The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Managing anxiety and depressive symptoms in adults with autism-spectrum disorders

A 22-year-old man presented with his parents to the family physician owing to progressive withdrawal from family and avoidance of social or vocational opportunities. He reported depressed mood with diminishing motivation and energy and ruminative thoughts before falling asleep and after waking. There were no detectable medical contributors or substance abuse. He had always been reluctant to make friends. His mother stressed that since early childhood he had exhibited unusual interest in Japanese anime and recurrent rituals that had intensified and now consumed his waking hours.

A full diagnostic evaluation indicated early childhood onset of impairments of social communication, lack of age-appropriate relationships, restricted interests and repetitive behaviours consistent with autism-spectrum disorder (ASD). Based on the history of social withdrawal and mood and sleep disturbance after high school, a major depressive disorder was diagnosed. There was no personal or family history suggestive of bipolar affective disorder. He was started on a typical adult dose of a selective serotonin reuptake inhibitor (SSRI). As the dose was increased, he became agitated with an increase in repetitive speech and sleep disturbance. His parents described his behaviour as "restless" and "inappropriate." As he did not meet the criteria for a hypomanic episode, his SSRI was reduced to the starting dose, which reduced his agitated, disinhibited behaviour and gradually improved his depressive symptoms.

Unfortunately, many adults have undiagnosed ASD. Accurate diagnosis requires early medical and developmental history with an emphasis on social communication, patterns of behaviour and interests and other commonly associated features. Although there are core features associated with ASD, there is great variation in how individuals are affected. Comorbid psychiatric conditions are described at different stages of development, resulting in diagnostic confusion. Adolescence, with the onset of puberty and a new set of psychosocial stressors, is a stage when vigilance for possible comorbid anxiety and depressive disorders is important. Primary care physicians are increasingly diagnosing and treating anxiety and mood disorders, and SSRIs are widely prescribed. High-quality studies of their efficacy in adult ASD are limited. Nonetheless, the usefulness of SSRIs in the general population justifies their use for ASD. A recent Cochrane review of 2 studies of adults with ASD treated with SSRIs provides no information on their usefulness for depression in adults. It concludes that treatment of comorbid depression and anxiety disorders should be made case-by-case.[1] Individuals with ASD taking SSRIs may exhibit akathisia, behavioural activation, disinhibition or manic-like symptoms.[2–4] Although the mechanism is unclear, it seems that some patients with ASD are not only at risk in adolescence and early adulthood for severe anxiety and depressive symptoms but also for side effects of drugs used to treat these disorders. Some guidelines for physicians seeking to assess and manage anxiety and depressive comorbidities for patients with ASD include the following:

- Clinicians should be alert to the risk of mental health comorbidity among patients with ASD.
- Management of depressive or anxiety disorders requires assessment of contextual factors affecting the person's mental health, which can lead to nonpharmacologic interventions that can be used before or concurrent with medications.
- Although there are no pharmacologic treatments for the core features of ASD, it is reasonable to treat specific psychiatric comorbidities, such as anxiety and depression.
- Discussion of possible benefits and risks, including common side effects, the possibility of activation and/or akathisia, with associated timelines is paramount.
- Minimizing side-effects by beginning at low doses and monitoring response is essential.
- Physicians should allow sufficient time at low doses (4–6 wk) to determine response.
- The optimal approach to adults with ASD is individualized and includes specialized multidisciplinary assessment and intervention as required.[2–6]

Kerry Boyd, MD, MRCPC
Marc Woodbury-Smith, PhD, MRCPsych
Peter Szatmari, MD, MRCPC
Department of Psychiatry and Behavioural Neurosciences
McMaster University
Hamilton, Ont.

Competing interests: Dr. Szatmari declares a grant to his institution and support for travel to meetings from the Canadian Institutes of Health Research. He has also received payment for expert testimony on

Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography, which will be available only on the journal website and can be accessed through a link at the bottom of the column.
Please submit appropriate columns online at http://mc.manuscriptcentral.com/jpn; inquiries may be directed to jpn@cma.ca.

autism-spectrum disorders, speaker fees and royalties for *A Mind Apart*. None declared for Drs. Boyd and Woodbury-Smith.

DOI: 10.1503/jpn.110040

References

1. Williams K, Wheeler DM, Silove N, et al. Selective serotonin reuptake inhibitors (SSRIs) for autism spectrum disorders (ASD). *Cochrane Database Syst Rev* 2010;(8):CD004677.
2. Kolevzon A, Mathewson K, Hollander E. Selective serotonin reuptake inhibitors in autism: a review of efficacy and tolerability. *J Clin Psychiatry* 2006;67: 407-14.
3. McCracken JT. Safety issues with drug therapies for autism spectrum disorders. *J Clin Psychiatry* 2005;66 Suppl 10: 32-7.
4. King BH, Bostic JQ. An update on pharmacological treatments for autism spectrum disorders. *Child Adolesc Psychiatr Clin N Am* 2006;15:161-75.
5. Rosenberg RE, Mandell D, Farmer J, et al. Psychotropic medication use among children with autism spectrum disorders enrolled in a national registry, 2007–2008. *J Autism Dev Disord* 2010;40: 342-51.
6. Deb S, Salvador-Carulla L, Barnhill J, et al., editors. *Problem behaviours in adults with intellectual disabilities. international guide for using medication. Section on psychiatry of intellectual disability*. Switzerland: World Psychiatric Association; 2008.