# Asperger Syndrome
## Council on Learning Disabilities

**What Is Asperger Syndrome?**
Asperger syndrome (AS) is a neurologically based disability of unknown origin that is thought to occur in approximately 1 in 250 to 500 individuals. First identified by Hans Asperger in 1994, AS is considered by many individuals to be primarily a social disorder; that is, individuals with AS, despite a desire to have friends, have difficulty with social interactions. This includes problems in understanding and using (a) nonverbal communication, (b) nonliteral language, and (c) conversational reciprocity.

Although the majority of individuals with AS have average to above-average intelligence, they often have (a) narrowly defined special interests, for example, electricity, photocopy machines, earthquakes; (b) an inflexible adherence to routines and subsequent anxiety when novel events unexpectedly occur; (c) sensory impairments; (d) fine-motor difficulties; (e) organizational problems; and (f) learning problems. Some children and youth with AS may exhibit behavioral problems (e.g., tantrums, meltdowns), but these often occur when stress and anxiety are present.

Individuals with AS frequently display characteristics seen in children and youth with other special needs (e.g., attention problems, obsessive/compulsive disorder, oppositional defiant disorder). Because to date little is known about this exceptionality, researchers and practitioners are unsure whether these behaviors are a part of AS or are comorbid disorders. AS, along with autism and pervasive developmental disorder, not otherwise specified, is considered by many professionals to be one of the autism spectrum disorders. Asperger noted that even though individuals with this exceptionality experience social deficits, they are capable of exceptional achievements and of obtaining eventual social acceptability.

**How Is AS Assessed?**
AS is a medical diagnosis based on the behavioral criteria set forth in *The Diagnostic and Statistical Manual of Mental Disorders? Fourth Edition, Text Revision* (DSM-IV-TR; American Psychiatric Association, 2000).

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
(1) marked impairment in the use of multiple nonverbal behaviors 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 behavior, interests, and activities, as manifested by at least one of the following:
(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in either intensity or focus
(2) apparently inflexible adherence to specific nonfunctional routines or rituals

(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole-body movement)
(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 delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

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

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia. (DSM-IV-TR)
Because it is difficult to provide a diagnosis based on brief personal contacts, psychiatrists and other physicians often rely on the reports of parents and teachers who know the individual well. To aid in diagnosing AS, physicians may rely on one of two existing norm-referenced measures: the *Asperger Syndrome Diagnostic Scale* (ASDS; Myles, Bock, & Simpson, 2000) or the Gilliam Asperger Disorder Scale (GADS; Gilliam, 2001).


**What Can Be Done to Help Children and Youth with AS?**
Educational and social interventions can provide children and youth with AS with the support and skills they need to be successful in life. Educational interventions that focus on making the environment more predictable are particularly helpful. Graphic organizers and other similar strategies that capitalize on a visual learning style are also beneficial. Because a greater percentage of individuals with AS than neurotypicals have IQs in the gifted range, they need to have learning opportunities commensurate with their skill levels. Therefore, enrichment activities should be a part of the curriculum for many of these children and youth.

For many students with AS, the unstructured or less structured times of the day-such as bus trips, physical education or recess, lunch, classes change times, changes in routine, and before- and after-school times-can be difficult. Each of these areas often requires modifications that provide predictability, structure, and support in order for the individual with AS to be successful.

Although these factors are problematic by themselves, a combination of them increases the likelihood that the student with AS will exhibit inappropriate behaviors and consequently be teased or bullied. Indeed, individuals with AS are more likely to be teased, assaulted, or shunned than are neurotypical children (Little, 2000).

For these reasons, social skills interventions are perhaps more important than educational modifications. A three-phase approach to teaching social skills is often necessary. The first phase, *instruction,* involves the actual teaching of social skills. Strategies such as direct

instruction, social stories, and the Power Card provide the foundation for understanding social skills (Myles & Simpson, 1998; Myles & Southwick, 1999).

Even when the person with AS receives such instruction, situations will occur that require *interpretation*-which is the second phase in effective social skills programs. Interpretative strategies such as (a) cartooning; (b) social autopsies; and (c) the Situation, Options, Consequences, Choices, Strategies, Simulation (SOCCSS) strategy can help turn seemingly incomprehensible actions into meaningful interchanges (Myles & Simpson, 1998; Myles & Southwick, 1999).

The third phase, *restructuring,* involves giving children or youth with AS interventions such as social scripts, visual supports, the Travel Card, and Circle of Friends (Myles & Simpson, 1998; Myles & Southwick, 1999). The goal of restructuring is to create predictability and provide needed support. This three-phase social skills package provides the comprehensive supports that can make the social world understandable.

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**Asperger Syndrome Coalition of the United States:** http://www.asperger.org
**Maap Services Inc**.: http://www.maapservices.org
**Oasis**: http://www.udel.edu/bkirby/asperger

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