CASE REPORT

School Refusal: How to Address When He is an Adolescent with Asperger's Syndrome – A Case Report

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Abstract

A fifteen and a half years old adolescent boy was referred by the psychiatrist to the Child Development Centre (CDC) for an evaluation of his mental status as he was stubbornly resisting to take medication in spite of regular counselling efforts. This boy presented with school refusal with manifestations of Obsessive Compulsive Disorder (OCD) with a complicated family dynamic to the psychiatrist. His interesting atypical development in early childhood led to clinician's concern of excluding Autism Spectrum Disorder (ASD). He was finally diagnosed and jointly managed as a case of High Functioning Autism (HFA) with co-morbid conditions by a joint multidisciplinary team approach of CDC and Psychiatry Department of AHD.

Key words

Adolescence, Asperger syndrome, school refusal, OCD

Introduction

Asperger's syndrome (AS) is a condition characterised by social-communication impairment and over focused, repetitive interests and behaviours without any significant learning disabilities or language delay which is considered as a special variant of ASD according to the Diagnostic and Statistical Manual- 4th edition (DSM-IV)[2] and International Classification of Diseases-10th edition (ICD-10).[2,3,4] These young people often are prone to bullying at school. Their vulnerability is due to their inborn social adjustment problems specially with their peer group which is in fact due to a difference and lack of flexibility in their pattern of thinking and they might also bear atypical ideas about goals and meanings of life.[5] Adolescence is the vulnerable time when these young adolescents often can't bear the typical social pressures anymore and present with school refusals and ultimately drop-out.[6,7] These cases with school refusal issues are often difficult to deal with. CDC of AHD is running a Child and Adolescent Mental Health clinic where we often come across such children. We are developing our clinical expertise in dealing with these children as we go along with the department of Psychiatry who often would refer them to us.

Case report

A 15 years 5 months old adolescent, was brought to the CDC by his mother who was referred by the Psychiatrist for a psychological evaluation as he was rigidly refusing to take medications for his problems. He was having school refusals, sleep disturbance, anxiety, lack of socializations, lack of interest in physical game, poor memory, lack of attention, time management difficulties, repetitive pattern of behaviour and deterioration of academic performance which has been affecting his social, occupational and daily activities for the last couple of years.

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He was born at 8 months of gestation and received ICU care for the first 6 days for Congenital Pneumonia. His early development indicates that he had normal motor development but his speech was delayed. He has uttered ''Daddy" meaning fully at 2 years of age. His mother used to think that it was due to a multilingual influence as their family used to speak in English mixed with Arabic and Bengali.

He is the only issue of an Egyptian father and a Bangladeshi Mother. He went to Egypt with his family when he was 4 years old and was put to an English medium school. He has been staying with his mother since his parents have been separated over the last 4 years. He had to study in 6 different schools at different times due to his frequent to and fro travels from Egypt to Bangladesh. Eventually, he developed adjustment difficulties at school with peers and teachers as he grew up. He also showed up with problems in keeping attention to tasks, poor fine motor skills and time management difficulties. He had great difficulties in remembering school home works & teacher's instructions. He had poor mathematical skill, poor creative writing abilities, poor memory and difficulty in comprehending the whole concept.

He is a good looking, gentle boy with kempt appearance. During the assessment, he took appropriate turns in conversation by using complex sentences. He exhibited much difficulty to sustain his attention on the tasks. He took much time to respond on the performance based tasks. He showed problems in following and comprehending the complex instructions; frequently he asked for repetition of the instructions. He showed difficulty to measure time and space (e.g. he found it difficult to find out the door of the assessment room). He was happy to share his future plans and hobbies with the examiner. He has expressed that he likes to learn through internet browsing. He was enthusiastic during the whole session.

A multidisciplinary assessment was conducted to shed light on his current development. The psychologist administered the Wechsler intelligence scale for Children (WISC-IV).[7,8] fourth Edition Indian version, Strengths and difficulties questionnaire (SDQ).[9] and the Obsessive Compulsive Scale (OCD).[10] Social Communication Questionnaire (SCQ).[11] screening was positive for ASD which revealed that he had rigidity of thought, poor peer interaction and repetitive pattern of interest from his childhood. Autism Diagnostic Interview-Revised (ADI-R).[12] and the Autism Diagnostic Observation schedule – ADOS (Module-4).[13] was administered on him for a further exploration of symptoms.

