

# Is it AD/HD or Asperger's Syndrome?

IT'S EARLY NOVEMBER. You have just arrived home from the orthodontist with ten-year-old Mark, a fourth grader, and his six-year-old brother, Randy, who is in kindergarten. Of course, you were late for the appointment because Mark forgot to give the teacher his note telling her that you would be picking him up early.

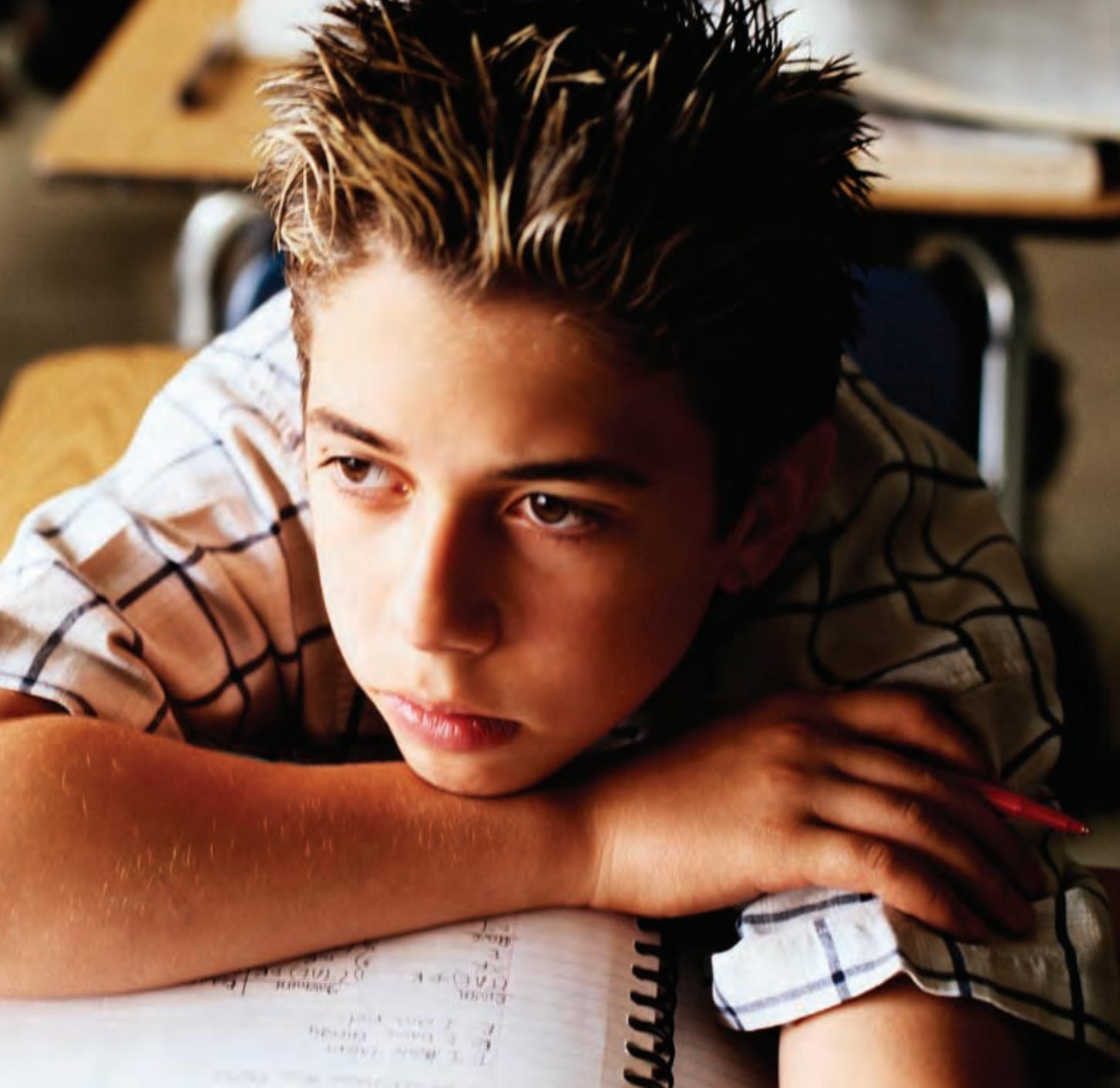
The day started well. Mark and Randy hardly fought that morning, and your sister called to say she would keep the boys so you and your husband could go away for a weekend to celebrate your anniversary. However, on the way home, you stopped at the store for eggs and milk. Mark became enraged because you also bought coffee and bread, and it took longer than “a minute.”

