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Adapting psychological therapies for treatment of mental health difficulties in ASD

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Evidence for effectiveness

Research evi

Study	Participants	Diagnosis	Intervention
Wood et al. (2015)	N=33 11-15 years VIQ>70	ASD *and* clinical anxiety (SAD, Social anxiety, OCD)	16 sessions of **individual** enhanced CBT with child & family- BIACA
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
Storch et al. (2013)	N=45 7-11 years IQ>70	AS *and* clinically significant anxiety	16 sessions of family CBT (parallel child and parent sessions)
Reaven et al. (2011)	N=50 7-14 years IQ>70	ASD, PDD-NOS or AS *and* GAD, SAD or Social Anxiety	12 sessions of modified **group** CBT
McNally Keehn et al (2012)	N=22 8-14 years IQ>70	Autism or AS (based on DSM) *and* anxiety symptoms	16 sessions of Coping Cat

Empirical Studies – promising findings

- All studies: decreases in reported anxiety symptoms
- CBT groups outperformed wait list groups in *diagnostic outcomes* and/or *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)
- Only a couple of studies compare interventions (Sung Ming et al 2011, Sizoo and Kuiper 2017)

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Research challenges and limitations

- Small samples, mainly wait list controls (except Sofronoff et al., 2005, Sung et al., 2011)
- ASD diagnosis not always systematically confirmed
- Children with clinical diagnosis of anxiety disorder vs. children with reports of anxiety symptoms
- Heterogeneity in children's anxiety and ASD diagnoses
- Investigators in most cases also delivering treatment
- Limited adherence measures
- Measurement issues (Limited, largely relying on parental reports, inappropriate for this population?)

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NICE recommendations

- Consider the following for children and young people with autism and anxiety who have the verbal and cognitive ability to engage in a cognitive behavioural therapy (CBT) intervention:
  - group CBT adjusted to the needs of children and young people with autism
  - individual CBT for children and young people who find group-based activities difficult.
- Recommendations then made for adaptations to CBT

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Overall…

- There is still a way to go before knowing which programs or components of programs work for whom…..
- Walters, Loades and Russell (2016) A systematic review of effective modifications to CBT for young people with ASD (JADD)

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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

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Skills required D. Bolton, CBT for children and families

Metacognition: thinking about thinking

1. Recognising thoughts
2. Understanding they can impact on how you feel
3. Recognising the controllability of thoughts

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ASD and metacognition

- ToM – difficulty identifying and conceptualising the thoughts and feelings of both self and others
- Lack of insight

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Emotion Recognition – skills required

- Recognise and label emotions – infer one's own emotional state
- Differentiate between emotions
- Measure emotions

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ASD and emotion recognition

- Emotional dysregulation/ reactivity/ immaturity
- Difficulty recognising and managing emotions on line

- But: can be taught

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Assessment of Prerequisite skills (Lickel et al 2011)

- Emotion recognition
- Discrimination between thoughts, feelings and behaviours
- Cognitive mediation

- Young people with ASD performed comparably to TD children (except on emotion recognition)

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CBT is

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

- Therefore can be very effective with the right adaptations

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Two key things needed

- Motivation
- Insight

- Just a bit is enough!

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Modifications to CBT

- Moree and Davis, 2010
- Anderson and Morris 2006
- Ozsivadjian, Magiati and Howlin 2011

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Psychological treatments for co-occurring mental health difficulties – adapted CBT NICE GUIDELINE 170 p22

- Emotion recognition training
- Greater use of written and visual information and structured wor
- A more cognitively concrete and structured approach
- Simplified cognitive activities, for example multiple choice worksheets
- Involving a parent or carer to support the implementation of the intervention, for example, involving them in therapy sessions
- Maintaining attention by offering regular breaks
- Incorporating the young person's special interests into therapy if possible

- And others including:
  - Include overt reinforcement for engaging in activities such as behavioural experin
  - Close liaison with school if possible
  - Imagery restructuring

