CHAPTER 10

Do You See the Forest or the Tree?

Utilizing Client Interests and Strengths in a Case of Asperger's Syndrome

Diane Yapko

MEET THE CONTRIBUTOR

Diane Yapko, MA, is a licensed speech-language pathologist residing in Fallbrook, California. She worked at the University of California San Diego Medical Center and in private practice for almost 30 years assessing and treating children with autism spectrum disorders and other neurological and developmental disorders. She writes, conducts workshops internationally, and consults. She is the author of *Autism Spectrum Disorders: Frequently Asked Questions,* two book chapters on the subject of autism spectrum disorders, as well as articles on this and related subjects.

Diane's exposure to positive psychology and the various models of psychological treatments began over 30 years ago when she married her husband, psychologist Michael Yapko. She has traveled internationally with Michael and has integrated many different professional disciplines, such as psychology, hypnosis, play, and humanism, into her work with children. When not working, Diane enjoys spending her time with Michael outdoors hiking, walking on the beach, or just hanging out in their backyard.

In this chapter, I describe the case of Mark (not his real name), an 11-year-old boy with a diagnosis of Asperger's syndrome (AS). I worked with Mark in individual therapy on a weekly basis over the course of several years in my private practice as a speech-language pathologist. The parent of another client whom I was treating referred him to me. The presenting concern was Mark's ''pragmatic language.'' This meant that Mark had difficulty with social language, which translated into difficulties communicating with his peer group and developing friendships.

It has been almost 30 years since I saw my first client with an autism spectrum disorder (ASD), and the challenge of working with this population continues to fascinate me. While there is a growing awareness for people who have autism and Asperger's syndrome worldwide, much of that information is about their *dis*abilities (what they *cannot* do, what they struggle with, and how they act "odd" or "unusual"). This chapter provides readers a glimpse into the positive attributes, or *a*bilities, that the ASD population possess. I describe Mark's case and how his unique *a*bilities were utilized in therapy to facilitate his social language and conversational skills.

AN AUTISM SPECTRUM DIAGNOSIS

The term *autism spectrum disorder* has come to be used to describe a group of five disabilities that have traditionally been called pervasive developmental disorders (PDD). These include:

1. Autism
2. Asperger's syndrome
3. Rett's syndrome
4. Childhood disintegrative disorders
5. Pervasive developmental disorder—not otherwise specified (PDD-NOS)

The diagnosis of ASD is based on a variety of subjective data, such as clinical observation, standardized questionnaires, and test instruments. Currently, there are no objective medical tests, such as brain scans, blood work, or genetic tests that can confirm a diagnosis of ASD. Wherever a person falls on the autism spectrum, from those severely affected by their symptoms to those higher-functioning individuals with less obvious symptomatology, a diagnosis on the autism spectrum essentially means that the person has difficulties in the areas of language, social communication, and behavior to one degree or another (D. Yapko, 2003).

There are inherent contradictions evident in people diagnosed with Asperger's syndrome. For example, despite their normal to above-average intellectual capabilities, they typically struggle to fit in with the social demands and expectations of society. Metaphorically speaking, they often have specific islands of intellectual strengths in an otherwise turbulent ocean of social confusion. Despite their advanced vocabulary skills, they often have significant difficulty understanding or being able to use subtle, indirect, and abstract language skills. And despite their obsessive interest and focused attention on certain idiosyncratic topics of interest, their ability to attend to things outside that singular and narrow sphere can be significantly limited. These contradictions present interesting challenges and unique opportunities to the clinician to make deliberate therapeutic choices about whether to focus on one's strengths and abilities or to reduce weaknesses and pathology.

Positive Psychology in a Therapist's Practice: Focus on Ability or Disability?

Do you see the forest or the tree? One of the basic perceptual rules of attention and a core concept in clinical hypnosis is that what you focus on, you amplify (M. D. Yapko, 2003). If

you focus on the forest you become less aware of an individual tree. Attend to the characteristics of that individual tree and you are less likely to see the big picture of the forest. Similarly, if you focus on disability that, too, is what you are likely to see more of. If you pay attention to ability, what do you see and help foster?

The children I work with have identifiable differences that can, and often do, affect their ability to relate to others in negative ways. The list of things that these children are unable to do is often extensive. But what happens when I choose to focus my attention—and encourage parents and teachers to focus their attention—on what a particular child can do and is doing *well*? In my experience, my interventions are greatly enhanced, and there is good research evidence to support these subjective impressions.

