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Daniel Carlat, MD

Editor-in-Chief

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Learning objectives for this issue:

1. Discuss the available options for treatment of autism in children through medication. 2. Describe practical solutions for diagnosing and treating autism. 3. Evaluate some changes in the field regarding child psychiatry diagnostics and treatment.

Medication Strategies for Helping People with Autism Spectrum Disorders

Joshua Feder, MD, child and family psychiatrist with an active clinical practice in Solana Beach, California

Dr. Feder has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Getting meds just right is challenging in autism. Sometimes we succeed. For example, a woman with minimal verbal ability is extremely aggressive. She is on a number of medications including valproate 1000 mg extended release, paroxetine 40 mg, ziprasidone 40 mg twice a day, alprazolam 1 mg twice a day, and a host of

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In Summary

- Because no two patients with autism are alike, psychiatrists must consider both FDA-approved drugs for treatment of autism as well as understand off-label medications.
- Determining the right medication for the individual patient is a case-by-case process of identifying specific target symptoms.
- The role of the psychiatrist in assessing and treating autism is unique in that it is often the next-line referral, and also critical in establishing a diagnosis.

Evaluating and Treating Autism: Practical Issues

Alex Kolevzon, MD

Associate Professor of Psychiatry and Pediatrics at Mount Sinai Hospital, New York, NY

Dr. Kolevzon has disclosed payments for research support from Neuren Pharmaceuticals for NNZ-2566 (an investigational drug for Rett Syndrome) and Hoffman-La Roche for RO5285119 (an investigational drug for autism). Dr. Carlat has reviewed this interview and found no evidence of bias in this educational activity.

Q&A
With the Expert

CCPR: Dr. Kolevzon, by the time a patient with autism walks into our office, that patient may have already been seen by other professionals. What is the particular role of a child psychiatrist?

Dr. Kolevzon: Child psychiatrists play something of a unique, and critical, role within autism, and as you said, we are often the next-line referral. Sometimes the patient goes from a general pediatrician to a developmental pediatrician or to a child psychiatrist or sometimes to a pediatric neurologist. There is a lot of overlap in the roles of all three of these medical specialties. And the critical role initially is to establish the diagnosis. While we may not be able to establish the diagnosis by ourselves, we should act as a team leader and bring the right people to the table. This is something I do all the time, and once I bring this expertise together, I can be fairly confident that a given child has autism.

CCPR: So let's say you are referred a 4-year-old kid from a pediatrician with a concern about autism. How can you be certain that this truly is autism and not some other condition that may be masquerading as autism?



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Medication Strategies for Helping People with Autism Spectrum Disorders

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supplements. She settles down considerably when her compliance-based behavioral intervention is replaced with a developmental approach: The new team listens to her, and they build on her ideas to engage her in a collaborative relationship. The team eases her off multiple medications, leaving her on a low dose of risperidone, and she does well.

It doesn't always work out so well. In another case, a young boy requires constant supervision, often by more than one person, to keep him from running into streets and climbing onto high

banisters. Multiple medications haven't worked, nor have any other treatment approaches. He has been tried on doses of aripiprazole up to 30 mg with no clear benefit; 1200 mg of oxcarbazepine, which gave him loss of motor tone; and 60 mg fluoxetine, which has only made him more impulsive and active and caused him to care even less about things or people. We keep trying, but he may require a restrictive placement.

Choosing meds: A practical approach

As these vignettes illustrate, no two people with ASD are alike, meaning that our medication choices have to be individualized even more so than in most other psychiatric syndromes. Only two medications, risperidone and aripiprazole, are FDA approved for ASD, and these approvals are limited to one specific set of symptoms—irritability/aggression. We must choose from a range of off-label meds to treat the wide variety of issues.

When I evaluate a patient with autism, here's my approach.

1. Identifying specific target symptoms

In my experience, there are 12 categories of symptoms that might respond to a variety of treatments, including medications (see Autism Treatment Planning Chart on p. 3). In real patients, it's not always easy to distinguish these symptom clusters.

