We are pleased to guest-edit this issue of Psychiatric Annals, which focuses on the challenges clinicians and their patients and families encounter upon diagnosing autism spectrum disorders and on the difficulties treating it when it presents with various comorbidities.

We find that many clinicians do not feel comfortable treating patients with autism spectrum disorder (ASD) because as they minister to them, they often respond in unexpected ways and experience unexpected side effects that can be intimidating or discouraging to the practitioner as well as the patient’s family.

Yet, in one population-derived sample, 70% of patients with ASD had one other comorbidity and 41% had two or more comorbidities. The most common codiagnoses were social anxiety disorder (29.2%) and attention-deficit/hyperactivity disorder (ADHD) (28.2%).

 Patients with ASD also manifest obsessive-compulsive disorder (OCD)-like behaviors that are actually a core symptom domain of the illness itself, and they often have issues with mood instability and disruptive behaviors, similar to symptoms of intermittent explosive disorder.

Our goals were to provide samples of cases likely to be encountered in practice, and to discuss treatment strategies available to clinicians so they know what benefits and side effects to anticipate in order to help families realistically select treatment options.

Autism is difficult to treat, even in the absence of comorbidities, because the spectrum includes pervasive developmental disorders grouped by common domains of symptomatic expression: deficits in communication, social interaction, and stereotyped or restricted/repetitive behaviors. These symptom clusters are likely of highly diverse origins, including those to do with genetic, autoimmune or inflammatory, metabolic, and environmental factors.

IMPACT OF PATIENT DIVERSITY

It is not surprising then that randomized, controlled clinical trials in patient populations that are not highly stratified based on a particular symptom domain do not always demonstrate clear results, as the members with the disorder are a highly diverse population; the trials require either very large numbers of patients to provide enough statistical power for results, or division of ASD patient populations into clearly delineated groups based on genetic similarity, common exposure, or endophenotype.

Although times are exciting for autism research, clinicians today already have a growing armamentarium of US Food and Drug Administration–approved and commonly prescribed off-label treatments at their disposal. The cases presented here, we hope, will expand clinician knowledge beyond use of risperidone and aripiprazole for the treatment of irritability and disruptive behaviors in ASD.

For example, clinicians may need to know that individuals with ASD taking selective serotonin reuptake inhibitors (SSRIs) to target inflexibility and anxiety may exhibit higher rates of akathesias, disinhibition, and manic-like symptoms. Treatment recommendations suggest slow titration and low doses over a period of 4 to 6 weeks to determine responses. Administration of SSRIs for depression in ASD is done on a case-by-case basis. Also of importance is that patients with ASD and ADHD symptoms tend to have a lower response rate and higher

This issue:

**Case Challenges in Autism Spectrum Disorder**

Laura N. Antar, MD, PhD; and Eric Hollander, MD

Guest Editors
The first challenge, presented by Amar Mehta, MD, explores the impact an ASD diagnosis may have on a patient’s family, and the importance of establishing a strong alliance with caregivers, as denying the truth of a diagnosis can deprive a child of much needed early intervention. Attendance to caregiver strain can also improve the outcome of the entire family.

Hillarie Budoff, MD, focuses her case challenge to the issue of interventions for ASD patients with accompanying anxiety disorders and the events that can lead patients with ASD to despair, such as being victimized or bullied. Patients with preserved insight experience added discomfort as they recognize their social challenges. This becomes a topic of anxiety and depression for patients with ASD.

Intellectual ability in patients with ASD can starkly contrast with their social capability, and the consequent disruption of harmony that this causes, if unchecked, may lead to further isolation of a child in an attempt to protect him or her, rather than helping build social skills. Zeypen Ozinci, MD; Tara Kahn, BA; and Dr. Antar discuss strategies for patients with depressive symptoms and ASD, such as SSRI treatment.

The case presented by Bonnie P. Taylor, PhD, helps clinicians discriminate between patients who may only be socially awkward and patients with ASD, whereas Dr. Antar examines diagnostic difficulties, such as trying to diagnose and treat patients with both ASD and ADHD (not technically permitted by hierarchical DSM-IV-TR criteria). A rule of thumb for both depressed individuals with ASD and individuals with ASD and ADHD symptoms is that medication interventions are statistically less effective, and that more and greater intensity of side effects are experienced by patients with ASD and these comorbidities. Furthermore, there appear to be slightly different responses to patients with “high-functioning” autism; for example, a higher rate of response to atomoxetine.

RANGE OF TREATMENT

Together, these case studies illustrate the breadth of complexity that patients, families, and clinicians encounter when trying to manage ASD and its comorbidities. There are more treatment options today than previously, as well as a better understanding of the risks and benefits associated with them; however, there is clearly a great deal of research that is yet to be conducted, and because of the heterogeneity of core and associated symptoms presenting in individual patients, treatments for patients with ASD often need to be personalized.

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REFERENCES


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