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Modifications to CBT

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

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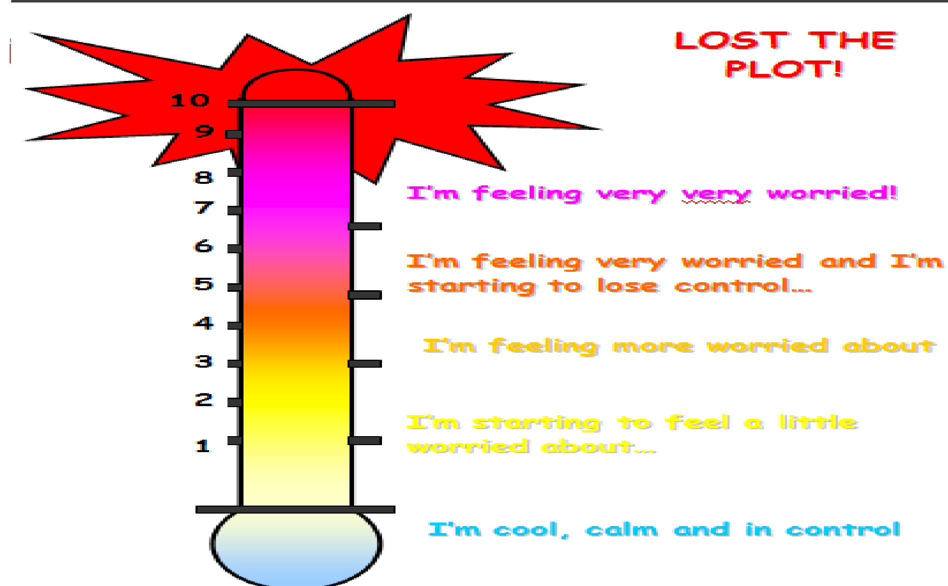
What can we try?



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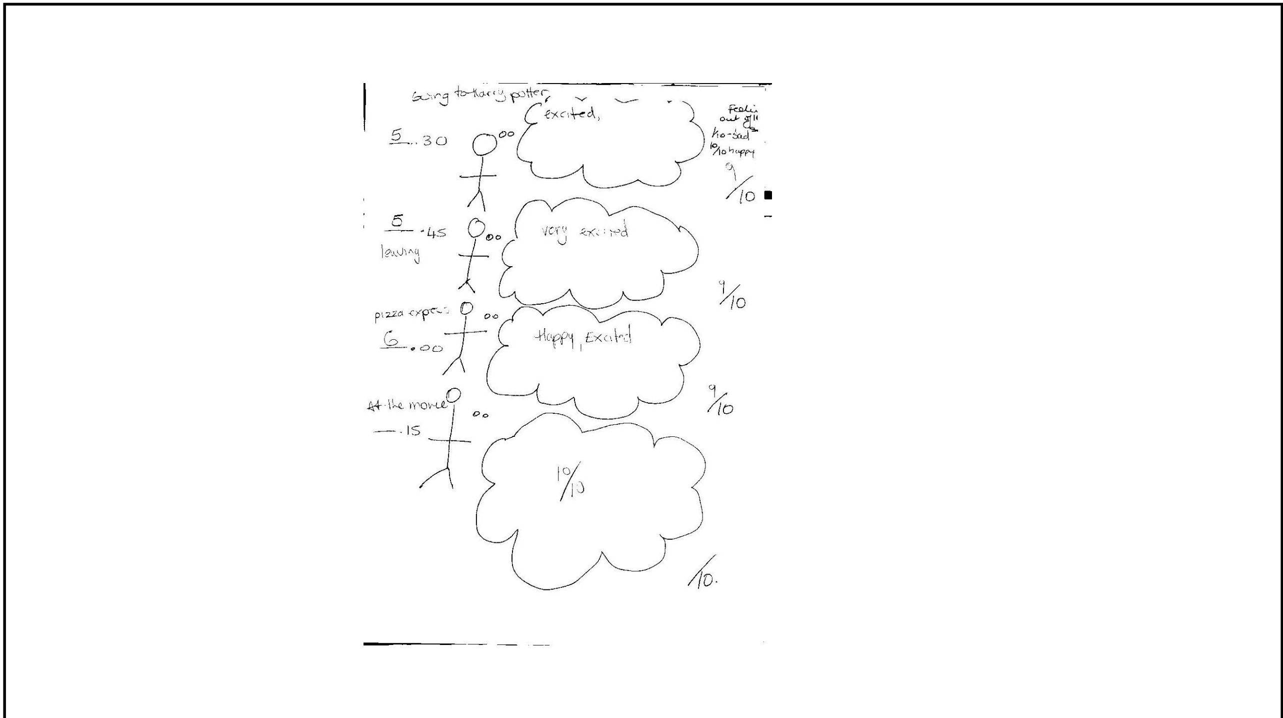

