

When should doctors diagnose high- functioning autism spectrum disorders in adults?

Dr. Sarah Abrahamson

FAFRM, Grad Dip Clin Epi

**Rehabilitation Physician, The Victorian Rehabilitation
Centre**

**PhD Candidate, Department of Psychology and
Psychiatry, Monash University**



Introduction

- As a rehabilitation physician I work with people with all disabilities
 - Undiagnosed high-functioning ASD can complicate other disabilities
 - There is still a low level of awareness of ASDs among doctors, even in rehabilitation services
-



Undiagnosed ASD

- ❑ An unusual level of disability compared to the known other disability
 - ❑ A whole unusual, eccentric family
 - ❑ Presenting as if they have had a brain injury
 - ❑ A psychologically-based physical presentation
 - ❑ Difficult to manage by staff, resulting in some staff refusing to work with them
 - ❑ Difficult to discharge home due to household state and/or limited social supports
-



Making an ASD diagnosis

Questionnaires

- RAADS: Ritvo Autism and Asperger's Diagnostic Scale
 - AQ: Autism Quotient
 - Only tested in those with ASDs who *know they have ASDs already and agreed to be studied*
-



Questionnaires for ASDs

Low score could mean:

- no ASD
- Poor insight into ASD
- Answering untruthfully
- Unable to understand the questions

Questionnaires cannot be considered
diagnostic



ASD diagnosis

- No neuropsychological test is diagnostic
 - Instead based on:
 - Patient interactions with staff and family
 - History from patient, family and friends, including developmental history
 - Objective examination of life skills
 - Functioning in the workplace
 - Functioning in making and maintaining appropriate social contacts
 - Functioning in managing household tasks and finances
-



Case 1: 30 year old man

- ❑ Seen in brain injury clinic
 - ❑ Mild brain injury years prior, “failed to recover”
 - ❑ Lifelong difficulty in social interactions, finding them very difficult and stressful
 - ❑ Limited social contacts
 - ❑ Varying levels of anxiety and depression
 - ❑ Strong interests which took up much of his day
 - ❑ Unable to last in jobs involving interpersonal skills
-



Case 1: 30 year old man

- Attempted neuropsychological assessment: general neuropsychologist did not feel comfortable commenting on possibility of an ASD
 - Investigated using the RAADS: scored very highly indicating high-functioning ASD
 - Diagnosed with Asperger's Syndrome
 - Diagnosis discussed with patient and family
 - Employment agency given information
 - Patient found this additional insight helpful in planning an appropriate lifestyle
-



Case 2: 80 year old woman

- Admitted to a rehabilitation ward with a minor stroke affecting power in one side
 - Past history of “schizophrenia” since young adulthood
 - Diagnosis was made due to some magical beliefs and paranoia: no documented hallucinations
-



Case 2: 80 year old woman

- ❑ No psychotic symptoms in time of current medical records
 - ❑ Personality function stable for decade
 - ❑ Maintained on no psychotropic medications
 - ❑ Had been married and raised a family
-



Case 2: 80 year old woman

- Lived alone with help with domestic tasks and support from psychiatric services
 - Enjoyed spending time with animals
 - Had contact with neighbours but rarely saw her family, had no reported friends
-



Case 2: 80 year old woman

- On exam: Appeared mildly anxious, impaired speech pragmatics; vague, tangential and unusual prosody
 - Complained of a painful leg, present since an injury as a teenager: diagnosed years prior as complex regional pain syndrome but no treatment provided
 - GP had stated he thought she had “delusional pain” in the setting of her “schizophrenia” so offered no treatment
-



Case 2: 80 year old woman

- Started a low-dose antidepressant (a recommended treatment for complex regional pain syndrome)
 - The leg pain and anxiety subsequently resolved
 - Neuropsychological profile
 - Similar to one several years prior
 - low normal intelligence with proportionately lower skills in language/communication and executive function
-



Case 2: 80 year old woman

- I felt that high-functioning ASD was a more likely diagnosis than schizophrenia:
 - No definite psychotic features; more “odd ideas”, consistent with schizotypal/paranoid features, possibly transient as not described for many years
 - Managed on no medications
 - Functioning well in the community throughout her life, except in social communication
 - No worsening in symptoms over the years
-



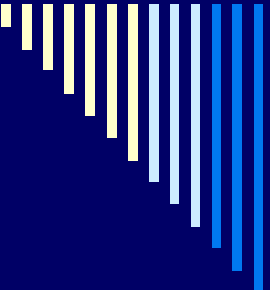
Case 2: 80 year old woman

- Possible developmental disability diagnosis discussed with her psychiatric team, who agreed this was possible, but a diagnosis would not change her management
 - Patient showed no interest in discussing psychological issues at any point, and appeared happy with her current formal services and label
 - She had NOT presented with psychological symptoms, but with a stroke
-



Case 2: 80 year old woman

- Therefore not further investigated or diagnosed ASD
 - If she lost the “schizophrenic” label she might not have been eligible for support from psychiatric services, her main support
 - Conversely if she had not been labeled “schizophrenic” she might have had her pain syndrome treated adequately!
-



