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Supporting anxiety and depression in autistic people

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Session outline

- Is there a relationship between autism, anxiety and depression?
- Recognising the signs of anxiety and depression in autism
- Tips for preventing or ameliorating depression – what can you do at home and at school to help?
- What treatment options are there?

Prevalence

- Thiele-Swift & Dorstyn 2023 Meta-analysis
- Community sample of sample of 4459 autistic young people 1 in 3 experience clinically elevated anxiety symptoms whilst 1 in 5 are diagnosed with a disorder, most commonly specific phobia, social anxiety, and/or generalised anxiety
- Hollocks et al 2018 – systematic review
- Pooled estimation of current and lifetime prevalence for autistic adults were 27% and 42% for any anxiety disorder, and 23% and 37% for depressive disorder.



How does anxiety present in autism?

- Very common presenting problem
 - Typical and also autism-specific presentations of anxiety
 - Autism-specific pathways to anxiety
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Causes

Typical:

- Worries about social expectations/judgments
- Worries about not meeting demands
- Typical fears

autism-specific:

- Worries about changes to routine and new situations
- Social fears but not driven by fear of social negative evaluation
- Sensory over-stimulation, unusual fears
- Being prevented from engaging in repetitive behaviour or focused interests
- School as a theme throughout

Signs and symptoms of anxiety

Somatic:

- Changes in eating and sleep
- Increase in arousal
- Escape, avoidance, reassurance, safety behaviours

autism-specific:

- Distressed behaviour or withdrawal
- Increase in sensory, repetitive behaviours
- Increase in socially inappropriate behaviours
- Behavioural rather than verbal communication of anxiety

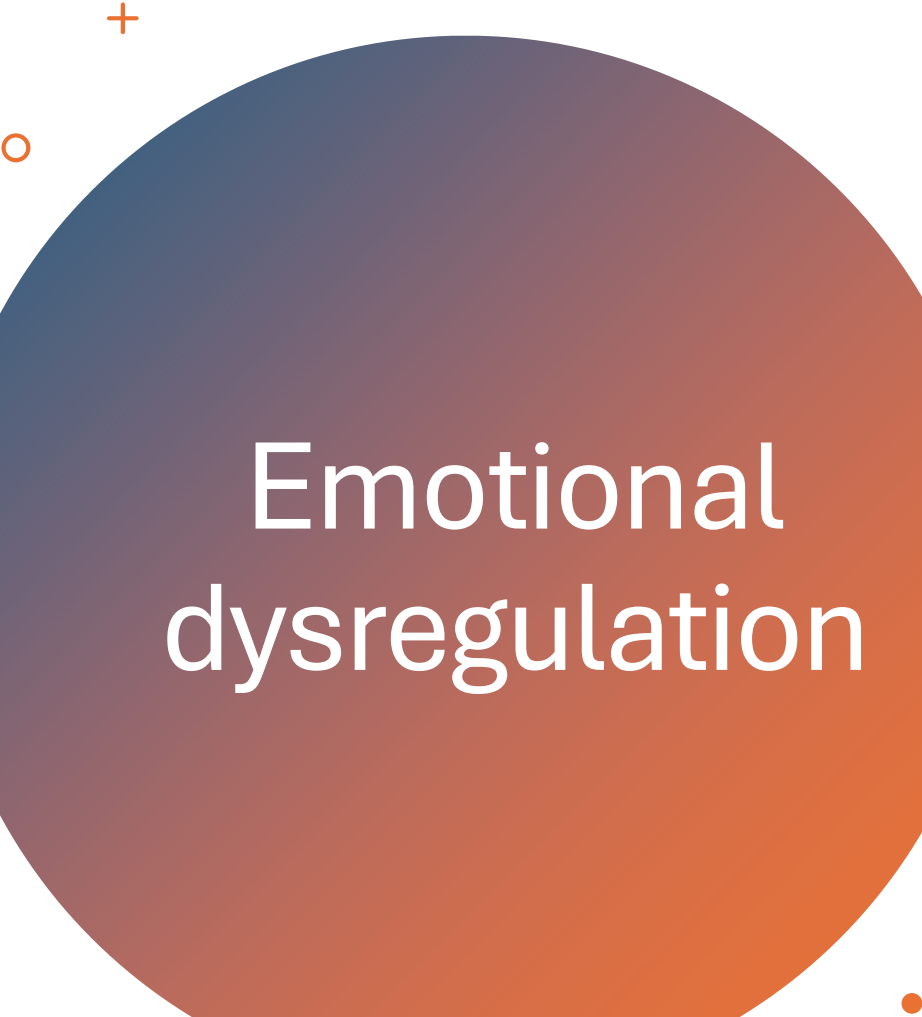
Aetiology- pathways to anxiety and depression

- Genetic – temperamental factors
- Neurobiological – medication may assist
- Psychological – therapy may assist
- Social/environmental factors- the most important starting point

Pathways to anxiety and depression

Autism-related challenges include:

