

## CASES THAT TEST YOUR SKILLS

33-year-old single woman seeks a companion but cannot maintain relationships. Does she have anxiety, a personality disorder, or a less obvious problem?

# Anxiously looking for love

**Andrea L. Seritan, MD**

Assistant clinical professor

Department of psychiatry and behavioral sciences

**Karen T. Hopp, MD**

Chief resident

Family practice/psychiatry training program

**Susan Bacalman, LCSW**

Licensed clinical social worker

MIND Institute

**Sally Ozonoff, PhD**

Professor of psychiatry and behavioral sciences

MIND Institute

University of California, Davis

### HISTORY A LOVELORN LIFE

**M**s. F, age 33, presents with one complaint: “I want to know how to maintain a relationship.”

Problem is, social situations have made her feel anxious since childhood. She has trouble keeping a boyfriend; she left two intimate, extended relationships at different times.

She says she is too ashamed to invite people over because she cannot keep her apartment neat. She is also sick of her job as a filing clerk and wants a new career.

Ms. F reports no other anxiety symptoms or mood changes but often cannot concentrate. She denies impulsivity or poor judgment but admits that she makes decisions without getting important facts. For example, she enrolled at a community college without knowing what skills her new

career would require. About 6 months ago, she left her boyfriend after realizing—18 months into the relationship—that he does not share her interests.

### What additional history would you elicit?

- a) academic performance
- b) attention, memory, and language skills
- c) social history, including abuse/neglect
- d) early relationships/social interaction skills.

### The authors' observations

Information on all the above factors is crucial to diagnosing a socialization problem. Outline your differential diagnosis as the interview progresses.

Ask the patient:

**How did you fare in school?** A childhood histo-



## How would you handle this case?

Visit [www.currentpsychiatry.com](http://www.currentpsychiatry.com) to input your answers and compare them with those of your colleagues

ry of pervasive inattention or impulsivity in at least two settings (at home and in school, for example) can signal attention-deficit/hyperactivity disorder (ADHD).<sup>1</sup>

**Are you forgetful?** Lack of organization or attention, memory loss, or other cognitive difficulties could suggest dementia, particularly if function declined from a previous baseline. This is unlikely for someone Ms. F's age in the absence of head trauma or other neurologic injury.

**Were you physically or sexually abused?** Childhood victims of physical or sexual abuse often suffer depression, anxiety, dissociative or somatoform disorders, or substance abuse/dependence as adults. Cluster B personality traits (especially borderline)—notable for a pattern of chaotic relationships—are also common.<sup>1</sup>

Ms. F denies early trauma and other anxiety or mood symptoms. Her poor concentration is not coupled with inattention or impulsivity, making ADHD less likely. We also rule out dementia because Ms. F's cognition is grossly intact.

### FURTHER HISTORY SCHOOL DAYS

**M**s. F's psychiatric history shows that a developmental pediatrician evaluated her when she was in preschool and diagnosed a learning disability and possible autism. She attended special education classes through high school and received vocational training, career coaching, and other services as part of a state program for the developmentally disabled.

State records indicate that at age 4, Ms. F had selective mutism and difficulty relating to peers,

habitually twirled small objects before her eyes, and engaged with imaginary friends instead of peers. We cannot discern if she is mentally retarded because test results are not available.

At age 9, Ms. F could read and spell in the 50<sup>th</sup> to 58<sup>th</sup> percentile for her age but fell below the 1<sup>st</sup> percentile in arithmetic. She had deficits in selective attention, auditory perception, and auditory memory, and fell below the 1<sup>st</sup> percentile in both fine and gross motor function. The psychiatrist changed Ms. F's diagnosis to pervasive developmental disorder (PDD) not otherwise specified after observing excessive fantasies, withdrawal, negativistic behavior, and erratic test performance.<sup>1</sup>

Ms. F has never taken psychotropics and has not been hospitalized. Medical history is unremarkable, but two maternal cousins have symptoms of autism and a younger brother has congenital renal disease. She was raised in a stable family and denies past emotional, physical, or sexual abuse, but says her brother's illness caused considerable stress.

After graduating high school, Ms. F enrolled in community college but later dropped out because she could not keep up with her schoolwork. Vocational training and career coaching have helped her hold a job for 5 years. She does not smoke, uses alcohol occasionally, and denies illicit drug use.

During her mental status examination, Ms. F is stylishly groomed. Except for brief eye contact with the interviewer, her eyes flit furtively about the room. She frequently clears her throat and laughs nervously. Her speech alternates between uncomfortable silence and rambling on about irrelevant details. Her mood is anxious with congruent affect, and she is sad and nearly tearful at times.

Ms. F's thought process is circumstantial and concrete. For example, she complains that lack of parking at her apartment complex discourages her from inviting friends over. She says she tries to socialize at school but cannot start conversations. She denies delusions, hallucinations, and suicidal or homicidal thoughts.

