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Adapting Cognitive Behavioral Techniques to Address Anxiety and Depression in Cognitively Able Emerging Adults on the Autism Spectrum

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Cognitive-behavioral approaches have been successfully modified to treat anxiety in cognitively able children and early adolescents on the autism spectrum; however, very few studies have examined modified programs for anxiety and depression in older adolescents and young adults. This key developmental period of emerging adulthood may be a particularly challenging time for individuals on the spectrum due to a number of factors, including the development of psychiatric disorders. Anxiety disorders and depression, which often co-occur with ASD, can impede coping and resilience and thus may be particularly important targets for intervention. Given the limited research on CBT for emerging adults on the autism spectrum, the present article is largely conceptual in nature. We provide an overview of the factors contributing to vulnerability during the transition to adulthood and the limited research regarding the prevalence and psychosocial treatment of anxiety and depression in adults with ASD. Drawing from clinical experience and the literature, we then highlight the unique challenges of adapting CBT for cognitively able emerging adults on the autism spectrum relative to children and adolescents. Potential modifications are offered, but further research will be needed to establish an empirically supported approach.

Autism spectrum disorder (ASD) is a neurodevelopmental disorder defined by two diagnostic criteria: social-communication deficits and restrictive and repetitive behaviors, both of which may negatively impact long-term outcomes, maximal community integration, and quality of life (Newschaffer et al., 2007). According to the Centers for Disease Control, the prevalence of ASD among 8-year-olds in 2010 was 1 in 68, a 30% increase since the 2008-based estimate of 1 in 88, with the largest growth noted in cognitively able individuals (i.e., those without co-occurring intellectual disabilities; Centers for Disease Control and Prevention, 2014). Furthermore, it is estimated that almost 50,000 individuals on the autism spectrum in the United States turn 18 each year (Shattuck, Roux, etal., 2012).

Comorbid psychiatric disorders are highly prevalent in this population, with estimates tending to cluster in the 70% range (Mattila et al., 2010; Simonoff et al., 2008) and anxiety and depression being among the most common comorbidities (Buck et al., 2014; Simonoff et al., 2008). Cognitive-behavioral approaches have been successfully modified to treat anxiety in cognitively able children and early adolescents on the autism spectrum (Lang, Regester, Lauderdale, Ashbaugh & Haring, 2010; Nadeau et al., 2011). However, very few studies have discussed the modification of programs for anxiety and depression in cognitively able older adolescents and young adults. This key developmental period of emerging adulthood is associated with a number of unique challenges for individuals on the autism spectrum that may complicate the implementation of cognitive behavioral therapy (CBT). Modifying CBT to address these barriers will be essential to effectively treat psychiatric disorders that may adversely influence life course outcomes.

This paper describes factors that may enhance risk for anxiety and depression during emerging adulthood for young adults on the spectrum and summarizes the limited research available on the prevalence and psychosocial treatment of anxiety and depression for this vulnerable group. Drawing from clinical experience and the literature, we then highlight some challenges of adapting CBTfor cognitively able emerging adults on the autism spectrum.

Emerging Adulthood and the Life Course

Emerging adulthood is conceptualized as a distinct period of the life course between adolescence and early adulthood (ages 18–25) typically characterized by change and exploration (Arnett, 2000). Historically, entry into adulthood was marked by fulfillment of sequenced social roles such as completing school, moving out of the parental home, marriage, and childbearing. However, in contemporary western society, emergence into adulthood

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is now less tied to a specific normative sequence of events and is instead marked by a set of behaviors including independent decision-making, management of one's finances, and personal responsibility (Arnett, 2000).

Emerging adulthood occurs within the context of the broader life course. With historical roots in a sociological framework, the *life course* framework complements the more psychologically oriented emerging adulthood framework by providing a contextual understanding of people's lives as rooted in specific historical times and social settings and emphasizing the influence of shifting social roles, social participation and relationships on development (Elder Jr, 1995; Elder & Shanahan, 2006; Mayer, 2009). A life course perspective also highlights the dynamic intersection between people's lives and social institutions such as schools and publicly funded systems of services.

