ASPERGER AND SCHIZOPHRENIA: BETWEEN BOUNDARIES

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Introduction

In psychopathology it is common co-occurrence of clinical disorders and deciding to establish a comorbid or differential diagnosis is one of the great challenges[(1)]. An example is the one between Autism Spectrum Disorders (ASDs) and Schizophrenia Spectrum and Other Psychotic Disorders (SSDs) whose distinction has been a topic of scientific dispute. Before the 1970s, autism was conceived as a manifestation of childhood schizophrenia. Later, autism and schizophrenia were differentiated according to the moment of appearance in the patient's history and since that, the connection among both has been continually debated[(2)]. Although being currently two different disorders, they share many phenotype similarities, risk factors and clinical symptoms and it has been reported to co-occur at elevated rates[(3)]. So that, there are some confusions between ASD symptoms and some non-psychotic behaviors such as affective flattening or lack of motivation, or between ASDs thoughts, ideas and attributions and positive psychotic symptoms such as delusions. Otherwise, deficits in social interaction, communication, emotional processing and executive functions are present in both[(1)]. In addition, in childhood onset schizophrenia there is a significant risk of neurodevelopmental alterations prior to the onset of psychotic symptoms similar to autistic symptoms[(1)]. So, the distinction is not yet clear. The main objective in this study is to show by a single case assessment the co-occurrence or comorbidity of these two psychiatric disorders.

Methods

Design: Retrospective analysis of clinical case.

Information of patient

Biography aspects: A 39-year-old male diagnosed with schizophrenia in infancy at age 11. Native of Barcelona. The younger of two brothers. Currently single, he lives independently and is supervised by a foundation. He has a degree of disability of 65%, is inactive in the workplace but linked to a sports and volunteer program of the Association for the Rehabilitation of People with Mental Illness. **Psychiatric family antecedents:** a third-degree relative diagnosed of Schizophrenia and a third-degree relative diagnosed of Affective Disorder and Substance Consumption Disorder. **Medical and psychiatric antecedents:** No medical-surgical or substance use history. At age 6 he was linked to the children's hospital due to problems in social interactions.

Psychopharmacological treatment: Since age 11 he has taken aripiprazol, risperidona, amisulpride and ziprasidona. Risperidone in doses lowers the best tolerated. **Psychological treatment:** Simultaneous follow-up of Cognitive- Behavioral therapy, Gestalt therapy and Psychodynamic therapy. Proved alternatives therapies as Miracle Mineral Supplement (MMS) or dilute sodium chlorite, gluten-free and casein-free restriction diet (kinesiology), cannabis spray treatment and Neurofocal dentistry. Frequent voluntary interruption of psychiatric and psychological follow-up. At Hospital discharge treatment with aripiprazole 10mg 1-0-0 and aripiprazole 5mg 0-0-1. **Other aspects:** parents linked to Scientology

Reason for consultation: admitted to the hospital acute unit for psychotic decompensation and behavioral disturbance due to voluntary abandonment of medication and psychiatric follow-up. In the unit, peculiar traits and behaviors are maintained despite pharmacological treatment and stabilization of the psychotic clinic. It seems to be compatible with the diagnosis of ASD.

Assessment Instruments: Clinical interview as the main tool. To evaluate the psychotic symptoms was used the *Brief Psychiatric Rating Scale (BPRS)*. The *Asperger's Adult Evaluator (AAA)* and the *Observation Scale for Autism-2 Diagnosis (ADOS-2)* scales were used to measure symptoms related to ASDs. Were administered the *Global Standard Progressive Matrices (SPM)* to measure the intelligence and the *Minnesota Multiphasic Personality Inventory-2 (MMPI-2)* to evaluate personality traits.

Results

Results of the clinical scales administrated are shown in Table 1. It can be seen that the patient meets criteria for comorbid high functioning ASD in addition to Schizophrenia. To see a functional analysis of the case see Fig. 1.

