ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES (AUCD)
ADAPTATIONS OF CBT FOR PEOPLE WITH ASD
Wednesday, April 29, 2020
12:45 p.m. – 2:00 p.m.
Remote CART Captioning

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>> Maureen Johnson: Hello and welcome to the adaptation of cognitive behavioral therapy for people with autism spectrum disorders webinar. Part of Autism Acceptance Month Series sponsored by AUCD's Special Interest Group. I'm Maureen Johnson, a program specialist at AUCD. We would like to thank all of you for joining us today. Before we begin, I would like to address a few logistical details.

Because of the number of participants, your audio lines will be muted throughout the presentation. However, we will unmute your audio lines one at a time during the Q and A portion at the end. You can also submit questions at any point during the presentation on the webinar console. You may send a chat to the whole audience or to the presenters only. We will compile your questions throughout the webinar and address them at the end. Please note that we may not be able to answer every question and may combine some questions.

This webinar is being recorded and will be available on AUCD's webinar library. There will also be an evaluation survey at the close of the webinar. We invite you to provide feedback on the webinar and also to proud suggestions for future topics. I will now turn the microphone over to Autism SIG co-chair Laura Carpenter.

>> I'm Dr. Laura Carpenter, I'm a training director for the LEND program. I have co-chaired the AUCD Autism SIG for the past couple of years. And at our most recent in-person meeting we broke up into groups in topic areas that were of high interest to the

SIG and one of them was mental health. And that group came up with a high priority area of -- of getting a speaker who could talk about adaptations of CBT for autism which led me to Dr. Wood. And he generously agreed to participate in this webinar. Dr. Wood is a psychologist at UCLA. He's had an incredibly prolific area focusing on childhood anxiety disorders in general. He's published I think almost a hundred articles about childhood anxiety and has a real interest in the comorbidity of autism and anxiety.

He has won awards from many places including NMIH. Has gotten grants from Cure Autism Now Autism Speaks and a couple others. He's had a really very impressive career. I'm not going to take up any more of his time. Dr. Wood, I'm going to turn it over to you.

>> Dr. Wood: Thanks so much, Dr. Carpenter. And nice to be invited and to be with you all today. Wish it was under slightly more normal circumstances. But as I was saying a few minutes ago, I guess this webinar format would have been what we would be using under any conditions. So, it's very convenient and it's great to be able to share some of our work and hopefully a few clinical insights.

I'm going to apologize in advance. We are, of course, working from home here at UCLA this month. And so, you may hear the sights and sounds of Los Angeles. At least the sounds. Whether it be my toddlers or some nice birds chirping outside my window. The sound confusion isn't to create -- we'll try to keep it under control.

Anyway, I'm going to talk with you a little bit about some of our research findings and why we've kind of gone in the direction we have. And also, to sure some of our clinical technique with you all and to try to explain sort of the rationale and some of the procedures.

So, obviously, we all know that anxiety is a very common comorbidity in autism spectrum disorders. And we have found over the last couple of decades that in general psychiatric comorbidity in people on the spectrum is quite high. Many diagnostic studies have found that one or more comorbid DSM disorders is sort of the norm among kids and adults on the spectrum.

Within the sort of area of anxiety disorders,

children often are the gamut of the typical childhood anxiety disorders along with autism such as separation anxiety, socialized anxiety disorder, generalized anxiety.

One of the sort of interests in our lab is been sort of the origin of this anxiety in kids on the spectrum. And although there are undoubtedly many, many factors that definitely converge on the anxiety outcomes and the higher prevalence rate of anxiety disorders in this population, one of which, of course, is just a general liability for emotion dysregulation that's probably genetic and neurological in origin.

