Autism and careers requiring empathy: Are they compatible?
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-Dr. A. Ruth Baker, MB ChB Dip Health Sci (Mental Health)

Introduction & Background
"New research is suggesting that adults with Asperger Syndrome can achieve, maintain & succeed in a wide range of occupations" wrote Tony Attwood (1). Yet the 'caring professions' are barely mentioned in the growing literature on career and employment issues for individuals on the autism spectrum.

My own interest in this topic began when, after two decades working successfully in my profession as a family doctor, I was myself diagnosed as having 'residual Asperger's Syndrome' (2, p26), and on disclosing this found the suitability of my career being scrutinized on the grounds that AS people allegedly have "difficulty understanding and identifying with the emotional reactions of human beings." At that time, I knew of no others with AS diagnoses working in medical or other 'caring professions'. Exploring this topic, I had by mid-2006 personally met some thirty-four among colleagues, clients, and friends in the autism community, and read accounts by a further fourteen. The experience of these forty-eight, together with review of literature on autism and empathy, provides the substance of this paper. No doubt there are many more of us out there somewhere: undiagnosed, diagnosed but not necessarily disclosing, perhaps unemployed or working in a job other than their chosen 'caring profession' career. May this paper help open some doors.

Terminology
In this paper, *Autism, Autistic* and *Autism spectrum (AS)* refer here to the whole autism spectrum, including Asperger's Syndrome (as do the informal terms *Autie* and *Aspie* where used).

Autism community refers to the worldwide fellowship of autistic people, networking mainly by internet but also in real life. Some terms used within the autism community, and some passages in this paper, are *neurotypical (NT)* or the term coined by Roger Meyer *non-spectrum (NS),* both referring to *non*-autistic people; and *AC,* embracing both *autistic individuals* (those with a formal professional diagnosis anywhere on the autism spectrum) and *cousins* (those with autistic features but no formal diagnosis, though they may be *self-diagnosed peer-confirmed*, meaning their self-diagnosis has been validated by autistic peers). *Neurodiversity* is an umbrella term encompassing conditions like autism and dyslexia, where the nervous system is considered atypical.

The *caring professions* cited in this paper include health professionals (doctors, nurses, therapists), counselors, social workers, teaching professionals, and ministers of religion. There are of course autistic people engaged in other vocations involving care and empathy, for whom this paper will also be relevant: for instance parenthood.

Autism: Relevant concepts and models
Most clinical work and research on autism is base on the **biomedical model**. However the current biomedical model of autism is controversial for a number of reasons, and may result in misdiagnosis, missed diagnosis, mis-understanding about the nature of autism, and thus inappropriate advice, treatment and support. Major concerns include: Firstly, that it's a deficit pathology-based model, emphasizing presumed deficits while overlooking strengths, adaptive strategies etc. Secondly, that it focuses on behaviors as interpreted by nonautistic observers, rather than the underlying processes. For instance a behavior that may appear to be a problem may actually be a compensatory strategy enabling that individual to function better than they would without it. Or the failure of AS individual to show a response to someone crying, may not necessarily mean lack of empathy, as will be explored later in this paper. Thirdly, that the emphasis in the current biomedical model on the so-called 'triad of impairments', risks overlooking other troublesome problems associated with autism like sensorimotor issues. Finally, that it's a categorical model for a multidimensional condition whose component features interact with one another, context, adaptations etc., all of which evolve over time.

An alternative is the **sociological model**, which considers autism as a 'difference' that only become disability because of society's current response to it. Perhaps, as Phil Schwartz writes (3, p148) "the truth … lies between the extremes: There are both intrinsically disabling factors in autism, and aspects of atypical individuality that are disabling primarily because society devalues them or fails to accommodate them."

Literature from the field of diversity studies, gives clues about possible benefits to our world of such differences: About diversity in general, Paul Grobstein writes (4) "The biological process produces variants, as the only way to be prepared for unknown challenges, times when the environment changes in unpredictable ways. It's the variants that provide the basis for dealing with such challenges." Thomas West (5), relating this to human culture, argues that neurodiversity may be "a deep survival strategy" for the human race, and that people with different ways of thinking may be needed for the complex problems ahead for society: "We should encourage diversity not only to be civil, respectful, humane and just, but also because we have a particular stake in diversity that is rarely, if ever, fully articulated. We want there to be people who have abilities we do not yet know we need, abilities that we have never tried to measure. … The solution to our problem [may lie] with turning to someone who may be a bit unusual, a bit of an outsider … Sometimes the visual thinkers and 'dyslexic visionaries' may see things that others do not see. They may be ready to take actions that others, in their pride and arrogance, are not ready to take".

