

Motnja avtističnega spektra – diferencialno diagnostični pomisleki pri fantu z dvojno obremenjujočim okoljem

Autism Spectrum Disorder – Diagnostic Dilemmas in a Boy with a Doubly Disadvantaged Background

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Izveleček

Namen: Primer fanta s simptomi, značilnimi za motnjo avtističnega spektra, predstavljamo z namenom opozoriti na diferencialno diagnostična vprašanja, ki se lahko porajajo ob spremljanju teh bolnikov.

Poročilo o primeru: Motnje avtističnega spektra so opredeljene s kvalitativnimi spremembami v socialnih stikih, sporazumevanju in v interesih ter aktivnostih. V primeru fanta, ki ga predstavljamo, so opisani simptomi prepleteni z vplivom dvojno stigmatizirajočega okolja. Prvič, bolnik pripada etnični skupini, ki je znana po svoji rezerviranosti v komunikaciji ne samo do tujcev, ampak tudi v sklopu družine. In drugič, njegova situacija v ožji družini je dodatno obremenjujoča.

Zaključek: Dvojno stigmatizirajoče okolje je po našem mnenju pomembno vplivalo na fantov razvoj in je ključno pri razumevanju njegovega stanja.

Abstract

Purpose: we present a case report on a boy with autism spectrum disorder (ASD) to illustrate the differential diagnostic questions that can emerge when working with such subjects.

Case report: ASD is defined with qualitative deficits in social interactions, communications, and interests and activities. In the subject of this report these symptoms are influenced by a doubly disadvantage background. First, the boy belongs to an ethnicity known for its reservedness in communication – not only with strangers but also within their own families. Second, he was further disadvantaged by his specific microfamily environment.

Conclusion: a doubly disadvantaged background appears to have interfered with the subject's development; consideration of this background was crucial for understanding his condition.

INTRODUCTION

Asperger syndrome (AS) is a subtype of autistic disorder according to the International Classification of Mental and Behavioral Disorders (ICD-10) (1) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (2). The essential features are severe and sustained impairment in social interactions and the development of restricted, repetitive patterns of behavior, interests, and activities (1,2). The prevalence of AS is not well established, with minimum prevalence of 3.6 per 1000 children (3). The Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM 5) abolished different subtypes of autistic disorder and defines typical symptoms of autistic disorders on a spectrum – therefore the new term autism spectrum disorder (ASD) (4).

CASE REPORT

The subject of this report, M, a boy then aged 16.5 years, was admitted to the Child and Adolescent Psychiatry Ward at University Clinical Center Maribor in 2010. The reason for admission was that he had refused to attend the school for the last month and had become tense, restless, and suspicious. In the week before hospitalization he had delusions of persecution and was aggressive towards his mother. He displayed repetitive patterns of behavior and had unusual interests and hobbies since childhood. During the first days of hospitalization he avoided any social or eye contact. He spoke slowly and monotonously with neologisms and had trouble understanding abstract questions.

Developmental history: M is an only child, born one month prematurely, and his early development was normal. He routinely made eye contact with familiar people and developed a rich vocabulary in his native Albanian language.

Family history: no known mental or somatic diseases. M spent the first four years of his life almost exclusively with his mother, who spoke only Albanian with him; he received no tuition in the Slovenian language. M's mother spent her days in their small apartment, social completely isolated. She neither cooked nor

took a proper care of any household chores, either for herself or M. She was reserved in communication and displayed behavioral features reminiscent of ASD, but remained undiagnosed and untreated. A social worker visited M and his mother regularly over a couple of years, but recorded no success in changing family life or social isolation.

History of problems: M systematically avoided situations where communication was required in kindergarten and he was considered to be a child with language and social problems. Hospitalization was recommended because of suspicion of autistic disorder at age 6 years, but this was refused by his mother. Because of bullying in primary school M refused to attend; the school agreed to his mother's constant presence in the classroom. At age 9 M was hospitalized at a Child Psychiatry Ward at University Clinical Center, Ljubljana. It became evident that his ability to communicate verbally was diminished because of insufficient familiarity with the Slovenian language. He was diagnosed according to DSM-IV with separation anxiety and selective mutism. Follow-up with a child psychiatrist was planned but M failed to visit any of the recommended therapists for 3.5 years.

