NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

New Jersey Pediatric Psychiatry Collaborative

ASD & Comorbid Mental Health Issues Toolkit and Resources

SEPTEMBER 2024

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DIAGNOSIS of AUTISM SPECTRUM DISORDER

Autism is a **clinical** diagnosis. Must meet DSM V-TR criteria A-E below:

A – Social (Meet all 3)

- Developing & maintaining relationships
- Social-emotional reciprocity
- Non-verbal communication cues

B – Behavioral (Meet 2 of 4)

- Repetitive Speech or behavior
- Need for sameness
- Restricted interests
- Atypical Sensory Responses

C, D, & E

C - Symptoms present in early development
D - Symptoms impair social, occupational functioning
E - Not explained by IDD

SEVERITY

Level 1. Requiring support. Low interest/ success socially, inflexibility
Level 2. Requiring substantial support. Marked social delays. Distress with change
Level 3. Requiring very substantial support. Severe social deficits, extreme inflexibility

SPECIFIERS

Language issue | IDD
Medical/ genetic condition
Catatonia| Other psych

STATS

- Prevalence 1 / 36 4M:1F
- 50% have avg or higher IQ
- 25% minimally verbal

RISK FACTORS

Advanced parental age
Premature birth
Perinatal complications
Maternal immune dx
Metabolic dx
Maternal infections
Family history & genetics

Tools can help with clinical diagnosis but are not required.

CLINICIAN

ADOS (1y+)
ADI-R (1.5y+)
STAT (2-6)
CSBS (.5-2y)

PARENT

ASQ
MCHAT (1-3y)
CARS-2 (2y+)
GARS-2 (3-22y)
SCQ (4y+)

Neurodevelopmental Clinical Pearls

Created by the AACAP Autism and Intellectual Disability Committee's Training and Education Workgroup. See website for sources and more details!

DIAGNOSIS of INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)

Must meet DSM-5-TR criteria A, B, & C:

A - Deficit in intellectual function: reasoning, problem solving, planning, abstract thinking, executive function – assessed via standardized evaluation.

B - Deficit in 3 domains of adaptive function

Academic	Memory, language, reading, writing, math; use of knowledge in novel situations; problem solving
Social	Awareness of other's thoughts and feelings; communication skills; social judgment
Practical	Self-management with ADLs, money, behavior, job responsibilities

C - Onset during developmental period

Severity: Mild, Moderate, Severe, or Profound based on level of adaptive functioning

Risk Factors

Prenatal	Genetic, chromosomal, malformations, growth errors; maternal infections, illness, malnutrition; teratogens, toxins
Perinatal	Delivery complications; infections
Postnatal	Trauma, infections, toxins, medical conditions, environment, abuse/neglect
Unknown	Most common cause of IDD

Prevalence 1-3% worldwide

Most common inherited cause is Fragile X

#1 chromosomal cause is trisomy 21

NEURODEVELOPMENTAL WORK-UP

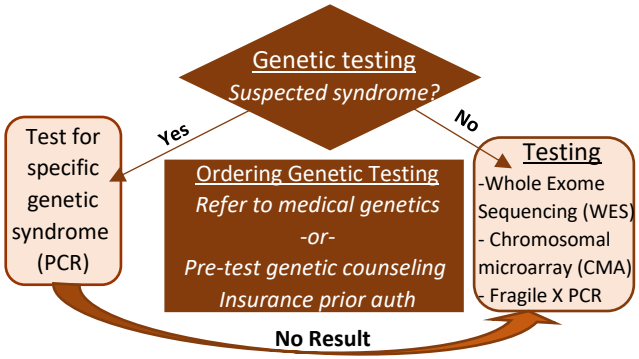
As part of initial evaluation…

History	Evaluate	Review Labs
Family History	Hearing/Vision Tests	Newborn Screen
Prenatal/Birth	Physical exam: include neuro & congenital exams	BMP, CBC, LFT, TSH
Developmental	Psychiatric eval	Lead, Metabolic
Medical	Behavioral eval	Genetic testing

