



Asperger Syndrome Disorder Diagnosed in Adulthood: A Case Report

İlk Defa Erişkin Çağda Tanı Konmuş Bir Asperger Bozukluğu Olgusu

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ABSTRACT

Asperger's disorder (AD) is a pervasive developmental disorder characterized by social impairment, restricted interests and repetitive behaviors. It is seldom that individuals with AD are referred to a psychiatry clinic only for their social and communication deficits. Quite often, the main reason for referral is the presence of other disabling symptoms, such as physical aggression and depression. Although diagnosed mainly in children, AD is increasingly being diagnosed for the first time in adulthood. Here, we present a 24-year-old patient with recurrent depression who was diagnosed as having AD for the first time in adulthood. This case is important to show the difficulty of diagnosing AD for the first time in adulthood and to show how a proper and effective treatment may be delayed if the underlying diagnosis of AD is missed for years. We wanted to emphasize the importance of developmental history and the usefulness of liaison with child and adolescent psychiatry in similar cases when the diagnosis is not clear. (*Archives of Neuropsychiatry* 2013; 50: 78-81)

Key words: Asperger's disorder, adulthood, diagnosis, depression.

Conflict of interest: The authors reported no conflict of interest related to this article.

ÖZET

Asperger Bozukluğu (AB), sosyal etkileşim bozukluğu, kısıtlı ilgi alanı ve davranışlarla karakterize yaygın gelişimsel bir bozukluktur. AB olan bireyler nadiren sadece sosyal ve iletişim zorlukları nedeniyle kliniğe başvurulur. Asıl başvuru sebebi sıklıkla, fiziksel agresyon ve depresyon gibi işlevselliği etkileyen diğer belirtilerin varlığıdır. AB tanısı genellikle çocukluk çağında konya da, erişkin dönemde tanı konma sıklığının son yıllarda arttığı bildirilmektedir. Bu makalede tekrarlayıcı depresif atakları olan ve ilk olarak erişkin çağda AB tanısı konan bir olgu sunulmuştur. Olgumuz daha önce tanı almamış erişkin dönemi AB olgularında tanı koyma zorlukların dikkat çekmesi, altta yatan AB tanısının yıllarca atlandığında tam ve etkili bir tedavinin nasıl gecikebileceğini göstermesi açısından önemlidir. Bu olgu sunumu ile psikiyatri kliniklerine çeşitli belirtilerle başvuran bireylerden gelişim öyküsü alınmasının önemi ve tanı karmaşası yaşanan benzer olgularda çocuk ve ergen psikiyatri bölümüyle liyezonun yararlı olacağını vurgulaması amaçlanmıştır. (*Nöropsikiyatri Arşivi* 2013; 50: 78-81)

Anahtar kelimeler: Asperger Bozukluğu, erişkin çağ, tanı, depresyon

Çıkar çatışması: Yazarlar bu makale ile ilgili olarak herhangi bir çıkar çatışması bildirmemişlerdir.

Introduction

Asperger's disorder (AD) is a pervasive developmental disorder characterized by social impairment and restricted interests and repetitive behaviors. It differs from classical autism by the absence of language and cognitive delay in the first years of life. (1). But it is still subject to debate whether AD is distinct from high functioning autism.

Although diagnosed mainly in children, AD is increasingly being diagnosed for the first time in adulthood. AD was not recognized as a clinical entity until its recent inclusion in only the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) and

International Classification of Diseases (ICD-10, World Health Organization, 1992) (1,2). As a result, many adults with AD have been misdiagnosed during their childhood (3).

Some individuals with high functioning autism or AD improve enough to live independent adult life and may come in contact with general psychiatry services in case of exacerbations of their illness or other psychiatric comorbid disorder (4). It is seldom that these individuals are referred only for their social and communication deficits. Quite often, the main reason for referral is the presence of other disabling symptoms, such as physical aggression and depression (5). Comorbidity studies show that mood and anxiety disorders are very common in individuals with AD (6,7). In a recent study with young adults with AD, it was

observed that 70% of subjects had experienced at least one episode of major depression and 50% of subjects had suffered from recurrent depressive episodes (8). Here, we present the case of a patient with recurrent depressive episodes, who has been diagnosed with AD for the first time in adulthood and we discuss the differential diagnoses, presentation of depression in individuals with AD and, we highlight the importance of early diagnosis of the underlying pervasive developmental disorder.

