PSYCHIATRIC CO-MORBIDITIES

PART 1

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Disclosures

- I have no financial relationships relevant to this presentation to disclose.
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Objectives

- To understand the prevalence and risks for psychiatric comorbidities in association with autism and IDD.
- To understand clinical presentation of specific conditions: anxiety, depression/mood and ADHD disorders.
- To understand evidence-based treatment modalities.

PREVALENCE : a heavier burden to bear

Children with Autism have high rates of co-occurring psychiatric conditions, ranging from 70 to 80.9 %.

Children and adults vary to some extent, but in general they are predisposed to a heavier toll across life span.

From metanalyses:

28% ADHD
20% anxiety disorders; 13% sleep-wake disorders;
12% disruptive, impulse-control, and conduct disorders;
11% depressive disorders;
9% Obsessive-compulsive disorder;
5% Bipolar disorders; and
4% Schizophrenia spectrum disorders.

Buck et al 2014, Lai et al 2019

CAUSAL RATIONALE

- Neurological/genetic underpinnings may be a common link (ex. tuberous sclerosis).
- Intellectual disability (ID) predisposes towards psychiatric condition (cognitive, interpersonal, adaptability).
- Overlapping psychosocial risks serves as link for both ID and psychiatric conditions.

Conversely psychiatric conditions are often underdiagnosed due to diagnostic bias, lack of specific screenings tools, protection from stigma, treatment bias.

Goodman and Scott 1997, James Harris 2006

RISKS

- Severity of intellectual disability
- Severity of adaptive abilities
- Gender and AGE (internalizing tendencies more in Female and with increasing age higher risks for dementia)
- Comorbid medical/ genetic disorders
- Psychological risks: less differentiation, negative self esteem/appraisal, problem solving inabilities, learned helplessness etc.,
- Family based stress, genetic, psychiatric disorders and adaptability
- Greater risk for abuse /neglect

CLINICAL ASSESSMENT

General considerations for assessing psychiatric comorbidity in ASD

1) **Establish a baseline.** Psychiatric conditions can be episodic or temporal across life span. Know the core symptoms of ASD to differentiate. Understand transdiagnostic symptoms.

2) **Assess for medical comorbidity.** Assess for medical problems that can exacerbate emotional and behavioral symptoms

3) **Factor in genetics/developmental disorders.** Observe increased prevalence in genetic DISORDERS (eg, fragile X syndrome has a higher prevalence of anxiety and ADHD, Williams syndrome has a higher prevalence of anxiety, and 22q11 deletion syndrome is associated with higher prevalence of psychosis)

4) **Consider symptoms in the context of DEVELOPMENT, EXPECTATIONS AND ENVIRONMENT**

ANXIETY

- Most Common Co-occurring DSM Anxiety Disorders in ASD
  (Simonoff et al., 2008, van Steensel et al 2011) :
  - Social Anxiety Disorder (17%)
  - Obsessive compulsive disorder (17%)
  - Generalized Anxiety Disorder (15%)
  - Specific Phobia (30%)

Manifested as clinginess, avoidance, freeze or flight, physical complaints, aggression, excess fear etc.,

ADHD spectrum

Inattention

- Fails to pay close attention to details
- Trouble paying attention to tasks or play activities
- Doesn't follow through on instructions, tasks
- Doesn't listen when spoken to
- Trouble organizing tasks/activities
- Avoids/dislikes tasks requiring mental effort
- Loses things
- Easily distracted
- Forgetful in daily activities

Hyperactivity

- Fidgets, squirms
- Leaves seat
- Runs/climbs inappropriately
- Unable to play quietly
- Often "on the go"
- Talks excessively
- Blurts out answers before question completed
- Trouble waiting turns
- Interrupts or intrudes on others

IRRITABILITY – Depression and anxiety disorders

- 24.5% aggression
- 30.2% severe tantrums
- 16% deliberate self-injurious behavior (SIB)

