Use of Modular Therapy for School Age Children with Autism

by

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Parent Acceptability of Cognitive Behavioral Therapy for

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Autism and Anxiety

Autism spectrum disorder (ASD) is a neurodevelopmental disorder distinguished by poor social communication and interpersonal skills, hyper-focused interests, sensory stimulation, and restrictive and repetitive behaviors (Preece & Howley, 2018). ASD symptoms differ from many other disorders in that they exist on a spectrum, suggesting that symptoms of autism may vary in severity by individual. Roughly one in forty-four children in our nation are diagnosed with autism spectrum disorder (Maenner et al., 2021). The *Diagnostic and Statistical Manual* (DSM-5), used for assessment and diagnosis of every known mental or behavioral condition in the U.S., has two categories that the child must fit into in order to have an autism diagnosis: "persistent deficits in social communication/interaction" and "restricted, repetitive patterns or behaviors" (American Psychological Association, 2013). Often, children with autism feel big emotions, behaving in ways that are atypical of other children their age. These behaviors are often in a destructive manner when their routines are changed, or when they are struggling to communicate their needs or feelings. Comorbidity, or the prevalence of multiple diagnosed disorders, is very common, almost expected, with children with autism, with roughly 70-90% of children with autism also having the diagnosis of one or more psychiatric disorders (McBride et al., 2020). Anxiety is present in roughly 40% of cases of ASD, making it more difficult for doctors, teachers, parents, and other members of the child's community to help the child because it creates even more intense behaviors (Zaboski & Storch, 2018). On average, there are differences in the presentation of anxiety between neurotypical children and neurodiverse children. Children with ASD may engage in stereotyped behaviors (e.g., flapping hands) because of some anxiety-

provoking situations. In contrast, neurotypical children may exhibit harder-to-detect symptoms like withdrawal or silence (Preece & Howley, 2018).

Cognitive Behavioral Therapy

With a prevalence in the comorbidity of these two disorders, it only makes sense to understand what strategies are available or should be created to help children minimize the symptoms of these two conditions. Evidence-based treatments have been used by school psychologists, behavior analysts, and behavior therapists to treat some of the most prevalent and outstanding symptoms of ASD, such as discrete trial training, social stories, and intensive language/communication skill building (Hungate et al., 2019). However, these strategies may not address internalizing symptoms such as anxiety. One important way to address anxiety symptoms is through cognitive behavioral therapy (CBT), in which the child can learn coping skills to use when they are presented in situations where they begin feeling anxious. CBT "has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness" (American Psychological Association, 2017). Some of the strategies CBT uses as defined by the American Psychological Association, include "gaining a better understanding of the behavior and motivation of others", "using problem-solving skills to cope with difficult situations", and "learning to develop a greater sense of confidence in one's own abilities".

A study conducted by Wood et al. in 2009 looked at the use of CBT with 40 children with autism aged 7-11 being treated for comorbid anxiety. This program used the *Building Confidence* CBT program but modified the program to fit the needs of the children with ASD (Wood et al., 2009). Children were randomly assigned to immediately be put into the 16-week program, or to be waitlisted. This study used the ADIS-C/P *Clinical Severity Rating* scale to

diagnose and determine the anxieties present in the children. The *Clinical Global Impression* (CGI)- *Improvement Scale* was also used to evaluate the children's anxiety levels at baseline, during treatment, or in some of the cases, during the waitlisted period. The study also used a third scale to measure anxiety, the *Multidimensional Anxiety Scale for Children* (MASC), which was administered to both children and parents at baseline as well as during treatment or the waitlisted time period. It is important to also note that parents were intended to fill out this scale from observing their child. The children's MASC scores from baseline to posttreatment/post waitlist were not significantly different, indicating very similar scores in both outcomes. However, the ADIS-CSR and CGI-S scale scores indicated a significant decrease in the anxiety levels of the children who were treated with CBT versus those who were waitlisted. The study proved to be successful in the children's decrease in anxiety, with over half of the children in the follow-up being considered "in remission". The study states that, "participating children had an average of 4.18 psychiatric disorders (including ASD)" whereas, "typically developing children with anxiety disorders in a recent clinical trial of CBT had an average of 1.88 total diagnoses" (Wood et al., 2009). With the overrepresentation of comorbidity in the population of children with autism and multiple mental health disorders, it is significant to note that modular CBT was successful in most of the children in this study. Because the modified CBT showed a decrease in anxiety levels for these neurodivergent children, it is significant to continue researching and using this method of treatment.