Case

XY, a 24-year-old single male was brought to our psychiatric emergency service by his parents after a violent outburst. His parents reported that he was crying, kicking the doors, and behaving hostile toward his parents for the last few days. He has been socially withdrawn and lost his interest to everything, and last year, started getting lower grades on exams. During psychiatric interview he was calm. He complained about having no girlfriend and poor concentration. He was obsessed with desire for sexual relationship - 'a natural human need like eating' with his own words -. He told that he wanted to have a girlfriend only for his natural sexual needs. It was learnt that, it was not his first visit to a psychiatric emergency service. According to our hospital records, he has been referred twice to the emergency department by his family. The symptoms were similar on these visits. Violent outbursts and depressive symptoms as well as suicidal thoughts were the most striking ones. For the past three years, he was followed by several psychiatrists. The diagnoses suspected by the psychiatrists were "reactive depression, prepsychotic personality, obsessive-compulsive disorder, narcissistic personality disorder" and he was started on many antidepressants and antipsychotics. He was referred to the psychotherapy unit because of no marked improvement in his symptoms. After a detailed assessment in the psychotherapy unit, he was suspected to have a developmental disorder and was referred to the child and adolescent psychiatry department. In his examination in the child and adolescent psychiatry department, his mother told that there was no problem during pregnancy, but caesarean section was made because of breech presentation during labor. He walked at eighteen months, his first words began at two years of age, and in a few months he could speak with long and complicated sentences. Since preschool period, he has been described as a child different from his peers. He learned reading by himself before he started primary school. He did not interested in his peers and he spent most of his time by reading books about nature, dinosaurs and animals. He has been very honest and rigid in adhering to the rules. He obeyed the rules very strictly and corrected his friends if they made mistakes. His special interest changed from nature and animals to airplanes at school years. He spent most of his time searching for details about airplanes on internet. He was rejected and bullied by his peers during school years. He was always a very successful student and with a very good degree he became eligible to attend one of the best high schools in Turkey. In high school, he had a friend who was withdrawn and aloof. He was more rejected by his peers because of this friendship, and the perfect degrees he made

in exams. He had been interested in swimming and playing piano accordion in these years. His mother told that he was not enjoying while doing these hobbies, he was making these in a greedy manner just for to be the best. He attended one of the best universities of Turkey with a very high degree in the university entrance examination. He chose aerospace and aviation engineering school. He stayed in dormitory because his parents lived in another city. In university, he became more social and he tried to form friendships but these were all superficial. He had never had a close friend and never talked about his private issues with someone. He described himself as awkward in group sports and social issues. He told that he never understood the social clues which his friends understood easily. He liked a girl from his friend group, a girl also from his department, but he was rejected when he told her about his feelings. During psychiatric examination, he told that he liked that girl because he and the girl had too many common points, such as attending same department, staying in same dormitory, being too hard working and getting high marks in exams. His mother stated that he was not interested in girls until these university years and that he was awkward when approaching a girl, he did not know how to behave in a youth group, he did not have political skills, he had difficulties in empathizing with others and expressing feelings, he always behaved logically not sensual, he was very obsessed with details, thus, he could not solve simple questions, he did not use facial expressions and gestures, he walked like a robot, and always dressed unfashionably. Besides, his depressive symptoms began after that girl's rejection of his proposal. He became very depressed and he had suicidal thoughts and; for the first time, he was referred to a psychiatrist by his family. He was started on an antidepressant medication and he showed some improvement. At least he had no suicidal thought anymore. From that time, he has been referred to several psychiatrists and started several antidepressants and antipsychotics. However, his depressive symptoms have never been disappeared totally and he has not benefited from antipsychotic treatment except some decrease in his violent outbursts. Depression was the most common diagnosis among the possible diagnoses considered by the psychiatrists was depression.

Discussion

The patient presented in our study, had marked social impairment and restricted interests and behaviors from the first years of life as well as depressive symptoms that emerged within the last three years. He had rigidity of rules, empathy deficits and unusual interest areas since preschool years. All of these findings were compatible with a diagnosis of AD and were defined as specific for AD by authors who were expert on autism spectrum conditions (9). Thus, the diagnosis of AD with a comorbid depression was established according to DSM-IV. Classical autism was excluded because of normal language and cognitive development.

In a few studies, average age for the diagnosis of AD was found to be eleven (10,11). But some patients with AD have very

supportive parents and teachers, thus, they may not decompensate until late adolescence or early adult life, when they are left on their own to cope with the stresses of everyday life. The diagnosis can remain hidden for a long time in some individuals with compensatory learning, like in our case.

