

Case Report

Unravelling High Functioning Autism in a Child with Comorbid Psychiatric Manifestations: A Case Report with Review of Literature

Komorbid Psikiyatrik Belirtileri Olan Bir Çocukta Yüksek İşlevli Otizmin Çözümlemesi: Literatür Derlemesi Eşliğinde Olgu Sunumu

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ABSTRACT

Background: Autism Spectrum Disorder (ASD) without accompanying language or intellectual impairment, previously termed Asperger syndrome, is characterized by deficits in social communication, restricted interests, and behavioral rigidity. In highly verbal and intellectually gifted children, particularly girls, core autistic traits may be masked, leading to frequent misdiagnosis as primary mood, anxiety, or psychotic disorders. Such diagnostic delays can adversely affect clinical outcomes.

Case Presentation: We report the case of an 8-year-old girl who presented with escalating aggression, obsessive behaviors, social withdrawal, sensory hypersensitivity, and self-injurious behavior. Over a two-year period, she received multiple psychiatric diagnoses, including schizophrenia and bipolar disorder, and was treated with antipsychotics and mood stabilizers, with worsening symptoms. A detailed re-evaluation focusing on early social developmental milestones, sensory profile, and symptom clustering led to the diagnosis of high-functioning ASD with comorbid depression and obsessive-compulsive disorder. Multimodal intervention including pharmacotherapy, cognitive-behavioral therapy, structured environmental modifications at home and school, and parental education resulted in marked clinical improvement. Quality of life improved significantly over one year, as measured using a standardized objective assessment tool.

Conclusion: This case underscores the importance of careful assessment of social developmental milestones and interpretation of behavioral symptoms as an interrelated cluster rather than isolated psychiatric entities. Early recognition of high-functioning ASD, especially in cognitively advanced children, enables appropriate interventions and significantly improves long-term outcomes.

Keywords: autism spectrum disorder, high-functioning autism, misdiagnosis, self-injurious behavior, pediatric psychiatry

ÖZET

Giriş: Dil veya zihinsel bozukluk eşlik etmeyen Otizm Spektrum Bozukluğu (OSB), eskiden Asperger sendromu olarak adlandırılırdı ve sosyal iletişimde eksiklikler, kısıtlı ilgi alanları ve davranışsal katılık ile karakterizedir. Konuşma becerisi yüksek ve zihinsel olarak yetenekli

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çocuklarda, özellikle kızlarda, temel otistik özellikler maskelenebilir ve bu durum sıklıkla birincil duygudurum, anksiyete veya psikotik bozukluklar olarak yanlış tanı konulmasına yol açar. Bu tür tanılarda gecikmeler klinik sonuçları olumsuz etkileyebilir.

Olgu Sunumu: Artan agresyon, obsesif davranışlar, sosyal geri çekilme, duyuşal aşırı duyarlılık ve kendine zarar verici davranışla başvuran 8 yaşında bir kız çocuğunun olgusunu sunuyoruz. İki yıllık süreç boyunca şizofreni ve bipolar bozukluk dahil olmak üzere birden fazla psikiyatrik tanı almış, antipsikotikler ve duygudurum düzenleyicileriyle tedavi edilmiş, ancak semptomları kötüleşmiştir. Erken sosyal gelişimsel kilometre taşlarına, duyuşal profile ve semptom kümelenmesine odaklanan ayrıntılı bir yeniden değerlendirme, komorbid depresyon ve obsesif-kompulsif bozukluk ile birlikte yüksek işlevli OSB tanısına ulaşılmasını sağlamıştır. Farmakoterapi, bilişsel-davranışçı terapi, evde ve okulda yapılandırılmış çevresel düzenlemeler ve ebeveyn eğitimi içeren çok yönlü bir müdahale, belirgin klinik iyileşme sağlamıştır. Standart bir objektif değerlendirme aracı kullanılarak ölçülen yaşam kalitesi bir yıl içinde önemli ölçüde artmıştır.

