The subject of this paper, a Jamaican, met the author on leave from his long-time residence in the Middle East. Unusually, he informed the author that she would be his doctor, based on no real acquaintance and despite the geographical distance. His statement was originally disregarded. Despite familiarity with autism, friends and acquaintances with autistic charges and a colleague specialist in autistic speech therapy, this case was a wake-up call proving to the author the medical profession's need for KAP information regarding autism.

CASE REPORT

The client was in his later middle years, a known hypertensive and, unbeknownst to the author at the time of meeting and for most of the therapeutic contact, reportedly had been diagnosed 10 years previously as autistic. Among blood relatives in the generation following his were another male on the spectrum (likely high-functioning based on observed social and academic success) and a female with a nebulous psychiatric diagnostic history. Based on her case notes, the author used the term 'nebulous' because the diagnosis was changed from bipolar to borderline personality with corollary diagnoses of narcissistic tendencies, depressive episodes and temporary psychotic episodes with a reference to the fact that the diagnostic path would remain under review even at the approximately 10-year mark of formal medical supervision. In addition, this woman's medications were also changed with a note regarding observation. The client's nuclear family grew up in a town within a five-mile radius of at least five other families with no blood links in which there were other formally diagnosed cases of autism, dyslexia and attention deficit hyperactivity disorder (ADHD) in the same and the following generations as the client's. The town was among those built around the bauxite and aluminium industry and not one of the Maroon or German settlements where intermarriage was common. Of note, the client's mother had a sclerotic condition, although it was not diagnosed as tuberous sclerosis (4). She had failed pregnancies before conceiving the client, a first-born. She stated that at an appropriate age, 'we had to insist he leave home'.

The request for a long-distance therapeutic relationship was eventually taken seriously when the client, *via* online sessions, made the following complaints: 'a bit depressed', a long-standing scalp lesion which he dug at relentlessly, repeatedly creating an approximately 1 cm craterous sore, and disillusion about not being stably married or having any children at his age and stage. On his third disintegrated marriage, he felt that the marriages had had severe emotional, financial and career advancement costs. He acknowledged himself as a 'bad husband' and felt himself victimized by his former and current spouses. He said he had never lived conjugally for more than three years. He had grown up in a family in which the mother loved and viewed him as 'different', but specialized investigation and contact were never undertaken. The 'difference' was subsumed in a competitive and academically successful household where all (parents and siblings alike) were achievement-oriented. This 'difference' also included the client's shyness which could have been a natural introversion or brought on by his own awareness that he was 'different' or a synergistic blend of both. The causality within and between corollary phenomena in the study of autism is often murky (2).

In retrospectively considering the client's probable earlier diagnosis of autism, dealings with him led this author only in the direction of Asperger syndrome now being considered the same as high-functioning autism (HFA), although still debated (2). In fact, the client's high IQ and his professional and verbal adeptness (congruent with advanced tertiary education) at first caused the author not to consider the autism spectrum. Only because literature review turned up Asperger syndrome followed by its relation to the spectrum did the author make the connection to autism. In those with HFA and Asperger syndrome, the IQ is always normal or above the neurotypical average compared to other forms of autism but still with the same social difficulties at their core (2). It is unknown whether the client's diagnosis was incomplete or if on hearing the term 'autism' he left therapeutic contact so that no further diagnostic fine-tuning could occur. He had no social or emotional support at the time of his diagnosis and was in the midst of a disintegrating marriage in which the then spouse could not accept or deal with the diagnosis. It is also unknown whether in contacting the author, the client was actually seeking an unbiased second opinion. This background information may never be known and is the kind that those with HFA commonly keep private in an attempt to control, avoid betrayal and/or manipulate given social situations (3). When it was finally believed that the correct diagnosis had been reached and, again retrospectively, considering the client's thrice-repeated statement, 'One day, I'll tell you my story', it occurred to the author that the client likely had known about himself and rather than tell him what had been deduced, the author simply asked how long he had known about his diagnosis. Ten years was the answer after the client's brief obfuscation.

