How do you know if your client has **autism**?

Autism spectrum disorder (ASD) is complex and difficult to diagnose. So, counsellors should think carefully before suggesting autism to a client, says *Elaine Nicholson*

Autism spectrum disorder (ASD) is an early onset neurodevelopmental condition that is associated with diverse social, occupational and educational challenges. ASD is characterised by impairment in qualitative social communication and interaction, alongside rigid, repetitive, routine, ritualistic behaviours and adverse sensory responses to certain stimuli. The estimated prevalence of ASD is between one and two per cent.[1–3]

Over half of adults who suspect ASD initially visit their GP,[4] yet ASD is frequently overlooked or misdiagnosed in adult patients by primary care physicians, due to lack of experience in detecting autism traits.[5,6] In addition, adults with ASD are at high risk of co-occurring mental health conditions,[7] non-suicidal self-injury,[8] and suicidality.[9]

I am the founder and chief executive officer of Action for Asperger's, a charity that offers counselling to people who have been adversely affected by the experience of ASD. I use a bespoke model of counselling, which I developed during my master's degree in autism. I also have personal experience of autism, as the spouse and parent of ASD individuals.

I am growing increasingly concerned by the number of clients who tell me their counsellor has suggested they have ASD. Whatever their neurological profile, clients are vulnerable and can cling to the notion of a diagnosis. A client who is autistic is particularly inclined to obsess and ruminate over an item of interest. They are also less likely to question the validity of a professional opinion, due to their 'all or nothing' thinking.

But diagnosing ASD is a complex process. In the DSM-5,[10] the bible of psychiatry, ASD consists of two diagnostic criteria:

- social and communication deficits
- restricted, repetitive behaviours and abnormal sensory sensitivity.

Repetitive behaviours are diagnostically defined as repetitive, non-functional movements or interests, including self-injurious behaviours, stereotyped movements, behaviours that involve objects, specific and obsessive interests and repetitive speech and language.[11] Also included are atypical sensory issues, specifically hypo and hypersensitivity to sensory input.

'Clients are vulnerable and can cling to a diagnosis'

Asperger's syndrome is described as ASD, or ASD 'of the Asperger's variant', or ASD 'of the higher functioning variant'. Individuals who have marked deficits in social communication, but whose symptoms do not perfectly fit the criteria for ASD, should be evaluated for social (pragmatic) communication disorder.[12] When they are diagnosing ASD, the DSM-5[10] asks clinicians to specify:

- with or without accompanying intellectual impairment
- with or without accompanying language impairment
- associated with a known medical or genetic condition or environmental factor
- associated with another neurodevelopmental, mental or behavioural disorder
- associated with catatonia.

According to the DSM-5,[10] clinicians should also evaluate the severity of the individual's difficulties in social communication and restricted, repetitive behaviours:

- level 3: requiring very substantial support
- level 2: requiring substantial support
- level 1: requiring support.

A diagnosis requires not only expert clinical knowledge of ASD, but also expertise in at least one, ideally two or three, diagnostic instruments for measuring ASD.

So, when a counsellor asserts the opinion that their client is on the autism spectrum, I believe they are playing Russian roulette with their client's mental health. Of course, they could be right. But even GPs struggle to recognise autistic traits,[13,14] so what can we expect of the individual whose only professional qualification is counselling? It's a bit like a healthcare assistant purporting to know everything about open-heart surgery, and scrubbing up ready to operate!

Let me tell you about Alex, a client who came to see me after his counsellor put forward a 'diagnosis' of autism. Alex was a scientist for a blue-chip company and had a strong work ethic. He was particularly driven because many of his colleagues were younger and he felt he had something to prove. Alex, however, struggled with his young colleagues, especially his boss, who was half his age. He could never please his boss and felt dejected and miserable. Alex reported three months of sleepless nights, reduced appetite, and a withdrawal from close family members. He was referred to a counsellor by the firm's occupational health department and was given six sessions of counselling. The counsellor told Alex that he was autistic – and he was now in my consulting room, describing himself as defective and dysfunctional.