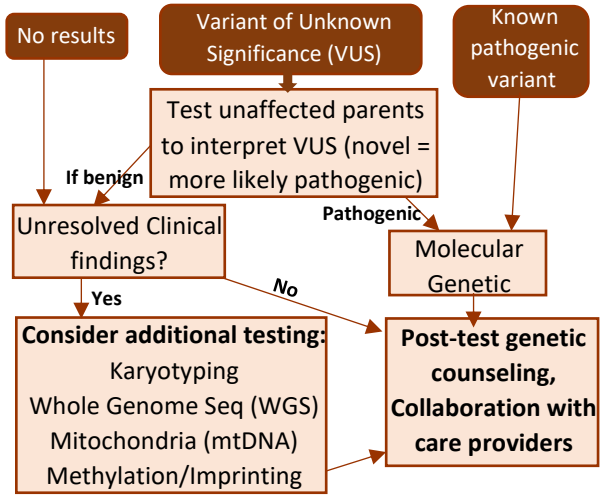
Further workup:

Evaluate baseline vs current and expected developmental age

Consider Neuro or Genetics Consult



Interpreting Genetic Testing Results



BEHAVIORAL INTERVENTIONS

Effective Use of Therapy
-Establish and prioritize target of therapy
-Therapy first, then medication (if feasible)
-Clarify function & motivation for behavior

INTERVENTIONS

***Other options** to promote adaptive function include: OT, PT, & school supports via IEP (IDEA) or 504 plan.*

APPLIED BEHAVIORAL ANALYSIS (ABA)
Most evidence-based approach
Review antecedents, behaviors, consequences
Apply reinforcers

EARLY INTERVENTIONS
Early Intensive Behavioral Intervention (EIBI)
Early Start Denver Model (ESDM)

PLAY-BASED THERAPIES
Pivotal Response Training (PRT)
Joint Attention Symbolic Play Engagement Regulation (JASPER)

SKILL-BASED PROGRAMS
Treatment & Education of Autistic and Related Communication Handicapped Children (TEACCH)
Social Skills Training (SST)
Modified Cognitive Behavioral Therapy (CBT)

PARENT TRAINING PROGRAM
Research Units in Behavioral Interventions (RUBI)
Stepping Stones Triple P

TRANSITION PLANNING PROCESS

Child Programming → **Adult Services & Roles**

Start early!

Self-determination
Self-management
Independence | Advocacy

INDIVIDUAL	TEAM	SUPPORTS
-Core symptoms -Adaptive Function -Psychiatric & medical comorbidity -Special needs -Interests & strengths	-Family -Case Manager -School Team -Medical providers -Therapy providers -Community agencies	-School -Vocational Training -Supported employment -Medical care -Guardianship -Housing assistance

PHARMACOLOGIC TREATMENTS

The Basics

-No medication can treat core autism symptoms
-Medications are used to treat psychiatric and behavioral comorbidity but could also worsen behavior
-Rule out medical/environmental/psychosocial causes of behavior first
-Assess for DSM-5-TR disorders (e.g. ADHD, anxiety)

-FDA approved medications in autism – risperidone and aripiprazole for the treatment of irritability
-Some data on other medications (e.g. stimulants, alpha agonists). Less data on SSRIs and other meds.
-Medication choices are often guided by data in typically developing children.
-To minimize side effects → ***start low and go slow***
-Increased sensitivity to side effects. Monitor closely, e.g. vitals bloodwork, EKG, weight, movements, etc.

