

Understanding Anxiety Disorders in Elementary School Children with ASD

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Children with high-functioning Autism Spectrum Disorders (ASD) commonly have concurrent psychiatric disorders, particularly those associated with anxiety, mood, and disruptive behavior.¹ Research suggests that as many as 30% of children with ASD have a comorbid anxiety disorder. For the past five years, our research lab at UCLA has been awarded grants from the National Institute of Mental Health, the Cure Autism Now Foundation, Autism Speaks, and the Organization for Autism Research, to study anxiety in elementary school aged children with ASD. Our studies, one of which was recently published in the *Journal of Child Psychology and Psychiatry*, found that almost all children had more than one anxiety disorder, including social phobia, separation anxiety, generalized anxiety, obsessive compulsive disorder, and other comorbid psychiatric disorders such as ADHD and depression. Strikingly, many of the children had four or five concurrent psychiatric disorders.²

When a child with ASD is simultaneously challenged by an anxiety disorder, his or her ability to function at optimal levels across environments can be greatly impaired.³ Anxiety can range from fluctuating, mild, and completely understandable to unremitting, severe, and irrational. Most children experience some form of anxiety on a regular basis. Moderate levels of anxiety can actually be a positive, motivating force to increase a child's level of effort and attention when working on tasks. However, research has also suggested that *high* levels of anxiety (anxiety disorders) can negatively affect academic and social success.⁴ Recent research found that children with high levels of anxiety tended to perform below their academic ability level, leading to lower academic mastery and poorer social adjustment.

Anxiety and fear are closely related emotions that occur in response to perceptions of *threat* and *danger*. Individuals tend to focus on negative future events that *might*, but won't necessarily, occur. For both children and adults, anxiety and fear are linked with physical discomfort including nausea, headaches, a racing heart and numbness or soreness. These physical sensations and corresponding negative mood result from the anticipation of unpleasant events such as failing a test, embarrassing oneself, or becoming lost. The sensations may gradually go away, once the possible "danger" passes, leading to a sense of relief, only to return again when a threat or fear is triggered. The "fight or flight" concept is closely related to high levels of anxiety and fear – for example, children often avoid situations that make them very anxious ("flight") or they may become more oppositional ("fight").

Because the experience of anxiety is somewhat private, other people may not be aware of a child's distress. This is especially true in the case of ASD where children are less likely to verbalize an experience due to difficulty in understanding and describing their own emotions. Certain behaviors may suggest to parents and teachers that a child with ASD is suffering from excessive levels of anxiety. In the case of *separation anxiety*, a child may worry about being separated from his or her caregivers because either the child or the caregiver is perceived to be in imminent danger. This will usually involve some type of concern about either the child or the parent being injured when they are away from each other (e.g., at school). For example, indicators of a child's anxiety might include, not wanting a caregiver to leave them during a play date, or having difficulty separating from the caregiver in the morning, such as delaying getting ready for school, tantruming and crying when the caregiver attempts to get the child out of the car, or insisting that the caregiver stay in the classroom. .

Behaviors that may suggest the presence of *social anxiety disorder* include, hesitation to ask or answer questions in class, reluctance to approach peers and engage in conversation, avoidance of working or playing in a group with other children, resistance to participating in performances in front of others, and a lack of confidence or fear of talking on the telephone. Children with high social anxiety tend to be afraid of embarrassment and humiliation in day to day situations; they often worry that they will be laughed at or made fun of. Common remarks such children make are, "I kinda feel shy than other kids. I don't really know what to say." "What if I give the wrong answer?"

Social phobia or *social anxiety* can interfere with social skill and friendship development as well as academic performance. Children with high social anxiety often misperceive social cues and situations with a bias towards perceiving and recalling failure and rejection. This in turn makes them more hesitant to approach situations in which they perceive they might get rejected or fail again. These children may also tend to overlook social interactions in which they were successful. They are also at risk for lower levels of academic achievement because they may not ask questions in class about concepts or about their homework assignments. They may then have an incomplete understanding of the material they will be tested upon, thus resulting in reduced performance.

Our research group at UCLA has developed a cognitive behavioral treatment (CBT) program and manual to address anxiety in children with ASD.⁵ Common CBT techniques such as cognitive restructuring of negative thoughts, role-play and modeling, and hierarchical exposure to feared situations are modified for children with ASD and are used to address anxiety and social communication skills. Incorporating "special interests" to motivate children during weekly treatment sessions has proven to be successful and promotes increased rapport between therapists and children. The manual includes additional treatment components including (1) development and direct application of friendship skills, (2) self-awareness of one's appearance and its effect on others, (3) suppressing stereotypes (stigmatizing repetitive behaviors), and (4) improvement in self-help skills. These strategies are incorporated into a 16-week treatment plan that requires parent involvement and weekly homework assignments in order to promote generalization of newly learned skills into the home and community. Small rewards are used to enhance children's motivation during therapeutic exercises conducted at UCLA as well as social skills application, play dates and independent performance of personal self-help skills conducted in the home and community. Social coaching is also taught to caregivers to improve children's social problem solving and communication skills in all settings.

Some children with ASD are hesitant or avoidant of social situations due to past negative social experiences—for example, peers laughing at awkward behaviors in class or during play. By setting up circumstances for a child to engage in social activities with a high level of success and enjoyment, he or she can develop competing pleasant memories alongside the former negative memories of social engagement with peers. With enough repetition and supporting cognitive "restructuring" with the therapist, the memories can eventually favor a more positive outlook or response in social situations.

Results from our randomized clinical trial and case studies⁶ indicate that the majority of children make significant improvements in their level of anxiety, social communication skills, development of friendships, as well as daily living skills. Most children no longer met criteria for an anxiety disorder at the end of the treatment. Currently, research is being conducted through the The Help Group - UCLA Autism Research Alliance to determine the effectiveness of this CBT treatment for anxiety disorders in children with ASD who are attending the Village Glen School in Sherman Oaks.

For more information, please contact Dr. Jeffrey Wood at (310) 825-0537.

References:

1. (e.g. de Bruin, Ferdnand, Meester, de Nijs, & Verheij, 2007; Leyfer et al., 2006; Muris, Steerneman, Merckelback, Holdrinet, & Meesters, 1998)
2. (Wood, Drahota, Sze, et al., 2009)
3. (e.g., Bellini, 2004; de Bruin et al., 2007; Drahota, Wood, Van Dyke, & Sze, under review; Wood, Drahota, Sze, Van Dyke, Decker, Fujii, Renno, & Spiker, 2009).
4. (Har & Wood, 2007; Wood, 2006)

5. (Wood, Drahota, & Sze, 2007).
6. (Drahota et al., under review; Sze & Wood, 2007; Sze & Wood, 2008; Wood et al., 2009; Wood et al., in press)