I didn't think it was necessary or appropriate to get Alex to a diagnostician immediately. Instead, my priority was to assist my client in the reparation of self. By the third session, it was clear to me that Alex did not have autism. He spoke of a *'Swallows and Amazons'*[15] childhood, where he communicated and interacted with other children without difficulty. Before the downturn in his mental health, Alex and his wife had also enjoyed country dancing and travelling in their camper van. Once we established that his past and current presentation were not congruent with an ASD, we could understand that Alex was a victim of workplace bullying. Recovery was not then far from sight.

Another example is Dave, a man in his late 20s, who felt strongly that his employers should make reasonable adjustments because he was not able to cope in a large and open-plan office. But when I interviewed Dave's parents during a pre-diagnostic assessment, it became clear that he, too, had enjoyed a *Swallows and Amazons* childhood and so his current presentation was unlikely to be ASD. I understand that he went on to receive a stand-alone diagnosis of sensory processing disorder.

'A number of other mental disorders mimic ASD'

Therapists who suspect a client is on the autism spectrum might be tempted to advise an Autism Quotient (AQ) test.[16] The AQ was not developed as a diagnostic tool; it was intended as a screening tool to quantify ASD symptoms in the population, because these symptoms were assumed to lie on a continuum. The AQ was conceived in 2001 and is a self-report measure of autistic traits for adults with an average IQ or above, who comprise at least 50 per cent of the autism spectrum. It is brief, self-administered and forced-choice. Individuals are required to respond to each of the 50 questions with one of four responses:

- Definitely agree
- Slightly agree
- Definitely disagree
- Slightly disagree.

The responses are scored using a binary system. A confirmation of the autistic trait (either strong or mild) is scored +1, while the converse response is scored as a 0, leading to a maximum score of 50.

A cut-off score of 32 is suggestive of autistic traits. Half of the 'agree' responses and half of the 'disagree' responses endorse the autistic trait and are scored thus to avoid a response bias.

The AQ relies on a receptive understanding of the 50 questions and is not suitable for people with a low IQ, language impairment and/or low verbal ability. The AQ has five subscales: social skills, attention to detail, communication, attention switching and imagination. Shorter versions of this test have been developed, but there is no single

screening test or diagnostic clinical instrument that is 100 per cent accurate.

The counsellor should also bear in mind that a number of other mental disorders mimic ASD. For example, the poor social communication skills, unique thinking and bizarre behaviours of ASD resemble the negative symptoms and disorganised behaviours and thoughts of schizophrenia. Some genetic studies[17] have indicated a close link between the two conditions, and schizophrenia can be a co-morbid condition of an ASD. Other common, co-morbid conditions include major depressive disorder, which is one of the most common psychiatric co-morbities.[18] In my experience of working with autism, I have never seen ASD as a single presentation; it always comes with one or more co-morbid disorders.

'I have never seen ASD as a single presentation'

Stand-alone conditions that can appear like ASD include Klinefelter syndrome. Klinefelter syndrome affects males and is also known as XXY because of an extra X chromosome.[19] Babies with Klinefelter can suffer a developmental delay in walking, crawling, speech and language and may have difficulty in expressing emotions. Klinefelter children can also be quiet, sensitive and lacking in social confidence. Generalised anxiety disorder (GAD) can also look like ASD, with symptomology that includes an inability to tolerate uncertainty, along with difficulty concentrating and avoidance of social situations.[20]

ASD is complex. It must have a developmental trajectory, but it's difficult accurately to diagnose and can resemble other disorders. Any diagnosis should also ideally be scaffolded by the opinions of others, such as educators, parents, health visitors, speech and language therapists.

I would therefore advise counsellors to think carefully before suggesting ASD to a client, who is perhaps already fragile. It's also worth remembering BACP's *Ethical Framework for the Counselling Professions*, particularly 2a, which requires us to 'work to professional standards by working within our competence'.[20]

So, what should you do if you suspect ASD? I would recommend the following, prudent approach:

- suggest to the client that the GP's input might be helpful
- discuss your sense that their presentation is perhaps something different from depression
- explain that you sense a pervasive and developmental basis to the client's presentation, and one that would benefit from further exploration by psychological services
- suggest some books. There are many autobiographical accounts of autism discovery. I personally recommend *A Pony in the Bedroom: A Journey Through Asperger's, Assault, and Healing with Horses*, by Susan Dunne.

Let the client explore their clinical self; you are there to assist the emotional journey, and that is all. It might be necessary for you to communicate with the GP. But remember, you are not a clinician, but a therapist.

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