

# The angry patient with Asperger's

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Mr. A's social skills are poor, and he has threatened and hit people when angry. What would you recommend for this anxious, depressed, developmentally disabled young man?



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### CASE 'Sad, worried, and angry'

Mr. A, age 24, is referred to our university psychiatric clinic. He reports that he's sad, worried, angry, and wants to hurt people. He endorses having chronic depressive episodes that last >2 weeks and consist of poor sleep, low energy, anhedonia, poor concentration, and psychomotor retardation.

He is developmentally disabled and has been living in a group home for almost 1 year. In former group homes, Mr. A threatened and assaulted other patients and staff. In 1 incident Mr. A broke a patient's nose and was incarcerated for 4 days. With the help of a job coach, Mr. A has been working in a department store for 8 months. He was fired from other jobs because he threatened co-workers.

### The author's observations

Problem behaviors in patients with pervasive developmental disorders include aggression and self-injury. These behaviors may improve with behavioral or pharmacologic interventions.<sup>1</sup> For example, risperidone is FDA-approved to treat irritability associated with autistic disorder in children and adolescents age 5 to 16 years.<sup>2</sup> Violence has been reported in

patients with pervasive developmental disorders, and such symptoms can lead to psychiatric referral.<sup>1</sup>

### HISTORY Difficult childhood

Mr. A's medical history is unremarkable. He has no history of hypomania, mania, psychosis, substance use, tics, seizures, genetic illnesses, head trauma, or physical or sexual abuse. He has never attempted suicide nor been hospitalized for psychiatric illness.

With Mr. A's permission, his mother is consulted. She says that as a child Mr. A would become extremely interested in various topics—including Pokémon, Magic cards, and video games—and had a strong desire to tell everyone the details of each. However, he rocked back and forth, had few friends, and would bite other children.

Mr. A has no history of language delay but received speech therapy during his childhood to help him "work on eye contact and social skills." He is estranged from and angry with his father, who has difficulty accepting his son's developmental disability.

At the time of referral, Mr. A is receiving paroxetine, 30 mg/d, for depression, risperidone, 1.5 mg/d, for aggression, and dextroamphetamine/amphetamine extended-release, 30 mg/d, for hyperactivity/inattention. The efficacy of these medications,

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### Clinical Point

Problem behaviors in patients with developmental disorders include aggression and self-injury

**Table 1**

## Diagnostic criteria for Asperger's disorder

<b>A. Qualitative impairment in social interaction, as manifested by <math>\geq 2</math> of the following:</b>
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 (eg, by a lack of showing, bringing, or pointing out objects of interest to other people)
4. lack of social or emotional reciprocity
<b>B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by <math>\geq 1</math> of the following:</b>
1. encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
2. apparently inflexible adherence to specific, nonfunctional routines or rituals
3. stereotyped and repetitive motor mannerisms (eg, hand or finger flapping or twisting or complex whole-body movements)
4. persistent preoccupation with parts of objects
<b>C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.</b>
<b>D. There is no clinically significant general delay in language (eg, single words used by age 2 years, communicative phrases used by age 3 years).</b>
<b>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.</b>
<b>F. Criteria are not met for another specific pervasive developmental disorder or schizophrenia.</b>
<small><b>Source:</b> Diagnostic and statistical manual of mental disorders, 4th ed, text rev. Washington, DC: American Psychiatric Association; 2000</small>

which were prescribed by an outside psychiatrist, is unclear.

On the Wechsler Adult Intelligence Scale-Revised, Mr. A's full scale IQ is 77, verbal IQ is 77, and performance IQ is 81, indicating borderline intellectual functioning. He feels frustrated with his job and depressed because he is not in a romantic relationship. Although Mr. A worries about his job and lack of relationships, he does not meet criteria for an anxiety disorder.

Based on Mr. A's impaired social interaction, repetitive interests and behaviors, and lack of language delay, Mr. A meets criteria for Asperger's disorder (*Table 1*). He also meets criteria for major depressive disorder, recurrent, moderate.

