Behavioral Support for Persons with Asperger's Disorder

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Persons with Asperger’s Disorder (AD) frequently present with challenging behaviors, interpersonal difficulties, and adjustment problems. This article reviews the rationale and implementation of behavior support interventions with this clinical population. First, the diagnostic criteria and defining characteristics of AD are presented. Some mental health and education concerns of persons with AD are described. Strategies for behavioral support and intervention are discussed for the areas of social skills, anxiety-related disorders, ritualistic responding, and interfering behaviors. A case example of a student with AD is presented to illustrate the process of behavioral assessment and treatment formulation. The article concludes with a discussion of critical issues that should be considered when designing behavior support plans for persons with AD.

The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) lists Asperger’s Disorder (AD) as one of the Pervasive Developmental Disorders delineated within the category of Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence. "The essential features of Asperger’s Disorder are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests, and activities." Although there are similarities in symptom presentation between Asperger’s Disorder and a diagnosis of autism, differences are apparent. In contrast to the typical profile seen in Autistic Disorder, persons with AD typically do not evince significant delays in language development. Furthermore, delays in cognitive functioning, self-help skills, and adaptive behavior usually are not evident in the person with AD. Volkmer suggested that AD can be distinguished from autism, "by higher levels of cognitive function and communication skills and an absence of central nervous system (CNS) dysfunction." Frith commented similarly that, "It may well be that this capacity to achieve near-normal behaviour is the single most distinctive feature of Asperger’s Syndrome as opposed to other forms of autism." Whereas previously AD was viewed as "high functioning autism," the classification contained in the DSM-IV reflects the view of many professionals that it is a separate subtype of pervasive AD developmental disorder. Table 1 depicts the diagnostic criteria for AD.

In our work with public school systems and mental health agencies we have encountered children, adolescents, and young adults with AD who required systematic behavioral support to address adjustment difficulties, interpersonal skill deficits, and problems related to fears, stereotypy, and compulsions. However, in contrast to persons with autism and the well-established application of behavior analysis procedures, there is little in the way of published research on behavioral intervention specifically for persons with AD. This is a somewhat puzzling phenomenon since the comparable features of Autistic Disorder and AD suggest similar treatment formulation and application. At the same time, the unique characteristics of AD likely demand alternative behavioral strategies from those commonly employed with persons who have autism.

This article discusses recommendations for the behavioral support of persons with AD. We review diagnostic features of the syndrome and highlight critical learning, social, and psychological concerns. Treatment planning and formulation suggestions then are presented for several clinical areas. A case example of a student with AD is described to illustrate the process of designing a behavioral support plan.
### Table 1. Diagnostic Criteria for Asperger’s Disorder

<table>
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<th>A. Qualitative impairment in social interaction, as manifested by at least two of the following:</th>
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<td>(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.</td>
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<td>(2) Failure to develop peer relationships appropriate to developmental level.</td>
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<td>(3) A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people.</td>
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<td>(4) Lack of social or emotional reciprocity.</td>
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<td>B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following.</td>
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<td>(1) Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.</td>
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<td>(2) Apparently inflexible adherence to specific, nonfunctional routines or rituals.</td>
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<td>(3) Stereotyped and repetitive motor mannerisms.</td>
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<td>(4) Persistent preoccupation with parts of objects.</td>
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<td>C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.</td>
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<td>D. There is no clinically significant general delay in language.</td>
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<td>E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior, and curiosity about the environment in childhood.</td>
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<td>F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.</td>
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### Mental Health and Educational Concerns

Ryan emphasized that persons with AD, “can develop the full range of psychiatric disorders.” They are particularly vulnerable to increased and generalized anxiety, most likely due to the profound effects of misunderstanding social cues, reduced social responsiveness, limited comprehension of behavioral expectations, and language restrictions. Anxiety also may be apparent in the display of specific fears and phobias which provoke avoidance behaviors. As an illustration, an adolescent girl was referred for consultation after she was absent from school for more than three months. Her previous pattern of poor attendance resulted in her falling behind in homework which sparked anxiety about not being able to keep up with the class. Along with one or two other stressors occurring at that time, the anxiety about the homework in large part prompted a school avoidance response. Mood disorders such as depression and bipolar disorder may develop. Ryan noted further that some features of AD may be mistaken for schizophrenia or schizoaffective disorder. Finally, as is common for many persons with developmental disabilities and comorbid psychiatric disorders, the presence of challenging behaviors may be a clinical concern. These behaviors include resistance to instructions, agitation, verbal protests, tantrums, and aggression.

