Asperger's Syndrome in Adults

Description/Etiology

Although Asperger’s syndrome (AS) as a distinct diagnosis was included in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, the DSM-5 now includes it under the umbrella of autism spectrum disorder (ASD). This change was made in an effort to make the diagnosis of ASD more valid and reliable, since AS was not considered distinct enough from ASD to warrant a separate diagnosis. Although the impact of this change is uncertain, it is possible that individuals with a diagnosis of AS who were denied some needed services through insurance companies may qualify for more comprehensive services with a diagnosis of ASD. On the other hand, many in the Asperger’s community express concern that some individuals will lose access to services because they do not qualify under the new, stricter diagnostic guidelines for ASD. The DSM-5 addresses this concern by stating that individuals with a well-established diagnosis of AS under the DSM-IV should be given a diagnosis of ASD. This change may also have an impact on those with a diagnosis of AS who have integrated this diagnosis into their identity and now must integrate a new diagnosis with more pervasive stigma attached to it.

The DSM-5 classifies ASD as a developmental disorder that is characterized by two psychopathological domains: persistent deficits in social communication and social interaction, and restrictive and repetitive patterns of behavior, interests, or activities. Deficits in social communication and interaction must be present in multiple contexts and may be illustrated by deficits in social-emotional reciprocity and nonverbal communication or deficits in developing, understanding, and maintaining relationships. The DSM-5 requires a specifier for the severity level of social deficits. Level 1 is the mildest and indicates that, without supports, the social deficits will cause noticeable impairments. Level 2 indicates that the individual requires substantial supports, yet even with them deficits may be apparent. Level 3 is reserved for those individuals who require substantial support because of severe deficits in both verbal and nonverbal communication.

The cause of AS is unknown. Although no specific gene has been identified as the cause of AS, a genetic component is likely, as AS often runs in families (Volkmar, Klin, Schultz, & State, 2009). AS affects more men than women and is more common among non-Hispanic Whites than among other races. Onset of ASD usually is before the age of 3, and it persists throughout the individual’s lifetime. Although no specific age of onset was required for a diagnosis of AS, symptoms usually were apparent by the time the child entered school. The DSM-5 requires that the age of onset for ASD be during the early developmental period.

Facts and Figures

In the United States it is estimated that 1–2 individuals per 10,000 have AS (Volkmar et al., 2009). With the new changes for the DSM-5, capturing an accurate prevalence rate in adults will be even more difficult because AS is not formally recognized as a separate diagnosis. In 2006, researchers surveying 27,749 children in Montreal found the prevalence of AS to be 1.01 per 1,000. In the United States, Europe, and Canada, rates of ASD including AS are increasing (Ouellette-Kuntz et al., 2014; Levy, Mandell, & Schultz, 2009). Prevalence of AS and ASD has risen over the past 20 years. This rise may be the result of improved awareness and detection of the disorder and changes in diagnostic criteria (Lai, Lombardo, & Baron-Cohen, 2014). AS is more common in males than females, at a ratio of 9 to 1 (Volkmar et al., 2009).
**Risk Factors**
The cause of AS and other autism spectrum disorders is unknown. There is a recurrent risk of AS in families in which one child has the disorder, indicating that there may be a genetic risk factor. There is no evidence that vaccinations or repeated vaccinations cause autism (Lai et al., 2014).

**Signs and Symptoms/Clinical Presentation**
AS is characterized by impairments in social interactions and restricted interests and behaviors. Individuals with AS often are socially isolated, but may not be withdrawn from others as is typical for individuals with more severe ASD. Adults with AS have difficulty intuitively and spontaneously interpreting social situations. Because of this, they may rely on formal rules of behavior and rigid social conventions. To others, this inability to adapt intuitively may make the individual appear rigid and insensitive to the feelings of others. Adults with AS express an interest in developing relationships with others, but this desire often is stymied by their awkward attempts to engage others and their difficulty with emotional reciprocity. Adults with AS generally have very restricted areas of interest. They may become extremely knowledgeable about a very narrow topic and talk incessantly about the favored subject regardless of the interest level of the audience or the appropriateness of the information given the social context. Adults with AS may adhere to strict schedules and rules of behavior and become overwhelmed by environmental stimuli when taken outside of these conventions and placed in unfamiliar situations. Some adults with AS maintain successful employment, especially if they work in fields where little social interaction is required and when the job allows them to utilize their vast knowledge in their specialized area of interest. Yet many adults with AS have difficulty gaining or maintaining employment because of their difficulties interacting with others, poor interviewing skills, eccentricities, and inflexibility. Many continue to depend on family members for both financial and social support. Adults with AS may appear naive and gullible and are vulnerable to physical and financial victimization by others. They may experience elevated levels of anxiety regarding decision-making and often experience comorbid depression related to their social isolation.

**Social Work Assessment**

› **Client History**
  • A comprehensive biopsychosocial-spiritual assessment should be completed
  • Assessments should be interactive in order to accurately assess the social-communication skills of the client
  • Early development and attainment of development milestones should be assessed
  • Assess the client’s work history, including gaps in employment and reasons for leaving prior places of employment
  • Adults should be assessed for current or past comorbid anxiety disorders and depression, possibly with suicidal ideation
  • Assess for other neurodevelopmental disorders and intellectual disability
  • The client should be referred for a medical examination to rule out any medical causes for symptoms and to identify any co-occurring medical disorders
  • Assess for signs of abuse or victimization by others
  • Assess the client’s past experiences with and response to educational, mental health, or developmental support services