### How would you treat Mr. A?

- increase paroxetine dosage
- switch to a different antidepressant
- increase risperidone dosage
- increase dextroamphetamine/amphetamine extended-release dosage
- provide social skills training and cognitive-behavioral therapy

### The author's observations

Psychosocial interventions for patients with an autism-spectrum disorder consist of educational, vocational, behavioral, and family interventions. Individual, group, and family psychotherapy may benefit patients with Asperger's disorder who have comorbid depression.<sup>1</sup>

## TREATMENT A rocky start

At Mr. A's initial assessment, the clinic psychiatrist increases risperidone to 1 mg twice daily to target aggression. Even after receiving this dosage for 1 month, however, Mr. A continues to display physical aggression toward peers in the group home whenever he becomes angry.

The psychiatrist refers Mr. A to a social worker for supportive therapy to help him cope with worry and chronic sadness. The social worker uses general cognitive-behavioral strategies for anxiety and aggression for 12 sessions over 8 months until scheduling conflicts end therapy. The efficacy of this therapy is minimal; Mr. A remains depressed, anxious, and aggressive. During this time, the psychiatrist increases paroxetine to 40 mg/d, but Mr. A continues to feel depressed after 1 month. Mr. A is cross-tapered to duloxetine, but continues to feel depressed after receiving duloxetine, 60 mg/d, for 1 month.

My first visit with Mr. A occurs 3 months after his last visit with the social worker. He states he does not remember anything from those sessions. Mr. A's goals for therapy are to reduce anxiety, manage anger, and improve relationship skills.

I begin the first 4 months of Mr. A's therapy with cognitive-behavioral interventions based on the Treatment of Adolescents Depression Study (TADS) manual.<sup>3</sup> Although Mr. A is an adult, I choose a manual that targets adolescents because my clinical impression is that his cognitive developmental level is more like an adolescent's than an adult's.

I assign homework such as mood monitoring. I ask him to use a form from the TADS manual to rate his mood on a scale of 0 to 10 every morning, afternoon, and evening, and write down what he is doing that makes him feel that way at the time he rates his mood. Mr. A never completes any homework; during each session he states he "just forgot to do it."

I discuss concepts such as goal setting, for a novel Mr. A says he wants to write, and relaxation strategies to address anger; in session, I

work with him on filling out the "What Helps Me to Relax?" form from the TADS manual. Mr. A lists "play games," "write my book," "listen to music," "go outside," and "exercise" as strategies to help him relax. We also work on visual handouts—such as "Safety Plan" and "What Can I Do to Relax"—to post in his room.

Mr. A does not show up for 3 sessions. When I call the group home, a staff member tells me they were busy with other patients and forgot about Mr. A. I decide to call the group home the day before each appointment as a reminder. This increases Mr. A's attendance rate.

During each session, Mr. A complains about the quality of the group home, the staff, and other patients. To get my own perspective of Mr. A's living environment, I consider visiting his group home, similar to how a geriatric psychiatrist sees patients in a nursing home or an assertive community treatment team psychiatrist sees patients in their home environments. Because I am concerned about boundary crossings/violations, I first discuss this action with 2 psychotherapists not involved in Mr. A's treatment. They recommend that I limit this action to a one-time visit.

I visit Mr. A's group home 2 months after my first session with him. Located in front of a dairy farm in a rural part of the state about 1 hour from our clinic, the isolated facility has a secured keypad entry. When I meet Mr. A there, he says he feels as if he is in jail. I meet the staff and find them willing to help with various aspects of Mr. A's treatment, such as discussing events, reporting behaviors, and helping carry out interventions.

