CBT for young people with Autism Spectrum Disorder

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Session outline

- What is CBT?
- What skills are needed for CBT?
- ‘Autistic thinking’
- Modifications to CBT for ASD
- Review of CBT research trials
CBT is….

- A talking therapy
- Basic principle is that the way you perceive and appraise events affect how you feel and behave
- CBT aims to modify maladaptive or unhelpful thinking/thinking patterns
Cognitive Behaviour Therapy – basic principles

- monitor negative automatic thoughts (NATS)
- recognise connections between affect, behaviour and cognition
- examine evidence for and against distorted NATs
- generate alternative rational thoughts
- test out thoughts/beliefs with behavioural experiments
- Link new thought and feeling
Skills required

- Metacognition: thinking about thinking
  - Recognition of logical or evidential connection between beliefs
  - Evaluation/appraisal of thoughts
  - Representation of controllability of mental states
  - Representation of what cognitive states are regulating behaviour
ASD and metacognition

- ToM – difficulty identifying and conceptualising the thoughts and feelings of both self and others
- Lack of insight
- But: more recent research yields mixed findings
Emotion Recognition – skills required

- Recognise and label emotions – infer one’s own emotional state
- Differentiate between emotions
- Measure emotions
ASD and emotion recognition

- Emotional dysregulation/ reactivity/ immaturity
- Difficulty recognising and managing emotions on line
- But: can be taught
CBT is

- Structured
- Scientific, logical – seeking evidence
- Goal-focused

Therefore can be very effective with the right adaptations
Two key things needed

- Motivation
- Insight

- Just a bit is enough!
## Research evidence to date: empirical studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Diagnosis</th>
<th>Intervention</th>
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</table>
| Wood et al. (2009)     | N=40
7–11 years
VIQ>70   | PDD–NOS, Autism or AS and clinical anxiety (SAD, Social anxiety, OCD)      | 16 sessions of individual enhanced CBT with child & family |
| Chalfant et al. (2007) | N=47
8–13 years
Borderline to superior IQ | HF ASD or AS and clinical anxiety (SAD, GAD, specific phobia, social anxiety, panic disorder) | 12 sessions of modified group CBT with parent component |
| Sofronoff et al. (2005)| N=71
10–12 years
IQ>90     | AS and anxiety symptoms (based on parental report)                        | 6 sessions of modified group CBT                 |
| Reaven et al. (2008)   | N=33
7–14 years
IQ>70     | ASD, PDD–NOS or AS and GAD, SAD or Social Anxiety                         | 12 sessions of modified group CBT                 |
| Ooi et al. (2008)      | N=6
9–13 years
IQ>80     | Autism or AS (based on DSM) and anxiety symptoms                          | 16 sessions of group CBT                         |
Empirical Studies – promising findings

- All studies: decreases in reported anxiety symptoms
- CBT group outperformed wait list groups in *diagnostic outcomes* and *reports* of child anxiety symptoms
- Active parental involvement condition: additional benefits over and above child CBT (Sofronoff et al., 2005)
- Some mixed findings
- Parental reports but not child reports decreased (Reaven et al., 2008), *but* child reports decreased, not parent reports (Ooi et al., 2008)
Autistic thinking
(Paxton & Estay 2007)

- Visual thinking
- Literal thinking
- Lack of self-concept,
- Difficulty with perspective taking
- Difficulty with change, flexibly shifting attention
- Often an acute sense of right and wrong
- Autobiographical memory deficits
- In-the-moment thinking
- Black and white thinking
Why are children with ASD predisposed to anxiety?

- Theory of mind difficulties
- Weak Central coherence
- Executive Functioning deficits
- Poor language/social processing
- Emotional dysregulation
- Sensory sensitivities
Which translates into…..