There's also a lot of stress in the lives of many people with autism spectrum disorders that seems to be associated in some ways with autism itself. We developed a hypothetical model a few years back that sort of outlines at least one set of causal linkages that would explain some of the exacerbation of people with autism. Related factors are confusion, and unpredictability. These could be some of the core onset symptoms that make it harder to read other people's cues and expectations. And to engage in sort of perspective-taking about where other people are coming from. And the confusion that can cause may make many social situations more difficult to navigate and more prone to be sort of partly negative experiences. Negative feedback and limitations that are unexpected from other people. Peer rejection sort of flows from some of those kinds of experiences related to difficulty understanding sort of expectations and social cues.

Also, for kids in schools, not being able to access or engage in highly preferred activities can be a stressful experience that will lead to a lot of conflict in the school setting. And also, the propensity to have sensory sensitivities can really increase stress in settings like schools where there are sort of intense sensory inputs, you know. Very loud classrooms and typical sort of being crammed together in different school situations and so forth.

So, in this model, these stressors are sort of a precursor or a risk factor for the increase of both general negative affectivity and prevalence for anxiety and depression. Also, specifically in the first stressor, social anxiety because sort of this direct sort

of linkage between negative social experiences and feelings of anxiety that they may generate.

Ultimately, anxiety, of course, is a precursor of other challenges of functioning. Increased social awe voidance, behavioral problems and frustration and, of course, reduced quality of life due to personal distress. So, this is just a model. But it's sort of to map out some of the ways we sort of think of the origin of anxiety for a lot of people on the spectrum.

I don't want to spend too much time on this cluster analysis. But I wanted to explain one good thing about it. This stems from one of our studies that sort of enumerated kids before a cognitive behavioral therapy clinical trial. And we asked parents to complete a five-factor model of personal form about their children on the autism spectrum. And one of the interesting phenomenons that we gleaned here is that there is quite a bit of heterogeneity at the sort of continuous level of emotion and behavior beyond sort of the world of comorbidity.

There's actually a huge amount of variability if you look at sort of these scoring ranging from the 10th percentile to the 100th percentile. Kids with autism were going between normal levels of neuroticism and anxiety, to high levels of neuroticism and anxiety. Whereas all of the children in the sample had sort of lower extroversion and lower sort of reward seeking and reward sensitivity as a really sort of common trait amongst them. And I think that's a really interesting sort of finding illustrating both the heterogeneity among some aspects of emotional behavior and autism and others that seemed sort of a common denominator to the -- to the syndrome.

And similarly, conscientiousness which sort of reflects an emotion regulation and behavioral regulation and goal-orientation, personals. See sort of a large amount of heterogeneity in some children having a lot more difficulty with this and some being rather good. So, at any rate, I wanted you all to know that, you know, part of our conceptualization is simply recognizing that autism is not the sort of homogenous phenomenon. And even through children who share the diagnosis differ from one another in really, you know, prominent ways that do make a difference. And sort of making plans for

intervention and conceptualization of their highest clinical needs might be interested to know that even the size of the clusters that we abstracted was fairly variable. I'm not going to get into that too much time at this time. But heterogeneity was definitely notable there.

One of the interesting findings from an anxiety perspective is that one of the groups which we call cluster 1 from this cluster analysis had really high social anxiety. But also, really low extroversion and high social withdrawal. So, one of the big questions that often arises in assessing children with autism and anxiety is, is the social anxiety that they may appear to have actually anxiety? Or is it more a lack of interest and avoidance of social engagement in peer interactions due to sort of a lack of motivation?

And, of course, the -- the cluster analysis cannot answer a question like that. But there is a few notable components of these findings that, you know, offer some insight. Amongst this group the children had normative trait anxiety and relatively high agreeableness which is a sort of -- another social variable in the world of the five-factor model of personality.

So, the question is: Are these children experiencing sort of a local sort of wariness or caution around social situations where there's been maybe rejection and victimization in spite of having some positive dispositions in their agreeableness? Or is there low extroversion with this phenomenon and the high social anxiety is essentially reflecting social avoidance due to a lack of interest?