Hyperactivity, Impulsivity, Inattention, Irritability	
Stimulants	-Methylphenidate immediate release – initial small trial dose (2.5mg), titrate as tolerated. Can try other stimulants. -Higher risk of side effects, e.g., mood lability, anxiety, movements
Non-Stimulants	-Guanfacine /clonidine- for those with co-occurring tics, anxiety, aggression -consider atomoxetine

Irritability, Aggression, Self-Injury (SIB)	
Dopamine blockers	-Risperidone/aripiprazole if severe -Less data on other dopamine blockers; try carefully

Anxiety, OCD, Depression	
SSRI SNRI	-Titrate slowly. High risk of activation (i.e., worsening behaviors)

Irritability, Aggression, SIB, Mood Dysregulation	
Other Meds	-Lamotrigine and VPA – if atypical EEG and epilepsy. Collaborate with neurology. -Lithium or propranolol for aggression

Sleep	
	-Primary sleep problems are common -Consider sleep hygiene, melatonin, trazodone, clonidine

AGITATION/BEHAVIORAL ESCALATION

Etiology

+Environmental and schedule changes
+Caregiver changes
+Overstimulation
+Sleep problems
+Iatrogenic, Med side effects
+Trauma
+Medical (HA, seizure, GI/constipation, infection)
+Hormonal changes
+Pain
+Dental issue
+Catatonia
+Allergies

Interventions

Step 1: NON-PHARMACOLOGY

-Assess pain, hunger, physical needs
-Establish routines via verbal and visual communication tools (e.g., schedule boards, social stories)
-Offer preferred items & sensory stimuli
-Reduce demands

-Identify calming spaces
-Maintain sleep hygiene
-Contact mental health providers including behavioral specialist
-Know about local ED, inpatient psych units, resources
-Support parents

Step 2: PHARMACOLOGY

-Ask about prior medication responses, such as to benzodiazepines/diphenhydramine, which can cause disinhibition.
-Consider extra dose/early dose of pt's regular meds
-Assess for drug interactions and side effects
-Advise parents to take prn medications to appointments and when in the community.

Tips

-Parents bring PRN medication to visit
-See patients more often if necessary
-Work with ED/Inpt/Outpt teams to share history/ offer guidance
-Know if local crisis teams/police are trained to work with individuals with developmental disabilities

Resources

Online Resources for Providers:

- List of Child Evaluation Centers (CECs)
- Autism Resources for Patients/Families and Providers (NIH)
- Autism Speaks
  - Applied Behavior Analysis (ABA)- Autism Speaks
- Autism NJ
- American Academy of Child and Adolescent Psychiatry (AACAP)
  - Autism Resource Center (AACAP)
- American Academy of Pediatrics
  - Developmental Coding for Standardized Assessment, Screening and Testing
- Screening Tools
  - ADHD Rating Scale IV – Preschool Version
  - Preschool Anxiety Scale (Parent Report)
  - M-CHAT-R/F

Online Resources for Caregivers:

- Transition Resources for Autism
- Autism Speaks
  - 100-Day Kit for Young Children
  - 100-Day Kit for School Aged Children
- Association for Special Children and Families
- Autism NJ
- American Academy of Child and Adolescent Psychiatry (AACAP)
  - Anxiety Resource Center
  - ADHD in Youth with ASD: Parents' Medication Guide
  - Autism Spectrum Disorder Medication Guide
- ASQ®-3 Intervention Activities
- Evaluation Request Letter Template
- Guiding families through the process of Child Study Team

Books for Providers & Caregivers:

- **The Asperkid's (Secret) Book of Social Rules, 10th Anniversary Edition**. (2022), by Jennifer Cooke
- **The Explosive Child [Fifth Edition]: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children** (2014), by Ross W. Greene, PhD
- **Uniquely Human: Updated and Expanded: A Different Way of Seeing Autism** (2022), by Barry M. Prizant, PhD.and Tom Fields-Meyer
- Magination Press® Children's Books.

Frequently Asked Questions

The following section contains Frequently Asked Questions, compiled throughout the ASD & Comorbid Mental Health Issues Learning Collaborative series.
A special thank you to the following subject matter experts for their contributions to these FAQs:

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Frequently Asked Questions

General ASD & Diagnosis Related Questions:

- How does ASD present in Adulthood?
- Can all pediatric providers diagnose ASD?
- What training does a pediatric provider need to start diagnosing ASD in their practice?
- Do cultural & ethnic differences impact the presentation of ASD?
- How can we meet the cognitive needs of high-functioning adolescent ASD youth in high school/college?
- How can I help families with ASD crisis-related episodes?
- What are the characteristics of older adolescents with ASD who have not been diagnosed?

