

ANXIETY

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Treating Fears and Phobias in Children with ASD

Part Two of a Three-Part Series

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In the first article in this series I outlined three steps for treating fears and phobias. In this article, while I specifically describe how to treat a child for the common phobia of getting shots or blood draws, similar steps can also be used for treating other concrete fears—for example, those related to haircuts, nail trimming, buzzers, or balloons.

Jared's Fears

Jared, a 10-year-old boy with ASD has a longstanding, intense fear of getting shots and blood draws. Whenever he learns that he has a doctor's appointment he becomes agitated, covers his ears, and yells, "NO SHOTS." Trips to the doctor are stressful for all involved whether or not they result in Jared's getting a shot. The family, pediatrician's nurse, and school OT agree to work on this problem together.

Step 1: Figure out the components of the event the child fears.

While initially the pain associated with the shot or blood draw was likely the impetus for this fear, given Jared's relatively high pain tolerance it didn't seem that this was the primary issue anymore. The family had noticed at "non-shot" doctor visits

that Jared was nonetheless afraid of many things associated with shots such as the latex gloves and alcohol wipes. Moreover, the doctor's office itself had become an anxiety trigger. Jared especially didn't like being confined / held down for medical procedures. To further complicate matters, as Jared's anticipatory fear of appointments took on more components, it evolved into a more generalized "fear of fear," as illustrated in Figure 1.

Step 2: Determine and use self- and/or co-regulation strategies.

Many things helped Jared to become calmer when he was mildly anxious, including listening to his favorite music, playing with Lego figures, and engaging in playful, slapstick humor. He adored his older brother and would sometimes do things with him that he was scared to do otherwise, such as going into noisy environments. His teacher noticed that Jared was less anxious when he had a specific job to do in anxiety-provoking situations (e.g., taking pictures during class parties).

Step 3: Determine the techniques to use for gradually exposing the child to each of the components from Step 1, and then pair these with the anxiety-decreasing measures from Step 2.

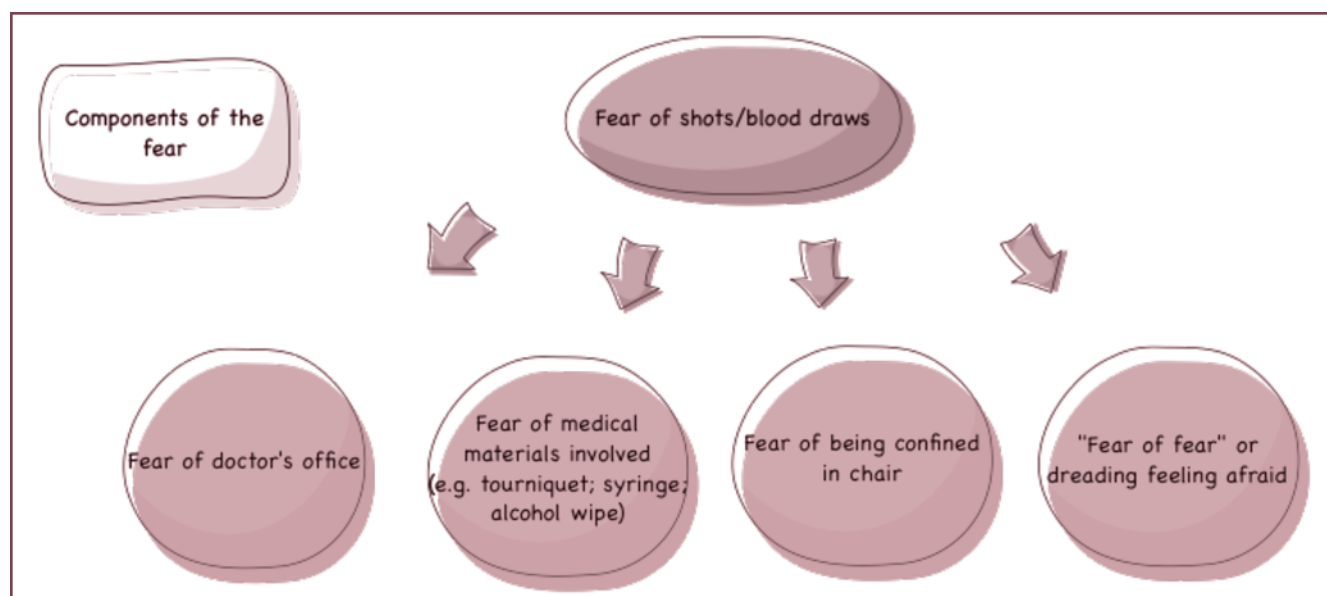


Figure 1. Components of Jared's phobia

The team obtained a variety of materials used in blood draws from the pediatrician's office (absent the needle!) in order to create gradually increasing approximations of the actual experience. In addition, the family purchased a toy doctor kit and downloaded from the Internet several video clips of children having shots or blood draws. Coincidentally, Jared's older brother had to have blood drawn and was happy to have his father videotape this. During the procedure, he made goofy faces to show that he was not scared and to help defuse the stressful situation.

The Desensitizing Process

Now the team was ready to combine gradual exposure to the components that caused the fear from Step 1 (e.g., the medical materials, the "fear of fear," the doctor's office), with the anti-anxiety measures (as will be delineated below) from Step 2.