In a classic study, called the Oak School experiment or the Pygmalion effect, Robert Rosenthal, a Harvard University professor, and Leonore Jacobson, a principal of a San Francisco elementary school, demonstrated that when teachers were told that certain children had the ability to blossom and succeed based on their test scores, the teachers treated those children differently (Rosenthal & Jacobson, 1968). The end result was that these children's test scores improved more at the end of the school year than did the scores of others in the classroom. This experiment, done in the late 1960s, highlighted the fact that one's expectation established a self-fulfilling prophecy, which played a critical role in behavior change in terms of what the teachers did with the children as well as how the children responded. Research regarding expectancy and self-fulfilling prophecy can easily be applied to enhancing the positive attributes in children with ASD by focusing on and developing those attributes in various contexts.

As a speech-language pathologist (note that even the formal title of my profession includes the word *pathology*!), my work has been exclusively with children who manifest a variety of different communication problems. You will notice I said "problems," not strengths. Realistically, when people come to therapy, it is because they are seeking help with something that is not working well for them. So, inherently, we start from a deficit perspective. But how we approach or focus on that perceived or real deficit in treatment is negotiable.

Finding My Focus

I learned to focus on the positive early in my career. One of my very first clients was a teenage girl, about 13 or 14 years old, in a coma. She had sustained a head injury after falling off a horse and was an inpatient at the University of California San Diego Medical Center, where I worked at the time. I will never forget the experience of walking into the intensive care unit (ICU) and seeing this young girl hooked up to tubes and intravenous drips and monitors, appearing lifeless, and watching her mother talk to her as if she was just at rest. I think that was when I first became aware of the "heart" of positive psychology and felt its impact on me and my work. Of course, I did not know then that such an approach would eventually be called positive psychology, but I became aware of the power of positive expectancy and the benefits of placing emphasis on the strengths and interests of my clients (Seligman & Csikszentmihalyi, 2000).

My therapeutic goal, as prescribed by my supervisor at the time, was to stimulate this young girl's senses in the hope it would facilitate her recovery and establish an eventual mode of communication with her. Communicate with her? What was my supervisor thinking? This girl was in a coma! It would have been easy to focus on all the things that she could not

do, but instead, I immediately went to work and began asking her mother questions about Stacy's (not her real name) interests. I encouraged her to bring in some of Stacy's favorite music from home, and I played it for her through headphones on my tape recorder (there were no iPods or MP3 players back then). I asked Stacy's mother to fill old 35 mm film canisters with various products that Stacy could smell. Strong smells like coffee, cinnamon, and lotions were used, as well as colored markers that had smells with familiar flavors ranging from licorice to cherry to lemon. I also asked her mother to bring in favorite items from home that I could put in Stacy's hand, such as a stuffed animal or blanket. Twice a day, five days a week, for a couple of weeks, I stood at Stacy's bedside in the ICU and stimulated her senses of touch, smell, and hearing for 20 to 30 minutes. I suggested her mother do the same when I was not there. I encouraged her to keep talking to Stacy ''as if'' she were hearing and understanding everything. I told her to talk to her about things such as what was going on in the hospital, about her recovery, and what was happening with friends and family outside of the hospital. I also asked her to talk about things that were planned for the future that Stacy might enjoy (e.g., ''When you get out of the hospital, we'll go to the beach and enjoy lying in the sand and swimming'').

The results of our efforts fascinated and inspired me. Stacy began responding. Initially there were nostril flares with certain smells, then head turns, and squeezing items placed in her hand. Eventually Stacy made noises to protest and eye blinks to affirm things we said and did. It was several months before Stacy was able to communicate again verbally. To my amazement, she told us that she remembered some of the stimulation techniques her mother and I had used to engage her.

To this day, I do not know what extent my work played in her recovery. I only know that it changed my expectations and my behavior in how I worked with *all* future clients, no matter how hopeless they may have seemed. I never again predetermined what a client could and could not do, especially based on physical appearance or anyone else's preconceived notions of what was possible. I strive to keep my mind open to any strategy or technique that might work with a particular client based on the conditions of the moment (the context) and the client's interests, regardless of whether it fits within any theoretical framework.