Well, at any rate, I think that you can see that there's a lot of difficulties in making some distinctions between anxiety and core autism symptoms. And this is an ongoing clinical issue in the field. So, as I touch a little bit more about our clinical trials, you will share a bit about how some of these distinctions, how we handle them and what the kids are like who end up being in the interventions. We've been working on a personalize the CBT for the children on the spectrum with all the 6 to 14 years total. We call it the behavioral interventions for anxiety for children with autism. And it is comprised of 16 weekly outpatient meetings, 90 minutes each. They're split roughly evenly between the -- the child and the

parents. And there is sort of a core element of a very recognizable cognitive behavioral therapy paradigm that in some ways resembles the intervention for children developed by Philip Wendell.

But simply it's more personalization. And sort of adjustment for some of the features of autism. Okay. Let's see. I wanted to check in the chatbox there. So, a strong correlation between depression and anxiety? Yes. There is a pretty strong correlation among people on the spectrum and as so, there's seemingly a generalized risk factor of sort of propensity for negative affect. And stress is internalized and promotes anxiety and depression for people on the spectrum. And yeah. The lower reward seeking behavior -- behavioral analysts do rely on reward quite a bit. It is true. And it is a cornerstone of the CBT program that we use as well.

And I think that there is this interesting distinction in the literature between sort of reward-seeking and you might say walking rewards versus the enjoyment of the consumption of rewards. And seemingly the pleasure of being rewarded can still be intact even if the drive to seek rewards maybe more limited in people. And that's certainly one of the characteristics of some kids on the spectrum in circumstances where social interactions may be rewarding when they were set up successfully. But the seeking out of them still might be more than in other kids of the same age group.

Okay. How verbal do kids need to be in the BIACA? Well, we have done pilot studies of kids down to IQs of 45 with minimal language. But most of the clinical trials have been done with kids with IQs of 70 or higher and you'll see why in a minute. But there's definitely modifications that we have made that make it possible with greater emphasis on exposure therapy and just sort of very simplified reward paradigms. Okay.

Let's talk a little bit about some of the adaptations to CBT that we've made over the years. Of course, standard CBT for anxiety is essentially a combination of exposure to situations in a hierarchical manner and development of coping skills that involve sort of coaching yourself to think more rationally about sort of cognitive distortions, about stimuli. And sometimes relaxation techniques. And self-coaching

or self-reward. But those are the core components.

So, one of the modifications that was made early on in developing BIACA was to include some social communication and repetitive behaviors and even under controlled behaviors that had clinical significance into the sort of hierarchy of goals for the student or the child. For example, a child who was being derailed by having frequent tantrums for shouting in class. Whether that was anxiety-based or not, we quickly learned we would not bother trying to parse that out because, A, it would be impossible to know for sure. It's just a guess. And B, obviously the clinical significance of a symptom like that may be much greater than a classic fear of snakes or spiders or whatever other phobia, you know, is happening concurrently.

So, being practical and dealing with the highest priority overall clinical challenges that a child presented with became clearly a high priority for making BIACA an effective clinical tool and not just sort of a research project.

We also learned that we could partially reverse some of the cognitive and behavioral elements of CBT doing more up front work with exposure therapy early on and there are reducing reliance on language and social interactions with the therapist. Or the, for example, aid sessions of that kind of work that occurs in the coping intervention. And we kind of boiled that down to a few introductory sections before having the active life participation that therapist entails. And sometimes after facing fears, of course, sometimes it's easier to talk about these in more of an abstract way. Because one has already had one's hands on it.

So, for example, if we're talking the fear of being in a room by yourself. Sometimes actual doing it, practicing it, taking small steps. And then having some language in about, hey, you know? Wasn't so bad, right? What made it possible to do that? Makes it more feasible for some of the cognitive restructuring components that are sort of classic CBT elements to be meaningful in working with kids on the spectrum. And certainly, produced a much better rapport too because the timing they have seen was more active and the language kind of came as an addendum to a shared experience.

