Have we made Progress in Diagnosing Mental Illness in People with Autism?

Samira Hayes*

Child & Adolescent Mental Health Service, Dochas House, Tralee, Ireland

It is generally accepted that people with Autism, just like their non-Autistic counterparts, experience the full range of mental illnesses (MI) and increased awareness has led to an increase in the dual diagnosis of Autism and MI by clinicians. Individuals with Autism are reported to experience higher rates of MI than the general population with some studies reporting co-morbidity of 65-80%, with increased vulnerability associated with individuals who have lower levels of cognitive ability. Thanks to carer and self-report we are now aware of the many predisposing factors and potential negative life events experienced by individuals with Autism that can increase their risk of developing a MI including: genetic and biological factors; health problems; communication difficulties; poor coping ability; social isolation and loneliness caused by social rejection, and low self-esteem (related to teasing or bullying). Although we know that individuals with Autism experience MI and are somewhat at risk for developing same given the many significant disorder relate challenges they experience, diagnosing MI in Autism has and continues to pose significant challenges to clinicians. The wide variability of MI identified in prevalence studies of between 9-89% reflects these challenges to some degree. So what have been the main challenges for diagnosticians accounting for such discrepancies and have we made progress in overcoming them?

What have been the challenges?

Difficulties diagnosing MI in individuals with Autism relate to a number of theoretical and practical issues that many agree can be broadly divided into four categories. a) overlap of symptoms; b) atypical presentation; c) impaired communication; d) lack of agreed standardized assessment tools.

Overlap of Symptoms

There is a considerable overlap between core symptoms of Autism and psychiatric disorders with similar behavioural indicators observed in both. For example, obsessive behaviours are a common feature of Autism but are also criteria used to diagnose OCD. Furthermore, specific phobias and hyperactivity are characteristic of Autism, but are also required to diagnose anxiety disorders and ADHD. Such commonality can hinder a psychiatric diagnosis in two ways:

• Psychiatric symptoms are attributed solely to the Autistic Disorder itself

• There can be a tendency to become focused on associated problems (e.g. aggressive behaviour) which may mask core features of an underlying disorder. For example, the aggressive behaviour presented by a person with severe Autism and intellectual disability (ID) may be caused by an underlying depressive disorder.

Idiosyncratic or atypical symptoms of Psychiatric Disorders

There is growing evidence that the presentation of psychopathology in people with Autism may present in an atypical manner compared with the general population although this appears to correlate with the level of cognitive ability. Subsequently, while people with mild ID may present with similar symptoms as the general population and meet the same diagnostic criteria, people with severe/profound ID may display an atypical presentation. For example, when an individual with Autism experiences a great deal of stress, they can exhibit much regressed behaviors that may appear bizarre to the onlooker. At times such bizarre behaviors have been diagnosed as psychotic; however, they may more likely reflect the limited resources that the individual with Autism has for coping, which then reverts to a more regressed state in the absence of alternative coping skills.

Impaired Communication

Communication difficulties are a hallmark of Autism and can interfere significantly with their ability to understand and express their own thoughts and feelings. Their inability to understand the meaning of questions being asked about their symptoms may also be impaired, making the assessment of MI challenging in both verbal and non-verbal individuals.

Limited Standardized Measures

Psychometrically sound measurement tools for assessing psychopathology in general ID began to emerge in the 1980's. The Diagnostic Assessment for the Severely Handicapped, Second Edition [1] was one of the first developed to screen for psychopathology in individuals with severe to profound ID. Although not specifically normed for individuals with Autism, it has been the most commonly used measure of psychopathology for this population in the literature. Although the challenges in screening and diagnosing people with Autism have been acknowledged for almost 20 years, it was only as recently as 2006 that an assessment tool designed specifically to screen for psychiatric disorders in people with Autism was developed (Autism Co-morbidity Interview—Present and Lifetime version) [2], followed quickly by another in 2008 (Autism Spectrum Disorder—Comorbidity for Adults [3]. Unfortunately, a major critique of both measures is that some of the symptoms may represent the co-morbid diagnoses but also Autism and therefore fail to differentiate between the two. One relatively new measure, The Psychopathology in Autism Checklist [4] suggests that it is possible to differentiate between symptoms associated with Autism and four major psychiatric disorders (psychosis, depression, anxiety disorder and OCD).

*Corresponding author: Dr. Samira Hayes, Child & Adolescent Mental Health Service, Dochas House, Tralee, Ireland, E-mail: samira_hayes@hotmail.com

Conclusion

Diagnosing MI in individuals with Autism poses many complex challenges and at present there is a) no consensus on the best way to assess psychopathology in adults with Autism and b) no consensus about the cut-off points for when symptoms should be considered to be a MI as opposed to being related to Autism. Furthermore, standardized measures to aid in the diagnosis of MI are minimal and require further research and development, although the PAC is a promising development and hopefully paves the way for a new generation of instruments with increased sensitivity and specificity to guide the clinician in their diagnoses of MI in people with Autism. No assessment tool can however can replace the expertise of an experienced clinician and the diagnostic challenges described above can alleviated to some degree by a) getting to know the individual over time, b) talking to their primary carer c) contacting other sources (e.g. GP, teachers, colleagues) and d) by developing expertise in assessing individuals with Autism over time.

A comprehensive assessment offers the only chance of developing an accurate differential diagnosis among disorders that share common symptoms, however, gathering such essential information from a variety of sources in different settings used to prove costly in terms of time. However, through the use of modern technology such as smart phones and ipads which can be used with consent to gather visual recordings of presenting concerns so that a complete picture of the individual can be established. It is important to examine all aspects of the person and their life including their temperament, home environment, life-line of life events (which may have had an accumulative impact on the individual over time). Furthermore, it is important to acquire very specific information about the individual's behaviors and this can be key information to inform whether a diagnosis is warranted.

For example, a person may always have engaged in counting and checking behaviors but have also recently started to engage in hoarding and tapping behaviors. Without specific explorative questions by the clinician such developments could be dismissed and unreported by the carrier as being part of the previously exhibited behaviors. However, when a person develops what can be viewed as new "coping behaviors" It is important to ask why? Also it is essential to remember that what may be viewed as small changes to many i.e. changing the curtains in the home can be distressing for a person with Autism and can't be discounted as predisposing factors.

So, have we made progress in diagnosing MI in Autism?: In relation to clinician's awareness and knowledge significant progress has been made, despite the field of MI in Autism being under-researched compared with other areas. It is also promising that specific measures to aid diagnoses have been developed. A good clinician however will not rely solely on a diagnostic screen to determine a diagnosis of MI in individuals with Autism but will assimilate as much information as possible from varied methods and sources because to do otherwise denies the individuality of each person with Autism.

References

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