Williams listed several primary characteristics of AD which impact significantly on the ability of a child or adolescent to perform optimally in an educational setting:

1. **Insistence on sameness:** Easily overwhelmed by minimal change in routines, sensitive to environmental stressors, preference for rituals.
(2) **Impairment in social interaction:** Unable to understand "rules" of social interaction, poor comprehension of jokes and metaphor, pedantic speaking style.

(3) **Restricted range of interests:** Preoccupation with singular topics such as train schedules or maps, asking repetitive questions about circumscribed topics, obsessively collecting items.

(4) **Inattention:** Poor organizational skills, easily distracted, focuses on irrelevant stimuli, difficulty learning in group contexts.

(5) **Poor motor coordination:** Slow clerical speed, clumsy gait, unsuccessful in games involving motor skills.

(6) **Academic difficulties:** Restricted problem-solving skills, literal thinking, deficiencies with abstract reasoning.

(7) **Emotional vulnerability:** Low self-esteem, easily overwhelmed, poor coping with stressors, self-critical.

As noted previously, the complex clinical presentation by persons with AD frequently occurs with serious externalizing behavior disorders. For example, one adolescent boy with AD was referred to the senior author for consultation because he exhibited high-intensity aggression toward his mother at home but was not physical with his staff at a private therapeutic school. Evaluation suggested that he was responding to setting-specific contingencies in the home environment that were not present in the school program. In this case, the variable related to how the mother presented instructions and requests to the boy and how she responded to him if he was noncompliant. Her way of interacting with him seemed to both provoke and reinforce behavioral difficulties. In contrast, staff at the school used a different "style of interaction."

A second adolescent who attended a public school was referred because her rigidity regarding time and order frequently produced disruptive behaviors. As an illustration, she would become extremely agitated, make negative verbalizations, and threaten staff in response to changes in her daily schedule or the postponement of anticipated activities. In the absence of these stimuli, she was a relatively compliant and well-behaved student.

These examples underscore the importance of completing a comprehensive functional assessment to understand the conditions which set the occasion for (provoke) and maintain (reinforce) identified challenging behaviors.

**Strategies for Behavioral Support and Intervention**

The following intervention approaches appear to have relevance for the behavioral support of persons with AD.

**Social Skills**

In discussing the interpersonal skills deficits posed by persons with AD, Ryan\(^4\) suggested that, "social isolation results from a lack of intuitive understanding of the rules of social behavior, including rules which govern speech, gesture, posture, movement, eye-contact, choice of clothing, and proximity to others. In effect, interaction skills are poorly developed because the individual with AD does not know "what to do" in social situations, both to initiate a social contact and to respond reciprocally to another person. This interpretation suggests that a **social skills-building** approach would be a meaningful therapeutic direction.

Social skills training programs that incorporate demonstration, roleplaying, rehearsal, performance feedback, and positive reinforcement procedures have been applied effectively with children, adolescents, and adults who have developmental disabilities.\(^12\) Such training begins by identifying discrete areas of skill deficiency and then operationally defining and sequencing the steps that comprise the desirable behavior. For example, the individual responses that make-up the behavior of "initiating a conversation" with another person would be identified and perhaps written out sequentially on separate index cards (one response per card). Next, a trainer would model (demonstrate) how these responses should be performed while emphasizing the verbal (e.g., tone of voice, speech volume) and nonverbal (e.g., making eye-contact, body orientation) characteristics of each one. The demonstration typically would occur with a "confederate" such as one or more "typically developing" peers of the person with AD. That person then is given instructions in how to respond similarly, followed by practice sessions which include rehearsal, role-playing, and performance feedback. Positive consequences in the form of social praise,
acknowledgment, or tokens would be used to reinforce appropriate performance. Training would continue within simulated sessions until the person is able to respond proficiently and independently.

Once the person with AD learns to respond appropriately during training, it is critical to introduce support procedures within naturalistic settings so that the newly acquired skills are used functionally in the relevant contexts. To illustrate, one adolescent with AD who was referred to the authors was taught the behaviors necessary to initiate and respond to social greetings with peers within skills training sessions. She then was required to demonstrate the social skills during natural opportunities in her school such as entering the classroom, eating in the cafeteria, and participating at recess. Her display of social greetings was recorded by staff observers and each correct performance was reinforced with a token. Tokens accumulated during the day were exchanged prior to school departure for several minutes of "free time" activity.