ASD Treatment Related Questions:

- How can I help undiagnosed kids with autism get services sooner?
- What is the first line of treatment for ASD?
- What is a first-line medication for aggressive behavior in young children with autism?
- What are the benefits of ABA therapy?
- Are there any alternative treatments besides ABA therapy?
- What diagnostic criteria is needed to obtain services such as ABA therapy?
- How can the school nurse aid in the treatment plan for students diagnosed with ASD?
- How can you find parent behavioral modification training programs and/or social skill groups for teens with autism?
- How can providers measure success in ASD patients?

Comorbid Mental Health Issues Related Questions:

- What are the comorbid conditions frequently associated with ASD?
- How to assess anxiety vs ADHD in ASD patients?
- For a child diagnosed with anxiety and/or ADHD, for whom you suspect has ASD, what are the benefits of ASD diagnosis for a school-aged child?
- What is a good medication for autistic teens who have anxiety?

General ASD & Diagnosis Related Questions:

How does ASD present in Adulthood?
ASD can be present in childhood but not identified until adulthood when social challenges increase. Individuals may have a previous diagnosis of ADHD and/or anxiety. There may be a history of rigidity and reactivity. Adults may recognize characteristics if their child is undergoing an evaluation and they may struggle at work because of difficulties understanding social cues and working cooperatively in groups. They may have difficulty using language for social problem solving which can lead to misunderstandings and even being let go from a job. They may have difficulty regulating their emotions which can lead to problems with interpersonal relationships. A limited range of interests and an unwillingness to try new activities may also contribute to social difficulties.

Can all pediatric providers diagnose ASD?
Similar to other skills required to care for pediatric patients, an appropriately trained pediatrician, APN, family practitioner, psychologist, and other clinician can make the clinical diagnosis of autism. This is distinct from whether the school district/department of education (DOE), other service providers or payors (insurance companies) will accept the diagnosis for the purposes of providing or paying for services. Depending on the state laws and individual insurance policies the diagnosis may need to be made by a particular type of provider with specific types of documentation. For example: the NJ DOE will only accept a diagnosis of autism from a "physician trained in neurodevelopmental assessment." One NJ Medicaid insurance accepts the diagnosis from a pediatrician, APN, pediatric neurologist, child psychiatrist or psychologist. Other insurance companies may require a developmental/behavioral pediatrician, neurologist, or child psychiatrist to make the diagnosis in order to pay for services.

What training does a pediatric provider need to start diagnosing ASD in their practice?
General pediatric training and ongoing clinical experience are the foundation skills that ground a clinician in typical child development and behavior. The clinician needs to be aware that the child is not progressing along the expected trajectory, triggering further exploration/clarification of what is occurring. For the primary care provider, participation in training such as ECHO projects or other in-person/web-based courses about autism can be very helpful in increasing knowledge about how autism can present and an approach to diagnosis.

What training does a pediatric provider need to start diagnosing ASD in their practice? (cont'd from previous page)

A clinician should be familiar with the DSM 5TR diagnostic criteria (social and behavioral findings), and if a child's symptoms of autism are clear based on the reported history and clinical observations, a diagnosis can be made. As with developmental screening, it is recommended to use a standardized assessment tool to guide the assessment and confirm one's diagnostic suspicions. Keeping in mind that autism is a clinical diagnosis, and these instruments were designed to "support" the clinical diagnosis and are not a definitive test.

Online training for level 2 screening instruments such as the STAT and the RITA-T are helpful in providing the clinician with a structured/standardized approach to assessment and include instructive videos. Various in-office questionnaires/rating scales are also available, but it is important to read the instruction manual and possibly review the administration/scoring with an expert clinician to ensure that the instrument is being utilized properly (e.g., Childhood Autism Rating Scale - CARS).

A clinician may ask a local expert clinician if they can shadow them to refine their diagnostic skills. Some health systems with child development centers are establishing part-time "mini fellowships" to train primary care providers in the evaluation and management of autism and other common pediatric developmental/behavioral issues.