- **Social challenges – anticipatory anxiety about being around people**
- **Intolerance of uncertainty/cognitive flexibility – a two way relationship with anxiety**
- **Alexithymia**
- **Sensory over-and under-responsiveness – also a two-way relationship**
- **Environmental factors can include: peer rejection, social isolation, inappropriate school placement**
- **Which can lead to perceived failure, loss of self-esteem, shame around behaviour – and lead to depression**
- **Anxiety can also lead to emotional dysregulation, and vice versa**



Emotional dysregulation

May present as:

- **Meltdowns**
 - **Irritability**
 - **Aggression**
 - **Self-injury,**
 - **Impulsivity**
 - **Rumination**
 - **And anxiety**
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Differences in presentations in those who speak few words

- Fewer than one might think
- Difficulty communicating causes of anxiety and internal experience
- Loss of skills or needing more prompting to use skills
- An increase in repetitive behaviours or movements
- Social withdrawal
- Irritability
- Avoidance
- Agitation, pacing, rocking, trembling for no (apparent) reason
- Aggression towards self, or others
- Loss of interest in activities they usually enjoy.

Depression in autism

Environmental risk factors:

- Inappropriate educational placement
- Lower perceived social support and social satisfaction
- Life stress/trauma - Autistic children experience many more adverse childhood events than neurotypical peers.(Kerns et al, 2017)
- Studies have shown that a lack of understanding of autism by the society as a whole is a significant factor that autistic people identified as contributing to depression as well as carers of autistic people less able to express themselves.
- Living with high levels of anxiety can cause depression

Identifying depression

- Communication differences and alexithymia may render accurate identification of depression challenging.
- Adapting assessment modalities, thorough information gathering and and also knowledge of autism-specific presentations are essential for best practice
- Indicators include:
 - Lowered mood, increased irritability
 - Changes in focused interests (Decreased pleasure in, increased intensity, change to darker/morbid content)
 - Increased repetitive behaviours
 - Increased anxiety or fear of change – increased preference for sameness
 - Increase in aggression or self-injury
 - Loss of skills such as self-care
 - Social withdrawal

Psychological risk factors

- Cognitive inflexibility – via anxiety to depression
- Perfectionism
- Repetitive thinking/rumination - perseverative thinking with a positive or neutral focus can lead to focused interests, positive mood states; a negative focus can lead to low mood and negative attributions characteristic of depression.
- Limited emotion regulation strategies

Differential cognitive style in depression in autism?

- Perhaps more typical than thought – one study found, contrary to pre-conceived ideas, that autistic people endorsed items about abstract concepts such as worthlessness and guilt
- Another study found that the more depressive symptoms the adolescents reported, the more the adolescents explained negative events by internal, stable, and global causes
- However, we know nothing like as much as we do about pathways to anxiety in autism

The role of camouflaging

- Suppressing autistic tendencies and/or effortfully engaging in “typical” social behaviours
- Particularly associated with autistic females, but increasingly recognised that males camouflage too.
- Adaptive camouflaging efforts may help autistic people fit in and avoid a range of social stressors associated with mental health concerns
- But camouflaging is also associated with feelings of not being accepted or belonging in society, which, in turn, increases risk of depression, suicidal thoughts and behaviours

Why is camouflaging associated with poorer mental well being?

- Creates unrealistic expectations
- Identity issues – perception of not being accepted for oneself
- It's exhausting, leads to “Autistic burnout” : a state of basic inability to function, exhaustion, and distress in every area of life. This can lead to depression

Autistic burnout

- The experience of feeling completely overwhelmed, exhausted and unable to function
 - Meltdowns
 - Shutdowns, like a computer going into sleep mode to conserve energy
 - Loss of interest in hobbies and interests
 - Numbness, anxiety and depression
 - Loss of skills such as language, working memory, organisational skills,
 - Sensory overload, heightened emotional experiences

Caused by.... (for example)

- Too much social interaction without down time in between
- Not stimming for fear of being negatively judged
- Taking on too much
- Perfectionism
- Masking

What can we do? Environmental approaches

- Close liaison with school. Reduce unnecessary stressors (detentions for not doing homework). Support for necessary stressors (fire alarms). Adapt, or change the environment if necessary. Typical adaptations include:
 - Visual supports (timetables, clear rules etc) to increase predictability and routine, and help process information
 - Go-to person, go-to quiet place to feel comfortable, reduce social pressures
 - Sensory adjustments such as uniform allowances, fiddle toys, movement breaks, 'den' in the corner of the classroom
 - Discussions around classroom practices such as sanctions, admonishments, expectations around putting hand up, contributing to discussions etc
 - Low arousal environments

Creating an autism-friendly environment

- Will differ greatly from child to child
- For example, for some, having a go-to person, or place might mark them out as 'different'. For others it might be hugely reassuring just to know the support is there, but don't necessarily use it
- For everyone, it will involve those around the child understand autism and 'getting' the child
- An individual support plan/communication passport
- Home-school communication is key

At home – co-regulation

- Warm and responsive interactions that provide the support, coaching, and modelling children need to “understand, express, and modulate their thoughts, feelings, and behaviours” (Murray et al. 2015)
- Modelling and prompting children in using skills to regulate:
 - Through voice – calm, upbeat vocal tones
 - Body language
 - Simplify your language, or stop speaking altogether – perhaps replace with low hums or quiet singing
 - Hugging and rocking (if your child can tolerate being touched in the moment) if not, being present, walking in step with each other, making a cup of tea together
 - Explanations – ‘I will respond as soon as I’ve finished this thing I’m doing’
 - Model regulation in daily life ‘I’m feeling quite cross right now so I’m going to take a deep breath!’