Sonuç: Bu olgu, sosyal gelişimsel kilometre taşlarının dikkatli bir şekilde değerlendirilmesinin ve davranışsal semptomların izole psikiyatrik durumlar yerine birbiriyle ilişkili bir küme olarak yorumlanmasının önemini vurgulamaktadır. Özellikle bilişsel olarak ileri düzeyde olan çocuklarda yüksek işlevli OSB'nin erken tanınması, uygun müdahalelere olanak tanımakta ve uzun dönemli sonuçları önemli ölçüde iyileştirmektedir.

Keywords: otizm spektrum bozukluğu, yüksek işlevli otizm, yanlış tanı, kendine zarar verici davranış, çocuk psikiyatrisi

INTRODUCTION

Autism Spectrum Disorder (ASD), as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), encompasses a continuum of neurodevelopmental conditions previously classified separately, including Asperger syndrome. ASD without accompanying intellectual or language impairment—often referred to as high-functioning autism—poses unique diagnostic challenges due to preserved or superior cognitive and verbal abilities. In such cases, social communication deficits and behavioral rigidity may be subtle or misattributed to personality traits, emotional disorders, or primary psychiatric illness.

The presence of comorbid psychiatric symptoms such as anxiety, obsessive-compulsive behaviors, depression, and self-injury further complicates diagnostic clarity. Girls with ASD are particularly vulnerable to delayed or missed diagnosis due to social camouflaging and atypical symptom expression. We present a case illustrating how failure to evaluate social developmental milestones and symptom clustering resulted in repeated misdiagnosis and delayed identification of high-functioning ASD.

CASE PRESENTATION

An 8-year-old girl was brought by her parents with complaints of frequent anger outbursts, aggressive behavior, emotional dysregulation, increasing possessiveness toward her mother, and progressive social withdrawal. Over the preceding year, she had become reluctant to leave home, avoided peer interactions, and preferred to play alone. She exhibited excessive crying spells, marked distress with minor

changes in her daily routine and resistance to unfamiliar environments.

She was born to non-consanguineous parents following an uneventful term pregnancy and normal vaginal delivery, with a birth weight of 3.1 kg. Antenatal, natal, and postnatal periods were unremarkable. Immunizations were up to date. There was no history of significant medical illness, hospitalizations, seizures, or head injury. Both parents were physicians, and there was no family history of neurodevelopmental or psychiatric disorders.

Early developmental history revealed timely attainment of gross motor, fine motor, and language milestones. However, parents were unable to clearly recall early social milestones, including joint attention behaviors and reciprocal social smiling. Retrospectively, the child had long demonstrated reduced eye contact, limited peer engagement, preference for solitary activities, ritualistic behaviors, and heightened distress when routines were disrupted. These behaviors were initially interpreted as shyness and introversion rather than neurodevelopmental concerns.

On physical examination, the child was conscious and oriented. Anthropometric measurements were appropriate for age (weight 20 kg, height 115 cm). Vital signs were stable. General examination revealed no dysmorphism, pallor, icterus, clubbing, edema, or lymphadenopathy. Cardiovascular, respiratory, and abdominal examinations were normal. Neurological examination showed normal cranial nerve function, tone, power, deep tendon reflexes, coordination, gait, and sensory responses, effectively excluding focal neurological pathology. Baseline laboratory

investigations, revealed hemoglobin 12 g/dL, total leukocyte count 5700/cumm, platelets 2.97 lakh/cumm, C-reactive protein- negative, bilirubin 0.5 mg/dL, Alanine Transferase /Aspartate Transferase- 18/20 U/L, serum albumin 2.8 g/dL, Blood Urea Nitrogen /creatinine 10/0.6 mg/dL, Sodium- 140 mEq/L; Potassium- 4 mEq/L; Calcium- 8.8 mg/dL, MRI brain was normal.

Over the next year, her behavioral symptoms worsened significantly. She developed rigid routines, compulsive behaviors, trichotillomania, and severe self-injurious behaviors, including repeated cutting of her hands and wrists using sharp household objects. She was referred to a psychiatrist for further evaluation.

