PSYCHIATRIC CO-MORBIDITIES
PART 2

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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:
  - Mood disorders
  - Psychosis
- To understand evidence-based treatment modalities

Prevalence

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

- Biological/genetic underpinnings may be a common link (ex tuberous sclerosis)
- Intellectual disability (ID) predisposes towards psychiatric condition (cognitive, interpersonal, adaptability)
- Overlapping psychosocial / environmental 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**

MOOD DISORDERS

- Prevalence is 5% compared to general population.

- PRESENTATION
  - self report is limited due to alexithymia
  - evaluate baseline mood and behaviors before symptom eval.
  - Look for increased self injurious behaviors, decreased self care, labile moods, decreased interests in special interests, regression of skills
  - Manic episodes are characterized by cyclical symptoms, reduced sleep and mood changes
  - Neurovegetative symptoms are present; sleep, changes in appetite, energy levels

- Assess other causal factors, before confirming diagnosis and progressing to treatment.

- RISKS: Social rejection, isolation, awareness into ASD symptoms and low self esteem, higher age and function and Family history of mood disorders

- TREATMENT: emotional regulation, CBT, social, vocational training, SSRI /mood stabilizers

DISRUPTIVE BEHAVIORS

- PREVALENCE 12 - 25 %

- PRESENTATION – aggression or nonfunctional behaviors often in avoidance/ resistance to task demand or stimuli, escape and/ or a biological underpinning of irritable mood /anxious temperament
- Assess other causal factors, before confirming diagnosis and progressing to treatment.
- RISKS Comorbid ADHD, anxiety, mood disorders, language and intellectual disabilities, and adaptive function

- TREATMENT
  - Learning and operant conditioning models and establishing behavioral therapy
  - Second generation antipsychotics, mood stabilizers, NAC, Naltrexone etc.,

PSYCHOSIS

- PREVALENCE ~ 4% typically around late adolescence or early adulthood

- PRESENTATION is different from the general population.
  - Symptoms need differentiation from concrete pragmatic language difficulties, overvalued ideas, social isolation, aggression towards caregivers, restricted affect to be identified as disorganization, delusions, constricted affect and isolative tendencies and paranoia which are hallmark for Schizophrenia/Psychosis NOS.
  - Symptoms are relatively transient and associated with affective symptoms
  - Catatonia, occurring in the spectrum of mood and psychotic conditions needs to be recognized and treated immediately (often presents as regression in self care, reduction of speech and difficulty initiating movements)

- RISKS Familial history, large overlap between ASD and Psychosis /Schizophrenia in both genetic and environmental risks,
- TREATMENT – early diagnoses of prodromal phases, early psychosis program, Antipsychotic regimen, as tolerated, management of treatment side effects

MEDICATION PRINCIPLES

- Start with behavioral interventions prior to medication trials, contingent on SAFETY
- Evaluate benefits and risks, due to increased incidence of side effects
- 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 and wean down

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 School accommodations
   - Parent management training/ CBT/ Social skills training/ interpersonal therapy/vocational rehab. /nidotherapy
3. Medications for Psychiatric conditions
4. Refer for specialized care as needed – medical management

References

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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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