Dusunen Adam The Journal of Psychiatry and Neurological Sciences 2015;28:382-386
DOI: 10.5350/DAJPN2015280408

Case Report / Olgu Sunumu

Asperger's Syndrome in Adulthood: a Case Report

Ferdi Kosger[1], Sinem Sevil[2], Zafer Subasi[2], Cem Kaptanoglu[3]

[1]Assist. Prof. Dr., [2]Psychiatry Resident, [3]Prof. Dr., Eskisehir Osmangazi University, Faculty of Medicine, Department of Psychiatry, Eskisehir - Turkey

ABSTRACT

Asperger's Syndrome in adulthood: a case report

Asperger's Syndrome (AS) is characterized by social deficits, communication difficulties, and stereotypical behaviors. Unlike autism, delays in language and cognitive development are not seen in Asperger's syndrome. AS is typically diagnosed in childhood, although some cases may be diagnosed in adulthood. Due to the clinical features of AS, diagnostically it can be confused with schizophrenia, anxiety disorders, obsessive-compulsive disorder, and personality disorders; hence, diagnosis of AS may be missed, especially in adulthood. This case is presented to emphasize the importance of adult AS, given that it is generally diagnosed in childhood, which leads to difficulties in diagnosis and differential diagnosis in adulthood if the condition has not been diagnosed in childhood.

Keywords: Adulthood, Asperger's Syndrome, pervasive development disorder

ÖZET

Erişkin Asperger Sendromu: Olgu sunumu

Asperger Sendromu (AS) sosyal etkileşim, iletişim sorunları ve stereotipik davranışlarla karakterize olan, otizmden farklı olarak dil ve bilişsel gelişimde gecikme görülmeyen bir bozukluktur. Genellikle çocukluk döneminde tanı konulmakla birlikte bazı vakalar erişkinlik döneminde tanı alabilmektedir. AS klinik özellikleri nedeniyle şizofreni, anksiyete bozuklukları, obsesif kompulsif bozukluk ve kişilik bozuklukları ile tanısal anlamda karışabilmekte ve özellikle erişkinlik döneminde AS tanısı atlanabilmektedir. Bu olgu genellikle çocukluk döneminde tanı konulan ancak o dönemde tanı konulmazsa erişkinlik döneminde tanı ve ayırıcı tanısında güçlükler olabilen erişkin AS'nun önemini vurgulamak amacıyla sunulmuştur.

Anahtar kelimeler: Erişkinlik, Asperger Sendromu, yaygın gelişimsel bozukluk

Address reprint requests to / Yazışma adresi:
Assist. Prof. Dr. Ferdi Kosger,
Eskisehir Osmangazi University, Faculty of Medicine, Department of Psychiatry, Odunpazari/Eskisehir, Turkey

Phone / Telefon: +90-222-239-2979/3600

E-mail address / Elektronik posta adresi: ferdikosger@gmail.com

Date of receipt / Geliş tarihi:
September 5, 2014 / 5 Eylül 2014

Date of acceptance / Kabul tarihi:
November 30, 2014 / 30 Kasım 2014

INTRODUCTION

Asperger's Syndrome (AS), classified among the pervasive developmental disorders according to ICD-10, is a disorder characterized by social interaction and communication problems and stereotypic behaviors (1). While the condition was identified for the first time by Hans Asperger in 1944 as a disorder describing individuals who have difficulty in expressing feelings, are lacking in empathy and are challenged in understanding socially acknowledged issues, who become a "little professor" in topics they are interested in but can barely balance their voice and use their mimics accurately, AS received greater interest following the study by Wing in 1981 (2,3). The syndrome had been defined by the absence of a delay in linguistic and cognitive development, in contrast with autism, according to DMS-IV (4); in DSM-V, it was not defined as a separate disorder but included in high-functioning autistic disorder (HFA) (5).

It is known that the incidence of AS is between 0.3-0.7%, and it is observed 9 times more in men compared to women. While AS is diagnosed on average at the age of 10-11, some cases are diagnosed in their twenties and in adulthood (3). AS symptoms increase especially in case of a new adaptation requirement. Our knowledge about the prevalence of AS in adults is still limited (6,7).

Clinically, AS can exhibit symptoms similar to those of the prodromal stage of schizophrenia, schizoid personality disorder, residual schizophrenia, as well as obsessive compulsive disorder (OCD), avoidant personality disorder, or attention deficit/hyperactivity disorder, and this can lead to misdiagnosis in persons with AS.

This case is presented to emphasize the importance of adult AS, which is generally diagnosed in childhood, but otherwise can cause difficulties in diagnosis and differential diagnosis in adulthood.

