Trainees on the Autistic Spectrum: Diagnosis & PSU/PSS Support

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Imagine:

- You are a tightrope walker
- The rope is your training experience
- Your survival depends on balancing multiple demands, a sense of “not knowing all of medicine”, yet feeling that you need to know everything to keep patients alive, and an ability to intuit what people are saying to you
- You face a myriad of human interactions, constantly changing and invisible expectations
Your tightrope is also your sense of confidence that you know medicine – it is wobbly
You have worked hard, passed all exams so far, have always buckled down under pressure – that is what gives you balance
You can put in the extra hours – this gives you weight, or the wind would blow you off
But somehow, things don’t seem quite right
People seem to be saying things
Educational / Clinical Supervisor

- Pick up issues to do with interaction in teams
- Occasional rudeness
- Some difficulty in processing information and get to the nub of the clinical problem
- Issues to do with over-comprehensive discharge summaries
- Being distracted by loud noises
- They refer you to the PSS/ PSU
The trainee may have Asperger’s Syndrome

■ What does this mean?

Any ideas?
ICD-10 Asperger’s

[1] **Social:** 2 of: a) abnormal facial expression, gaze, gestures, posture in social regulation b) Fail to *develop relationships* c) Lack socio-*emotional* reciprocity d) Don’t *seek to share* interests/ enjoyment

[2] **Language:** no delays in childhood

[3] **Interests/ routines:** >= 1 of: a) abnormal preoccupation, b) compulsive ritual, c) repetitive mannerism, d) preoccupied w part objects
ICD-10 **Autism**: as for AS except:

[2] **Language**: 
>1 of a) delay, lack spoken language before 3 yrs, unaccompanied by attempts in other modes communication 
b) Failure to initiate, sustain conversation 
c) Stereotyped repetitive, idiosyncratic use 
d) Lack varied spontaneous make believe, social imitative play
Social Deficits

- Feel as though from ANOTHER PLANET
- Society full of INVISIBLE rules
- NO-ONE has told them about
- So either:
  a) Try work out rules in their head
  b) Or give up, get isolated & depressed
- Can appear a little detached
Social questions to ask

- Prefer own company?
- Prone to Faux pas?
- Understand social rules? Purpose of please, thanks, chit chat?
- Prefer people or things...?
- Able to spot others’ feelings eg discomfort?
- View of personal space: too much or little?
Communication

Receptive:

- Poor auditory discrimination, problem focus
- Literal (cannot put myself in others’ shoes)
- Theory of mind deficit: can’t read expressions, assumptions, minds, feelings
- Lack subtlety: don’t get jokes, TV ads

Expressive: overinclusive talk at you (rant) or too little, idiosyncratic, formal speech
Interests / Routines

- Intense, all-absorbing Obsessional Preoccupations ask them to tell you about them
  - Classifying, collecting (hoarding)
  - Stamp-collectors, avid collectors of anything – watches etc.

- Compulsive [not useful!] routines, rituals – means can be late for things
**Mechanism for sifting information:**

- *Excessive Attention to Detail* - *with every detail equally important* - reduced *central coherence* – struggle to see wood for trees
- Processing info can be a challenge – some show *executive function deficits*
Mind can be overloaded
Focus on

1. **Narrow interests/detail** – **assimilate** info into schemas; gives sense of control
2. **Rigid/ inflexible** - struggle to **accommodate/process** new info
3. **Rigid Routines** to keep life in **order**
4. **Themselves** “**back to me**” conversationally – other people’s lives a) unpredictable, b) dull (unless same interest eg eosinophils)
COGNITION: questions to ask:

- Cope with *vague instructions* at work? eg “sort this patient out...” easier to have *detail* spelt out?
- Would it help if *new tasks were identical*?
- Ever struggle with *too much info*?
- Problem *organising yourself*?
- Get anxious if others not *punctual*?
Prevalence

AUTISM:
- British Survey 2003: 26/10000 or 0.26%
- Cambridge Community Survey: ~ 1%

Asperger’s:
- Population survey Sweden: 0.7%+
- **M:F 4:1** but features in F ignored, latest **1:1**
- Greater FH of Asperger’s in doctors
Comorbid Mental Disorders - Depression

- **33 %** prevalence in AS (Abramson 92)
- **Causes:** isolation, self-esteem issues, rejection, awareness of limitations associated with AS
- **Sx:** withdrawal, increase in compulsive behaviours, irritability
- Don’t confuse: too little talk seen in depression with AS but equally an AS ramble, excitement re. favourite interest with hypomania
Secondary Mental Disorders
Anxiety Disorders including OCD

- Both depression and trivial changes in environment → anxiety – up to 80% in ASD
- AS patients like rituals so diagnose OCD only if distressing/dysfunction (Maudsley study)
- Compulsions - repetitive questioning, ordering, hoarding, checking
- Also check for social phobia, PTSD (if trauma), eating disorders [≈20% AN F = AS]
Acute Stress Reactions

- Very common in AS – quick to appear despair, anger, anxiety – quick to resolve
- Adjustment disorders – a month to appear in response to stressor - depression, anxiety, sometimes psychotic behaviour
- Processing emotional content of stress can take up to a year
Back to the Deanery Pathway