Initial Psychiatric Assessments and Diagnostic Reconsideration

The first psychiatrist attributed her symptoms of obsessive behaviors, social withdrawal, affective flattening, and anxiety to a primary psychotic disorder. Psychological assessment using the Rorschach test yielded a score suggestive of severe depression. Based on these findings, she was diagnosed with disorganized-type schizophrenia and started on clozapine (25 mg twice daily). Cognitive assessment using the Wechsler Intelligence Scale for Children-IV revealed a full-scale IQ of 145, indicating superior intellectual functioning.

Despite treatment, the girl self-harm behaviour worsened over 6 months, leading to repeated harming over her hand and wrist as shown in **Figure 1**, so sought for second opinion with a psychiatrist who diagnosed her as *Bipolar disorder*(severe depression + self harm) started on Tab. Lithium 300mg twice daily, Tab. Fluoxetine 10mg once daily in the morning-SSRI(Selective Serotonin Reuptake Inhibitors), Tab. Risperidone 0.5mg a day (minimum dose of antipsychotic), Cognitive Behaviour Therapy session and referred to Child Psychologist. However, her symptoms continued to worsen over the following year.



Figure 1. Repeated self-injurious cutting marks over the child's hand and wrist.

A comprehensive evaluation by a child psychologist focused on behavioral observations, social communication patterns, sensory sensitivities, and rigidity, inclined to revisit the diagnosis. Again, a child psychiatrist, took elaborate history since childhood and asked questions to mother from infancy which helped to clench the diagnosis of Asperger syndrome. In this case, developmental milestones were normal as per the history given by the parents. Previously, only the Gross motor, fine motor skills and language milestone were addressed. But the most important milestones to be assessed for ASD especially when it is a high functioning ASD with normal language are the social milestones which were missed due to associated behaviour problem displayed in the child. This child had a history of difficulty in maintaining eye contact when spoken. Parents were not able to recall history regarding joint attention and were not able to recall the social milestones clearly as well. The child always preferred to play alone which was taken as a shy and introverted child, rather than evaluating further. There were several ritualistic behaviors as shown in **figure 2** and the child experienced meltdowns when there was a change in the routine. This was interpreted as adamant behavior and aggression. The self-injurious behavior in some children is due to alteration in sensory perception. There seemed to be no emotional trigger for self-injurious behavior in this girl. The anger outburst and aggressiveness is usually precipitated when there is change in routine of the child. The child always preferred mother over others and gets agitated when the caregiver is changed. The meltdowns, anger outbursts were misdiagnosed as a bipolar disorder previously. A lack of understanding in taking the symptoms as a cluster rather than individual symptoms led to the misdiagnosis.

