be explored further.

1) Exploring the quality of supervision of therapists working with people with AS:
    a. Is there opportunity in supervision to discuss the cognitions and emotions of clients with AS, to develop case formulations, to consider treatment and technique options as well as discussing obstacles to these, all identified as important aspects to supervision? (Pretorius, 2006).
    b. Is there opportunity for therapist reflection and do therapists feel "held"? (Gabbay et al, 1999).
    c. Is the supervisor experienced with clients with AS? Do they have the knowledge about specific client characteristics, shown to be important in effective supervision? (Fazio-Griffith & Curry, 2009).
    d. What is the supervisor style? Does the supervisor match their style of supervision to the needs of the supervisee, in relation to this specific client group? (Fernando & Hulse-Killacky, 2005).
    e. What values and beliefs do supervisors hold and how do these influence the supervision.

In terms of this study, intensive research with regard supervision might help to explain and ultimately support therapists like the 41% of therapists in this study that believed that their knowledge was poor in relation to clients with AS (please see section 7.8.2.2. within the results section for results regarding therapist knowledge) as improving supervision through this type of research may help to increase their knowledge, one important aim of supervision (Bernard & Goodyear, 2004, cited in Fernando & Hulse-Killacky, 2005) and thus their self-efficacy, an important outcome associated with good quality supervision (Cashwell & Dooley, 2001, cited in Fernando & Hulse-Killacky, 2005).

2) Exploring further the working alliance between the therapist and the client with AS:
    a. Explore what might have accounted for the 26% of participants in this study who rated the working alliance as poor and what differentiated them from the participants who rated the working alliance as good.
    b. To explore whether the construct of the working alliance as proposed by Horvath and Greenberg (1986, 1989) is the same for people with AS.

c. To explore whether the working alliance in client work with people with AS is associated with therapy outcome and drop out. This might be interesting, particularly given the gender ratio differences in AS (e.g. Gould, 2011) and that Samstag et al (1998) found that men are more likely to remain in therapy irrespective of the quality of the working alliance, in contrast to women.

3) Explore further therapist satisfaction and what might mediate therapist satisfaction when working with clients with AS:
    a. Explore whether particular client dimensions are associated with therapist satisfaction when working with people with AS, such as intact interpersonal skills (Teasdale & Hill, 2004), the topics they bring to discuss in therapy, cognitive ability and conceptual complexity (Davis et al, 1977), their psychological mindedness (Teasdale & Hill, 2004) and whether they are logically minded (Davis et al, 1977).
    b. Explore whether particular therapist dimensions are associated with therapist satisfaction including whether they are similar to their clients with AS within such dimensions as values, preferences and cognitive style (Lopez, 1989; Murray & Abramson, 1983, cited in Garnets, Hancock, Cochran, Goodchilds & Peplau, 1991).
    c. Explore therapist expectations of the client group they work with in relation to satisfaction.
    d. Explore how therapists might manage particular client characteristics in session such as a particular cognitive style such as “autistic preoccupation” (Couture et al, 2006).

8.5. Statement of Originality and Contribution

Overall, it is believed that this study does constitute an original contribution to knowledge. For the first time therapists’ ratings of their perceived knowledge, their experience, the quality of the working alliance, as well as the influence of the model used and both the quality of supervision and degree of therapist satisfaction when working psychotherapeutically with clients with AS has been illuminated beyond anecdotal evidence and shown to be linked. This study revealed some interesting results and goes some way in challenging the dominant “medical” discourse of AS. This construct has somewhat pathologised people with AS which could leave some

therapists avoiding doing psychotherapeutic work with people with AS due to a number of assumptions, including difficulties in forming a working alliance, thus leading some therapists to expect the work to be rather dissatisfying. However, the opposite was found in this study, that doing therapy with people with AS can be satisfying and building a working alliance is quite possible.

This study has also revealed interesting findings with regard other areas not previously explored in the literature. It was found that although the literature already identifies the importance of supervision when working psychotherapeutically, it is believed that for the first time it has been found that satisfaction is directly linked with the quality of supervision.

This study also builds on and supports the limited research that exists describing the types of co-morbid psychopathology and other co-morbid concerns clients with AS might present with. This is valuable in terms of providing further insight into the types of problems therapists might encounter in their practice with people with AS. Given that this study found that knowledge is associated with satisfaction and with the quality of the working alliance (which supports research such as Davenport & Ratliff's, 2001), this may help to encourage therapists to increase their knowledge and understanding of these co-morbid concerns particularly when manifest in the context of AS.

Despite the positive findings of this study there are inevitably some limitations. The methods employed within the study can be criticised in terms of the procedure taken by the author, the methods themselves as a means of enquiry and more fundamentally in terms of the epistemology that underpins them.

8.6. Considerations

8.6.1. The Interview Sample

The therapists that were used for the interviews were quite inexperienced with regard therapy generally and working psychotherapeutically with people with AS specifically. It has already been shown within this study that knowledge and experience appears to be associated with degree of therapist satisfaction. The participants from the interviews had minimal experience therefore may have had lower satisfaction with regard the work with AS; this may have been reflected in the material gathered from the interviews. Overall, the respondents to the questionnaire were experienced relative to the trainees interviewed. The questionnaire respondents appeared to rate their satisfaction as

relatively high compared to the trainees interviewed, thus low therapist satisfaction reported qualitatively by the trainees within the interviews may be due to minimal experience and in particular of trainees. In addition, trainees may also be relatively naive with regard to supervision and hold very different opinions from more experienced therapists. Despite this assertion being highlighted as a possible problem in this study, this may in itself be an important finding.

Another possible limitation may have come from the analysis of the transcripts from the five interviews with which the main body of the questionnaire was created. An exploration of the construction of the attitude statements from both the interviews and from the literature will now be conducted.

8.6.2. Constructing the Attitude Statements

Inevitably the researcher would have influenced the analysis of the transcripts from the five interviews and the coding of the responses in terms of tentative themes. The tentative themes were created from the utterances that appeared consistent between interviewees and/or with the research literature and/or with the early discussions with colleagues. This process describes a content analysis whereby units of information either at the level of word, sentence or paragraph are sorted into categories based on emerging themes.

Content analysis is described as "…a research technique for making replicable and valid inferences from data to their context" (Robson, 2002, p.21). There are a number of potential difficulties when doing a content analysis, as classifying responses in terms of shared content or themes reduces the overall data set in order to produce the attitude statements for the questionnaire, thus important information could have been lost. Qualitative analysis that concentrates on categories and themes have been criticised for "fracturing the data" (Charmaz, 1995, p. 49, cited in Madill et al, 2000) in that utterances can be separated from the overall context including the researchers reasons for the interpretations (Madill et al, 2000) and the interplay between the researcher and researched. However, Robson (2002) points out that content analysis can highlight the relationship between the content and the context. The context would include the reason for the interview i.e. the research question(s), physical aspects such as the room used for the interviews and the timing of the interviews; as well as the more complex issues relating to the interviewer style and processes going on between the interviewer and interviewee. Thus transparency with regard all these influences were important, these issues are discussed below as well as within the reflexivity

section later on. Despite the positives argued for a content analysis, this method could have been replaced with other methods that capture more about the inter-play between the interviewer and interviewee, methods that capture divergence of therapists' experience in order to move towards a more complete and satisfying account, for example, the use of discourse analysis could have been applied (Madill et al, 2000).

With regard the procedure for the content analysis, units (i.e. words, sentences and paragraphs) of low inference were looked for (e.g. looking for the word "supervision"), what Robson (2002) calls *manifest content.* However, sometimes more interpretation was required when utterances were ambiguous, including analysing the previous sentence or paragraph to provide context. Within the positivist paradigm, this *latent content* (Robson, 2002) requires methods to overcome the potential "biasing" of the researcher resulting in possible "error," to use language that is consistent with that epistemology. As consistent with the original epistemology of the researcher, in order to reduce this "error," a second person who had a background in psychology also selected salient and consistent material and concordance was calculated. This procedure may have been consistent within the original post-positivist paradigm in order to establish consistency of meaning (Madill et al, 2000), but for critical realism this is simply another positivist method which restricts the depth and breadth of the study and another obstacle to a more complete explanation of therapists experiences. Fundamentally, the method of content analysis, from the author's current critical realist epistemology, would be viewed as reductionist and critical realism would challenge categorising as it can fracture the data as it separates statements from the context.

Further criticisms can be made when converting the important material taken from the interviews and literature into attitude items that could be rated by the respondents (please see Appendix 10 and Appendix 11 respectively). The guidelines proposed by Oppenheim (1992), de Vaus (1991), Dillman (2000, 2009) and Robson (2002) were used in order that the respondents to the questionnaire would understand the attitude items. When creating the attitude items, precautions were taken such as avoiding too long a statement, double barrelled statements, proverbs, double negatives, acronyms and abbreviations. The utterances used by the respondents were altered as little as possible. In order to provide opportunity to establish if therapists understood the attitude statements, piloting was conducted which led to some alterations based on respondent feedback, author review and on correlation coefficients. Finally, it was hoped that the inclusion of several opportunities within the final questionnaire for participants to respond as they wished would reveal any aspects of consistent themes

and attitudes not picked up from the interviews or discarded and/or misinterpreted through the coding process.

Despite these precautions, some of the respondents to the final questionnaire may not have understood all of the items used within the questionnaire. One way to overcome this issue was to have several items make up an attitude scale. However, despite the approaches described to deal with potential error, several criticisms can be made of some of the items within this study:

- The interchangeable use of the word “counselling” and “therapy” within the attitude items was viewed as unhelpful and confusing by one respondent. The design of the questionnaire meant that respondents had to answer all questions in order to continue, they may therefore have checked the uncertain/unsure box or checked any box within the Likert scale when faced with an item they did not understand. It is hoped that this was rare and would have been overcome by having a number of items make up the factors and therefore the overall score would reflect their opinion accurately despite any possible misinterpreting of a single item.
- The rewording of the utterances produced by the interviewees from a positive to a negative phrased statement or vice versa may have completely changed the meaning of the statement (Robson, 2002). Robson (2002) argues that even “small and seemingly innocuous changes in wording can sometimes have substantial effects on response” (p.253). Again, this issue may have been overcome by piloting the questionnaire and having several items make up a factor. The internal consistency analysis helps to ascertain consistent meanings across items.
- The attitude items and other closed type questions may have left respondents feeling frustrated, leading to non-response or measurement error (Dillman, 2000, 2009). However, the closed type of questions in this measure were created using methods that should not have left the participants feeling constrained and unable to answer as they wished to. As discussed earlier, this was because the closed questions and attitude statements were created from open ended interviews thus should relate directly to the population completing the questionnaire i.e. therapists, are exhaustive and use the language the population would recognise. Despite the criticisms, the closed type of question was very necessary within the original post-positivist epistemology as it was the authors view that in

> *"…using the 'closed' approach we ensure that the results of several groups can readily be compared and that all respondents have considered the same universe of content before giving their replies"* (Oppenheim, 1992, p.114).

Oppenheim states "free-response questions are often easy to ask, difficult to answer, and still more difficult to analyse" (p.113). On the other hand closed questions provide a choice of response. Despite the potential difficulties relating to the items being over restrictive, closed questions appear relatively simpler to administer, straightforward to answer and quantify which means more questions can be asked. However, spontaneity and degree of expressiveness is sacrificed. In order to combat this, opportunities were provided for respondents to add any comments that they wished to throughout the questionnaire within the qualitative aspects.

Another source of potential difficulty relating to the integrity of this study may come from the questionnaire itself as a method of enquiry.

8.6.3. The Questionnaire

A brief critical appraisal has already been conducted earlier in the discussion about the use of a questionnaire as a method of enquiry from a critical realism perspective. These criticisms included a questionnaires inability to capture sufficient and complete explanations due to its reductionist, homogenising and ridged procedure and underlying belief in successionist regularity, that for critical realists do not reflect the dynamic interaction between contexts and mechanisms. However, in addition to these fundamental epistemological arguments there are a number of other potential criticisms with regard the questionnaire, leaving epistemology aside.

A web based questionnaire survey design was used in order to anonymously attempt to target a representative sample of the survey population i.e. therapists of all backgrounds, experience, settings and levels of training who have worked psychotherapeutically with clients with AS, borderline personality disorder and depression. However, a mixed mode survey may have been more helpful, as different modes of data collection can produce very different results, such as between interviews and questionnaires (Dillman, 2000) and different people prefer different approaches (Groves & Kahn, 1979, cited in Dillman, 2000). Interviews and questionnaires could

have been used together at the final stage of the research; this mixed modal approach may have provided opportunity to compensate for the weakness of both approaches. For example, any problems that the participants experienced with the questionnaire online would not necessarily be raised with the researcher despite all participants being offered contact details to make comments or ask questions, thus *measurement error* could have been reduced (Dillman, 2000, 2009). Despite the advantages of using an alternative to the questionnaire and/or using a mixed modal approach, the main reason for using a purely questionnaire type approach was in order to keep anonymity, essential for honest responses. Interviews would not keep anonymity and a postal survey could only secure confidentially, not anonymity as post marks would identify possible senders.

An alternative method to survey could have been Interpretative Phenomenological Analysis or Grounded Theory. However, these were rejected in this study. Grounded Theory was not used because the author had some knowledge about the area of study prior to the beginning of the study which is incompatible with this method. Interpretative Phenomenological Analysis was rejected from the author's original epistemology. In contrast to the usual small number of participants that are normally used in Interpretative Phenomenological Analysis as this is an intensive research method, this study was extensive from the scientific realist paradigm. The author desired attitudes from a large number of therapists with a wide range of experiences, in order to make comparisons of a number of attitudinal dimensions from which generalisations could be made; this is consistent with the post-positivist approach originally taken. This latter point is another possible exclusion criterion for Interpretative Phenomenological Analysis, as Interpretative Phenomenological Analysis would not advocate attempting to group experiences in relation to predefined categories. However, both types of methods could have led to much more detail and greater depth of analysis, something that this study lacked.

In order to target a representative sample of the survey population a total of 13362 questionnaires were sent out to various therapist directories. However, only 163 people completed the questionnaire. This may have been due to *non-response error* (Dillman, 2000, 2009), which may have been due to a number of reasons. As a guide, it was established through investigation via the British Association for Behavioural and Cognitive Psychotherapists website that 62 people on that directory had experience of both AS and borderline personality disorder (depression could not be selected), which constituted 8.4% of the total number of therapists on that directory. If this figure is

extrapolated then there should have been a total of 1123 therapists across the different directories that were targeted that could have worked with both AS and borderline personality disorder, this would mean 1123 of the total 13363 people surveyed, 163 responded, constituting a response rate of 15%. This may mean that the sample within this study was not representative; the poor response rate may have been due to a number of reasons.

The questionnaire may have been viewed as a mass mail out and impersonal, both things that are well known for producing poor responses (Dillman, 2000, 2009). The internet mode of survey may not have been accessible to certain members of the sample due to lack of access to the internet, inability due to disability or simply as this mode would not appeal to all (Dillman, 2000, 2009). It might be that some of the sample believed that the "cost," such as the perceived time spent doing the questionnaire, outweighed the reward, such as social validation, or that the research failed to gain their trust or stand out from many other pieces of research also being received (Dillman, 2009).

The reason for the non-response may also have something to do with the topic of research (Oppenheim, 1992). For example, the responders, in contrast to the non-responders, may have been therapists who share particular attitudes such as high satisfaction with clients with AS and non-responders may be from a population that feels very dissatisfied with this client group. Another reason for the lack of response may have been due to the questionnaire being very time consuming thus putting respondents off from the outset (Heberlein & Baumartner, 1978, cited in Dillman, 2009). This could have been reconciled by shortening the questionnaire.

In order to improve uptake an incentive was provided, this was contingent on the completion of the questionnaire. Overall, the research supports this strategy of providing modest incentives (£1 to £2) following questionnaire completion in order to improve response rates and the accuracy of responses (Church, 1993, cited in Dillman, 2000, 2009). Other incentives could have been provided instead of vouchers, such as an offer to be included within a prize draw (Carlson, 1996, cited in Dillman, 2000) or a material incentive such as a pen (Boynton, 1995, cited in Dillman, 2000), but the research suggests that money is better at improving response rates (Dillman, 2000).

