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GENERAL HOSPITAL

PSYCHIATRY ACADEMY

Diagnosis and Treatment of Anxiety & Mood Disorders in Autism Spectrum Disorder

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DEPRESSION



Depression in ASD

Diagnosis can be more challenging in individuals with ASD

- Difficulty identifying and reporting mood
- Baseline differences in affect and prosody
- Language or cognitive limitations

Features to look for:

- Increased repetitive movements
- Irritability
- Self-injurious behaviors

Case example

35F with ASD (Level 3) who presented 6 months after her mother passed away with crying, negative speech “Me no feel good. Me bad girl.”, irritability, swearing, loss of interest in hobbies, and no interest in food (15 lbs. weight loss and regression to spoon feeding). No improvement on fluoxetine 80 mg.

Individuals with ASD are at increased risk for suicide.



Depression in ASD

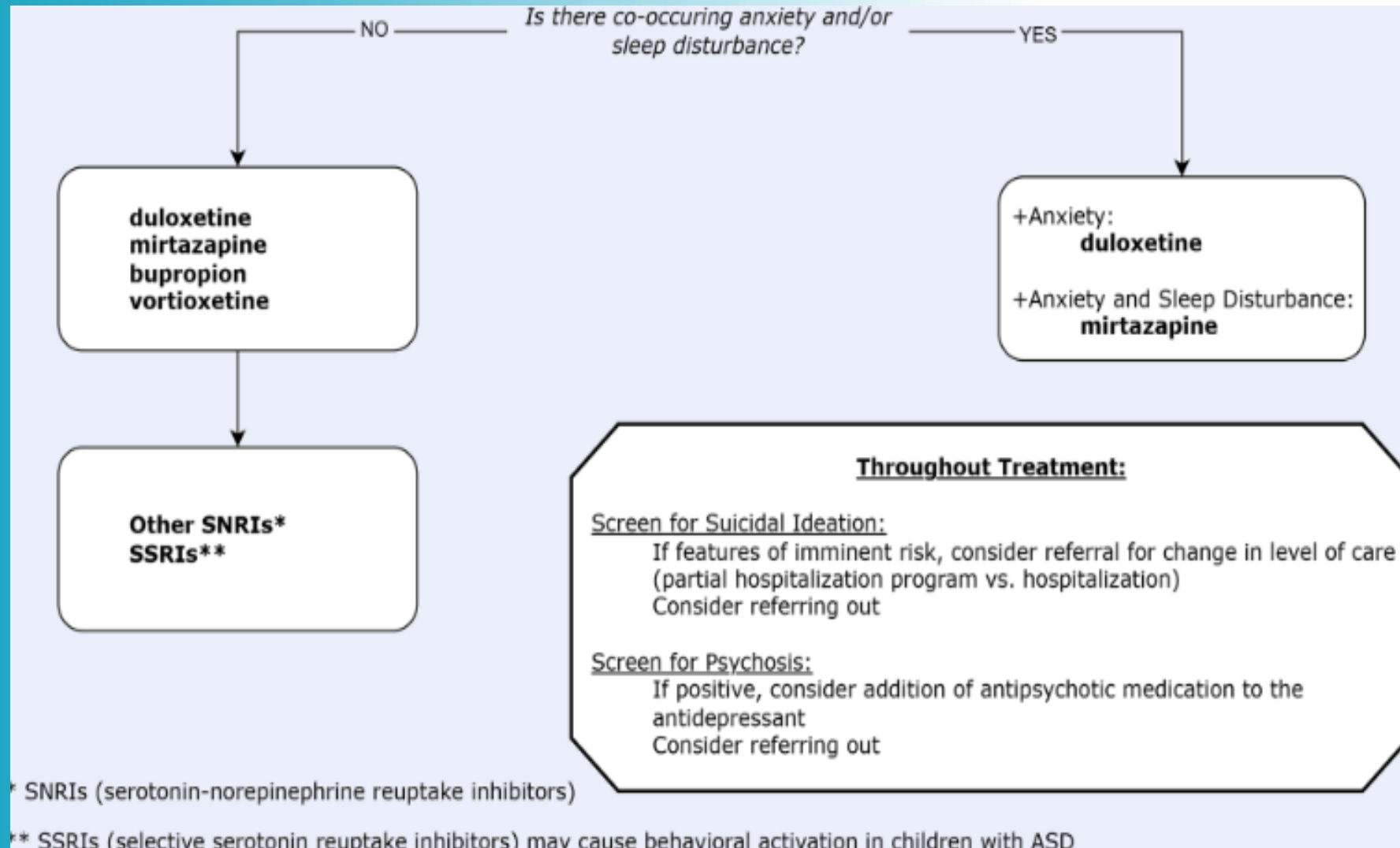
There are no published double-blind, placebo-controlled trials of medication for treating depression in ASD.