Another element that we learned we needed to add were sort of social supports. Including really learning how to have effective play dates. Lawing a lot of the work of Fred Frankel and his friendship training concepts and peer buddy programs at school for children who were really struggling even after putting a better foot forward in connecting with others. And that was used relatively rarely. But still became a tool that was sort of available.

Social coaching became a really kind of core fundamental addition that, although not necessarily just treating social anxiety, was in our view a very critical element in helping children learn to more effectively assess sort of situational demands in social situations. And learn to read social cues on the spot by having a parent or other sort of involved adult essentially on the spot, sit down with the child for 30 seconds, 60 seconds. Say, hey, let's do -- look at what's going on here. What do people expect of us? Whether it's sort of the behaviors we want to be shooting for to be successful. A reward would be such and such in this situation. For acting in sort of the expected way and helping the child participate in the conversation and helps them keep them processing of the concepts that the parents were trying to share about how to assess a particular social situation.

So, that was a very fundamental addition to classic CBT. And then you had asked a minute ago about rewards. Rewards are really critical in BIACA for sort of facing fears and you want to face fears on a daily basis at home. And sort of take homework assignments home from the CBT sessions. And how parents become sort of a peer professional when helping the child to really work on these therapeutic assignments daily and then earn small kinds of rewards daily in a quid pro quo format. Earning screen time. Earning treats or stickers. Whatever the child finds motivational that's feasible for the family. Also earning screen time is one of the most fundamental rewards that it keeps giving throughout the course of treatment.

BIACA stands for behavioral intervention for anxiety in children with autism. And then increasing the use of visual supports in CBT and not just relying on sort of conversations as the primary format of

intervention. And trying really hard to incorporate special interests into the examples and the conversations to make it more engaging. Drawing a lot from pivotal response treatment with that concept.

For example, when a child was obsessed with cats that we remember fondly. So, all of the cartoons we drew involved cats. There was a super-hero cat that was facing fears that was very motivational for this child. And even some cognitive work he imagined having a cat on his shoulder sort of coaching him to be brave in certain situations. So, using sort of preferred interests as a metaphor became a really key element.

We talked about the parents roles in the last slide. So, I'm going to move ahead for the moment. I'm going to briefly review our most recent study on BIACA and then get back to a bit more clinical technique in a minute. We just finished a three-site study of BIACA. We compared it to coping cat and usual care with 167 children on the spectrum which were 7 to 13. And let's see.

Yes. The modified CBT does apply to kids with ASD and OCD as well. The technique for OCD is exposure with prevention. And the BIACA manual sort of incorporates that concept. It's a very slight adjustment from typical with anxiety disorders. We always included kids with OCD even if that was the only comorbid diagnosis and it seems to work just as well. Okay.

Usual care, we kept this to a small number of families because we wanted to give most of the families active treatment. So, I think there were 17 in usual care. Or 19. Here are the demographics of the -- of the full sample. And the other two sites were Temple University and University of South Florida.

And in terms of outcomes, but I did have a greater improvement in clinical anxiety on our primary outcome measure. We call it the pediatric anxiety rating scale. It's a diagnose those in addition-based interview given by someone who didn't know the treatment condition for the child. Sort of a masked diagnostic assessment. Even so coping cat and TAU didn't differ. But BIACA differed from both of those groups. However, both coping cat and BIACA had better treatment response, clinical ratings from the diagnostics. Kids from coping cat improved in their

overall symptomology. It was a little bit less in the severity. The same was seen on the scores, coping cat and treatment as usual didn't duffer. But BIACA had lower scores over the course of the treatment. Same with the anxiety depression sub-scale.

Okay. So, is coping cat no better than treatment as usual and outcomes? It was no better than treatment as usual on the main outcome measure. But on the CGI, it clearly outpaced treatment as usual in terms of at least making measurable improvement. And I think that the best way of thinking of it when you look at all the measures in total is that Coping Cat had a middle position between BIACA and treatment as usual in terms of its outcomes. And since it wasn't adjusted for kids on the spectrum and didn't take into account, you know, sort of the particular needs and clinical phenomena of autism, it was sort of not a big surprise.

