



Interdisciplinary

LINKSCIENCEPLACE

DOI: 10.17115

ISSN: 2358-8411

Scientific Journal



Interdisciplinary Scientific Journal. ISSN: 2358-8411

Nº 5, volume 6, article nº 07, May 2019

D.O.I: <http://dx.doi.org/10.17115/2358-8411/v6n5a7>

Accepted: 10/12/2018 Published: 30/05/2019

I SEMINÁRIO DE SAÚDE MENTAL DO NORTE E NOROESTE FLUMINENSE

– 27 A 30 DE NOVEMBRO DE 2018 – CAMPOS DOS GOYTACAZES - RJ

AUTISM AND THE APPLICABILITY OF COGNITIVE-BEHAVIORAL THERAPY: A CASE STUDY

AUTISMO E A APLICABILIDADE DA TERAPIA COGNITIVO-COMPORTAMENTAL: ESTUDO DE CASO

Cristina de Fátima de Oliveira Brum Augusto de Souza¹
Mestranda em Cognição e Linguagem

Bianca de Souza Fonseca²
Psicopedagoga

Cristiana Barcelos da Silva³
Doutoranda e Mestra em Cognição e Linguagem

Fernanda Castro Manhães⁴
Doutoranda em Ciências da Educação

Abstract

According to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders in the 5th edition (DSM-V), for a person to be diagnosed with autism, they must present symptoms in two groups. The first is the deficit in communication and social interaction and the second is the pattern of restricted, repetitive behavior, interests and activities. Considering these two groups of symptoms, Cognitive-Behavioral Therapy (CBT) is used in the therapeutic treatment of a young person with autism. CBT has as its principles to work individuals in their totality, strengthening their emotional and cognitive schemes, seeking to produce functional behaviors to solve problems in daily life. The elaboration of the work plan in the cognitive-behavioral approach will be based on the principles of learning, reinforcement and behavioral modeling. The goal of therapeutic treatment with the autistic youngsters is to maximize their potential in language skills, social skills, problem solving, and self-care, freeing them from self-aggression, self-stimulation and aggression. The technique of psychoeducation aims to teach patients to

¹ Universidade Estadual do Norte Fluminense Darcy Ribeiro, Laboratório de Estudos de Educação e Linguagem, Campos dos Goytacazes-RJ, cristinafbrum@gmail.com

² Faculdade de Ciências, Educação, Pesquisa e Gestão, Cidade-Estado, bfonseca7075@gmail.com

³ Universidade Estadual do Norte Fluminense Darcy Ribeiro, Laboratório de Estudos de Educação e Linguagem, Campos dos Goytacazes-RJ, cristianabarcelos@gmail.com

⁴ Universidade Autônoma de Assunção, Assunção-Paraguai, castromanhaes@gmail.com

recognize their problems, which generate their difficulties and reinforce their dysfunctional behaviors. CBT assumes that the patient can become his own therapist, and knowledge about what is being done with him or her and how that subject works is the first step in making this happen. The present work aims to identify the behavior of a young man with autism, pointing to an effective intervention using the cognitive-behavioral approach, scoring the symptoms, the contribution of the therapy with the use of CBT and their impact on the quality of daily life.

Keywords: Cognitive-Behavioral Therapy (CBT); Autism Spectrum Disorder (ASD).