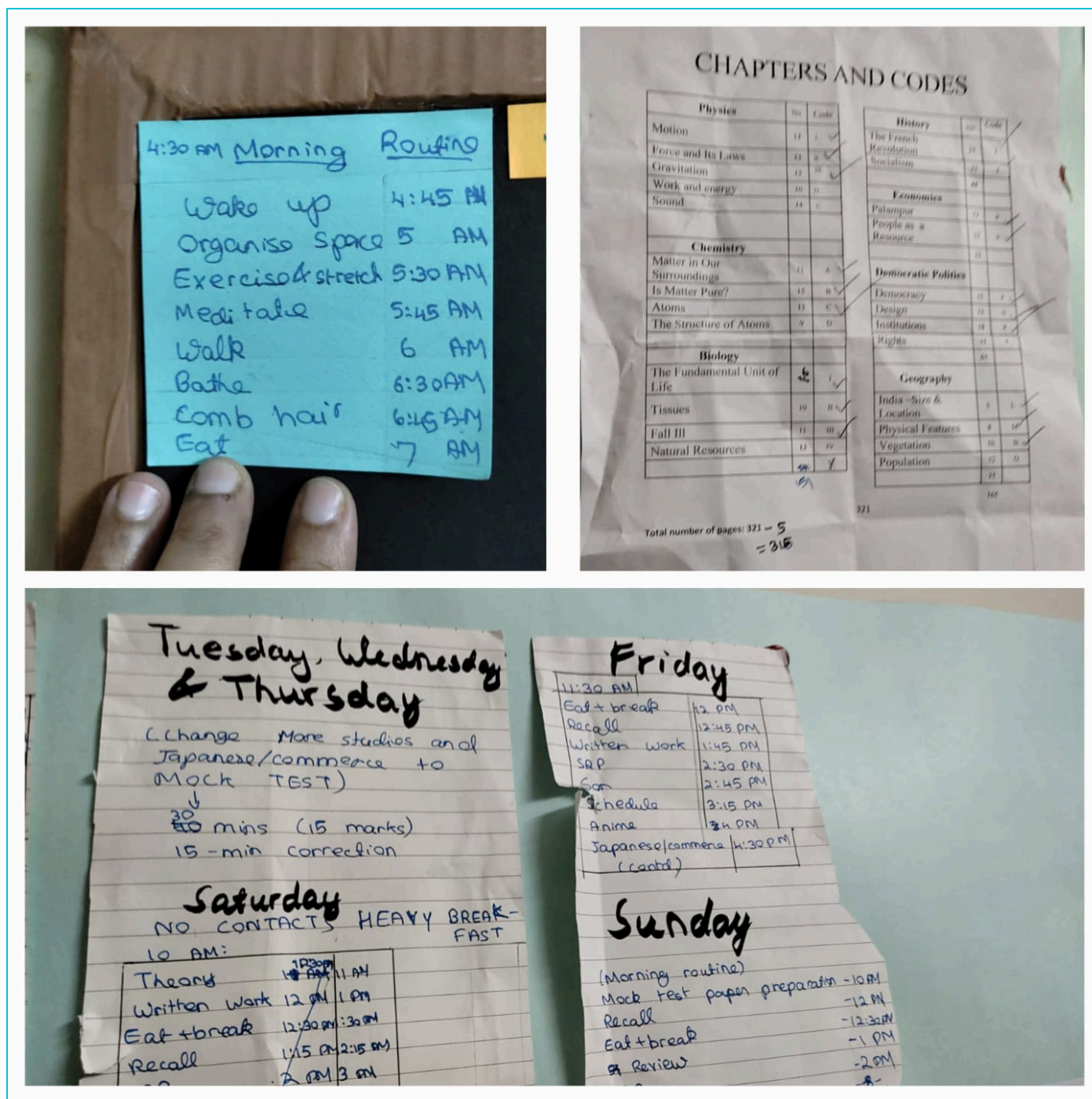


Figure 2. Ritualistic behaviors observed in the child.

This longitudinal and contextual assessment revealed that her symptoms were best explained by high-functioning ASD rather than primary mood or psychotic disorders. The previous diagnoses were reconsidered due to the absence of hallucinations, delusions, mood congruent psychotic features, or episodic mood cycling, and the presence of lifelong social communication deficits, sensory

hypersensitivity, insistence on sameness, and poor social reciprocity.

Diagnostic Assessment

Mental status examination revealed a well-groomed child with age-appropriate attire. Eye contact was fleeting and poorly sustained. Rapport was difficult to establish. Speech was fluent but monotonic, with increased response latency. Affect was blunted, and mood was subjectively neutral. Thought content

revealed preoccupation with routines, without delusions or suicidal ideation. Sensory hypersensitivity to sound, touch, and smells were evident. Insight was limited, while cognition and higher mental functions were intact.

Autism Diagnostic Observation Schedule (ADOS-2), Module 3, was administered. The calibrated severity score was 4, indicating mild-to-moderate autism symptom severity, with elevated social affect scores and restricted, repetitive behaviors as shown in **table 1**.