At age 12.5 years M visited a child and adolescent psychiatrist outpatient clinic because of obsessive thoughts and auditory hallucinations. He was diagnosed according to DSM-IV as obsessive-compulsive disorder and suspected psychosis. Pharmacotherapy with sertraline and risperidone was proposed but compliance was poor. At age 13.5 years M was diagnosed brief psychosis according to DSM-IV. Psychotic symptoms diminished in two weeks on risperidone, but ASD symptoms remained. Autism Diagnostic Observation Schedule (ADOS) (5) was typical for Asperger Syndrome (AS) and M was diagnosed as AS according to DSM-IV at age 14 years.

The above-mentioned second hospitalization followed at age 16.5 years. Physical evaluations, neurological status, and laboratory tests were normal. Genetic testing was refused. An average global intellectual level was revealed at the Wechsler Intelligence Scale for Children (WISC-III) (6), but M scored significantly below average in the subtest measuring social judgment and understanding of social events, and in the

test for mathematical skills. Results on the eyes and faces test were in the average range. His mother did not see him with specific features, behaviour or symptoms and scored him with 22 on the Autism Spectrum Quotient – Adolescent Version, indicated that M fell below the cut-off score for ASD of 32 (7). Because of brief delusions of persecution before and at the beginning of hospitalization (lasting in total less than two weeks) M was diagnosed as brief psychotic disorder according to DSM-IV. He returned to a premorbid level of functioning without pharmacotherapy. However, his level of functioning before brief psychotic disorder was typical of AS (repetitive patterns of behavior, unusual interests and hobbies since childhood, slow and monotonous talk with neologisms, and difficulty in understanding abstract questions). Because M fulfilled the diagnostic criteria for AS according to DSM-IV this diagnosis was confirmed.

DISCUSSION

The possibility of ASD, and probably AS, was considered already at age 6 years, but M's mother refused the necessary diagnostic procedures. At age 9.5 years M was hospitalized for the first time and was diagnosed as separation anxiety and selective mutism, and not with AS or ASD. The primary distinguishing features of AS are considerable language maturity and reciprocal conversation, and these are very difficult (and often impossible) to evaluate clinically in a child with selective mutism (8). M was only diagnosed with AS at age 14 years and this diagnosis was confirmed at age 16.5. Symptoms which were consistent with AS (ASD) in M's case were: qualitative impairment in social interactions and preoccupation with restricted patterns of interests and specific rituals. However, we do not overlook the important impact of minority ethnicity and his specific family situation on M's condition. He belongs to an ethnicity with a separate culture, language, and tradition. According to the study of Berishaj (9), the Albanian people of Slovenia have two major characteristics. First, they are known for their reservedness in communication (not only with strangers but also within their families) and are to some extent isolated within their own society. Albanian children mostly associate among

themselves and their assimilation is generally slower than for other minority ethnicities in Slovenia. The second characteristic is that they generally master the Slovenian language well (9), which was not the case for M. In our opinion, the extent of M's social exclusion for the first four years of his life cannot be explained solely by differences in culture and tradition. M spent the first years of his life almost exclusively with his mother, who was not able of proper care either for herself, M or household and displayed ASD-like behavioral features. Mother refused help and diagnostics when M was 6 years old and in the last 3 additional years that he was diagnosed and treated in a hospital at the age of 9. But after discharge M did not visit any of the recommended therapists for another 3.5 years. This isolated, help-refusing and un-encouraging family micro-environment may have additionally contributed to M condition.

CONCLUSION

The diagnostic dilemma faced here is of diagnosing AS (ASD) in a child living in special circumstances. In our opinion, doubly disadvantaged background interfered with the child's development and proved to be crucial for understanding his state, although he is fulfilling the diagnostic criteria for AS (ASD). It is known that in early childhood the clinical picture of children who have lived in severe social deprivation appears to be similar to autism, although there is usually more social reciprocity than typically with autism, and the course is different (10). If his linguistic and social problems had been addressed as soon as they were detected (in kindergarten and at the beginning of primary school), it is possible that his development would have taken a more normal course. AS (ASD) can be accompanied by symptoms of different mental disorders, as in the present case (brief psychotic and obsessive-compulsive disorder). However, if AS (ASD) had been recognized earlier we feel that this would have reduced the risk of additional mental symptoms/disorders. This case emphasizes the need to take into account ethnicity, language, and family background in evaluating children and adolescents for possible ASD.

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