- I talk to as many informants as possible, including parents, teachers, and therapists, and in collaboration with parents we try to prioritize the symptoms.
- While I refer patients for a general physical exam, I do vitals and a screening neurological exam. I also generally get a CBC, chemistries, fasting lipids and glucose, a genetic CMA (chromosome microarray assay) screen, look at metabolic and nutritional status, and consult others as indicated. I often get an EKG for neuroleptics, and I consider a 24-hour EEG.
- Before prescribing anything, I make sure that all of my patients have appointments for occupational therapy assessment, speech and language assessment with attention

to nonverbal communication, and developmental testing.

- I gather as much specific symptom data as possible, such as frequency, severity, and duration of difficult moments, as well as the circumstances surrounding them. I often work together with parents to design an individualized template for tracking symptoms.
- I have parents keep detailed sleep logs that include bed time, activities before bed, food, medication, and time to sleep and awakenings at night along with the outcomes of those awakenings (eg, child comes to parent's bed, child easily redirected back to bed, etc).

2. Choosing the right medications: A case-based discussion

The most common candidate medications for ASD are alpha agonists, stimulants, SSRIs, neuroleptics, and anti-epileptics. Because there are so many symptoms and so many possible treatments, I often use the Autism Treatment Planning Chart to help guide my decision making.

Here's how I treated a 10-year-old boy with ASD who presented with symptoms of anxiety, inattention, over-activity, depression, perseverative thinking, sensory sensitivity, and tantrums.

Alpha agonists. I began by prescribing an alpha agonist. These medications are often my first choice, because they reduce the 'fight-flight' response by shifting autonomic function to give parasympathetic tone more of an edge over sympathetic tone. They can also help ease anxiety and tics.

I started with guanfacine 0.5 mg at night, and gradually increased it as needed. I try to avoid going beyond 2 mg twice a day and I adjust the dose based on sedation or, rarely, dizziness. I am less impressed by its cousin clonidine, which is far more potent, more sedating, but also short acting, so when used for sleep induction it can lead to rebound wakefulness. On guanfacine, my patient was more able to interact, but otherwise he was still quite symptomatic.

Stimulants. While in the ideal world, ASD patients would not be pre-

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EDITORIAL INFORMATION

Editor-in-Chief, Publisher: **Daniel Carlat, MD**
Deputy Editor: **Talia Puzantian, PharmD, BCPP**, is a clinical psychopharmacology consultant in private practice in Los Angeles, CA.
Executive Editor: **Matt Phillion**

Founding Editor: **Caroline Fisher, MD, PhD**, is training director and Chief of Child Psychiatry at Samaritan Health Systems in Corvallis, OR.

Editorial Board:

Jonathan C. Gamze, MD, is a psychiatrist in private practice in Arlington Heights, IL.

Georgia Gaveras, DO, is the director of training and education in child and adolescent psychiatry and the director of the child and adolescent psychiatry consultation liaison service at Mount Sinai St. Luke's Hospital in New York, NY.

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Jess Shatkin, MD, MPH, is vice chair for education at NYU Child Study Center at NYU School of Medicine in New York, NY.

Dorothy Stubbe, MD, is director of residency training and an associate professor of psychiatry at Yale Child Study Center in New Haven, CT.

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Medication Strategies for Helping People with Autism Spectrum Disorders

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scribed multiple medications, in my practice they often need combination treatment to address their symptoms. For this boy we added amphetamine mixed salts, extended release, at 5 mg in the morning. This seemed to help, but there was still a thorny depressed mood and negative mindset, perhaps a bit worse in the afternoons as he withdrew from the stimulant. To address this, we added an SSRI, fluoxetine.

SSRIs. While studies generally have not shown SSRIs to be helpful for perseveration, there are individuals who respond at times, perhaps especially those who have more classic looking obsessions and compulsions. Similarly, while some people worry about SSRIs and suicidal ideation, I find these meds sometimes critically helpful in treating depressive symptoms, particularly suicidal ideation, in children and adolescents with ASD. They can help with anxiety as well.