One critique is that the *Improvement Scale* used to measure anxiety over time, in response to the intervention, was completed by the therapist who had a biased reason to want the children in the CBT groups to improve. The parent ratings using the MASC did not show

significant differences in response to the intervention. More research is needed to see if CBT interventions will result in observable changes in anxiety across raters and settings.

Another study conducted by McBride et al. in 2020 looked at the responses to CBT in children ages 7-16 with an autism and anxiety diagnosis. This study also used the CGI-S scale and the ADIS-C/P scale like the study previously mentioned, but additionally used the *Pediatric Anxiety Rating Scale* (PARS) to measure the child's personal anxiety levels. The PARS is a much shorter scale than the MASC scale, as it is only five self-report questions that children complete. This study also split up groups of children based on their comorbidity diagnosis outside of just anxiety and autism, including children with ADHD, ODD or OCD, or no external diagnosis (McBride et al., 2020). This study used the *Behavioral Interventions for Anxiety in Children with Autism* (BIACA) modular CBT program as the treatment program being assessed as it specifically addresses the symptoms of children with both an ASD and clinical anxiety diagnosis. In this study, the children who also had an ADHD diagnosis were more responsive to treatment. This study also indicates that "the BIACA program includes modules targeting social and behavioral difficulties that may be particularly present in youth with externalizing disorders" (McBride et al., 2020). This study furthers the importance of CBT training in children with anxiety and ASD, while also showing that it can be used for children with other externalizing disorders.

Both studies indicate the significance that comorbidity plays in the treatment of children with ASD and anxiety, and how those can affect the outcomes of CBT treatment. The studies also highlight two different kinds of CBT modular programs modified in different ways to accommodate the needs of the different children in the study. These studies also came out roughly a decade between each other, and the small sample sizes in each were not generalizable

to the national population of children with anxiety and ASD. Another limitation of these studies is that parent/caregiver viewpoints were rarely recorded, and most of the data from questionnaires was filled out by an outside observer or the therapist. This can lead to bias in the child's anxiety ratings by the researchers or therapist who want to see change in the child's anxiety, as well as not giving perspective to both children and the person that knows them best, their parent. Little information exists in research related to parent satisfaction and perceived effectiveness of the therapies, and most of the data is collected by the researchers themselves.

MATCH-ADTC

This study utilizes the *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC).* This is an evidence-based treatment in the form of modules to combat symptoms of mental health disorders by combining practices from different clinically tried systems (*Practicewise,* n.d.). Roughly 9 of the 33 modules specifically address anxiety symptoms and will be utilized for this study. There are also several worksheets and handouts available in the modules that can be used in the CBT sessions, for example a Fear Thermometer is accessible to let the child explain their feelings in more simple terms. The MATCH-ADTC has proven successful in controlled settings of treatment, especially in reference to "transdiagnostic treatments" in which children may have multiple diagnoses and would need more specialized treatment plans (Study Results from Harvard University, 2016). While the MATCH-ADTC has proven successful in controlled studies, there is still much research needed to be completed related to its success in more realistic settings, such as schools, and its use with special populations, like ASD.

Parent Perception of Interventions

It is important that parents find treatment acceptable because they are the person in a child's life who chooses which treatments their child will endure based on how likely they think it will work in reducing their child's specific symptoms. The *Credibility/Expectancy Questionnaire* (CEQ) was originally developed in the year 2000 by Grant James Devilly and Thomas D. Borkovec (Devilly & Borkovec, 2000, as cited in Silva et al., 2021). It is a 6-item questionnaire broken into two smaller subscales with questions regarding client's overall satisfaction, expected treatment success, and recommendation of the treatment they are enduring. The CEQ remains to be one of the most used measures to understand client's expectancy in satisfaction of treatment across many different disorders including depression and anxiety (Silva et al. 2021).

The CEQ has been used across studies, especially in the realm of studying treatment acceptability of other evidence-based practices. For example, a study conducted by Drapalik, Grodberg, and Ventola (2022) looked at the use of pivotal response treatment (PRT) in its effectiveness at helping increase social communication amongst children with autism. The study utilized the first four items of the CEQ, which the researchers of this study referred to the *Client Credibility Questionnaire*, to measure parent's confidence in the efficacy and nature of the PRT (Drapalik et al., 2022). For this study the CEQ will measure parent's pre-intervention perceptions of how well they think the MATCH-ADTC treatment will work for their child's anxiety.