Table 1. Standardized Assessment Findings

Assessment Tool	Domain / Subtest	Result	Interpretation
WISC-IV	Full Scale IQ	145	Very superior intellectual functioning
ADOS-2 (Module 3)	Calibrated Severity Score	4	Mild-moderate ASD symptom severity
ADOS-2	Social Affect	8	Significant social communication deficit
ADOS-2	Restricted & Repetitive Behaviors	Present	Behavioral rigidity and repetitive patterns

MANAGEMENT AND OUTCOME

The child was managed using a multidisciplinary approach. Pharmacological treatment included escitalopram (15 mg/day) and quetiapine (50 mg/night). Cognitive-behavioral therapy was continued with autism-specific adaptations.

At school, an Individualized Education Plan (IEP) was implemented, including seating away from sensory triggers, access to a quiet sensory room, reduced school hours, small-group activities, modified assessments, and teacher-assisted de-escalation during meltdowns. At home, environmental modifications included a dimly lit, predictable setting, visual planners, consistent routines, calming sensory inputs, and pet-assisted emotional regulation. Parental education focused on understanding sensory triggers, routine management, and emotional regulation strategies.

Over one year, there was a marked reduction in self-injurious behavior, obsessive routines, improved emotional regulation, enhanced academic performance, and better social adaptation. Quality of life improved significantly, as measured using the Pediatric Quality of Life Inventory (PedsQL™ 4.0), summarized in **table 2**. Written informed consent was obtained from the parents.

Table 2. Objective tool for measuring outcomes

Measurement	Part A(Quality of life)	Part B(Impact)
Baseline	61	81
After 1 year of therapy	84	110

DISCUSSION

High-functioning ASD can present diagnostic challenges due to preserved language and cognitive skills, which often mask deficits in social communication, non-verbal interactions, and behavioral rigidity (2). The removal of Asperger Syndrome as a distinct diagnosis in DSM-5 and its integration into the broader ASD classification underscores the dimensional nature of autism and the continuum of functional impairments (3). High-functioning individuals may be articulate, intellectually advanced, and academically successful.

The presence of comorbid psychiatric conditions such as obsessive-compulsive disorder, generalized anxiety, and depression further obscures the underlying neurodevelopmental disorder, particularly in high-IQ children who are adept at camouflaging or masking symptoms.(4) Camouflaging is especially prevalent in females and contributes to diagnostic delays (5). Self-injurious behaviors, though alarming, are not uncommon in ASD and often stem from sensory processing difficulties, particularly hyperresponsivity to tactile and auditory stimuli. These behaviors are often misinterpreted as signs of mood disorders or psychosis, leading to inappropriate treatment strategies. Psychiatric comorbidities, including anxiety, obsessive-compulsive symptoms, depression, and self-injurious behavior, frequently coexist with ASD and should be interpreted as part of a symptom cluster rather than isolated psychiatric disorders. Sensory processing abnormalities are strongly associated with

emotional dysregulation and self-injury in ASD and may mimic affective or psychotic illness (6)

Effective identification hinges on a thorough developmental and behavioral history, detailed observation across contexts, and standardized assessments tailored to autism symptomatology (7). Misdiagnosis can lead to inappropriate pharmacotherapy and delayed implementation of effective, autism-specific interventions. Interdisciplinary collaboration among pediatricians, psychologists, occupational therapists, educators, and psychiatrists is vital ⁸. Quantifiable outcome measures

such as the Childhood Depression Inventory (CDI-II) provide objective metrics to monitor the response to interventions and guide clinical decision-making (9).

Recent studies emphasize that early diagnosis and individualized, context-sensitive interventions significantly improve adaptive functioning, reduce psychiatric comorbidities, and enhance quality of life ¹⁰. **Table 3** outlines contemporary literature that highlights the ongoing issue of misdiagnosis in high-functioning ASD and reinforces the need for heightened clinical vigilance, especially in atypical or ambiguous presentations.

