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Letter

Autism diagnosis and the double empathy problem

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Autism; autism spectrum disorder; post-diagnostic support; autism spectrum condition.

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Rates of autism diagnosis continue to rise, with an increasing number of diagnoses made in adulthood.[1] Although many report receiving a diagnosis as a positive milestone, the diagnostic process can be challenging owing to the pathologising and deficit-based language of diagnostic criteria, including 'deficits in social-emotional reciprocity', 'abnormal social approaches' and an 'absence of interest in peers'.[2]

Psychology, linguistics, neuroscience and philosophy have led a recent shift in autism research. Instead of autistic communication being studied at the individual level, interactions are examined at the dyadic level within a 'double empathy' framework,' which refers to the 'disjuncture in reciprocity between two differently disposed social actors who hold different norms and expectations of each other,' such as autistic and non-autistic people.[3] By comparing how autistic and non-autistic people interact with people of the same (i.e. autistic pairs, non-autistic pairs) and different (i.e. one autistic person, one non-autistic person) diagnostic statuses, we can learn more about how the diagnostic status of an interaction partner shapes the way that people communicate.

Research shows two key findings. First, communication difficulties are not exclusive to autistic people; non-autistic individuals also struggle to understand autistic social behaviours, leading to a 'double' problem in mixed-neurotype interactions.[4] Second, autistic people prefer interacting with other autistic people and share information just as effectively with other autistic people as do non-autistic people with other non-autistic people.[5] However, information-sharing breaks down in mixed-neurotype interactions.[5] Autistic people disclose more to, feel closer to and empathise more with other autistic individuals than with non-autistic people.[6]

What does this mean for autism, as clinically defined by deficits in social and communicative behaviours? The current research shows that many social difficulties experienced by autistic people are not due to an individual deficit or an intrinsic autistic failure of social behaviours, but rather a mismatch between the way that autistic people behave, experience the world and communicate and the way that the non-autistic majority do. Autistic people can interact very well with autistic others, and, during autistic interactions with non-autistic people, both parties experience similar difficulties.[5] Understanding autism social difficulties contextually rather than individually is important for three reasons. First, for autistic self-understanding: the way autistic people interact is not deficient, it is different to that of the non-autistic majority. This understanding can reduce self-stigma and help autistic people find ways to communicate that work for them, without resorting to masking their autistic behaviours to adhere to non-autistic norms, which can be damaging to their mental health. Second, for designing support systems for autistic people: encouraging ways to communicate that support autistic communicative styles and provide opportunities to engage with other autistic people. Finally, for non-autistic people: to understand that the non-autistic way is one way of communicating, but it has limitations. It is not superior to autistic ways of communication (as indicated by studies of how autistic people share information and build rapport with other autistic people just as well as non-autistic people do with non-autistic people[5]), merely different. Rather than the myriad 'social skills' interventions that encourage autistic people to learn non-autistic social norms, it is time to consider how non-autistic people can meet autistic people half-way.

How can these findings be embedded into clinical practice? First, it is important to consider the pathologising nature of language used in diagnosis[7] and understand that although autistic and non-autistic communication styles may be different, that does not mean one is superior to the other.

Second, given the relative ease with which some autistic people interact with other autistic people, peer support has been suggested as a promising model for post-diagnostic support.[8] Although post-diagnostic peer support pilots have shown promising results, provision is geographically inequitable.[8] However, encouragement to engage with an autistic community after diagnosis may be beneficial for autistic adults[9] in the absence of formal peer support.

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Declaration of interest

None.

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Reflections

A psychiatrist's best friend

Adam Bayes

Inspired by my psychotherapy supervisor whose dog sat in with her, 8 years ago I decided to do the same with my *greyhound*. Willy is tall, lean and lanky with a black coat and one distinctive white paw. A reserved demeanour and knowing gaze infuse a calming presence – and my patients are deeply attached to him. His long naps, interspersed with 'downward dog' stretches, evoke a yogic mindfulness – a reminder to be present. As long ago as 1860 the *London Gazette* published a scene of two small greyhounds owned by the resident physician, meandering around a ward at Bethlem Hospital. The most famous psychiatrist's best friend was Freud's *chow chow* Jofi, who sat in during psychoanalysis sessions. Initially a personal comfort, he came to see that the presence of Jofi enriched the therapeutic process.

My hound's non-verbal communication provides useful information about an individual's mental state - deepening my understanding of the countertransference. Sometimes he lays millimetres from a patient's shoes – when emotions are just below the surface – inviting them to 'let it all out'. Other times he turns his head away – mirroring their avoidance. Anxious teenagers, attempting to be invisible on the waiting room couch, are disarmed by a glimpse of this miniature racehorse cantering by. At times he acts as a transitional object – traumatised patients sit on the floor, patting him like a child does a stuffed toy. A patient with post-traumatic stress disorder once arrived in an unusually dissociated state. I worried how I would 'stick him back together' by the end of the session. Willy intuitively stood up and moved next to him. Sensing his presence, the patient placed a hand on his back. An emotional discharge followed – the patient cried – returning him to reality. He's a barometer of bipolar mood elevation: increased playfulness suggests hypomania, while 'zoomies' – running in circles – is indicative of mania. Or he can mirror a patient's progress, as Osher Günsberg wrote in 'Back, after the Break': 'once I learned to deal with my brain at full volume, [Willy] started to become more and more calm . . . now [he] just sleeps on the floor . . . I consider it a massive win'.

At the end of the day, he is tired, with attendance limited to once per week – avoiding 'canine burnout'. What makes for the right (or wrong) clinic dog? Breed is important. A colleague once trialled a *cattle dog* – but it would 'round up' children in the waiting room. Temperament is another key factor. A friend's neurotic *lagotto* only infused nervousness into the practice. A well-behaved dog is essential. Willy is now 13 years old – and sadness wells up in me when I reflect on the day he'll no longer be with us. The bond my patients have with him will elicit grief. Loss being universal, I hope the experience provides an opportunity to process their own losses. For now, he sits at my feet – Sphinx-like – atop his outstretched legs – helping me to understand the riddles of the mind.

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