THRIVE EMERGE

MEDICATION MANAGEMENT AND ASD – PART THREE
By Rick Silver, MD
www.ThriveEmerge.com

This is the third of a three-part series on Medication Management and ASD. In this segment, I cover several psychiatric conditions frequently seen as part of the ASD picture:

- Depression
- Social anxiety
- Sleep
- Psychological presentations that masquerade as psychosis and bipolar disorder

*If you have any questions and would like a **FREE 15 MINUTE CONSULTATION** with me, please contact Amanda Johnson at 410-740-3240 and ask her to schedule this.*

TREATING DEPRESSION AND SUICIDALITY

The multiple symptoms that mark a depressive episode – lower mood, loss of interest, low motivation, negative self talk, hopelessness and suicidal ideation and actions – are frequently seen in autists. Antidepressants have a good track record for helping manage these symptoms and returning the person to improved functioning. Side effects need to be managed carefully and – for those medications that alter serotonin signaling in the brain such as Prozac or Viibryd – typically fall into three areas: wt gain, fatigue and sexual dysfunction.

Depression can stem from a number of sources: small “t” trauma associated with the developmental challenges of neurodivergence including bullying, academic failures and social struggles; conflicts in the family around neurodivergence; and from genetically-driven brain structures and processes.

If the antidepressants are not fully effective in resolving depression symptoms, the medication manager might augment with an atypical antipsychotic such as Seroquel or Abilify, which can also play an important role in reducing symptoms of severe anxiety. Used at lower doses than for treating psychotic symptoms, these medications are powerful treatment agents but have to be monitored carefully for a variety of side effects.

Suicidality often arises for autists, stemming from poor self-esteem, hopelessness about future prospects for life and at times an impulsive response to unmanageable feelings of overwhelm. Antidepressants generally help with the management of these symptoms, but can have a paradoxical effect of increasing dark thoughts and suicidal ideation.

Frequent communications, access to the treating provider and support from family all need to be part of the picture of risk management.

Suicidal thought can have an acute or chronic nature. Although acute suicidal plans present the most urgent risk to the patient, chronic suicidal ideation is significant in that marks an long-standing, underlying despair about life – a giving up, as it were – and at times a sense of inner emptiness that pervades the person's experience and diminishes their desire to make life changes or to believe that changing will make any difference in a relatively grim outlook.

It is quite understandable that for autists who have experienced years or decades of failures and trauma that a chronic, deep sense of hopelessness and vague suicidal ideation is part of their psychological makeup. Medication can play a role here, but these complex perceptions require multiple interventions that establish a sense of belonging and connection, provide successes and lead toward the development of meaning and purpose in life.

TREATING SLEEP ISSUES

Sleep is one of the more frequently dysregulated processes in people with ADHD and ASD. Causes can range from rumination at night, the "racing freight train" of ADHD, sensory sensitivities, sleep apnea and the impact of depression on sleep onset and maintenance. If the individual is chronically sleep deprived, it is critical that this problem be tackled early in treatment, as the sleep dysregulated brain will struggle to normalize cognitive and emotional functions and will exacerbate symptoms of ADHD, anxiety and depression.

A wide range of sleep medications exists that can improve sleep onset and duration. Although controversy exists about the value of medicating insomnia over a long period, my practice is to utilize sleep medications as long as is necessary to produce consistent quality sleep foundational to brain and psychological health.

TREATING SOCIAL ANXIETY

Not surprisingly, many autists experience some level of social anxiety, often severe. The primary driver is often the experience of the struggle to "get" neurotypical social interactions and the fear of making social mistakes, not fitting in and being judged. Avoidance of social engagement is a frequently utilized coping mechanism, despite the impact that poorly-practiced "in real life" social interactions can have on the person's life functioning.

Although there is no medication that can alter the challenges in social awareness and cueing that are often part and parcel of the autist's experience, the antidepressants can positively impact social anxiety and markedly alter social functioning. Techniques to improve distress tolerance such as Dialectical Behavioral Therapy and training in specific social skills also help reduce these symptoms. A recent patient of mine moved from a situation in which severe social anxiety that prevented him from leaving the house over an extended period resolved with the use of an antidepressant and allowed him to return to a normal level of social engagement.

TREATING PSYCHOLOGICAL MASQUERADES

When diagnosing autists, I often observe symptoms that seem to masquerade as other disorders but are instead phenomena that arise from the unique ways the autistic brain processes sensory and emotional information, or dwells very concretely in detail and in less flexible thought patterns. Some examples:

PSYCHOSIS

JOHN – "I hear voices". This patient responded positively and very concretely, without elaboration, to a question of hearing voices. He did not by himself, without prompting, expand this to when or what he had experienced, to the nuances that help us distinguish between one diagnosis and another. He. Heard. Voices.

On face value, this would be diagnosed as a psychotic experience. But a more subtle understanding was that he was having hypnopompic hallucinations — the perceptual aberrations that can occur while falling asleep. But without understanding the autist's tendency to dwell in the concrete and to have poor interoception - i.e., challenges in sensing and naming internal experience — a diagnostician might have moved quickly to an incorrect diagnosis of psychosis and missed the complexity of how the autistic brain processes information.

ELLA – Ella's sensory sensitivities keep her from functioning in socially complex situations. At the airport, she becomes so overwhelmed by sound and movement that "I dissociate. Everyone turns into 2 dimensional paper people who stop moving, then move a little bit."

Our patient Ella above has a similar challenge. By some criteria, if you report seeing "paper people" at the airport, you are psychotic. But for Ella, this experience was rooted in a highly sensitive and dysregulated sensory system, where her perceptions were actually adaptive in that they briefly allowed her brain to "freeze" when it had an overload of sensory data to process, then returning to what we might recognize as a more neurotypical sensory experience.

A neurosensitive clinician would be familiar with the very common phenomenon of sensory sensitivities — sometimes so severe that they are highly disruptive of an individual's ability to adaptively organize sensory data or to function in the face of this dysregulation. Failure to appreciate the fascinating ways that autistic brains experience the world can lead to treatments that are inappropriate, ineffective and potentially even harmful.

BIPOLAR DISORDER

KATHY – The ability to regulate one's emotional reactions forms the foundation of all other adaptive skills. For Kathy, as for many individuals with ADHD or ASD, emotions are hard to manage, with excessive emotional responses that are difficult to bring back to center. Her emotions can swing widely and frequently, disrupting her ability to function.

From some diagnostic perspectives, these “mood swings” bear a resemblance to bipolar disorder and are diagnosed as a “rapid cycling” variant. My observations are that this phenomenon lacks most of the symptoms characterizing bipolar disorder and is better grouped with the many executive dysfunctions so typical of ADHD and ASD.

For some individuals, using stimulant medications — a standard treatment for ADHD — helps the brain organize itself and reduces some of the troublesome emotional variability. A diagnosis of bipolar disorder, on the other hand, would lead us away from this treatment option, since stimulants may increase the risk of a manic episode.