**Case Report** **Allied sciences**

**International Journal of Pharma and Bio Sciences** **ISSN 0975-6299**

# ASPERGER'S SYNDROME: A CASE REPORT

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## ABSTRACT

Asperger syndrome was named for the Austrian doctor, Hans Asperger, who first described the disorder in 1944. Asperger syndrome is a type of pervasive developmental disorder.Pervasive developmental disorders are a group of conditions that involve delays in the development of many basic skills, most notably the ability to socialize with others to communicate and to use imagination. Objective: to define the syndrome, its etiology, management and prognosis. Method: describing the symptomatology, etiology and proposed pathogenesis of the syndrome. Result: a case of age 11 years bought by his mother who was concerned that he was being bullied and teased at school. He was a poor mixer with other children and finally diagnosed to have Asperger syndrome and was treated for it. Conclusion: Asperger syndrome is not a mental illness. It is a developmental disorder affecting communication, social relationships and social imaginations. Everyone with Asperger syndrome is unique. Some are able to cope better than others in some areas of their life at different times in their life.

**KEYWORDS:** **Aspergersyndrome, pervasive developmental disorder, socialization, communication, tease and bullying**

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## INTRODUCTION

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, management and nursing management of this condition.

## CASE REPORT

Mr.X was brought to the surgery at the age of 11years 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.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 behavior at home is worrying - he is surrounded by imaginary people. He loves to dress up and has 22 outfits, all of which represent people of great power, including Napoleon and Julius Caesar. 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 and, protected by a large armed military police force, effect control over the land. He has a videotaped programme about India, 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, the intelligence of the children and the outcome. Common 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. There does seem, however, to be some bias towards higher social classes, but this need to be substantiated. There is evidence to suggest a familial tendency to the disorder and other etiological factors may include pre-, peri- or post-natal anoxia.

## CLINICAL MANIFESTATION

*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 beware 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
takeaway from familiar surroundings.
*Clumsiness and poor coordination, often most obvious in games involving motor skills.
*Excellent remote 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 full developmental history and the presenting clinical picture, Not merely on the presence or absence of any individual items.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, 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 continue on the basis of supportive psychotherapy for the child and family. 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 an 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 practitioners are 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 the 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, MR.X is not seen on a strictly regular basis, 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 nursing personnel. 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.MR.X. 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.

## 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. Mr.X'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.

## NURSING MANAGEMENT

- Use kindness and humor for mistakes and enjoy the child's strengths
- Teach new concepts by using their special interests
- Determine what a tolerable social and physical environment is for the child and provide it
- Advocate for your child to have the school program that they need.
- Provide direct instruction in all areas of need, especially social behavior and communication skills
- Use routines, minimize change and prepare for all types of transitions
- Provide and teach the child to use visual organizational supports for all weak areas
- Talk less, slower, calmer and in clear language that the child can understand
- Teach emotional regulation with visual systems and feedback to the child and provide breaks from social situations as needed
- Teach the child to know what they need and the language to ask for it
- Use visuals to teach the child a problem-solving method for when they are stuck
- Learn how and when to talk to others for help, both professionals and other parents or friends
- Pull together a team of professional supports (therapist, psychopharmacologists', OT, S&L, sensory specialist or others) as needed.

## CONCLUSION

Asperger syndrome is not a mental illness. It is a developmental disorder affecting communication, social relationships and social imaginations. Social communication refers to difficulties with both verbal and non-verbalcommunication. Social relationship is about some one's ability to make friends and instinctively knowing, learning and applying social rules such as greetings. Social imagination concerns our ability to make up on verbal andnon-verbal cues to inter what someone else might be thinking. Everyone with Asperger syndrome is unique. Some are able to cope better than others in some areas of their life at different times in their life.

## ACKNOWLEDGEMENT

I would like to express my gratitude towards prof. Hemavathy ,principal of sree Balaji college of nursing for successful completion of this work.

## CONFLICNT OF INTEREST

Conflict of interest declared none.

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