Brief Report

Asperger Syndrome in India: Findings from a Case-Series with Respect to Clinical Profile and Comorbidity

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ABSTRACT

Asperger syndrome (AS) is an autism spectrum disorder with a high rate of psychiatric comorbidity. We describe the clinical profile and psychiatric comorbidity in a series of affected individuals referred to an Indian general hospital psychiatry setting. Gilliam Asperger’s disorder scale was used to evaluate the clinical characteristics while Mini-International Neuropsychiatric Interview (MINI)-KID and MINI-PLUS were used to assess psychiatric comorbidity. The profile of subjects with AS in our case-series appears similar to that published elsewhere with high rates of psychiatric comorbidity. Mental health professionals should evaluate for psychiatric comorbidity in individuals with autism spectrum disorders.

Key words: Asperger syndrome, autism spectrum disorder, comorbidity

INTRODUCTION

Asperger syndrome (AS) is a low prevalence autism spectrum disorder characterized by significant impairments in social interaction, social communication, and restricted patterns of interest in the presence of intact language.[1] The first known description suggestive of this condition was reported by Hans Asperger in 1944, but it was only after Lorna Wing’s description of a similar series that the world took notice of this syndrome.[2]

Subjects typically show marked social difficulties with unusual preoccupations, low empathy, reduced understanding of social norms, and difficulties in dealing with their own emotions and poor motor coordination.[2] Despite adequate linguistic skills in areas of semantics and syntax, subjects have poor nonverbal and pragmatic language skills and poor understanding of social rules of behavior.

There has, however, always been considerable debate regarding the validity of AS as a diagnosis separate from other autistic conditions as intact language skills have often been the only differentiating factor between AS and other autism spectrum disorders.[3] Currently, AS is subsumed under broad category of autism spectrum disorder and will stop existing as an independent diagnosis once DSM-5 and International Classification of Diseases-11 become operational.[4] This nosological change could lead to decreasing interest in various clinical domains that characterize individuals with autism.

Individuals with AS also show high rates of psychiatric comorbidity with attention deficit disorder being the most common comorbidity.[5-7] From India, although two separate case reports have reported the presence of co-morbid anxiety disorders in affected subjects, there is...
no published literature that has systematically evaluated Indian patients with AS with respect to their clinical profile and psychiatric co-morbidities.\cite{8,9}

It is in this background that we report on our findings in subjects with AS with respect to their clinical profile and psychiatric co-morbidities.

**MATERIALS AND METHODS**

**Aim**
The aim of this report was to describe the clinical profile of subjects with AS and associated psychiatric comorbidity.

**Sample**
The subjects of this study were obtained from referrals of individuals with AS to our center.

**Procedure**
We used Gilliam Asperger’s disorder scale (GADS) to assess clinical profile of affected individuals and Mini-International Neuropsychiatric Interview (MINI)-KID and MINI for adult subjects to assess for comorbidity.\cite{10,11} GADS has four domains representing the core areas characteristic of AS like social, restricted patterns of behavior, cognitive patterns, and pragmatic skills, which yield an Asperger disorder quotient (ADQ).\cite{10} An ADQ above eighty gives a high probability of the subject having Asperger’s disorder. Similarly, domain scores above three indicate a high probability of subject having Asperger’s like clinical profile in that particular domain. MINI-KID and MINI are standardized interviews often used for assessing comorbidity with excellent inter-rater reliability.\cite{11}

**RESULTS**
The subjects consisted of 12 male individuals with AS of which 5 were adults and 7 were children. The results with respect to the scores of the subjects on GADS and psychiatric comorbidities are displayed in Tables 1 and 2.

**DISCUSSION AND CONCLUSIONS**
Our findings reveal that the mean ADQ from GADS in all subjects is above the cut-off, showing that the clinical profile of our case-series is similar to what has been described in the West [Table 1]. Our series also showed a high prevalence of other mental health comorbidities as detected by MINI-KID and MINI-PLUS [Table 2]. Only one subject did not have another comorbid psychiatric disorder while five of the remaining eleven subjects had two or more psychiatric comorbidities. It would be premature to extrapolate these findings to an Indian community setting though as it is possible that those individuals with AS without comorbidities might not seek help at all. Another limitation of our series is that the subjects were not formally assessed for intellectual disability.

While the relevance of studying the clinical phenotype of AS in view of its exclusion from modern classificatory systems can be debated, we feel that by identifying associated clinical domains in various autism spectrum disorders, we can formulate relevant therapeutic strategies for affected individuals. This is particularly highlighted by our case-series.

Our case-series also show high rates of psychiatric comorbidities. This could be a reflection on the underdeveloped psychiatric health services in India, where subjects with multiple comorbidities are more likely to seek help from mental health services. Certain authors hypothesize that increasing detection of comorbid conditions is a consequence of structured interviews, and this could interfere with a holistic approach to management.\cite{12} However, there is also acceptance that increased rates of diagnosis of psychiatric co-morbidities could lead to more comprehensive clinical treatment and more reliable prediction of future disability.\cite{12} We feel that the detection of comorbidities in subjects with autism spectrum disorders can lead to the identification of specific areas for targeted interventions leading to optimal management.

We feel that the term “AS” is still of clinical relevance and a diagnosis of “autism spectrum disorder” alone might not capture the difficulties faced by subjects with this particular condition. We agree with Kaland, who has concluded that differences in social behavior between AS and other high-functioning autism...
Spectrum disorders exist and due to the fact that there is little research on neurobiological aspects underlying various clinical subtypes, it would be sensible to retain at least a mention of the term “AS” in classificatory systems.[13]

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