Do cultural & ethnic differences impact the presentation of ASD?

Cultural and ethnic differences can impact the understanding of the child's challenges. It may be helpful to clarify what the family understands and describe specific observed behaviors consistent with ASD. Providing information in the family's primary language can also improve their understanding of the diagnosis. Both Autism NJ and Autism Speaks have information available in other languages. Eliciting the family's story about their child's functioning may provide more information. Consider asking what other family members are saying to better understand the family culture. Emphasizing the need for services in order to help the child progress gives the family hope and a plan.

How can we meet the cognitive needs of high-functioning adolescent ASD youth in high school/college?

Adolescents and young adults with ASD may have co-existing ADHD and executive functioning difficulties that interfere with organization, time management, and study skills for which strategies may be useful. Section 504 accommodations/modifications can provide additional support. If the student needs special education services, referral to the Child Study Team is recommended. Disabilities services at colleges can be an excellent resource. Services can be provided under the Americans with Disabilities Act (ADA). Services need to be individualized to the student. Types of services may include tutoring/coaching, notes provided, extended time on tests and exams, testing in an alternative location, and preferential registration for classes. Students should be encouraged to utilize resources before problems arise.

How can I help families with ASD crisis-related episodes?

During crisis-related episodes, families should be referred to crisis agencies such as Perform Care/ Mobile Response. The individual may need to be taken to the emergency room if they are at risk of harming themselves or others. If they are not in immediate danger, ABA therapy can provide a plan for the individual to learn coping skills and use language for social problem-solving. Medications for irritability, agitation, and reactivity can be effective along with these other strategies.

What are the characteristics of older adolescents with ASD who have not been diagnosed?

Older adolescents suspected of having high-functioning ASD may have a previous diagnosis of ADHD and/or anxiety. They may present as rigid, reactive, and oppositional. They may have strong interests that they engage in for long periods in isolation. These interests can be electronics/video games. They may have trouble using language for social problem-solving, elaborating on events or interests, and engaging in reciprocal conversation. Consider the degree to which these challenges may be interfering with functioning.

ASD Treament Related Questions:

How can I help undiagnosed kids with autism get services sooner?
Undiagnosed children with signs of autism can be referred to the Early Intervention system if they are less than 3 years old. A diagnosis is not needed to receive services. From the age of 3-5 years, the child can be referred to their district Child Study Team for evaluation to determine if they qualify for the special education preschool program. A diagnosis is not needed for preschool services. School-aged children can also be evaluated by the Child Study Team to determine appropriate supports at school. If there are safety concerns, Perform Care/ Mobile Response can provide in-home counseling and guide the family to additional resources. Identifying and treating coexisting ADHD and or anxiety can also be helpful.

What is the first line of treatment for ASD?
Developmental/behavioral intervention that is individualized and focuses on the child's profile of strengths and weaknesses is the first line of treatment. Parent training to support engagement with their child and managing challenging behaviors is also important. Depending on a child's age and the locally available resources, a referral to the state early intervention program, school district special education services, and/or private therapy providers is warranted. Currently, there is no medication that "treats" autism. In cases where educational/behavioral interventions are not sufficient, medications can be used to address co-occurring diagnoses such as ADHD or anxiety.

What is a first-line medication for aggressive behavior in young children with autism?
One of the first-line medications used to treat aggressive behavior in young children with ASD is the alpha-adrenergic agonists clonidine or guanfacine. These medications act to reduce reactivity, irritability, and aggression. They are generally well tolerated and have minimal side effects. When considering the need for medical management in young children, consider the level of aggression to self, others, and the destruction of property. Unless the behaviors are severe, the atypical antipsychotic medications are not considered first line. If the family and child are in crisis they may need to consider a low dose of an atypical antipsychotic until stable and then consider medications with fewer side effects.

What are the benefits of ABA therapy?