Together, the emerging adulthood and life course frameworks (a) establish the period between adolescence and adulthood as critical to the life course of an individual on the autism spectrum, (b) emphasize the enhanced vulnerability conferred by comorbid developmental and psychiatric disabilities, and (c) highlight the inadequacy of the mental health service systems to support this vulnerability in emerging adults on the autism spectrum.

Emerging Adulthood: A Critical Period

Emerging adulthood represents a critical juncture in the life course wherein young adults on the autism spectrum must transition to adult social roles amidst simultaneous changes in service availability. The process of taking on adult social roles has become less predictable and more protracted over recent decades (Settersten Jr & Ray, 2010). Youth on the autism spectrum may be especially vulnerable during this transition to adulthood due to difficulties tolerating uncertainty and ambiguity (Boulter, Freeston, South, & Rodgers, 2014), high rates ofcomorbid mental health problems (Buck et al., 2014;Simonoff et al., 2008), and executive functioning deficits, which may impede independent functioning and the assumption of adult responsibilities (Hendricks & Wehman, 2009; White, Ollendick, & Bray, 2011). Such demands may be particularly taxing for youth who lack understanding of their disability and struggle to advocate for themselves—a prerequisite for service access in postsecondary education (Sperry & Mesibov, 2005; VanBergeijk, Klin, & Volkmar, 2008).

National-level data shows that over 50% of young adults on the autism spectrum are completely disconnected from any employment or education opportunities during the first two years after high school (Shattuck, Narendorf, et al., 2012). Compared with youth who have other types of disabilities, they are also less likely to socialize with friends, to participate in community social activities with peers, and to live away from their parents' home (Howlin & Moss, 2012; Anderson, Shattuck, Cooper, Roux & Wagner, 2014; Shattuck, Orsmond, Wagner, & Cooper, 2011). Only about half have paid employment in these first years and even fewer (35%) attend college (Roux, Shattuck, Cooper, Anderson, Wagner, & Narendorf, 2013; Shattuck, Narendorf, et al., 2012).

Autism and Psychiatric Disability: The Double Vulnerability

State-administered services for developmentally disabled adults often require an intellectual disability for qualification. On the other hand, many state mental health agency departments that serve those with psychiatric disabilities are reluctant or ill equipped to provide services to those with developmental disabilities. Cognitively able young adults on the autism spectrum who also have psychiatric and behavioral issues thus fall between the cracks, as they are too able to qualify for intellectual disability services but also clinically distinct from the populations seen in inpatient psychiatric units, eating disorder and drug rehabilitation centers, or specialty anxiety, traumatic stress or mood clinics, which do not specialize in ASD and may be reluctant to admit individuals with this diagnosis. Among adults who are diagnosed with ASD, approximately 34% of families report unmet mental health needs (Nicolaidis et al., 2013), and a major contributor to this service gap is the lack of health care providers trained to meet the needs of this population (Bruder, Kerins, Mazzarella, Sims, & Stein, 2012). The Pennsylvania Autism Needs Assessment (Bureau of Autism Services, Pennsylvania Department of PublicWelfare, 2011), a survey of over 3,500 youth and adults on the autism spectrum, found that almost half of older adolescents and three out of five adults on the autism spectrum reported unmet mental health needs. Of those adults receiving mental health supports, over 30% were dissatisfied and described their care as ineffective.

Anxiety and depression are the most commonly noted comorbidities in ASD, particularly for those without intellectual disabilities (Buck et al., 2014; Simonoff et al., 2008). Anxiety and depression symptoms share many features, most notably a high degree of internalized distress that is associated with poorer physical health, social, academic and vocational functioning in the general population (Kupfer, Frank, & Phillips, 2012; Stein et al., 2005; Verboom, Sijtsema, Verhulst, Penninx, & Ormel, 2014). In individuals with ASD, co-occurring anxiety and depression have been associated with increased rates of self-injurious behavior, suicidality, social difficulties, somatic symptoms, and family stress (Cassidy et al., 2014; Kerns, Kendall, Zickgraf, et al., 2014; Mazurek et al., 2013; Storch, Sulkowski, et al., 2013).

The high rate of psychiatric comorbidity in ASD likely goes hand-in-hand with the frequent use of polypharmacy in this population (Frazier et al., 2011; Lake, Balogh, & Lunsky, 2012; Spencer et al., 2013). In a study of youth on

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