However, most patients show some degree of behavioral activation on SSRIs, so dosing needs to be extremely gradual, and here we started with 5

mg fluoxetine. Even at this low dose, he became somewhat activated, so we reduced to 2.5 mg with good results. There are a couple of other potential side effects to keep in mind. First, a recent study (<http://www.medscape.com/viewarticle/842606>) found that normal doses of SSRIs can increase seizure risk, and patients with ASD are already prone to seizure activity. Second, while not relevant for this young boy, sexual side effects can actually be beneficial for people with ASDs who are struggling to control their libido.

Neuroleptics. Because he still had a lot of irritability, we added a small dose of neuroleptic. In my experience, haloperidol, risperidone, aripiprazole, olanzapine, and quetiapine all may be effective in helping people with ASDs to have less reactivity and, occasionally, far more clarity and complexity of thought. I have had less luck with medications that do not increase appetite, such as ziprasidone and lurasidone. Since these meds can cause cardiac rhythm changes, I get an EKG in addition to monitoring fasting lipids and glucose. I screen for

abnormal involuntary movements using the AIMS if possible at a minimum of every six months, and I educate families about the possibility of neuroleptic malignant syndrome. In this case, we used 2 mg of aripiprazole and ended up in a common clinical dilemma because the medication was incredibly helpful but it caused an insatiable appetite and weight gain.

Anti-epileptic drugs (AEDs). Because of the weight gain, we discontinued the aripiprazole and tried an AED. Beyond treating seizures, many AEDs are used to treat irritability, but each has its potential issues. Valproate can be very helpful but requires careful monitoring of levels and liver function. Lamotrigine has few side effects beyond the serious though rare Stevens-Johnson Syndrome. Oxcarbazepine can reduce motor tone, leading to floppier posture. Gabapentin is very benign and can be helpful for anxiety and for sensory hypersensitivity. Topiramate can reduce perseverative thinking and typically reduces appetite, but may interfere with word finding,

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Autism Treatment Planning Chart

Targets	Overactivity	Attention*	Anxiety	Cognition*	Depression	Aggression/ Irritability	Motor Planning	Rigidity Perseverative	Reciprocal Interaction	Sensory Sensitivity	Tics	Sleep	Main Side Effects**
Central Alpha Agonists	+	+	+	+/-	+/-	+/-	+/-	+	+	+	+	+	Sedation Blood pressure
Stimulants	+/-	+/-	-	+/-	-	-	+/-	-	+	-	-	-	Weight Height Tics
SSRIs	-	-	+/-	+/-	+	+/-		+	+			+/-	Overstimulation Seizures
Neuroleptics	+	-	+	+/-	+	++	-	+	++	+	+	+	Weight Seizures Tardive dyskinesia Neuroleptic malignant syndrome
Anticonvulsants	+	+/-	+	+/-	+	++	-	+	+	+	+	+/-	Multiple side effects

Notes

++	Very likely to be helpful for given symptom
+	Likely to be helpful
+/-	May help, may worsen
-	Unhelpful, may worsen
No mark	Probably not applicable
	*Attention refers to the basic ability to attend; cognition refers to more abstract processes such as insight or understanding
	**Side effects listed are not comprehensive but are reminders of particularly important side effects to consider

Expert Interview
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Dr. Kolevzon: The core deficit in autism is the social cognitive deficit. There are a number of features around repetitive behaviors and anxiety that can as you say masquerade as autism, but I am looking very carefully at social engagement, social attention, eye contact, responding to name, reciprocal play. And you want to rule out all these other types of problems. Kids can have a lot of anxiety and social phobia, for example, which can masquerade as autism. They can have ADHD and attentive, impulsive types of symptoms that impair their social function dramatically and can look like autism. And then there are a whole host of other developmental disorders.

CCPR: What kinds of behaviors do you see in your office that cause you to zero in on autism as opposed to other disorders?