Purpose of the Study

Research suggests that there is a need for treatments for school-age youth with ASD who are at-risk for anxiety (Hungate et al., 2017). Likewise, there is evidence that CBT may be

effective with this group of students (Wood et al., 2009; McBride et al., 2020). Because ASD is a social communication disorder, anxiety symptoms are likely to emerge more frequently for students with ASD, given the social demands of the school climate. This study is part of a larger project aimed at examining the effectiveness of small-group MATCH-ADTC sessions as an anxiety-related treatment for school-age students with high-functioning ASD. The research question I addressed with this study is: How do parents rate perceived effectiveness regarding modular therapy treatment and its outcomes?

Parent ratings of their child's anxiety levels will be measured before the intervention begins. In addition, parents will complete a questionnaire to assess their anticipated effectiveness of the CBT intervention for their child. The hypothesis is: When the parents indicate a higher anxiety score for their child, the parent's perceived effectiveness score will decrease.

Methods

Study Design

The larger pilot study used CBT to help children grades 3-8 that have ASD and anxiety to find better coping skills when they are feeling anxious. The interventions used in the project came from the *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct Problems* (MATCH-ADTC), which is a manual with specific intervention strategies for children aged 7-13 with one of the four disorders previously listed. Child anxiety levels were monitored using the highest scored subscale on a standardized rating scale, *Screen for Child Anxiety Related Emotional Disorders* (SCARED) as rated by both the child and parent, and a child-reported feelings thermometer used during the sessions. Pre-post parent *Credibility/Expectancy Questionnaire* (CEQ) data was also collected. The larger pilot study utilized multiple AB research designs across participants to measure the effectiveness of the

CBT to combat the children's anxiety. Specifically, a nonconcurrent multiple baseline design (MBD) measured the baseline anxiety levels of the child and then monitoring their anxiety during the treatment.

For this part of the study, the pre-intervention parent-reported SCARED and CEQ data were examined. The CEQ is a 6-item questionnaire that uses a Likert scale to determine how successful the parents, in this case, would anticipate the child's anxiety to decrease over the course of the treatment. The correlation of the parent's scores on the SCARED, and their scores on the CEQ were evaluated to understand the extent to which they believed the intervention would help lessen their child's anxiety levels.

Participants

Participants were 5 parents of children in grades 3-8. These children have both an autism diagnosis and anxiety symptoms. Schools identified potential participants using existing Exceptional Children (EC) records documenting which students are served under the category of Autism (AU). To determine risk for anxiety, students with autism were nominated by their teachers for signs of anxiety. Teachers may have referred students based on behavioral observation (e.g., crying after drop-off), student self-report (e.g., reports stomach pain/headaches, complains about bad things happening, self-reported data from universal screeners), and/or other concerns (e.g., appears nervous, seems to worry about what others think).

Once students were identified, the child and parent completed research-based anxiety screener (SCARED) to determine if their anxiety symptoms were mild or moderate. Those who screened with severe anxiety were referred to school mental health teams for more intensive

supports. Parent participation consisted of SCARED scale completion pre-treatment to gauge how they interpret their child's anxiety levels, as well as CEQ completion pre-intervention, before the MATCH-ADTC sessions.

Dependent Variable - Measures

This study used the SCARED scale to measure the child's anxiety before treatment to determine the child's initial anxiety rating before treatment was instated. The *Screen for Child Anxiety Related Emotional Disorders* (SCARED) is an anxiety screening tool for youth 6-18 years old. The SCARED is a 41-item Likert scale with moderately high reliability (Cronbach's alpha= .90) (OHSU). It is comprised of statements related to five categories of anxiety: general anxiety disorder, separation anxiety disorder, panic disorder, social phobia, and school avoidance/phobia. The following responses are used for each rating: 0= "not true/hardly ever true", 1= "somewhat true/sometimes true", and 2= "very/often true" (Birmaher et al., 1999). Higher scores indicate greater symptoms of anxiety. Each subscale gets a score and there is an overall anxiety score. The SCARED was normed on a neurotypical population; however, researchers have used this measure on children with ASD. Schiltz and Magnus (2021) recommend that if the SCARED is used for diagnosis with children with ASD, that an additional follow up measure is supplemented to capture autism-related anxiety (e.g., atypical fears).

This study will also use the *Credibility/Expectancy Questionnaire* (CEQ) to measure parental satisfaction related to the MATCH-ADTC intervention. The CEQ is a 6-item questionnaire with four of the questions using a 9-point Likert scale, and 2 of the questions scored by percentages ranging from 0% to 100% at 10% increasing intervals. The psychometrics of the CEQ show high internal consistency with a total ranging from $0.84<\alpha<0.85$ (Silva et al., 2021). It also has high test-retest reliability "with significant correlations in the outcome

expectation (r=0.82, P<0.001), and in the credibility subscales (r=0.75, P<0.001)" (Silva et al., 2021). The CEQ was administered pre-intervention to the parents to determine how confident they were that the intervention would be effective for their child and if they would recommend the intervention to other parents of children with autism and anxiety.