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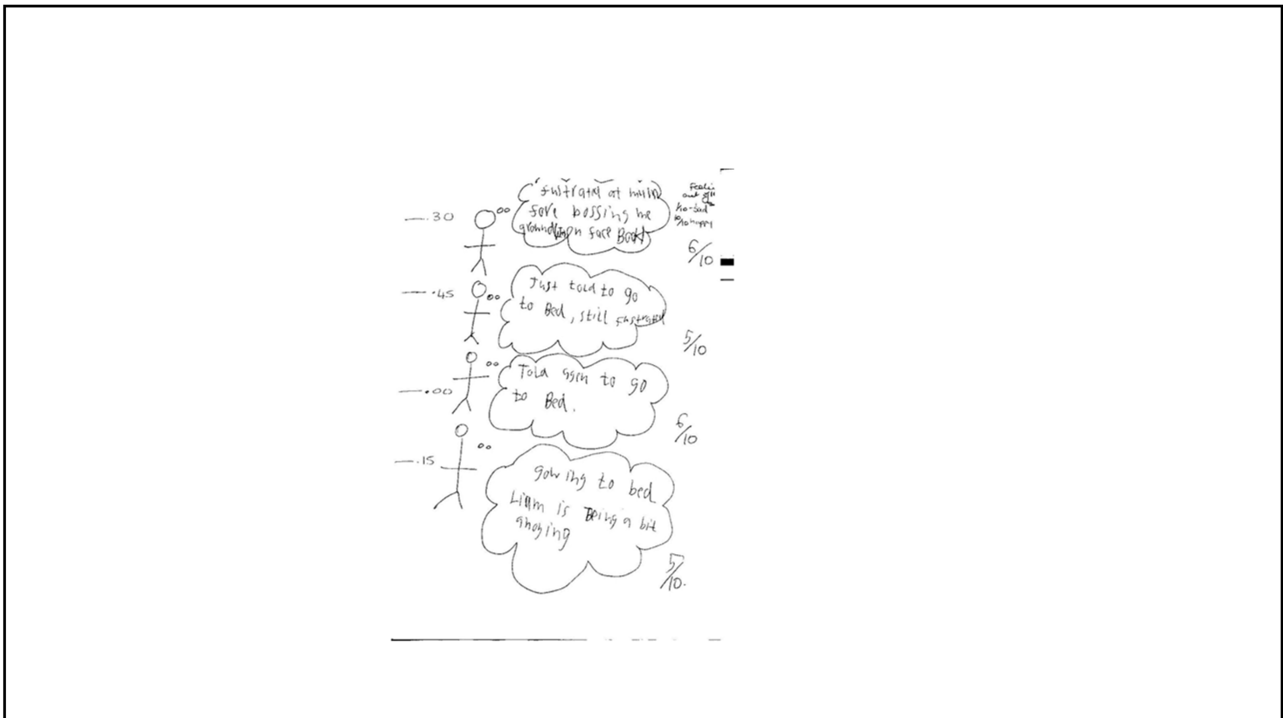