Resumo

De acordo com a última edição do Manual Diagnóstico e Estatísticos dos Transtornos Mentais em 5ª edição (DSM-V), para que uma pessoa seja diagnosticada com autismo ela deve apresentar sintomas em dois grupos. O primeiro é o déficit na comunicação e interação social e o segundo é o padrão de comportamento, interesses e atividades restritas e repetitivas. Considerando esses dois grupos de sintomas, busca-se na Terapia Cognitivo-Comportamental (TCC) embasamento para o tratamento terapêutico de um jovem com autismo. A TCC tem como princípios, trabalhar o indivíduo em sua totalidade, fortalecendo seus esquemas emocionais e cognitivos, buscando produzir comportamentos funcionais para resolução de problemas e vida diária. A elaboração do plano de trabalho no enfoque cognitivo-comportamental vai basear-se nos princípios de aprendizagem, reforço e modelação comportamental. O objetivo do tratamento terapêutico com o jovem autista visa o alcance máximo do potencial dele nas habilidades de linguagem, sociais, na resolução de problemas e no autocuidado, livrando-o de autoagressão, autoestimulação e agressão. A técnica da psicoeducação tem por objetivo ensinar o paciente a reconhecer seu problema, o que gera suas dificuldades e reforça seus comportamentos disfuncionais. A TCC parte do pressuposto que o paciente pode vir a ser seu próprio terapeuta, e o conhecimento sobre o que está sendo realizado com ele e como aquele sujeito funciona é o primeiro passo para que isso aconteça. O presente trabalho tem como objetivo identificar o comportamento de um jovem com autismo apontando uma intervenção eficaz a partir da abordagem cognitivo-comportamental, pontuando os sintomas, a contribuição da terapia com o uso da TCC e o reflexo destes na qualidade de vida diária.

Palavras-chave: Terapia Cognitivo-comportamental; Transtorno do Espectro Autista.

INTRODUCTION

Early in life, parents are already concerned about the development and behavior of their children, expecting they will be typical of other children. When

parents encounter a child who does not speak or exhibit “strange” behavior, or does not show affection and pleasure in social life, a warning sign is lit.

When a child is diagnosed with Autism Spectrum Disorder (ASD), a whole change happens in their family structure. Parents seek help, therapies, and exams so that child to have a typical global development. And when they get to the therapeutic offices they are faced with a world of new paths for their child, a great flood of information. The role of the therapist is to guide and welcome this family and then to draw up a therapeutic plan for the child.

Like other deficiencies, autism can be incapacitating without proper diagnosis, treatment and intervention (Fonseca, 2014).

According to Sampaio (2005), Cognitive-Behavioral Therapy is a form of psychotherapy that has been scientifically tested and seen as effective in more than 300 clinical researches for various types of disorders. It is a therapy for solving patient problems.

For Leboyer (1995) considers that in the cognitive-behavioral approach it is possible to intervene effectively in several disorders such as those of the autism spectrum.

Autism is a neurodevelopmental disorder on which many doubts and divergences remain about its etiological factors.

According to Assumpção Jr (2007) and Leboyer (1995), it was from the definitions of Leo Kanner in 1943 that emerged the first conceptualization of autism as a psychotic syndrome, related to phenomena of the schizophrenic line. This conceptualization described under the name of autistic disorders of the affective contact, a picture characterized by extreme autism, obsessive-type behaviors with tendency to sameness, stereotyped movements and echolalia, involuntary repetition of words or phrases that heard characterized by language alterations, represented by the absence of communicative purpose (Zafeiriou et al., 2007). According to the authors, in 1944 Hans Asperger described under the name autistic psychopathology of childhood, in which children are quite like those described by Kanner, but without any delay in the development of language. The concept of autism is attributed to both Kanner and Asperger.

According to Watson (2008), in 1995, Dr. Simon Baron-Cohen proposed a new theory on autism. He suggested that many people with autism suffered from mental blindness, that is, the inability to understand that other people have their own thoughts and emotions, with difficulty understanding the point of view, the ideas or feelings of others. It is this inability to relate to the differences in the way of thinking of others which results in the social and communicative difficulties of the autistic individual (Oliveira, 2002).

Autistic disorder was characterized by a difficulty in contact with people, a special connection to objects, language without communicative function, difficulties in contact and interpersonal communication (Bender, 1959, apud Stelzer, 2010, p.6). Kanner's description in 1943 was organized around the disorder, which is the inability of children to develop and establish interpersonal relationships and to react in a normal way to situations, from the beginning of life. This disorder is defined as a set of symptoms visualized as a specific disease of organic origin with neurological, genetic and environmental implications.