Our case was referred to a psychiatrist for the first time when violent outbursts and depressive symptoms emerged and depression was the main diagnosis considered by most of the psychiatrists who followed the patient. The mother stated that, although she was aware of the social problems her son had from the beginning, she have not sought psychiatric help. It is consistent with literature that, for most individuals with AD, the main reasons for referral are other comorbid conditions not the core symptoms of the disorder (5). In most of the comorbidity studies, depression was found to be one of the most common comorbid disorders in adolescents and adults with AD (6). For young persons with AD, the demand for sophisticated social abilities can be overwhelming and confusing, causing them to have more negative social experiences and to withdraw from the social world (12). It is not surprising then that young persons with AD are considered particularly vulnerable to developing mood disorders and depressive symptoms. It has been reported in a study that, an increase in depressive symptoms might result in an increase in aggressive and oppositional behaviors (13). In another study mostly including children and adolescents with AD, it was seen during the clinical follow-up that behavioral problems were related to depression in two subjects, who were diagnosed as having oppositional defiant disorder by semi-structured clinical interview (7). The same author in another study concluded that, symptoms of oppositional defiant disorder in individuals with AD could represent the expression of other major psychiatric disorders (14). In the present case, violent outbursts and hostile behavior toward his parents have emerged during depressive episodes.

Obsessive-compulsive disorder (OCD) and prepsychosis were the other diagnoses considered by the psychiatrists. Obsessional and repetitive behaviors are the core symptoms of autism and AD and may increase during an episode of depression (15). Typically, individuals with AD have characteristics, such as pedantic speech, eccentricities, emotional lability, anxiety, poor social functioning, impulsivity, intrusive repetitive behavior and fixed habits that can mimic symptoms of other illnesses, including schizophrenia, bipolar disorder, anxiety disorder and OCD. Schizophrenic psychosis can also be accompanied by social withdrawal and lack of empathy. Important distinctive features include disorganized thinking and delusions, which are characteristic for schizophrenia (16). But in a study, people with AD reported higher levels of delusional ideation (predominantly paranoid and grandiose-type delusions) than the general population and, it was proposed that, high levels of anxiety, self-consciousness and depression in people with AD might be associated with an underlying attentional bias, such that the individual focuses on information that confirms their negative thoughts, leading to the development of paranoid or persecutory-type delusions (17). Sometimes, extreme anxiety in response to stress, which may be accompanied by increased oddness of speech, can easily be misinterpreted as psychosis (4). But the symptoms of AD can be observed in early childhood,

whereas the onset of hebephrenic schizophrenia does usually not predate adolescence. The onset of illness is also important in differential diagnostic distinction to simple schizophrenia disorder, which does not have productive symptoms (16). Hostile behavior toward the parents, poor social functioning and obsession with sexuality in our patient may have been misinterpreted as prepsychosis and thus, he have been started on antipsychotics. Sometimes it is difficult to differentiate between the spectrum of autistic syndromes and psychotic disorders, so a detailed developmental history and longitudinal observation may be necessary to distinguish these different nosological entities.

It has been previously proposed that grandiose delusions may serve the function of protecting a vulnerable self-esteem for individuals with autism spectrum disorders (17). In our patient, narcissistic personality disorder (NPD) was one of the diagnoses suspected by the psychiatrists. Criteria for NPD include a pattern of grandiosity as well as an unwillingness to recognize feelings and needs of others (18). The 'inability' (not unwillingness) to recognize feelings and needs of others and the grandiose ideation to protect the vulnerable self-esteem in the present case may have contributed the misdiagnosis as NPD.

Some studies found that, people with autism spectrum disorders generally meet criteria for cluster A and C personality disorders (18,19). It is difficult to make a differential diagnosis of personality disorders and autism spectrum disorders without a careful developmental history from a collateral informant, preferably a parent.

The case presented here is important to show how a proper and effective treatment may be delayed if the underlying diagnosis of AD is missed for years. Cognitive restructuring, training in social competency and psychological interventions, such as cognitive behavioral therapy may be useful in addressing some of the underlying social difficulties and beliefs. Also assisting parents to develop effective management techniques is likely to avoid or minimize the emergence of secondary behavioral problems. In addition, the diagnosis of AD made for the first time seems to have a strong impact on patients and their relatives. Most of them seem to calm down when they recognize the clinical features of AD in their relatives and can conceptualize symptoms and behavior in term of a rather specific biologically based disorder instead of a heterogeneous disorder.

In this case report, we aimed to emphasize the importance of developmental history from all individuals referring to psychiatry clinics with various symptoms and the usefulness of liaison with child and adolescent psychiatry in similar cases when the diagnosis is not clear.

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