Some autism professionals are now adopting this idea of difference not necessarily meaning deficit, for instance replacing the word 'deficit' by '(qualitative) difference', and even showing how (6) 'the diagnostic criteria for Asperger's Disorder' could be reframed as 'the discovery criteria for aspie', defined by (a triad of) strengths and talents instead of a triad of deficits.

'The invisible end of the spectrum' (7) refers to so-called 'mild' or sub-clinical autism, where the individual's autism difficulties are easily overlooked or 'invisible' to others (even to some professionals), perhaps hidden beneath another disorder (like depression) or by compensatory strategies. Referring to conditions at this end of the spectrum as 'mild' can be very misleading, as autistic writers & some professionals (8, 9 p27) have pointed out. For instance Uta Frith suggests (8) that Asperger's Syndrome might better be regarded, not as "a very mild form of deficit" but as "compensatory learning in the presence of a severe deficit", a view with which many on the spectrum identify (though generally preferring the term difference to deficit). Specific issues faced by individuals at this end of the spectrum (7) include unique dilemmas around disclosure, and the tendency for their autistic oddities to be attributed by others to moral defects. In a benign environment and with good supports, such individuals may never be diagnosed, as Dinah Murray writes (10) "Many able people of Aspie disposition can find a welcoming niche in which they flourish. In those 'right circumstances', such people may never attract clinical attention because they do not fulfil the diagnostic criteria of social dysfunction. They may spend their lives on the right side of the official boundary because the circles in which they mix do not find them worryingly odd … [or] dysfunctional: a virtuous circle of success through confidence and confidence through success keeps them free from diagnosis-attracting calamities." But if circumstances suddenly change, such an individual may decompensate dramatically and their underlying autism become apparent. Such 'invisibility' is a particularly common experience among certain sub-populations (such as females, gifted autistics, and those with co morbid conditions such as depression or anxiety), and might be expected also among AS individuals working in caring professions.

Empathy and autism

What is empathy? Among both professionals and lay people, there is considerable variation and overlap in the use of terms like *empathy, sympathy,* and *compassion.* For the purposes of this paper I have adopted Dziobek & Rogers' (11) definition, that empathy "broadly refers to the reactions of one individual to the observed experiences of another person [and has as its] two main components *cognitive empathy*: the ability to engage in the cognitive process of adopting another person's perspective [involving *theory of mind / social cognition*] and *affective empathy*: the ability to experience emotional reactions to the observed experiences of others". Two facets of affective empathy are (11) "*empathic concern*: the tendency to experience feelings of sympathy and compassion for unfortunate others" and "*personal distress*: the tendency to experience distress and discomfort in response to extreme distress in others."

Most professional literature about autism, describes impairment of empathy as a core feature. 'Sufferers' are often depicted (11) as *"cold, emotionless, and indifferent, [even] culminating in comparisons with psychopaths: '…it would appear that both Asperger Syndrome and psychopathy … share some common characteristics, notably the total absence of human empathy …' (International Journal of Psychophysiology, 1998)."* In stark contrast is literature by some AS individuals, whose personal accounts portray rich unique inner lives, including the experience of feelings and empathy.

Research on empathic capacities in autism, though limited (for summaries see 11, 12, 13), does mostly suggest that autistics lack appropriate empathic response. Recently Dziobek & Rogers, in their study (11) designed to overcome shortcomings of previous research by separately measuring component skills and using more naturalistic methods of assessment, found that subjects with Asperger Syndrome scored significantly lower than NT controls on cognitive empathy, significantly higher on personal distress, and equivalently on empathic concern. These researchers concluded, "Because individuals on the spectrum have problems in social cognition they appear to lack empathy. In reality they have as much empathic concern (the core aspect of empathy) as neurotypicals … Empathy is one of the most remarkable human characteristics and for the longest time autism has irresponsibly and mistakenly been depicted as an 'empathy disorder.' We would like to contribute … towards giving autistic individuals back the place on the empathic spectrum that they deserve."