- Difficulty recognising early signs of anxiety
- Few coping/rescue strategies
- Information processing skills even more disrupted in a heightened state of anxiety
- Difficulty discriminating between other people’s emotions, may perceive excitement as anger, quiet calm as sadness
- Often feel emotions are directed towards them when they are not
- Hypervigilance
- Poor organisational skills
- Poor recall of events
Cognitive style

- ‘there’s a visual (memory) bank already there...you don’t have to update it all the time (if things stay the same). ‘I’ve seen this before, I’ve scanned it’, I’m not there thinking ‘oh my God, I have to log all of this, I can’t do this because it makes my head hurt’. And also when I’m logging it, I’ve got to look out for lions and tigers because they might kill me’. Their heads are full of junk and they cannot process it...I think a lot of it is the basic desire to survive.’
“It’s still in the memory bank and will still trigger anxiety, because it hasn’t been filed away. Nobody’s the filer, the filing doesn’t work, it’s never ever put away”; “Putting it in some sort of order before they can talk about how they felt...for M that order will be really jumbled for a while, so he’ll tell you bits of it, he might even tell you key words and in between those key words he’s on the floor and crying”.

Assessment

- Diagnostic tools such as the ADIS–C, Spence, MASC, Beck
- Clinical interview
- Behavioural observations and record keeping
Presentation of problems

- May be difficult to recognise due to difficulty communicating feelings of distress
- Eg key features of depression rarely reported by the individual but via caregivers – difficulty of assessing subjective feelings
- May have a different presentation, for example, increase in repetitive/stereotyped behaviours, aggressive behaviour, decrease in personal care skills, increased withdrawal.
Formulation

- Not just about adaptations
- How to be collaborative and share formulation
Underlying beliefs may not always be obvious or fit into a model

<table>
<thead>
<tr>
<th>Situation</th>
<th>Typical underlying beliefs</th>
<th>Atypical underlying beliefs</th>
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</thead>
<tbody>
<tr>
<td>Fear of detentions</td>
<td>fear of negative evaluation</td>
<td>litter duty.....germs...'I'll get ill if I have a detention’'</td>
</tr>
<tr>
<td>Fear of separation</td>
<td>fear of something bad happening to self or parent</td>
<td>I wont know what to say’</td>
</tr>
<tr>
<td>Elaborate OCD rituals</td>
<td>Prevention of harm</td>
<td>to get rid of the smell of school (no harm beliefs, just sensory sensitivity)</td>
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Parent perspectives

- Difficulty talking about anxiety – detective process required
- Intensity
- Pervasiveness
- Persistence – can’t be reassured as easily
- Behavioural expression of anxiety
- Triggers of change ++ specific to ASD
Modifications to CBT

- Taken from the literature, and also a small survey of psychologists working in ASD
  - Moree and Davis, 2010
  - Anderson and Morris 2006
  - Ozsivadjian, Magiati and Howlin 2011
Modifications to CBT

- A more concrete, structured, tangible and visual approach:
  - Thought bubbles
  - Worksheets
  - Thermometer
  - A visual image to ‘beat OCD’
  - Tool box
**Modifications**

- **Maintaining attention:**
  - Regular breaks if needed
  - Less abstract spoken language
  - Incorporate child’s special ASD–related interests—within reason
Modifications ctd.....

» CBT tools:
  ◦ Initial focus on emotional literacy
  ◦ Focus on rules, self-statements and in vivo practice vs. verbal discussions
  ◦ May need to be less socratic – give choices to endorse or reject
  ◦ Exposure – balance between allowances for ASD/avoidance
Parental involvement

- Facilitates generalisation
- Addresses systemic maintaining factors
- Psychoeducation
- Can treat parent simultaneously?
- Great for role play
- Better outcomes
- Regular liaison with school staff
Practical points

- Some children fill in thought records religiously, others find it impossible
- Very difficult to plan number of sessions in advance – may need more at the beginning focusing on emotional literacy, case conceptualisation, or forming a relationship
Engagement and process issues

- Lack of eye contact/poor social skills
- Sudden therapeutic ruptures – eg making a mistake
- Emotional dysregulation – sudden outbursts
- Child may be very controlling – only use certain words etc
- Endings/discharging
Address these by...

