The Revelatory Journey of Fine-tuning the Diagnosis of an Adult Male on the Autistic Spectrum – Asperger Syndrome/High-functioning Autism with Corollary Diagnoses
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ABSTRACT
This article provides an account of the revelatory experience of diagnosing a high-functioning, autistic, adult male by a non-specialist medical practitioner and its implications for knowledge, attitudes and practice in dealing with the autistic spectrum.

Keywords: Adults, Asperger syndrome, diagnosis, high-functioning autism

INTRODUCTION
This paper was inspired by the fact that despite the upsurge in the prevalence or diagnosis of autistic conditions, the majority of information on knowledge, attitudes and practice (KAP) concerning autism is shared only among those with the condition, those that care for/live with them and the still relatively few specialists in the field (1, 2). Medical authorities remain unwilling/unable to make a categorical statement about whether the upward trend is due to more diagnosis or actual prevalence (2). This paper was written by a non-specialist in autism and reviewed by the client in keeping with the fact that although an autistic person, particularly the high-functioners, can resort to manipulative behaviours, any interaction with them must be seen to be convincingly free of the same (3).

Autism is viewed as a spectrum of conditions with the cardinal issue being social and interpersonal dysfunction and difficulty, although the intelligence quotient (IQ) can range from low to genius level. The ability to function socially can also range from poor to high, and with the latter, it is often unclear what is atypical, other than that the person seems ‘different’ or ‘weird’ (2).

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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 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, cul-
  tural and impersonal professional settings
- Deflated/vacillating narcissism encompassing (6):
  - Capacity for great charm
  - A victim mentality with a ‘hero or zero’ atti-
    tude to himself and relentless self-comparison
    to others, self-abnegation to please or com-
    plete lack of empathy
  - Controlling and manipulative behaviours
  - Much intimate conversation initiated in a neg-
    ative 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 com-
    munication – neurotypical acknowledgement
    or timely response was absent
- Decisive and abrupt approaches to given
  situations
- Ambivalence about love and conjugal rela-
  tionships 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/infatu-
  ations including much falsehood
- Body image challenges – teased about appear-
  ance 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 dis-
order 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 neurotypical world (9).

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

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

My Pledge
I will:
– always respect you
– never be ashamed of you
– protect all your secrets
– honour your virtues
– dignify your shame
– cry, laugh and dance with you
– hold your hand on the journey
You will always have my time, trust and loyalty.

Sirijs

I want to unfold.
Let no place in me
Hold itself closed.
For where I am closed
I am false.

Rainer Maria Rilke

1. Use programmes and software marked in bold lines (left side) in The Adult
2. Reconfigure filter to accept the Elder and block Scrooge
3. Fully incorporate Kid into RAM/CPU of Adult. Kid software not designed for troubleshooting and spot fixes
4. Download and install Anima driver
5. Human contact to challenge, stimulate and support

Tasks
1. Reparative relationships including normal intimacy and orgasmic meditation¹
2. Regular normal meditation
3. Some coaching (better with (1) and/or (2))
4. Massage once a week, preferably a masseuse, but any gender will do
5. Possible judicious use of oxytocin therapy² after all other tasks well underway

End game
Computer can register and override own glitches, fill own requirements by sending requests to others based on default true line code. (Adult can acknowledge and compensate his/her own glitches by asking others for help and support based on honest communication.)

Computer not sidelined by other computers, conscripts them as part of friendly network that builds in local and network failsafes. (Adult is not threatened by intimate relationships with women or friendships with other bright men and forms long-term intimate and friendship bonds that are his/her life support system.)

Computer can run its own programme in parallel with others in network, working through and compensating incompatibilities on a day-to-day basis without system/network failure. (Adult comfortable being himself/herself in intimate relations and friendships, working through and out disagreements and incompatibilities on a day-to-day basis without destruction of relationships.)

Something to do
Someone to love
Something to look forward to

Sources of images:
The Old Man: https://pixabay.com/en/
The Adult: https://all-free-download.com/
The Kid: https://all-free-download.com/

• Continuation of self-initiated exercise routine, special interest travel and improved materno-filial relations
• Final acceptance of diagnosis if made by a specialist
• Lessening geographical distance to/greater contact with family and loved ones
• Divorce
• ‘Coming out’ to family
• Specialized work on dysfunctions
• Planning social support for retirement
• Cessation of use of pornography and more direct physical, interpersonal contact beginning with therapeutic massage
• Practise at ceasing falsehood/confabulation

It was also shared with the client that those with HFA may have singular affinity with the computer because modern computing was invented by Alan Turing, who was likely to have had HFA (10). There appears to be peculiar synchronicity between the rise of the incidence/diagnosis of autism and the age of computing; for those with HFA in their middle years today, the whole life journey may have been very difficult due to a lack of awareness, knowledge and resources in the therapeutic and academic spheres, but there is still a great deal of unresolved stigma (11).

The Figure is a schema based on transactional analysis and the client’s particular affinities and gifts. It was used to help increase self-awareness and suggest therapeutic approaches before the final proposal of diagnosis of HFA and corollary diagnoses were formulated (12). They are still applicable after diagnosis and expand basic suggestions above. At this client’s stage, should he choose to undertake the challenge of a relationship again, a rewarding one with a partner whose IQ is high enough to interest him, who knows the client’s status and is prepared to deal with it or who herself has HFA is likely the client’s ultimate route to balance. It remains to be seen if the client’s past bravery is used to pursue further specialized attention.

The autism tools caused humour for the author because some traits caused self-recognition as a neurotypical, culturally defined eccentric, being spared outright schizotypal disorder (13). Know thyself if you intend to fencer with an ‘Aspie’, a name the Asperger community has given itself (9).

Improvement in KAP regarding autism should prevent over-diagnosis and over-prescription of drugs and tolerate differences and ‘thinking outside the box’ (9, 14). The greatest need is interaction with others. Altered neural circuitry for needing others remains, although there is an overall deficit in the circuitry for achieving socialization. The input of the Asperger community itself is critical to improving KAP regarding autism, particularly those with HFA (15, 16).

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This paper is dedicated to the late Dr Marigold ‘Molly’ Thorburn (1935–2018), formerly of The University of the West Indies, advocate for Jamaicans with disabilities and clarion voice on autism in the Caribbean.

REFERENCES