Recognizing and differentiating safety concerns among anxious and depressed individuals with ASD

Martin E. Franklin, PhD, and Joshua M. Nadeau, PhD

Friday, April 23, 2021

ROGERS Behavioral Health

1

Disclosures

Martin E. Franklin, PhD, and **Joshua M. Nadeau, PhD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

2

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe three important reasons for including affective education in the treatment of anxious and depressed individuals with ASD.
2. List three advantages to using the SUDS among anxious and depressed individuals with ASD.
3. Summarize the seven critical components of an effective safety plan for anxious and depressed individuals with ASD.

3

What we'll cover in this webinar

Affective education

- Affective education overview
- Alexithymia in ASD
- Emotional identification skill-building techniques

Mood monitoring

- Objectively rating a subjective experience (SUDS)
- The transitory nature of mood
- "How was your day?" Momentary ratings and summative evaluations

Safety planning

- Revisiting SUDS as a decision-making tool
- When is a safety plan necessary?
- Critical elements of an effective safety plan

Moderated Q&A

4

Affective education

Please use the Q&A feature to send your questions to the moderator.

5

Affective education – overview

The "big idea" in treating OCRD/anxiety…two critical elements:

1. Activating the fear cortex
   - Learning skills is not enough
   - Skills must be practiced *while afraid/anxious* to be effective
2. Presenting disconfirmatory information
   - Did the feared outcome occur?
   - Were you able to function even though you were anxious?
   - Did the anxiety last forever?

(Attwood & Scarpa, 2013; Foa & Kozak, 1986; Franklin & Foa, 2014)

6

But what about depression?

Think more broadly…

- The emotion in question must be "activated"
  - Failure here drives non-response (or non-generalization)!
  - Teaching emotional regulation skills in a vacuum is futile
- Disparity between perception and reality must be confronted
  - Was the predicted outcome correct?
  - Was the predicted *impact* of the outcome correct?
  - Did the emotion remain activated?

(Dimidjian et al., 2014; Hopko et al., 2011)

7

Alexithymia in ASD

The "big idea" in anxious (or depressed) people with ASD…

- Difficulty with emotional:
  - Recognition (*alexithymia*)
  - Communication
  - Linking mood to behavioral urges/patterns
- Affective education needs augmentation…how do we:
  - Ensure the emotion is activated (and to what extent)?
  - Effectively process disconfirmatory/disparate information?

(Iniesta-Sepulveda et al., 2018; Milosavljevic et al., 2016; Shah et al., 2016)

8

Emotional identification: Skill-building

- Learning about "tells" (our own and those of others)
- Emotional style education (awareness, expression, regulation)
- Developmental scaling:
  - Younger (cartoon faces/figures, concrete expressions/gestures)
  - Older (interest-specific, exploring context, setting events/triggers)
- Content of psychoeducation is traditional, delivery is not
  - Increased behavioral and concrete focus
  - Decreased cognitive and abstract focus

9

Mood monitoring

Please use the Q&A feature to send your questions to the moderator.

10

SUDS: Objectively rating a subjective experience

Subjective **U**nits of **D**istress **S**cale

- Not just an acronym (also indicates advantages):
  - **S**ubjective: Reflecting uniqueness of experience
  - **U**nits: (with Scale) Quantification
  - **D**istress: Overall arousal, not a specific emotion
  - **S**cale: (with Units) Change and trend

(Culpin et al., 2018; Kerns et al., 2015)

11

SUDS

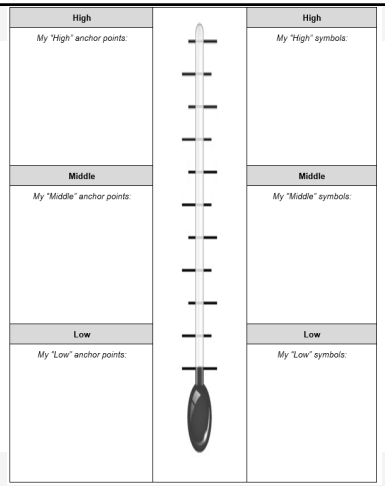
Notice…

Subjective: YOUR anchors

Units: YOUR units

Distress: Overall, not specific

Scale: Graphic display



12

The transitory nature of mood

Some common beliefs (across presentations):

- When I feel badly (anxious, depressed, etc.)…
  - This is how I always feel
  - Nothing I do can make me feel differently
  - Something is wrong with me for feeling this way

The SUDS provides us a unique and powerful method for challenging these beliefs!

13

"How was your day?" Momentary ratings and summative evaluations

"*This is how I always feel…*"

Two common check-in errors:

1. Spilled my drink…
2. Playing my favorite song…

Summative evaluation is difficult (and prone to error) when used with people who live in the moment!

Multiple barriers:

- Limited insight
- Perspective-taking difficulty
- Attention deficits
- Restricted interests

(*Leyfer et al., 2006; Selles et al., 2014; Wood et al., 2009*)

14

Safety planning

Please use the Q&A feature to send your questions to the moderator.