Procedures

After IRB approval, children were recruited by school personnel and consent forms were sent to their parents. Baseline data was collected regarding the child's initial anxiety level through administering the SCARED scale to both parent and child. The SCARED scale established not only a baseline level of anxiety for each of the children, but it also identified situations that the child is particularly anxious about so the treatment was more specific to their needs. Children must have had a high enough total score from the SCARED scale, but not so severe as to need more intensive supports. The highest rated subscale on the SCARED helped to identify the specific area of anxiety that was monitored. Parents also filled out the CEQ to determine their initial feelings about the CBT and its anticipated effectiveness for their child. Parents' SCARED and CEQ scores were analyzed using Spearman's Rho correlation for rank order data to understand the relationship between anxiety levels and parent-perceived acceptability of the intervention.

<div align="center">

Results

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Descriptive Statistics

This study aimed to understand how parents expected the modular CBT program to improve their child's anxiety symptoms. The research question was: How do parents rate levels of child anxiety and perceived effectiveness regarding modular therapy treatment and its

outcomes? This was measured through initial SCARED scores provided by the parents of the 5 children, as well as the CEQ scores of the parents to gauge their initial thoughts on the effectiveness of the therapy.

The students ranged in age with three aged 8, one aged 9, and one aged 14. Four of the five students were white, and one was biracial. Also, four of the five students were male, and one was female. Two of the students' SCARED scores did not meet criteria for the larger pilot study, however their information regarding their SCARED scores provided by their caregiver were relevant for this study.

Table 1

Descriptive Statistics of SCARED and CEQ Scores

	SCARED Somatic	SCARED Generalized	SCARED Separation	SCARED Social	SCARED Avoidant	SCARED Total	CEQ Total
Valid	5	5	5	5	5	5	5
Mean	8.600	9.800	9.000	10.000	3.200	41.600	42.200
Std. Dev.	5.320	5.020	4.796	2.000	2.588	12.542	8.899
Minimum	3.000	4.000	2.000	8.000	0.000	27.000	33.000
Maximum	15.000	16.000	13.000	13.000	7.000	60.000	56.000

Here we can see the different statistics related to the different sections of the SCARED, as well as the total average scores of the CEQ for the five participants. Social anxiety and Generalized anxiety were the two more highly scored areas across participants. The average CEQ score of 42 suggests an average rating of about 7 out of 9 on the scale. This suggests that, on average, parents thought the intervention would be between "somewhat" to "very" useful.

Table 2

Spearman's rho Correlation

Variable		Severity Rank	CEQ Rank
1.Severity Rank	Spearman's rho	—	
	p-value	—	
	Effect size (Fisher's z)	—	
	SE Effect size	—	
2.CEQ Rank	Spearman's rho	-0.100	—
	p-value	0.950	—
	Effect size (Fisher's z)	-0.100	—
	SE Effect size	0.580	—

Correlation between SCARED scores and CEQ scores were analyzed through the Spearman's rho which runs its analysis based on rank order. No significant relationship was found between parent-rated severity of anxiety and their perceived usefulness of the intervention. A scatter plot of the results is below.

Figure 1

Parent Anxiety Rank and CEQ Rank
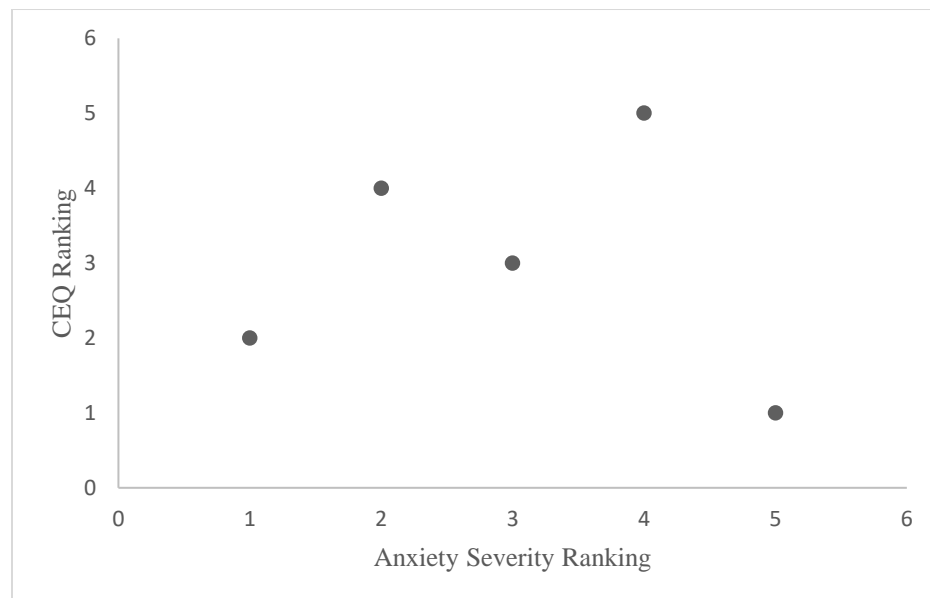
Hypothesis Testing