But there was good news that it seemed to still be beneficial in some measures. Let's see. Yeah, the mask, we had essentially the same findings. Interestingly on the sort of more adaptive behavior end of the spectrum, the anxiety impact scale, social score, BIACA and Coping Cat had similar trend lines. Slightly different. But, you know, both outpaced treatment as usual.

BIACA and Coping Cat had almost identical scores for sort of school-related impairment and improvement. As compared to treatment as usual. And on the other hand, on the social responsiveness scale, there wasn't much of a difference between coping cat and treatment as usual. Which doesn't really surprise me because Coping Cat didn't make any attempt to address autism -- core autism symptoms. Whereas that's sort of baked into the BIACA approach. And the control treatment was treatment as usual. So, the children in that condition essentially just carried on with their either psychopharmacology, their counseling interventions. They were all given referrals. Some of them chose to do in intervention during sort of the period in which they were in that condition. And then they were given their choice of Coping Cat or BIACA after they finished three months of being in this treatment as usual condition.

There is a BIACA manual. I'm actually going

to share at the end of this talk shortly a free website that we've developed that has both the manual and kind of guidance on how to use it and training videos. So, will share that shortly. We had developed that. Just going to get a sip of coffee here.

So, yeah. I think that at this point I want to show you actually one of the videos we had developed in our dissemination and implementation grant that I just mentioned. You will see that really exposure therapy is a fundamental and necessary tool for behavior change in CBT for kids with autism. And in many ways, it shares that common denominator with all other CBTs for anxiety disorders. And you'll see that pretty clearly in the video I'm about to show you. There's some effort here to utilize the child's special interest in Harry Potter as sort of a motivating topic and a way of engaging this around the exposure process.

But ultimately, we do have the quality of needing to be individualized to what the child is willing to do in the moment. What can be negotiated with the child regardless of whether they have autism or not on the spot. And using rewards and sort of the trust in the therapeutic relationship to help the child to push themselves to face more challenging fears and start to experience habituation and recognize that the fears are largely unfounded. So, these are actors who are portraying sort of modified scripts from actual therapy sessions from our clinical trials work. So, there's no concerns about confidentiality and so forth. Our training videos are up on YouTube.

Maureen, if it would be possible to show the video link now, I think this would be a great time for it.

>> Maureen Johnson: Okay. Sounds good. Hold on one second.

>> Dr. Wood: Yes, facing your fears is essentially exposure therapy and you'll see what I mean with this video.

>> Maureen Johnson: All right. Can everyone see my screen? All right. I'm gonna play the video now. Hold on one second, please.

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>> That's a good kick plan for Harry Potter. So, how about you? What about a calm thought for

right now when you stay in the room by yourself for a minute?

>> It rarely happens.

>> So, what can you think as your calm thought?

>> If I knew that, I wouldn't have come here today.

>> Yeah. And what's another way that you know that it's extremely rare to be kidnapped.

>> No one I know has ever been kidnapped.

>> Yeah. And remember that day that we figured out that you have been alive like 3075 days and you probably know about a hundred people. So, that's like 300,000 days that you've been alive and people you know have been alive without anyone ever being...

>> Kidnapped. Yeah.

>> Okay. Good. So, that's for calm thoughts. And then K. Keep practicing.

>> I'm just staying in the room by myself. That's easy.

>> Okay. So, ratings. Let's say you stay in this room by yourself with the drapes closed, door unlocked, lights out, no phone, without knowing where we are. For how long?

>> 30 seconds.

>> Okay. What rating would you give it for 30 seconds? Zero is easy, and 10 is hardest ever.

>> A 6.

>> Good. So, that's about where we want it to be since we have been working on this for a few weeks. So, go ahead and focus on your calm thought. And you'll be just lake Harry Potter. I'll be back in 30 seconds.

So, how did it go?

>> Kinda hard.