Turning now to social cognition (theory of mind), which has been more extensively researched than empathy (11): Difficulty shown by autistic individuals in research does not necessarily mean inability to understand others' perspectives. For instance, according to Roeyers et al (13) "The available evidence suggests that able adults with PDD … clearly know that mental states exist and they seem to recognise that certain situations require them to obtain knowledge of the mental state of other people … [and] are, at least to some extent, able to 'infer' … these mental states." Nuyts and De Roeck (14) found '"that high-functioning adults with autism make normal use of mental states in one-to-one conversation". Roeyers et al called for studies to clarify whether autistic difficulties with social cognition are *"due to information-processing problems and / or, as suggested by Pierce et al (15) to an attentional problem caused by over arousal in complex social environments."*

Accounts by autistics support this idea, that apparent difficulty with social cognition may indeed be due to slow processing, difficulty attending to more than one cue at a time, difficulty interpreting nonverbal / other social cues, etc; resulting in *differences or delays* in (rather than lack of) empathic understanding and response. This may be problematic in some but by no means all situations. For instance:

> "It is difficult to analyse social encounters in a busy environment. Meeting people is more confusing than ever because I am less able to attach any meaning or to interpret what is going on correctly. Busyness makes me feel very unsure and my generally poor level of coping drops even more…. It can even be too great an effort to greet somebody, which complicates the situation even more." (16, pp32-3)

> "I develop great insights into people over time, but in the moment … It seems impossible to try to focus on my own thoughts or feelings and consider different thoughts or feelings in another person or persons at the same time especially if I am talking or actively listening to the other person talk. It takes time to process all the various components of a social interaction. I believe I spend huge amounts of time doing this, a lot of the time I spend alone goes into this." (17)

> "My slow way of apprehending people can … seem quite "penetrating" when NTs become aware of it … more a case of resonance than of penetration … They don't realise anything is happening in / with me because I am not reacting (positively) to all those ripples and they assume I am not sensitive to other people. Well, I am. But I am 'slowly' sensitive." (17)

The following AS individuals, who all work in the caring professions, go on to outline strategies they use in such situations, and how they acquire them:

> "I'm an intensely sensitive person. I'm just not always able to call up the appropriate emotion 'in the moment' without the opportunity to process it … [but have learnt that] knowing the acceptable diplomatic thing to say in the moment can be of immeasurable benefit even if one doesn't feel it just then." (18, p141)

> "Emotions are a sort of 'second' language to me. … having to 'read between the lines' confuses things. When this happens, I know that something is going on but I'm not sure what it is. I want to do something about it, but not only am I unsure of what to do, I don't know how to do it. As a result, too much energy goes into processing the situation and a shutdown occurs in the communication arena … I find it helpful if others can say exactly what they mean along with creating a feeling of safety and trust. … Some phrases that I keep in my response repertoire for these situations include "What can I do to make you feel better about this?" … While having an algorithm or method for handling these types of situation helps, it does not approach the

facility others off the autism spectrum seem to have for these emotionally charged situations" (19, pp121-2)

"Delayed reaction or temporal distortion seems to happen with my emotional reactions at times. This can be handy for keeping my cool in a disturbing situation but may create an impression of lack of empathy. If a chance arises to express my feelings a day or two later, it is often easier to do so then … I find it difficult to find the words to say to terminally ill patients and their families. I hope that giving my time, and my being there, has shown that I cared … Over time we can build a repertoire of suitable responses to help show we do care." (20)

"I am a great person to have around in the case of accidents and the like. I remain cool as a cucumber and am able to deal with everything quite effectively, because due to the visual stress, my emotions are suppressed and cannot get in the way." (21 pp9-42)

"All my social behaviours have been learnt, as I lack such insights myself…. What comes naturally to anyone else I need to capture intellectually and learn by heart. What anyone else fells intuitively I have to translate into rules, the way you try to understand maths. … The breakthrough came when I did a course in Educational Science … where social rules were discussed in great details … I developed techniques for dealing with feelings, for talking, for taking part in meetings … In order to deal with other people's feelings I need to put on my 'professional hat', otherwise I won't manage." (16, pp75-6):

Some professionals now acknowledge such AS capacities. As Glenys Jones writes (22) "We frequently read that those with autism … lack social empathy. … Perhaps because individuals with autism have to work out consciously and scientifically what is appropriate, they develop more insights than NTs who do not consciously have to pay such attention to this."