- ES refers to the PSS (PSU)
- CM – Case Manager appointed
- Various aspects raise the possibility of AS
- 10 AQ screening questions administered: if the score and social communication issues date from childhood and the trainee agrees then refer to the VSG AS psychiatrist
Screening questions: 10 AQ

1. I find social situations confusing
2. I find it hard to make small talk
3. I am good at picking up details and facts
4. I find it hard to work out what other people are feeling
5. I can focus on certain things for very long periods
6. People say I was rude but this was unintentional
7. I have unusually strong, narrow interests
8. I do certain things in very inflexible, repetitive way
9. I have always had difficulty making friends
10. I tend to turn any conversation back onto myself or my own topic of interest
The Trainee perspective: You meet the PSS:

- They seem to support you, appear friendly...
- Your case manager has noted that you struggle to understand people’s emotions, relationships, teamworking
- He has asked you a set of “screening questions”
- And refers you to someone for a diagnosis?
- Not always easy, being a doctor
- May want to be a superspecialist soon as
Deanery Pathway

- Diagnostic assessment by psychiatrist
- Consent to share with GP sought
- Refer to 6 sessions of psychological / educational assessment and support
- Results in “what you need to know about me report” in addition to CBT/Ed sessions
- Any further support will require private payment, eg OT for sensory assessment
- CM role is advocacy + help trainee decide who to share information with
DIAGNOSIS – Trainee Education

Trainee is told Asperger’s:

1. Is not an illness: brain is wired differently
2. Evidence that people develop/ adjust
3. Strengths: honesty, conscientious, attention to detail – to a degree all medical jobs require this, some more eg surgeons, pathologists etc
4. Carries a risk of vulnerability to exploitation/ to being misunderstood, and other comorbidities (2-6 fold increase) and therefore knows to seek help, when notices these occurring
Treatment

- No specific treatment for AS in and of itself
- Treat comorbidities but use lower doses of meds to begin with as sensitive to medication
- Limit choices, set targets
- Visual cues helpful
- CBT for Aspergers’ – see below
Psychologist notes & does what?

- Interpersonal difficulties
- Judgment, problem solving, common sense
- Information processing → organization, self-direction poor yet success in academic pursuits
- End up in careers far ‘beneath’ their ability. This leads to a sense of failure which leaves them vulnerable to mental health problems
- CBT: monitor & re-evaluate interpretative errors
CBT in Asperger Syndrome

- Logical, Non-interpretative, non metaphorical
- Pictorial mood self-rating scales

Addressing distortions:
- All or nothing thinking
- Polarised thinking
- Fatalistic thinking
- Inaccurate attributions

If recognise, modify these, then better ‘reading’ of social interactions, others’ behaviours

- Modify own behaviour in response
- Improve social functioning; increase coping
Formulating Profile & Objectives

- Essential to understand what AS means for each individual – how the profile of difficulties maps on to their experience.
- ‘What can be changed? Which things are not possible to change?
- Role-play; self-reflection: how would you feel if?
- Cognitive rigidity vs cognitive restructuring
- Identify problem; goals; brainstorm alternatives
- Self-regulation, self care, low self-esteem
- Validate, anticipate catastrophic thinking...
- Assume nothing; explain everything!
Evidence Base

- Evidence where is some skill, but not where new communication skill needed
- Single literature providing evidence-based interventions for this population. However, evidence comes from:
  - Social cognition in typical people
  - The risk factors and effects of stress in typical people
  - Cognitive dysfunction in typical people with anx/dep
  - Efficacy of CBT for typical people with anx/dep AND:
  - Information-processing dysfunction in AS
  - Efficacy of CBT for children/teens with AS (Gaus, 2007)
  - Doctors with AS: Impact of Diagnosis (Price et al, 2017)
CHALLENGES

- Employers may not employ someone for whom they need to make reasonable adjustments
- What reasonable adjustments? (easier for trainee to negotiate individualised ones)
- Double edged sword: don’t want special T, prejudice

BENEFITS

- Increased self-awareness, informed, seek info:
  - what can and can’t modify; What help to seek
  - How to learn most effectively (training, education)
  - Finding a community of like-minded people
  - Awareness that many AS drs out there managing
  - Career choices; Ethical duty to share
What can you do..?

- Refer to PSS for support, insight
- Discuss with diagnostician or expert
- Be aware AS is disability in Employment law but contentious issue for trainee
How to communicate with the trainee with AS?

- Be explicit – state the obvious clearly
- Detailed instructions
- Keep it Simple
- Check they’ve understood, due to receptive problems
- Be directive, better than giving choices
- Don’t tackle symptoms/behaviours head-on → try understand what AS means for them
Management – External support

- National Autistic Society: Nas@nas.org.uk info on local groups including post-diagnosis
- Hampshire Autistic Society; ADRC; Winchester
- Tony Attwood: Asperger’s Syndrome
Assessment of Autism Spectrum Disorders

The Complete Guide to Asperger's Syndrome

Asperger's Syndrome For Dummies

Mental Health Aspects of Autism and Asperger Syndrome

Psychiatric services for adolescents and adults with Asperger syndrome and other autistic-spectrum disorders

Council Report CR136
April 2006

Kathy Hoopmann
All cats have Asperger syndrome

Tony Attwood