>> Okay. Did anything happen? Any problem guys?

>> No, definitely not.

>> So, if you had to do it again right now, what rating would you give it? Zero to 10.

>> Probably a 5. Maybe between 4 and 5.

>> Okay. Cool. So, it's getting a little easier.

Just like before. So, let's keep practicing. I was thinking you could pretend to be Harry Potter. Imagine Voldemort and Bellatrix with your eyes closed and think about Harry's calm thought.

>> Dr. Wood: Or, you know, AKA facing your fears which is just a general term used in CBT for exposure therapy. Is preceded by a little bit of cognitive work referencing what we call a kick plan. Which is just an acronym for a coping plan. Knowing I'm nervous, icky thoughts, calm thoughts, keep practicing. Sorts of an easy rubric to remember to -- which would result in some way to think about this supposition rationally. A rating from zero to 10 and how difficult. And most importantly, simply some kind of negotiation with the child about how long am I going to face my fear? What will it entail? What are the conditions? Will the lights be on or off and so on and so forth?

This is -- the child obviously has separation anxiety issues. Being in rooms alone is difficult. And, you know, these are the kind of exposure therapy techniques that make all the difference. Exposure therapy can be adapted for any anxiety symptom. It does not all resemble, of course, being in a room by yourself. But it's a classic example of a common childhood fear. And one that is easily remedied by -- by doing this and then increasing the amount of time and difficulty. Generalizing situations outside of the therapy room is critical. Different rams and different circumstances. If the -- they need to start working on their own in their own room if they're a co-sleep, or at least in some independent manner and so on and so forth.

There is a whole logic behind exposure therapy, and this encapsulates one small example of it. But an important one. One of the things to know about it, even though the child is giving ratings before and after the exposure how hard it would be, we're not concerned about the ratings and whether they go down or not. The research is clear that the longer that a person can stay in an exposure situation without avoiding it, the more clinically effective it is in reducing their overall anxiety symptoms.

And so, simply learning to tolerate the feeling of anxiety and to stick with sort of facing the fear and not avoiding is seemingly the single most important

factor in most exposure therapies so it has to be long enough. Has to be done with a calm enough attitude for it to be processed as a success. And these are factors that you want to make sure that become a part of associate of negotiating with how the child is going to do a particular exposure activity like that. If the child's extremely nervous and crying, it's probably not going to work. And it needs -- it needs to be sort of done in a collaborative way and where the child can say, I'm going to try this. And I am going to try to do it calmly.

So, at any rate, let's see. Can modified CBT -- yeah -- be applied to children also with intellectual disability? And definitely with adults. I think there is no doubt about that. For children with intellectual disability, again, our research has done pilot work with children going down to an IQ of 45 and higher with relatively limited verbal language. And with greater emphasis on just exposure and less emphasis on sort of the verbal conceptualizations of, you know, cognitive distortions and icky thoughts and calm thoughts and so forth. It's still definitely has some potency and our small multiple baseline study found it was effective in reducing anxieties and fears.

So, one of the reasons -- a lot of people ask at this point, if exposures are so important, why not just do exposures and leave all of the talk and sort of concept work from CBT behind? And, of course, there's a strong behavioral tradition for autism of doing primarily behavioral kinds of interventions. But there is a sort of strong grounding in the cognitive science model of CBT that suggests that without the concept -- the mental concept that a particular class of situations is essentially safe and non-threatening, the generalization is really hard to achieve.

So, you, for example, will see in studies that you can overcome a fear of spiders in a lab setting. But if nothing's been done to help with generalization such as building up cognitive concepts of spiders as being essentially harmless, then you can walk into a garden or any other outdoor area and get what we call a return of fear. It's the exact same level of fear and avoidance and panic that you would have if you had never been in the lab-based exposure therapy setting.

