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Reflections on asperger syndrome and comorbidity with psychotic disorders

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A reflection on Asperger syndrome (AS) and schizophrenia (S) comorbidity could be of great interest to psychiatrists for adult patients. There is little awareness of Asperger syndrome in adult clinical practice due to the early age of onset of the disease. When AS is present, it often persists for many years without being diagnosed. Patients come into contact with psychiatric services because they present a variety of psychopathological symptoms, and they are described as being odd, with bizarre behavior in addition to the rest of the symptomatology. We briefly report a case to illustrate this point.

The circumstances on which clinicians should focus in order to distinguish between the two diagnoses and improve diagnostic reliability and the possibility of correct diagnosis are explained.

Key words:
Pervasive developmental disorder, psychotic disorder.

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Una reflexión sobre el síndrome de asperger y la comorbilidad con los trastornos psicóticos

Unas reflexiones sobre la comorbilidad del síndrome de Asperger (SA) y la esquizofrenia (E) pueden ser muy interesantes para los psiquiatras que atienden a pacientes adultos. Hay poca consciencia del síndrome de Asperger como entidad diagnóstica en la práctica clínica para adultos porque es una enfermedad que comienza en la juventud. Cuando está presente el SA, a menudo persiste durante años sin diagnosticar. Los pacientes toman contacto con los servicios psiquiátricos porque presentan diversos síntomas psicopatológicos y son caracterizados como personas "raras" con un comportamiento bizarro, además de presentar otros síntomas. Describimos brevemente un caso ilustrativo.

Se explican las circunstancias en las que deben centrarse los clínicos para distinguir entre estos dos diagnósticos y mejorar la fiabilidad diagnóstica y las posibilidades de diagnosticarlo correctamente.

Palabras clave:
Trastorno generalizado del desarrollo, trastorno psicótico.

Several authors[1,2] have pointed out the scarcity of literature on cases of schizophrenia (S) in patients with previous Asperger syndrome (AS), which is why schizophrenia is diagnosed later or overlooked. We would like to reflect further on this point. We believe that the lack of literature reflects the child and adult psychiatry dichotomy. On many occasions, AS remains undiagnosed and this fact (in addition to the functional repercussions of the disease) makes later diagnosis complicated or difficult when the comorbidity appears.

Our case was a 36-year-old man who from the early childhood never showed any interest in his peers due to a social reciprocity alteration (he had no friends in school and he stayed in class humming songs during recess or recreational periods; his isolation did not cause him any distress). His speech was monotonous and perseverant. Although it was appropriate in content, it was not appropriate in form due to his attitude (which could be described as a "rote repetitious capacity"). His cognitive management of information was absolutely literal, which translated into lack of capacity for emotional approximation and modulation. His particular interests (the patient chose to read the Bible in depth as bedtime reading when he was 12 years old) could

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sometimes be described as bizarre and constituted authentic obsessive rituals or routines. He earned a degree in law, but after years of working as a lawyer he stopped practicing because he felt that he could not continue working. At present, he does not have a social network. He clearly has a psychopathology picture that went undiagnosed for all these years.

In addition, at the age of 34 his particular interests and literal and stereotyped thought patterns and speech apparently changed qualitatively, leading to overvalued ideas, delusional and delusion-like ideas, and possible kinesthetic hallucinations. This poses a dilemma: could they really be classified as delusional ideas and true hallucinations? There is room for doubt and this is the topic of the present debate: Did the patient have AS that was unnoticed because it had not been diagnosed, or did he have an initial AS to which a schizoid disorder, schizotypal disorder or brief psychotic disorder was added at that time or, in contrast, was the additional diagnosis schizophrenia? Another possibility is whether schizophrenia was only diagnosed after excluding the comorbidity with AS. This clinical picture presents an interesting and complicated diagnostic challenge.

The patient's current picture of decompensation began with symptoms of anxiety, increased social isolation and physical complaints (he was concerned about a sulfurous taste in his mouth), to which a reiterative discourse centering on religious and mystical subjects was added. His symptoms had begun during the week prior to admission and had been preceded by a flu episode. He remained hospitalized for 25 days, during which time the symptoms responsible for admission diminished but never disappeared completely. During admission he said that "the devil was in his body and he felt that he was condemned," so he had decided to dedicate all his time to prayer. He began to feel condemned when he gave his mother his indulgence (granted by the Catholic Church) because she had been diagnosed of Alzheimer disease and he thought that this could save her. However, when he gave her his indulgence, he was condemned to purgatory and he was convinced that the world was reaching its end because the angels were determined to separate the wheat from chaff to bring peace to people of good will. Every time that he felt a burning sensation in his chest, he interpreted it as the devil in his body; this burning sensation was relieved by prayer." He was treated with antipsychotics and benzodiazepines, which relieved most of the symptoms. However, his delusion-like and delusional thoughts remained just as intense. However, his anxiety and the emotional repercussions of his condition were relieved and the kinesthetic hallucinations disappeared.

This patient had been previously hospitalized three years earlier. He presented the same symptoms as during the previous admission. His first episode began after he had a tooth removed. He was released 22 days later with only partial recovery from his symptoms. During the first admission, an MRI disclosed calcifications on the convexity of the right parietal lobe (he suffered meningitis as a complication of measles when he was a child) and increased occipital horn volume on the left side of the lateral ventricle.