The main way to aid response rates was to target the specific sites where the survey population was likely to be (Dillman, 2000, 2009). However, as argued, it was not known how many or who on the directories targeted had experience of all of the three

client groups: AS, borderline personality disorder and depression and therefore everyone was surveyed who had an email address. Using these directories and peoples' email addresses may have not only resulted in a non-response error but also may have caused a *coverage error* (Dillman, 2000, 2009) as not everyone from the survey population would have the same chance of being included in the sample, moreover, only therapists who were on the national directories, have access to the internet, have an up-to-date email address on this directory and have access to it would be surveyed. However, at the time it was known that all psychologists needed to be registered on the British Psychological Society directory in order to practice. In addition to targeting this directory, an advert was also placed in the Psychologist magazine which was sent out to all those registered with the British Psychological Society, including psychology students, trainee psychologists and academic psychologists. Furthermore, although not mandatory, other types of therapists are encouraged to register on the directories: British Association for Behavioural and Cognitive Psychotherapies and the British Association for Counsellors and Psychotherapists, which were also targeted.

Postal survey could have helped with non-response and coverage error by targeting those that were not on the professional directories i.e. psychotherapists that did not belong to the professional bodies targeted, or did not have an email address on the directory targeted, those that no longer used the email address that was on the directories or simply those who preferred another approach. However, anonymity could only be guaranteed with the research method employed.

Despite these possible errors, the research had a very restricted inclusion criteria, therefore despite extrapolation from the proportion of therapists working with AS and borderline personality disorder of the total number of therapists on the British Association of Behavioural and Cognitive Psychotherapist directory suggesting that this was a rather low 15% response rate, the low number of respondents may have actually been a reflection of the small survey population i.e. therapists working with all three client groups, moreover, the extrapolation may not be an accurate reflection of the other directories targeted. It might be, for example, that the British Association of Behavioural and Cognitive Psychotherapist directly have more therapists with experience of clients with AS, borderline personality disorder and with depression than the other directories. Therefore, it could be argued that those that responded and completed the questionnaires could have actually been a representative sample of the population and reflecting an adequate sample size

> *"It is possible…for a survey with a very low response rate to adequately represent the survey population or for a survey with very high response rates to fail to represent the intended population"* (Dillman, 2009, p. 63).

It would be difficult to work out exactly the sufficient sample size due to the author not knowing the entire survey population size and whether the number of participants that responded is representative. There is certainly no directory or research that the author is aware of that states the number of therapists who have or are currently working with all three of these populations, their identifying characteristics and therefore where they might be reached etc. Therefore, it would be difficult to establish the definitive reasons for the potentially low uptake and whether the respondents are representative of the survey population. It is very possible that the non-respondents came from a different population to the respondents and are different with regard the areas of interest in this study, but without being able to contact the non-respondents it would be hard to know.

Another important issue related to the sample size was that this study required a minimum of 650 participants for the 65 variables (10 participants per variable based on discussions with my supervisors). However, this number was not achieved and in hindsight the number of variables made this number of participants impractical. In addition, the huge number of variables resulted in a huge number of correlations being performed by the exploratory Principal Component Analysis. Therefore, the likelihood of getting some high (or low) correlations by chance is that much higher, moreover, this study may have been prone to a Type I error (false positive). Therefore, the results should be taken as exploratory and provisional, to be confirmed by future replications.

The design of the questionnaire may have influenced the uptake of the research (Dillman, Sinclair & Clark, 1993, cited in Dillman, 2000, 2009) and may have also led to measurement error (Dillman, 2000, 2009) such as participants not reading questions properly, having their answers influenced by things extraneous to the actual question, such as colour and format. In light of this, the guidelines outlined by Oppenheim (1992) and Dillman (2000, 2009) were followed. It is believed that the questionnaire was easy to follow with a consistent layout throughout: was attractive with good use of visual elements to enhance the written; interesting and salient to the participants; had good face validity; incorporated a good balance of positive and negative phrased statements; a good balance of attitude statements, factorial questions, multiple choice questions and qualitative questions; the questionnaire was simple, concrete, technically accurate,

avoided confusing wording such as double negatives; filter questions were used so as not to waste responders time, an ethical consideration and finally; placing particular questions at key points so as to enhance the flow and grouping questions that were to be viewed as such, thus a holistic approach was taken that together created cohesion (Dillman, 2000, 2009). This hopefully decreased perceived cost, increased reward and increased trust for the questionnaire and research as perceived by the potential respondent (Dillman, 2009); it should have also reduced the possibility of error. It is believed that this professional presentation began with the first statement of introduction to the final statement of thanks. However, the questionnaire may have seemed daunting due to its size and anticipated time to complete, thus putting some respondents off, creating frustration and therefore a potential bias (Dillman, 2000).

Finally, the dates of the emails may have also reduced the response rates. The dates were generally over the holiday periods thus respondents may have been on holiday.

The errors explored above may have accounted for some of the shortcomings within this study. However, another source of error is based on the assumption that the researcher made about the participants' abilities to retrospectively reflect on their work with three client groups and generalise those reflections.

8.6.4. Defining the Groups

As explored within the literature review, there may be fundamental or essential aspects of these populations that can be agreed upon, but still, these are heterogeneous populations and social processes and constructions can fundamentally influence how these characteristics are manifest, experienced and reported by others. For example, different individuals with AS often manifest the core diagnostic characteristics in very different ways, they may have different developmental trajectories, psychosocial circumstances, different strengths and protective factors, there may be other disabilities or difficulties including different co-morbid psychopathology and other co-morbid concerns and these differences can be experienced and interpreted differently according to the physically and social context including an environment that is accepting of difference and enables through cueing skills to one that pathologises and disables. Therefore, it would have been challenging for the respondents to think of a "typical experience" as defined in the introduction of the questionnaire. Their opinion may have been influenced, for example, by a recent particularly rewarding or challenging session with a client; this is an issue of recall bias (Bardone-Cone, Wonderlich, Frost, Bulik, Mitchell, Uppala & Simonich, 2007). However, it is hoped that

the high degree of reflexivity that often characterises therapists will enable them to acknowledge this recency effect and still generate a “typical” client in their minds. Furthermore, it is hoped that this level of reflexivity will enable them to unpick what is common in all their experiences with clients with AS despite potentially over shadowing co-morbidity such as mental health problems. However, a more fundamental criticism related to this area of exploration is with regard how the therapists’ values and cultural backgrounds may have influenced their social construction of AS, as this was not a critical realism study this level of exploration was absent. However, at worst this study could be viewed as a measure of social prejudice with regard working psychotherapeutically with people with AS therefore even if therapists are not “accurately” recalling their sessions with their clients with AS the results may reflect a belief constructed from many sources including their sessions with people with AS and broader social influences including the media; these sources are not viewed as bias’s but viewed as very important in terms of defining in some way the explanatory matrix, to use critical realism terminology, although explanations are lacking.

The other area of potential difficulty is that the respondents might have been reflecting on experiences of working as a therapist per se, with all client groups, or those that are complex, rather than specifically AS. However, the therapists in this study produced significantly different ratings of the quality of supervision between the groups, suggesting they were reflecting on the quality of supervision differently for each group. Furthermore, the qualitative data in the form of comments made by the therapists about their experiences of working with people with AS within the questionnaire mirror the literature review on AS, this correspondence or convergence of multiple sources of information, known as *triangulation,* suggests they are reflecting on different groups (Madill, Jordan & Shirley, 2000).

The importance of the reflexivity of the therapist has been highlighted. In the same respect, the researchers’ capacity to reflect was also important in this study.

8.6.5. Reflexivity

The author’s background, experience, knowledge, beliefs, attitudes and behaviour may have influenced the particular approach taken, the ways in which the interview sample was selected, interviewed, the attitudes that the therapists formed and subsequently elicited, the coding of the transcripts and how the questionnaire was created and the data analysed (Oliver, 2008).

The social context can influence attitude formation, therefore when it comes to measurement, the act of eliciting and recording in itself can be viewed as influential in the construction of attitudes. The intention of this study was to reveal the attitudes that therapists' share about providing therapy to people with AS. However, it is acknowledged that one social influence might be how the researcher interacts with the participants. It is acknowledged that the author has a background in therapy with people with AS and therefore brings a number of preconceptions and potential dogma.

With regard the interviews, it is possible, despite the precautions taken such as using a non-directive approach (Morton et al, 1990), that the interviews where guided towards areas that were felt to the author as important and salient rather than allowing free reign. For example, even the minimal encouragers (Mearns & Thorne, 1988) such as "mmmhmm…" (Robson, 2002) or "can you say more about that?" may have empathised particular points, points important to the author.

The relationship between the author and the interviewees may have also influenced attitudes (Robson, 2002; Morton-Williams, 1993). The interviewees may not have been as honest as possible, due to the relationship the researcher had with the participants or the implicit imbalance of power that can exist within such an encounter (Robson, 2002), including social desirability (Dillman, 2000). Despite this, it is believed that the participants provided an honest and accurate reflection of their views of therapy with clients with AS.

As already argued, the choices of methods from within the scientific realist paradigm do not lend themselves to the depth of analysis that is required from the critical realism paradigm. Within the original epistemology the author chose methods and procedures to minimise researcher bias and contamination. However, the author now argues that the researcher's position should not be viewed as another source of bias that needs to be controlled for but instead made transparent as this position inevitably guides the research frame and process. The critical realism paradigm accepts that the researcher interprets and constructs, alongside the participants, but these constructs do not necessarily intertwine with the participants in the moment. Whilst the author believes that intertwining between the researcher and the researched can exist, the two can be distinguished. However, the interplay between the researcher and researched was not made transparent within this study due, for one, to the choice of methods. A discourse analysis of the interviews, for example, instead of the content analysis may have led to

a more complete and satisfying account and enabled a richer reflexivity section within the discussion.

Despite the original epistemology and the limitations of the methods employed, the author did acknowledge the possible influence of the researcher on the researched and particular procedures were followed and precautions taken. The researcher did a number of things from the outset in order to deal with the potential concerns highlighted. It was necessary for the author to be aware and explicit about the processes involved in the research and the possible influences on the research including the researchers desires, thoughts and feelings, as well how the authors behaviours may have influenced the respondents and the interpretations of the data (Oppenheim, 1992). In a general sense it was very useful throughout the research to reflect on these beliefs and explore them in order that they did not negatively influence or contaminate the research and that any possible influences are made transparent, the intention was to try and separate out the malign from the benign influence of the researcher (Sayer, 2000). In this regard, the use of a personal journal was helpful throughout this process as was reflecting with a number of supervisors both clinical and academic.

8.7. Conclusion

Using a mixed design within the scientist realist paradigm, therapists' attitudes to working psychotherapeutically with clients with AS were explored. Following preliminary discussions with colleagues, interviews with five trainee psychologists and completed questionnaires from 129 therapists, a number of areas were revealed as potentially important to psychotherapists working with people with AS. These areas were the quality of supervision, therapist satisfaction, the quality of the working alliance, therapist knowledge and experience, the model used and co-morbid psychopathology and other co-morbid concerns.

Following correlational analysis, the quality of supervision, the amount of therapist knowledge and experience as well as the quality of the working alliance appeared to be significantly positively correlated with therapist satisfaction. The use of cognitive behavioural therapy did not correlate with either therapist satisfaction or the quality of the working alliance. In terms of the type of co-morbid concerns that the therapists observed in their clients with AS, the results appeared to support the limited research and literature on this topic.

Overall the sample in this study viewed clients with AS satisfying to work with despite these clients being viewed as not necessarily fulfilling a number of therapist preferences as described within the literature and also based on the views of the therapists established through the qualitative analysis of both the interviews and the questionnaire. It was postulated that the high ratings of overall satisfaction when working with people with AS may be due to the relative positive ratings on the factors: therapist knowledge, the quality of supervision and the quality of the working alliance. It was proposed that the high ratings of satisfaction may also be due to factors over and above these dimensions such as therapist characteristics and the wider social context which may view people with AS positively. In relation to therapist characteristics the author focused on the therapist's capacity to support the client with AS to use their skills through an enabling environment and therapeutic approach.

In order to increase the confidence in the ratings of therapists and to help insure that therapist ratings were in relation to working with people with AS and did not merely reflect providing therapy per se or to providing therapy to complex groups per se, comparison groups were used comparing two of the factors: therapist satisfaction and the quality of supervision. The comparison groups were clients with borderline personality disorder and clients with depression. It was found that there was a significant difference comparing therapist ratings of the quality of supervision suggesting that therapist ratings might be valid and not an artefact of reflecting on therapy per se or complex groups per se.

A number of criticisms were identified within this study with regard the epistemology, the methods of enquiry, the questionnaire as a method and the layout, the interview and questionnaire data analysis and with the main assumption of this study, namely, the ability of therapists to reliably reflect on their experiences of three distinct client groups.

The results illuminate some interesting findings, albeit partial explanations, about therapists experiences and attitudes to working psychotherapeutically with people with AS. The author believes that the overall message of this thesis goes some way in challenging the dominant "medical" discourse on AS and may help to erode some of the myths and prejudices with regard working psychotherapeutically with people with AS that may leave some people with AS at a loss when it comes to accessing psychological therapies. This study may also go some way in encouraging therapists to work with this population as it provides a positive image and it is acknowledged that

"…positive expectations, faith in the therapy as a practice and a belief in (allegiance to) the approach and methods utilized" is important, particularly for a positive outcome to therapy (Bertolino et al, 2011). It is hoped that the findings in this study leads to further research and helps to begin to dispel the "mystique" surrounding psychotherapeutic work with people with AS which can lead to deskilling in many clinicians (Hare & Flood, 2001). It is hoped this study helps to build on the growing positive image of psychotherapeutic work with people with AS.

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10. Appendix

Appendix 1. The Pilot Questionnaire

Thank you very much for agreeing to complete my questionnaire. It may be helpful to provide you with a little background information first.

My name is Matty Chalk and I am currently doing my Doctorate in Counselling Psychology. My research is looking at therapists' experiences of working with people with Asperger Syndrome in comparison to working with other populations.

The information in this questionnaire is anonymous. This means that the information you provide cannot be traced back to you. This is important as your honesty is vital for the results to represent a true picture of what therapists' attitudes are when working with those with a diagnosis of Asperger Syndrome.

By completing the questionnaire you are consenting for the information you provide to be used within my research and not to be circulated to any third party. Your participation in this research is voluntary therefore if you choose not to complete the questionnaire then that is fine.

I am happy to share with you any information about the research at any time or the findings when it is finished. You can indicate whether you would like this by emailing me within a separate email in order to retain your anonymity.

CONSENT FORM

Name of Researcher: Matty Chalk

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I agree to take part in the above study. ☐

Throughout this questionnaire I ask you to refer to your work with clients who have Asperger Syndrome (**AS**), borderline personality disorder (**BPD**) or to those without these conditions who just have depression (**depression**). **If you have not worked with any of these populations that is fine, please just leave those parts of the questionnaire blank.**

Please think about the therapy **YOU** have and are currently providing to those with **AS**, **BPD** and to those without these conditions who have depression (**depression**). When completing this questionnaire please think of a **TYPICAL** experience and not the best, worst or most recent experience. These must be **YOUR** experiences of providing therapy.

Please read each statement carefully and indicate your agreement with that statement by placing the corresponding number in the appropriate box indicating whether you:

STRONLY AGREE= 1 AGREE= 2 UNCERTAIN/UNSURE= 3 DISAGREE= 4 STRONGLY DISAGREE= 5

If you have not worked with one of these groups then just leave that column of boxes blank.