- More frequent in young children
- More severe in adolescence, given increase in size and strength

Project ECHOVA, Lecavalier et al 2006

DISORDER	ADHD	ODD	DMDD	DEPRESSION	BIPOLAR
Definition	ADHD with mood problems	Angry/irritable/defiant	Recurrent outbursts and persistent irritable mood	Depressed mood, lack of interest, poor sleep	Mania, Mania and depression and cyclothymic
TARGET symptoms	Inattention, irritability, aggression	Irritable and resentful	Aggression and irritable mood	Irritable and sadness	Irritable and elated mood
TREATMENT Therapy	Parent management/ social skills/ Educational support/ Individual therapy	Parent management training	Family and individual therapy	CBT /DBT /Family therapy	CBT, Social Rhythms, Family therapy and support
Medications	Stimulants, Alpha agonists, Atomoxetine		Stimulants and SSRI	SSRI	Mood stabilizers, lithium, anticonvulsants

MEDICATIONS and THERAPY

- ANXIETY
  - Alpha AGONISTS
  - SSRI /SNRI (ex; fluoxetine, venlafaxine)
  - CBT / Exposure response prevention/
  - TRAUMA focused CBT
- MOOD/DEPRESSION
  - SSRI /SNRI
  - Mood stabilizers (Lithium, Depakote and antipsychotic agents)
  - CBT / interpersonal therapy
- ADHD
  - Stimulants
  - Alpha AGONISTS
  - Atomoxetine
  - SOCIAL skills, Parent management, School support
- IRRITABILITY
  - Contingent on diagnostic category

CLINICAL PEARLS for medications

- Start with behavioral interventions prior to medication trials, contingent on SAFETY
- Evaluate benefits and risks, due to increased incidence of side effect profil
- Start LOW and SLOW (prepubertal age consider 1/3 of recommended dose)
- Allow 4 weeks for titration to next dose
- Monitor side effects in (SI, activation, apathy, GI and weight changes etc.)
- PERIODIC LABS AND WEIGHT CHECK FOR ANTIPSYCHOTICS
- Continue successful plan for 6 – 12months which is MAINTENANCE phase
- Consider streamlining to less aversive agent, when symptoms are low
- If outcomes are partial or poor, reassess for comorbid conditions

TREATMENTS

Multimodal approach

1. Support a safe environment – develop a safety/ CRISIS plan
   - Family
   - School
   - Neighborhood
2. Optimize EVIDENCE BASED interventions
   - Psychoeducation to family/school and caregiver
   - ABA – start early
   - Educational interventions, SLT, OT/PT
   - Parent management training/ CBT/ Social skills training/ interpersonal therapy
   - School accommodations
3. Medications for Psychiatric conditions
4. Refer for specialized care as needed – Neurology/ Gastroenterology etc.

References

Buck TR, Viskochil J, Farley M, et al. Psychiatric comorbidity and medication use in adults with autism spectrum disorder.
J Autism Dev Disord. 2014;44(12):3063-3071. doi:10.1007/s10803-014-2170-2

Lai MC, Kassee C, Besney R, Bonato S, Hull L, Mandy W, Szatmari P, Ameis SH.
Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis.
Lancet Psychiatry. 2019 Oct;6(10):819-829.

Intellectual disability, James Harris MD, 2006 OUP

Lecavalier, L., Leone, S. and Wiltz, J. (2006) The Impact of Behaviour Problems on Caregiver Stress in Young People with Autism Spectrum Disorders. Journal of Intellectual Disability Research, 50, 172-183.

PROJECT ECHO VA and MCHCOR slides – autism and irritability, anxiety and ADHD.

RESOURCE
https://www.aacap.org/App_Themes/AACAP/Docs/resource_centers/autism/Autism_Spectrum_Disorder_Parents_Medication_Guide.pdf

Questions

THANK YOU!

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