In response to the diagnostic doubts described above, some authors question whether hallucinations and delusions per se justify a diagnosis of schizophrenia when these symptoms appear in a patient with AS.[3] They also indicate that it seems inappropriate to omit the diagnosis of AS in the presence of such symptoms only because they satisfy DSM IV-TR criteria for the diagnosis of schizophrenia.[3]

As regards this point, we wondered if a debate on what we could call schizophrenia-AS comorbidity is a fruitless effort or, in fact, interesting, in view of our reflections on this comorbidity. We tend to favor the second interpretation because it offers an opportunity to shed some light on questions like those raised by Dossetor,[2, 4] who considers that psychosis is overdiagnosed in patients with pervasive developmental disorders, such as AS. AS syndrome is gaining recognition thanks to increased awareness of the clinical importance of a more extended and pervasive autistic spectrum.[2] As a result, it is being diagnosed more frequently.

The DSM IV specifies that in the case of previous history of pervasive developmental disorder, the presence of hallucinations or delusions of at least one month in duration is required in order to establish a diagnosis of schizophrenia (APA, 1994).[5] The ICD-10 offers no special considerations on this subject (WHO, 1992).[6]

Dossetor[2] stated that this does not mean that a patient cannot have a diagnosis of schizophrenia and AS, but just the opposite. This comorbidity is feasible, although there may be little information on the matter in the literature.

Child psychiatrists say that they are frequently called on as consultants to assess patients under the age of ten referred for suspected psychotic disorder in which they simply find alternative or different thought phenomena that are normal for the child's age.[2]

Without a doubt, patients with AS resemble patients diagnosed of schizophrenia, particularly patients who have positive symptoms,[7] which may present as or seem disorganized, with tangential thought, overvalued or delusion-like ideas, particularly with paranoid content and grandiose content relative to their superiority with respect to other people.[8] Nevertheless, this does not mean that all these patients have a comorbid mental disorder because such thoughts can sometimes be overvalued or quasi-

delusional. In any case, they differ from true delusional thoughts, although the differentiation and correct identification can sometimes be an arduous task.

On the other hand, any disorder in the autistic spectrum can present psychotic symptoms within the context of a brief psychotic episode or mood disorder (some studies have found a marked prevalence of depression and other affective disorders in patients with AS and their relatives).[7]

In any case, all clinicians agree about the need to make a differential diagnosis, not only with schizophrenia, but also with schizoid and schizotypal disorder.

Finally, we would like to make the following reflections:

1. We agree with Soppitt[9] when this author stresses that patients with AS have a literal mental function that must be taken into account at the time of the clinical examination.
2. In pervasive developmental disorders there is a problem of reliability when assessing the existence of subjective mental phenomena.[2] This is especially important given the overlap exists in the alterations in perception and cognition in AS and psychosis.[2]
3. It may not be easy to differentiate the pseudohallucinations, stereotyped interests, difficulties in emotional processing and social reciprocity alteration of AS from hallucinations, delusional ideas and blunted affect of schizophrenia. (This difficulty derives partly from what authors such as Dossetor[2] say about the possibility of making a clear distinction between imagination, memories, illusions and hallucinations, which can sometimes be difficult).
4. As for the kinesthetic hallucinations that the patient in question may have: are they really hallucinations or are they different perceptive phenomena deriving from the peculiarities in cognitive processing characteristic of AS? That is to say, is this a different way of expressing the physical symptoms of anxiety by a patient who, due to the emotional limitations of AS, cannot manifest them any other way?
5. The fundamental factors that make the psychopathological distinction difficult are:
   - The peculiarities in language and problems of communication like literal interpretation, overelaboration and lack of emotional processing with the impact this has on gestures and nonverbal communication.
   - The lack of emotional processing per se.
   - Alterations in social interaction (reciprocity).
   - Stereotyped interests.
6. Although the presentation of AS might seem bizarre and imitate other mental disorders, the diagnosis is based partly on the observation that stereotyped behavior occurs within a context characterized by a sort of ingenuousness and social awkwardness.[2]

Finally, we would like to discuss our thoughts about the diagnostic differentiation of AS and schizophrenia, and thus increase diagnostic reliability and reduce the rate of diagnostic error. Differentiation is based fundamentally on:[2,3]

1. Increasing awareness of the existence of AS, thus facilitating its diagnosis.
2. Observation of the clinical course (repeated episodes of decompensation in schizophrenia, which are also possible in brief psychotic disorders).
3. It is necessary to take into account the duration of the present episode (AS and schizoid disorder do not course with episodes, so assessing the duration does not make sense. However, duration could be a determinant when differentiating between brief psychotic disorders and schizophrenia).
4. In relation to the previous point, watch for the presence of deterioration in the clinical, social and academic evolution that occurs in schizophrenia.
5. Monitor the response to psychotropic drug treatment (psychotic disorders respond to antipsychotics).
6. Prepare a careful and detailed clinical history with regard to the beginning of the disease and make exhaustive attempts to ascertain the time of appearance (onset in childhood—AS by definition begins in childhood—or later, which is more frequent in psychotic disorders).

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