- Maintain a calm, constant style
- Give permission not to make eye contact, etc
- Know what you will and will not accept in terms of behaviour
- Reassure child if a rupture occurs that nothing has changed
- Make use of ‘golden moments’
What therapists say is challenging about this group

- Hard to know when to end therapy – core ASD problems always there
- Rages/high levels of emotion can be difficult to manage
- Need to be organised in your thinking
- Lack of insight difficult – reduces motivation to change
- Therapy doesn’t go the way the text books say
What therapists say is positive about working with this group

- Rewarding relationships are often formed, with parents as well as children. Neglected group
- Clients honest, forthcoming and open, not manipulative, interesting, funny, unusual in their thinking,
- Rigidity can work in a positive way
- Specialist area. Therapy needs adapting – forces therapist to be creative
Mental Health problems overlap with......

- social impairment
- sensory hypersensitivity
- behaviour problems
- Other, possibly unidentified neurodevelopmental problems, eg dyspraxia, dyslexia
Prior to or during CBT – consider

- Environmental modifications, systemic changes
- Psychoeducation on core autism difficulties
- Address poor social skills and difficult social situations
- Assessment of other possible contributing factors, eg OT assessment
- May in many cases be sufficient
Take home points

- CBT is possible with young people with ASD
- There is emerging evidence for CBT being effective, particularly for anxiety disorders
- It can be challenging, but also incredibly rewarding
Useful resources

- Tony Attwood’s ‘Exploring feelings’
- The Cat–Kit (Attwood, Callesen and Nielsen 2008)
- Paul Stallard’s ‘Think Good Feel Good’
- Counselling people on the Autism Spectrum (Paxton & Estay, 2007)
Reference list

- Ann.ozsivadjian@gstt.nhs.uk
Two contrasting cases
Case 1

- ASD
- Challenging behaviour – destructive rages
- Mood disorder – bipolar?
Social/environmental

- Never received any input from social services disability teams – only for profoundly disabled children
- Several school placements failed, including an EBD school
- Currently home schooled – on line learning, very successful
Anxiety

- Regular ‘crises’ – hitting mother, ripping up flooring
- Sensory worries – cheese and onion
- Health worries – tickle in throat
- Obsessional worries – will (team) win their league– expects people to answer. Worries world tipping upside down.
- Wasting time/ not having anything to look forward to/ if something to look forward to, worries when its over
- Demands that people help him and gets upset if they won’t/can’t
CBT

- Thoughts labelled as ‘messages’
- Took to CBT like a duck to water. Identifying messages, discussing with mother whether there was any evidence for or against messages, controlling messages, ‘one thought at a time’, identifying distorted messages (eg if things aren’t perfect, it doesn’t mean they’re dreadful)
- Role play to increase insight
- Reduce parental reassurance seeking
Family CBT

- Sister involved at points because of exacerbation of situations, and deterioration of relationship with brother/mother
- Step father involved – very useful perspective – psychoeducation about temperament/mood states
Current situation

- Only occasional appointments for review
- Occasional downturn in mood but no recent major crises in past two years
- Aggressive episodes reduced to zero
- Insight/empathy greatly increased
- More able to walk away from situation or accept reassurance
- Anxiety reduced and importantly, ability to manage anxiety independently increased
Case 2

- Direct referral for treatment of anxiety/low mood in the context of Asperger syndrome
- Specific phobias
- Rages
Presenting problems

- Very rigid, egocentric and unempathic
- ‘I don’t like my mother, I never have’
- Arguments start over minor things and get blown out of proportion – ‘one way street’ At worst, brandishing knives
- Dad has ‘undiagnosed Asperger syndrome’ – exacerbates situations – neither back down
- Rigid views, eg ‘children have rights and adults shouldn’t have authority over them’
- Perceived injustices, misunderstandings (discipline/beating people up)
CBT

- Very successful in treating phobias
- Not at all successful in increasing insight, identifying thoughts, changing thinking/behavioural patterns
- Behavioural management only effective – mother employing effective strategies (e.g., reward systems, clear rules, locking knives away), father walking away