For example, I ask staff to remind Mr. A of his relaxation strategies when he becomes angry. On the "Safety Plan" handout, I had Mr. A identify 5 people he could talk to when he becomes angry; I ask staff to remind him of those people when Mr. A becomes angry. I also ask staff to ask Mr. A every day if he is writing the novel he wants to complete. After my visit, Mr. A starts putting more effort into therapy. When I set a daily goal of working on his novel for 15 minutes, he starts bringing pages of his writings to sessions.

## Clinical Point

A combination of psychosocial and pharmacologic interventions may benefit Asperger's patients who have depression

continued

## Clinical Point

Enlisting the help of staff in Mr. A's group home led to the patient putting more effort into therapy

**Table 2**

### Social skills training for patients with Asperger's disorder

**Starting a conversation:** "Hi, how was your day?"

**Staying on topic:** "Oh, that sounds interesting. Tell me more about..."

**Making eye contact:** Look at people's eyes when talking to them

**Greetings:** "Hi, how are you?"

**Ending a conversation:** "Well, I have to go now. I'll see you later!"

**Shifting topics:** "Speaking of..., did you hear about...?"

**Source:** Reference 7

Two months into therapy, Mr. A is cross-tapered from duloxetine to bupropion extended-release, 150 mg/d. This attempt to improve his restricted affect is ineffective. Risperidone and dextroamphetamine/amphetamine extended-release dosages are unchanged.

#### The author's observations

In a study in rural Appalachia, telephone reminders increased attendance at psychiatric intake appointments.<sup>4</sup> Calling the group home before each of Mr. A's appointments took extra time out of my schedule but improved Mr. A's attendance rate.

In residential treatment of children, Monahan notes that childcare workers could contribute useful observations and benefit from the therapist's advice.<sup>5</sup> Establishing rapport with the staff at Mr. A's group home helped me proceed with therapy.

#### Social skills training for patients with Asperger's disorder can be optimized by:

- using a manual developed specifically for this population
- practicing skills in "real-world" settings
- enlisting the help of caregivers
- all of the above

#### TREATMENT Social skills training

In the second 4 months of therapy, Mr. A changes jobs to become a greeter in a local video game store. He is happy, and group home staff members are pleased they no longer spend 2 hours each day transporting him to his previous job.

Soon after, during a reminder phone call, a staff member tells me that Mr. A's brother and father were murdered the prior week. Three staff members attend Mr. A's brother's funeral, which he appreciates. Mr. A refuses to attend his father's funeral because of continued anger toward him.

When I ask Mr. A if he wants to talk about the deaths, he declines. I subsequently spend half a session discussing strategies to address grief,<sup>6</sup> such as imagining a conversation with his deceased brother.

I decide to review Mr. A's therapy goals because he still has a lot of anger toward his recently deceased father. I am concerned he might discharge this anger onto a staff member, coworker, or fellow patient. Mr. A states he wants to focus on relationships, especially his anxiety around women. He discusses his anxiety with starting and maintaining conversations with women.

I begin role-playing in sessions by pretending to be a woman for Mr. A to speak with, but he feels this is silly. I teach him exercises from a social skills training workbook developed for patients with Asperger's, such as "Starting a conversation," "Staying on topic," and "Making eye contact" (Table 2).<sup>7</sup> Mr. A says group home staff members occasionally take him out to a nearby nightclub and encourage him to talk to women.

To see how Mr. A behaves in public, during our sessions I take him to different parts of the hospital, such as the gift shop, library, and deli. I instruct him to ask various women non-threatening questions, such as how much a certain entrée costs. I note his body language, such as tilting his head down and fidgeting during conversations. I provide him with immediate feedback, which slowly increases his awareness of these behaviors.

With Mr. A's permission, I educate the group home staff about how to point out these behaviors when Mr. A is in public. I ask them to focus on body language and emphasize that Mr. A needs to apply what I teach him to other settings.