› **Relevant Diagnostic Assessments and Screening Tools**
  • The Ritvo Autism Asperger Diagnostic Scale–Revised (RAADS-R) is a valid and reliable instrument to assist with the diagnosis of ASDs in adults
  • The Autism Diagnostic Observation Schedule–Generic (ADOS-G) can be used to detect autism in both children and adults
  • The Autism Diagnostic Interview–Revised (ADI-R) is a series of interview questions that can be used to assist in diagnosis of ASD in adults and children

› **Laboratory and Diagnostic Tests of Interest to the Social Worker**
  • Genetic testing may be used to rule out congenital abnormalities and other causes for symptoms

**Social Work Treatment Summary**
› Because the symptoms experienced by the adult with AS are neuropsychological in nature, a solution-focused approach to treatment is preferred over an insight-oriented approach. Particularly for young adults with AS, resistance to treatment may exist as the client may not perceive that there is a need for treatment. Providing logical reasons and concrete examples for why the intervention is needed can increase motivation. Interventions should be targeted toward specific behaviors and incorporate coping skills and the development of problem-solving skills. Peer support groups can decrease the social isolation experienced by adults with AS by allowing them to interact with others who experience the same issues and to develop relationships with others who may share their same area of interest. Peer support groups also provide a place in which to practice social skills, problem-solving, and decision-making in a supportive environment (Jantz, 2011). Because
many of the symptoms of AS interfere with an individual’s work environment, attaining self-sufficiency should be a focus of treatment. Referral to vocational supportive services may be needed for those with poor workforce participation. Cognitive behavioral treatment modalities can be used with individuals with AS and comorbid depression and anxiety disorders (Weiss & Lunsky, 2010). Anxiety is frequently a problem for adults with AS, and often these adults are more anxious than a comparison sample of neurotypical adults. Researchers found that the anxiety was most often self-focused, worries about everyday occurrences, or episodes of rumination. Though this is similar to generalized anxiety disorder, these anxious feelings were not always connected with anxious cognitions by the individual. A typical cognitive behavioral therapy approach will not work unless the client with AS is able to recognize how the thoughts are connected to the feelings. If this is not possible, therapy that is more strictly behavioral may be more successful (Hare, Wood, Wastell, & Skirrow, 2014).

Psychopharmacology may be used to address comorbid anxiety or depression, but is not recommended for treatment of the core symptoms of AS. Coordination of care is a critical part of treatment, as many of the social services that were available to persons with AS as children, primarily through the school system, are no longer available to them as adults (Lawrence, Alleckspn, & Bjorklund, 2010). Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the societies in which they practice.

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<tr>
<td>Individual with previously diagnosed AS is seeking a diagnosis of ASD</td>
<td>Establish ASD diagnosis if appropriate, maintain services</td>
<td>Refer to psychologist or medical professional to establish that individual still meets criteria for ASD</td>
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<td>as in order to maintain existing services</td>
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<td>Individual with AS is experiencing inconsistent workforce participation as a result of symptoms of the disorder</td>
<td>Maintain workforce stability</td>
<td>Use cognitive behavioral and problem-solving strategies to assist individual with the development of job-related skills, connect individual with vocational supportive services</td>
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<tr>
<td>Individual with AS is experiencing loneliness and isolation</td>
<td>Improve social skills and increase social supports</td>
<td>Utilize cognitive behavioral and solution-focused social skills training, refer individual to peer support group</td>
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<tr>
<td>Individual with AS is experiencing anxiety and depression</td>
<td>Decrease depression and anxiety</td>
<td>Utilize cognitive behavioral interventions to reduce symptoms, refer for psychopharmacology if indicated, assess for suicidal ideation and safety plan as indicated</td>
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### Applicable Laws and Regulations

Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in the UK) and practice accordingly.

### Available Services and Resources


**Food for Thought**

- Persons with ASD and AS may have a greater sensitivity to the side effects of psychopharmacological interventions because of increased sensitivity to sensory stimuli
- More than 70% of individuals with AS or ASD have co-occurring conditions. These conditions may be medical, psychiatric, or developmental (Lai et al., 2014)
- Social difficulties remain the most stable and constant symptom over time for individuals with AS (Helles, Gillberg, Gillberg, & Billstedt, 2015)
- Difficulty in reciprocal communication can cause issues in intimate relationships for adults with AS who are in a relationship with a neurotypical adult. Researchers believe this may be attributable to the reliance of many adults with AS on prompt dependency (i.e., where a person responds to prompts instead of cues to produce the targeted behavior). If an adult with AS is in counseling for improving relationships with others, this may be an area that needs focus (Wilson, Beamish, Hay, & Attwood, 2014)
- Researchers found that adults with AS had more difficulty recognizing emotions from facial expressions than adults without AS did. This difficulty can have a significant impact on social functioning (Sawyer, Williamson, & Young, 2014)

**Red Flags**

- Adults with AS are at an increased risk for victimization and abuse
- More than 35% of adults with AS report that they have attempted suicide in the past (Paquette-Smith, Weiss, & Lunsky, 2014)
- Individuals with a prior diagnosis of AS will need a reevaluation to obtain a diagnosis of ASD in order to access services
- Bipolar disorder is a common comorbid diagnosis with AS, with prevalence ranging from 6% to 21.4%. The symptoms of bipolar disorder when present with AS can include hypomanic phases with more anger and irritability than euphoria. If psychotic symptoms are present, they can be dominant. These two elements result in frequent misdiagnosis of schizophrenia (Vannuchi et al., 2014)
- Other symptoms in adults with AS that can lead to a misdiagnosis of schizophrenia include strange or idiosyncratic speech that is misinterpreted as delusions, issues with self-care, and social impairments

**Discharge Planning**

- Ensure client can still access necessary services even with DSM-5 changes
- Encourage client to continue to utilize ongoing supportive services such as peer support groups and vocational services

**References**