Dr. Kolevzon: One of the key features of autism that you can pretty dependably see in the office is a deficit in shared attention, also known as joint attention. A good way to diagnose this is to point at various things and see how the child responds. You make sure the child is looking at you and then just point out the window and see if the child follows your gaze. In that situation, almost all kids, even kids with ADHD, will divert their attention and follow your gaze and look out the window with you. But kids with autism are completely oblivious to it. Or you ask the child, “Where is your mom?” Do they look at their mom? If you point at her, will they follow your point? Or you ask them to point at something “orange” in a picture. Remarkably, a child with autism will not be able to point to orange, even if you are looking right at the color.

CCPR: That is fascinating. What do you think is happening in their world, in their mind, when they are not following your gaze?

Dr. Kolevzon: This is one of their core social cognitive deficits. They have significant impairment in their capacity to take the perspective of somebody else. What is going through your mind or your internal emotional state are very mysterious to them. They are not particularly interested in what you are doing; it doesn’t have the same salience to them. They don’t recognize emotional expressions or the tone of your voice; they may not even recognize basic facial expressions.

CCPR: What else do you do to elicit diagnostic behavior?

Dr. Kolevzon: You can just call their name. If you call their name and they don’t respond, that is pretty specific to autism. Kids with ADHD may not respond quickly, but they will respond. Also, kids with autism will not imitate reflexively: If you clap, they should clap, and so on; kids with autism may not.

CCPR: What about deficits in language development? How do you pick up on that?

Dr. Kolevzon: There are two levels of that. The first is just not developing language appropriately—for example, they are not using single words by 12 months, or they do not have phrased speech by 36 months. Or if they are fluent in their speech and they are able to use phrases, for example, they might use scripted phrases; they might use phrases inappropriately; they may have trouble going back and forth in a conversation. So you can ask them a question and they can answer it, but then there are not any follow-up questions.

“The core deficit in autism is the social cognitive deficit. There are a number of features around repetitive behaviors and anxiety that can as you say masquerade as autism, but I am looking very carefully at social engagement, social attention, eye contact, responding to name, reciprocal play.”

Alex Kolevzon, MD

CCPR: Give me an example.

Dr. Kolevzon:

“What did you do today?”

“I ate lunch.”

“What did you have for lunch?”

“I had French fries.”

That is it. In normal back and forth speech, someone will reciprocate and ask you, “What did you have for lunch?” There will be some sort of shared engagement, but that doesn’t happen in autism. You can even say something like “Tell me what kinds of food you like to eat?” And they will give you kind of a one-word answer: “I like French fries.” They will just repeat the same thing. This goes back to the social deficit. Language is our social currency, and if social interaction doesn’t have meaning for you, then you are much less likely to use the social currency.

CCPR: How do you communicate the diagnosis to the parents?

Dr. Kolevzon: More often than not, by the time parents actually get a referral to a specialist they are relatively convinced that something is wrong, so often there is a sense of relief. “Oh, now I have a name for this and a plan for what to do. All along I sort of knew something was off, but now you are giving me a universe where I can focus my energy; I have a map of the road ahead, and I have a whole community that I can relate to.”

CCPR: But what do you say to parents who ask how you know their child has autism?

Dr. Kolevzon: That can be challenging, because in fact autism is a completely artificial diagnosis. It is just a collection of behavioral symptoms, and the diagnosis is made irrespective of etiology, and whatever behavioral symptoms we identify cross a dozen different diagnostic boundaries like many other diagnoses in psychiatry. Parents will sometimes get frustrated when I tell them that I know it is autism “because it fits the diagnostic criteria.” But in fact the criteria just changed two years ago [Editor’s Note: See sidebar on p. 5 for more on these changes], and they changed 15 years before that.

CCPR: When families ask me to explain what autism is, I find I am really not sure what to say.

Dr. Kolevzon: That’s because there is no one “autism.” There is a famous quote: “if you’ve seen one child with autism, you’ve

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The Autism Diagnostic Shuffle

Daniel Carlat, MD, Editor-in-Chief, Publisher, The Carlat Child Psychiatry Report

Autism is the poster child for the dramatic effects that changes in diagnostic criteria can have on apparent prevalence rates of disorders. CDC reports that the prevalence of autism was 0.05% in 1980, vs. 1.5% in 2015—a 30-fold increase. Most agree that diagnostic changes, especially DSM-4, drove this “epidemic.” Let’s look at the three most important benchmarks in autism diagnosis history.