Another behavioral strategy to address social skills of persons with AD is peer initiation training. Extensive research has shown that when socially competent peers increase their initiations towards a child or adolescent who lacks similar abilities, the social responsiveness and reciprocity of that individual frequently improves. The strategy requires that an adult such as a teacher or care-provider cues one or more peers to make initiations (e.g., "Hi, Bill, do you want to play with me?" or "Look what I have-do you want to see?"). Such prompting is delivered on a predetermined schedule (e.g., once every 3 minutes) within appropriate social conditions. Because this method is not time-intensive and capitalizes on the person's natural peers as change agents, it is relatively easy to implement within school and community settings.

A third intervention possibility that also focuses on peers as mediators is the establishment of social networks. Evaluated primarily in public school settings, it consists of recruiting a group of peers who agree to assume responsibility for providing supports to a fellow student who has a disability. A team of peers meets regularly with the student and a group leader to identify how these supports will be implemented. For example, the peers might arrange their schedules to meet the student with AD during specific times of the day (e.g., between classes, at lunch, after school), engage in conversations on social topics of interest, and provide feedback to the target student on relevant behaviors such as maintaining eye-contact, staying on-topic, and refraining from interfering behaviors. This multifaceted intervention combines several behavioral strategies to increase and enhance social interactions, school participation, and friendship-building.

Anxiety and Anxiety-Related Problems

There exists a vast literature concerning the positive effects of behavior therapy procedures on anxiety disorders of children, adolescents, and adults. Contingency-based approaches and several cognitive behavioral techniques have been particularly useful. As applied with persons who have developmental disabilities, adapted methods of progressive muscle relaxation have been evaluated clinically. It is possible, for example, to address the pervasive anxiety characteristic of persons with AD by teaching them how to induce relaxation through tense-release exercises, regulated breathing, and similar calming techniques. Once an individual is capable of reducing anxiety through these procedures, cuing interventions can be introduced as in situ methods. As an example, the person with AD could learn how to mediate anxiety in particular situations following a verbal reminder to "relax and be calm" which is presented by a significant other such as a teacher or parent. Or, the person potentially could learn how to use a self-control technique to cue relaxation. Self-management strategies are extremely advantageous because they increase the likelihood of generalization by virtue of the fact that the source of therapeutic control exists with the person in contrast to an intervention that requires the presence of an external mediator.

Where fears and phobias are involved, the procedure of reinforced practice or contact desensitization are applicable. A hierarchy of approach behaviors would be constructed initially before treatment is introduced. Imagine, as an example, an adolescent with AD who states that he is "afraid" to spend time in the community whether it is to go shopping, eat in a restaurant, or see a movie. This individual prefers to stay at home, spending endless hours in his bedroom looking through books about, and drawing pictures of, insects. His parents indicate that he resists when requested to leave the house or a suggestion is made that he "go downtown." In this example, the first objective would be to identify
any "community situation" that the boy will tolerate in the absence of agitation, distress, and avoidance behavior. Since he attends a neighborhood public school without difficulty, the first step might be simply talking with his parents while standing in front of the school. Positive reinforcement in the form of praise or tangibles (e.g., a portion of his weekly allowance) would be presented for his desirable behavior. The next step might be tolerating a walk of 25-30 yards from the school towards a downtown area. Reinforcement would continue to be offered as this step is "mastered." Then, the steps would advance to walking past several stores, standing outside of the stores, going into a store for gradually increasing periods of time, making a purchase in one or more stores, and so on. As depicted in this description, an individual is taught to experience activities and conditions which provoke fear through confrontation with them that is incremental and with an absence of arousal and avoidance. Pleasurable consequences are made contingent on success to induce motivation to participate in the hierarchy of steps. This method of in vivo desensitization can be highly effective in reducing and eliminating fears so that a person has an improved quality of life.

Ritualistic Behavior and Preference for Sameness

Resistance to change, perseveration on sameness, and ritualistic behavior are characteristics of persons with AD. An initial step for the clinician is to determine whether such a presentation represents Obsessive Compulsive Disorder (OCD) as defined in the DSM-IV or occurs for other reasons. Many persons with AD, for example, prefer set routines and patterns such as following a particular school schedule or performing the same activities but they do not engage in checking rituals or repetitive acts common to those with OCD. If OCD is diagnosed as a comorbid condition in a person with AD, prescriptive interventions which include exposure and response prevention techniques likely would be considered.