I have found that when providing therapy to people with Asperger Syndrome, Borderline Personality Disorder or to those without these conditions who have depression:

	AS	**BPD**	D
These clients beliefs are often extreme			
These clients beliefs are usually well balanced			
These clients thoughts are often rigid			
These clients thoughts are often flexible			
I have often thought that working with this client group is right for me			
I have often thought that working with this client group is not right for me			
Generally these clients appreciate me			
Generally these clients do not appreciate me			
Progress in therapy is generally straight forward			
Progress in therapy is often difficult			
Building a relationship with these clients is usually straight forward			
It is often difficult to build a relationship with these clients			
These clients normally remember things to work on in session			
These clients often do not remember things to work on in session			
Changes often occur quickly in these clients			
Changes usually occur very slowly in these clients			
These clients often rigidly follow themes in therapy			
Often in therapy these clients follow themes with flexibility			
Generally I can help with most of these clients problems			
These clients often have more problems than I am able to help with			
Generally it is clear that these clients care about me			
It is often clear that these clients do not care about me			
I often get adequate feedback from these clients			
These clients often do not give enough feedback			

It is straight forward to gauge what is going on for these clients			
It is often hard to gauge what is going on for these clients			
I generally work more from intuition than from an evidence base			
I often work more from an evidence base than from intuition			
The relationship with these clients is generally reciprocal			
The relationship with these clients is often very one sided			
Exploring emotions is often straight forward for these clients			
Exploring emotions is often difficult for these clients			
Exploring thoughts is often straight forward for these clients			
Exploring thoughts is often difficult for these clients			
Making connections between ideas is often straight forward for these clients			
Making connections between ideas is generally difficult for these clients			
I often do not need to break things down into simple parts for these clients			
I often need to break things down into simple chunks for these clients			
Generally my supervisor gives me the support I need with these clients			
Generally my supervisor does not give me the support I need with these clients			
The techniques/models I use are often effective with these clients			
The model/techniques I use are often not effective with these clients			
I am usually confident in my ability to help these clients			
I often feel confident in what I am doing with these clients			
These clients are not usually perfectionistic			
These clients are usually perfectionistic			
These clients often keep focus in therapy			
These clients often lose focus in therapy			
These clients usually need a lot of time to process information			
Generally not much time is required in order for these clients to process information			

I often need to regularly check that what I have said is understood by these clients			
Generally I do not need to regularly check with these clients that what I have said is unde			
It is not important to be directive with these clients			
It is important to be directive with these clients			
These clients often do not remember important things from one session to the next			
These clients usually remember things of importance from one session to the next			
I am often able to give answers to the questions these clients bring			
These clients often want answers to questions which I am often unable to give them			
These clients are normally grateful for what I am trying to do			
These clients are generally not very grateful with what I am trying to do			
Supervision is usually not very helpful in my work with these clients			
Supervision is often very helpful in my work with these clients			
There are usually many obstacles to change in these clients			
Change is usually straight forward for these clients			
Sessions are usually not repetitive with these clients			
Usually sessions are very repetitive with these clients			
Generally these clients can not easily work with broad concepts			
These clients often find working with broad concepts straight forward			
Generally it can be difficult to make a connection with these clients			
Overall making a connection with these clients is straight forward			
I often feel like I do not know enough when working with these clients			
I often feel that I know enough when working with these clients			
Working with process issues is usually straight forward for these clients			
Process issues are often difficult for these clients to work on			
It is generally difficult to form a working alliance with these clients			
Forming a working alliance is generally straight forward with these clients			

Generally these clients are able to deal with complex issues in session			
Therapy usually has to be very simplistic for these clients			
A counsellor is often just what these clients need			
These clients problems could often be better helped by someone other than a counsellor			
Providing therapy to these clients is often much more trial and error than based on theory			
I normally work much more from theory than from trial and error			
These clients are often clear about the goals we are working on together			
These clients are often not clear about the goals we are working on together			
These clients often lack the necessary insight			
These clients often have the necessary insight			
I often feel confused when providing therapy to these clients			
I do not often feel confused when providing therapy to these clients			
Generally I do not feel out of my depth whilst providing therapy to these clients			
I often feel out of my depth whilst providing therapy to these clients			
All in all it is easy to be hopeful with these clients			
Generally it is hard to be optimistic with these clients			
I often struggle to know what to do in therapy with these clients			
I often know what to do in therapy with these clients			
These clients usually do not know how to use therapy			
These clients usually know how to use therapy			
These clients often know why they are coming to therapy			
These clients often do not know why they are coming to therapy			
These clients are usually very happy to come to therapy			
Generally these clients are not very happy to come to therapy			
Therapy is often very interesting with these clients			
Therapy is usually not that interesting with these clients			

All in all I am satisfied with my work with this client group			
In general I do not like working with this client group			
In general I like the work with these clients			

Appendix 2. Invite Email

Please can you help?

My name is Matty Chalk and I am a doctorate psychology student from City University.

I have an interest in Asperger Syndrome and psychotherapy. I have designed a questionnaire and need people who have provided therapy, however limited, to people with Asperger Syndrome AND also to people who have borderline personality disorder AND also to people who have depression. If you are happy and willing to complete this questionnaire then I will send you some vouchers. It's only a small token but a way I can say thank you.

It is very easy to complete as it is on the internet and it's completely anonymous, your details are not recorded only the data. Once you complete it I will send you the vouchers to the value of £2.

I hope you are able to at least have a look at the questionnaire before deciding.

The link to click on is:

http://www.staff.city.ac.uk/psychstudies/MC/

Thank you very much for your time. Please be reassured that I will not email you again if you do not reply.

Kind regards
Matty chalk

Appendix 3. Further Information

My research is an exploratory study investigating therapists' perceptions of providing therapy to those diagnosed with Asperger Syndrome. I am building on my MSc dissertation which proposed that those with a diagnosis of Asperger Syndrome (AS) may have a number of processing and memory differences that could lead to mental health problems and the seeking out of counselling. In my MSc I compared two groups: therapists working with AS and therapists working with non-AS. I also took data from the clients themselves. I found no significant difference when comparing clients' scores on the working alliance inventory but there was a significant difference between the two groups on the working alliance inventory when comparing therapist scores.

Using a questionnaire design I wish to now investigate further therapists' attitudes and perceptions of working with clients who have AS. I want to compare their perceptions of working with AS with their perceptions of working with a similar group (in terms of interpersonal difficulties) i.e. borderline personality disorder, but were there are differences in terms of e.g. amount of evidence based practice (e.g. DBT) and also their perceptions of working with clients with depression.

The dimensions of interest are:

- Quality of the Working Alliance
- Quality of supervision
- Whether therapy assumptions are met e.g. able to access thoughts, emotions, build report, adequate memory etc.
- Effectiveness of the technique's and model(s) used
- Therapist knowledge and experience
- 'depth' and 'complexity' of counselling sessions
- Satisfaction with working this group
- And many other dimensions taken from research and interviews with therapists.

I hope this is helpful.

Regards

Matty

Appendix 4. Final Questionnaire

Appendix 5. Diagnostic Criteria for Asperger's Disorder: Various Measures

Diagnostic Statistical Manual – IV- TR (American Psychiatric Association, 2000).

A. *Qualitative impairment in social interaction, as manifest by at least two of the following:*
   1. marked impairment in the use of multiple non-verbal behaviours such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
   2. failure to develop peer relationships appropriate to developmental level
   3. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest to other people)
   4. lack of social or emotional reciprocity

B. *Restricted repetitive and stereotyped patterns of behaviours, interests, and activities, as manifest by at least one of the following:*
   1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
   2. apparently inflexible adherence to specific, non-functional routines or rituals
   3. stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole body movements)
   4. persistent preoccupation with parts of objects

C. *The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.*

D. *There is no clinically significant general delay in language (e.g. single words used by age two years, communicative phrases used by age three years).*

E. *There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behaviours (other than in social interactions), and curiosity about the environment in childhood.*

F. *Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.*

International Classification of Diseases and Disorders (World Health Organisation, 1993).

1. *There is no clinically significant general delay in spoken or receptive language or cognitive development*

   Diagnosis requires that single words should have developed by 2 years of age or earlier and that communicative phrases be used by 3 years of age or earlier. Self-help skills, adaptive behaviours, and curiosity about the environment during the first three years should be at a level consistent with normal intellectual development. However, motor milestones may be somewhat delayed and motor clumsiness is usual (although not a necessary diagnostic feature). Isolated special skills, often related to abnormal preoccupation, are common, but not required for diagnosis.

2. *There are qualitative abnormalities in reciprocal social interactions (in at least two of the following areas):*
   a. failure adequately to use eye-to-eye gaze, facial expression, body posture and gesture to regulate social interaction
   b. failure to develop (in a manner appropriate to mental age, and despite ample opportunities) peer relationships that involve a mutual sharing of interests, activities and emotions

c. lack of social-emotional reciprocity as shown by an impaired or deviant response to other people's emotions, or lack of modulation of behaviour according to social context; or a weak integration of social, emotional and communicative behaviours

3. *The individual exhibits an unusually intense, circumscribed interest or restricted, repetitive and stereotyped patterns of behaviour, interests and activities (in at least two of the following):*
    a. an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that are abnormal in their intensity and circumscribed nature though not in the content or focus
    b. apparent compulsive adherence to specific, non-functional routines or rituals
    c. stereotyped and repetitive motor mannerisms that involve either hand-or finger-flapping or twisting, or complex whole body movements
    d. preoccupation with part-objects or non-functional elements of play materials (such as their odour, the feel of their surface, or the noise or vibration that they generate).

Gillberg (1991).

1. *Social Impairment (extreme egocentricity) (at least two of the following):*
    - difficulties interacting with peers
    - indifference to peer contacts
    - difficulties interpreting social cues
    - socially and emotionally inappropriate behaviour
2. *Narrow interest (at least one of the following):*
    - exclusion of other activities
    - repetitive adherence
    - more rote than meaning
3. *Compulsive need for introducing routines and interests (at least one of the following):*
    - which affect the individual' every aspect of everyday life
    - which affect others
4. *Speech and language peculiarities (at least three of the following):*
    - delayed speech development
    - superficially perfect expressive language
    - formal pedantic language
    - odd prosody, peculiar voice characteristics
    - impairment of comprehension including misinterpretations of literal/implied meanings.
5. *Non-verbal communication problems (at least one of the following):*
    - limited use of gestures
    - clumsy/gauche body language
    - limited facial expression
    - inappropriate facial expression
    - peculiar, stiff gaze
6. *Motor clumsiness:*
    - Poor performance in neurodevelopment test

Appendix 6. Diagnostic Criteria for Borderline Personality Disorder.

Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000).

A pervasive pattern of instability of interpersonal relationships, self-image, and effects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behaviour covered in Criteria 5.
2) a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation
3) identity disturbance: markedly and persistently unstable self-image or sense of self
4) impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behaviour covered in Criteria 5.
5) recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6) affective instability due to marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7) chronic feelings of emptiness
8) inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays or temper, constant anger, recurrent physical fights)
9) transient, stress-related paranoid ideation or severe dissociation symptoms

Appendix 7. Diagnostic Criteria for Major Depressive Episode.

Diagnostic Statistical Manual IV- TR (American Psychiatric Association, 2000).

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
   Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

   i. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observations made by others (e.g. appears tearful).
      Note: In children and adolescents, can be irritable mood.
   ii. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
   iii. significant weight loss when not dieting or weight gain (e.g. a change or more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
      Note: In children, consider failure to make expected weight gains.
   iv. insomnia or hypersomnia nearly every day
   v. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
   vi. fatigue or loss of energy nearly every day
   vii. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   viii. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
   ix. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode (see p.171).
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
E. The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, psychomotor retardation.

Appendix 8. The Salient Utterances from the Interviews.

Person number 1.

Background

Four years working in a variety of settings including GP surgery and a college. Worked with clients who had anxiety, depression, psychosis and enduring mental health problems. Worked with two adults with AS in a specialist service.

Salient Utterances

"I find people with Asperger's very concrete…whereas if you take the students that I work with at university they are very abstract…so it is a very different level of conversation."

"…one of them [a person with Asperger Syndrome] I felt like it was possible to have an actual relationship with, there was a connection and the other one I didn't feel any connection to."

"So that impression was about difference, that is quite difficult to work with because you are not getting much feedback."

"Well I think that my overall concern was that one of the people that I was seeing perhaps counselling was not something that was the right choice for her and that she could actually engage with. That was my concern. And that the client actually said at the end you know she didn't really want to come to counselling to start with and so what she did was the end was she actually said I do not want to continue with this."

"She doesn't initiate things."

"There's never, I mean again when I think back to some of the clients that I've had, some of the clients would say how are you today? How was your holiday? I have had clients buy me flowers. I couldn't imagine that ever happening. Bereavement, often people would buy you thinks and be terribly grateful and find you terribly supportive. Whereas with the Asperger's that is definitely not the same."

"…it is a lack of emotion for the other person"

“Imaging what something could be like for the other’s point of view which I understand is part of the Asperger’s and you can really see that.”

“I kind of wonder whether Asperger is right for me a it feels much more…I have to be much more directive I think essentially that is my feeling. That I’ve got to move myself from my preferred kind of way of working…actually its been quite kind of psycho-educational directive.”

“I actually prefer working systemically with individuals which really isn’t possible with Asperger’s…so I …work within the cognitive behavioural therapy framework but I find it very much like a straight jacket.”

“…hypothetical questions…don’t…work.”

“I try to use Socratic questions, if it not going anywhere I might ask them sort of leading questions and so I would often do things like, do you think it might be this? Do you think it might be that ? So do it that way, I mean haven’t found the Socratic questioning has been particularly successful.”

“I dot use broad questions.”

“I might simply thing for them. Yes I mean ye definitely in comparison to working with students. And certainly of the clients I work with at the GP surgery because it’s their thought prices that’ different, they are to make connections that I don’t see with people with Asperger’s making.”

“So I suppose it’s because its about your idea about counselling, what is therapy and what is counselling. And I suppose it doesn’t fit with what my idea of counselling and therapy is. It feels like I am like a teacher…so it leaves me feeling that I am put into a teacher role then I begin to question well why don’t they just get a teacher then who would teach them friendship skills or whatever it might be”

“…I write everything down…everything is done very visually.”

“…there is no abstractness.”

"…they don't find it so easy to connect with me in terms of having a reciprocal relationship."

"…the client didn't really want to come to therapy…"

"…you have to slow things down because the actual processing takes longer…so that is a difference."

"My level of satisfaction is higher with the non-Asperger's group because you actually see changes and that's what make it exciting in therapy, seeing changes…so it is less satisfying if my criteria is about change."

"…its hard to be hopeful with Asperger's."

"…the dissatisfaction is that it's more a system level. It's not about the individual, it' about the system…They are part of the system that in which they are not recognised and they're disempowered and all those things. It's nothing special about that person, it's systemic."

Person Number 2.

Background

Four years working with adult, children and adolescent clients with learning disability and general mental health problems. Experience of working with one adult with AS.

Salient Utterances

"There were many differences…I guess in the alliance and the communication…she was relating to me in a different way from my other clients…the progress rate was different…the perception was different and I guess transferential issues were different as well."

"…used cognitive behavioural therapy in the beginning but I saw a resistance in terms of the exercises…but later I used some dynamic concepts."

"…I felt that cognitive behavioural therapy for that client was very directive. And she could not cope with it because she was colluding with it a lot and was like crashing onto her like a wall…"

"She was saying yeah I understand what you are saying, she wouldn't relate back to herself…"

"…obsessed with things or why she was like this with things and she couldn't really get an explanation."

"…she was not sure what she was coming."

"…the progress was very slow…there was not massive changes…"

"I had to offer many explanations because at some point she didn't have the insight I mean she was very intelligent, he could understand but on the social interaction of things she didn't have an explicit understanding so I had to be more explicit as to what was happening."

“Other clients can relate more to me or much much quicker so the trust, you need quite a lot of time to be established and quite a lot of time to understand what we do here. What we are doing here, what we do in counselling.”

“…she didn’t know what I meant with certain things or she didn’t know what I mean in terms of how I relate to her, it was not very clear. With other clients even though the resistance was quite high they could pick up what was happening between us but the process of transference was very difficult with her.”

“She didn’t have any intuitions.”

“…I was adapting the model for the needs of the client, for the need of her…it can happen for any client but with this specific one I know that I couldn’t get far with a lot of interpretation because she wasn’t going to be able think abstractly about things…my interpretations was more simple in a sense.”

“Very challenging relationship.”

“…connection I would say it was very challenging…And I think there was a connection there. Not the same quite like the other clients because there was something missing for her…”

“…very egocentric…she didn’t care about my satisfaction…she was not aware of how I felt.”

“…I was trying to relate and compare things with other clients but obviously you cannot compare with someone with such a syndrome because they are different, their level of connectivity differs from others…other people who don’t have Asperger’s Syndrome obviously there is a far more easier connection. A connection which involves both parts, both the therapist and the client. ”

“I was getting angry…why that was happening and why there is not connectiveness with her like the other people. But if you don’t experience that and you don’t go after that you cannot really understand what I going on…I was really wondering what the problem was, what was so difficult…”

"…she would say yes but wouldn't see any change…"

"I guess I was alone in that process because my supervisor didn't help me…"

"I felt quite ignorant. How shall I put it in deep waters in a sense. What style to use, what style not to use and about tapping into intuition…"

"I did feel overwhelmed, I did feel unsure."