Autism, when compared to other pathologies, presents a certain incompleteness, since there are no tests that directly determine its diagnosis, being established based on medical evaluations and behavioral observations. The various spectrum stereotypes further increase these barriers to case identification. Even today, autistic patients receive the most different medical diagnoses, such as obsessive-compulsive disorder, schizophrenia, mood disorders, among others (Baron-Cohen et al., 2009).

From this assumption, Assumpção Jr (2007) considers that autism is described as a behavioral syndrome with multiple causes, due to a developmental disorder. It is characterized by deficits in social interaction. It does not present abilities to relate to the other, tied with language deficit and behavioral changes.

Thus, according to Assumpção Jr (2007) and Luppi et al. (2005), autistic individuals can't organize the thought to express themselves with clarity; they experience difficulties in initiating conversations, interpreting attitudes and communicative expressions in themselves and in others. And, regarding their activities and interests, they are resistant to change and maintain routines and rituals.

Routines and rituals for autistics translate an aptitude or a feeling to feel comfortable, which makes their lives predictable and look safer to them.

In order to diagnose a child as autistic, it is necessary to know the criteria determined by the Diagnostic and Statistical Manual of Mental Disorders in the 5th edition (DSM-V). It is the agreement or not to those criteria that a condition diagnosed as a disorder in the autism spectrum. The manual has been revised and it was last updated in 2013.

With the changes in the DSM-V (American Association of Psychiatry, DSM-V, 2014), Autism Spectrum Disorder is considered if the symptoms appear in the early stages of child development. These symptoms should cause clinically significant impairment in social, occupational areas and areas that are significant to the patient's current functioning.

Among the deficiencies, those that are related to communication and social interaction, where limitations in the emotional and social reciprocity are observed, considering non-verbal communication behaviors and repetitive and restricted patterns of behavior, using objects, body or speech in which there is an abnormal intensity of focus on restricted interests and hyper or hypo reactive to sensorial stimuli from the environment (APA, 2014).

It is important to emphasize that many individuals diagnosed with ASD may also present intellectual and/or language impairments (speech delay and very poor language comprehension). Motor deficits are common and frequent, one example being atypical gait and lack of coordination.

DEVELOPMENT

CBT works by strengthening emotional and cognitive schemes, seeking to produce functional behaviors for problem solving in the individual's the daily life. It is based on a formulation of continuous development of the patients and their problems. This formulation begins with anamnesis, at which point the therapist investigates the patient's history (Beck, 1997).

According to Beck (1997), it is extremely important to build a therapeutic alliance, with attention and cordiality. The therapist must have genuine empathy and

respect for the patient and thus gain the patient's trust. The patient should feel safe and believe that the therapist can assist him or her.

Therapy should be seen as a cooperation, where the patient has active participation, and both him or her and the therapist make exchanges. CBT is an educational therapy that aims to teach the patient to be their own therapist. This is the reason why psychoeducation is used, so patients can learn and identify their issues (Beck, 1997).

CBT uses several techniques to achieve the expected results, to minimize the problem and to seek a better solution. These techniques may be based on cognitive or behavioral therapy, and both techniques can be used in combination when necessary, being adapted for use with children, youngsters or adults.

Silvares (2000) affirms that a well-conducted follow-up and behavioral assessment are necessary to adapt the techniques for the work with the autistic youngster, since the techniques used seek a lasting behavioral change, and can also be used preventively to minimize future problems. Still according to Silvares (2000, p.231),

Behavioral assessment is intrinsically linked to treatment. Successful interventions confirm hypotheses raised; interventions that do not lead to the expected result lead to the reformulation of hypotheses or the procedures used. The treatment program is considered to be more important than the diagnostic label, although it is useful, especially for parents, because it often reduces their sense of guilt and eventually stops the search for new professionals.