When you got home, there were three messages on the answering machine. The first was from Mark's teacher who said that he is slipping behind the class, that he absolutely refuses to rewrite his spelling words, and that he pushed another child out of *his* favorite swing when several others were available. The second message was from your neighbor who suggested that Mark stole five of her son's favorite Pokémon cards when he was at their house on Sunday. And the third message is from your husband, who asked if you took \$40 out of his wallet this morning.



by Edward B. Aull, M.D.

Mark was diagnosed with AD/HD in first grade and has been on long-acting methylphenidate since school started this year. You know he has AD/HD because he was so much harder to handle this summer when he was off the medication, but it just doesn't seem to be working like it did back in September. Mark's counselor wants him to enroll in social-skills training, is worried that you are depressed, and keeps bringing up something called oppositional-defiant disorder (ODD). The books on AD/HD seem to describe his problems, but not entirely. His room is neat and his handwriting is adequate. He seems very bright, knows a lot about dinosaurs, NASCAR and Pokémon. He torments his brother incessantly and never seems



to know when to stop. You limit the television programs he can watch, monitor his diet and help him nearly every night with his homework. He doesn't always bring home the correct books, and his assignment planner only has a few legible entries.

This is a common scenario across America, and while it is possible that this could be ODD with AD/HD, it could also be Asperger's syndrome (AS). As with AD/HD, AS presents a broad spectrum of symptoms and two children with the same diagnosis may not appear all that much alike. AS is basically a

symptom complex including anxiety, AD/HD and a language-based learning disability. Patients with AS often take language in too literal a fashion, have difficulty reading non-verbal language and have little intonation in their statements. They have social difficulties, but they exhibit differently than in patients with AD/HD. Kids with AD/HD tend to interrupt, have difficulty waiting their turn, touch too much and are sometimes just too "hyper" for some playmates. Children diagnosed with AS fail to respect personal space, are too bossy, get upset if someone else breaks

**Patients with AS are not always clear-cut in their symptoms, but it is a common alternative diagnosis in children first diagnosed with AD/HD.**

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**Children diagnosed with AS are frequently teased, but they often don't understand why it is humorous.**

the rules, are gullible, and have a great deal of difficulty with non-verbal cues and puns. They are frequently teased, and while they may understand that they are being teased, they often don't understand why it is humorous. The higher-functioning patients with AS will often be viewed by others as oppositional and defiant. Patients with AS are rarely oppositional, but are often adamant that it must be the way they see it. A substitute teacher who chooses to ignore a mild behavioral issue by another student, may be berated by a child with AS because he or she did something differently than the regular teacher.

They are not afraid to debate the correctness of a specific statement with another child, adult, parent, teacher or other authority figure. This behavior could easily be viewed as defiant, but these patients are only defending what they see as a very black-and-white issue. I had a teenaged-patient who once argued that he had not knocked his father to the ground, but rather that the father fell to the ground after the teen had kned him in the groin. He completely over-

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looked the issue that he should not be injuring his father at all! They believe adults lie when they use metaphors and puns, (i.e., "Dad's in the dog house," or "It will only take a minute.") They don't understand why a joke is funny in one situation and yet not in another.

The language issues may also create trouble with directions in school. For example, when the teacher says, "You're bothering me when you do that," the student doesn't always hear, "don't do that!" The teacher's hint, "You might want to take your math home this weekend in case we have a quiz Monday" may be taken by the student as, "You might not!"

There was one student who turned in a paper and was then told to rewrite it. After the rewrite, which was turned in late, the student sensed the teacher's displeasure and asked if he should rewrite it again. The teacher told him, "Don't bother." The student then believed the essay was satisfactory and was surprised when he got a "D" on the paper.

This problem can be further exacerbated when the child is caught looking at another student's work in class. If the teacher already believes this child is being

defiant, he or she may immediately assume that the student is cheating, when he is really trying to figure out what he is supposed to be doing.