THE CASE OF MARK

The Assessment

Mark was the 11-year-old boy with Asperger's syndrome whom I mentioned at the beginning of the chapter. His mother reported that Mark had poor eye contact, difficulty with personal space, odd posture and gait, an unusual tone of voice, poor hygiene, inability to take personal responsibility for his actions, difficulty with recognizing cause and effect as it related to personal relationships, and a rigid cognitive style that included all-or-none thinking. And that was to name just a few of the issues, along with the ''pragmatic language'' problems, that were identified when he came to therapy. When I spoke with Mark, these issues were immediately apparent in our initial session. However, none of the psychological or educational tests that had been administered to Mark previously had revealed any of these behavioral, cognitive, or social issues. They did, nonetheless, reveal his above-average IQ and his outstanding vocabulary abilities. I conducted a number of standardized language tests as part of a comprehensive protocol required by his school

district to help develop Mark's individualized education plan at school, but the test results were not nearly as helpful in assessing him as was simply talking to him. As is often the case with individuals with AS, test scores do not adequately represent either their abilities or disabilities. Tests may be a starting point for some clinicians or may be required by some bureaucracies, such as a school district or funding agency, but most often it is the "real-life" interactions that allow a clinician to see what a client can and cannot do and what the client wants or needs to do in order to accomplish a goal. My treatment is goal oriented and begins with this question: What does the child want or need to do to be effective in the contexts that are limiting him or her?

Mark easily fell within the average range on all the standardized language tests that were administered. Anyone reading the test results could easily conclude that Mark's language was within normal limits (a strength). But nothing could be further from the truth in terms of his *social language* abilities. Mark's inability to carry on a normal conversation and read the nonverbal cues of others, such as tone of voice and facial expression, were clearly deficits. Thus, the formal tests did not tell me anything about Mark's deficits or his strengths and interests. They did not tell me how extensive Mark's knowledge of trees was or his inexhaustible ability to talk about them. The test results did not show me his artistic abilities or his ability to recall details of his life experience, albeit mostly negative experiences of being bullied. It was only through talking to him that I learned this information. Formal test results lacked an ability to capture Mark's desire to have friends, even though his behaviors led most people to assume otherwise. It bears repeating that there is no substitute for personal interaction, keen observational skills, and a positive emphasis on looking for a client's resources in order to use them in treatment.

Setting the Stage

Unlike adults who typically choose to come to therapy to address a problem for which they want help, children often do not have goals in therapy. In fact, they often question why they are even there in the first place. I usually address this directly by asking kids if they know why they have come to my office. Some do, and will give the explanation that they have heard from their parents. For example, they may say, "You help kids with their speech," or "You help kids learn how to have friends." Other times, though, when kids say they do not know why they have come or perhaps do not want to discuss it, I simply offer a global answer, such as "Your mom [or dad, or teacher] tells me that you can do _____ really well, but you seem to be having some trouble with _____. They thought I could work together with you and we'd figure out how to help you with _____."

I like kids to know from the start that I am aware of something they can do well. I do not want to immediately address a problem that they are likely already too aware of. My goal is to help them resolve it in some collaborative way by first establishing a positive expectancy for change(s) that we can make happen together. Depending on the child's interest, this explanation may continue into a discussion or simply end with no further comments. I follow the child's lead here, as I do in most of my work. When children recognize an area of need, either on their own or in agreement with a presented concern from a parent or teacher, that is usually where I begin my treatment. However, in some instances, when children do not believe they have any problems and may in fact be angry about coming to my office, I suggest that we might simply forget about what the parents and teachers are worried about and play a game of the child's choosing.

This was the case with Mark, who seemed oblivious to his own shortcomings. He simply blamed all those around him for not being polite and listening to him when he talked (as he had been told to do with others). As we played the game (it does not matter what game is chosen, since the game is only a distracting context for engaging the child in conversation in a less direct and threatening way), I encouraged Mark to tell me about things he liked and things he could do really well that he might be able to teach me. He began by telling me that he knew a lot about trees. I asked him what kinds of trees he knew about—and that was the last time I spoke for at least the next 10 minutes. He launched into a monologue leaving no room for a balanced interaction.

Mark rarely paused in the litany of information he gave, there were no questions asked of me, there were no chances for me to comment about a shared piece of information or experience, and the minutia of detail was well beyond any level of interest I had in trees. Mark did not appear to be aware that I was in the room and ostensibly his conversation partner. He often looked around or down rather than at me, seemingly talking to empty space. He was therefore not able to observe any feedback available to him from my body posture or facial expression regarding my level of interest or understanding, much less interpret such cues appropriately and respond to them.

Goal Setting

I could have addressed a number of different goals with Mark when he began therapy. By starting with his area of interest (talking about trees), it was an easy introduction into the art of conversational skills. Had his interest been in pipes and plumbing instead, I might have chosen to start therapy with hygiene issues. Or had his interest been in physics and atoms colliding in space, I could have addressed the issues he had with physical proximity to others.

