There is a growing number of reports that ASDs are associated with mental health problems\(^1, 2, 3, 4\).

Children and adolescents with ASDs are at risk of suffering high levels of anxiety and mood disturbance, disruptive and self-absorbed behaviour as well as communication disturbance and social relating problems \(^1\). These emotional and behavioural disturbances may persist throughout childhood and adolescence and the intellectual and emotional development of adolescence may bring new mental health issues, particularly depression and anxiety disorders.

It is important to understand and acknowledge the high level of emotional and behavioural problems (psychopathology) suffered by young people with ASDs beyond the core symptoms of impaired social relating, communication difficulties and restricted and stereotyped patterns of interests and behaviour. The absence of gender differences in the prevalence of psychopathology in children with an ASD compared to gender differences seen in the general population, points to the overriding influence of organic brain dysfunction on emotional and behavioural problems. Adverse environmental experiences influenced by the perceptual and interactional distortions of ASDs are also likely to account for the even higher levels of psychopathology than those seen in children with intellectual disability without autism\(^5\). Adolescents and young adults with high functioning autism (HFA) and Asperger’s Disorder (AD) (no intellectual disability) also experience high levels of emotional and behavioural difficulties\(^3\). Tonge et al., found that 65% and 85% of individuals with HFA and AD respectively fell into the clinically significant range for emotional and behavioural problems. When compared to the general population incidence of 10-15%, the seriousness of the prevalence of psychopathology for adolescents with HFA and AD is apparent\(^5\). The mental health of young people with autism, HFA and AD and the burden on their families might be improved if health, education and welfare providers and clinicians are aware of this increased risk of a range of emotional and behavioural problems.

The student with an ASD at secondary school can become increasingly emotionally vulnerable when peer group social interaction increases in complexity and change becomes part of every school day. The risk of being bullied, teased, or socially manipulated may increase. It is a priority to ensure the safety of the student with an ASD at school. Protection from bullying and teasing, and building self esteem is essential. Whether the student with an ASD is moving from primary school to secondary school or making other transitions, he/she is vulnerable to mental health difficulties, particularly if there has been insufficient preparation for change. There is some evidence that if the young person is supported through the transition to secondary school that there is improved longer term mental health outcomes\(^4\). In a recent study, the most prevalent mental health problems in adolescents with ASDs were anxiety and depression\(^5\).
Assessment

Assessment and diagnosis takes a biopsychosocial approach, with consideration of the contribution made by biological development and medical illness, cognitive and personality characteristics and the family, school and social environment. The components of a child psychiatric assessment are:

Family interview; Interview with the child; Structured questionnaires and rating scales; Other investigations such as psychological assessment (IQ profile), EEG, chromosome tests.

Anxiety

Young people with ASDs often have high levels of anxiety, partly as a consequence of their ASD symptoms and also in response to their ASD symptoms and also in response to the biological and emotional changes of adolescence. The symptoms of anxious behaviour include:

- fear of separation from familiar people
- specific fears or phobias (e.g. certain sounds, smells, objects, animals)
- resistance to change (e.g. new clothes, food, routines)
- panic and emotional distress for little or no apparent reason
- tenseness, shyness, irritability
- physical symptoms such as headache, stomach ache and palpitations.

Symptoms of anxiety, apart from the distress they cause the person, have the potential to disrupt education, further impair social interaction and create management problems and stress for parents, carers and teachers. In a student with an ASD, symptoms of anxiety may also include:

- Anger and temper tantrums
- Non-compliance
- Exacerbation of ASD symptoms
- More rigid behaviour
- More social avoidance
- More time on special interest
- More stereotypic behaviours

Depression

Adolescents with an ASD are at increased risk of suffering depression and mood disturbance. This is probably due in part to an increased biological (genetic) vulnerability for mood disorders but is also a consequence of increasing insight, developing an identity and the more sophisticated thinking of adolescents. Apart from depressed mood there is a range of other symptoms including:

- irritability
- sleep and appetite disturbance with weight loss or failure to gain weight
- obsessional thoughts and preoccupations often of a negative or depressive nature
- compulsive behaviours, such as hand washing
- withdrawal and lethargy or slowed down behaviour (psychomotor retardation)
- thoughts of suicide with a potential to act on these thoughts.

Additional signs of depression in a young person with an ASD may include:

- Exacerbation of ASD symptoms
- Social withdrawal
- Change in character and intensity of interests and activities
- Loss of interest in usual preoccupations
- Irritability
- Regression in skills

These symptoms of mood disorder (depression) are likely to impair the young person’s education and school adjustment and also further impair their already compromised social interactions and interfere with the quality of their family life.