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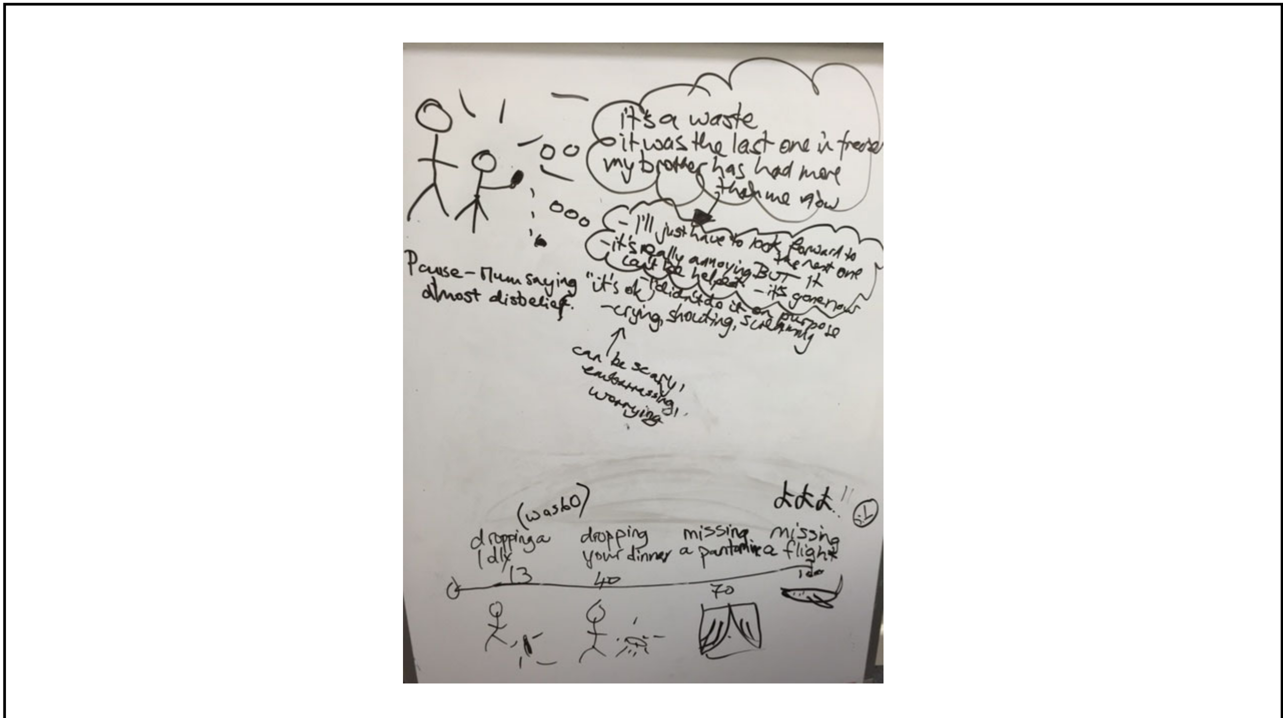

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What is anxiety? What are anxiety disorders?

Perceived **probability of threat**

X

Perceived **cost / awfulness of danger**

Perceived **ability to cope** with danger

X

Perceived **rescue factors**

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Daily Record of Dysfunctional Thoughts

Situation	Emotion(s)	Automatic Thought(s)	Rational Response	Outcome
Describe what led to you experiencing an unpleasant emotion, whether it was: • An actual event • A stream of thoughts, a daydream, a memory, or an image	1) Record whether you were feeling scared, angry, sad, etc. 2) Rate how strong the feeling was (0-100%)	1) Record the automatic thought(s) that went through your mind just before the unpleasant emotion 2) Rate how strongly you believe in the automatic thought (0-100%)	1) Write a rational response to the automatic thought(s) 2) Rate how strongly you believe in the rational response (0-100%)	1) Re-rate how strongly you now believe in the automatic thought(s) (0-100%) 2) Record your emotions linked to the automatic thought(s) (0-100%)
at Tower of London	Guilt - 75.	I haven't earnt this wonderful visit 50/100	My uncle + aunt just want to spend time with me! 85/100. - this is not something I had to earn, it's just nice! 78/100 - it'll be fun!	- Guilty 1/100. +ve feelings? Wow - I'm so lucky to see the crown jewels (forgot about guilt)
playing football and I accidently kick a person from the opposition	Bad - 55/100 He makes a fuss	oops! I shouldn't have done that.	ow I think I've broken my leg! 0/100 (He's standing up) It was an accident, happens all the time in football	bad 10/100
I was playing on the Wii and I won a race against a person who had come to my house and he said: "you beep"	65/100 angry	Why is he saying "you beep" What does it even mean. He should just say well done. 85/100	you don't know what you beep means! Wow! Not really a worry.	65/100