DSM-3

DSM-3 was published in 1980, and the diagnosis of “infantile autism” required *all* of the following:

- Onset before 30 months of age
- Pervasive lack of responsiveness to other people
- Gross deficits in language development
- Peculiar speech patterns such as immediate and delayed echolalia

These days, such criteria would apply to only the most severe cases of autism.

DSM-4

With DSM-4’s publication in 1994, diagnosing autism became more complicated, and paradoxically, much more likely. The updated manual included an umbrella category called “pervasive developmental disorder,” and it encompassed five conditions related to autism: autistic disorder, Asperger’s disorder, Rett’s disorder, childhood disintegrative disorder, and for not qualifying for any other diagnosis, PDD not otherwise specified.

Focusing specifically on “autistic disorder,” DSM-4 introduced the well-known triad of symptoms: impairment in social interaction, impairment in communication, and restricted, repetitive behaviors or interests. Each of these symptoms included 4 items (for a total of 12 items), and a child met the autism threshold if 6 of the 12 were met. Gone were the DSM-3 requirements of gross language deficits, pervasive lack of responsiveness, or bizarre responses to the environment. Instead, DSM-4 proposed symptom domains that varied widely in severity. It was inevitable (and perhaps reasonable) that clinicians would bring many more children into the autism fold.

The most problematic aspect of DSM-4 was that the separate disorders were too similar to be reliably diagnosed.

DSM-5

DSM-5 was published in 2013, and the neurodevelopmental disorders work group decided to make some pretty drastic changes. First of all, since DSM-4’s publication, Rett’s syndrome was shown to be a genetic neurological disorder, so that diagnosis has been eliminated from DSM and is now under the purview of pediatricians and neurologists. More significantly, there was a scientific consensus that the other four DSM-4 autistic disorders were actually a single disorder that varied in severity in two core domains.

Therefore a new label was created, autism spectrum disorder, and the following DSM-4 disorders were lumped into this new category: autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and PDD not otherwise specified. Don’t look for any of these in DSM-5—they’re gone.

A third major change was to truncate the symptom triad into a dyad. Since all communication is social, separating communication from social interaction didn’t make sense. So there are now two major symptoms categories: 1) impaired social communication and social interaction, and 2) restricted, repetitive patterns of behavior or interest.

A child who qualifies for both of these impairments now falls on the autism spectrum, and your next step is specifying

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Autism Diagnosis: DSM-5 vs DSM-4			
	DSM-5	DSM-4	Main differences
Labels	Autism spectrum disorder	Autistic disorder, Asperger’s disorder, Rett’s disorder, childhood disintegrative disorder, and PDD not otherwise specified	DSM-5 lumps all DSM-4 categories under ASD, except for Rett’s syndrome, which is removed from DSM.
Key impairments	1. Social communication and social interaction 2. Restricted, repetitive behaviors or interests	1. Social interaction 2. Communication 3. Restricted, repetitive behaviors or interests	DSM-5 combines social interactions and communication into one criterion.
When symptoms start	“Early developmental period”	Before age 3	DSM-5 does not specify an age at onset.
Severity specifiers	Level 3: Requiring very substantial support Level 2: Requiring substantial support Level 1: Requiring support	Optional use of Global Assessment of Functioning	DSM-5 substitutes more specific specifiers for GAF, which is no longer used in DSM.

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which can be problematic for this population. In this case we tried topiramate 25 mg, gradually increasing to 50 mg twice a day, with reasonable results in reducing both irritability and some of the perseveration.

3. General guidelines that may be helpful

Regardless of which meds you recommend, here are some things to keep in mind—based on long, humbling experience.