Which diagnostic tests could narrow Ms. F's diagnosis?

- a) neuropsychological testing
- b) questionnaires relevant to autism spectrum disorders
- c) testing for fragile X syndrome

**The authors' observations**

Repetitive behavior, impaired social interaction and communication, and often comorbid mental retardation are hallmarks of autism. Highly functioning persons with autism cannot master the nuances of interpersonal communication (decoding nonverbal and contextual cues, taking turns to talk, considering others' perspectives). These deficits frustrate efforts to establish and maintain relationships.

Ms. F, however, has relatively good insight, desires meaningful interaction, has been involved in relationships, and is much more self-sufficient than most adults with autism. Aside from her fleeting eye contact, poorly regulated speech, and concrete thinking, her presentation does not suggest autism (*Table 1*).

Whereas extensive neuropsychological testing would not target her particular deficits, a standardized symptom assessment tool, such as the Autism Diagnostic Observation Schedule (ADOS),<sup>2</sup> can help clarify the diagnosis. The ADOS provides multiple opportunities for interaction and elicits spontaneous social behaviors, such as eye contact,

Table 1

**Mental status examination signs that suggest a PDD**

**Little direct or sustained eye contact**

Eyes flit around the room  
Patient talks without looking at anyone

**Few facial expressions**

Flat affect

**Impaired speech production**

Although prosody (intonation) is normal, rate is rapid, with cluttered bursts followed by long pauses and occasional unusual emphasis on certain words

**Tangential thought process**

Patient changes topics quickly without transition  
Non-sequitur responses

**Brief responses to questions, offering little spontaneous information**

**Very detailed answers that include irrelevant information**

**Pedantic phrasing**

**Repetitive use of language**

**Does not pick up on nonquestions**

**Concrete answers to questions about emotion**  
Patient cannot describe how emotions "feel"

**Appears uncomfortable during conversation with examiner**  
Rapport strained; patient does not seem to enjoy interaction

PDD: pervasive developmental disorder

conversational reciprocity, and empathy. A total ADOS score  $\geq 10$  suggests autism; a total score between 7 and 9 signals PDD not otherwise specified or Asperger's syndrome.

Because each of its four modules is geared to different language and developmental levels, the ADOS can be used for a range of patients, from nonverbal children to highly functioning adults.

Testing for fragile X syndrome—the most

Table 2

**Autism or Asperger’s?**  
**Watch for these distinguishing features**

Clinical feature	Autism	Asperger’s syndrome
Impaired nonverbal behavior	+	+
Language delay	+	–
Stereotyped behavior (routines, mannerisms)	+	+
Impaired social relationships	+	+
Cognitive delay	±	–

+: Present    -: absent    ±: Might be present

common inherited cause of mental retardation—may also shed light (*see article on fragile X syndrome, page 80*). Boys with the fragile X premutation have a higher rate of ADHD symptoms and autism spectrum disorders than do boys without this premutation.<sup>3</sup> Ms. F’s test showed two normal alleles, thus ruling out fragile X premutation.

**TREATMENT MEDICATION AND EXPLORATION**

**M**s. F agrees to an ADOS test. Her total score of 9 (7 in social, 2 in communication, and 0 in stereotyped/repetitive behavior) suggest a moderate PDD. We rule out autism based on the test score and Asperger’s syndrome because of her early language development delays (*Table 2*).

We start escitalopram, 10 mg/d, to address Ms. F’s anxiety. We see her weekly for medication management and start weekly psychotherapy to explore her two previous relationships and her desire to find a partner.

Ms. F, however, reacts anxiously to the therapist’s exploratory techniques. She has difficulty taking the lead and becomes extremely uncomfortable

with silences in the conversation. The therapist tries cognitive-behavioral tactics to engage her, but Ms. F does not respond.

The therapist then conceptualizes her role as “coach” and tries a more-direct, problem-solving approach. She addresses specific challenges, such as an overwhelming class assignment, but Ms. F does not discuss or follow through on the problem.

After 6 months, Ms. F asks to stop psychotherapy because she has made little progress. She also asks to reduce medication checks to monthly, saying that weekly sessions interfere with

her schoolwork. She says she would consider resuming psychotherapy.

At this point, Ms. F’s anxiety is significantly improved based on clinical impression. She continues to do well 6 months after stopping psychotherapy, though she is still without a boyfriend.

**What psychosocial treatment model is best suited to Ms. F?**

- a) insight-oriented psychodynamic therapy
- b) career coaching and vocational training
- c) cognitive-behavioral therapy (CBT)
- d) social skills training.

**The authors’ observations**

The ability to possess a theory of mind—or “mentalize”—helps us understand others’ beliefs, desires, thoughts, intentions, and knowledge. Attributing mental states to self and others helps explain and predict behavior, which is critical to social interaction.