First, Jared's father showed him one of the video clips of a child getting a blood draw, but Jared ran out of the room yelling, "NO SHOTS." This reaction meant that they had to switch to less direct, less anxiety-provoking, exposure initially. Jared's mother got out the real medical material to play doctor, but this also was too scary for Jared, so they shifted to starting with the toy doctor kit.

Where to start; what to include; and how quickly to proceed in the desensitizing process, is based upon the child's response. The goal is to have the child interested, but not afraid. If the child is scared by what you do, start with something less realistic and more playful and add more anti-anxiety measures. If the child doesn't seem to make the connection between what you are doing and the real event, add more realism.

Jared's mother then moved to less realistic and more playful activities, putting a Lego figure in a chair and giving him a "shot" with the toy syringe. She had the figure pretend to run away saying, "NO SHOTS!" thus using the type of symbolic play scenario described in *Replays* (Levine and Chedd, 2009). Jared watched, laughing; not afraid, but fascinated. He said, "Again!" and she did it again. She then handed him the toy syringe and he gave the figure a shot as Mom pretended to have the figure wiggle away saying, "No Shots." Jared wanted to play this game over and over again. Sometimes his mother would have the figure say, "Okay" and sit still; other times she would have it wiggle away saying, "No Shots." She used her son's reactions as a guide for determining how much he wanted to "practice" pretending the figure was afraid.

Jared's parents and school OT then began to add pieces of the real medical equipment and to include aspects of the

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procedural elements of the process into the Lego play. For example, they set up a chair in the living room to serve as the blood-draw chair, taped a pillow to the armrest, and used a toy golf club over the "patient's" lap to simulate the confinement component of the procedure. His big brother sat in the chair and Jared gave him pretend shots using doctor gloves and alcohol wipes, as his brother at times playfully pretended to be scared and at other times to be "okay," based on Jared's interest and responses. Jared laughed when his brother pretended to be scared, sometimes telling him, "Be scared," sometimes saying, "It's Okay." Soon Jared was willing to have the family give *him* pretend shots in the chair using the real medical materials. Thus, through this type of play Jared was becoming desensitized to each of his fear components.

As the child becomes more comfortable at one level of exposure, add more realistic props, sounds, etc. Add more anti-anxiety measures as needed. The goal is always to keep the child's interest without scaring him or her.

The next step in the process was to show Jared the video of his brother getting a blood draw. He watched it over and over, laughing each time. Given Jared's positive reaction to this video, the parents now re-introduced the Internet video clips that had initially frightened him. This time they turned the sound off and put on his favorite music at the same time. Jared no longer seemed afraid. He especially focused on when the boy in the video expressed mild fear, wanting to watch just that part many times, desensitizing himself to this fear component. His parents also introduced several different video clips to generalize desensitization to more than just one very specific script.

The pediatrician's office even allowed the family to have some practice visits. His parents told Jared that he could take pictures of equipment and select some toys to bring to the doctor's office for the playroom. These "jobs" were given both to decrease his anxiety (as per his teacher's earlier comments) and to make it clear that it wasn't a medical appointment for him. After a few of these non-appointment visits Jared was no longer anxious about going to the doctor's office.

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The Real Thing

When the time came for an actual blood draw, the team felt that Jared was ready. Both the video of his brother and one that Jared found particularly funny of the Lego figure getting a shot were loaded onto his mother's cell phone. Jared watched the videos in the car on the way to the visit and in the waiting room. Although he was becoming more anxious as his turn approached, he began to relax when the phlebotomist watched the videos, laughing with Jared as she got him seated in the chair.

For the first time Jared was able to sit through the blood draw without being terrified. In fact, he was so proud of himself that he even asked to do it again!

In the final article in this three-part series I will discuss how to treat more abstract or complex fears such as losing in games,

and fear of being late, making mistakes, doing things out of order, or not being first. 📖

Reference

Levine, K. and Chedd, N. (2007) *Replays: Using Play to Enhance Emotional and Behavioral Development for Children with Autism Spectrum Disorders*, Jessica Kingsley Publishers, London UK

BiO

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Research
NewsBrief

Nearly One-Third of Children with Autism Also Have ADHD

Researchers find children with co-occurrence of ASD and ADHD face greater impairments

BALTIMORE, Md. (June 5, 2013)—In a study of the co-occurrence of attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) in early school-age children (four to eight years old), researchers at the Kennedy Krieger Institute found that nearly one-third of children with ASD also have clinically significant ADHD symptoms. Published in *Autism: The International Journal of Research and Practice* (Epub ahead of print), the study also found that children with both ASD and ADHD are significantly more impaired on measures of cognitive, social and adaptive functioning compared to children with ASD only.

Distinct from existing research, the current study offers novel insights because most of the children entered the study as infants

or toddlers, well before ADHD is typically diagnosed. Previous studies on the co-occurrence of ASD and ADHD are based on patients seeking care from clinics, making them biased towards having more multi-faceted or severe impairments. By recruiting patients as infants or toddlers, the likelihood of bias in the current study is significantly reduced.

“We are increasingly seeing that these two disorders co-occur and a greater understanding of how they relate to each other could ultimately improve outcomes and quality of life for this subset of children,” says Dr. Rebecca Landa, senior study author and director of the Center for Autism and Related Disorders at Kennedy Krieger. “The recent change to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to remove the prohibition of a dual diagnosis of autism and ADHD is an important step forward.”

Participants in this prospective, longitudinal child development study included 162 children. Researchers divided the children into ASD and Non-ASD groups. The groups were further categorized

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