To what extent is the supposedly superior NS capacity to understand another's perspective, due to greater inherent capacity, and to what extent an illusion due to the greater ease with which anyone (NS or AS) understands someone similar to self? Some autistics thus question NS theory of mind (17) and empathy (23) as exemplified in NS-AS interactions. As Jim Sinclair writes (23) "When I am interacting with someone, that person's perspective is as foreign to me as mine is to the other person. But while I am aware of this difference and can make deliberate efforts to figure out how someone else is experiencing a situation, I generally find that other people do not notice the difference in perspectives and simply 'assume' that they understand my experience … If I know that I do not understand people and I devote all this energy and effort to figuring them out, do I have more or less empathy than people who not only do not understand me, but who do not even notice that they do not understand me?"

AS individuals working in caring professions

Given that some of us on the autism spectrum are already out there working in the caring professions, do we do an adequate job? What gifts might we bring to such work? How do we cope? What challenges & issues does this raise? The remainder of this paper will consider these questions. First, some more personal accounts to illustrate. Note that what we enjoy or excel at, goes beyond the usually cited AS assets like being systematic or good at details:

"I am convinced that in some respects my autism makes me an excellent care worker, leader and guide. … [via] clarity and structure [which] create feelings of safety and trust … I acknowledge them and let them believe in themselves… and always try to take them seriously. … [BUT] I have never really managed very well with colleagues. This is the reason why I keep changing my job or getting fired. Each time I got the same comments 'There are no problems with your work, but we don't know you, you're awkward, you're obstructing the team and your colleagues, nobody can get close to you, you don't anticipate, we have no idea what goes on in your mind.'" (16 pp78 & 102-3):

"Teaching elementary age school children was great fun because I so related to their naïve sense of wonder and joy in exploration and discovery of self-expression through art … but in the staffroom, I was as hopelessly inadequate as I had been during any other unstructured time in my own school career." (18 pp138-9)

"Teaching is a challenging job, especially for those of us with social and organizational issues, but it is worthwhile and interesting. For those with the inclination, I'd say go for it. After all, every failure is just another step on the road to success." (24 p81)

"Having had to acquire the [theory of mind] skill instead of being able to simply assume that I can use my own thoughts and thought processes as a model for those of other people is a huge advantage interacting with patients. … Another rather unexpected advantage of autism is better communication. … Social communications are difficult for us, because they often have as priority, not to explain something, but 'bonding' between conversational partners … In actually getting a message across NTs aren't very effective communicators. … So-called normal communication is just as defective as autistic communication. The mistakes made in 'normal' communication are simply so omnipresent that nobody notices them anymore. … I have often noticed how teachers do not listen to what students are really asking and

consequently do not give an informative answer. After the lecture, I have to explain to my fellow students what the 'real' answer to their questions is. Most people don't really answer appropriately to what has been said to them. They simply go off like alarm-bells in a completely predictable way, repeating old reaction patterns to perceived slights or attacks." (21 pp9-42)

The following are excerpts from a discussion about such careers by AS professionals (a teacher, a doctor, a chaplain, and an occupational therapist), as captured in "Women from another planet?" (25):

"Jean: Ava, you said something about your clients feeling listened to for the first time, then later on, something about your interest in knowing how it is that people like us, in the professions requiring lots of social contact, do it. I'd like to explore that as a thread, especially since so many of us here are in or aspiring to professions that involve people, something that on the surface seems unlikely.

Sue: … I actually empathize with the children I work with and advocate for them tooth and nail … sort of like fighting for the self that I didn't fight for. …

Ava: I've acquired the art of listening through years of listening listening listening because I couldn't participate in conversations. When one gives up trying to make oneself heard, it's more possible to focus on what the other person has to say … my difficulty with words means that firstly there are more silences, well silences can be therapeutic! For example enabling the other to suddenly say the most significant thing of all, something they maybe needed time and courage to voice that wouldn't have happened if I had plunged straight into a quick-fix answer. And the client seems to appreciate my putting time and thought into their problem, so has patience, knowing their problem is complex (attempts to solve it elsewhere having failed) and they really do want an accurate answer, unlike in social life. Secondly, even when there aren't silences, I generally get the client talking and say as little as possible myself, which elicits a fuller more accurate story than firing questions does …

Jean: My students say I'm excellent at conducting discussions on sensitive topics in such a way that they feel free to open up because they're in a safe setting. And I can be diplomatic about a lot of things in settings that aren't threatening. This is a consequence, though, of an awful lot of thinking and deliberate learning campaigns on my part.