A therapeutic relationship can help teach patients to handle social situations.<sup>4</sup> In autism or

continued on page 126

continued from page 124

PDD,<sup>5,6</sup> however, theory of mind deficits typically frustrate relationship building.<sup>4</sup> Because ability to mentalize is critical to psychodynamic psychotherapy,<sup>7</sup> exploration does not help patients with PDD. By contrast, therapists can be more successful by being active in sessions and giving directions, suggestions, and information.

**Which psychotherapy models work?** Limited data address psychotherapy for adults with PDD; most studies have followed children.

CBT for persons with autism or PDD is directive, problem-focused, and targets automatic reactions.<sup>8</sup> Social skills groups and CBT focusing on day-to-day problem solving can help older children and adolescents.<sup>9</sup> A 20-week social skills intervention employing a CBT approach, paired with psychoeducation for parents, has helped boys ages 8 to 12 with autism, PDD, or Asperger's syndrome.<sup>10</sup>

Other interventions use pictures, cartoons, and other visuals to help patients identify and correct misperceptions and determine how different responses might affect people's thoughts and feelings.<sup>9,11</sup> Role play allows the patient to practice social interaction but requires make-believe,<sup>11</sup> so getting a PDD patient to participate can be challenging.

Medication can help manage comorbid anxiety, obsessive-compulsive, and mood symptoms

Pervasive developmental disorders can elude diagnosis, especially in adults who have partially compensated for their deficits. A thorough history and standardized assessment tools—such as the Autism Diagnostic Observation Schedule—can narrow the diagnosis. Cognitive-behavioral and problem-solving approaches, role play, concrete instructions and suggestions, and social skills training can improve outcome.

**BottomLine**

## Related resources

- ▶ Ozonoff S, Dawson G, McPartland J. *A parent's guide to Asperger syndrome & high-functioning autism: how to meet the challenges and help your child thrive*. New York: Guilford Press; 2002.
- ▶ MAAP Services. A global information and support network for more advanced persons with autism and Asperger syndrome. [www.asperger.org](http://www.asperger.org).

### DRUG BRAND NAME

Escitalopram • Lexapro

### DISCLOSURES

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

in PDD. Limited data support using selective serotonin reuptake inhibitors for this purpose.<sup>12</sup>

### References:

1. *Diagnostic and statistical manual of mental disorders, 4th ed, text rev*. Washington, DC: American Psychiatric Association; 2000.
2. Lord C, Risi S, Lambrecht L, et al. The Autism Diagnostic Observation Schedule-Generic: A standard measure of social and communication deficits associated with the spectrum of autism. *J Autism Dev Disord* 2000;30:205-23.
3. Farzin F, Perry H, Hessl D, et al. Autism spectrum disorders and attention-deficit/hyperactivity disorder in boys with the fragile X premutation. *J Dev Behav Pediatr* 2006;27(S2):S137-S144.
4. Ramsay JR, Brodtkin ES, Cohen MR, et al. "Better strangers:" using the relationship in psychotherapy for adult patients with Asperger syndrome. *Psychotherapy: Theory, Research, Practice, Training* 2005;42:483-93.
5. Hill E, Frith U. Understanding autism: insights from mind and brain. *Philos Trans R Soc Lond B Biol Sci* 2003;358:281-9.
6. Castelli F, Frith C, Happe F, Frith U. Autism, Asperger syndrome and brain mechanisms for the attribution of mental states to animated shapes. *Brain* 2002;125:1839-49.
7. Gabbard GO. *Psychodynamic psychiatry in clinical practice, 4th ed*. Arlington, VA: American Psychiatric Publishing; 2005:60.
8. Beebe DW, Risi S. Treatment of adolescents and young adults with high-functioning autism or Asperger syndrome. In: Reinecke MA, Dattilio FM, Freeman A, eds. *Cognitive therapy with children and adolescents. A casebook for clinical practice, 2nd ed*. New York: Guilford Press; 2003.
9. Atwood T. Frameworks for behavioral interventions. *Child Adolesc Psychiatr Clin N Am* 2003;12:65-86.
10. Solomon M, Goodlin-Jones BL, Anders T. A social adjustment enhancement intervention for high functioning autism, Asperger's syndrome, and pervasive developmental disorder NOS. *J Autism Dev Disord* 2004;34:649-68.
11. Rajendran G, Mitchell P, Rickards H. How do individuals with Asperger syndrome respond to nonliteral language and inappropriate requests in computer-mediated communication? *J Autism Dev Disord* 2005;35:429-43.
12. Namerow LB, Thomas P, Bostic JQ, et al. Use of citalopram in pervasive developmental disorders. *J Dev Behav Pediatr* 2003; 24:104-8.