Mark and I addressed many different goals over the three years we worked together. For this chapter, I have chosen to write about my goal of helping Mark develop his conversational skills for three reasons.

1. This goal is a common one for people with AS and, therefore, I hope it will have broad applicability for clinicians working with this population.
2. This goal encompasses a number of other related goals, including the opportunity for Mark to: develop more flexibility in his thinking, learn about perspective taking, read nonverbal cues, take personal responsibility, and understand cause and effect as it relates to interpersonal skills.
3. It illustrates some of the principles and processes for working from a positive perspective with a client's *a*bilities.

Philosophically, as a therapist, I am inclined to focus on individual strengths and personal resources. Yet, practically, I could not ignore the fact that some of the odd or unusual behaviors that Mark exhibited would not be tolerated within society or his peer group. They would only subject him to ridicule or allow him to be taken advantage of by others. Therefore, I found myself alternating between minimizing Mark's deficits while enhancing and utilizing his strengths. I was modeling the very flexibility that I wanted to teach Mark. I wanted him to learn that our interactions did not have to be "all or none," as was typical of his own rigid thinking style, a cognitive distortion often referred to as dichotomous thinking (Beck, 1976).

The Intervention

I knew from Mark's mother and the reports that were shared with me that Mark did not communicate effectively with or fit into his peer group. It is common in many individuals with AS that their personal areas of interest (trees, in Mark's case) become an exclusive conversational topic maintained at the expense of other people's interests. I generally focus on how I can use the resources that a client presents. In this case, those resources included Mark's memory for details, his knowledge about trees, and his ability to articulate this information using appropriate vocabulary and grammar. After Mark spent about 10 minutes talking about trees, I finally interrupted him and said, "Wow, you really do know a lot about trees!" The next exchange highlights how I proceeded to introduce several of the goal areas we would address in therapy, including the mechanics of conversations such as turn taking, questioning, recognizing, interpreting, utilizing nonverbal cues (eye gaze, facial expressions, tone of voice), taking personal responsibility for being an active conversational partner, and flexibility in how to manage wanting to talk only about trees when others were not interested.

"Do you know what *I* know about trees?" I asked.

"No," replied Mark.

"Why not?" I inquired.

"You didn't tell me," he answered.

"You didn't ask!" I responded.

This was the first opportunity to share with Mark that he had a personal responsibility to be an active partner in this exchange and that learning to ask questions was an important way to do that. To determine whether Mark knew *how* to ask a question or just did not want to ask questions, I simply asked him, "Can you think of a question to ask me about trees?" When he said, "Do you know about the Redwood trees in California?" I discovered he knew about the mechanics of questions. I reinforced this skill and told him that was a really good question, then asked if he could think of any others to ask me. He generated several others, such as: "Do you have a favorite tree?" "What trees are at your house?" "Do you know what the biggest tree is?" Because these questions were not identical in structure to his previous question, it indicated to me that he had yet another resource I could use in therapy. He was able to be flexible in his questioning, at least when the topic was trees. This would eventually be a good starting point to build on his ability to ask various types of questions on other conversational topics.

Mark knew *how* to ask a question; now my goal was to focus on teaching him to know *when* and *why* to ask questions in a conversation. I explained that he was good at asking questions and wondered if he would play a game with me to see how many questions he could ask. He would get 1 point every time he asked a question and 2 points if the question was directly related to something I had just said. I began with the comment, "I like ice cream." Mark asked, "What's your favorite flavor?" I responded, "Great question. Two points!" and promptly made 2 marks on a piece of paper. I offered another arbitrary comment. "I'm going to Australia next month." Mark said, "They have eucalyptus trees there." I picked up the pencil to make a mark on the paper and then stopped and slowly made an exaggerated facial expression, representing uncertainty or curiosity or maybe even confusion. Mark took several seconds to process the situation before he spontaneously asked, "Have you ever seen the eucalyptus trees there?" My pencil immediately hit the paper, my face turned into a broad smile of satisfaction, and I said, "Two points!" I went on

to compliment Mark and said, "You just did something great. Do you know what you did?" Mark was obviously pleased that he had been complimented but was also confused by the question. He responded, "I asked you a good question." I confirmed that indeed he had asked a good question but that he had done something else really great. He had actually changed his original comment ("They have eucalyptus trees there") into a question ("*Have you ever seen* the eucalyptus trees there?) by observing many different aspects of the situation. He had to recall that the goal was to ask questions, to recognize that he had not asked a question, to see my face as showing some expression (I did not know at the time whether he had actually processed any meaning from the expression) and he had to observe that I had not made any mark on the paper. He had just demonstrated to me (and to himself) that he could learn to read nonverbal cues! This was only a first step on a long road for all that would be necessary to teach him the skills for understanding nonverbal cues. But it highlighted a strength I could identify and utilize for him, empowering him to know he could do this.

