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LETTER TO THE EDITOR

Obsessive-compulsive disorder in a woman with high-functioning autism

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Dear Editor,

The diagnostic criteria for Autism Spectrum Disorder (ASD) have changed drastically over the last decade, especially with the inclusion of what was formerly known Asperger Syndrome (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR); International Classification of Diseases, Tenth Revision (ICD-10)) (1, 2) into the already broad spectrum of autism defined in the DSM-5-TR and ICD-11 (3, 4). This poses additional diagnostic challenges, particularly when considering that Obsessive-Compulsive Disorder (OCD) often presents as a comorbid pathology, with the two disorders frequently occurring concurrently (5). We present the case of a 24-year-old woman diagnosed with ASD at Level 1 severity, indicating a need for support in daily activities. This diagnosis was established without any accompanying intellectual disability or language impairment. Additionally, she has been diagnosed with OCD, characterized by an absence of insight. Both diagnoses were confirmed according to the DSM-5-TR criteria and informed consent was obtained.

This case is notable as the patient had no documented psychiatric history prior to the onset of OCD and was considered partially functional by her family.

Her initial presentation occurred in a private practice setting in September 2021, accompanied by her mother. She reported that symptoms of OCD began in 2020 during the Coronavirus Disease 2019 (COVID-19) pandemic and have progressively worsened. Both her family and personal history are devoid of somatic and psychiatric disorders, substance abuse, or traumatic events. During the clinical evaluation, the following characteristics were observed and noted to have been present since childhood: monotonous speech, a limited ability to comprehend non-verbal cues, a need for explicit explanation of social rules, and a strong adherence to routine. She is highly dependent on her mother for various activities, such as opening doors and carrying her handbag, and for providing most of the information during consultations. Although she communicates in English—a language her mother does not understand—she still consistently refuses to be left alone. There are no noted impairments in her concentration and memory.

Her mood is anxious; she reports experiencing palpitations and diffuse sweating during the interview, along with initial insomnia. Her speech is fluent and organized, showing no perceptual disturbances, suicidal ideation, or delusional thoughts, and she denies having experienced them in the past. Her ideation centers on her lifelong feelings of being different and her struggles with socialization ("I was weird," "Feeling different from other children," "There has always been something wrong with me"). She reports intrusive thoughts that cause high levels of anxiety ("What if you get infected if you touch

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this?" "There must be viruses on that bottle") and compulsions to wash and disinfect everything. She wears two pairs of latex gloves and has isolated herself in her room, only using the bathroom after it has been disinfected. This behavior has severely impaired her functionality; she quit her university studies abroad and has been unable to focus on finding a job. Although she has insight into the ASD symptoms present since childhood and recognizes her intrusive thoughts, she shows no insight regarding her compulsions.

An extended history taken from the patient and her mother revealed the symptoms of autism: she began walking with support at 15 months old and did not speak or achieve proper toilet training until the age of 4, despite being delivered full-term without complications. She exhibited little to no interest in socializing from the age of 12 months, rarely cried, and made almost no eye contact with her caregivers. She has had great difficulties in communication and maintaining close relationships, along with associated hypersensitivity and restrictive repetitive behavior. Although her school performance was good with no evidence of intellectual delay, she required assistance from her mother and teachers to keep up with her peers. Her only personal interests are stenography and online gaming, which remain her main activities today.

The patient had a body mass index (BMI) of 26.7, with no physical abnormalities and a normal abdominal ultrasound. A complete blood count, biochemistry, blood electrolytes, serum B12 and vitamin D levels, thyroid function tests, and folic acid levels were all within normal ranges. A contrast-enhanced brain magnetic resonance imaging (MRI) revealed slightly enlarged subarachnoid spaces and a posterior fossa arachnoid cyst without mass effect. No other abnormalities were noted; the pituitary gland appeared normal. The neurological examination identified an essential tremor. The arachnoid cyst, found incidentally, was deemed congenital with no need for monitoring.

Additionally, the Adult Asperger Assessment battery was administered alongside the psychiatric interview, yielding scores of 45 on the Autism Quotient (cut-off point >32) and 16 on the Empathy Quotient (cut-off point <30) (6). The case meets the DSM-5 diagnostic criteria for OCD with absent insight and ASD without intellectual disability. As there is no pharmacological treatment for ASD, treatment for OCD was initiated with a Selective Serotonin Reuptake Inhibitor (SSRI) and a second-generation antipsychotic: sertraline was started at 25 mg and gradually increased to 200 mg, and risperidone was started at 0.25 mg/day and increased to 0.75 mg/day, then switched to cariprazine up to 3 mg/day due to an increase in the patient's prolactin level to 735.1 µ UI/mL. Cognitive-behavioral therapy (CBT) was also commenced.

The clinical course was favorable, with mild adverse effects from sertraline including light sedation and nausea during the first two weeks. The treatment led to the resolution of insomnia and a significant reduction in anxiety. The patient gained insight into her compulsions, reported fewer intrusive thoughts, and was able to delay acting on compulsions, although ritualistic behavior persisted. She was able to leave the house more often and reduced the frequency of disinfecting and washing, but she continued wearing two pairs of gloves. As there was no improvement in her social isolation and cognitive flexibility, sertraline was switched to fluoxetine, increased up to 60 mg/day, while maintaining cariprazine at 3 mg/day. An improvement was noted after four weeks.

The results of the new treatment regimen, combined with weekly CBT, were favorable, as her OCD symptoms nearly disappeared. She stopped wearing gloves and gained more independence, stating, "I can touch things now without thinking about billions of viruses and bacteria." She also began bike riding, saying, "I'm not afraid I'm going to fall and get dirty anymore." She continued engaging in her hobbies, stenography and online gaming, and started working on small projects. After three months on 40 mg of fluoxetine and 3 mg of cariprazine, the outcome remained positive, and she continued therapy. She also began exercising to improve her health and lose weight.

The diagnosis of ASD in adult women, (7) especially when comorbid with another pathology, is rare. In this case, some OCD symptoms overlapped with the ASD, which made the diagnosis difficult. To our knowledge, this is the first reported case of late-diagnosed, high-functioning ASD with OCD comorbidity in a young woman with no family history of ASD. We emphasize the importance of extensive history taking, as neurodevelopmental disorders like ASD and attention deficit can remain undiagnosed. OCD is an important differential diagnosis for ASD, but symptoms can be misinterpreted when these comorbidities overlap. Accurate diagnosis of high-functioning ASD is crucial as it can significantly impact quality of life. Addressing autism symptoms while treating OCD, alongside psychoeducation, played a pivotal role in the positive outcome of this case.

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