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Modifications

- Maintaining attention:
  - Regular breaks if needed
  - Less abstract spoken language
  - Incorporate child's special ASD-related interests- within reason

Parental involvement

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

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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

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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

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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

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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’

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Rumination

- Almost part of ASD profile – loop thinking, getting stuck
- Worry time at home or school
- Anger rumination – noticing and letting go.
- How much part of formulation? Is it a problem?

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Techniques to stop ruminating

- Be aware you are ruminating and realise it isn’t helpful
- Think ‘stop!’ or even say it out loud
- Centre yourself in the here and now
- Think about your favourite thing instead – anything that’s absorbing

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Don’t forget the ‘B’

- Use rewards wherever possible to shape new, ‘brave’ behaviour
- Rewards can also be useful for very rigid children, who are resistant to change

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Differences in exposure

- Differences carrying out exposure work

e.g. developing hierarchy, preparing for behavioural experiments, more relaxation techniques before..

in vivo exposure, rather than reflection afterwards.

What do you think would happen if? I don't know I haven't done it yet.

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Challenging issues

- Lack of insight into difficulties and their impact
- Rigidity – moving on from thoughts, feelings & behaviour
- Rages & meltdowns
- Lack of social skills
- Circumlocutory style/tangential thinking
- Endings

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Other challenges (from group)

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Lack of Insight:
Whose problem is it anyway?

- Why am I here? Don't assume the child knows
- Who identified the problem? May be parents/school/GP
- Really important to clarify a shared understanding at the start and revisit this as sessions progress

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Lack of insight: The child's understanding of their difficulties

- Does the child identify having any difficulties at all and do these match up with the referral question?
- Are they aware of the impact of their difficulties on others?
- Information from questionnaires
- Consider the child's response (verbal and non-verbal) when others describe concerns:
  - -do they listen?
  - -do they understand?
  - -do they dismiss the problem, or deny it?
  - -black and white responses – introduce scaling

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Lack of insight: Motivation for change

- Goal setting (miracle question, motivational interviewing techniques, externalising/narrative approaches)
- Shared goals between child and parents?
- Think about where the problem is located…what else might need to change in the family/school environment first?
- May not be internally motivated and need external rewards

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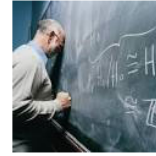
Rigid thinking style



- Lack of flexibility in thinking > ‘stuck’ in therapy
- Cognitive distortions e.g. black & white thinking can be difficult to shift
- Shifts may appear small but actually relatively large
- Consider alternative approaches to managing thoughts – e.g. mindfulness.

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Rigidity in feelings

- Resistance to engage in any behaviour that is not congruent with mood e.g. behavioural activation in depression

‘I will try if I feel I can..as and when I feel comfortable to do so’

‘I can’t push past the feelings’

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Rigidity in behaviour

- Poor generation of ideas – limited problem solving (give ideas & alternatives to choose from)
- Practice alternative ideas – over-learning
- Resistance to anxiety exposure work as avoidance is main coping strategy>high levels anticipatory anxiety

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Catastrophic thinking

- Confidence in own ability to change

'I've slipped through the cracks and that's it'

- Progress in therapy

'Nothing is working'
'There's no point'
'I'm not coping'

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Rages & meltdowns

- Challenging but useful
- Opportunity for discussion and generating new ideas
- Case examples

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Lack of social skills

- How does it feel if your client doesn’t make eye contact with you?
- Appears nervous every time you ask them a question?
- Gives one-word answers?
- Is quite off-hand with you when you had a great session the week before?

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How does this impact on therapy?