CASE REPORT

A thirty two year old male patient, high school graduate, single, unemployed, living with his family, presented to our emergency service with complaints of anxiety about being left alone if anything happened to his parents. He reported distress, inability to communicate with people, and thoughts about schizophrenia and suicide. It was understood that the patient, who was admitted to our clinic, had acquired these complaints in childhood. He did not have many friends and was marginalized by his companions at school for acting "different". He reported that the same condition continued at high school: he was not able to adapt to his friends, was not able to engage in games they played, did not succeed well at school, and completed high school education through distance learning after the second grade of high school. It was understood that he was not able to continue with his studies at school from the age of eighteen, and he attended psychiatry policlinics for complaints of low-spiritedness, malaise, reluctance, and anhedonia, using antidepressant medication of which he could not remember the names. The patient reported he was not willing to serve in the military for having a soft character; he was ostracized for speaking loudly in the military, and he was continuously warned about this behavior but was not able to adapt the volume of his voice. On a day of leave during military service, not wanting to return to the service, he attempted suicide by diving into a river but was saved by the people around. He did not leave the house for about one year after military service. He used to think "If I go outside, I will have to stay on the streets, I don't know which direction I need to go, so I have to stay at home". One day, he started to throw out objects found in the house from the balcony because he believed he was not understood by his family. The family called the police and the patient was hospitalized in the psychiatry clinic in 2004. He received paroxetine, carbamazepine and risperidone treatment. One year later, he was hospitalized at the same clinic for one month with a diagnosis of mixed-type personality disorder. Between 2006 and 2013, the patient was hospitalized for a total of seven times at another psychiatry clinic, diagnosed with psychotic disorder and anxiety disorder, and received sertraline, risperidone and ziprasidone treatment. The patient reported that he did not benefit much from the medication; he managed to communicate more while in psychiatry services, as other patients and allied healthcare staff understood him better, and he generally did not want to be discharged from the hospital. When he was discharged, he did not go outside his home, and his hesitations about not being able to communicate with and be understood by other people started again. In the examination of his mental health, it was found that his general appearance and self-care had deteriorated. He talked clearly in an easily understandable way at a high volume and his associations were goal-oriented. Anxious affect was observed. No significant deterioration was found in his cognitive abilities. Perceptional deviation was not identified. Regarding the content of his thoughts, it was reported that he was concerned about not being able to live alone if anything bad should happen to his parents; he believed that his penis would be pulled into his stomach if he did not manage to sit properly on a chair twice, and he was always concerned about the diagnosis of his disorder. It was observed in his expressed behaviors that he frequently leaned forward to control his penis while sitting, and especially while talking to someone, he would stop speaking and go to the lavatory for control.

In order to exclude the general medical condition, electroencephalogram (EEG), hematological tests, thyroid function tests, serum B12 vitamin and folic acid levels were analyzed. Results were evaluated as normal. The patient scored 93 points at the Kent verbal performance test and 104 points at Porteus labyrinths performance test. A score of 99 points was found for the average intelligence quotient.

The patient began to receive 50mg/day sertraline, which he had reported to have been partly beneficial previously, and 4mg/day clonazepam for intensive

anxiety symptoms. Risperidone and ziprasidone treatments were gradually reduced and terminated as the patient presented with no psychotic symptoms. One month later, clonazepam treatment was gradually reduced and terminated. Sertraline was increased to 100mg/day. It was noted that he continuously talked loudly at the clinic, reacted rapidly and corrected others saying anything wrong on topics he was especially interested in; similarly, he yelled out and corrected when somebody said the physicians' names wrong, and he would always sit on a chair, not on a couch or any other seat. He believed that he had been diagnosed with schizophrenia, and this belief almost reached a level of "self-stigmatization". From interviews with his parents, it was understood that he had gone through a timely mental-motor development: He had started talking when he was twelve months old and walking at the age of fourteen months. In childhood, he liked talking, and he always talked in a loud voice; he did not listen to what others said but always wanted to be listened to, so he was not able to make any friends from the time of primary school. He showed medium-level achievements at school, and long-term hospitalizations at the psychiatry clinic helped him to get better.

The patient was diagnosed with AS according to ICD-10 (1) as he was clinically limited in mutual social interactions and communications and in behaviors, interest and abilities, he showed repetitive stereotypical behaviors but did not have significant linguistic and cognitive development deficiencies. Clinical features of AS were shared with the patient and he was informed about associations and support groups for AS. The patient ceased thinking about suicide, his anxiety symptoms receded and he improved self-care. Policlinic control was recommended and he was discharged with a 100mg/day sertraline treatment. At the interview four months after his discharge from our clinic, it was understood that he was able to leave the house for at least one hour a day and he did not ask for continuous medication and hospitalization at psychiatry services as in the pre-hospitalization period.