- Whenever we medicate a child, the team often becomes overly focused on medication, failing to look at other system problems. For example, a child who is reacting to parental separation may need more time in therapy rather than a new pill.
- People with ASDs may have more

sensitivity to medication, and families frequently want to stop a medication early when anything seems amiss. So make sure the team is aware of possible side effects ahead of time.

- Start lower and go slower than usual when treating this population, and avoid multiple changes and big dosage alterations that can be poorly tolerated and cause confusion about what is or is not working.
- Predict that if things get better, there will still be tough times when people may throw up their hands saying “nothing works.” If you’ve carefully documented the initial target symptoms, it will help you remind caregivers that there has been overall progress.
- When the results are not clear after

a decent trial, I ease down on a medication in a gentle on-off-on trial to help assess whether a medication is helping.

CCPR
VERDICT:

Meds for autism: A complex art and science.

Seeking Contributors

We’re looking for experts for articles, research updates, and books for all three of our newsletters (general psychiatry, child psychiatry, and addiction treatment).

If you’re interested, please contact Executive Editor Matt Phillion at mphillion@thecarlatreport.com.

Expert Interview

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seen one child with autism.” because it is so heterogeneous. The core features of autism are behaviorally defined where there are clearly social cognitive impairments, language delays, and repetitive behaviors. The debate is how specific that is because these kids all look so different.

CCPR: What can be done after the diagnosis is given to the parents? What’s the next step?

Dr. Kolevzon: That really depends on what is going on with the child. You basically select your target symptoms, and some of these symptoms will require educational interventions, some of them require behavioral interventions, some of them require speech and language interventions, some of them require physical therapy, some of them require parent support and sibling support, and some of them require medication.

CCPR: That’s a lot of work!

Dr. Kolevzon: It feels like a lot to land on the psychiatrist, but a lot of it gets farmed out. You establish the diagnosis. Then you establish the IQ and the adaptive functioning. That gets incorporated into an educational plan, which dictates where the child goes to school, and that educational plan also incorporates things like speech and language therapy, and social skills training, and counseling, and it is the whole package. From the psychiatrist’s perspective, a significant amount gets referred out with the psychiatrist acting as team leader and someone the family consults with.

CCPR: What would it mean for me to be the team leader when I am just sort of doing one small piece, say the medication piece?

Dr. Kolevzon: It means that you are overseeing everything and you are making sure that this kid is making gains and staying on track, and if the school isn’t doing its job you are writing a letter; you are forcing them to update an IEP meeting. If the psychologist is sort of missing a piece that the family is concerned about, you are speaking with the psychologist and trying to jigger the treatment plan a little bit.

CCPR: What are the elements that you are trying to assess at every visit?

Dr. Kolevzon: There are a lot of medical issues that can be part of the etiology, so I am often checking in on problems like seizures, cardiac issues, kidney problems, gastrointestinal problems, and so on. I’ll ask about specific psychiatric symptoms if I am using medicines to target them, such as attention deficit, anxiety, irritability, and aggression. And then I’ll check in on educational issues—what is going on in school, are they making appropriate gains? I also tend to ask about the family functioning in general. How is the sibling doing with all this? How are the parents feeling about all this? Is the family starting to feel more and more isolated because their friends don’t want to hang out with them because their kid is so difficult, so are there additional sort of family supports you can recommend? It sounds like this is a very comprehensive and idealized process, but the reality is that these are things that you want to keep track of, and I do think that as a “team leader” it is the physician’s job to pull all these pieces together.

CCPR: We always like to get experts’ philosophies about medications. There are only two FDA-approved meds for autism: risperidone and aripiprazole.

Dr. Kolevzon: As a result of the FDA approvals, these two medicines have turned into first-line treatments, and more often than

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on p. 1.