MM: My work with persons with Alzheimer's disease is like coming home. They are people who also have a neurological difference. They are blunt and honest, no longer hiding behind cultural norms. … They don't expect greetings, they live in their own world, they are discriminated against as they lose their ability to speak. Where I have a problem is having to report and attempt to explain to NT administrators. It is an uphill climb that frustrates me to no end. I get very tired of the dehumanisation of people with dementia. Most people ask them the wrong questions, and treat them like a little child instead of the adult that they are. So they're going to get angry. I am a good chaplain because cultural norms are dropped during this time. NTs fall apart and don't know what to do. It is an area in which instinctively I do well and shine. …

Jean: I hear from my students that I do it well, and I know that my particular way is much more inclusive than that of some teachers. Because I have no capacity to put people in social categories, I take what students say seriously."

An in-depth example: AS 'GP's (general practitioners / family doctors)

An AS colleague & I, each with over 30 years' GP experience, compiled some lists from our own experience, feedback from patients, and a BMJ article by a third (anonymous) "doctor with the full-blown syndrome" (26). As there are entire books on strategies autistic people use for coping with life in general, and the workplace in particular, our main emphasis here was on specific ways we apply AS strengths and strategies in our medical work, a topic not covered elsewhere.

AS features that may enhance the 'art and science of medicine' (20, 26):
Many of the twenty-six listed 'aspie criteria' (6) are an asset in this work: for instance, taking one criterion from each of the 'triad', "listening without continual judgment or assumption"; "determination to seek the truth"; and "unique perspective in problem solving". So do many other AS qualities beneficial in employment in general, for instance Tony Attwood (27) lists, among others: loyalty, reliability, persistence, conscientiousness, thriving on routine and consistency, perfectionism, attention to detail, accuracy, skill at identifying mistakes, technical ability, factual knowledge, logic, not letting emotional factors become a distraction, sense of social justice, speaking their minds, conversation free of hidden meaning or agenda.

Cognitive features like different styles of thinking (spatial, non-linear etc (25)), along with other traits, may contribute to finding novel solutions to problems.

As for communication and social style, there may be advantages in both innate features (like 'that slight reserve which makes a good GP': being caring & interested but a little removed?; staying objective, focusing on content, with emotions switched off or 'on back-burner'; not

biased by issues of status / 'liking' / 'being like' patient, etc) and those we've *worked on consciously* (for survival in an NS world) such as the ability to translate between perspectives (e.g. NS vs. AS); and being good listeners (using prompts to elicit story, pauses / silences & what may come out of those, being careful & precise e.g. "What do you mean by that?" instead of assumptions).

The above, together with a 'passion for patient care'; alertness to anxiety; thoroughness; excellent memory (for patients' lives, families, details of illnesses); taking patients seriously; awareness things can go wrong, are not always as they seem, and that it's our job to find a solution, may account for the following comments by patients and staff: that they appreciate our spending more time reassuring them, being less dismissive of those 'minor' complaints (that are worrying for the patient or not in the textbooks), 'going a further mile' in listening & investigating so uncovering a diagnosis earlier than might otherwise have occurred, and overall determination 'to get it right' for the patient, in diagnosis and treatment.

AS strategies to cope with challenges of medical work (20,26)

Features making *doctor-patient interactions* easier than other social encounters include their fixed timing, being one-on-one, clear purpose and structured format (whereby doctor elicits problems, then offers explanations and discussion of possible solutions). The process is enjoyable (the diagnostic 'detective-work', and / or translating between perspectives), as is even the social experience itself! (compensating for our limited abilities & satisfaction in unstructured social interactions?). Props such as appointment books help disguise such difficulties as recognising faces.

Interactions with colleagues and staff are more problematic: We may relate better not to our medical colleagues but to those in other roles, like receptionists or cleaners.

In general, for us, managing career and the rest of life go hand in hand, and involve solving issues such as finding a balance between relaxed acceptance & anxious self-monitoring, and establishing a realistic workload and suitable work environment: For instance, while I've spent my last seven years in a solo practice that I purpose-built around both my own AS peculiarities (which also suits my AS clients), an AS colleague has developed an impressive set of strategies for coping in a group practice. These and other strategies (for organisation & planning, communication, sensorimotor, and other issues) are important but lengthy: details are available from the author on request.