Why not?

Can psychopharmacology research on depression in the general population be extrapolated to patients with ASD?

What are the limitations of this?

Depression Treatment Pathway



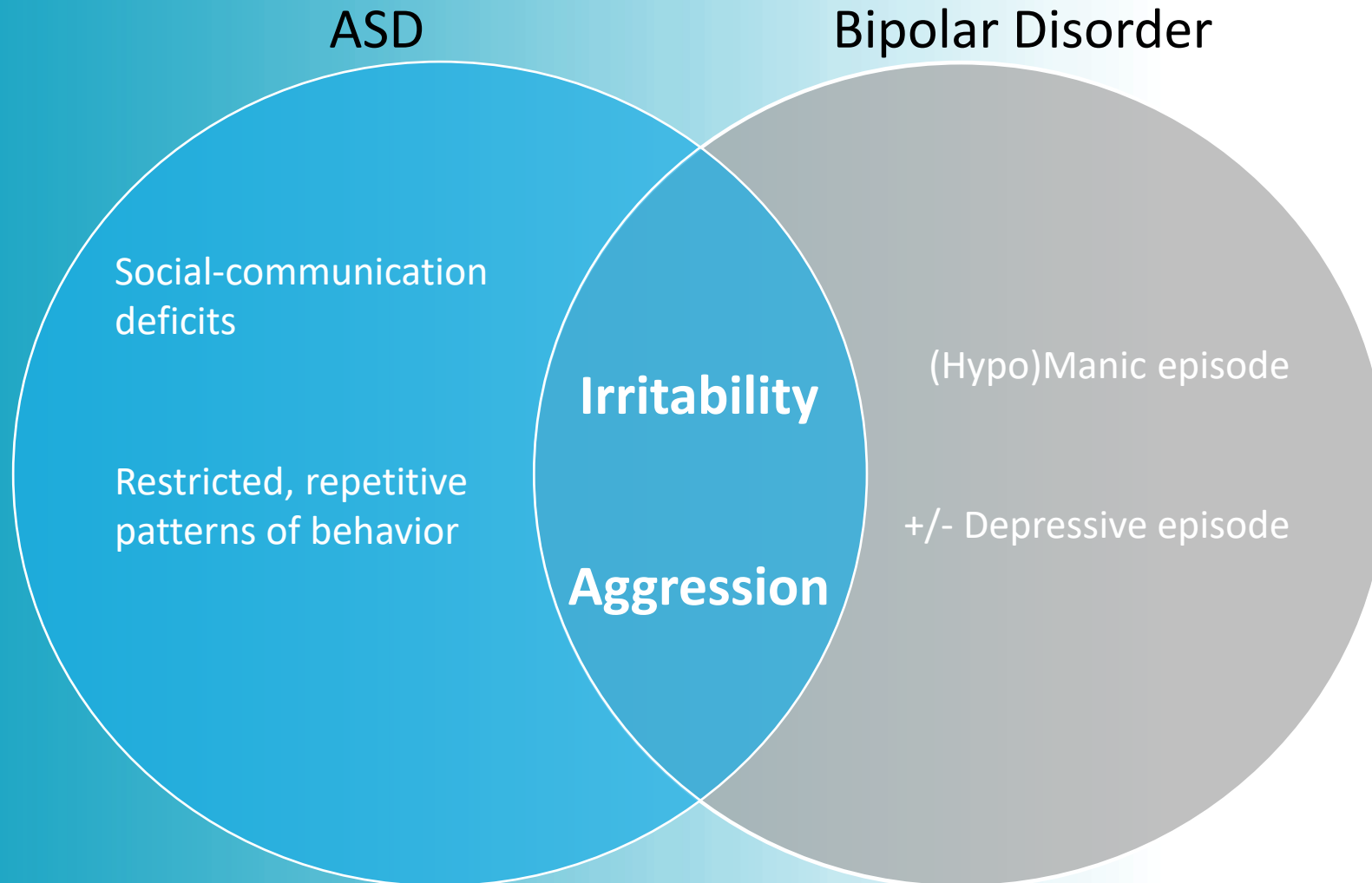


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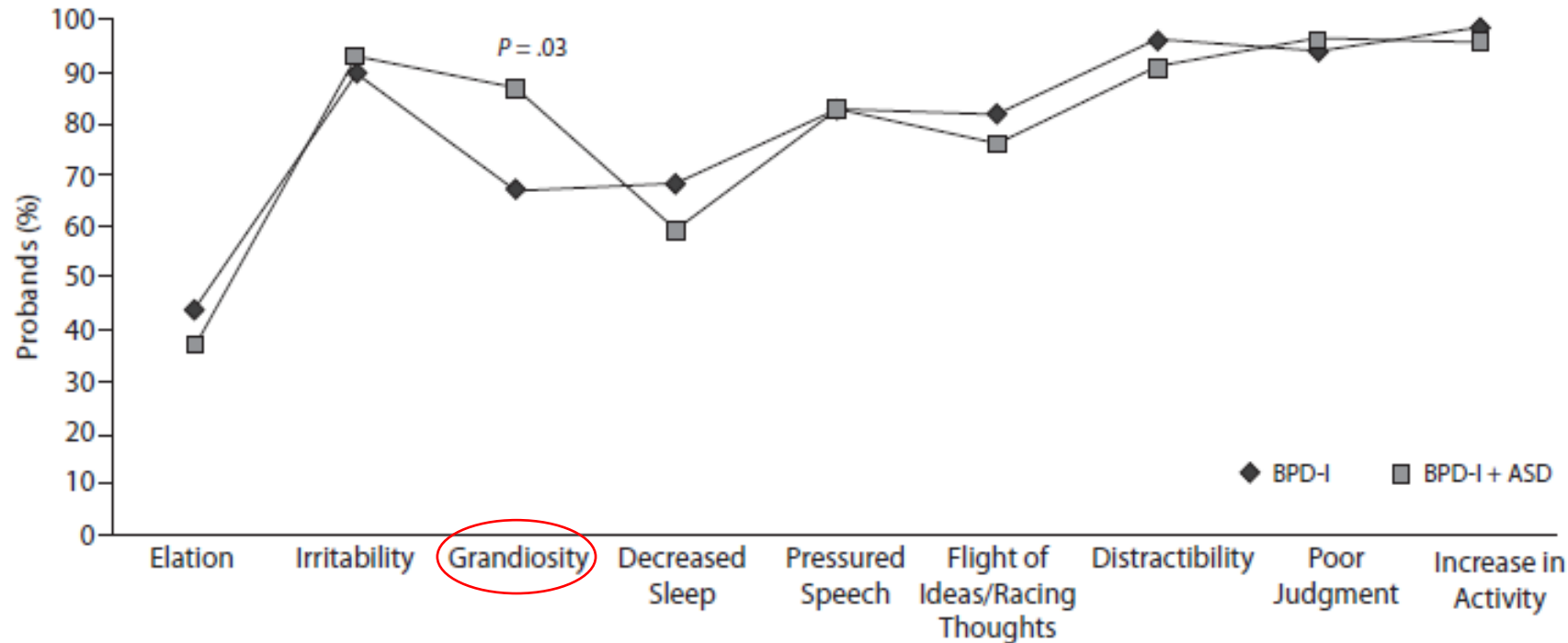
BIPOLAR DISORDER

