AHA Annual Spring Conference

Mental Health Care and Adults on the Autism Spectrum

by Alison Gilbert, PhD

In April I had the opportunity to give a presentation at the AHA spring conference. The topic of the workshop was medical comorbidities among adults on the autism spectrum. This is a highly significant area of interest for patients with ASD and their families given the complexity of living with both a developmental and psychiatric disorder.

As the clinical director of an outpatient center specializing in bipolar disorder, I was asked to speak about ASD and comorbid bipolar disorder. Indeed, increased rates of ASD have been found among individuals who have a first-degree relative with bipolar disorder. As ASD and comorbid psychiatric illness have gained heightened awareness, we have paid considerable attention to the developmental history of our population of patients with bipolar disorder. Through our rigorous screening process we have found that a subset of our clinical population (approximately 10%) report a clinically significant history of developmental delays requiring intervention with physical therapy, speech-language intervention, occupational therapy and/or ABA. In order to address the needs of adult patients with bipolar disorder and a co-occurring ASD we have adapted the primary evidence-based intervention used at our outpatient clinic.

Traditionally, we provide Interpersonal and Social Rhythm Therapy (IPSRT) for patients with bipolar disorder. This is an evidence-based intervention developed by Ellen Frank, PhD and shown to delay the onset of episodes of mania and depression. The focus of IPSRT is on addressing biological vulnerabilities in the circadian system and environmental stressors related to interpersonal life triggers. The treatment is based on the idea that significant interpersonal events that alter daily routines (social rhythms) can result in shifts in mood. The goal is to achieve mood stability through regular routines, especially social routines involving others. Establishing regular social routines also means finding reasonable levels of interpersonal stimulation.

For adults with bipolar disorder and a history of ASD, we see an inherent challenge in addressing social routines. Specifically, individuals with ASD have interpersonal difficulties that may cause them to isolate themselves or to become easily socially overstimulated, thereby perpetuating shifts in mood. We established a small social skills peer group in order to address concerns related to social motivation and social overstimulation. The group format involves initiating reasonable social interactions within the group setting through social scripts and role-playing and then generalizing them to everyday life. We also address the social isolation that is a consequence of receiving a diagnosis of bipolar disorder. Specifically, individuals on the spectrum may have greater difficulty knowing how to or whether to communicate with others about their diagnosis of bipolar disorder. Social overstimulation is addressed in the group by ensuring that patients have adequate coping strategies (i.e., breaks) during heightened sensory experiences (i.e., large/loud family gatherings). Similar to individual IPSRT, the social skills IPSRT group seeks to establish regular sleep and meal times that incorporate achievable and manageable social interactions.

Outside of group work, we work with patients and their families to help create appropriate social routines that often involve establishing greater social independence (e.g., school and/or vocational training). Of additional importance is working with families to accept the comorbid diagnosis of bipolar disorder and ASD and to help the affected family member establish reasonable social routines with the ultimate goal of mood stabilization.

Alison Gilbert, PhD, is the clinical director of the Center for Treatment and Research of Bipolar Disorder at Zucker Hillside Hospital, Northwell Health System. Dr. Gilbert is also a clinical assistant professor in the department of psychiatry at Hofstra Northwell School of Medicine.

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behaviors for intervention programming that an individual is capable of but not performing with independence. Together with results from a comprehensive evaluation that include cognitive and diagnostic profiles, Vineland scores can be essential to identifying patterns of strengths and weaknesses and how areas of strength can be capitalized upon to build up areas of vulnerability. Through appropriate intervention to either teach the missing skill or address associated behaviors that might be preventing independent application of the skill to daily contexts, progress can be directly measured over time. This can ensure closing the gap that is typically evidenced between cognition and functional skill application in individuals with ASD.

Information on the Vineland-3 is available at www.pearsonclinical.com and webinars are available to learn more about administration.

Celine A. Saulnier, PhD, is the Director of Research Operations at Marcus Autism Center, Children's Healthcare of Atlanta. Dr. Saulnier is also an Associate Professor at the Department of Pediatrics at Emory University School of Medicine, Atlanta, Georgia.