"We were working in a collaborative manner."

"She didn't have any feelings of being fond of me or liking me…But she did appreciate our work but that is as far as it could go."

"I think it was more satisfying [working with other non-Asperger's clients]. It was more satisfying because you could see emotionally, you could see much more progress."

Person Number 3

Background

15 years of "informal" counselling with the church and then trained as a psychologist 2.5 years ago; about 300 hours of counselling experience. Experience of bereavement, anxiety, depression psychosis, drug and alcohol and enduring mental health problems. Worked for about four months with two adult clients with AS.

Salient Utterances

"The one with the higher IQ is much less compliant…You know respect for authority and much more will to do things just because you say o and it has been to his therapeutic advantage."

"…the reward of therapy [for the therapist] with non-Asperger's client which is this obvious rapport."

"…there is virtually no eye contact and smiling is quite minimal. In the case of the lower IQ client there is virtually no shared humour…"

"…no doubt that working with Asperger's clients helps you to appreciate the things that are less or missing with the Asperger's clients."

"He is quite resistant to suggestions…"

"…there is a requirement that one is more directive otherwise you are going to be there, not just all day but all year you know."

"…they do not find it that easy to generalise."

"…in both cases its not their idea to come to therapy and one case is at best cynical and at worse extremely reluctant and in the other case, the low IQ case, he just kind of does what he is told really."

"…there is something about taking on a challenge [discussing working with AS)."

"…I am not sure that I feel a sense of vocation as it were to this population…[because of]…lack of familiarity."

"…the organisation provides external supervision which I of the highest confidence. It is the best supervision I have had. And so I do think that I am supported."

Person Number 4

Background

Four and half years working within a psychiatric inpatient unit and GP surgery with adult clients with learning disability and bereavement, depression and PTSD. Has worked with adult clients with borderline personality disorder and one adult client with AS.

Salient Utterances

"She presented in an extremely concrete way."

"She really had no conception, she used to get angry but she had no conception of the emotion of anger."

"She would recite exactly what had been said the week before, exactly, dates, times, who sais what and that took up a third of the session every week."

"Very rigid…very concrete……it left me feeling actually quite frustrated."

"…wasn't able to tolerate difference…And anything that wasn't how she perceived it to be."

"…really wasn't able to work with the unconscious, she had no concept of free association…It was quite a struggle working psychodynamically but I felt she could benefit from counselling."

"…I had to be more concrete, I had to be more directive than perhaps more hat I would normally have done."

"…I felt out of my depth…I certainly wasn't experienced in dealing, in working with someone lile this client."

"…I was having supervision here [work placement] but it wasn't, at the time, it wasn't really very structured, it was much more ad hoc. But I was getting supervision weekly at college…And again that had its difficulties because…there was no understanding of

actually working with LD and working with a very structured client like that…and I think that obviously had an impact."

"…she had felt it had really helped…Now in what way it helped I don't know. I really don't know."

"Yeh [in agreement to adapting the model], but I didn't know how I was adapting it. That's the trouble. I wasn't experienced enough at the time to actually know and I was just, it was very ad hoc. And I don't think it was very…professional…I was working purely on intuition…Not on any kind of theory base or anything because I dint have any theory to work with this client. I really didn't."

"But it was interesting. And I was fascinated...her recall, of certain dates and times. It was absolutely amazing."

"I can't say we were working with any focus or any goals."

"…she wanted answers. She needed to have answers, she needed structured answers. In order to hang on to something. And that wasn't something I was necessarily giving her…And I think that was perhaps an area of conflict."

Person Number 5.

Background

Two years counselling experience. One year within a specialist organisation using cognitive behavioural therapy. Worked in a research centre and also within secondary care working with anxiety, depression and panic disorder.

"…they find it very difficult to understand emotions and being in another person position…"

"And as hard as you try to explain and you, the biological, the physical, the emotional, sometimes it um, it's difficult."

"I have to be, go slowly…I have to have a lot of patience sometimes."

"…because they tend to forget."

"…you stop and you start to explain, for example to a 40 or 50 years old what are emotions and you can , you start by you know, showing them pictures of people who are happy and sad, you know, you know, you have to step back a bit and not start talking about thoughts and beliefs and core beliefs…and this in a way stops the process and make it slower."

"They have a different standard…They can be very perfectionistic."

"Get frustrated sometimes, but ah, sometimes I feel sorry to be honest…"

"So I told him we got another 10 sessions left and he got, he was panicking…How will I cope, what will I do so, as you say, its like I believe it has become a routine for him seeing counsellors…[comparing to other nonAS clients]…I learned those things and now I'm free to go."

"…because they don't have people to talk with, they don't have any other support, they will come with other issues that you wouldn't expect from another person that would come."

“I got a great supervisor, It think I need to mention that.”

“I’ve been enjoying it [referring to work with AS].”

Appendix 9. Salient Utterances from the Interviews Placed within the Tentative Categories

Tentative Category	Participant Utterance
Working Alliance	• "Very challenging relationship." • "I can't say we were working with any focus or any goals." • "…they don't find it so easy to connect with me in terms of having a reciprocal relationship." • "…connection I would say it was very challenging…And I think there was a connection there. Not the same quite like the other clients because there was something missing for her…" • "…the client didn't really want to come to therapy…" • "Other clients can relate more to me or much much quicker so the trust, you need quite a lot of time to be established and quite a lot of time to understand what we do here. What we are doing here, what we do in counselling." • "…she didn't know what I meant with certain things or she didn't know what I mean in terms of how I relate to her, it was not very clear. With other clients even though the resistance was quite high they could pick up what was happening between us but the process of transference was very difficult with her." • "…very egocentric…she didn't care about my satisfaction…she was not aware of how I felt." • "She didn't have any feelings of being fond of me or liking me…But she did appreciate our work but that is as far as it could go."
Therapist Preferences	• "I kind of wonder whether Asperger is right for me as it feels much more…I have to be much more directive I think essentially that is my feeling. That I've got to move myself from my preferred kind of way of working…" • "I actually prefer working systemically with individuals which really isn't possible with Asperger's…so I…work within the cognitive behavioural therapy framework but I find it very much like a straightjacket." • "So I suppose it's because it's about your idea about counselling,

	what is therapy and what is counselling? And I suppose it doesn't fit with what my idea of counselling and therapy is. It feels like I am like a teacher…" • "I find people with Asperger's very concrete…whereas if you take the students that I work with at university they are very abstract…so it is a very different level of conversation." • "…hypothetical questions…don't…work." • "He is quite resistant to suggestions…" • "…there is no abstractness." • "I had to offer many explanations because at some point she didn't have the insight I mean she was very intelligent, she could understand but on the social interaction of things she didn't have an explicit understanding so I had to be more explicit as to what was happening." • "She didn't have any intuitions." • "…they do not find it that easy to generalise." • "…they find it very difficult to understand emotions…" • "She really had no conception, she used to get angry but she had no conception of the emotion of anger." • "…because they tend to forget." • "…she wanted answers. She needed to have answers, she needed structured answers. In order to hang on to something. And that wasn't something I was necessarily giving her…And I think that was perhaps an area of conflict." • "Very rigid…very concrete…it left me feeling actually quite frustrated." • "…the progress was very slow…there was not massive changes…" • "I might simplify things for them..." • "…you have to slow things down because the actual processing takes longer…" • "She would recite exactly what had been said the week before, exact dates, times, who said what and that took up a third of the session every week." • "…you have to step back a bit and not start talking about

	thoughts and beliefs and core beliefs…and this in a way stops the process and makes it slower."
Therapist Satisfaction	• "… when I think back to some of the clients that I've had, some of the clients would say how are you today? How was your holiday? I have had clients buy me flowers. I couldn't imagine that ever happening. Bereavement, often people would buy you things and be terribly grateful and find you terribly supportive. Whereas with the Asperger's that is definitely not the same." • "My level of satisfaction is higher with the non-Asperger's group because you actually see changes and that's what makes it exciting in therapy, seeing changes…" • "…it's hard to be hopeful with Asperger's." • "But it was interesting. And I was fascinated...her recall, of certain dates and times. It was absolutely amazing." • "…I am not sure that I feel a sense of vocation as it were to this population…"
The Quality of Supervision	• "I guess I was alone in that process because my supervisor didn't help me…" • "…I was having supervision here [work placement] but it wasn't, at the time, it wasn't really very structured, it was much more ad hoc. But I was getting supervision weekly at college…And again that had its difficulties…there was no understanding of actually working with a very structured client like that…and I think that obviously had an impact."
Therapist Knowledge	• "I felt quite ignorant...What style to use, what style not to use and about tapping into intuition…" • "I did feel overwhelmed, I did feel unsure." • "…I felt out of my depth…I certainly wasn't experienced in dealing, in working with someone like this client." • "…I was working purely on intuition…Not on any kind of theory base or anything because I didn't have any theory to work with this client. I really didn't."

Appendix 10. Examples of Questionnaire Items Transformed from Utterances Taken from the Interviews

Utterances taken from the interview	Transformed into an attitude item
"…the client didn't really want to come to therapy…"	These clients are usually happy to come to therapy
"…she didn't have the insight…"	It is clear in therapy that these clients often lack the necessary insight
"…they find it very difficult to understand emotions…"	Exploring emotions is often difficult for these clients
"…because they tend to forget."	These clients often do not remember things to work on in session
"…I suppose it doesn't fit with what my idea of what counselling and therapy is. It feels like I am like a teacher…"	With these clients I feel more like a teacher than a counsellor
"I kind of wonder whether Asperger is right for me…"	I have often thought that working with this client group is not right for me
…it left me feeling actually quite frustrated."	I often feel frustrated when working with these clients
"…I felt out of my depth…"	I often feel out of my depth whilst providing therapy to these clients
"…they don't find it so easy to connect with me in terms of having a reciprocal relationship."	The relationship with these clients is generally reciprocal

Appendix 11. Examples of Questionnaire Items Transformed from the Literature

Taken from the literature	Transformed into an attitude item
"The person with Asperger Syndrome who has emotional problems often presents with the same forms of cognitive distortions which are involved in maintaining anxiety and depression in people without autistic conditions. Examples of these include…polarised thinking…" (Hare, 1997b, p.5).	These clients beliefs are often polarised
*"…the psychologically minded client might be highly preferred" (*Teasdale and Hill, 2004, p.63).	These clients are psychologically minded
"My client and I are working towards mutually agreed upon goals" (Busseri & Tyler, 2003, p.1).	Generally these client and I are able to work towards mutually agreed goals
"1:1 work with people with Asperger Syndrome can be very difficult as many of our unconscious expectations about relationships…are often violated…examples include…empathy may not be reciprocated…" (Hare, 1997b, p.8).	Empathy is often not reciprocated
"Sometimes the person with ASD may act omnipotent and arrogant…" (Paxton and Estay, 2007, p.91).	These clients can often be arrogant and omnipotent

Appendix 12. Attitude Items within the Final Questionnaire by Tentative Category

Working Alliance

Item	Source
These clients and I usually agree on what is important to work on in therapy	Busseri and Tyler (2003)
Generally these clients and I can build a good understanding together of the kind of changes that would be good for my client	Busseri and Tyler (2003)
These clients often believe that the way we have worked with their problem(s) was correct	Busseri and Tyler (2003)
These clients are usually happy to come to therapy	Interviews
Generally these clients appreciate me	Interviews
It is generally difficult to form a working alliance with these clients	Interviews
These clients and I often do not agree about the steps to be taken to improve their situation	Busseri and Tyler (2003)
These clients and I often have different ideas of what my clients' real problems are	Busseri and Tyler (2003)
It is often difficult to build a rapport with these clients	Interviews
Generally these clients and I are able to work towards mutually agreed goals	Busseri and Tyler (2003)
It is often clear that these clients do not care about me	Interviews
These clients are normally grateful for what I am trying to do	Interviews
These clients and I often feel confident about the usefulness of the activity in therapy	Busseri and Tyler (2003)
I often appreciate this client group as people	Busseri and Tyler (2003)

Generally trust is mutually built	Busseri and Tyler (2003)

Therapist Preferences

Item	**Source**
These clients often do not know why they are coming to therapy	Interviews
Empathy is often not reciprocated	Hare (1997b)
These clients do not readily accept responsibility for change	Weiss and Lunsky (2010)
It is clear in therapy that these clients often have the necessary insight	Interviews and literature e.g. Teasdale and Hill (2004)
Generally it can be difficult to make a connection with these clients	Interviews
Forming a working alliance is generally straight forward with these clients	Interviews and literature e.g. Horvath and Symonds (1991)
The relationship with these clients is generally reciprocal	Interviews and literature e.g. American Psychiatric Association (2000)
These clients usually know how to use therapy	Interviews
These clients' thoughts are often flexible	Interviews and literature e.g. American Psychiatric Association (2000)
Progress in therapy is generally straight forward	Interviews
Sessions are usually not repetitive with these clients	Interviews and literature e.g. American Psychiatric Association (2000)
All in all it is easy to be hopeful with these clients	Busseri and Tyler (2003)
Working with process issues is usually straight forward for these clients	Interviews

It is often not the clients' idea to attend therapy	Interviews and Paxton & Estay (2007)
Often in therapy these clients follow themes with flexibility	Interviews and literature e.g. American Psychiatric Association (2000)
Exploring emotions is often difficult for these clients	Interviews and literature e.g. Frith (2004) and Baron-Cohen et al (1985)
Exploring thoughts is often straight forward for these clients	Interviews and literature e.g. Baron-Cohen et al (1985).
These clients often do not remember things to work on in session	Interviews and literature e.g. Bowler et al (2000, 2003)
It is straight forward to gauge what is going on for these clients	Interviews
These clients are psychologically minded	Interviews and Teasdale and Hill (2004
Generally these clients can not easily work with broad concepts	Interviews and literature e.g. Davis, et al (1977)
Making connections between ideas is often straight forward for these clients	Interviews and literature e.g. Davis, et al (1977)
Changes usually occur very slowly in these clients	Interviews
I often do not need to break things down into simple parts for these clients	Interviews
There are usually many obstacles to change in these clients	Interviews
Therapy usually has to be very simplistic for these clients	Interviews
Generally it is hard to be optimistic with these clients	Interviews
These clients are often perfectionistic	Interviews and Paxton and Estay (2007)

These clients' beliefs are often polarised	Interviews and literature e.g. Reaven and Hepburn (2003)
These clients often do not know why they are coming to therapy	Interviews

Therapist Satisfaction

Item	**Source**
I have often thought that working with this client group is not right for me	Interviews
Therapy is often very interesting with these clients	Interviews
All in all I am satisfied with my work with these clients	Beehr (2006)
In general, I do not like working with these clients	Beehr (2006)
In general, I like the work with these clients	Beehr (2006)
I often feel frustrated when working with these clients	Interviews
These clients can often be arrogant and omnipotent	Interviews and literature e.g. Paxton and Estay (2007) and Attwood (2004)
With these clients I feel more like a teacher than a counsellor	Interviews and Paxton and Estay (2007)

Therapist Knowledge

Item	**Source**
Generally I can help with most of these clients' problems	Interviews
The techniques/models I use are often effective with these clients	Interviews

I am usually confident in my ability to help these clients	Interviews
I often feel out of my depth whilst providing therapy to these clients	Interviews
I often know what to do in therapy with these clients	Interviews
I often feel confused when providing therapy to these clients	Interviews
I often feel like I do not know enough when working with these clients	Interviews
Providing therapy to these clients is often much more trial and error than based on theory	Interviews
I often struggle to know what to do in therapy with these clients	Interviews
These clients often want answers to questions which I am often unable to give them	Interviews

Quality of Supervision

Item	**Source**
Generally my supervisor gives me the support I need with these clients	Interviews and literature e.g. Butterworth and Woods (1999) and Pretorius (2006)
Generally my supervisor does not give me the support I need with these clients	Interviews and literature e.g. Butterworth and Woods (1999) and Pretorius (2006)
Supervision is usually not very helpful in my work with these clients	Interviews and literature e.g. Butterworth and Woods (1999) and Pretorius (2006)

Appendix 13. Wilcoxon Signed-Rank Post-Test to Establish Differences among the 3 Groups Based on the Factors: Supervision and Satisfaction

Ranks

		N	Mean Rank	Sum of Ranks
Satisfaction BPD – Satisfaction AS	Negative Ranks	53(a)	46.81	2481.00
	Positive Ranks	38(b)	44.87	1705.00
	Ties	38(c)		
	Total	129		
Satisfaction D – Satisfaction AS	Negative Ranks	40(d)	42.04	1681.50
	Positive Ranks	47(e)	45.67	2146.50
	Ties	42(f)		
	Total	129		
Satisfaction D – Satisfaction BPD	Negative Ranks	31(g)	39.19	1215.00
	Positive Ranks	52(h)	43.67	2271.00
	Ties	46(i)		
	Total	129		
Supervision BPD – Supervision AS	Negative Ranks	15(j)	23.80	357.00
	Positive Ranks	37(k)	27.59	1021.00
	Ties	77(l)		
	Total	129		
Supervision D – Supervision AS	Negative Ranks	18(m)	27.31	491.50
	Positive Ranks	46(n)	34.53	1588.50
	Ties	65(o)		
	Total	129		
Supervision D – Supervision BPD	Negative Ranks	21(p)	24.40	512.50
	Positive Ranks	31(q)	27.92	865.50
	Ties	77(r)		
	Total	129		

a. Satisfaction BPD < Satisfaction AS
b. Satisfaction BPD > Satisfaction AS
c. Satisfaction BPD = Satisfaction AS
d. Satisfaction D < Satisfaction AS
e. Satisfaction D > Satisfaction AS
f. Satisfaction D = Satisfaction AS
g. Satisfaction D < Satisfaction BPD
h. Satisfaction D > Satisfaction BPD
i. Satisfaction D = Satisfaction BPD
j. Supervision BPD < Supervision AS
k. Supervision BPD > Supervision AS
l. Supervision BPD = Supervision AS
m. Supervision D < Supervision AS
n. Supervision D > Supervision AS
o. Supervision D = Supervision AS
p. Supervision D < Supervision BPD
q. Supervision D > Supervision BPD
r. Supervision D = Supervision BPD

Section C: The Critical Literature Review

A critical literature review exploring and contrasting the multidimensional and unidimensional models and the possible implications with regard our understanding of Asperger Syndrome and interventions for co-morbid mental health problems in people with Asperger Syndrome.