Assessment findings of ADI-R were based on both the patients' current behaviour and his childhood behaviour (At the age of 4 to 5 years) as specified by the ADI-R directions. Based on ADOS-2 Comparison Score Conversion Table for Module-4 (Fluent speech): Classification of Diagnosis was Autism Spectrum Disorder.

Results of the WISC-IV assessment indicated that Amit's verbal comprehension and perceptual skill was high average. His working memory skill was average and processing speed skill was at a low average level. Based on some verbal & performance based tasks, his overall full IQ was found at an Average level.

Wechsler intelligence scale for children –Fourth Edition Indian version is a standardized psychometric test for measuring Children's cognitive ability.

Scoring profile of Wechsler Intelligence Scale for Children –Fourth Edition:

WISC -IV/Sum of scale score	Composite score	Percentile rank	-------% Confidence interval 95%	Distribution level in normal curve
VCI (39)	118	88	110 - 124	High average
PRI (36)	111	77	102 - 118	High average
WMI (21)	103	58	95 - 110	Average
PSI (16)	89	23	81 - 99	Low average
FSI (112)	110	75	105 - 115	Average

Obsessive compulsive scale was applied to elicit OCD symptoms, which indicated that he has moderate level of Obsessive Compulsive Disorder. Conner's Parent rating scale was applied to check his attention, impulsivity and hyperactivity, where the scores indicated that he has significant problem with his attention.

He was finally diagnosed as High Functioning Autism (IQ> 70)[14,15] with poor executive function with attention deficit with symptoms of Obsessive Compulsive disorder according to the DSM-IV diagnostic criteria.

The CDC team has eventually ensured a proper educational placement for him where he would be encouraged to study on his own (under 1:1 educational supervision) by using his own creative ideas and interests. In this way, he can avoid the extra burden of being bullied by peer group at school. They were given psychological education on how his current symptoms were related to Autism Spectrum Disorder.[17] In his case, he read out all the side-effects of the medications prescribed to him and decided not to take them by any chance. He became more and more rigid and stubborn as his mother was forcing him to take medication. Over a few counselling sessions, he was offered cognitive behaviour therapy regarding this issue.[10] However, it was not possible to convince him to take medication till date. During the following sessions, we rather worked with his mother to help her handle the daily struggles with assertiveness and dignity. At the same time, he had few sessions where we worked on social skills development strategies, sex education, skills for improving his daily living style, and how to improve his executive function deficits and time management.[17] Progressive muscle relaxations and deep breathing and mindfulness exercises were practiced at almost every session.

They seemed quite convinced with the explanations of his poor adjustment with peer group, struggles with social skills development, OCD symptoms, rigidity of thinking style and stubborn behaviour. He was advised to follow up with the psychiatrist to continue the medication which was needed for improving his social and occupational functioning.

Discussion

Adolescence itself is a time of mystery in everyone's life. It becomes even more challenging when it comes into the life of young person with Asperger's syndrome (AS)5. The core symptoms of ASDs often mask the symptoms of the co morbid psychiatric condition[4,5].

The challenge in treating this case was to determine if psychiatric symptoms observed in him were part of his High Functioning Autism / AS – or of his High Functioning Autism / AS – or whether they represented psychiatric disorder as a co-morbid presentation.[15,16] The boy in this case, ultimately was not convinced to take medications nor to go back to school. We have rather taken the strategy of counselling the family to be with him and bear with him ensuring a safe and secure environment for him to help him grow and expand with his own strengths and resources.[17] Despite the intense problems in the areas of social interaction, communication and lack of flexibility of thought, some of the children with AS are blessed with unusual strengths as in his case. He was extraordinarily focused with an atypical interest of space technology. Some of them may also develop mastery in right brain resources due to their superb artistic talents, extraordinary fascination for music, linguistic or gymnastics etc. Family, friends and professionals working with these children must be more sensitive to their specific needs and help them with information and let them think by themselves to make sense of what is happening around. Rather than pushing them against the tide to behave in a so called "normal" way, which may be "abnormal" to their original nature, we need to be with them and bear with them for a while. Time, support, spacing and recognition of their atypical talents may help them to grow and bloom out in their own natural pace.

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