The elaboration of the treatment plan in the cognitive-behavioral approach will be based on the principles of learning, reinforcement and behavioral modeling. In this elaboration the therapist will focus on the behavior emitted and not the description of the disorder, and by this he or she will evaluate its functionality in the environment and social development.

The goal of therapeutic treatment with autistic youngsters is to maximize their language, social, problem solving and self-care skills, freeing them from self-aggression, self-stimulation and aggression.

The first step is anamnesis, a set of questions that will put the therapist abreast of the patient's history, family structure, social interaction, and initial demand (Rangé, 1995).

The second step is to use the cognitive restructuring technique in which the patient must learn to identify dysfunctional thoughts (also known as cognitive distortions), which reinforce the inappropriate behavior, identifying them, questioning them so that they are worked and reconstructed. Cognitive restructuring is a change in thinking, functionally and qualitatively (Rangé, 1995).

The third step is the use of Socratic questioning based on a structured dialogue, where the therapist directs questions that help patients to study and perceive their ideas in a rational and logical way, broadening the patient's view of the thoughts about a given situation. Thus, the objective is to see the situation in a more rational and structured way (Rangé, 1995).

The fourth step is problem-solving training in which the individual works with the possibilities and possible consequences of each choice. The patient makes an evaluation and broadens his or her look of opportunities, seeking not only one but several possible solutions to a certain problem, assessing each of them (Caballo, 2005).

The technique of psychoeducation aims to teach patients to recognize their problems, which generates their difficulties and reinforces their dysfunctional behaviors. CBT acts on the premise that the patient can become his or her own therapist, and the knowledge about what is being done with it and how that subject functions is the first step to make it happen (Caballo, 2005).

The coping card is another technique used, in which cards are produced during the session and used as reminders of what has been worked on, so that it is reinforced for a thought or functional behavior (Beck, 1997).

There is also the technique of role-playing, where the therapist uses a specific situation already worked in the session and, as in a small theater, the patient has the opportunity to interpret roles that will vary according to the situation in question. The therapist can also assume the role of the patient so that the patient can observe his or her own actions. This technique is also used to train situations that generate

anxiety or fear in the patient, as a preparation for when he or her must exhibit a given behavior outside the therapeutic environment (Beck, 1997).

Also used is technique of modeling, in which the patient learns to observe the other, his or her behavior and the consequence of the choices of the other. In this way we work their behavior, modeling it from observed behaviors (Rangé, 1995).

The relaxation technique is another feature that can be used when the patient arrives or becomes very anxious during the session. It can be done by using music, breathing, and stretching. The technique can also be used by the patient in idle moments outside the session. The training is done with him or her, then the patient repeats it when the necessity arises in daily life situations (Rangé, 1995).

Training of social skills is another very important technique for autistic individuals, since one of their main issues is the social deficit. Through this training, patients works empathy, putting themselves in the place of the other, to improve their interpersonal relationship, to seek more assertive behaviors in their relationships, to recognize other people's emotions and to express their emotions better (Beck, 1997).

And lastly, there is the assertiveness training, in which, to be effective, the patient must be able to plan assertive reactions, matching with a previous positive reinforcement. The individual then learns to respect him or herself, to know how to behave without being passive or aggressive, say yes or no according to his or her needs, without being selfish (Caballo, 2005).

DISCUSSION

The autistic subject on which this case study is based, R., is a 21 years old male individual who lives with his recently divorced father, and is in his senior high school year. He had speech therapy when he was a child and went without psychological care for almost a year.

Initial contact was made with the parents, who sought help in response to their son's difficulty to relate, not wanting to leave home, taking initiative, making little eye contact, presenting great anxiety in situations of social exposure and expressing little or almost no emotions. Anamnesis was conducted in this first contact, followed by a

quick psychoeducation about CBT and an explanation on how the work would be carried out.