> *"One of the most important distinctions between the efforts of the true masters of their craft and those of the perfectionistic person is that the striving of their group brings them solid satisfaction. They are happy with the results. Their efforts enhance their self esteem. They rejoice in their mastery. This is not true for the perfectionistic person. His striving is accompanied by the corrosive feeling "I am not good enough, I must do better"* (Missildine, 1963, p.25, cited in Frost & Marten, 1990).

It is the intention of this critical literature review to explore the construct of perfectionism and ascertain whether it adds anything to our understanding of Asperger Syndrome (AS). It is hoped that this exploration will help to guide clinicians when supporting people with AS who present with co-morbid mental health problems. The author will attempt to achieve these aims by reviewing two competing models of perfectionism and a variety of mental health problems where perfectionism has been implicated, as well as reviewing particular treatment protocols and assessing whether they could be applied to psychotherapeutic work with people with AS where perfectionism has been revealed.

11. The Construct of Perfectionism: Unidimentional and Multidimensional Models

Perfectionism has been implicated in a number of different psychiatric disorders such as anxiety disorders (e.g. Alden, Bieling, & Wallace, 1994; Frost & Steketee, 1997; Rheaume, Freeston, Dugas, Letarte, & Ladouceur, 1995; Rheaume, Freeston, Ladouceur, Bouchard, Gallant, Talbot, & Vallieres 2000) including obsessive compulsive disorder (e.g. Veale & Willson, 2005) as well as eating disorders (e.g. Bastiani, Rao, Weltzin & Kaye, 1995; Fairburn, Cooper, Doll & Welch 1999; Hewitt, Flett, Besser, Sherry & McGee, 2003; Shafran, Lee & Fairburn, 2004) and depression (e.g. Alden et al, 1994; Hewitt & Flett, 1991). Perfectionism has also been highlighted by some researchers and clinicians as a possible feature of people with AS (Hare, 2005; Paxton & Estay, 2007; Gillberg, 2002). Yet understanding perfectionism and how it is experienced and manifest in people with AS and its role in psychopathology is a complex and confusing task. The reason for this is because perfectionism has a rather loose definition (Tozzi, Aggen, Neale, Anderson, Mazzeo, Neale, & Bulik, 2004), there are competing models which attempt to define its structures and its relationship with AS is purely anecdotal and conjectural. The models that attempt to define and measure perfectionism can be divided by their belief in either a unidimensional or

multidimensional model of perfectionism which give rise to a different set of core features and treatment protocols. An exploration of these competing models may help to ascertain whether perfectionism might be a possible feature of some people with AS and the relationship perfectionism has with psychopathology.

The contemporary debate regarding the nature of perfectionism as either a unitary or multidimensional construct reflects its historical roots. Assertions can be split depending on which historical figure is used and what interpretations are taken. Horney (1950), within her generally unidimensional model, includes social expectations, as an influence to the perfectionistic "tyranny of the shoulds," thus making it look more like a multidimensional model. In 1958 English and English (cited in Bastiani et al, 1995) and then in 1965 Hollender described perfectionism as "…the practice of demanding of oneself or others a higher quality of performance than is required by the situation," thus also highlighting multi-dimensions to perfectionism i.e. self and other. Hollender (1965), Hamachek (1978), Burns (1980) and Pacht (1984) heavily focus on cognitions relating to self-direction such as unrealistic standards, selective attention to failure, dichotomous, all-or-nothing thinking and the belief that there is a perfect state to attain. Burns (1980) describe people with perfectionism as measuring their own worth entirely on the compulsive and unremitting accomplishment of impossible goals, which he argues leads to self-defeat. In keeping with these assertions Burns (1980) adapted the Dysfunctional Attitudes Scales (Weissman & Beck, 1978, cited in Burns, 1980) which is a measure of unitary perfectionism; however, interestingly he does also include motivational, cognitive and interpersonal factors to perfectionism in his general cognitive behavioural model, thus reflecting multi-dimensions.

By the early 1990's the balance was shifting towards one main model of perfectionism, that being the multidimensional perspective. In order to bring clarity to the debate on perfectionism, Frost, Marten, Lahart and Rosenblate (1990) and Hewitt and Flett (1991) present a multidimensional model which views perfectionism as pervasive and dynamic and one that implicates both inter and intrapersonal dimensions that can manifest in adaptive and maladaptive perfectionism in a number of areas of life. The multidimensional model of perfectionism led to the development of two of the most extensively used multidimensional perfectionism models (MPS, Bardone-Cone, Wonderlich, Frost, Bulik, Mitchell, Uppala & Simonich, 2007) developed by Frost, Marten, Lahart and Rosenblate (MPS-F, 1990) and Hewitt and Flett (MPS-H, 1991).

The measures developed by Frost et al (1990) incorporate the following characteristics:

- "Concern Over Mistakes," where mistakes lead to negative reactions such as feelings of failure and the fear that one will lose the respect of others following these mistakes.
- "Doubts about Actions," where one has doubt about the quality of ones' performance.
- "Personal Standards," which is where self-evaluation is measured by excessively high self-imposed standards.
- "Parental Expectations," which is the perception that ones' parents have high expectations.
- "Parental Criticism," which deals with perceptions of ones' parents being overly critical.

Hewitt and Flett's (1991) model is similar to Frost et al's (1990) in that it incorporates *self-orientated* perfectionism, which relates to stringent self-evaluation being measured by the attainment of perfection with self-imposed high standards. Similarly to the Frost et al's (1990) model, it also includes *socially-orientated* perfectionism where there are perceptions that others have unrealistically high expectations about them which these people stringently evaluate. Finally, Hewitt and Flett (1991) proposed a third dimension which Frost et al's (1990) model does not include; this is called *other-orientated* perfectionism, which is the belief that significant others are required to achieve the same excessively high standards as they are.

In support of their model there exists a wide range of evidence from mere theorising to research based on non-clinical and sub-clinical groups as well research on clinical populations; although this is limited in number. Their models have been helpful in understanding a range of mental health problems such as depression (Alden et al, 1994), social phobia (e.g. Juster, Heimberg, Frost, Holt, Mattia & Faccenda, 1996), obsessive compulsive disorder (e.g. Frost et al, 1990; Frith & Gross, 1992; Frost, Steketee, Cohn & Gries, 1994; Rheaume et al, 1995; Frost & Steketee, 1997; Juster et al, 1996) and eating disorders (Pratt et al, 2001, cited in Hewitt et al, 2003; Sherry, Hewitt, Besser, McGee & Flett's, 2003; Hewitt et al, 2003; Bardone-Cone et al, 2007; Fairburn et al, 1999; 2003; Dunkley, Blamkstein, Masheb & Grilo, 2006) as well understanding perfectionism when it is positive or adaptive within non-clinical groups (Frost & Henderson, 1991; Mor, Day, Flett & Hewitt, 1995; Frost et al, 1995).

However, despite some positive insights gained from this research there is difficulty in establishing causal inferences and extrapolation is limited due to some general methodological problems. For example, most of the research is cross-sectional (Bardone-Cone et al, 2007), is based on non-clinical groups, student or single gender populations, using self-reports or based on the use of "unnatural" laboratory settings. In addition to sampling and data collection biases within this research, the multidimensional model of perfectionism being tested appears so all-encompassing and complex that it lacks clarity and therefore it is hard to make extrapolations and extract themes that might be helpful to clinicians. These problems may be some of reasons why there appears to be mixed findings regarding the relationship each of the categories or dimensions have with each other within each of the two MPS's and the link with psychopathology. The multidimensional model of perfectionism contains so many dimensions that things can easily become confusing particularly as some of the dimensions are argued to be at best redundant and at worst measuring competing constructs depending on the research that is reviewed. For example, when analysing the *self-orientated* dimension of the MPS-H, this dimension has been associated with positive or adaptive skills such as academic achievements (Cox et al, 2002 cited in Kobori & Tanno, 2005), self-confidence (Frost & Henderson, 1991), self-control (Flett et al, 1991, cited in Kobori & Tanno, 2005) and social skills (Flett at al, 1996, cited in Kobori & Tanno, 2005) as well as negative or maladaptive aspects such as suicide ideation (Hewitt et al, 1991; Hewitt et al, 1997; Hamilton & Schweitzer, 2000, cited in Kobori & Tanno, 2005), depression (Alden et al, 1994) and eating disorders (e.g. Dunkley et al, 2006).

In relation to the multidimensional model of perfectionism and in particular the Frost et al's (1990) measure, Rheaume et al (1995) argues that after leaving out the *doubting* subscale for being merely a correlate to perfectionism and *personal standards* which does not distinguish between functional and maladaptive perfectionism, all that is left is *concern over mistakes*. Rheaume et al (1995) believe that this is basically what the two MPS's are measuring and would be inadequate as high perfectionism can manifest without high degrees of *concern over mistakes* therefore this would lead to some clients with perfectionism being missed and therefore data regarding correlations between the MPS and psychopathology would be misleading. They continue by stating that perfectionism is essentially self-referent (Freeston, 1994, cited in Rheaume et al, 1995) so the two out of three social-referent domains within the MPS-H are not essential in the classification of perfectionism, although they may be related. They

conclude that perfectionism should be conceptualised by a simple definition which could influence many different areas of one's life such as morality and appearance; this could include, but not solely deal with, *concerns over mistakes* (Rheaume et al, 1995). Similarly Rice, Lopez and Vergara (2005) argue that the development and interpersonal aspect of both the MPS's are

> *"…relational dimensions of perfectionism [and] are best conceptualised as causes or perhaps correlates of perfectionism, but not perfectionism per se. That is, perceptions that parents or others in one's social environment have (or had) high expectations for performance, are overtly or subtly critical, and are rarely pleased are consistent with conceptual (e.g. Flett et al, 2002; Hamachek, 1978; Sorotzin, 1998) as well as empirically based (Sober, 1998) arguments that place these relationship appraisal in a causal link with perfectionism or as a construct separate from perfectionistic expectations one has for oneself (Kawamura et al, 2002) as opposed to considering them essential features of perfectionism…" (p.582).*

This definition is consistent with Shafran et al's (2002, 2004) unidimensional model of perfectionism. Shafran et al (2002, 2004) argue that their 'leaner,' less complex and more pragmatic unidimentional model to perfectionism is better placed to increase our understanding and improve interventions with regard psychopathology where perfectionism is implicated. The last two decades, they argue, has seen little advances in both understanding and with regard interventions relating to psychiatric disorders because of the validity issues relating to the multidimensional models (Shafran et al, 2002). Their model has led to testable constructs of perfectionism that outlines specific developmental trajectories and mechanisms of maintenance, which has led to clear therapeutic protocols. The author believes that the unidimentional model of perfectionism can be more usefully applied to people with AS than the multidimensional model for the reasons outlined above that are not specific to AS including methodological problems. The unidimentional model will now be explored before ascertaining whether it adds anything to our understanding of AS and co-morbidity.

12. The Unidimentional Model of Perfectionism

In order to deal with the contentions that exist with regard the multidimensional models Shafran et al (2002) present a unidimensional model to perfectionism. Similarly to Rheaume et al's (1995) and Rice et al's (2005) arguments, Shafran et al (2001) argue

that the multidimensional models are overly complex and include dimensions that may relate to, but are not integral to the construct of perfectionism.

They accept that *self-orientated* perfectionism, *personal standards* and some items on the *concerns over mistakes* subscales may be close to assessing the construct of perfectionism but the other subscales and items just assess related constructs (Shafran et al, 2002). Furthermore, Shafran and Mansell (2001) were interested in the pursuit of understanding and treating mental illness where perfectionism is implicated therefore they argue that measuring functional and 'positive' perfectionism (Frost et al, 1993, cited in Shafran & Mansell, 2001) where striving leads to feelings of satisfaction (Terry-Short et al, 1995, cited in Shafran & Mansell, 2001) is not clinically relevant. They argue that clinical perfectionism occurs when there is an

> *"....overdependence of self-evaluation on the determined pursuit (and achievement) of self-imposed personally demanding standards of performance in at least one salient domain, despite the occurrence of adverse consequences…"* (Shafran et al, 2002, p.773).

Shafran et al (2002) state that the *high standards* are always in areas of personal significance and the *adverse outcomes* are often related to self-criticism, which is the area that Shafran et al (2002) argues differentiates clinical from adaptive perfectionism. They argue that clinical perfectionism is maintained by number of factors including self-criticism which maintains their negative view of themselves and thus the pursuit of goals, the cognitive distortions of dichotomous thinking (e.g. Greenberger & Padesky, 1995) and the filtering of positive experiences such as error free aspects of experience and the hypervigilance of negative aspects such as perceived or actual errors. Shafran et al (2002) believe this latter bias can include overt and/or covert checking behaviours such as replaying and scrutinising a social interaction which leads to rumination. Procrastination and avoidance (Burns, 1980; Frost et al, 1990) within the *salient domain* can also maintain the perfectionism as well as the dismissing of standards as insufficiently demanding if they are achieved and raising them accordingly (Shafran et al, 2002). They assert that when perfectionism overlaps with a co-morbid psychiatric condition it has a negative contributing influence, certainly the research suggests this. For example, within the eating disorder literature it was found that higher ratings of perfection as measured by the Eating Disorders Inventory in relation to anorexia nervosa correlated with dropping out of therapy (Sutandar-Pinnock et al, 2003, cited in

Bardone-Cone et al, 2007) and poor prognosis post therapy (Bizeul, Sadowsky & Rigaud, 2001, cited in Bardone-Cone et al, 2007).

