CASE REPORT

Asperger's syndrome: a case report

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SUMMARY. A case report is presented of an 11-year-old boy who has been diagnosed as having Asperger's syndrome. There follows a review of the clinical features, course, prognosis and management of this condition.

Case report

A BOY (G.W.) was brought to the surgery at the age of 11 years by his mother, who was concerned that he was being bullied and teased at school.

Born by Caesarean section after an 18 hour trial of labour, his early development was unremarkable. From the age of five years or possibly earlier, he was noticed to have unusual preoccupations. He was a poor mixer with other children, always standing alone in the playground and showing no aptitude for ball games. Between the ages of seven and 10 years, he attended three schools and a further move brought the family to Harrogate in 1986. Here he was consistently distressed by school, being the victim of bullying and teasing.

He has always been articulate and is supercilious in his attitude to others, considering other children (and many adults) to be 'imbeciles and morons'. He is of average intelligence only, but to hear him speak on his favourite topics suggests he is extremely bright.

His behaviour at home is worrying — he is surrounded by imaginary people. He loves to dress up and has 22 oufits, all of which represent people of great power, including Napoleon, Julius Caesar, the Duke of Monmouth and a Nazi officer. When dressed up, he spends hours admiring himself in a mirror. At other times, he is immaculately smart and has worn a shirt and tie every day since the age of seven years. He plans to become Dictator of Poland and, protected by a large armed military police force, effect control over the land. He has a videotaped programme about Poland which he watches repeatedly.

He is afraid to go out, fearing attack and cannot tolerate being teased. He has no friends and is increasingly isolated now that he has just started secondary school. When angry or upset, he carries out a mock hanging procedure with a rope and a cushion over his bedroom door, and on two occasions stated that he would be better off dead.

To talk to he is tense and unable to relax. His speech is strangely staccato and he has a rather sinister, intimidating facial expression with a penetrating stare, which is almost continuous.

His parents are both professional people and he has a younger brother of seven years. There is a history of schizophrenia on the paternal side of the family, which has only served to increase parental anxiety and concern.

Following psychiatric referral and six weeks in a child psychiatric unit, a diagnosis of Asperger's syndrome was made.

Asperger's syndrome

This syndrome, otherwise known as autistic psychopathy was first described by Asperger in 1944 and again in 1979.[1] He described the condition as related to, but distinct from, Kanner's infantile autism. While the two have some features in common there are also marked differences regarding age of onset, intelligence of the children and the outcome.

Commoner in boys (male to female ratio approximately 9:1), the exact prevalence of the condition is unknown, one of the main reasons for this being the difficulty in distinguishing this syndrome from other similar conditions.[2] There does seem, however, to be some bias towards higher social classes but this needs to be substantiated. There is evidence to suggest a familial tendency to the disorder and other aetiological factors may include pre-, peri- or post-natal anoxia.

There are several features of the clinical picture described originally by Asperger and modified by Wing:[3]

- Normal speech development, but abnormal speech content, with monotonous tones and lengthy disquisitions on favourite subjects.
- Impaired two-way social interaction which the child may be aware of and try to overcome, but their failure to do this only enhances their oversensitivity to criticism and suspicion of others.
- Lack of facial expression except with strong emotions, such as anger or misery.
- Repetitive activities and resistance to change, with intense attachment to particular possessions and distress when taken away from familiar surroundings.
- Clumsiness and poor coordination, often most obvious in games involving motor skills.
- Excellent rote memories and intense or obsessive interest in one or two subjects to the exclusion of all else.
- The combination of impairment of social communication with certain 'special skills' gives the impression of an 'eccentric professor', which may be accepted by other children or may result in merciless bullying, with resultant anxiety and fear. The sufferers make unsatisfactory students, as they follow their own interests regardless of teachers' instructions and the activities of the rest of the class.

Obviously all these features can be found to varying degrees in the normal population and the diagnosis must be based on a full developmental history and the presenting clinical picture, not merely on the presence or absence of any individual items.[3] The main difference between Asperger's syndrome and behaviour which might be described as 'eccentric' but otherwise normal, is that in the latter case the child is able to take part appropriately in two-way social interaction and is influenced by social experiences. Any child with Asperger's syndrome, which may exist in varying degrees of severity, is cut off from the effects of any outside contacts.

Asperger's syndrome is a form of schizoid personality — the features of lack of empathy, single-mindedness, odd communication, social isolation and oversensitivity are common to both,[4] indeed, it has been suggested that there is no justification in identifying Asperger's syndrome as a separate entity. However, it is useful to keep the term if only to help when explaining the problem of these children to parents, teachers and other adults who find the term autism unacceptable as they associate it with silence and total withdrawal. The use of the term also serves to identify these children as patients with real problems necessitating careful management.

Management

The management of Asperger's syndrome must be aimed at attempting to diminish the handicaps of the illness and involves all adults concerned with the child. Psychiatric referral initially establishes the diagnosis and can then continue on the basis of supportive psychotherapy for the child and family.

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The general practitioner should also be closely involved, as he or she is in an ideal position to develop good rapport with the child and to have the time to offer explanation and support to the family, helping them to adapt to their child and cope with new worries and problems as they occur. The general practitioner is also in an ideal position to inform the child's teachers and acquaint them with the details of the problem, stressing the difficulty the child has in adapting to the social requirements of school. No one type of school is particularly suitable, and much depends on the skill and understanding of the staff.

With regard to the case presented, G.W. is not seen on a strictly regular basis by the author, but has regular contact with his psychiatrist. Instead, all efforts have been made to establish a good relationship with him, perhaps more on a personal, friendly basis rather than as simply another medical adviser. A similar amount of time has been spent with his parents, initially discussing the problem and subsequently, once the diagnosis was confirmed, trying to explain the disorder and allowing them time to voice their fears and thoughts. Consultations that were at first fraught by the anxiety and concern of the parents are now much more relaxed. The parents have been very relieved that at last their son's problem has been given a name. Both the author and the family owe much of their education to the extremely lucid and helpful information provided by the National Autistic Society. Although there is no local self-help group that is appropriate, the national organization has been invaluable.

The future

G.W. has now finished his first year at secondary school, to the relief of his parents, who rejected suggestions that he should be placed in a school for the maladjusted, in order that he could lead as normal a life as possible. The year has not been without problems of bullying and ridiculing, and his parents have noticed considerable increased tension and anxiety at home. His teachers are understanding and seem to have coped well — there seems no reason why he should not complete his education at this school.

He continues to receive behavioural management and relaxation instruction, directed towards modifying his facial expression and way of talking and there has definitely been some improvement in this.

With regard to prognosis, the special abilities of the individual may lead them to be accepted as an 'eccentric professor', as mentioned previously, and many will settle in jobs with sympathetic employers. Problems with depression, however, are common in adolescence and later life.

G.W.'s parents are aware of the further problems that they may have to face, but now feel more confident that these can be discussed and dealt with as they occur. There remains the inevitable anxiety that accompanies an unpredictable prognosis, but it is hoped this can be kept to a minimum by continuing close communication between the child's doctors, teachers and family.

References

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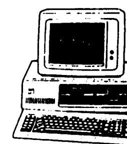

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