1. Only two drugs are currently FDA approved for autism, and these drugs are only approved for one specific symptom: (Learning Objective #1)
 a) Impulsivity b) Short attention span c) Irritability/aggression d) Hyperactivity
2. While studies have generally not shown _____ to be helpful for perseverance, there are individual patients who respond at times, particularly those autism patients who have more classic obsessions and compulsions. (LO #1)
 a) Alpha agonists b) SSRIs c) Neuroleptics d) Anti-epileptics
3. While there are numerous other diagnoses that can masquerade as autism, the core identifier is what symptom? (LO #2)
 a) Social cognitive deficit b) Anxiety c) ADHD d) Poor impulse control
4. The criteria for diagnosing autism changed 15 years ago, and again even more recently, _____ ago (at the time of publication). (LO #2)
 a) Six months b) One year c) Eighteen months d) Two years
5. A major feature distinguishing DSM-5 from DSM-4 is _____ (LO #3).
 a) DSM-5 combines four diagnoses within autism spectrum disorder b) DSM-5 requires bizarre behavior or responses
 c) DSM-5 requires onset before 30 months d) DSM-5 introduces a specific triad of symptoms

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Expert Interview

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not people are too quick to prescribe these medicines. Normally when I end up recommending risperidone or aripiprazole, the family is kind of desperate. When kids are aggressive to the point where they are going to hurt themselves or somebody else, that is an appropriate use of risperidone. It's also appropriate if they're in danger of getting kicked out of school or if they're psychotic. But for anxious, irritable, pain in the ass kid who can't tolerate changes in routines, I would want to start with things that reduce anxiety or impulse control problems. [Editor's Note: See p. 1 for more on medications and autism.]

CCPR: Do you see a big difference between risperidone and aripiprazole in terms of side effects?

Dr. Kolevzon: Not really. It is not like aripiprazole doesn't cause weight gain and metabolic problems; it does. There have only been two really large, well-done studies of aripiprazole. There have probably been a dozen with risperidone, and it clearly causes weight gain and it clearly causes dystonia and those kinds of problems. I do think the metabolic risks are a little bit lower with aripiprazole, but on the other hand I believe aripiprazole is a little bit less effective than risperidone. So once I'm there I usually start with risperidone because I don't think aripiprazole has some massive advantage over risperidone by any means.

CCPR: When you are looking at anxiety, what kind of meds do you tend to reach for?

Dr. Kolevzon: I will use SSRIs and nonstimulants, such as extended-release guanfacine, clonidine, even atomoxetine, which can bring their anxiety down and enhance their attention, and improve their impulse control. For ADHD hyperactivity-type symptoms, I use stimulants all the time. There are plenty of studies that suggest methylphenidate is extremely effective. And then for the kind of more irritable, aggressive kids, I use antipsychotics or I use anticonvulsants like divalproex sodium.

CCPR: And then within the SSRIs, are there any in particular that you have found easier to prescribe or more effective?

Dr. Kolevzon: I go with the safety data in pediatric populations in general, so Prozac and Zoloft are usually my go-to medications because we have so much more experience with them. They also both come in liquid, allowing you to use miniscule doses. The key thing when you treat kids with autism is you have to acknowledge that overall the response rates are lower than they would be in typically developing kids with anxiety or ADHD, so don't expect necessarily the same effect. And then also they are exquisitely sensitive to side effects so that you really want to start at much lower doses than you otherwise would.

CCPR: Thank you, Dr. Kolevzon.

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This Issue's Focus:

Autism

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The Autism Diagnostic Shuffle

Continued from page 5

the degree of severity, which is based on a judgment of how much treatment support the child will need (see table for details).

Finally, a new disorder was carved out called social communication disorder—reserved for people with impairment in social communication and interaction but without any restricted repetitive behaviors. The thought was that this might become a new diagnostic home for those patients formerly diagnosed with Asperger's syndrome.

The DSM-5 changes were greeted with concern in some quarters because of studies indicating that the new criteria could substantially reduce autism diagnoses. The jury is still out, but one recent study found that the vast majority of patients with DSM-4 autism met criteria for DSM-5 ASD or for the new SCD (Kim YS et al, *JAACAP*;53(5):500–508).

**CCPR
VERDICT:**

Autism spectrum disorder: A simpler and probably more useful label for diagnosing a complex problem.

References:

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV*. (4th ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- See also this very comprehensive comparison chart: <http://bit.ly/1HJPFom>

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