Next, I returned to the issue of *when* and *why* to ask questions in conversation by making a list with Mark. I titled the page "*Why* Do We Ask Questions?" and then started to list the reasons: (1) to gain information, (2) to clarify something that is not understood, (3) to show interest in someone else, and (4) to maintain a conversation. Examples were given and as new situations arose, and as therapy progressed, we added to our list. I developed another list for Mark titled "*When* Do We Ask Questions?" I explained that some of these would be duplicates of "why" we ask questions, for example: "We ask questions when we want to show interest in what someone is talking about." We added other things to this list regarding the timing of "when" to ask questions, including (1) when there is a break in the conversation, you can ask a question to maintain the conversation; (2) when someone takes a breath, you can ask a question to get clarification; (3) when you want to change the subject, you can ask a question as a bridge from one conversational topic to another.

While this was just the beginning of therapy, it was a positive way to highlight for Mark that he had many strengths and skills he was already using and that we could develop them further. I told him I was confident that we could work together to help him learn to have conversations with his "friends" at school, but it would require much practice and repetition.

Falling back into his routine of a tree monologue was common for Mark. So I explained that we were beginning to "plant the seeds" of what it would take to have a good conversation with someone. The seed metaphor was simply another way to help Mark understand and, I hoped, be interested in what we would be doing together in therapy. I often use metaphor with clients to help them comprehend something they might not otherwise understand or even be interested in understanding. Typically, individuals with ASD do not comprehend subtle or abstract language and have difficulty with figurative language and metaphor. As a generalization, this is true. However, metaphor can be a helpful and a *concrete* way to explain a concept by using one idea to represent another. I have found that many children understand and benefit from metaphor, especially if it utilizes an area of their interest, such as Mark's trees. It can make a difficult or uninteresting concept more interesting, accessible, and more easily remembered by the client. I frequently referred back to the seed metaphor when Mark became frustrated in therapy, such as when there had been no immediate positive feedback from friends despite him trying some of the strategies he had learned in therapy. I reminded him that it takes a lot of water and sunlight, which I

associated to time and patience, for the tree to grow. This served Mark well in realizing that it would take a lot of practice and repetition before the skills he was learning were more automatic and comfortable for him to use with friends. It also helped Mark build frustration tolerance.

Another important aspect of the conversational goal was the ability to understand other people's perspectives. Comic-strip conversations are a common approach used for this purpose. Developed by Carol Gray (1994), this method can help children on the autism spectrum concretely see what people say and what people think by using the speech and thought bubbles commonly employed in comic strips. I have modified the technique to use the thought and speech bubbles whenever I want a child to see the relationship between one's own thoughts, speech, or actions and those of others. I do not necessarily develop it into a sequential comic strip or story but may instead use only a single drawing to represent the idea I am trying to teach. In Mark's case, the thought and speech bubbles were especially relevant therapeutically when I wanted to show him that he had to take some personal responsibility in a conversation. He needed to see that there was a cause-and-effect relationship between his talking about trees and others' disinterest—and then their ultimate teasing him.

I drew a stick figure (representing Mark) and the speech bubble coming from his mouth with the word *tree* written many times to symbolize that he always talked about trees. Then I drew three other stick figures standing together with thought bubbles coming out of their heads to represent peers and their thoughts as Mark talked about trees. I wrote such things as: "Oh no, here he goes again," "Let's just leave, he's so boring," "Why can't he talk about anything else!" I used this to show Mark in a concrete way (a) that the boys were not interested in trees the way he was, (b) that they were tired of always hearing him talk about the trees, and (c) that whenever they saw him, they associated those thoughts to him. Therefore, he needed to understand that he was part of that picture. He may have been a cause of the undesired effect. I am always cautious when addressing this issue of cause/effect and personal responsibility, because I do not want to blame the child for his or her problems. Yet, at the same time, I have found that too many of the children I work with take no responsibility and blame everyone else without realizing that they contribute, at least in part, to their situation. It may not be socially correct or therapeutically helpful to "blame the patient," and that is why I am careful about the words I use when having this discussion. I use words like "*may* have been a cause" (leaving room for the chance that it might not be the client) or "*part of* the cause" (leaving room for other causes). But there is no doubt a relationship between what the client is doing and the end result, and that is what I want my clients (young children and adolescents alike) to know.