15

SUDS as a decision-making tool for safety

"*Nothing I do can make me feel differently…*"

The SUDS also links emotion (arousal) and behavior (response)

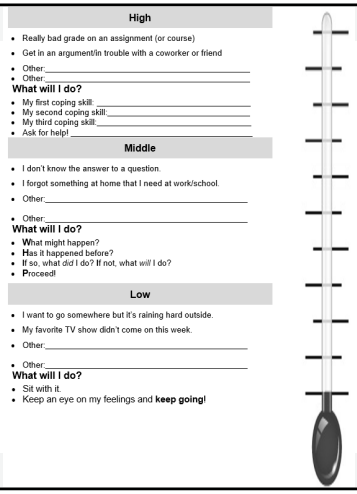
- Regardless of what my SUDS units look like, they can be roughly categorized into three decision points
  1. **Low:** Although I may be experiencing some distress, I don't need to change what I'm doing…*keep going and keep monitoring*!
  2. **Middle:** My distress is noticeable, I need to double-check the situation…*stay in the moment and use my coping questions*!
  3. **High:** I am feeling overwhelmed and likely to make a poor or dangerous decision…*take a short break, reorient and re-engage*!

16

SUDS and decisions

Linking emotion and behavior…

1. **Low:** Although I may be experiencing some distress, I don't need to change what I'm doing…*keep going and keep monitoring*!
2. **Middle:** My distress is noticeable, so I need to double-check the situation…*stay in the moment and use my coping questions*!
3. **High:** I am feeling overwhelmed and likely to make a poor or dangerous decision…*take a short break, reorient and re-engage*!



17

A closer look at decision points

1. **Low:** keep going and keep monitoring
   - Should be the default position
   - Frequent polling to build emotional identification skills
2. **Middle:** stay in the moment and *coping questions*?
   - K-I-C-K, F-E-A-R, W-H-I-P (Disturbing trend in acronyms…☺)
3. **High:** break, reorient and re-engage
   - Emotions are not inherently dangerous…but the behaviors or choices we make *when our emotions are high* can get us in trouble
   - Taking a break is okay, if you come back!

(*Kendall & Hedtke, 2006; Wood, et al., 2009*)

18

When is a safety plan necessary?

"*Something is wrong with me for feeling this way…*"

- Treatment (CBT) is a skill-building approach
  - I say "Coping," you say…?
  - Emotional identification, expression and regulation are *skills*
- A safety plan is an organizational chart for our skills
  - What is my emotional status? (*identification)*
  - How can I keep things from getting out of control? *(expression)*
  - What do I do if things do get out of control? *(regulation)*

19

Safety planning: Seven critical elements

1. Unsafe ("target") behaviors/symptoms
2. Early warning signs (that the individual notices)
3. Actions and tools (self-care and prevention)
4. Early warning signs (that others notice)
5. Actions and tools (that others can use to support)
6. Signs of trouble (noticed by individual or by others)
7. Assistance/Contact path (who, how, when)

(*Oliphant et al., 2020; Storch et al., 2013*)

20

Example

1. Unsafe behaviors/symptoms
2. Early warning signs (me)
3. Actions (self-care/prevent)
4. Early warning signs (others)
5. Actions (others can support)
6. Signs of trouble (anyone)
7. Assistance/Contact path (who, how, when)

Safety plan: Example

	Safety plan
When I notice these signs (feelings, behaviors, thoughts)	*Feeling anxious, worried, and irritable. Pacing, hitting myself. Thinking I am a waste or a failure.*
That lead to	*Thoughts of suicide, self-harm.*
I plan to do the following (Consider using your distress protocol, looking through your crisis kit, and/or including information about safeguarding your environment if you have worked on these thus far)	*Use my DMR and breathing strategies.* *Put on soothing music, take a bubble bath, call my mom or my sister.* *Look through my crisis kit. Use my distress protocol.*
When others notice the following signs	*Crying a lot, being short-tempered, irritable.* *Missing work, or lying in bed a lot*
I would like others to	*Acknowledge my feelings. Ask if there is anything they can do to help. Remind me to look over my safety plan and try skills that have helped in the past. Help walk me through skills.*
I am in serious trouble when I or others notice that	*I have impulses to hurt myself / begin to hurt myself. I become completely apathetic and I talk about going to sleep forever.*
When I am in serious trouble (Include sources of support with phone numbers as well as skills)	*I will call my mom (555) 555-2222 or my sister (555) 222-8888 and ask them to come over and help me soothe myself and keep me safe.* *If this does not work, they will encourage me to call my psychiatrist (555) 333-4444 and my therapist (555) 333-7777 or the Psychiatric Emergency Room (555) 555-2000* *If this does not work, then I will go to the Emergency Room with my mother or sister, or I will call 911.*
Additional Notes (add anything that will make this more effective for you)	

21

Enhancing safety planning

How good is your safety plan if you can't remember what's on it?

- **Ease of recall:** Design and practice
  - Strategic questions and logical flow of elements
- **Ease of use:** Individualization and practice
  - No two safety plans should be identical!
- **Ease of access:** Stimulus control and practice
  - Copies in "problem" areas (or picture on phone)
  - Technology (e.g., Virtual Hope Box application)

(Dubad et al., 2018; White et al., 2018)

22

Time for questions and answers…

23

Where to get additional information…

NATIONAL AUTISM ASSOCIATION

https://nationalautismassociation.org

AANE ASPERGER / AUTISM NETWORK
Empowering Individuals · Building Community

https://www.aane.org

24

About the presenters....

Martin E. Franklin, PhD

Clinical Director, Philadelphia

Dr. Franklin is an internationally renowned expert on OCD, OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. In addition to serving as the clinical director of Rogers' Philadelphia location, Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine.

Joshua Nadeau, PhD

Clinical Director, Tampa

Dr. Nadeau is a licensed psychologist who directs the clinical programs at Rogers Behavioral Health's Tampa location. Dr. Nadeau focuses on the use of cognitive behavioral therapy for the treatment of OCD and related disorders, as well as in the adaptation of evidence-based techniques to address the unique needs of youth and adults with autism spectrum disorder (ASD) and other neurodevelopmental disorders.

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