Asperger’s Disorder: A Review of Its Diagnosis and Treatment

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Asperger’s disorder is a pervasive developmental disorder that shares similar features of social impairment disorder, restricted interests, and repetitive behaviors with autistic disorder. Although both Asperger’s disorder and autistic disorder persist into adulthood, autistic disorder is usually apparent before the age of 3, while Asperger’s disorder usually manifests itself at preschool age. Asperger’s disorder in the majority of cases is not associated with delay in language development and there is an increased likelihood to seek social interactions and to engage in activities and friendship with others. In contrast to autistic disorder, most Asperger’s disorder patients have normal intellectual functioning and some have motor clumsiness.

Although the etiology of Asperger’s disorder is still undetermined, this article will review the assessment and treatment interventions that could improve the prognosis of this illness. The historical background, epidemiology, diagnostic features, differential diagnosis, and course and overall management/treatment of Asperger’s disorder will be discussed. Despite the absence of a cure for Asperger’s disorder, the awareness of its distinctive clinical features that differentiate it from autistic disorder could improve its prognosis and differentiate response to treatment and comorbid conditions.

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Asperger's syndrome as being a PDD subtype with specific diagnostic criteria that are different from autistic disorder. The validity of Asperger's disorder as a different diagnostic entity has been documented through several lines of evidence, including a DSM-IV field trial. Among these differences are higher verbal intelligence quotient (IQ) than performance IQ, which is often associated with a nonverbal learning disability. This differs from autistic disorder that is not associated with mental retardation in which, typically, nonverbal skills are more likely to be higher than or equivalent to verbal skills. Also there appears to be a higher incidence of Asperger's disorder in first-degree relatives. In addition, there is a different pattern of comorbidity in Asperger's disorder, with a higher level of psychosis, violent behavior, and depression.

**Epidemiology**

Information on the prevalence of Asperger's disorder is limited, and although it appears to be more common in males, the prevalence rate may depend on the stringency of the diagnostic criteria used for case selection. An epidemiological study determined a prevalence of 3.6 per 1,000 children with a male-to-female ratio of 4:1. However, when possible cases were included, the prevalence rate changed to 7.1 per 1,000 children with a male-to-female ratio of 2.3:1. A stringent approach to the diagnosis would suggest a rate of 1 in 10,000 with an apparent 9:1 male predominance. Gillberg and Gillberg found Asperger’s syndrome to be five times as common as autism.

It is estimated that about 50% of children with Asperger’s disorder reach adulthood without ever being evaluated, diagnosed, or treated.

**Etiology**

Although the precise cause of Asperger’s disorder is still undetermined, genetic, metabolic, infectious, and peripheral factors have been suggested as possible etiologies. Available familial studies appear to show an increased frequency of Asperger’s disorder among family members of individuals who have the disorder. Right-cerebral hemisphere dysfunction, structural brain abnormalities, and disturbances in the limbic system as well as in the dopaminergic and serotonergic neurochemical systems also have been implicated as the possible etiology of Asperger’s disorder.

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<th>Table 1. ICD-10 Research Diagnostic Criteria for Asperger’s Syndrome</th>
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<td>A. A lack of any clinically significant general delay in language or cognitive development. Diagnosis requires that single words should have developed by 2 years of age or earlier and that communicative phrases be used by 3 years of age or earlier. Self-help skills, adaptive behavior, and curiosity about the environment during the first 3 years should be at a level consistent with normal intellectual development. However, motor milestones may be somewhat delayed and motor clumsiness is usual (although not necessary diagnostic feature). Isolated special skills, often related to abnormal preoccupations, are common, but are not required for diagnosis.</td>
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<td>B. Qualitative impairments in reciprocal social interaction (criteria for autism).</td>
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<td>C. Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities (criteria for autism).</td>
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<td>D. The disorder is not attributed to the other varieties of pervasive developmental disorder; schizotypal disorder; simple schizophrenia; reactive and disinhibited attachment disorder of childhood; obsessional personality disorder; obsessive-compulsive disorder.</td>
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**Diagnostic and Clinical Features**

The diagnostic criteria of Asperger’s syndrome as described in the ICD-10 research diagnostic criteria are summarized in Table 1, while DSM-IV diagnostic criteria for Asperger’s disorder are outlined in Table 2. The unique characteristics of Asperger’s syndrome as elaborated by Gillberg are described in Table 3.

**Differential Diagnosis**

The differential diagnosis of patients with Asperger’s disorder is at times complicated by the fact that it may coexist with disorders like Tourette’s disorder and other psychiatric conditions, including attention deficit hyperactivity disorder (ADHD), anxiety disorders, mood disorders, learning disability, motor clumsiness, antisocial behavior, and unusual social interactions.

Sometimes children with Asperger’s disorder are first diagnosed as “aphasic” or “dysphasic” or “language-disordered” because of their difficulty processing language in the same way as normal children.
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