Treatment Summary

My treatment with Mark, and all my clients for that matter, tends to include many different interventions. I do not think of myself as ascribing to any one theoretical orientation. In presenting this case, I have shown the use of positive psychology by recognizing Mark's strengths and orienting my approach to what Mark *could* do as a way of teaching him what he needed to and could learn to do *better*. I also used behavioral therapy principles in my sessions with Mark, as I reinforced positive or desired behaviors and either minimized or ignored negative and ineffective behaviors. And finally, at the heart of my therapy was

Milton Erickson's utilization approach incorporated by using the client's available resources and interests to facilitate a positive change. The techniques naturally vary according to a child's interests and the therapeutic goals, but I always include visual strategies in my work with children. By visual strategies, I mean anything that accompanies the spoken word to help explain and make concrete a concept or skill development. With young children, the visual aspects of therapy are play. With older children, it may be the thought and speech bubbles that I used in Mark's case.

Mark learned many skills and achieved the conversational goals we set after much rehearsal and support from his family and teachers. He continues to present as a unique individual with qualities and characteristics that some people will find odd or eccentric, but Mark has also learned to accept who he is with all his strengths and weaknesses. To his credit, he now chooses to focus on his strengths.

In therapy, we have the choice with each and every interaction whether to focus on positive or negative, strength or weakness, ability or disability—whether, metaphorically, we see the forest or the tree. I hope my discussion of the case of Mark highlights that we can focus on strengths, highlight abilities, and utilize resources to advance our clients' goals, even in complex cases that traditionally have been seen only through the lens of pathology.

Putting It into Practice

1. Focus on strengths.
   The principle is simple: What you focus on is what you amplify. When the therapist chooses to focus attention—and encourages clients, parents, and teachers to focus their attention—on what a child can do and is doing well, the therapeutic interventions are greatly enhanced.
2. Highlight abilities.
   Ask what your client likes, can do really well, or can teach you. This enabled me to discover Mark's interest in, and intimate knowledge of, trees. Rather than seeing his monologues on trees as a problem, his abilities were highlighted and utilized in the therapeutic process.
3. Set positive expectancy.
   Prior to helping the client resolve a problem, it is desirable to establish a positive expectancy for change. Although some children recognize an area of need, some do not believe they have a problem and may even be angry about coming to therapy. Engage the child—such as in a game of his or her choosing—to establish a therapeutic alliance and set positive expectations.
4. Utilize resources.
   Recognizing Mark's strengths and orienting both his attention and therapy toward what he *could* do was a way of teaching him what he needed to and could learn to do *better*. He had learned an intimate knowledge of trees; how could he also learn to communicate that better? He knew *how* to ask a question; how could he also know *when* and *why* to ask questions?

5. Build skills.

   The interventions with Mark aimed to build three sets of skills.

   a. You can minimize client deficits *and* enhance strengths by modeling the flexibility you want to teach. I wanted Mark to learn that our interactions did not have to be "all or nothing."
   b. Teach your client to take personal responsibility. By effectively asking questions, Mark became an active partner in conversational exchanges.
   c. Mark knew *how* to ask a question. My goal was to focus on teaching him to know *when* and *why* to ask questions in a conversation.

6. Employ positive therapeutic interventions.

   In this case I have sought to give examples of some of the potential therapeutic interventions that could be used for enhancing positive outcomes. These included:

   a. Client-relevant metaphors—such as "plant the seeds"—to help clients understand a concept they might not otherwise understand.
   b. Comic-strip conversations to facilitate a concrete way of seeing what people think and say.
   c. Behavior therapy principles to minimize ineffective behaviors and to reinforce positive or desired behaviors.

REFERENCES

Beck, A. (1976). *Cognitive therapy and the emotional disorders*. New York: New American Library.

Gray, C. (1994). *Comic strip conversations*. Arlington, TX: Future Education.

Rosenthal, R., & Jacobson, L. (1968). *Pygmalion in the classroom: Teacher expectation and pupils' intellectual development*. New York: Rinehart and Winston.

Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5–14.

Yapko, D. (2003). *Autism spectrum disorders: Frequently asked questions*. London: Jessica Kingsley Publishers.

Yapko, M. D. (2003). *Trancework: An introduction to the practice of clinical hypnosis*. New York: Routledge.