Using online coaching sessions and guided by available adult test instruments (5), personal interview, emails,

and conversations with friends and family, the profile and diagnosis of Asperger syndrome were posited. Corollary diagnoses were narcissistic traits and avoidant personality disorder (6). The client had alternately accepted and rejected all repeatedly.

History included:

- High IQ and gift with information technology
- Over-achiever approach to life, career and academics
- Childlike behaviours and habits
- Academically, materially and professionally successful
- Preference for solitude with occasional feelings of loneliness
- Alternation between gross unreliability and utter reliability in personal life
- Addiction to online pornography and consequent interpersonal sexual dysfunction (7)
- Fixation on conspiracy and alien theories
- Self-assessment as 'looking like a kook' when shown present list
- Mimicking of appearance and preferences of social company
- Cultivated social norms/behaviours sometimes practised with third-person commentary
- Marked adaptability to highly varied physical, cultural and impersonal professional settings
- Deflated/vacillating narcissism encompassing (6):
    - Capacity for great charm
    - A victim mentality with a 'hero or zero' attitude to himself and relentless self-comparison to others, self-abnegation to please or complete lack of empathy
    - Controlling and manipulative behaviours
    - Much intimate conversation initiated in a negative vein, often making reference to physical ailments and disorders as introductory subject matter
    - Marked benevolence towards underdogs with deep feelings of betrayal if the underdog 'bites'
    - Academically controversial issue of veracity *versus* falsehood in communication (8)
    - Great affinity with pets – much time spent massaging them as a child and younger man
    - Extreme agitation, distraction and avoidant behaviours in personal/therapeutic interview
    - Irregularities and avoidance in written communication – neurotypical acknowledgement or timely response was absent
    - Decisive and abrupt approaches to given situations
    - Ambivalence about love and conjugal relationships with difficulty offering others long-term emotional support
    - Acknowledgement that he was emotionally 'a mess'
    - Extreme procrastination in some personal matters and over- to super-production in the work arena
    - Lack of health-seeking behaviour re mental/emotional therapies/support although the urge was there
    - Great admiration of father and brother, and difficult relations, although love and loyalty, towards mother and sister
    - Precipitous falling in and out of love/infatuations including much falsehood
    - Body image challenges – teased about appearance as a child, weight challenges in late adulthood and repeatedly made references to body image/physical prowess, sometimes as non-sequitors
- Whole body scarring which may or may not have begun with genuine dermatological cause or been psychosomatic from the beginning
- Dysthymia and/or frequent depressive episodes
- Insomnia
- Long-standing great geographical distance from family, spouse and milieu of his formative years

DISCUSSION

The first impression was of a negative personality who was a narcissist, but it did not fit other genuinely kind and considerate behaviours observed in many cases. The impression of defence or covering insecurity arose. With the single formal interview (which was never repeated due to the client's agitation and distraction behaviours), the avoidance disorder diagnosis was formulated. Did a decision between negative narcissism and avoidance disorder have to be made? Signs and symptoms overlapped (2). However, neither diagnosis was global enough for the personality being witnessed, and this is a hallmark of the final HFA diagnosis – much is suggested but does not quite fit (2). Those with HFA are more self-aware than classically autistic people but with marked 'blind spots' (9). Many are materially self-sufficient and can mask, at cost, their internal difficulties (2, 9).

Regarding this diagnostic confusion, the history of the female relative with the borderline personality described

above is not uncommon when there is a missed diagnosis of autism. Corollary diagnoses are the norm with autism, and each element requires specific therapy (2). Autism is highly case-specific, and corollary diagnoses can have bio-physiological or social roots *eg* traits developed as defences against the stresses of being autistic in a neuro-typical world (9).