So, generalization is really -- it's facilitated by

having concepts such as sort what have we call calm thoughts, rational thoughts about the feared stimulus such as monsters don't exist, in this case. To help ground cognitively a sort of schema of a situation and build that schema up so that it becomes a more likely schema to be sort elicited from memory when presented with the cue or stimulus of the feared situation.

Memory research has often been cited in CBT models to explain why and what elements are particularly important to include in -- in an intervention. One of these elements is elaborated rehearsal with deep semantic processing. We remember things better when we're not merely parroting what we have been told and regurgitating it. But we actually think through and do some of the -- the logical reasoning for ourselves.

So, in other words, instead of saying, repeat after me. There are no monsters. It is more effective to say, hey, let's try to understand whether there are monsters. What can we do to learn about this? What can we find out from the Internet? What do scientists say here? Let's find a little video clip. Now, let's put in your own words. What can you tell me about monsters now? So, helping people to verbalize in their own words through their own mental conceptualization sort of the basis of the rational assessment of the feared stimulus is really helpful. And it produces a much more potent, strong memory of the adaptive appraisal of a feared stimulus such as there's no monsters. Or being in the room is perfectly safe and even pleasant. And this is something that only comes from the child doing some of the processing and thinking for her or himself.

One way that this has been achieved in some of our work in BIACA in sort of an efficient manner is actually leaving sentences unfinished. And that was demonstrated in the video back then when the therapist sort of used that example of, like, the number of days that people he knew had been alive without there having been quote, unquote, a monster or bad guy being seen by anybody. And he eventually, you know, came up with his own word to finish the sentence which helped him kind of process the -- the verbalization from the therapist more effectively. Helped him stay sort of in the

conversation and not merely listen rotely and maybe immediately forget what she had to say.

So, it's an important tool in sort of promoting this way of thinking calmly to give scaffolding by offering some of the words for coping thoughts. But letting children also finish some of these sentences to ensure that they have a voice and are participating in processing more deeply.

Okay. The second principle, maximizing the similarity of the cues of the formation of the cues at the formation of the new memory. So, it's a lot of memory jargon here. But what this refers to is the truism that if you are looking to develop a change in appraisals and perceptions and -- of a feared stimulus, you are best off changing that appraisal in the place where the problems are occurring.

So, for example, if you, again, are afraid of spiders and the fear developed because you saw a really big spider in your house, then you need to do some of the exposure therapy work in your house. If you have been feeling scared of rejection on the playground, then it's not enough to sit around in a therapy room and practice social engagement and hope that that is going to transfer. But instead, the therapist really needs to set up some kinds of systems and supports for that transfer to be encouraged and incentivized and rewarded for it to be done in the setting where the problems actually occur. And that is going to lead, according to this model, to a greater likelihood that memories of adaptive social behavior and social responses and essentially not avoiding social encounters in this example would occur again in this example at school.

Lastly, encoding distinctive features for the new competitor memory. So, the competitor memory would be the idea that feared stimulus are safe. They are not necessarily so threatening that they need to be avoided. And, again, spiders, playing with peers at recess, being in a conversation. Being in a bedroom alone and so on and so forth.

So, how do you help people encode distinctive features for sort of non-threatening appraisal of focused stimuli? One way is through humor and fun and pleasure. So, this cannot be guaranteed in one's clinical work with every person. But generally speaking, it is important to try. So, again, using a

child's preferred topics as an engaging metaphor. Always trying to use incentives to keep things pleasant. Negotiating with the child it make sure that they're on board and able and willing to do a particular form of exposure willingly. 9-minute warning, got it, thanks.

Is some elements that are fairly attainable in most therapeutic relationships. And, of course, if humor and fun can be woven into the interaction, then all the better. Again, the video you just saw really illustrated, this isn't always possible. Some children can be very serious in CBT work. And not be very open to humor and sort of playful interactions. And other sort of didactic relationships don't have that element in how hard we try. But efforts can be made try to find that more fun vibe that can lead to sort of a -- a lighter and more distinctive experience.