Core & associated features of ASD and Bipolar Disorder



Mania profiles are similar with, or without ASD

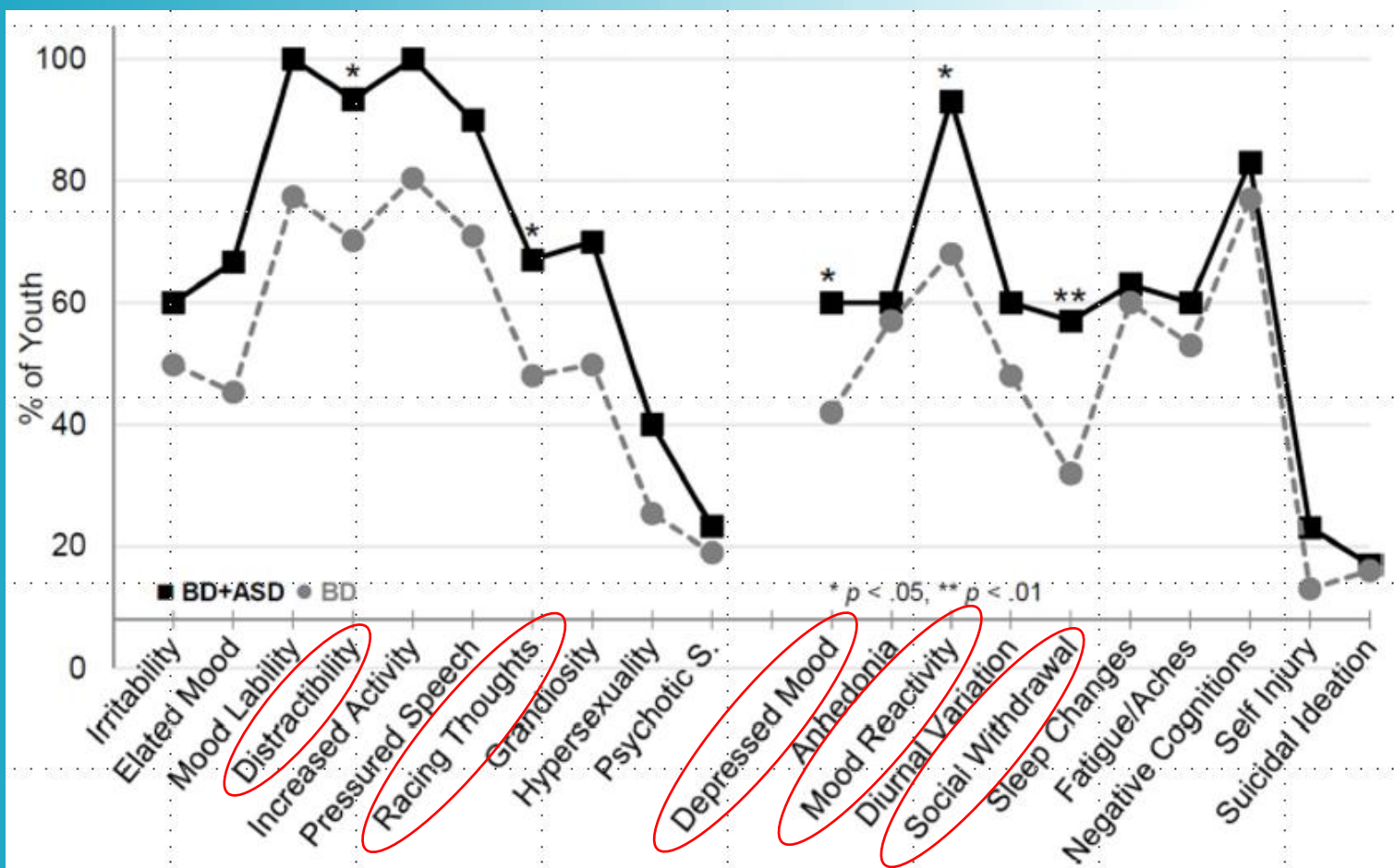
Figure 1. Mania Symptom Profile



Abbreviations: BPD-I= bipolar I disorder without autism spectrum disorder, BPD-I + ASD = bipolar I disorder and comorbid autism spectrum disorder.

Joshi et al. 2013

Mania & depression profiles are similar, with or without ASD



Borue et al. 2016.



Standard DSM-5 criteria should be used to diagnose bipolar disorder

How

Earlier age of
onset

More commonly
mixed episodes



Red flags for bipolar disorder in a patient with ASD

- Episodic changes in mood and behaviors (e.g. “bad stretches”)
- Developmentally unusually severe aggression or other dangerous behaviors (eloping)
- Psychosis (odd thinking vs. delusion)
- “Seasonal allergy” sign