Applied Behavior Analysis (ABA) therapy can be beneficial by improving adaptive functional skills, teaching social language for problem-solving, and reducing maladaptive behaviors by teaching coping strategies. In order to receive ABA services, a family needs a prescription for ABA therapy with the diagnostic code of F84.0 and documentation of appropriate evaluation. The primary provider should not specify the number of hours of service even if requested by an agency. The goals developed by the team, along with parents, should be functional and measurable.

Are there any alternative treatments besides ABA therapy?

There are a variety of evidence-based interventions that can effectively support developmental progress in individuals with autism. As a data-driven intervention, applied behavior analysis (ABA) has the most data to support its use and often is covered by insurance. It is important to remember that ABA is more than discrete trial instruction. It is a behavioral approach that uses different schedules of reinforcement and incidental learning to teach skills across developmental domains and/or reduce maladaptive behaviors. The specific behavioral program depends on the individual's profile.

There are other intervention formats that also have evidence of efficacy for specific skill domains. The Early Start Denver Model (ESDM) has been shown to be effective in supporting progress in social, language, and cognitive skills in toddlers and preschoolers. Developmental, Individual-differences- Relationship-based (often referred to as DIR-floortime) focuses on building foundational relationships and emotional connections to support development. Speech/language, feeding, occupation, and physical therapies may be appropriate depending on an individual's specific profile. Verbal individuals may benefit from social skills instruction, and there are evidence-based programs (e.g., Socially Thinking, PEERS). For some individuals, depending on the target skills, different approaches may be used simultaneously. There are other intervention curricula such as TEACCH (utilizing principles of structured teaching) that may not be available locally. The type of intervention program depends on multiple considerations: the skills of interest, the individual's response to the intervention type, local availability, and cost.

What diagnostic criteria is needed to obtain services such as ABA therapy?
ABA, as an intervention, is not specific to individuals with a diagnosis of autism. ABA was initially demonstrated to be effective in individuals with developmental delay/intellectual disability and there is literature to support efficacy in individuals with Down syndrome. From a research and clinical perspective ABA can be effective for individuals with delays and/or maladaptive behaviors independent of genetic or developmental diagnosis. It is health insurance that created the requirement that ABA may only be covered for individuals with a diagnosis of autism. Some insurance companies will approve coverage for a diagnosis of autism based on DSM 5 criteria by a qualified healthcare professional. Other insurances may require that the diagnosis be made by a specific type of subspecialist and/or more extensive documentation involving specific standardized instruments to support the diagnosis. Early intervention and the public school system do not require a diagnosis of autism to provide ABA services. The decision to provide this type of therapy, like other therapies provided by these programs, is based on the child's specific profile of needs. Other interventions such as speech/language, feeding, or occupational therapy can be obtained based on the diagnosis of language, feeding, and fine motor delays, independent of the diagnosis of autism.

How can the school nurse aid in the treatment plan for students diagnosed with ASD?
The school nurse can be an important liaison between teachers, parents, and primary care providers. Because many children on the autism spectrum have other medical issues, it may be helpful to involve the school nurse in team meetings. It may also be helpful for the child to meet the nurse individually in advance of the need for any emergent treatment such as an injury on the playground so they are familiar with the nurse and the nurse's office. It may be helpful to teach the child that the nurse's office is a safe place when feeling upset or sick. The school nurse can also work with children to help them learn to tolerate medical procedures such as height, weight and blood pressure that may not be able to be obtained in the primary provider's office. The school nurse can work with the team to develop an effective plan to keep the child in school when a child is acting out as a form of work avoidance or the child is demonstrating school refusal. If a child with ASD is exhibiting increasing behavior difficulties, the school nurse can be involved to help the team consider other medical causes such as an ear infection, toothache, or GI upset. The school nurse plays an important role in medication administration or monitoring for side effects of medications. If there are serious co-occurring medical conditions such as a seizure disorder, the school nurse can set up an Individualized Health Plan with the family and medical provider. The school nurse can also be involved if the child has toileting or feeding issues. Ultimately, the school nurse can be a vital team member who provides creative and individualized solutions for issues that may occur due to ASD and its comorbid conditions.