Teaching acceptance of change by a person with AD requires systematic intervention that ideally, should be implemented gradually to avoid provoking agitation and distress. One student with AD was referred to us for consultation because of his extreme difficulty tolerating changes in his daily schedule participated in a program that began with his present (and preferred) school schedule written-out in order on individual cards. He was informed that one time per day, one scheduled activity (e.g., 10:30-11:00am) would be changed and he could select one of three alternatives as a substitute. The substitute activities were all pleasurable ones for the student. Furthermore, when he "accepted" the schedule change, he received positive reinforcement from his teachers in the form of praise, approval, and several minutes of "free time." The next step in the program was to provide positive reinforcement when the student accepted the one-activity daily change and the substitution of the alternative activity but based upon the decision of his teacher. Following success at this step, the teacher then made an activity change each day that was unanticipated by the student. Finally, the terminal step in the program was teacher-initiated changes in activities that occurred at anytime and more than once during the day. This intervention was very effective in eliminating the student's resistance to change at school.

Challenging Behaviors

Previously, the potential benefits of utilizing self-management strategies as a method of behavioral support was suggested. Self-control approaches for persons with AD seem particularly relevant given their relative strengths in the areas of cognitive and language development. Furthermore, a step-by-step training sequence in how to implement a program of self-management likely would be acceptable to most persons with AD because it capitalizes on their preference for order and repetition. Of note in this regard is a study by Koegel et al. that evaluated a self-management treatment "package" to improve social skills and reduce challenging behaviors (e.g., self-injury, tantrums, stereotypy) of four children with autism (6-11 years old). The intervention included teaching the children to self-monitor correct and incorrect responses during conversations with adults by prompting them to record behaviors on a wrist counter, positively reinforcing them for compliance, and gradually withdrawing prompting and reinforcement procedures. In the end, the children learned to use self-monitoring skills independently within home, school, and community settings. This intervention produced significant improvements in social skills and reductions in challenging behaviors.
Another viable approach towards the design of support plans for challenging behaviors displayed by persons with AD is the incorporation of antecedent control methods. Strategies that are based on an antecedent control orientation seek to reduce challenging behaviors by identifying provoking conditions and then attenuating their influence in several ways. First, the conditions that are associated with or set the occasion for challenging behaviors can be eliminated. Or, conditions that pre-empt the occurrence of particular responses can be programmed. A third alternative is to introduce situations and interactions which make it more likely that alternative and acceptable behaviors will be demonstrated. It should be noted that antecedent control interventions also can be effective by altering the "potency" of reinforcement contingencies. Thus, if a person's challenging behaviors are maintained by the social attention of others, the "attention seeking" motivation might be lessened by providing him or her with undivided and noncontingent attention periodically during the day.

Although we have not located any published accounts of antecedent control procedures applied specifically to persons with AD some of the methods described previously in this review would be relevant. The use of activity-schedule cards is one example of incorporating an antecedent control intervention. Similarly, initiating behavioral support plans and clinical procedures by gradually "fading" them in (as in the case of fear-reduction through in vivo desensitization) is based on antecedent control. The growing interest in antecedent approaches toward behavioral support is encouraging and we suspect that many persons with AD will benefit from this non-invasive therapeutic approach.

**Case Example**

The following case illustrates the process of treatment formulation and behavior support consultation for an individual diagnosed with AD. Jean (a pseudonym) was an eighth-grade student who attended a public school. She was aware of her diagnosis and her teachers suggested that this situation seemed to contribute to her distress and anxiety. Jean was described as a "bright" and creative student but one who exhibited many behavioral challenges. She sometimes used profane language in her classes, was loud, and occasionally exited the school building when "upset." Verbal outbursts were observed frequently when Jean was confronted with instructional "demands" that appeared to be confusing to her, were lengthy, and did not adhere to her expectations. She did not complete homework assignments consistently and this erratic performance, combined with her challenging behaviors, were priority concerns of her teachers, particularly because Jean was scheduled to make the transition to high school next year.

Three consultation visits consisting of classroom observation, discussions with teachers, and review of records were completed by the third author. The following intervention strategies were designed and implemented:

1. Contingency "contracts" for homework assignments were established. Jean and her teachers determined behavior-specific criterion related to homework such as the quantity and accuracy of work to be completed. These criteria were set initially at a level that ensured success. Jean also was provided with a period in school each day to review her homework assignments and receive support.

2. Verbal outbursts and suspected precursor behaviors were targeted for an individualized plan. Teachers were instructed to give Jean a "pass" to go to the library when these behaviors were observed so that she could remove herself appropriately from stressful situations instead of running indiscriminately from the school building. She was able to sign-in to the library and remain there for up to 15 minutes before returning to the previous setting to complete the preceding activities.

