Module 3: Treatment of Mood Disorders, Anxiety, & PTSD in Transitional Age Youth with Autism

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Learning Objectives

After this presentation residents and students will be able to:

• Describe the prevalence and risk factors for Mood Disorders, Anxiety Disorders and PTSD in ASD
• Summarize key findings from clinical research on the treatment of Depression, PTSD and Anxiety in ASD
• Identify evidence supported approaches for assessment, diagnosis and treatment
• Identify appropriate pharmacological treatment options
ASD and Psychiatric Comorbidity

• Ricky is 19 years old with high functioning ASD and depression, and anxiety, he wants to start college but feels anxious about his inability to get along with other students and he hates his part time job because of his co-workers who make him upset.

• Sarah is a 20 years old TAY on the spectrum, with depression and anxiety. She spends a lot of time at home and she has dropped out of junior college.

• Pedro is a 17 year old who is non-verbal. He witnessed severe violence and homelessness in the last year and just moved from Puerto Rico. He has become increasingly agitated, with poor sleep, and refuses to go to school. He can’t verbally express what he is feeling but his mother has noticed that his general functioning and sleep, has declined quite a bit.
ASD and Mental Health Problems

• Research suggests that as many as 70% to 80% of children and adolescents with ASD have co-morbid mental health problems, anxiety the most common

• A large percentage use mental health services for comorbid mental health problems
  – Narendorf et al. (2011) found 46% had used a service in the last year

• Can place significant limitations on youth’s ability to function, transition out of high school and enter into the adult world
Why are depression and anxiety rates so high?

• Poor understanding of social world
  – Difficulty understanding thoughts – own and others
• Difficulty regulating emotions
• Strong preference for sameness
• Changes in routine
• Language difficulties
• Learning difficulties
• Sensory processing difficulties
Mood Disorders

Some symptoms may appear more frequently in youth with ASD and depression as compared to their typically developing counterparts with depression:

- Sleep disturbance
- Loss of appetite
- Changes in activity level
- Aggression
- Self-injurious behavior
Depression and ASD

Diagnosis

• Symptoms of depression that are diagnostic in general population are also seen in ASD
• Use DSM V Criteria are applicable
• May be difficult to diagnose depression because of challenges in reporting symptoms and feelings
• Several symptoms of depression closely mimic those of ASD (e.g. social withdrawal)
  – Appropriately validated assessment instruments are lacking for evaluating comorbid diagnoses in ASD (Mannion and Leader, 2013)
Depression and ASD

• Rates of depression increase with age and cognitive ability
• Greater increase over time for females (Gotham, 2016)
• Youth who judge their own social competency as lower, have more depression symptoms (Vickerstaff 2007).
• Youth with ASD who have depression, also have higher rates of family history of depression than their counterparts without depression
• Depression is often preceded by negative life event similar to general population
Traumatic Experience and Mood

• Studies suggest that contextual factors such as trauma may be important for development of mood symptoms in youth with ASD
• Taylor and Gotham (2016)
  – 90% of youth with clinical level mood symptoms had at least 1 trauma, compared to 40% of those without mood symptoms.
• Important to assess for traumatic stress and adversity
Bipolar Disorder and ASD

• Relatively little systematic research on the relationship between bipolar disorder and ASD

• Children with family histories of mood disorder may have more cyclic behavior, more extreme affective features, and more complex obsessive interests and are higher functioning than children without family histories.

• Atypical bipolar disorder often misdiagnosed as depressive illness or schizophrenia in youth with ASD (Hellings, 1999)
Psychological Trauma and PTSD

• Traumatic events including abuse, bullying and exposure to violence are common among typically developing children and occur at least as often among those with ASD

• Youth with ASD who become more angry and upset in response to ridicule and bullying may in turn become more vulnerable to even more aggression targeted toward them
<table>
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<tr>
<th>Higher Functioning Youth</th>
<th>Lower Functioning Youth</th>
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<td>• Higher functioning youth with ASD report more depth of relationships but also more bullying and victimization (Rowley 2012) than lower-functioning.</td>
<td>• Language delays may get in the way of reporting or expressing reactions to trauma</td>
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<td>• Vulnerable to anxiety and other behavioral problem responses to bullying and victimization</td>
<td>• Limited availability of validated diagnostic/ symptoms measures</td>
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<td>• A study using the Vineland showed changes in functioning after earthquake in youth with ASD (Valenti, 2012)</td>
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Assessment of Trauma and PTSD

Appropriately validated instruments are lacking, but some options:

• ADIS-IV (Silverman et al, 2008)
  – Has shown very strong inter-rater reliability for the PTSD subscale for use with youth with ASD (Ung et al, 2014)
  – Has been widely used with comorbid anxiety disorders (Chalfant, 2007)
  – Has both self and parent report scales to help allow comparisons between different reporters on the same instrument

• Vineland Adaptive Behavioral Scale (Sparrow et al, 2005)
  – Study showed changes in Communication, Daily Living, Socialization, and Motor Skills domains after earthquake in ASD group (Valenti, 2012)
  – 30% average decrease in scores across domains in first month after earthquake, and 17% decline compared to baseline 1 year after trauma.
  – Comparison group with ASD unexposed to traumatic event showed no declines (Valenti, 2012)
Why Anxiety and Stress?