AS careers in caring professions: Broader issues

The following apply to other AS careers as well, but in the caring professions they have their own particular nuances. For these issues, there are no simple strategies or solutions:

Diagnosis and disclosure ('Recognition and acknowledgment')

With a positive model, 'insider' insights and what I call 'enlightened knowledge and support' throughout assessment & adjustment, the process of discovering one is autistic, whether by formal professional diagnosis, or 'self-diagnosed peer-confirmed' within the autism community, is an important key to making sense of one's life. As Jane Meyerding puts it (28) "Instead of failing to succeed at what you're not, you can start learning how to succeed at what you are." There are many ideas about how to do this, brainstormed within the autism community via Internet & real-life support groups, and books *by* adults on the spectrum.

For those in 'caring profession' careers, obtaining an official diagnosis may not be easy though, needing a diagnostician well versed in the subtleties and paradoxes at this end of the spectrum, where misdiagnosis, missed diagnosis and late diagnosis are so common (7). Those with formal AS diagnoses are likely to have been diagnosed late, and though on the one hand this may have meant years of distress and confusion, on the other hand, while the deficit model and its assumptions prevail, perhaps earlier diagnosis might have barred us from these very careers we find so fulfilling? As Dominique Dumortier writes (16 pp 92-3) "I am glad that I wasn't diagnosed until much later… While I may not have had a lot of understanding or the right support, I did get many chances. … as they didn't know about it I was able to go into mainstream education and then on to study Educational Science … which I probably wouldn't have … if they had known about my autism. The course helped to turn me into the kind of person I am now."

After diagnosis comes the question of disclosure to others, an issue especially tricky at this 'invisible end of the spectrum' and in careers like these. Though disclosing the diagnosis 'should' result in better understanding and support, in reality it is commonly met with negative

responses such as disbelief ('But you don't seem any different to anyone else, we all have times like that') or loss of credibility, as a teacher who disclosed her diagnosis relates (29) "I did the wrong thing by telling a so-called trusted colleague I had autism. After being praised for years for how well I did my job by parents and colleagues, I wasn't thought capable anymore so I was pushed out in a tactful way. Colleagues, family and friends didn't want to visit or communicate any more. So please keep AS hidden if you want to have a professional and happy life!" Even Liane Holliday Willey, regarded as one of the most confident and experienced at talking about her diagnosis in a positive informative way, writes (30)

> No amount of self-confidence can keep away all the risks intrinsic to telling others about AS … [or] stop others from reacting in ways that might make our lives more difficult…. People who hear I'm Aspie are still wont to look at me differently, either pitying me or worrying that ultimately I'm not up for the task at hand. … Sometimes I even find people alter the way they speak to me, using slower speech or simple terms, as if my AS means I am stupid, dense or deaf. No matter how many good facts you tell when disclosing your AS, there will be others who fail to hear the good stuff, so unnatural is it for them to understand that neurological differences do not mean unable … you will run the risk of others having reservations and doubts about your abilities and maybe even your personality on the whole…. For me, the risks are worth taking, but I have a very big group of supporters who make me whole no matter how much society tires to chop me up.

There are many issues to consider, well outlined in recent literature such as the book 'Coming out Asperger' which encompasses many viewpoints and situations. As editor Dinah Murray writes (10) "Disclosure of an autism spectrum diagnosis means disclosure of the fundamentally flawed personhood implied by the diagnostic criteria. It is likely to precipitate a negative judgment of capacity involving permanent loss of credibility." On the other hand, she suggests, were we to think of *diagnosis* as *recognition*, and *disclosure* as *acknowledgement*, a completely different outcome might ensue!

In the current climate, it probably behoves ACs to postpone *full disclosure* till very confident and secure about themselves, work & workplace, diagnosis, and the issues involved. *Partial disclosure* can, however, be a good compromise: disclosing only the issue relevant to the particular situation, for instance *central auditory processing disorder* to explain why information need to be written, or *prosopagnosia* (difficulty recognizing faces) to explain that ignoring colleagues met away from the usual context (work) is a neurological issue not snobbery. As one survey respondent explains (31) "I choose not to [disclose] because of the inevitability of being treated as a 'Case'. Instead, I'm slowly opening up about my individual AS traits, without giving them a label, so that people can treat me as a 'person who is over focused and can't develop routines and has a really quirky way of looking at some things' etc., rather than 'autistic.'" Such partial disclosure can be well combined with requesting *accommodations* to help one work better. Sensory issues may be more easily accepted and accommodated than social ones, even though accommodating those may benefit others too: the whole workplace, or even society at large. As Stephen Shore (32) suggests "It may be appropriate to say 'I work best if people are very direct with me instead of trying to mince words on a subject they might think would be upsetting to me.' In short: … clear direct communication makes for better understanding all round", i.e. for everyone – not just autistic people.