Other possible psychiatric labels for ASD

- ❑ Bipolar disorder
- ❑ Schizophrenia
- ❑ Chronic depression and/or anxiety
- ❑ Social phobia
- ❑ Personality disorders

The above labels may be accurate in addition to an ASD

If inaccurate, removing these labels after many decades likely to be difficult and may reduce access to services



Possible benefits of diagnosis

- ❑ “Finally an answer”
 - ❑ Education; patient, relatives, employer, carers
 - ❑ Access to reading autobiographies, meeting and writing to others with ASDs
 - ❑ Practical advice; career, lifestyle, training in activities of daily living
 - ❑ Access to autism-related social services (eg. DHS case management)
 - ❑ Speech therapy (especially pragmatics)
 - ❑ Remedial physical/exercise therapy, avoiding team sports if too difficult
-



Possible benefits of diagnosis

- Neuropsychological profile; target weaknesses, build confidence in areas of strength (may lack confidence)
 - Appropriate psychiatric/psychological care
 - psychoanalysis may not be helpful
 - focus on practical strategies eg. CBT
 - Appropriate medications; antidepressant and anti-anxiety rather than anti-psychotic and mood stabilisers (eg. lithium)
-



Possible adverse effects of diagnosis

- ❑ Anger/disbelief towards clinician making diagnosis
 - ❑ Anger at previous clinicians for NOT diagnosing
 - ❑ Damage to relationships with clinicians who have previously not made a diagnosis
 - ❑ Increase the level of self-consciousness
 - ❑ Might be used as a reason to avoid attempting social interaction or employment
 - ❑ Disclosure dilemma; who to tell (family, friends, employer)
 - ❑ If disclosed could be used by others to discriminate
-



Possible adverse effects of diagnosis

- May have complex personal explanations for lower social functioning
 - moved from overseas or interstate
 - too busy to make friends
 - “my parents didn’t teach me to socialize”
 - “People here aren’t friendly”
 - Giving a diagnosis may
 - Force them to change their entire self-concept
 - Make them reassess their whole life historymay not be willing to do this!
-



Who to diagnose?

- We do not know if being diagnosed with a high-functioning ASD as an adult is helpful in general
 - Self-diagnosing high-functioning ASD adults (? the majority diagnosed currently) are generally intelligent and psychologically aware
 - People with high-functioning ASDs occur across the intellectual spectrum, with widely varying degrees of psychological awareness and interest
-



Suggested rules for diagnosis

- A diagnosis should be given when a person has specifically presented with psychiatric or neurological problems which may be explained by the ASD
 - A diagnosis should be given whenever a patient or relative specifically asks about the possibility of an ASD or developmental disability in general
-



Suggested rules for diagnosis

- A diagnosis should not routinely be offered if the patient has little interest in psychological issues and no psychological complaint
 - In the above situation, where there are existing social or psychiatric services, the possibility of adding the diagnosis as guidelines for staff, rather than the patient, should be considered
-



Where to diagnose?

- ❑ Currently few specialised diagnostic services
 - ❑ Many adult psychology and psychiatry services are not comfortable making ASD diagnoses
 - ❑ I'm now able to see people with ASD and other developmental disabilities for diagnosis and long term care
 - ❑ I'm encouraging my rehabilitation colleagues to considering enhancing their developmental disability training and doing the same
-

Janet Frame₁



- Well-known New Zealand author: 1924-2004
- Life depicted in the NZ movie “An Angel at my Table”

Strong signs of an ASD:

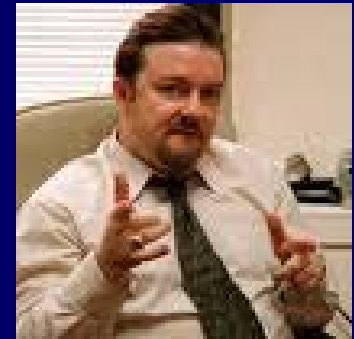
- Extreme difficulty with most social interactions
- Strong special interests (literature and poetry)
- Unable to function in many low-skilled jobs
- Left teacher training due to difficulties interacting with others

Janet Frame



- Developed mood disorder and suicide attempts
- Diagnosed with schizophrenia then personality disorder, spent many years in mental hospitals
- High level of self-awareness and interest in psychology
- Narrowly avoided having a frontal lobotomy
- Might have benefitted from an ASD diagnosis to
 - Avoid inappropriate treatment and labels
 - Target areas of difficulty with psychosocial therapies
 - Plan an appropriate lifestyle
 - Help advocate for herself and others with ASDs

David Brent



- Fictional character: “The Office”
- Based on real co-workers of the writers
- Strong signs of an ASD:
 - Poor social communication skills
 - Strong interest (comedy)
 - Poor organisational skills and attention (possible ASD-related, possible comorbid ADHD)
- Possibly would not accept or benefit from diagnosis due to low self-awareness and psychological interest
- Might however require a diagnosis if he presented depressed having lost his job due to his ASD/executive dysfunction!



Summary Reference

High-functioning pervasive
developmental disorders in adults.
Abrahamson SJ, Enticott PG, Tonge BJ.
MJA 4 Jan 2010