This cognitive behavioural model of perfectionism was further developed in 2005 by Riley and Shafran through of piece of grounded theory research with 15 participants who fulfilled the criteria for clinical perfectionism and 6 who did not. They found within this qualitative phenomenological exploration using content analysis of semi-structured interviews that clinical perfectionism was consistent with the three core characteristics as argued by Shafran et al (2002). Furthermore, in keeping with the original model several maintenance factors were found, namely, ".... self critical reaction to failure...positive emotional reaction to success...cognitive biases...rule and rigidity" (Riley & Shafran, 2005, p.370). A number of other maintenance factors were also found that had not been proposed within the original model, these were *safety behaviours*, *procrastination*, *fear driven motivation for achieving* and *value driven for achieving* (Riley & Shafran, 2005). Riley and Shafran (2005) explain that safety behaviours are designed to avert the fear outcome, motivation for achieving is the fear of failure in relation to self-evaluation and procrastination is the avoidance of beginning a task for fear of adverse outcome or used as an 'excuse' for not achieving perceived success (e.g. "I didn't have time") and driven by values relates to motivation originating in values such as "…being perfect is the right thing to be…" (Riley & Shafran, 2005, p.373). Interestingly, although they argue procrastination is a new component to their model it does appear in their 2002 paper. A fundamental criticism which Riley and Shafran (2005) did not attend to, is that in keeping with grounded theory the theory should emerge from the data (e.g. Robson, 2002), however, this research was driven by researchers with a clear model to be tested through semi-structured interviews which they carried out thus leading to a possible significant bias.

The unidimentional model of perfectionism has been implicated in a variety of mental health problems. The simplicity of the unidimensional model in its use in understanding and targeting mental health problems where perfectionism is implicated is clearly demonstrated by Shafran et al (2004). They showed in a case study design how targeting the clinical perfectionism when it is a co-morbid feature of eating disorder led to improvements in the eating disorder and clinical perfectionism in eight sessions, as measured by the Eating Disorders Examination (Fairburn & Cooper, 1993, cited in Shafran et al, 2004), Beck Depression Inventory (Beck, 1967) and the Clinical Perfectionism Questionnaire (Fairburn et al, 2003, cited in Shafran et al, 2004). As well as illustrating the positive implications of this study on using a simplistic,

unidimensional model of maladaptive perfectionism, Shafran et al (2004) also highlighted a number of limitations. They argue that in single cases generalisability is reduced and it is hard to show that the intervention used was completely responsible for improvements. Furthermore, it cannot be ascertained that the clinical perfectionism would have hindered therapy using other more established methods (Shafran et al, 2004). However, they do also argue that longstanding clinical perfectionism, as shown by the client in this study, does not usually spontaneously dissipate (Shafran et al, 2004).

The unidimensional model has also been applied to obsessive compulsive disorder. Rheaume et al (2000) conducted a study on a non-clinical population using the Unidimensional Perfectionism Questionnaire (Rheaume et al, 1995). In keeping with previous research on the distinction between positive and negative or neurotic perfectionism (e.g. Burns, 1980) it was found that although showing the same "perfectionistic tendencies," 16 "dysfunctional" and 16 "functional perfectionists" differed on their perceptions of the negative consequences to these, the former expressing more. Furthermore, Rheaume et al (2000) also found that "dysfunctional perfectionists" displayed more obsessive compulsive behaviours. They consider how these results could translate to clinical populations and with regard to obsessive compulsive disorder. However, Rheaume et al (2000) may be making incorrect assumptions regarding the relationship obsessive compulsive disorder has with non-clinical obsessive compulsive behaviours in that they may not share the same linear continuum as implied and may be etiologically and functionally very different. Despite the encouraging assertions made by the advocates of the unidimentional model of perfectionism, inevitably there are criticisms; these need to be thoroughly explored before it can be ascertained whether this model can applied to people with AS who may also have a co-morbid mental health problem.

13. An Appraisal of the Unidimentional Model of Perfectionism

When reviewing the literature and the unidimentional model of perfectionism Hewitt et al (2003) argue that although Shafran et al (2002) present some interesting ideas their arguments are limited in focus and description. Hewitt et al (2003) argue that the supporting research is limited and the information provided by Shafran and Mansell (2001) and Shafran et al (2002) from other authors and measures is biased. In support of the unidimensional model Shafran et al (2002) argue that perfectionism as a unitary construct is included in the Eating Disorders Inventory (Garner et al, 1983 cited in

Hewitt et al, 2003) and the Neurotic Perfectionism Questionnaire (Mitzman et al, 1994 cited in Hewitt et al, 2003), however, Hewitt et al (2003) argue that Shafran and her colleagues fail to mention that half of the items within the former and a quarter of the items in the latter refer to socially prescribed perfectionism (Hewitt et al, 2003). Furthermore, Hollender (1965), Hamacheck (1978), Burns (1980) and Pacht (1984) all state that *self-referent* perfectionism and *interpersonal factors* are all implicated in the construct of perfectionism but Shafran et al (2002) unfortunately only mentions the *self-orientated* aspects when quoting these authors in their paper (Hewitt et al, 2003). Hewitt et al (2003) also argue that Shafran et al (2002) ignored influential historical accounts from authors like Adler (1956, 1998 cited in Hewitt et al, 2003) and Horney (1950) who clearly include the *interpersonal* domain into a better and more complete understanding of perfectionism.

Hewitt et al (2003) continues by stating that although Shafran et al (2002) do identify a number of cognitive maintaining characteristics to perfectionism such as cognitive distortions they neglect rumination on imperfection and mistakes as an important aspect that has been implicated (e.g. Frost et al, 1997, cited in Hewitt et al 2003). Furthermore, Hewitt et al (2003) argue that any cognitive model of perfectionism should include frequent automatic thoughts on imperfection as demonstrated by the Perfectionism Cognitive Inventory (Flett et al, 1998, cited in Hewitt et al, 2003).

In attending to Shafran et al's (2002) view that perfection only has to exist in one salient domain, Hewitt et al (2003) also argue that research does appear to demonstrate that individuals with high perfectionism in one area also demonstrate it in other areas (Hewitt et al, 2003) and the greater the importance placed on being perfect on many areas the greater the depressive symptomology (Hewitt et al, 1990, cited in Hewitt et al, 2003). Again, Hewitt et al (2003) appear to suggest that Shafran et al (2002) do not attend to the pervasive issue of perfectionism, as they do not demonstrate that perfectionism affects many areas of life and how intensity relates to psychopathology. Hewitt et al (2003) argue that

> *"Although it is possible and desirable to identify the one area of greatest importance to perfectionists, one defining feature of extreme perfectionism is a tendency to want to be perfect in many life domains because flaws and failures of any sort indicate that the self is not perfect"* (p.1229).

In order to tackle Shafran et al's (2002) and Shafran, Cooper and Fairburn's (2003) arguments that the multidimensional model does not add anything to the understanding and treatment of mental health problems Hewitt et al (2003) argue

> *"…that much is to be gained from an interpersonal approach that includes an emphasis on the self in relation to significant others….and an explicit emphasis on the interpersonal behaviours expressed by perfectionists (Habke & Flynn, 2002). Failure to examine the interpersonal dimensions of perfectionism may result in an under appreciation of the role of perfectionism in a variety of disorders, suicide behaviour, and in marital and family distress"* (p.1226).

Dunkley et al (2006) also criticise Shafran et al (2002, 2003) and their critical assessment of the two multidimensional models. They state that it is incorrect to categorically label the subscales/items in terms of whether they assess perfectionism or not and therefore accepted or thrown out; they argue that this is arbitrary and should be replaced with a scale of strong to weak association with perfectionism (Dunkley et al, 2006). Furthermore, in relation to eating disorders, Dunkley et al (2006) criticise Shafran et al's (2003) assertions that interpersonal factors are not necessary in the maintenance of clinical perfectionism when they argue that low social support and self-concealment have been found to be "…unique explanatory variables in EC [evaluative criticism] perfectionism's relation with distress" (Dunkley et al, 2002, 2003, p.79, cited in Dunkley et al, 2006). They continue by asserting that "…overlooking the importance of interpersonal processes might hinder attempts to improve treatment outcomes for perfectionists" (Dunkley et al, 2006, p. 80).

Hewitt et al (2003) clearly demonstrate the influence of the interpersonal aspect to perfectionism when concentrating on Shafran et al's (2002) and others (e.g. Flett et al, 1992, cited in Hewitt et al, 2003) assertions that fear of failure is paramount in perfectionism. Using the MPS-H, a measure of perceived performance failure called the Performance Failure Appraisal Inventory (Conroy, 2001, cited in Hewitt et al, 2003) and the Centre for Epidemiology Studies Depression Scale (Radloff, 1977, cited in Hewitt et al, 2003) they found that when a structural equation analysis was conducted *socially prescribed* perfectionism was the only construct that had a link in the *fear of failure* construct and this appeared to mediate the link between *socially prescribed* perfectionism and depression. Hewitt et al's (2003) research demonstrates that fear of

failure is a socially determined aspect of perfectionism, as those with perfectionism try to avoid criticism from others and less relevant to *socially orientated* perfectionism.

However, more recently, Shafran and her colleagues have themselves argued the importance of socially prescribed perfectionism. Glover, Brown, Fairburn & Shafran (2007) found that when clinical perfectionism was targeted, those that did not improve had high scores on the socially prescribed perfectionism dimension, using the MPS-H, thus identifying the importance of this aspect of perfectionism. In fact, Glover et al (2007) admit that when socially prescribed perfectionism is indicated it needs to be targeted with longer term therapy. In order to reconcile this finding Shafran and colleagues appear to have taken a pragmatic perspective of perfectionism whereby, the default is to take a simpler unidimensional perspective, when the shorter term therapy associated with this model fails to improve symptoms a multidimensional perspective can then be taken targeting more interpersonal aspects of perfectionism, this often means longer term therapy.

The reason for this rather protracted exploration and appraisal of the models of perfectionism was in order to attempt to grasp the construct of perfectionism so that the author could then move on to ascertaining whether these models adds anything to our understanding of AS and co-morbidity. As some relative clarity has now been achieved the author will now move to exploring how might models of perfectionism relate to AS.

14. Asperger Syndrome and Perfectionism

AS has been described as a pervasive developmental disorder defined by a cluster of behaviours related to social interaction, communication and repetitive, restricted behaviours or inflexibility (Wing & Gould, 1979, cited in Jordan, 1999). In addition, some people with AS appear to exhibit a number of the characteristics that are associated with perfectionism as explored above within the unidimensional model. Hare (2005) has noted that people with AS might have polarised and dichotomous thinking as well as arguing directly that they can often be perfectionistic, and Paxton and Estay (2007) argue that people with an Autism Spectrum Disorder have a propensity to perfectionism. Gillberg (2002) argues that "The subclinical variant of AS is often characterised by…rigid thinking, inflexible behaviours…[and] perfectionism" (p.71). By definition AS is characterised by amongst other things a "restricted pattern of interest that are abnormal either in intensity or focus" and "apparently inflexible adherence to specific, non-functional routines or rituals" (The American Psychiatric Association, 2000), rigidity (Ferrari & Mautz, 1997, cited in Egan et al, 2007) and

dichotomous thinking (Egan et al, 2007), all features that have been associated with the construct of perfectionism as explored within the unidimentional model above. For example, Riley and Shafran (2005) argue that people who are perfectionistic have a particular cognitive style that predisposes, precipitates and maintains the perfectionism and any associated mental health problem, this style includes a tendency for "…rule and rigidity" (Riley & Shafran, 2005, p.370) and the person may think in a rather restricted way in terms of how they evaluate themselves (Shafran et al, 2004).

Paxton and Estay (2007) describe how people with an Autism Spectrum Disorder can avoid tasks unless they feel they can do them perfectly, completing the task exactly as they believe they should be completed. This perfectionism, they argue, can lead to problems with daily functioning in that tasks can take much longer than perhaps their employer or their school require due to the level of precision the person can take in order to avoid mistakes and/or in order to correct mistakes. Paxton and Estay (2007) describe a client study of a young man with Asperger Syndrome who would "…strongly refuse to try anything until he was completely confident that he would do it right…" (p.132).

The development of perfectionism as proposed by Juster, Heimberg, Frost, Holt, Mattia and Faccenda (1996) in those without AS may also indicate that those with AS may be vulnerable to developing perfectionism as described by the unidimensional model. Juster el al (1996) argue that perfectionism develops from genetic susceptibility precipitated by particular early social experiences, all of which can contribute to the development and maintenance of mental health problems such as social phobia. A theory of genetic susceptibility is well founded with those with AS (e.g. Gillberg & Billstebt, 2000) which could influence the development of perfectionism in some of those with AS (as defined by Heimberg et al, 1995, cited in Juster el al, 1996) and furthermore, could influence the development of some mental health problems associated with perfectionism.

It is well documented that the behavioural features associated with AS and the possible underpinning processing differences (e.g. Ozonoff, Pennington & Rogers, 1991; Frith, 1989; Baron-Cohen, Leslie & Frith 1985) and possible memory anomalies (e.g. Bowler, Gardiner & Grice, 2000, 2003) that have been implicated in some people with AS might disproportionately lead people with AS to mental health problems (Tantam, 1991; Hare, 1997). When those with AS exhibit additional mental health problems they appear to be the very same as those identified to be associated with perfectionism as already

explored, such as depression (e.g. Gillberg, 1998 cited in Gillberg & Billstebt, 2000; DeLong & Nohria, 1994, cited in Tantam, 2000; Attwood, 1998; Tantam, 1991; Ghaziuddin, 2005) and anxiety disorders (e.g. Simonoff, Pickles, Charman, Chandler, Loucas & Baird, 2008; Gillott, Furniss, & Walter, 2001) including obsessive compulsive disorder (Kerbeshian & Burd, 1986, cited in Tantam, 2000; Szatmari, Bremner & Nagy, 1989). Given these assertions, there is a real possibility that some people with AS may develop perfectionism as a result of their particular developmental trajectory, possibly following genetic vulnerability and life experiences or perhaps simply in relation to a mental health problem which has been associated with perfectionism.

However, very importantly, if and when a particular person with AS does show features that are consistent with perfectionism it might be adaptive/positive rather than negative/maladaptive, to use the jargon of the researchers connected to the perfectionism construct, thus leading to feelings of success and well-being. Therefore, perfectionism as a cognitive style, when applied to people with AS, does not have to be viewed as a negative feature; on the contrary, perfectionism could be viewed as a real strength. For example, there has been a relatively recent trend for people with AS, as well as authors, clinicians and researchers within the field to identify various people in the public arena both past and present that are believed to have AS including Einstein (Fitzgerald, 2000) as well as in fictional characterisations. These various sources would argue that these famous people have a number of things in common including a tendency to pursue particular topics with extreme focus leading to tremendous achievements, moreover, they have a tendency for high standards that could be likened to adaptive perfectionism explored within the research above, such the type exhibited by athletes (Frost & Henderson, 1991) where striving can lead to feelings of satisfaction (Terry-Short et al, 1995, cited in Shafran & Mansell, 2001). After all, the research on perfectionism suggests that the setting of high standards per se is not unhelpful, it becomes negative when self-worth is based on their achievement (Dibartolo et al, 2004) or when the person is self-critical irrespective of whether the standards are reached or not (Shafran et al, 2002).

It would seem then that people with AS might be more prone to perfectionism whether that is positive or negative perfectionism. However, whether or not it is adaptive or maladaptive perfectionism, when the perfectionism overlaps with a co-morbid psychiatric condition it might have a negative contributing influence (Shafran et al, 2002). Given that perfectionism has been associated with all the disorders that can coexist with AS, and that people with AS may be more prone to mental health problems

than the general population (Tantam, 1991; Hare, 1997), it is suggested that when people with AS present to clinical settings for possible intervention, perfectionism is explored as a possible maintaining feature of the mental health problem. If perfectionism is indicated, then in keeping with consensus, intervention may require consideration and adaptation to meet the needs of the person with AS in therapy (Kellner & Tutin, 1995; Fullerton & Coyne, 1999; Gray, 1998; Reaven & Hepburn, 2003; Bebko & Ricciuti, 2000) and in order to target the perfectionism (Blatt, Quinlan, Pilkonis & Shea, 1995; Tallis, 1996; Bruce & Steiger, 2005; Shafran et al 2002; The American Psychiatric Association, 2000; The National Institute for Clinical Excellence, 2004). Applying these principles to those with AS is a unique proposition; the few therapeutic studies that do exist with people with AS (e.g. Stoddart, 1999; Lord, 1995 cited in Reaven & Hepburn, 2003; Sofronoff, Attwood & Hinton, 2005; Wood, Drahota, Sze, Van Dyke, Decker, Fujji, Bahng, Renno, Hwang & Spiker, 2009; Weiss & Lunsky, 2010; Hare & Paine, 1997; Hare, 1997a) make no attempt to specifically and explicitly explore perfectionism as described in this literature review and/or attempt to target it within therapy either in isolation or in conjunction with the co-morbid mental health problem. Given the debate so far on the utility of the unidimentional model of perfectionism the author will now attempt to explore how the unidimensional model of perfectionism might support clinicians in their work with people with AS.