R. arrived for the first session sweating a lot and looking very uncomfortable to find himself there. He stayed in the waiting room for some time, where he did not talk or interact with anyone. Our first session served to gather information about his needs and explain the reason for the therapy, thus doing a Psychoeducation.

The second session was a continuation of the previous one, an important step required to emphasize that the patient presented cognitive conditions to be exposed to the triple CBT, explaining about emotions, thoughts and behaviors.

From the third session on, the patient began to sweat less and put on a little more. We began to identify which were the reinforcers of their dysfunctional behaviors and emotions. We worked out a plan and a direction for what we were going to work on.

In the following sessions, the patient began to report problems at school. He felt alone and could not present work in front of the class or read aloud. Based on these statements, we began to make a cognitive restructuring, using techniques such as Socratic questioning and modeling.

R. took some time to feel safe and verbalize emotions such as fear, anguish, anxiety and sadness, but as soon as he did it, he reported feeling free. We began to associate emotions, situations, and behaviors that made him feel that way.

One session was separated to build the coping cards and do a Psychoeducation on them. R. came to the following sessions reporting that the cards helped him have the courage and requested that new cards be made.

Despite the advances, R. was still at home for a long time, since there was already a therapeutic bond and a confidence that I was there to help him, we got him one more step. He joined a football team that he attends three times a week and was able to go out a few times with his teammates, including inviting them once to the movies.

Currently, the parents report that R. is more open to conversing with them, participating more in family dinners, going out with them and occasionally going out

with a colleague. But he still has a good time in front of the computer and is very worried about finishing his studies.

A session that marked a lot R. was the one when we worked with the technique of “role-playing”, in which there was work to be presented to the entire school class. He arrived at the session saying he would run, but he would not show up. We went back to what had been worked until then, and then rehearsed how it could happen during the presentation. In the following session R. reported that instead of been booed, he was applauded in the class. Let’s recall all the dysfunctional thoughts of the previous session by comparing with the thoughts of the current session and separating which ones contributed to such situations.

R. still described feeling his hand freezing, some words did not go as he wanted, nervousness, but now he can present all the work and read aloud. He said that fear was his worst enemy.

Social skills training began at the end of the year, along with preparation for leaving school. We listed his plans, his longings and his fears, structuring the thoughts that would be worked on and those that would be avoided. In the latter sessions, we worked on problem solving and together we decided that R. would look for a technical course alone for that year. Still in this period R. reported to have written a text for his teacher, in which he exposed some of his difficulties, the repetition of series in previous years, the isolation, the intense feeling of failure and, concluding the text, he said to have been taken to the therapy, and how much he believed that he could go far at that moment. This account was passed on to the parents, who passed it on to the author. We prepared what he was supposed to do during this recess. After three weeks he enrolled in a technical computer course.

FINAL CONSIDERATIONS

At the cognitive-behavioral level, autistic youngsters present characteristics that resemble those of other young people without the disorder, but present themselves at different levels of intensity, duration and frequency of symptoms. Thus, it can be stated that the behavioral deviations presented by this autistic individual whose case is herein presented agree with the theories of learning to which the other behaviors in general are subject. That is, through an assertive behavior modeling it is

possible to obtain an improvement of the autistic picture. And to intervene the therapist needs to encourage behavioral change. In this intervention, the therapist must be aware not only of the deficits that a young autistic individual presents, but also the behaviors that he or she is able to do successfully. All the behaviors that are emitted by the young person, as well as the situations in which they occur, and possible reinforcements to maintain these behaviors are essential to be surveyed, studied and worked by the therapist.

It can be concluded with this case study that cognitive-behavioral therapy, for its theoretical and practical foundation, can contribute positively to the therapeutic treatment of a young autistic, albeit in a light frame, but within the characteristics mentioned by the DSM-V, and as reported suffering the reflexes of these deficits.

The CBT approach, therefore, sought to value the potentiality and not the incapacity of the human being, evidencing the need for diagnosis and intervention as early as possible, as fundamental means to obtain a more efficient and effective treatment, giving this young person with autism the opportunity to have a more satisfying educational partner life.