Children with AS are often anxious and can be very obsessive. They frequently have difficulty with transitions and denials. They can have severe tantrums ("meltdowns") when they are faced with a denial, which appears unjust, or when there is a change in their schedule. In class, this may happen when the teacher is ready to change subjects and the student hasn't yet finished his paper. It may simply be that the paper isn't yet up to his level of perfectionism. Some students with AS, however, are very sloppy and would turn in anything just to be finished, a characteristic also very common in children with AD/HD.

Another symptom of AS is poor eye contact. Eye contact may be fine with familiar friends and adults, but it is often very poor with new acquaintances, or friends and relatives who are rarely encountered. It is also not uncommon for a child to begin a conversation without giving the listener sufficient background information about the topic or event being discussed. For example, the student may tell his dad about some-



**A child with AS is not afraid to debate the correctness of a specific statement with an authority figure. This behavior could easily be viewed as defiant, but these patients are only defending what they see as a very black-and-white issue.**



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thing he saw in my office, but forget to tell dad that he was even at my office! They believe people are already aware and understand the unmentioned details.

Individuals with AS are typically very sensitive to medication changes. It is common to see a stimulant medication work well for a while and then diminish after two or three months. A stimulant may also increase their focus on their anxieties or obsessions, and their symptoms may worsen.

A correct diagnosis will help explain many of the behaviors and aid in directing therapy. Treatment often begins with an anti-anxiety medication, such as fluoxetine (Prozac) or sertraline (Zoloft), before trying to improve concentration with a stimulant. The purpose of the first level of treatment with the anti-anxiety medication is to decrease anxiety, lessen obsessive-compulsive behavior and ease transitions. The second level of treatment involves improving eye contact and reciprocal conversation. Patients with AS talk at you, tell you what they want and need, and then tell you more than you want to know about their

favorite topic. The third level of treatment is to disinhibit them so they will be able to do what others want them to do. One patient could eat a greater variety of food after treatment, and another learned to water ski when he wouldn't even ride in the boat before treatment.

The titration of medications may be very difficult because the effects of too much and too little medicine may appear alike. Once the anxiety issues are improved, then a stimulant medication may be used to treat the AD/HD symptoms. If attention improves after the use of an anti-anxiety agent, the anxiety was likely interfering with attention, rather than the medication directly improving attention. The prior use of an anti-anxiety agent also seems to prevent the waning of the stimulant's effects after a month or two of treatment. The language issues are not correctible through medication, and the patient must learn to work around them through training or behavioral therapies. However, traditional cognitive-behavioral counseling rarely works well in these cases. Patients with AS have great difficulty expanding the lessons learned

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in therapy to a larger or barely dissimilar paradigm.

The child mentioned at the beginning of this article exhibited the following:

1. He failed to relay the note to his teacher (also common in AD/HD).
2. He had a meltdown over the fact that his mother bought extra things in the store (and hadn't notified him in advance).
3. He was adamant that he didn't have to redo his work. (He'd already done it!)
4. He has language-related learning disabilities. (He's falling behind.)
5. He felt justified in removing the fellow student from *his* swing.
6. He stole the money and Pokémon cards. (He really, really wanted them!) This could also be impulsivity of AD/HD, ODD, or conduct disorder.
7. He has one or two areas of intense interest where he can excel. For example, he may know exactly how many Pokémon cards he owns, when he got them (he took them from the neighbor or bought them with the money he took from dad's wallet), and what he is missing.



**Like AD/HD, Asperger's Syndrome is more common in males, but it is also present in females.**

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8. A previously adequate dose of stimulant medication waned.

The symptoms of AS are not always clear-cut, but it is a common alternative diagnosis in children who are first diagnosed with AD/HD and subsequently do not do well with standard treatment. Like AD/HD, this is more common in males, but it is also present in females.

By the way, is the mother depressed? Perhaps. It doesn't matter whether we diagnose AD/HD or AS. We are going to find an increased incidence of depression and other psychiatric disorders in the family, and her life may also be affected by the fact that Mark is just like his father! ■

Edward B. Aull, M.D., is board certified in pediatrics, has practiced general pediatrics for 24 years and has a special interest in AD/HD and autism. In 1996, he began a practice limited to these disorders. Dr. Aull has spoken at national conferences on AD/HD and autism, including the Annual CHADD Conference.

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