DISCUSSION

Similar to autism, in AS, a life-long psychiatric disorder that can be diagnosed in childhood, disorder in social interactions, limited and repetitive areas of interests and activities are present. ICD-10 and DSM-IV emphasize that the fundamental difference of AS from autism is that no delay or deficiency in linguistic and cognitive development is found. Many patients are ineffective despite having a normal level of intelligence. Wing, however, suggested that AS can also be diagnosed in those with delay in linguistic development and with threshold and sub-threshold intelligence quotient, and he criticized DSM-IV and ICD-10 diagnostic criteria (2,3).

It is known that children diagnosed with AS can exhibit superior achievement in primary education with their raw memory, memorization and calculation skills, but may have problems in writing and manual skills (6,7). However, with elementary school and adolescence requiring more social abilities, inability to adapt to peers and marginalization by them as well as limited areas of interest reduce academic success (3). It was reported that increased incidence of depression in adolescents diagnosed with AS/HFA can be associated with academic problems (7). Similarly, our patient had difficulty in adapting to peers from adolescence, was marginalized by them, and received a diagnosis of depression in a period when he was not able to go to school and fulfill his responsibilities. It is known that training of individuals with AS about their limited areas of interest can increase their academic success (8).

In studies on professional functionality of individuals diagnosed with AS/HFA, Szatmari et al. (9) reported that 37.5% of cases could work in a fulltime job, and Venter et al. (10) found a rate of 21.1%. Both studies reported individuals diagnosed with AS/HFA working at lower-level jobs which did not require special abilities. It was understood that our patient attempted to work at a hair salon for two days in his early twenties but was not able to continue due to his communication problems. It is known that employees diagnosed with AS may lose their jobs due to social interaction and communication problems (9,10). It is

recommended to make workplace arrangements and provide social support for employment of people with AS. It is believed that they can be more successful in previously planned, clearly defined and repetitive jobs (11).

It is known that in individuals with AS, deterioration in family relations is less prominent compared to social interactions. However, they are challenged in social interactions with their peers (12,13). Increased social skills were reported with higher age (14). Larsen and Mouridsen reported that 22% of individuals diagnosed with AS got married (15). However, it was also reported that their marriage did not last long and divorce rate was high (16). We also learned that our patient did not have a girlfriend, nor did he attempt to get into a relationship.

In adulthood, diagnosis of AS can be missed in individuals who had not been diagnosed in childhood. The most frequent psychiatric diagnosis given to adults with AS is schizophrenia (3). Especially in late adolescence, limited social relations and weird behaviors can suggest schizophrenia. However, it is very rare for schizophrenia to accompany AS (16). Schizophrenia and other psychotic disorders were excluded from the diagnosis of our patient as delusions, hallucinations, disorganized speech and behaviors during his disease period were never identified in the history received from the patient and his family. It is possible to make a diagnosis on OCD before AS again due to repetitive behavioral patterns. Repetitive behavioral patterns were also identified in our patient. While in OCD, these patterns are induced by anxiety, in AS demand and comfort create a source for these interests. The fact that our patient always chose a chair to sit on and reported a feeling of comfort more than concern about controlling his penis was evaluated as showing that these actions were behavioral patterns observed in AS rather than compulsion. It is known that uncertainty and unpredictability in social relations of individuals diagnosed with AS cause severe anxiety, and therefore they are frequently diagnosed with anxiety disorder. Significant anxiety was observed in our patient, especially in the initial hospitalization period, but this condition was evaluated as a symptom observed in AS rather than a separate anxiety disorder. It is very hard to make a differential diagnosis with AS in personality disorders, especially in schizoid personality disorder. Deterioration in social interactions is higher in AS and repetitive behavioral patterns are observed more in AS. Moreover, emotional distance and affective slumber, which we did not observe in our patient, are more specific to schizoid personality disorder. It was observed that our patient, who was continuously concerned about his diagnosis and believed he was diagnosed with schizophrenia, felt relief and showed reduced anxiety symptoms after he received the diagnosis and related psychoeducation. Properly sharing diagnoses with patients can develop, albeit limited, insight in patients. Moreover, informing the family about the diagnosis can help them live with these different individuals, exhibit proper attitudes and give proper directions. Our patient's history in the military and in school is an example of the problems an individual with AS encounters when he is treated as "normal".

In a study evaluating development of individuals diagnosed with HFA from preschool period to adolescence, it was reported that partial development was obtained with age in cognitive skills and social functionality in the presence of early intervention (12). AS is a rare diagnosis made in adult psychiatry policlinics, because diagnostic criteria are not completely known or the development history cannot be obtained sufficiently with a sectional evaluation (17). It is very important to obtain development history and make family interviews for differential diagnosis in AS.

Although AS/HFA are grouped among disorders generally diagnosed in childhood, it is important to know that AS/HFA can be encountered also in adulthood, and adult psychiatrists need to be more prepared in this respect. It is suggested that long-term observational studies are necessary in adult AS, which is a lifetime condition and progresses with severe impairment of the individual's social and professional functionality.

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