Once ACs do feel confident & secure, ideally with the support of *mentors, allies (3)* and if necessary *advocates,* disclosure can be of far-reaching benefit. As expressed by Jane Meyerding (31) "When we do come out autistic at work, we can try to do it not only for our own advantage (or survival), but also as part of a broader current of social change, a 'neurodiversity movement' that will pave the way for other autistics to have a smoother ride as they enter the workplaces we have pried a little bit wider open" and Phil Schwartz (3) "[The social-model approach would] … advocate acceptance of our aesthetic sensibilities, cognitive patterns, emotional responses and socialization preferences as diversity issues – establishing neurological diversity as a legitimate dimension of diversity alongside religious, ethnic, racial, gender and physical-ability diversity in mainstream society."

That might require society to re-examine its definitions of 'normality' and 'social acceptability', as Dinah Murray points out (33): "The route towards social acceptability by current standards is a route towards disguise, concealment and presentation … [which] places the highest value on presentation skills. … We might see that being the sort of person who attracts an ASD diagnosis is likely to mean having an honourable and scrupulous disposition and a concern for 'getting it right' which includes a concern for truth and may confer tremendous capacity for work."

Fatigue

Social fatigue in the workplace is common for autistics, compounded by sensory, executive function and processing issues in and beyond the workplace. Managing work plus life becomes a major challenge, as Jane Meyerding outlines (31) "Given how much interaction is required by most jobs, it can feel as if we are working two jobs simultaneously. We need to do our work but we also must expend huge amounts of energy on generating and maintaining a social interface. That's why I've been working part-time most of my life. If I try to work a full-time job, I need to spend the rest of my waking hours recuperating. Literally. … It wasn't so bad when my mother was alive; she provided a lot of support with what the therapists call 'activities of daily living.' Food, cleaning, planning … Unfortunately being employed part-time usually eliminates all access to supplemental income … [and] publicly funded support. The theory seems to be that either you are disabled and need both financial and practical support, or you can work and therefore need / deserve nothing. For many employed autistics, the result of that dichotomy is steadily accumulating stress, which, sooner or later, spills over into the job …".

This is echoed by AS individuals working in the caring professions:

> "I work part-time because I need a sizeable proportion of the week to 'reload'. … work itself [is not] a problem, but having to be around other people is very tiring for me." ((21 pp 9-42)
>
> " My brain gets tired, especially when I've had to talk a lot, rather than just listen. To cope with this 'brain drain' I try to relax when possible, such as for a minute or two between patients, and to keep my arousal level around 5. And work part-time, in short bursts. When I did work all day, I needed a long lunch break at home to lie down." (20)

Social aspects of the workplace

As per accounts quoted earlier, fathoming 'workplace politics', and coping with unstructured time like tea breaks, are more difficult for autistics than relating to clients: It can seem that 'fitting' socially while doing a mediocre job (neither too good nor too bad), are the criteria for success, whereas the AS combination of social 'mis-fit' with high work ethics is a 'recipe for disaster'. Autistics are easy targets for bullying and more subtle forms of sabotage (24, 31). Whatever the career, these social problems do vary from worksite to worksite, depending on attitudes of 'boss' & co-workers (24), and may be more prevalent when autism is 'invisible' (7). In a survey of thirty autistic people concerning work issues (31) the three most common AS-related reasons for being fired were 'lack of ability to network or socialize with co-workers', 'not liked by co-workers or supervisor', and 'seen as weird or odd'. Such discrimination, as well as the increasing emphasis (24, 31) on team skills and interpersonal communication in all jobs, even IT, are also barriers when seeking a job, as survey participants detailed:

> "It seems that NTs are only interested in people's personalities. They don't care about what you can actually do. Since to them I look like a nut or a zombie, they wont hire me; they judge me because of my slightly off body language." (31)
>
> "Now on job applications, they all put 'must have interpersonal skills, must be able to work as part of a team' … It discriminates against auties, but what can we do? If the job description said 'must not be blind' or 'must be able to walk' there would be an outcry as that would be against people with those disabilities. But when it comes to AS, I do not think any companies understand." (31)

Jane Meyerding (31) compares this challenge to that thirty years ago when women were seeking access to full participation in the workplace, on their own terms rather than by being expected to "act like men (e.g. adopt stereotypically 'male' communication styles) … We need an analogous cultural change … a chance to demonstrate how relaxing the boundaries of what is considered 'normal' will benefit everyone…when society becomes able to integrate more of the marginalized into greater participation."