### The author's observations

Patients with Asperger's disorder need specific training to build a repertoire of social skills.<sup>7</sup> Teaching in real-life settings helps patients generalize these skills.<sup>1</sup>

Zimmerman<sup>8</sup> discusses how caregivers might have an unrealistic, "magical" view of psychotherapy and feel suspicious of the process. With Mr. A's permission, I ask group home staff members to meet with me for 10 minutes at the end of each of Mr. A's sessions to make them aware of what is happening with his therapy. I want them to feel that they are an important part of Mr. A's therapy. These meetings may have alleviated staff members' fears about my time with him. Even though Mr. A granted me permission to disclose all details of our sessions with the staff, I was careful to not disclose sensitive issues, such as the patient's dreams and fantasies.

### TREATMENT 'Fear'

Mr. A rates his anxiety as a 4/10 whenever he speaks with women. To more specifically understand his underlying cognitions, I use Kendall's FEAR plan (Table 3).<sup>9</sup>

I ask him to divide his automatic "E" thoughts into "she" and "I" thoughts. Examples of automatic "she" thoughts include "She probably won't like me" and "She thinks I'm not cute." Examples of automatic "I" thoughts include "I'm probably not smart enough for her" and "I think we won't have anything in common."

I instruct him to first rate how sure he is of each automatic thought, then to find evidence for or against each thought, and finally to come up with a coping counter-thought. I

Table 3

### The FEAR plan\*

F=feeling anxious

E=expecting bad things to happen

A=attitudes and actions that can help

R=results and rewards

\* Developed to help anxious children and adolescents recognize signs of anxiety, relax, and modify anxious self-talk and thinking.

Source: Reference 9

educate his caregivers about this process and ask them to work through these steps when they take Mr. A out in public.

### The author's observations

Schwartz<sup>10</sup> discusses countertransference challenges in nursing home patients, where therapists identify with patients' hopelessness. Schwartz recommends addressing these challenges by thinking of realistic expectations. Even though a facility might be far from perfect, it may be "good enough."

Mr. A's group home was far from perfect and located in an isolated setting. Even so, I was able to help him complete psychotherapy at our clinic by adapting my practice to his needs, including:

- making reminder phone calls for appointments
- visiting the group home
- enlisting the help of caregivers with therapeutic techniques.

As a result of our psychotherapy and medication changes, Mr. A displays no aggressive behaviors during the last 9 months of therapy.

### OUTCOME Improving

In the final 4 months of therapy, we continue to work on social skills lessons, practice exercises in the hospital, and the FEAR acronym. I continue to include caregivers in these efforts.

### Clinical Point

Teaching social skills in real-life settings helps patients with Asperger's disorder generalize these skills

## Clinical Point

Psychotherapy and medication changes result in Mr. A displaying no aggressive behaviors during the last 9 months of therapy

During 1 session, I tell Mr. A I will be leaving at the end of my fellowship. In the final month, I gradually transition him to a new therapist. I decided to transition him to a male therapist so Mr. A will continue to feel comfortable sharing his feelings, rather than shutting down from anxiety with a female therapist. As I end therapy, Mr. A is promoted to a cashier at the video game store and enrolls in classes to study for a General Education Development (GED) certificate.

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## Related Resource

• National Institute of Mental Health. Autism spectrum disorders. [www.nimh.nih.gov/health/publications/autism/complete-publication.shtml](http://www.nimh.nih.gov/health/publications/autism/complete-publication.shtml).

### Drug Brand Names

Bupropion extended-release • Wellbutrin XL	Duloxetine • Cymbalta
Dextroamphetamine/amphetamine extended-release • Adderall XR	Paroxetine • Paxil
	Risperidone • Risperdal
	Ziprasidone • Geodon

### Disclosure

The author reports no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

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## Bottom Line

Aggressive, anxious, and depressed patients with developmental disability can benefit from social skills training and cognitive-behavioral therapy in addition to psychopharmacology. Patients may benefit from adaptations to usual practice, such as phone call reminders of appointments. Enlisting the aid of caregivers with these interventions has potential to increase treatment efficacy.

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