How can you find parent behavioral modification training programs and/or social skill groups for teens with autism?
Typically case managers and social workers can help parents find resources such as behavior modification training programs and social skills groups. Our navigators at the NJPPC can help connect to some of those resources. Please email info@nj-ppc.org for more information on how to refer or connect with your Hub. There are other organizations such as Autism NJ. Each county in the state of NJ also has a resource network and can provide a lot of great services.

How can providers measure success in ASD patients?
Providers may measure success in children with ASD based on the child's academic progress, functional skill development, and emotional well-being. Goals should be clear, measurable, and achievable within a set time frame. Comprehensive coordinated care can lead to successful outcomes.

Comorbid Mental Health Issues Related Questions:

What are the comorbid conditions frequently associated with ASD?
There are several comorbid conditions frequently associated with autism spectrum disorder including attention deficit hyperactivity disorder (ADHD). More than half of all individuals who have been diagnosed with autism spectrum disorder also have signs of ADHD. ADHD is the most common comorbid condition in children with autism spectrum disorder. Other common comorbidities include anxiety disorders, particularly social anxiety disorder, obsessive-compulsive disorder, and generalized anxiety disorder. Depression is also a frequently comorbid condition.

How to assess anxiety vs ADHD in ASD patients?
First, a thorough history can help differentiate between anxiety versus ADHD. Symptoms of ADHD tend to be present in early childhood whereas anxiety might present later on during school-age years. ADHD leads to difficulty regulating attention, hyperactivity, and impulsive behaviors. Often parents may come with concerns for "inattention " and it becomes important to understand what is going on for the child when they try to engage in a non-preferred task. If they are inattentive because they are preoccupied with random racing thoughts then you might want to further explore ADHD. If they are inattentive because they are preoccupied with worries about the task, past events, future events, etc.. then you may want to explore anxiety.

How to assess anxiety vs ADHD in ASD patients? (cont'd from previous page)
Utilizing screeners such as the Vanderbilt and SCARED can certainly help you to differentiate whether the symptoms are due to anxiety versus ADHD. If the patient has comorbid anxiety and ADHD, and you are deciding which to treat first, ask the parents what the most problematic issue is in their opinion, and then go from there. If it's a profound level of anxiety that might be contributing, that might be a good place to start. If it's the difficulty at school/being able to focus and academics, that might be a good place to start. If they are unsure, many times treating ADHD can help with a lot of the difficulties and takes a shorter amount of time to see results and relief.

For a child diagnosed with anxiety and/or ADHD, for whom you suspect has ASD, what are the benefits of ASD diagnosis for a school-aged child?
Diagnosing ASD in children with anxiety and/or ADHD can be beneficial in clarifying their profile so that they are receiving appropriate strategies and interventions in order to optimize their functioning. Consider to what degree the child's challenges are interfering with their functioning. For our kids with ASD, the primary problem is social interaction, and sometimes the anxiety is secondary to that difficulty with social interaction. If you were to just think of it as anxiety and treat that, it may not get better- you may wind up changing medications and losing time, what the child needs may be medications and other supportive interventions targeting ASD.
In addition, addressing ASD with the school would allow for accommodations and modifications that could be beneficial in reducing the intensity or frequency of symptoms which might then reduce the need for medication or the amount of medication. Thinking about the size of the classroom, sensory stimulation, thinking about transitions in the course of the day, are just some examples of changes that can be made throughout the child's day that would reduce anxiety for performance situations.

What is a good medication for autistic teens who have anxiety?
Several children with autism tend to have comorbid anxiety disorders such as social anxiety disorder, generalized anxiety disorder, and obsessive-compulsive disorder. The only FDA-approved medication for generalized anxiety disorder in children seven and older is Cymbalta; however, it is not common practice among child and adolescent psychiatrists to use Cymbalta as a first-line agent. SSRIs can be very beneficial for children with autism who have comorbid anxiety. Due to the CAMS study, sertraline is a common first-line agent.

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Questions?
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