Inattention, impulsiveness and hyperactivity (ADHD)

Approximately 20%-30% of children with ASDs suffer from severe symptoms of developmentally excessive inattention, impulsiveness and hyperactivity. These symptoms disrupt the child’s interaction with others and seriously impair learning and social adjustment. Young people with an ASD combined with ADHD have the highest levels of disturbed behaviour even when compared to youth with an ASD or ADHD alone. They create an exceptionally high burden of care and stress on parents and teachers.
Principles in the management of emotional and behaviour problems

The key to effective management of emotional and behavioural problems is a comprehensive assessment and diagnosis upon which to base the treatment plan. This process can of itself provide families with an understanding of the problem and generate possible solutions. Even if the child/adolescent receives an individually focused treatment, involving the parents helps to improve outcome and facilitates treatment compliance. Psychological treatments are the most effective. Drugs have a limited role in childhood but an increasingly important role during adolescence as more adult psychiatric conditions occur. The first consideration is to ensure that the child/young person is safe. In depressed young people, suicide risk is assessed by determining a past history of suicide attempts and risk-taking behaviour, the experience of a sense of hopelessness, helplessness and having no future, and current suicidal ideas, plan and means. Referral to specialist services is required when the young person is suicidal.

General Management

The identification of anxiety and depression creates an opportunity for management. Psychological treatments, particularly cognitive and behavioural approaches are effective treatments. Management of anxiety and depression includes altering the environment to reduce stress and anxiety, improving communication skills, creating the experience of successful achievement at school, and psychological treatments such as cognitive behavioural therapy modified to take account of the person’s cognitive abilities and ASD symptoms.

Psychological treatments

Psychological treatments might need some modification in order to compensate for language impairments.

Cognitive–behavioural therapy (CBT). Each treatment program is modified according to the symptoms, but involves:

- relaxation training, with progressive muscle relaxation and breathing exercises which can then be used to cope with greater exposure to anxiety-provoking or stressful situations
- modelling and reinforcement of confident behaviours to help reduce anxiety and improve self-esteem
- formulating more positive thoughts (cognitions) and self-attributions to alter maladaptive beliefs and self-appraisal,
and to relieve anxiety, depression and angry antisocial thoughts

- the experience of rewarding structured tasks, and activities using positive behaviour support to develop pro-social behaviour and improve social skills

The evidence for the effectiveness of cognitive–behavioural treatment approaches is substantial for the general population. Therefore if a young person with an ASD is intellectually able enough to respond, then modified CBT should be used as the first option.

**Play and psychodynamic psychotherapy.** These approaches rely on using play, discussion and the relationship with the therapist to help children develop insight into their problems and learn to understand and cope with their emotional distress. There is growing evidence that these approaches do work, but they are generally not as efficient and effective as cognitive–behavioural therapy. The more recent structured approach referred to as “interpersonal psychotherapy” is providing results that are more equivalent to cognitive–behavioural therapy when applied to the treatment of internalising conditions. These treatments can be helpful for a young person with an ASD if they have sufficient language ability.

**Family therapy.** There are a variety of different approaches to working with families, but most are based on working with the family as a group, improving communication and problem-solving skills, developing more effective methods of discipline of behavioural control and the expression of emotion, and encouraging new patterns of interaction. Studies of family therapy often have methodological problems, but, overall, it has been shown to be useful in treating a range of child psychiatric problems including conduct disorder and delinquency, anxiety and depression and bereavement.

**Pharmacotherapy**

Medication may have a role in managing psychopathology in children. Even in cases where they have a clear therapeutic benefit, they should be used as an adjunct to a more broadly based management plan which involves the parents and, when appropriate, the school. Specific symptoms that are a target for medication should be regularly monitored, preferably by the use of a symptom checklist to demonstrate therapeutic effect. The emergence of any side effects should also be monitored to determine if treatment continuation is warranted.

Selective serotonin re-uptake inhibitors (e.g. Fluoxetine) may be helpful in the treatment of depression and anxiety disorders. Tri-cyclic anti-depressants (e.g. Imipramine) may reduce anxiety in children. Risperidone in low doses has been shown to be effective in the treatment of disruptive, aggressive and self injurious behaviour in children with an ASD but should only be initiated by a specialist paediatrician or child psychiatrist because of potentially serious side effects such as dystonic reactions (e.g. tremor, muscle rigidity), weight gain and risk of development of a metabolic disorder. Stimulant medication and other drugs used for the treatment of attention deficit hyperactivity disorder (ADHD) might be prescribed but are usually not as effective and are more likely to cause troublesome side effects than in the general population. A sedative antihistamine or Melatonin might help manage persistent problems with sleeping. Regular review of medication is necessary to respond to the development of any side effects and treatment response should be followed using a systematic behavioural record.
References


