

Comorbid psychopathology with autism spectrum disorder in children: An overview

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Abstract

Comorbidity, the co-occurrence of two or more disorders in the same person, has been a topic receiving considerable attention in the child psychopathology literature overall. Despite many publications in the ADHD, depression and other child literatures, autism spectrum disorder has not received such scrutiny. The purpose of this review will be to discuss the available evidence. We address specific variables in diagnosis and classification of comorbid symptoms, and propose potential avenues for research and practice with respect to differential diagnosis. A brief discussion of the implications for treatment is also provided.

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Comorbidity, defined here as the occurrence of two or more forms of psychopathology in the same person, has received a considerable amount of attention in the child literature. Perhaps the most prominent of these areas of research focuses on attention-deficit/hyperactivity disorder (ADHD) where comorbidity has been reported to be as high as 50% (Anderson, Williams, McGee, & Silva, 1987; Bird et al., 1988; Caron & Rutter, 1991). Similarly, for those ADHD children referred to a clinic, 87% have a comorbid condition and 67% have two or more additional forms of psychopathology (Kadesjo & Gillberg, 2001).

Other childhood disorders have also been studied, although to a lesser degree. Angold, Costello, and Erkanli (1999) for example, found that comorbidity between depression with

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ADHD, anxiety or conduct/oppositional defiant disorder was common. Similarly, children and adolescents with eating disorders are likely to exhibit a variety of psychopathology with comorbidity rates as high as 90% (Lewinsohn, Striegel-Moore, & Seeley, 2000). Substance abuse, anxiety and mood disorders appear to be the most common comorbid conditions (Grilo, Levy, Becker, Edell, & McGlashan, 1996). Perhaps not surprisingly, multiple disorders present in the same person result in more frequent mental health referrals compared to children who evince only one disorder (Mash & Barkley, 2003).

Comorbidity in the assessment of autism spectrum disorder (ASD) is a topic that has infrequently been addressed, particularly when compared to the childhood disorders noted above. When the topic has been discussed, it has often been in the context of ASD with intellectual disability (ID) since, with the exception of Asperger's syndrome, these two conditions co-occur frequently, and symptoms of autism, particularly language delays, stereotypies, and self-injury, increase as the severity of ID increases (Wing & Gould, 1979). For the purposes of this review, we will forgo that discussion and focus on specific forms of emotional problems and challenging behaviors which constitute DSM-IV diagnoses, such as self-injury, stereotypies, and conduct disorder. However, the reader should be aware that disagreement exists over whether many of these diagnoses warrant separate categories or should be viewed as symptom clusters of ASD (AACAP, 1999). Autism can be distinguished from psychosis while stereotypy and self-injury are not differentially diagnostic between autism and ID (Matese, Matson, & Sevin, 1994; Sevin et al., 1995). Given that they are not diagnostic of ASD, but may co-occur with the disorder, describing these behaviors as comorbid conditions versus core features of an ASD appear to be more consistent with the data.

Some researchers have debated over whether comorbidity, at least with some disorders, has perhaps slowed the development of knowledge in this area. However, the notion that "standard diagnostic instruments should be employed to delineate impairment, including the full range of diagnosable disorders," has been asserted (Kazdin, 1993). Kazdin (1993) made these remarks with respect to treatment outcome research with ASD. However, diagnosis would appear to be equally applicable with respect to this point. An additional confounding variable is the complexity of diagnosing ASD and its various subtypes in children, the majority of whom are also ID (Long, Wood, & Holmes, 2000).

While Asperger's does not involve ID, the more prevalent conditions of PDD and autism do involve high rates of the latter condition. Autism in particular has been studied in relationship to ID and occurs in most cases (Folstein & Rutter, 1987; Ritvo et al., 1989). In the latter study, 66% of their sample of autistic children scored below 70 on an I.Q. test.

Given the overlap in ASD and ID, it is difficult and perhaps not particularly profitable to discuss issues of psychopathology that occur conjointly in one of these conditions taken alone. In fact, many of the same factors that make definition and diagnosis difficult with one, applies to another. And, with the exception of Asperger's syndrome, most cases will involve ASD and ID together. Second, it is asserted that diagnosing comorbid psychopathology in these persons is appropriate, although the symptoms may vary from those seen in the general population. At present it seems reasonable to conclude that issues of comorbidity are poorly understood (Matson & Barrett, 1982; Ghaziuddin, Ghaziuddin, & Greden, 2002). Third, there is considerable heterogeneity in symptoms of ASD. This variability leads to additional complications regarding what constitutes core symptoms and whether the disorder should be conceptualized on a dimensional scale with subtyping of ASD or whether distinct disorders within the continuum of ASD should be specified (e.g. PDD-NOS, autism, Asperger's syndrome) (Sturmeijer & Sevin, 1994; Szatmari, Volkmar, & Walter, 1995).

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