15. How Might the Unidimentional Model of Perfectionism Help Clinicians?

The unidimensional model advocates using an adapted cognitive behavioural therapy approach. The unidimensional model is useful as it appears to provide the best intervention protocols for those with AS as they are consistent with contemporary thinking regarding psychotherapy with this population i.e. the use of cognitive behavioural approaches (e.g. Hare, 1997). This is in contrast to the multidimensional models which argue that perfectionism develops from a disrupted sense of self which requires 'schema-focussed therapy' or long term, intensive psychoanalysis (Blatt & Ford, 1994; Blatt et al, 1988; Blatt et al, 1992, cited in Blatt et al, 1995). However, a pragmatic approach would be to target the self-orientated perfectionism using cognitive behavioural therapy and if things do not positively shift then longer term therapy may be helpful targeting multiple dimensions such as any socially orientated perfectionism. In addition, it is the authors view, in contrast to Shafran et al (2002), that any positive aspects of perfectionism should also be noted as it is believed that this is clinically relevant in terms of focusing on things that are meaningful and positive in the clients

life, for example, in order to motivate the client (Kobori & Tanno, 2005); this is particularly important for clients with AS where there may be a restricted range of interests to use as motivators (Clements, 2005).

Authors, researchers and clinicians have considered how to improve the perfectionism that has been implicated in barriers to intervention, whether to solely target the perfectionism or tackle it in conjunction with the associated mental health problem. Given perfectionism is viewed as an interfering and a potential obstacle to therapy in relation to a number of mental health problems, thus a significant transdiagnostic issue (Egan & Hine, 2008) and that if targeted might result in symptomatic relief across a number of domains, research has looked at targeting perfectionism directly and solely. Shafran et al's (2004) study showed that adaptations to the cognitive behavioural therapy model led to improvements in both clinical perfectionism and eating disorder symptoms when perfectionism was solely targeted. Riley, Lee, Cooper, Fairburn and Shafran (2007) found using a random control trial that 75% of participants improved, in terms of clinical perfectionism, anxiety and depression, following 10 sessions of the cognitive behavioural therapy clinical protocol developed by Fairburn et al (2003), over eight weeks targeting perfectionism in isolation; these improvements were maintained at 16 week follow up. The intervention protocol consisted of four elements: 1) identifying clinical perfectionism and the maintaining mechanisms e.g. avoidance; 2) conducting behavioural experiments in order to understand the impact of perfectionism on daily living; 3) psychoeducation and cognitive restructuring e.g. to modify personal standards and self-criticism; 4) modifying and broadening the ways in which the client currently self-evaluates. The improvements were based on the scores using the MPS-F, the Clinical Perfectionism Examination (Riley, Copper, Fairburn & Shafran, unpublished), the Beck Depression Inventory-II (Beck, Steer & Brown, 1996) and the Beck Anxiety Inventory (Beck & Steer, 1987).

There are a number of criticisms that can be made of the research above including the use of self-report outcome measures, some of which are not validated, administered by the therapists themselves which are prone to biasing. In addition, longer term follow up would have helped to explore the criticism that Hewitt and colleagues put to Shafran and colleagues regarding the short term gains of targeting perfectionism in this way. However, the most significant criticism of all the above research is that it is unclear whether solely targeting the perfectionism led to the improvements in mental health problems and whether instead targeting the mental health problems directly, or targeting both the perfectionism and the mental health problem would have resulted in

the same or more improvement in both the mental health problem and the perfectionism. For example, Ashbaugh, Antony, Liss, Summerfeldt, McCabe and Swinson (2007) found that following intervention which targeted social anxiety not only did the anxiety reduce but also the perfectionism characteristics such as less concern about making mistakes and the participants doubted their actions less. Furthermore, Egan and Hine (2008) found using an A-B single case experimental design that perfectionism improved in two out of the eight cases when it was targeted solely, but with no improvement of the associated anxiety or depression. Finally, Glover et al (2007) found using a multiple baseline A-B single case experimental design, that although 10 sessions of cognitive behavioural therapy improved perfectionism in six of the nine participants on measures of self-referential perfectionism, using the MPS-H and the Perfectionism subscale of the Dysfunctional Attitude Scale (Weissman & Neck, 1978, cited Glover et al, 2007) and three out of the nine participants using the Clinical Perfectionism Questionnaire (Fairburn et al, 2003, cited Glover et al, 2007) no improvements were found in ratings of anxiety and only three out of the nine participants showed improvements in depression. Therefore, overall, it cannot be ascertained that targeting perfectionism solely can lead to the most beneficial impacts on the associated mental health problems. Furthermore, none of the research above measured how the clinical perfectionism effected daily functioning in its own right, therefore, it is difficult to see why perfectionism should be solely targeted in this way given the lack of improvement in associated psychopathology in some of the studies. A pragmatic approach might be to target perfectionism alongside the associated mental health problem.

The argument of solely targeting perfectionism is one made on the assertion that perfectionism appears pervasive, it has been found to cut across a number of mental health problems and has been shown to hinder therapy with regard co-morbid psychopathology. However, the utility of solely targeting perfectionism using the clinical perfectionism model rather than targeting perfectionism in conjunction with targeting the associated mental health problem such as anxiety, depression or eating disorder is unclear. Certainly, some studies that have tackled perfectionism as part of the overall therapy for mental health problems have shown positive results. For example, Hirsch and Hayward (1998) found that adding specific techniques to the cognitive behavioural therapy model to include targeting co-morbid perfectionism decreased anxiety and depression in this single case study. In addition, Enns, Cox and Pidlubny (2002) found using a group cognitive behavioural therapy approach that both depression and

perfectionism in the clients was reduced over an eight week period (cited in Bardone-Cone et al, 2007).

Despite the lack of evidence, Shafran and her colleagues have put forward a clear and workable model that could be applied to perfectionism which in turn could be applied to some people with AS when indicated. Included in that model are specific areas which can be targeted such as modifying personal standards, self-criticism, broadening the ways in which the client currently self-evaluates (Fairburn, Copper & Shafran, 2003) and targeting cognitive distortions such as dichotomous thinking e.g. I am either "perfect/good" or "imperfect/bad" (Egan et al, 1997). However, further research on this cognitive behavioural therapy approach and the construct of perfectionism is indicated, in particular in relation to working with different client groups such as those with AS. It is hoped that through further research the construct and the interventions that target perfectionism can move beyond mere speculation (Glover et at, 2007) and might include its application to a broad range of populations to include those with AS. Certainly, there is a real possibility that some people with AS may be more vulnerable to perfectionism given that they might experience the kinds of mental health problems associated with perfectionism and possibly due to their particular developmental trajectory and cognitive style. However, it is unclear whether people with AS are more prone to perfectionism than the general population and what type of perfectionism they are more likely to exhibit if they are more prone: adaptive, problematic, clinical; unidimentional or multidimensional perfectionism; further research could establish this. Finally, research on perfectionism and AS may also uncover whether targeting perfectionism in its own right or in conjunction with the co-morbid mental health problem is best for certain people with AS. Certainly, targeting perfectionism when indicated in those with AS may be very helpful as it may help alleviate the symptoms associated with a mental health problem and may increase the possibility of a good therapeutic alliance (e.g. Hewitt et al, 2003; Shafran et al, 2002). For example, Dunkley et al (2006) believes that difficulties in alliance formation in some of those with perfectionism may be due to the lack of contribution by the perfectionistic clients to the therapeutic alliance. Therefore, when perfectionism has been found to influence the co-morbid mental health problem in the person with AS this provides another possible reason to target it specifically or alongside the intervention for the mental health problem or problems.

16. Conclusion

In order to bring clarity to the debate on perfectionism, Frost et al (1990) and Hewitt and Flett (1991) present a multidimensional model which views perfectionism as pervasive and dynamic and one that implicates both inter and intrapersonal dimensions that can manifest in adaptive and maladaptive perfectionism in a number of areas of life. However, as well as suffering sampling and data collection biases, the construct being tested appears so all-encompassing that the research evidence lacks clarity and can appear rather confusing.

In contrast, Shafran et al (2002, 2004) present a 'leaner,' less complex and more pragmatic approach to perfectionism. Their model outlines specific mechanisms of maintenance, which has led to clear therapeutic protocols. However, their model has been argued to be rather restrictive by the multidimensional advocates (e.g. Hewitt et al, 2003). Research within the multidimensional construct have found that although perfectionism is not specific to any particular disorder, different disorders can show different dimensions of perfectionism, therefore the unidimensional model would not be able to detect these difference such as the more adaptive, positive form that has been postulated to be linked with anorexia nervosa (Terry-Short et al, 1995; Mitzman et al, 1994, cited in Shafran & Mansell, 2001).

Finally, it was postulated that some of those diagnosed with AS may exhibit some of the characteristics that may be consistent with perfectionism. Indeed it was proposed that some of those with AS might be more likely to develop perfectionism given some of their neurodevelopmental differences and particular developmental trajectories and the over representation of particular mental health problems in this population where perfectionism has been implicated. However, the perfectionism in some people with AS may be of a more adaptive and positive type. It was suggested that when people with AS present to clinical settings with mental health problems the possibility of perfectionism may need to be acknowledged, explored and added to the intervention whether it is positive or negative perfectionism. However, no matter whether unidimentional or multidimensional perfectionism is revealed, an adapted cognitive behavioural therapy approach is advocated given the evidence base for psychotherapy with people AS.

It is clear that the construct of perfectionism is still quite elusive. Further research is required to explore the construct of perfectionism and its implications on practice including its identification and relationship with different mental illnesses. This should

include the neglected area of research into genetic factors in relation to etiology, course and the maintenance of perfectionism. This research may reveal whether perfectionism in some of those with AS (perhaps just because they may be suffering with the mental health problem(s) associated with it and therefore not intrinsic to AS) are either unidimensional or multidimensional, helpful or unhelpful or a totally different construct altogether.

17. References

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Section D: The Client Study

This study was chosen in order to demonstrate the use of an adapted cognitive behavioural therapy approach for people with Asperger Syndrome (AS) and co-morbid mental health problems. In doing so it hopefully addresses the lack of research within this field (Paxton & Estay, 2007; Weiss & Lunsky, 2010) and illustrates some considerations when working with this population.

18. Introduction

The client in this study was a late adolescent girl with AS, an eating disorder alongside what appeared to be clinical perfectionism, as conceptualised by Shafran, Cooper and Fairburn (2002). Due to the features of the AS and the co-morbid presenting concern, cognitive behavioural therapy was proposed as the most effective psychotherapeutic intervention. Cognitive behavioural therapy was chosen as it has been well documented to be effective in the treatment of eating disorder in adolescents (e.g. Carr, 2006), particularly when it accompanies clinical perfectionism (e.g. Shafran et al, 2002). Furthermore, cognitive behavioural therapy has been shown to be particularly effective for people with AS who exhibit co-morbid psychopathology (e.g. Paxton & Estay, 2007; Hare & Paine, 1997, Hare, 1997a; 1997b; Sofronoff, Attwood, Hinton & Levin, 2007; Wood, Drahota, Sze, Van Dyke, Decker, Fujji, Bahng, Renno, Hwang & Spiker, 2009; Chalfant, Rapee & Carroll, 2006; Weiss & Lunsky, 2010) because it may help to overcome possible difficulties those with AS may have with information processing and social interaction as its approach is systematic, structured, explicit, concrete and avoids using reciprocation as the means of effecting change per se (Hare, 1997b).

The client's personal details have been changed in order to keep confidentiality.

19. The Reason for the Referral

I met Jane within my capacity as a Counselling Psychologist within a tier 4 inpatient child and adolescent inpatient unit. Jane was referred because she was rapidly losing weight secondary to increased anxiety due to school exams and long term bullying, within the context of long-standing vulnerabilities including rigid thought and behaviour patterns, perfectionism, obsessiveness particularly with regard body image and weight, social cognitive difficulties and social isolation.

20. Sources of Information

The pre-assessment phase included reading all relevant information from Jane's background including from her previous admission at the unit, her school reports and CAMHS community team reports. The assessment included initial clinical interviews with Jane, her parents and other professionals and formal standardised measures were

also taken using the Beck Youth Inventory – Second Edition (2005) at admission, midway and upon discharge.

21. Background Information

In order to construct a client formulation I was guided by a number of resources: Hawton et al (1989); the Diagnostic Statistical Manual IV – TR (American Psychiatric Association, 2000); Beck Youth Inventory – Second Edition (2005); National Institute for Clinical Excellence Guidelines; Antony and Barlow (2004); Fairburn, Copper and Shafran (2003); Shafran and Fairburn (2004); Carr (2006). What follows is a very brief consolidation of that information.

Jane was referred following marked weight loss due to significant under eating. Jane had been losing weight over several months. It appeared that Jane had lost almost half her body weight on admission. Jane was well known to the unit having been admitted once before. The last admission was due to depression, social isolation and overeating leading to her being significantly overweight. Jane reported during this admission that the overeating during the last admission served the same function as the under eating did on this admission i.e. to protect her from criticism from peers.

On admission and throughout her stay until discharge, there was no evidence of vomiting/purging and her difficulties seemed more related to restricted and rigid beliefs regarding her eating alongside long-standing difficulties with social judgement and social reciprocity leading to amongst other things, social ridicule and loneliness. Jane appeared to lack insight into the impact of her dieting behaviour and over exercise on her physical health and psychological well-being. Similarly, according to written reports, when Jane was overweight during her previous admission, she also appeared to lack insight into the negative consequences of her behaviour, becoming very upset and “oppositional” (taken from written reports by psychiatry) when challenged about the health implications. It appeared on both admissions she was instead fixed on pursuing a rigid line of thought and behaviour, determined to gain weight on the last admission and lose weight on this admission in order, Jane reported, to reduce bullying, which she felt was related directly to her weight and only her weight. Jane reported during interviews that as gaining weight had led to increased bullying she decided to lose weight; this appeared to further demonstrate Jane’s rather restrictive, ridged and polarised cognitive style that appeared to maintain her difficulties. Finally, Jane and her parents reported during interviews that when Jane initially lost weight she experienced more social inclusion and less critical comments from others, thus

appearing to reinforce dieting behaviour. However, as per the clinical perfectionism model (Shafran et al, 2002) Jane soon appeared to increase her expectations about weight loss, wanting to lose more weight and do more exercise in what appeared to be an endless pursuit of perfection in order, Jane believed, to increase her social inclusion.

In terms of Jane's early history it appeared that she experienced many difficulties consistent with her diagnosis of AS. According to school written reports, family and Jane's verbal reports, Jane's general cognitive and academic ability appeared within the normal range, however, socially, Jane appeared to lack confidence and appeared socially naïve. For example, on more than one occasion Jane was duped into doing extremely socially inappropriate and socially embarrassing things in public, although she did not experience the embarrassment despite these events leading to significant ridicule. According to Jane and the family, when she developed through adolescence her differences and difficulties became more apparent. As well as difficulties with peer relationships, family relationships also became strained; both can be common experiences of people with AS and can be common in eating disorders (Carr, 2006) during the life cycle transition of adolescence.

During Jane's previous stay at the unit, it was the consensus of the mental health professionals (e.g. psychiatrists, psychologists and nurses) that the psychological interventions were found to be slow and difficult with little improvement observed. According to the previous psychologist, Jane and the family, Jane experienced difficulties expressing her internal experiences relating to her mood, her processing of information seemed slow and arduous and she appeared to find it difficult to work collaboratively with her psychologist and understand the relevance of particular interventions. Consequently, although she appeared stable in terms of her weight on discharge, she seemed to remain socially isolated and still appeared to experience significant and pervasive clinical perfectionism as characterised by a rather restricted and ridged perspective on her self-worth based purely on weight and body shape, experiencing little pleasure from meeting her rather ridged expectations.