REFERENCES

- American Psychiatry Association (APA). (2014). Manual of Diagnosis and Statistics of Disorders. DSM-V, Porto Alegre: Artmed.
- American Psychiatric Association (APA). (2000). Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association.
- _____. DSM-5 development: autism spectrum disorder. (2015). Available at <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=94>. Accessed March 14, 2015.
- Assunção JR. F. B. (1997) Invasive Disorders of Child Development. São Paulo: Lemos Ed.18.
- _____. (2007). Childhood Autism: New trends and perspectives. São Paulo: Atheneu.
- Bahls. S.C; Navolar. A. B. B. Cognitive-Behavioral Therapy: Concepts and theoretical assumptions. (2004). In: Electronic journal of psychology. Curitiba, n.4. Jul 2004. Available in: . Accessed on: Jan. 14 2016.

- Baron-Cohen S, Scott FJ, Allison C. (2009). Prevalence of autism-spectrum conditions: UK school-based population study. *Br J Psychiatry* 2009; 194: 500-9.
- Beck, J. (1997). *Cognitive therapy: theory and practice*. Porto Alegre: Artmed.
- Caballo, V. E. (2005). *Manual of clinical psychology in children and adolescents: general disorders*. São Paulo: Santos.
- Fonseca, B. (2014). *School Mediation and Autism - The Pedagogical Practice Intermediated in the Classroom*. Rio de Janeiro: WAK Publisher.
- Leboyer, M. (1995). *Childhood autism: facts and models*. 2. ed. São Paulo: Papirus.
- Luppi, G.S .; Tamanaha, A.C .; Perissinoto, J. (2005). The analysis of executive functions in childhood autism: a preliminary study. *Development Topics Magazine*. v. 14, n. 79, Mar / Abr 2005. p. 32-6.
- Oliveira, A. C. (1993). *Autism and the "wild children": from the practice of exposure to educational possibilities*. 2002. Master's Dissertation, Federal University of Rio Grande do Sul. Oliveira, Z. M. R. & Rossetti-Ferreira, M. C. 1993.
- Oliveira, Z. M. R., & Rossetti-Ferreira, M. C. (1993). The value of child-child interaction in child care centers in child development. *Cadernos de Pesquisa*, 87, 62-70.
- Rodrigues, M., C, Spencer E. (2010). *The autistic child, a psychopedagogical study*. Rio de Janeiro: WAK Publisher.
- Rangé, B.P. (org.). (1995). *Behavioral and cognitive psychotherapy of psychiatric disorders*. São Paulo: Editorial PSY.
- Sampaio, A. S. (2016). *Hyperactivity and cognitive-behavioral therapy: a literature review*. 2005. Available at: www.portaleducacao.com.br. Accessed on January 10. 2018.
- Serra, A. M. (2008). *Fundamentals of cognitive therapy. Science and life psyche*. São Paulo: Editora Escala, year 1, n. 3, 2008. p.10-12.
- Silvares, E.F.M. (2000). *Case studies in child behavioral clinical psychology*. Campinas: Papirus.
- Stelzer, F. G. (2010). *A Little History of Autism: Pandorga Books of Autism, Volume 1*. Rio Grande do Sul: Oikos.
- Velasques, B.V, Ribeiro, P. (eds.). (2014). *Neurosciences and learning, basic processes and disorders*. Rio de Janeiro: Rubio.
- Watson, S. *How autism works. The*. Available at: <http://saude.hsw.uol.com.br/autismo.htm>. Accessed on: 10 Jan. 2018.

Zafeiriou, D.I., Vargiami, E., Mayapetek, E., Augoustidou-Savvopoulou, P., & Mitchell, G.A. (2007). 3-Hydroxy-3-methylglutaryl coenzyme a lyase deficiency with reversible white matter changes after treatment. *Pediatric neurology*, 37 (1), 47-50.