- Transference
- Withdraw
- Make assumptions (they don’t like me, I’m not a good therapist)

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Tangential thinking

- Negotiation of how spend time
- Balancing rapport with structure
- Mindfulness techniques for noticing where attention gone using parents

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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

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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

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Predictors for effectiveness

- IU (Keefer et al 2017)
- The family (van Steensel et al 2016)
- Cognitive inflexibility? (unpublished data)

- Exposure – parents and young people like it more than clinicians do!

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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

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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)

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Dugas model of GAD

- Intolerance of uncertainty
- Positive beliefs about worry
- Negative problem orientation (attentional bias – focus on what can go wrong)
- Cognitive avoidance (distraction, using 'worrying' to try and suppress more threatening thoughts)

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Is this a problem or a worry?

- If it's a problem, solve it
- If it's a worry, use strategies to stop worrying (psychoeducation about worry, positive imagery, review beliefs about worry)
- Expose to mental image of feared scenario (eg worry about getting into trouble – expose to getting a detention)

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Positive beliefs about worry

- Do worries really help me be prepared?
- When have worries ever helped?
- What are the costs/benefits of worrying?

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Treating IU

- CBT- impossible to avoid uncertainty, so develop a tolerance through graded exposure and behavioural expts

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Exposure to uncertainty

- Plan a surprise (positive, negative, neutral)
- Reduce ‘safety behaviours’ which aid feeling prepared
- Try and reduce thinking around every situation
- Some parents like to have an element of uncertainty in the daily schedule

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Imagery

- Very little research in children, let alone ASD
- But intuitively a useful approach – visual thinkers, reduces verbal load

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Imagery techniques?

- Ask the question: do you think in words or pictures?
- Re-live a troublesome memory, identify fragments and missing bits, run on past the worst point
- Modify images
- Re-evaluate beliefs about self

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Metaphor

- To say autistic people can't understand metaphor is also a myth.

(Donna Williams)

Metaphor

- Can be used VERY effectively
- Sat nav
- Peers classified as friends or enemies. Sees self as ‘at war’ with enemies. Used analogy of behaviour being different when at war – vigilant to threat, ready to attack. Modify to ‘peace time’ behaviour – stop monitoring enemies, no need to be on the defensive. Focus on friends not enemies.

Treatment implications

- Imagery-enhanced CBT may be more effective than traditional CBT
- Imaginary rescripting
  - Moving on past hotspot
  - If a fictional image, change to a more benign image
  - Creating a coping image and using when necessary (eg adult self)
- Cognitive restructuring within imagery – update thought

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Narrative therapy

- Systemic model of therapy
- Non blaming approach, which centres people as the experts in their own lives.
- Views problems as separate from people
- Assumes people have the resources that will help them to reduce influence of problems in their lives.

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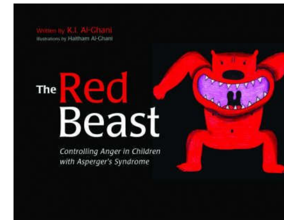
Externalising conversations

(e.g. Michael White (see Carr, 1998); Morgan, 2000)

- Externalising problems: understanding & talking about problems being separate from the person

- Characterisation or naming of the problem

What image comes to mind when you think of it?
How has the problem had you acting/talking /thinking/feeling?



(e.g. ASD – Cashin, 2008)

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Tips for externalising

- Use child's name/characterisation for problem e.g. *'the black hole' (depression)*
- '***The***' anger rather than '*your*' anger
- Taming problem/ ignoring the problem/talking life back from the problem
- Externalise positive things too *e.g. 'using strength'* rather than *'being strong'*

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Stories in the therapeutic context

- Collaboratively exploring the stories that people have about their lives, their effects & meanings
- Problem saturated stories maintain the problem
- Inquiring about unique outcomes
- Generating alternative stories that do not support or sustain problems

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Narratives of ASD

- Creating a meaningful narrative of ASD can be challenging for parents (e.g. Gray, 2001) and young person.
- Narratives influence relationship to help
- Co-existence of multiple stories between parents & professionals - co-create a narrative to hold all complexities of their journey (e.g. Solomon & Chung, 2012)

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