• ASD population prevalence of anxiety: 20-40%
• Non ASD population prevalence of anxiety: 3-13%
• Growing awareness of anxiety problems in the ASD population is not yet accompanied by growth in scientific knowledge about assessment and/or treatment of anxiety, especially in youth.
Anxiety Disorders in Childhood and Adolescence

- Separation Anxiety Disorder (SAD)
- Specific Phobias
- Social Phobia
- Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder (GAD)
- Panic Disorder
Why are individuals with ASD vulnerable to Anxiety Disorders?

• Genetic factors (family history of anxiety or other mood disorders)
• Disposition: temperament, personality (shy, anxious)
• Relationship factors – parenting styles & modeling of caution/anxious behaviors
• Cognitive factors- information processing styles and negative self-talk
Why Is Anxiety Difficult To Overcome?

• ASD might mean individuals have reduced information or an incomplete picture of the situation. This leads to:
  – Lack of knowledge of other ways to respond
  – complete belief in the outcome of the feeling
  – Feelings stronger than words
Psychosocial Treatments: Evidence for CBT in ASD

– A number of large studies have also found CBT to be effective for reducing anxiety and mood disorders in youth with ASD
– Group programs typically involving an adoption of a program for typically developing kids, such as “Cool Kids”

- Reaven et al. (2012)
- McNally et al. (2013)
- McConachie et al. (2014)
- Sofronoff, Attwood, and Hinton (2005)
- Chalfant, Rapee, and Carroll (2007)
- Wood et al. (2009) – Individual therapy
Studies provide support for using CBT in the treatment of mental health problems of young people with a diagnosis of ASD.

– The literature has focused on anxiety
– Anxiety may precede later mood difficulties
– Many of the CBT strategies aimed at helping anxiety may also be helpful for mood disorders and traumatic stress
– Anxiety may be more present in the under 12 age group

*(Donoghue et al., 2011).*
Anxiety in ASD and Psychopharmacology

• Children with Autism Spectrum Disorders (ASDs) often exhibit agitation and anxious responses to many stimuli, including ritualistic and obsessive behaviors.

• The most common comorbid diagnosis with ASDs is social anxiety disorder.

• One meta-analysis of the limited data on treatment of children with ASDs found that SSRI treatment was associated with reduced anxiety, decreased repetitive behaviors, and improved global function.

• However, two recent autism studies using citalopram and fluoxetine for ritualistic behaviors were negative.
Cochrane Review on SSRIs in Treatment of Youth with ASD, Williams et al., 2013

• Nine trials, involving 320 people, which evaluated four SSRIs: fluoxetine, fluvoxamine, fenfluramine and citalopram.

• Five studies included only children and four studies included only adults. One trial enrolled 149 children, but the other trials were much smaller.

• No trials that evaluated sertraline, paroxetine or escitalopram.

• There is no evidence to support the use of SSRIs to treat children.

• There is limited evidence to suggest effectiveness of SSRIs in adults with autism.

• Treatment with an SSRI may cause side effects.
SSRIs and Other Antidepressants

• While it is possible that SSRIs may have efficacy for anxiety in ASDs, care is needed when prescribing medications for youth with ASDs.

• High rates of behavioral activation (e.g., agitation, irritability, aggression and disinhibition) and diminished tolerability have been reported across trials youths with ASDs.

• It is unclear if this pattern holds for adults with ASDs. Therefore, the use of SSRIs should be determined on a case-by-case basis, and dosing schedules that rely on slower titration may yield the greatest tolerability.
Summary

• Co-morbid mood disorders and anxiety are common in youth with ASD and may impede functioning and transition into adulthood.

• Anxiety is most common and may precede depression.

• Traumatic stress can also present in youth with ASD and assessment and treatment can be challenging, especially among non-verbal youth.

• Cognitive behavioral therapy can be useful as a treatment modality especially in higher functioning youth.

• Decisions about the use of SSRIs for established clinical indications that may co-occur with autism, such as obsessive-compulsive disorder and depression in adults or children, and anxiety in adults, should be made on a case-by-case basis.
References