In fact, AS individuals *can be* capable of excellent teamwork and interpersonal skills, in our own style, as shown by communication and collaboration within the autism community (for instance, see 34).

Unemployment, under-employment & their effects:

It's been estimated that some 90% of Asperger adults who want to work and are able to, are unemployed or under-employed (24 p11). What the figures are for those qualified in the 'caring professions' is unknown, but some tragic examples are documented (21 pp 81-4, 29, 35). For instance David Andrews describes (35) his 'bleak future as an Aspie psychologist',

feeling that his diagnosis is regarded by NS professionals and public as invalidating his abilities, knowledge and hard-won qualifications.

<u>Fitness for such work</u>
This issue of fitness is likely to be viewed differently, according to which lens one examines it through: Through the 'biomedical deficit' lens, anyone 'diagnosed' as having Asperger or Autistic 'disorder', may be assumed inherently and permanently lacking empathy etc. Yet through the 'sociological' lens, 'discovering' & accommodating those with positive 'aspie' traits, may reveal plentiful empathy etc.

Tony Attwood (36) describes four adjustment strategies that an AS individual may adopt from an early age, upon realising they are 'different': 'imitation', 'reactive depression', 'escape into imagination', and 'denial & arrogance'. It is those adopting the last strategy, who may pose a particular risk in the caring professions, if unwilling to accept and learn from their differences. However, denial and arrogance as human defences are also prevalent among NTs. Moreover, care is needed not to falsely assume 'arrogance' in an autistic merely because of mannerisms like pedantic speech, literal insistence on rules, difficulty recognising faces etc. Perhaps whether or not an individual copes by denial & arrogance, comes down to other aspects of our common humanity. How much do we want (whether AS or NS) to learn about our strengths and weaknesses, about how to use our strengths to help compensate for our weaknesses? Once aware of the existence of other perspectives (an awareness that may indeed develop more slowly for someone on the autism spectrum), how willingly do we (whether AS or NS) apply this in our interactions? What choices do we make (whether AS or NS), as free human beings: to act in a safe or unsafe, responsible or irresponsible, moral or immoral, manner towards our fellow human beings? I suspect that most of us on the spectrum, who end up in careers such as these, chose our paths for humanitarian reasons, and have worked hard to understand ourselves and our fellow humans.

Summary: What hinders & helps AS 'caring profession' careers

Common barriers include
1. biomedical deficit model of autism, with associated myths & prejudices
2. AS-unfriendly social environment (worksite, boss, 'workplace politics')
3. arrogance & denial (by some ACs, like some NTs)
4. limited knowledge about ACs in such careers → limited careers advice / support
5. 'one size fits all' emphasis on teamwork & interpersonal skills
6. 'all-or-nothing' approach to full-time work / help with ADL (activities of daily living)
7. naive disclosure
8. intolerance of difference

In contrast, key factors for success include
1. positive model of autism e.g. sociological
2. AS-friendly social environment (worksite, boss, 'workplace politics')
3. insight into own strengths & weaknesses & how to work with these; self-recognition of autism (with or without official diagnosis)
4. knowledge & supports: from AS peers (strategies, culture, support, ongoing learning) and well-informed mentors, allies, advocates, careers advisors
5. creative inclusive approach to teamwork, interpersonal skills, adaptability
6. support for part-time work & / or help with ADL
7. care around disclosure: partial (initially) with essential accommodations: to protect self; full (when confident & secure): for societal benefit
8. acceptance and celebration of neurodiversity

Conclusion

The ideas and personal accounts presented in this paper, suggest that with insight, and the opportunity to work from autistic strengths and style, autistics can be capable of empathy, compassion, responsible wise problem-solving, and of mastering, perhaps even excelling at, careers requiring these capacities: not only in the 'caring professions', but in all occupations where empathy is essential, including parenting. Further professional and societal shift to foster a more creative inclusive attitude in these and all vocational niches, is likely to benefit human culture as a whole.

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