Keys to an accurate diagnosis

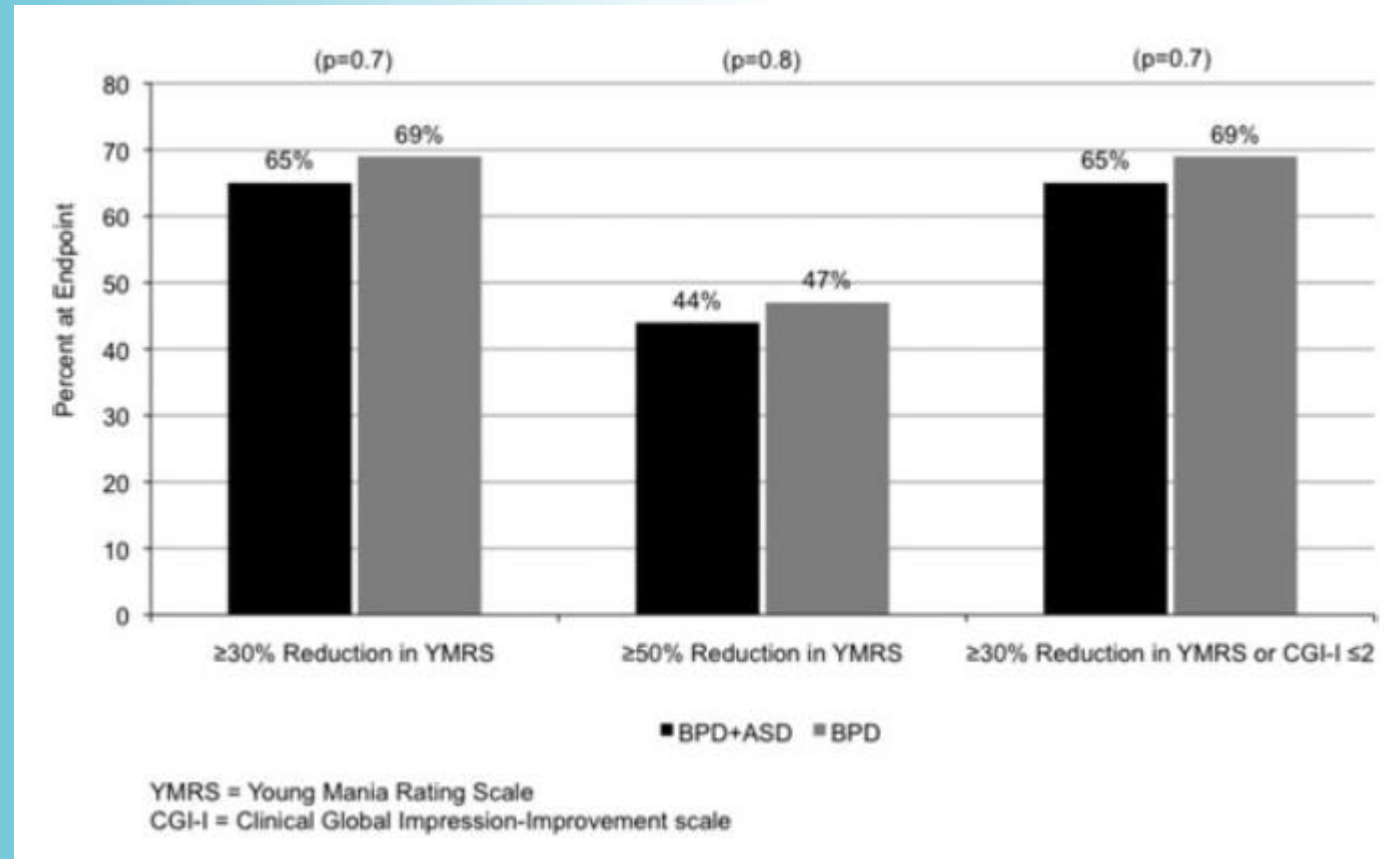
- Solid understanding of the patient's **baseline ASD features** and **developmental profile**.
- Look for **episodic, extreme changes** in baseline mood state and behaviors that are developmentally unusual.
- Use standard **DSM-5** criteria.
- Don't overestimate prevalence of irritability not attributable to a psychiatric comorbidity in ASD. Treat **diagnoses** rather than symptoms.
- Diagnostic certainty will evolve with **time** with the natural history of illness and as you get to know your patient. It is difficult to make a retrospective diagnosis if the patient is euthymic at the first visit.



Secondary analysis of 8 open-label SGA trials for bipolar disorder

15/151 subjects enrolled in bipolar trials with current (hypo)mania had comorbid ASD.

Similar rate of response and tolerability.





Summary

- Limited evidence-based treatments for comorbid psychiatric disorders in ASD
- Existing evidence and clinical experience suggests that standard, FDA-approved treatments may not work as well or be as well-tolerated
- **Anxiety:** consider non-SSRI options such as buspirone or mirtazapine
- **Mood disorders:** minimal evidence exists to guide medication selection