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Letter to the Editor

Asperger's Disorder with co-morbid Social Anxiety Disorder: a Case Report

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Children with autistic spectrum disorder have been reported to have higher scores on various subscales of anxiety in comparison to children with specific language impairment and normal controls.[1,2] Kim et al reported significantly higher rates of generalized anxiety disorder and separation anxiety disorder in Asperger's disorder subjects in comparison to normal subjects.[3] A case of Asperger's syndrome with co-morbid separation anxiety disorder was described by Bhardwaj et al.[4] We are presenting a case of Asperger's disorder with social anxiety disorder.

CASE HISTORY

Master P, a 12 years old student of VIIth standard, presented with chief complaints of poor socialization. The patient's mother had suffered from a depressive episode during the antenatal period. He achieved developmental milestones at appropriate ages and managed average grades at school.

The patient was noted to cry when anybody other than his parents tried to hold him even when he was about 3-4 months old. Later, it was noted that he expressed his needs only to and made eye contact only with his parents. He appeared distressed in social situations, where he never initiated conversation and responded to questions only on coaxing (and in a low volume). He played and interacted with his peers only in the presence of his parents. He would not go to the market on his own because of anxiety in facing shopkeepers. At school, he would not answer questions verbally because of fear of making mistakes and he was overtly anxious before and during exams. He was particularly shy of girls.

He was a fussy eater, e.g. he ate only when the food was cold. Between the ages of 18 and 36 months, he was noted to rotate his arms and to turn his face towards the shoulder, several times a day. He enjoyed solitary activities, e.g. he played computer games for hours together. His conversation was limited to discussions on cartoon characters like He-man, GI Joe etc. While playing with such toys he would converse with them and treat them as living things. Parents also reported that he did not reciprocate the non-verbal expressions of others. There was no history of self-injurious behavior, deterioration of acquired skills, perceptual abnormalities, sustained mood change, free floating anxiety, agoraphobia, articulation difficulties, speech delay, head injury, fever or seizures. His physical examination was unremarkable.

On mental status examination, he was noted to avoid eye contact and appeared anxious. His IQ was 91. A diagnosis of Asperger's syndrome was made according to ICD-10 in view of the marked abnormality in social interaction, and stereotyped, repetitive repertoire of interest and activities, and the absence of developmental delay. Marked anxiety in presence of strangers, selective attachment to family members, fear of social interactions, and

apprehension of criticism in social encounters led to an additional diagnosis of social anxiety disorder as per ICD-10 description. Diagnosis of elective mutism was ruled out on the basis of lack of persistence in speech difficulty in particular situations and lack of total mutism in social situations. He was managed by psychoeducation, social skill building, cognitive-restructuring, and exposure to social situations. Follow up at 3 months showed partial improvement in features of social anxiety disorder.

DISCUSSION

The index case had normal speech development, social anxiety, impairment in reciprocal social interaction, restricted interests, and stereotypic movements. Some of his deficits in social interaction are characteristic of Asperger's syndrome. Change in routine and expectations, poor comprehension of occurrences in surroundings, apprehension in social situations, and minor environmental changes have been reported to lead to anxiety in patients with Asperger's disorder. However, unlike the index case, children with Asperger's disorder usually do not report intense social anxiety and social worry and they often lack an insight into their difficulties. The intensity, pervasiveness and gradient (less anxiety with familiar persons, more with teachers and girls) of his social anxiety, fear of social interactions, and apprehension of criticism in social encounters suggested the additional diagnosis of social anxiety disorder. In the presence of features suggestive of behavioral inhibition that started in infancy, a definite onset of social anxiety disorder was difficult to specify. However, the full syndrome could be discerned only in middle childhood. In the absence of specified training in the use of diagnostic interviews, the authors did not apply a standardized interview for assessment; however, this constituted a limitation.

Social anxiety disorder is believed to have an onset in late childhood, but the seeming continuity between symptoms like crying if picked up by strangers at the age of 3-4 months and later shyness; raises an intriguing possibility that social anxiety disorder may have an onset in infancy in some cases. Kagan's formulation of social anxiety as an expression of biologically based behavioural inhibition would support such a possibility. Literature suggests a specific association between behavioural inhibition and social anxiety disorder.[5]

Studying comorbidity in childhood psychiatric disorders is important as it may help in understanding underlying pathophysiological connection between disorders and may influence the management plan.

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