By the end of a year, the following path to balance was suggested (Figure):

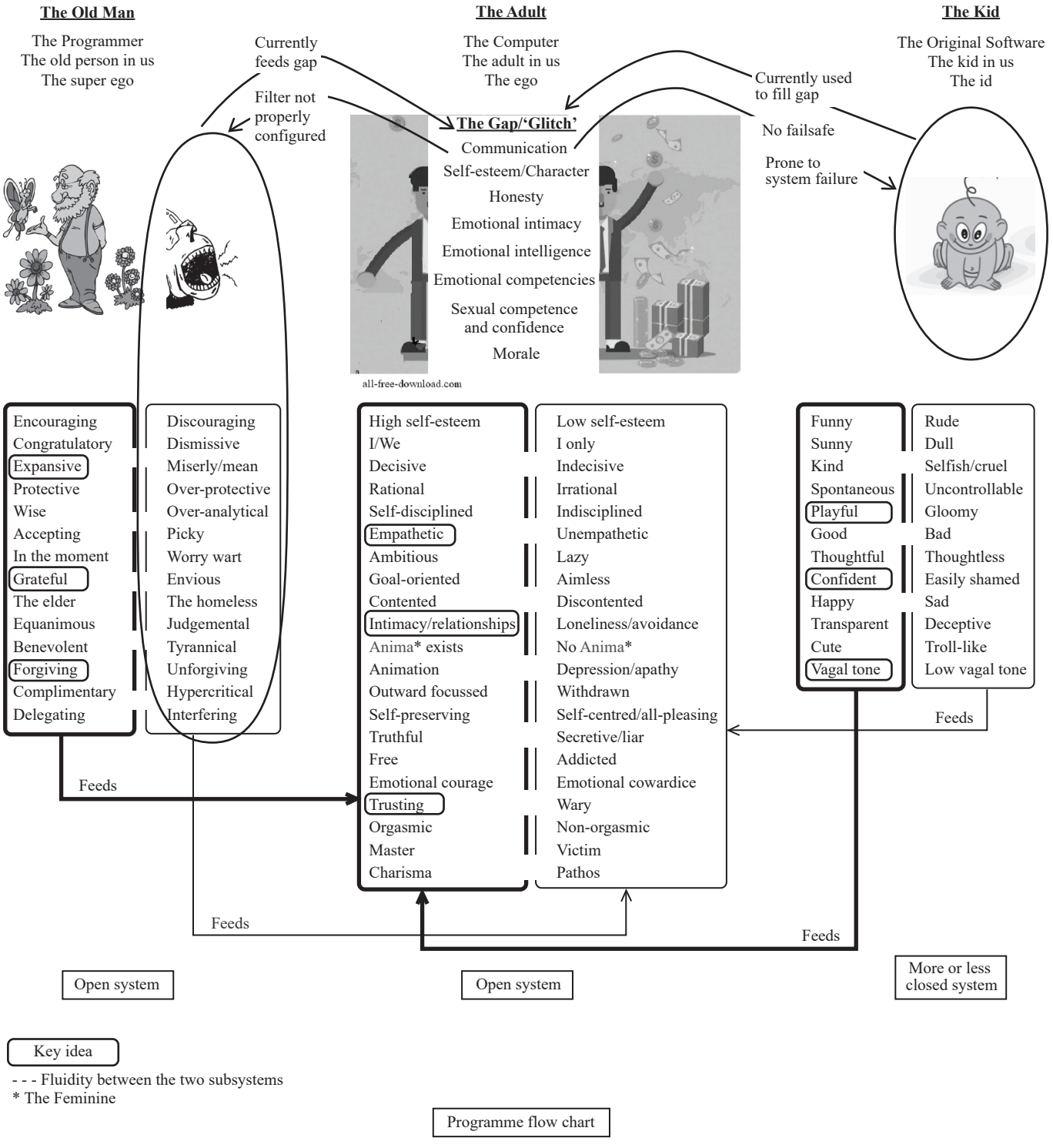

Figure: Schema developed on the principles of transactional analysis to help the client visually appreciate his condition and aims of therapeutic interaction.