22. Formulation

Through the assessment process it became clear that Jane seemed to have a number of vulnerabilities that may have influenced the development of a set of core beliefs and assumptions following particular critical life events. Jane stated that she had always been socially awkward and struggled to fit in with her peers, despite how hard she

tried. Her family stated that she had always shown rigidity of thought and behaviour, appearing to pursue circumscribed interests with high intensity and at the exclusion of other things. Then as she matured, according to informants, Jane appeared to struggle to manage the transition of adolescent and all the demands that went with it. Jane and her family are clear that they all struggled to renegotiate their relationships; Jane appeared to want increased independence but seemed frustrated by the realisation that she also needed continued support from her parents. Initially she became obese and depressed during adolescence. At this time unhelpful negative and pervasive core beliefs appeared to be brought to the fore including "I am fat" and "I am ugly" and in turn unhelpful, although understandable, assumptions seemed to have been created including "I must lose weight to be liked" and "I must be perfect to be liked." In turn negative automatic thoughts seemed to be activated during day-to-day events such as looking in the mirror or other shiny surfaces, thoughts including "my hips are too big, I must lose weight." She would often stand and stare at her reflection. As well as the maintaining behaviour of mirror gazing, a set of cognitive distortions (Wills & Sanders, 1997) appeared to also maintain the unhelpful behaviour of under eating and over exercising including filtering out positive experiences and experiences that might enable her to challenge the negative automatic thoughts through alternative explanations; generalising negative experiences; interpreting events, some of which were ambiguous, negatively and personally. Features associated with AS might also have acted to influence some of these cognitive distortions in Jane including: inflexible (Bishop & Norbury, 2005, cited in Attwood, 2007); black and white and polarised thinking (Reaven & Hepburn, 2003; Hare, 1997b) such that Jane might think she either is or has to be, fat or thin; perfectionism (Paxton & Estay, 2007) such that she has very high standards that she cannot possibly meet, leaving her feeling low in mood; over focusing on detail such as weight as only defining her self-worth or focusing on particular body parts that are appraised as "ugly," which Jane reports to doing in the mirror.

The under eating also appeared to be maintained by her receiving fewer critical comments from others and mastery over her weight, thus raising her self-esteem and increasing her mood. However, this was temporary, according to Jane, as she was soon subjected to critical looks and comments from others again as she began to look gaunt and continued to experience problems with social cognition as per her diagnosis of AS, thus leading to her raising her standards further in order to lose more weight.

The initial family praise for losing weight and then later the family conflicts due to her

losing too much weight also appeared to maintain the under eating and over exercise, in the latter it allowed her a sense of control over her body, a sense of autonomy and separateness (Carr, 2006), during a time when she felt little control over her life and there was enmeshment; this was particularly pronounced as the family and professionals became more intrusive as they worried about her obsessive pursuit of perfection over her weight leading to physical ill health.

Finally, there was also evidence that dysregulation of the neuroendocrine system due to starvation may have led to low appetite and further cognitive rigidity in Jane (Carr, 2006).

Despite the difficulties there were a number of protective factors. In terms of Jane, she was intelligent, optimistic and was quick to understand the formulation and model used. Unlike her previous admission, once Jane understood the gravity of the situation, established through motivational interviewing, she appeared motivated and engaged in the therapy. Finally, Jane did not appear particularly socially anxious and therefore was happy and able to build on her social skills and practice them *in vivo* with no apparent avoidance thus she made progresses in these areas relatively quickly. In terms of the family, they understood the gravity of the problem but also seemed optimistic in terms of her recovery. Both parents appeared flexible in their approach to parenting and they appeared committed to helping Jane and engaging in the therapy, including being part of the formulation.

23. Therapeutic Model and Intervention

Following discussions with Jane, the family, my supervisor and colleagues it was decided that therapy should primarily target her eating (healthy stable weight collaboratively agreed upon), exercise (reasonable level of exercise collaboratively agreed upon), social skills (greeting peers, maintaining conversation and ending conversation in specific situations e.g. youth club) in conjunction with the clinical perfectionism using an adapted cognitive behavioural approach. The choice of goals was based on the Recovery Model (Webb, 2011) and chosen as they were of interest to Jane; tapping into the often restricted range of interests is very important when working with those with an Autism Spectrum Disorder (Clements, 2005). The areas chosen were also chosen because these areas appeared to be the most pervasive aspect of her presentation, it appeared to have led to a huge reduction in quality of life and most importantly it was the area Jane was most keen to tackle, moreover, these areas appeared to be the core areas, the area's most likely to improve and positively

impact on other areas of her life.

Cognitive behavioural therapy emphasises the role of negative core beliefs and assumptions which have developed from a combination of both vulnerabilities in the individual and particular significant life events. These core beliefs and assumptions can lead to particular patterns of negative automatic thoughts and dieting behaviour following critical comments from others. A set of cognitive distortions can maintain the dieting behaviour as can a range of unhelpful behavioural patterns including weight loss through negative and positive reinforcement. Therapy can help by targeting the eating disorder by setting up contingency management enabling weight gain to be reinforced alongside the establishment of more adaptive thought patterns. In addition, increasing adaptive skills that are functionally equivalent to dieting such as social skills was also added to the treatment as was work with the parents to enable them to become co-therapists and to adapt their approach to parenting accordingly.

An adapted cognitive behavioural approach was used in order to accommodate Jane's AS (e.g. Kellner & Tutin, 1995) and also the clinical perfectionism. A repetitive, logical, concrete and explicit approach to cognitive behavioural therapy including agenda setting and explicit homework tasks was used, which have been shown to be helpful for people with and without AS (Reaven & Hepburn, 2003; Weiss & Lunsky, 2010). In addition, I was aware that visual aids might be helpful (Fullerton & Coyne, 1999; Gray, 1998). In terms of the clinical perfectionism the theoretical framework advocated by Fairburn, Copper and Shafran (2003) and Shafran and Fairburn (2004) were used to also guide the therapy. Overall, the treatment protocol consists of four elements: 1) identifying clinical perfectionism and the maintaining mechanisms e.g. avoidance; 2) conducting behavioural experiments in order to understand the impact of perfectionism on daily living; 3) psychoeducation and cognitive restructuring e.g. to modify personal standards and self-criticism; 4) modifying and broadening the ways in which the client currently self-evaluates.

The priority upon admission was to help Jane understand the gravity of her dieting behaviour as she was physically very unwell. Alongside this, and in order to facilitate this, it was also important to establish a good working alliance (e.g. Bertolino, Bargmann, & Miller, 2011) and to socialise her to the cognitive behavioural model, including helping her to reformulate her current situation and presenting concerns (reformulate as she already had a formulation, but unhelpful as it currently stood). Together we explored her eating disorder within a biopsychosocial perspective,

concentrating on her vulnerabilities around social cognition, her history and current and on-going difficulties related to psychosocial issues and school pressures (e.g. upcoming exams) and normal development through adolescents into young adulthood (i.e. renegotiating of relationships with her parents and peers).

Initially a motivational interviewing style was used (Rollnick & Miller, 1995). For example, I helped her weigh the costs and benefits of her over exercising and under eating behaviours and explore with her how they may interfere with her goal of social inclusion. Together we explored more adaptive ways to fulfil the desired function/outcome of over exercising and under eating, moreover, functional equivalent behaviours were collaboratively generated with her. Jane reported that exercise helped her relax so we explored relatively low impact techniques such as the progressive relaxation technique (Paxton & Estay, 2007) and other ways to relax such as listening to music. We also explored ways in which she could increase her self-esteem through increasing the number of ways in which she appraises herself and helping her join groups where she can share interests with others as the exercise she was doing was in isolation. I continued to encourage her to have a more balanced perspective on such areas such as eating and her performance within social situations. We also explored generating specific formulas or rules to help her in specific situations she found challenging and to decrease particular maintaining behaviours. For example, we practiced social skills in session prior to attending youth clubs to enhance her experience and we also generated some rules around mirror gazing (please see Appendix 1.).

To supplement the therapy with Jane I also met with the parents, this was collaboratively agreed upon with Jane. Within these sessions we explored possible ways that the parents could improve the ways in which they communicated with Jane that does not lead to conflict e.g. using techniques such as Socratic questions (e.g. Antony & Barlow, 2004). Together with Jane, we explored the conflict that arises when her parents ask her to reduce her exercise and increase her food intake. Together we found a way to help renegotiate the relationships so that Jane could feel independent and pursue her interests whilst at the same time the parents and professionals could feel reassured that she was eating properly. In that regard an eating, exercise and weighing schedule was set up which would be supervised by the parents and professionals, when targets were met then she would not have to abide by these potentially intrusive techniques (Carr, 2006). In relation to this and to help her increase her autonomy, we explored practical ways to help manage her health, exercise and

weight. Jane very much valued the gym and personal trainers and would often not listen to her parents, as reported by Jane and her parents. Therefore, as a pragmatic approach we discussed helping her find a person who would take a holistic view of her, would concentrate on exercise as well as eating (on admission it was just exercise) as a way to maintain the body image she desired in a way she valued i.e. structured and explicit but within healthy limits.

24. Progress

Despite the limited time that Jane and I worked together, she made good progress. However, I had to often compensate for a number of difficulties she experienced. It was quickly apparent that she required a lot of support. Consistent with research on AS, in particular Jane appeared to experience difficulties with mentalising (e.g. Ponnet, Roeyers, Buysse, De Clercq and Van Der Heyden, 2004; Beaumont & Newcombe, 2006), conversation cohesion and fluency (e.g. Dahlgren & Sandberg, 2008; Adams, Green, Gilchrist & Cox, 2002; Attwood, 2007; Attwood, 2007; Fine, Bartolucci, Szatmari & Ginsberg, 1994) and memory (e.g. Bowler, Gardiner & Grice, 2000, 2003), Jane found it difficult to discuss internal states and provide an account of her situation, both past and present and she would often switch topics abruptly and not provide enough information to help me understand what she was trying to communicate. Although her anxiety appeared to contribute to this, these difficulties appeared over and beyond anxiety. In keeping with the research on cognitive models of AS (e.g. Frith, 1989), Jane also appeared to over focus on particular details in session, finding it difficult to automatically and spontaneously process relatively simple global themes, appearing to often find it hard to tie together a number of issues covered in session that appeared to me to be clearly linked (e.g. Jolliffe & Baron-Cohen, 2001). At times I found the above issues quite frustrating in terms of slow progress, misunderstanding and her difficulties with generating or understanding alternative courses of action, thoughts or behaviours, something that Bowler (2005) coins ‘if-then’ courses of action, moreover, her apparent rigidity could sometimes frustrate me. Jane appeared to experience significant difficulties with reflecting upon the meaning and motivations of her own and others thoughts, behaviour and feelings, appearing to lack psychological mindedness (Farber, 1985)

Within supervision I was helped, albeit in a limited capacity due to the limited experience of my supervisor, through the use of formulation that incorporated every aspect of Jane including her AS. I was helped to recalibrate my expectations, to

accommodate and compensate for all these issues by keeping everything simple, structured, specific, concrete and I tried to help her with the complexity of inference making. In order to best support Jane I provided supports such as giving frequent prompts (e.g. Kaland, Moller-Nielsen, Callesen, Mortensen, Gottlieb & Smith, 2002), cueing (Blackshaw, Kinderman, Hare & Hatton, 2001) and providing plenty of time for her to process things (e.g. Kaland, Moller-Nielsen, Callesen, Mortensen, Gottlieb & Smith, 2002); in session I also made it explicit how issues discussed might link and when I was changing the topic and why.

As therapy progressed Jane became more relaxed and was able to ask for particular needs to be met, for example, she wanted to meet in a Café rather than at the unit; she associated the unit with illness and therefore the café was less stigmatising to her. Jane's difficulties are underpinned by a maladaptive interpersonal schema and in addition the difficulties she had with autobiographical recall consistent with those with AS (Bowler et al, 2000, 2003) a lot of the work looked at problems played out in the therapeutic relationship; these can be seen as directly relevant to difficulties outside the therapy room.

> *"As other therapies have long emphasised, there is often a strong relationship between the interpersonal factors outside the therapy situation and those within"* (Strupp and Binder, 1984, p. 19, cited in Wells & Sanders, 1997).

As the sessions progressed Jane became more relaxed, open and assertive as observed by Jane and me. With help she was able to see her increased confidence in articulating more private and emotive material and the increased speed of thinking and decision making.

Over this short period Jane also showed improvement in her weight as well as her mood, confidence and interpersonal behaviour. Upon discharge her parents stated that she seemed calmer and more engaged. Within session Jane appeared more confident, coherent and realistic about her future and the steps that needed to be taken such as with regard college. Upon discharge she was very much looking forward to leaving school and starting anew. On admission Jane's social interactions with peers and staff had been very limited; however on discharge she was beginning to initiate and appropriately maintain conversations with both staff and peers, albeit, with a "lack of gusto," as reported by the psychiatrist. During structured times such as during

groups with the Occupational Therapist, Jane appeared to “interact better” and could be “quite helpful to younger peers,” as reported by the Occupational Therapist.

Her stay in the unit in general and the psychological therapy in particular, very much enabled her to have opportunity to explore her concerns, to practice the skills she might need in the future and begin to erode some of her unhelpful patterns of thoughts and behaviours such as subtle social avoidance including not talking in social situations. It was important to do this through utilising her motivations and already established skills. For example, Jane travelled independently to and from the unit therefore these independent skills were built upon when helping her join outside groups to help reduce social isolation and broader her interests, this was in conjunction with social skills training. Upon discharge Jane had joined some new friends from school at the weekend for bowling, which she reported she really enjoyed.

During her stay at hospital she completed the Beck Youth Inventory – Second Edition (2005); at the beginning of her stay, midway and then upon discharge. The inventory explores five areas: self-concept, anxiety, depression, anger and disruptive behaviour (please refer to Table 16 for the results).

Date	**Self-concept**	**Anxiety**	**Depression**	**Anger**	**Disruptive Behaviour**
Start	23	22	22	28	10
Mid-way	34	17	12	20	10
Discharge	36	15	12	14	10

Table 16. Results for the Beck Youth Inventory at Start, Midway and End of Therapy

As can be seen, the results support the qualitative information explored within this report i.e. that overall Jane was functioning much better upon discharge compared to when she was admitted. The parents supported this view stating that she was much more flexible and spontaneous at home and seemed more "freed up" (parents words).

However, upon discharge Jane remained vulnerable in social situations. She still appeared perfectionistic about a number of areas in her life, such that she strives for very high and sometimes unachievable standards thus leaving her feeling low when these are not achieved; this has included her body image although this is now

managed. She remains vulnerable due to rigidity of thought and behaviour, inflexible and obsessive thought and behaviour patterns and a tendency to hide a lot of uncomfortable thoughts and experiences thus restricting what can be explored in therapy. Her communication and unusual interpersonal style also leaves her vulnerable to social isolation.

25. Summary and Recommendations

Jane is an adolescent girl with AS, an eating disorder alongside what appeared to be clinical perfectionism. She attended 12 sessions of therapy using an adapted cognitive behavioural therapy approach. The difficulties she experienced with her eating disorder can be seen to have been contributed to and maintained by the features consistent with AS and what appeared to be clinical perfectionism in terms of holding very high standards despite adverse experiences associated with them and with her difficulties around understanding and verbalising internal states, difficulties with social understanding and social skills, rigid, black-and-white and all-or-nothing cognitive style and difficulties in terms of generating and generalising problem solving strategies with which to overcome difficulties. An adapted cognitive behavioural therapy approach partly based on Shafran et al's (2002) model has enabled Jane to begin to identify, explore and modify some of the unhelpful beliefs, emotions and behaviours that appear to be precipitating and maintaining her eating disorder. Subsequently her quality of life and daily functioning has improved. In the future it will be important to continue helping her maintain this progress and generalise her learning. It will also be important to continue targeting the possible clinical perfectionism as a possible pervasive factor in the etiology, maintenance and course of her psychopathology (Shafran et al, 2002) but perhaps using longer term psychotherapy that also taps more interpersonal and socially prescribed dimensions of perfectionism (Glover, Brown, Fairburn & Shafran, 2007) in addition to intrapersonal. Jane agrees that these areas need to be worked on in the future following a therapeutic break. In addition, alongside this, social skills should also be developed to help continue to improve her relationships as it was clear that both her anxieties and social deficits make encounters with others less successful thus confirming her fears about herself and therefore creating a vicious cycle.

26. Appendix

Appendix 1.

Use of the mirror:

- Use mirrors at a slight distance
- Use mirrors that you can see most of your body
- Use mirrors just to do make-up and hair and for short periods only
- Resist using a mirror when you are anxious and worried and want to check and try and reassure yourself about how “pretty” you are or when you feel ugly
- Focus attention on the whole face and body rather than just focusing on specific points
- Only use mirrors, do not use other things not designed for reflection such as CD covers, windows and cutlery

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