The main study hypothesis was: Parents indicating a higher anxiety score for their child will report lower perceived effectiveness scores. In order to support the hypothesis, the data in Table 2 would have had to show a strong negative correlation, and the Spearman's rho would have to indicate a p-value less than or greater to 0.05. The p-value created by the data in this study indicates 0.95. Therefore, the data shows no significant relationship between the ranking of anxiety levels and CEQ scores. The points in Figure 1 are scattered around the graph, and while some of the data plots indicate a relationship, there are outliers on the graph so we cannot conclude a significant correlation. This may be due to the small sample size of this study.

Discussion

The larger pilot project aimed to understand how effective modular CBT was on the anxiety symptoms of children with autism. Populations like this have not yet been studied, and with a growing prevalence of ASD, researchers should begin to focus their study on these diverse populations. This study wanted to look at how parents would anticipate the effectiveness of the therapy on their child's anxiety, another topic not presented in previous research.

Overall, the hypothesis was not supported. To show correlation between parents SCARED and CEQ scores, we would have expected a much higher effect size and a p-value less than or equal to 0.05. Therefore, we cannot confidently conclude any correlation between the anxiety levels and perceived acceptability scores provided by the parents of the children in this study. Figure 1 showed the scatter ploy between the ranking of parent's SCARED scores and their CEQ scores. Rank 1 would have been the parent that indicated the highest anxiety rating for their child, and it would decrease to 5 as there were five participating parents in this study. In

order to support the hypothesis, there should have been a strong linear correlation in this graph as we anticipated that high anxiety scores indicated low perceived effectiveness, and low anxiety scores indicated high perceived effectiveness. Although some parents SCARED and CEQ scores support the hypothesis, we cannot conclude for certain that a correlation exists. The effect size on the Spearman's rho test in Table 2 needed to show strong correlation between the ranking of children's anxiety levels rated by the parent and the CEQ score.

Though we know there is not much research on parent acceptability of CBT, we know there is research related to perceived effectiveness of other evidence-based practices related to ASD symptom treatment. With high reliability of the CEQ as a measure for this, we know that it's application in studies like this one will help to create better understanding of parent acceptability in the future.

Implications for Research and Practice

In terms of the larger pilot study, previous research indicates a strong positive correlation between CBT and children's anxiety levels. However, not much research exists on how effective it is for children with autism, or any other kind of neurodivergence. We know that autism affects one in every forty-four children, and that many of these children have comorbid disorders, and so it is important that further research focuses on these diverse populations.

This study also introduces the need to understand parent perspective when it comes to CBT, as the parent ultimately chooses what treatments their children will participate in. Research can show the positive effects of modular therapy, but if a parent is not confident in how it will aid their child, they may not want to even put their child through the process. Future research should include the understanding of parent satisfaction, and perceived acceptability, as it will

predict how likely these parents are to put their children into these kinds of therapies, as well as how active of a role they may take in the process with activities such as take-home assignments or in-home modules provided by the therapist. It is important that future research adjusts their focus from outside observers filling out rating scales and allowing parent and child to share their own feelings about how they perceive the therapy to be helping them.

Limitations of Study

This study only utilized the results of 5 parents, and the larger study was only able to use 3 of the children for research based on their eligibilities. This small sample will serve the purpose of the larger project because it is a single-case design study that capitalizes on internal validity. However, the small sample size of this study means that the information gathered cannot be generalized to the greater population of school-aged children with autism. Further research needs to be conducted on larger sample sizes and across more demographically diverse groups of children to predict the success of modular CBT. This would also predict greater perceived effectiveness by parents of these future participants.

There is also not much current research related to parent satisfaction and acceptance of therapy like MATCH-ADTC, especially related to special populations like children with autism. Post-treatment acceptability should have been measured in this study to have a more accurate understanding of if parents' thought the treatment was affecting, and if effectiveness increased the more their child participated in the therapy. Further research would need to be conducted to understand this concept.

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