Table 3. Studies Highlighting Misdiagnosis of High-Functioning Autism

Author(s) and Year	Country	Sample Size	Misdiagnosis	Observation
Taiminen (11)(1994)	Finland	Not specified	Schizophrenia	Early-onset schizophrenia often confused with ASD in adolescents.
Nylander & Gillberg (12) (2001)	Sweden	54	Schizophrenia, Personality Disorders	Adults with ASD retrospectively diagnosed; social withdrawal common.
Raja & Azzoni(13)(2009)	Italy	26	Schizophrenia, Bipolar Disorder	Asperger's underdiagnosed in psychiatric settings; diagnosis improved care.
Lai & Baron-Cohen (14) (2015)	UK	Review	Various (OCD, Anxiety, Mood disorders)	Emphasized the spectrum and comorbid masking; recommended multidisciplinary diagnosis.
Mandy & Tchanturia(15) (2015)	UK	Review	Anorexia Nervosa	High rates of undiagnosed ASD in females with eating disorders.
Wigham et al(16). (2017)	UK	83	ADHD, Anxiety Disorders	Found high ASD traits among children with prior psychiatric diagnoses.
Brewer et al(17). (2016)	Australia	34	Mood Disorders, OCD	Misdiagnosis common in high-IQ females; supported structured autism screening.
Ying et al.(18)(2023)	Not specified	1 (case)	Psychosis, OCD	ASD misdiagnosed as psychosis then OCD; revised after comprehensive assessment.
Iversen (19)(2022)	Norway	1 (case)	Borderline Personality Disorder	Severe NSSI led to BPD misdiagnosis in autistic adult; correct diagnosis reduced symptoms.
Misdiagnosis in Autistic Adolescent (20)(2024)	Not specified	1 (case)	Suicide Attempt/Psychosis	Autism masked subdural empyema; non-verbal traits delayed accurate diagnosis.
Rim et al.(21)(2023)	South Korea	Meta-analysis	Schizophrenia (4%), ADHD (28%)	Psychiatric comorbidities increase misdiagnosis risk in high-functioning ASD sciencedirect

Management of Asperger Syndrome involves a multidisciplinary approach tailored to the individual's unique needs. Key strategies include individualized education plans (IEPs), speech and language therapy,

occupational therapy, and behavioral interventions such as Applied Behavior Analysis (ABA) (8). Creating a structured, predictable environment at school and home helps reduce anxiety and promote adaptive functioning . Social skills training is particularly

valuable for helping children understand and to deal social cues.

Family involvement plays a central role in management. Parent education should focus on understanding the child's unique behavioral profile, recognizing signs of distress, and developing strategies for managing meltdowns, selective eating, or rigid routines (22). Communication with the child should be calm, consistent, and non-authoritarian. Empowering parents with practical tools and knowledge fosters a nurturing and structured home environment that complements formal interventions and supports the child's overall development. (23)

This case reinforces the importance of comprehensive developmental history, standardized autism-specific assessment tools, and interdisciplinary collaboration. Early diagnosis and individualized intervention strategies are associated with improved adaptive functioning and quality of life.

CONCLUSION

Lessons Learnt

1. Careful evaluation of social developmental milestones is essential for diagnosing autism spectrum disorder, particularly in high-functioning children.
2. Psychiatric symptoms such as obsessive-compulsive behaviors, depression, aggression, and self-injury should be interpreted collectively as potential manifestations of ASD.
3. A multidisciplinary approach combining medication, behavioral therapy, environmental modification, educational support, and parental education significantly improves outcomes in ASD.

Patient Consent Form / Hasta Onam Formu

Written informed consent was obtained from the parents of this patient for this study.

Conflict of Interest / Çıkar Çatışması

The authors declared no conflicts of interest with respect to authorship and/or publication of the article.

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Author Contributions / Yazar Katkıları

Concept: AV,AA; design: AV,NM; supervision: NM; materials: AA,NM; data collection and/or processing: AV,AA; analysis and interpretation: NM,AV; literature review: AV,AA; writing manuscript: AV; critical reviews: NM. All authors contributed to the final version of the manuscript and discussed the results and contributed to the final manuscript.

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