3. For interpersonal skills development, "social narratives" were prepared by incorporating historical figures that were of personal interest to Jean (e.g., Eleanor Roosevelt and Marlene Dietrich). These persons were included in stories that depicted particular social situations and Jean and her teachers discussed how they might have "solved" interpersonal conflicts. Jean was encouraged to generate different solutions to the problems and to discuss them accordingly. Emphasis was placed on using these skills during similar, everyday encounters.
Within classes, teachers were encouraged to set-up a "buddy system" by allowing Jean to work cooperatively with another student during selected instructional activities. By pairing Jean with one or more peers, social skills were addressed in addition to providing remedial academic support.

Jean was introduced to the new high school setting and relevant personnel such as the principal, guidance counselor, and teachers. Familiarizing Jean in this way was seen as an important step in reducing her anxiety about the grade-level transition.

Although time-limited in scope, the consultation implemented with Jean and the school staff was very effective in achieving targeted objectives. Teachers and ancillary personnel learned a great deal about AD and how to conceptualize and apply behavior-support procedures for a student with this diagnosis. Overall, Jean's school adjustment improved and a profile of intervention strategies was identified for use in the high school setting.

**DISCUSSION**

This review of behavior-support procedures for persons with AD originated from our perception of a greater recognition of the syndrome as revealed in DSM-IV and more frequent referrals for clinical assessment and treatment recommendations. The understanding of AD as a distinct diagnostic category that is separate from autism is prevalent within the professional community. The fact that so few studies in the behavior analysis literature have addressed AD specifically may be the result of many participants having been classified as "high functioning autistic." Also, this clinical population likely has been served poorly because until recently, the recognition and treatment of psychiatric disorders in persons with developmental disabilities has largely been neglected. It now seems appropriate to conclude that AD has its own distinct profile which suggests particular intervention approaches.

Diagnosis in and of itself, however, should not be the basis of treatment selection. Children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), for example, exhibit inattention, impulsivity, and hyperactivity but these characteristics can and do occur in different forms, at varying frequencies and intensities, and not always in the same contexts. On the same theme, symptoms of depression are manifested in many ways and cannot be assigned to a singular etiology. A more functional, as opposed to a structural, approach to diagnosis of AD is to identify those interpersonal, environmental, and contextual variables which influence symptom presentation and then match behavior support procedures accordingly.

Our review of behavior analysis methods highlighted several areas. First, as revealed in the discussion of social skills, skill-building approaches should be an essential component for the behavior support of persons with AD. Skill deficiencies and limited response options in a child, adolescent, or adult seriously reduce access to pleasurable life experiences and as a result, increase the likelihood that behavioral challenges will be encountered. By fostering improved interpersonal and language competencies through behavioral training programs, one should expect to see fewer adjustment problems and greater self-esteem.

A second area of clinical attention outlined in this review is introducing treatments for difficulties that are anxiety-mediated. Cognitive-behavioral methods and contingency management procedures that address fears, agitation, and avoidance behaviors should be considered. As emphasized previously, the treatment orientation is to focus on what the person can cope with presently, strengthen success at that level, and then gradually intensify intervention without disrupting previous gains and behavioral stability.

Finally, behavior-support programs for persons with AD should encompass multiple procedures which are complimentary. Although any treatment "package" must be tailored to each person, a set of common procedures would include (a) a prompting hierarchy, (b) a system of graduated prompt-fading, (c) contingent positive reinforcement which is based on stimulus preference assessment, (d) manipulation of antecedent conditions, and (e) behavior-contingent interventions. The combination of techniques, of course, should be designed so that they can be implemented efficiently, within relevant settings, by both the person with AD and significant others.

In closing, we emphasize the fact that misconceptions and in some cases, clear misrepresentations, of learning theory approaches to treatment continue to be encountered and have
an impact on the behavioral support of persons with AD. As an example, one of the authors participated recently in consultation in which the parents of a student with AD were told by a professional that behavior analysis and intervention "were detrimental and would cause irreparable harm" to persons with this diagnosis. Hopefully, the information and discussion presented in this review reveals how such a comment reflects an inadequate understanding of applied behavior analysis, its breadth, and contribution to a science of human behavior. Persons with AD are as responsive to learning-based approaches to intervention as any other individuals who have emotional, social, and behavioral challenges. The empirically-based orientation, prescriptive process of treatment formulation, and commitment to outcome evaluation which distinguish applied behavior analysis from other therapy models should be seen as an advantage for designing comprehensive and individually tailored behavior-support plans for the child, adolescent, or adult with AD.

References


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