Figure 1. Functional analysis

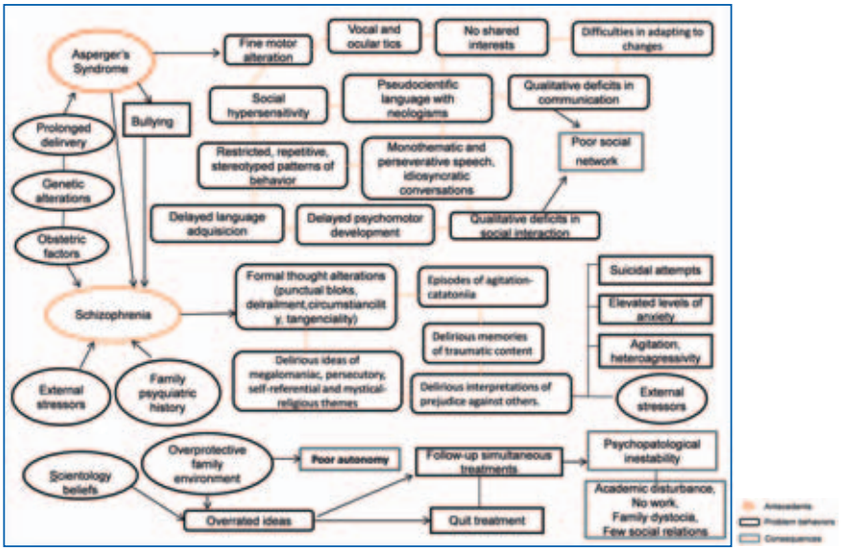

Table 1. Clinical scales results

TESTS	SCORES
SPM	IQ:115
BPRS	DS: 28
MMPI-2	
(¿)Unaswered items	52
(L)Sincerity or social desirability	20
(F)Validty or infrequency	46
(K)Correction or Defense	58
(Hs)Hypochondria	53
(D)Depression	48
(Hy)Hysteria	67
(Pd)Psychopathic Deviation	62
(Mf)Masculinity-Feminity	70
(Pa)Paranoia	56
(Pf)Psychasthenia	52
(Sc)Schizophrenia	47
(Ma)Mypomania	50
(Si)Social Introversion	41
VRIN	9
TRIN	10
F-K	-14
ADOS-2	
Communication	2
Reciprocal social interaction	4
Total score	6
Imagination and creativity	1
Stereotyped behavior and restricted interest	1
AAA	
QDSC	3
RRSPB	3
VNVCQD	3
IAD	1
P	5

SPM: Standard Progressive Matrices; IQ: Intelligence quotient; BPRS: Brief Psychiatric Rating Scale; DS: Direct Score; MMPI-2: Minnesota Multiphasic Personality Inventory- 2; VRIN: Inconsistency of variable responses; TRIN: Inconsistency of true responses; ADOS- 2: Autism Diagnostic Observation Scale-2; AAA: Adults Asperger Evaluation; QDSC: Qualitative deficits in social communication; RRSPB: restricted, repetitive, stereotyped patterns of behaviour; VNVCQD: verbal and no verbal communication qualitative déficits; IAD: imaginative ability deficits; P: prerequisits.

Discussion

In the line of studies, our results show a clear comorbidity between ASDs and SSDs. In our assessment, we have observed common symptomatology as a psychomotor development delayed and social communication deficits. **In relation to positive psychotic symptoms:** 1. Stereotypes, repetitive movements, rigid adherence to routines and reactions to stress got confused with psychotic disorganized behavior, 2. Idiosyncratic conversations focused on an obsessive theme and deficits in pragmatic and functional use of language implied a non-cohesive discourse perceived as disorganized thinking, 3. Restricted interests and obsessive ideas were conceived as delusional ideas. **In relation to negative psychotic symptoms:** 1. The lack of emotional reciprocity typical in ASD seemed psychotic dull affection, 2. the lack of emotional expression, deficits in the use of nonverbal counting patterns and the lack of motivation for social world got categorized as affective flattening. Other symptoms are clearly distinctive. **Supporting ASDs diagnosis:** Delayed acquisition of language (intelligible at 7 years), cognitive rigidity, literal use of language and difficulties in adapting to changes. The absence of intellectual deficits and language impairment leads to the specification of a high functioning ASD. **According to SSDs diagnosis:** Self-referential, megalomaniacs and mystic delusional ideas, delusional memories with traumatic content, delusional interpretations of prejudice, auditory hallucinations and behavioral alterations.

References

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