And so, one example would be like, okay. am going to be the one to be stuck in the room and I'm so scared! And trying to make a little bit of a game of it. And sort of switch roles and allow the child to not just be the subject, if you know what I mean. And there are many other ways, of course, of lightening things up. But it's important to try.

Thank you, Brian. Such a gad point. Okay. Here is a sample hierarchy. Assuming that difficulty ratings are zero, this isn't hard at all, to 10, this is way too hard. Being alone, being separated at the stairs at dad's house. Pretty specific. This is from an actual participate. So, going to the top of the stairs alone and staying for 10 seconds. Zero. And staying at the stop of the stairs alone and going into a room were 10 seconds with no one upstairs, 5. In early planning for exposure therapy, it's important to think of very specific child-personalized symptoms that they have that can be transformed into steps that would become part of the therapeutic program. And then have the child and her or his parents make ratings on those steps. How hard would this be right now?

Slowly as program goes along, generally the hardest items on the hierarchy get easier. But, you know, it's variable. And the ratings aren't so important in terms of, oh, they've come down or they haven't come down as they're a guide to where to start. You have to start with pretty easy steps. Build

up confidence, build up some momentum. And then start negotiating or engaging with some of the harder steps that are far more clinically potent in changing fears and anxieties.

Making mistakes on purpose addresses perfectionism. Losing games with a calm attitude does that too and also has some important social skills that, you know, can be learned from that engaging therapy paradigm. Trying difficult schoolwork by myself calmly. Notice the sort of the emphasis on the attitude in that particular category of exposures. A lot of parents with children in this sub-population with autism and anxiety find themselves doing a lot of sort of maximum homework support and often sort of going overboard in many ways and things that the child could do independently if they -- if they just had more sort of emotional flow.

And so, turning it into an exposure can be very effective to achieve that goal. Trying new activities at home with a great attitude. Targeting sort of rigidity which is somewhere at the borderline of anxiety and core autism symptoms. And being calm when packages are laid. Also addressing rigidity in some ways. Dealing with bad dreams. I wish I had time to talk more about the bad dreams exposure paradigm. But it is possible to address them with CBT.

Okay. Daily reward charts. So, on the sort of task list we have some examples of exposure therapy and non-exposure tasks that are clinically important for the child to address every day. Their parents will take this home. Work with them and they would earn credit towards things like screen time and other little daily rewards each day for achieving each of these goals. This is a really, really, really, really important in BIACA. And it makes a huge difference in sort of the child east success and the program in most cases. So, parents do have to learn how to -- how to engage in some behavioral contracting and to be consistent.

Okay. I know I am running fairly low on time here. So, I will, I think, just cover a couple of these bullet points. Probably the top one is the need for therapist flexibility and acceptance. Although it is obvious that our manual, if you ever check it out on the Internet, is very detailed and descriptive. It does leave a lot of room for sort of clinical ingenuity for

each child or teen that you work with. And most importantly, outside of the manual, is simply the need for recognizing that each child is going to have really different sort of personalities and needs and that no matter how they're coming across and whether they seem stubborn or unmotivated and so forth, that being really accepting and flexible is going to be a cornerstone of building up the needed relationship with the child in order to have a successful CBT experience that still will require negotiation and efforts to engage with initiatives and fun and so forth. And each child's formula for sort of successful progress and engagement, of course, is going vary a bit.

And it looks like I may be out of time here. So, Maureen, I will just quickly fast forward here. I promised even that I would share the website where we have, you know, the manual available for free and the training videos and some clinician guidance. It's just meya.ucla.edu. You have to fill out some information about who you are to get access to the website. But it's free of cost and we'd gladly, you know, share our materials with you.

>> Maureen Johnson: Thank you some of the, Dr. Wood. This was a great presentation. Thank you all for attending the webinar. This webinar has been recorded and will be archived in the webinar library at AUCD.org. Please talk a few minutes to complete our survey at the close of the webinar. Thank you so much.

>> Dr. Wood: Thank you very much. Nice to be with you all this morning.