From co-regulation to self-regulation

- Conscious control of feelings
- Teach emotional vocabulary – in calm moments
- Reward signs of self-regulation – either low key praise or a more formal reward system
- Visual reminders of things that work
 - Eg physical strategies such as controlled breathing, squeezes, jumping up and down
 - Sensory strategies
 - Flexible thinking. Eg Plan A and plan B!

What can we do?

- Allow for preferences – not everyone will want to read/learn about autism, others may find it central to their identity development
- Creating a positive environment, eg educating classmates about stimming behaviour – again not everyone will want to do this
- Foster a positive identity

Focus on strengths

- Detail focus
 - Persistence
 - Honesty, authenticity
 - Creativity
 - Pleasurable activities
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- Double empathy

Therapeutic approaches

- CBT
- Third Wave approaches
- EMDR

Key adaptations to therapy

- Knowledge and understanding of neurodivergence
- Sensory considerations
- Structure and predictability – visual or otherwise
- Be mindful of attentional differences, masking, processing time
- Potentially extended period on emotion recognition, relationship building

Therapeutic approaches

- Cognitive behaviour therapy – well delivered, with an understanding of neurodiversity throughout, can be very effective- although not for everyone
- Aims to modify unhelpful thinking of behavioural patterns
- NOT changing the way someone thinks to fit into a neurotypical world
- Thinking patterns associated with anxiety and depression include:
 - All-or-nothing thinking
 - Over-generalisation ‘I will NEVER...I will ALWAYS....’
 - Labelling ‘I’m such a failure, a loser’
- Good therapy will aim to help someone rescript some of their ideas about their identity, and consider issues central to neurodivergence such as masking – where, with whom and how to ‘un-mask’, for example.

Imagery rescripting

- Autistic people – visual thinkers?
 - Images (in difference modalities) are associated with high levels of emotional arousal (fear, disgust, shame)- more than verbal routes. Vivid, distressing.
 - ‘in the moment’
 - Flashbacks and flashforwards
 - Actual memory/distorted reflection of a memory/imagined events
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- Appraisals/meaning attributed to imagery: Eg 'I'm a weak person'; 'I must be a bad person for having these images'; 'I need to be on high alert for danger'
 - Clinically powerful- rich source of information, rapid response to targeted intervention
 - Restructuring or rescripting an image can be a very powerful way of effecting change

Therapeutic approaches – ‘third wave approaches’

- Third wave therapies, are about being mindful of inner experiences and accepting of them - promoting acceptance, compassion, metacognition, flexibility.....

The focus is less on change/amelioration of thoughts and more on the process of thought –non-judgmental observation

- Acceptance and Commitment therapy (ACT), Dialectical Behaviour Therapy (DBT)
- Not a large research evidence base as yet as to the effectiveness with autistic individuals – however some of the principles potentially work well with autistic clients – eg values rather than goals, initially. Cognitive defusion techniques.

Therapeutic approaches- EMDR

- EMDR utilises the natural healing ability of the client's body.
- While focusing on a particular memory, eye movements, similar to those during REM sleep, are recreated simply by asking the client to watch the therapist's finger moving backwards and forwards across your visual field. Sometimes, a bar of moving lights or headphones is used instead.
- The eye movements will last for a short while and then stop. The client is then asked to report back on the experiences they have had during each of these sets of eye movements. Experiences during a session may include changes in thoughts, images and feelings.
- With repeated sets of eye movements, the memory tends to change in such a way that it loses its painful intensity and simply becomes a neutral memory of an event in the past. Other associated memories may also heal at the same time.

EMDR and autism

- Emerging research evidence, and lots of excitement
- Lots of discussion about the clinical utility for autistic people – less reliance on verbal interchange, increased risk of trauma...an evidence-based alternative to CBT

Managing self-harm

- Active listening
- Support with emotional literacy, expressing feelings
- Adopt a compassionate and non-judgmental stance
- Maintain a presence – checking in without stifling
- Safety of course
- Risk assessment
- Above all, identify and address underlying causes
- For behaviour with a sensory element, identify substitute behaviours

Medication approaches

- SSRIs
- ADHD medications
- Medications for managing extreme emotional dysregulation
- Medication should only be considered if environmental approaches are not effective and if someone is unable to engage in therapeutic approaches
- We would not, for example, medicate someone to get them into school – if the environment is causing dysregulation, lowered mood or anxiety, we need to change the environment first and foremost
- Similarly I would not offer therapy for school avoidance if the environment is the cause of anxiety

Thank you!

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