Children Australia
Volume 37 ▌ Number 3 ▌ pp. 108–114 ▌ © The Authors 2012 ▌ doi 10.1017/cha.2012.29

Coping Strategies and Perceived Coping Effectiveness for Social Stressors among Children with HFASDs: A Brief Report

Gloria K. Lee,[1] Marcus L. Thomeer,[2] Christopher Lopata,[2] Audrey L. Schiavo,[3] Audrey M. Smerbeck,[4] Martin A. Volker,[1] Rachael A. Smith,[1] and Joshua E. Mirwis[5]

1 Department of Counseling, School & Educational Psychology, University at Buffalo – the State University of New York, Buffalo, New York, USA
2 Institute for Autism Research, Canisius College, Buffalo, New York, USA
3 Summit Educational Resources, Getzville, New York, USA
4 Department of Neurology, University at Buffalo – the State University of New York, Buffalo, New York, USA
5 Pioneer Middle School,Yorkshire, New York, USA

This brief report investigated coping strategies and their perceived effectiveness in response to a social stressor for 7–12 year olds with high-functioning autism spectrum disorders (HFASDs). Ninety-eight participants completed a self-report coping scale in response to a self-identified socially stressful situation. Responses yielded three categories of use and perceived effectiveness: (1) strategies used frequently and viewed as effective, (2) strategies not used frequently and not perceived as effective, and (3) strategies used frequently but not perceived as effective. Respondents reported high frequency use and high perceived effectiveness of six strategies that are generally considered as positive/engagement oriented coping. They also indicated low frequency use and low perceived effectiveness of five strategies broadly regarded as negative and avoidant/disengagement coping. The last cluster of four strategies, identified as frequently used but not effective, consisted of strategies less clearly categorised as positive/engaged vs. negative/disengaged. Implications for future research and clinical considerations are proposed.

■ **Keywords:** coping, effectiveness, social stressors, high-functioning autism spectrum disorders

Individuals are confronted with stressors and challenges across the life span. While an extensive amount of literature has been devoted to model development and clinical aspects of coping among adults with and without disabilities, less attention has been dedicated to children (Compas, Connor-Smith, Saltzman, Thomsen & Wadsworth, 2001; Donaldson, Prinstein, Danovsky & Spirito, 2000; Pincus & Friedman, 2004). Pincus and Friedman asserted that children are equally and continuously confronted with interpersonal problems in their daily routines. The ability to cope with challenges is imperative, as evidenced in high correlations between adaptive coping and positive psychological adjustment for children (Rutter, 1994; Stark, Spirito & Stamoulis, 1991). Furthermore, studies have indicated that children's ability to cope effectively with daily stressors is a major mediating factor in their behavioural and emotional adjustment (Compas, 1987; Eisenberg, Fabes & Guthrie, 1997), future psychological well being, and psychopathology (Compas et al., 2001; Dubow & Tisak, 1989).

According to the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, 2000), social impairment is a central and defining characteristic of children with high-functioning autism spectrum disorders (HFASDs). HFASDs include Asperger's disorder, autism (high-functioning), and pervasive developmental disorder not otherwise specified (PDD-NOS) (American Psychiatric Association, 2000; Rogers, 2000). Despite being considered high functioning due to relative strengths in cognitive and formal language abilities (Klin & Volkmar, 2000), the social dysfunction of these children is an ongoing source of difficulty and it most often persists into adulthood (e.g. Portway & Johnson, 2005). Children with HFASDs are also

ADDRESS FOR CORRESPONDENCE: Gloria K. Lee, Baldy 419, Department of Counseling, School & Educational Psychology, University at Buffalo – the State University of New York, Buffalo, New York, 14260, USA. Email: glee4@buffalo.edu

at risk for social stress and anxiety resulting from negative social experiences and repeated social failures (e.g. Groden, Baron & Groden, 2006; Klin, McPartland & Volkmar, 2005). Portway and Johnson (2005) proposed that many of the long-term difficulties of individuals with HFASDs including anxiety and stress, are the result of restricted coping resources. Despite the suggestion of impaired coping, little is known about the coping strategies used by children with HFASDs in response to socially stressful situations. It has been noted, however, that these social stressors and social failures can result in withdrawal and social isolation for individuals with HFASDs (Klin et al., 2005).

While there is a dearth of research on coping in children with HFASDs, the broader literature suggests that many factors may contribute to one's ability to cope such as age/developmental level (Compas et al., 2001), the uniqueness of the stressor (e.g. nature of the disability), degree of impairment, socio-ecological factors (availability of support/treatment), and intrapersonal factors (e.g. self-esteem) (Wallander, Varni, Babani, Banis & Wilcox, 1989). The literature has also identified a number of coping strategies, yet there is a lack of consensus in terms of the various dimensions that distinguish different coping strategies in childhood and adolescence (Compas et al., 2001) and/or which orientation(s) is/are most valid and/or effective. Of the coping dimensions noted in the literature (e.g. problem- versus emotion-focused coping, primary versus secondary control coping, cognitive versus behavioural coping, active versus passive coping, and self-focus versus external focus) (Compas et al., 2001; Compas, Connor, Saltzman, Thomsen & Wadsworth, 1999; Rudolph, Denning & Weisz, 1995), the dimensions of engagement (approach) versus disengagement (avoidance) coping appears particularly applicable to children with HFASDs given their pervasive social impairment, repeated social failures, and suggested tendency to withdraw/isolate (Klin et al., 2005). According to this conceptualisation, engagement (approach) coping involves strategies and responses that are oriented either toward one's emotions or thoughts, or toward the source of the stressors (e.g. problem-solving or seeking social support), while disengagement (avoidance) coping refers to responses that orient away from the stressors or one's emotions or thoughts (e.g. withdrawal or denial) (Compas et al., 2001).

Given the paucity of studies examining the coping strategies of children with HFASDs and the long-term pervasive nature of their social challenges, research into the strategies they employ when confronted with a social stressor appears to be warranted. This pilot study was conducted to document the types of coping strategies children with HFASDs reported using and the perceived effectiveness of the strategies in dealing with social conflicts. The current study examined the frequency and perceived effectiveness of ten commonly used coping strategies (distraction, social withdrawal, wishful thinking, resignation, self-criticism, blaming others, problem-solving, emotional regulation, cognitive restructuring and social support) in response to a child-identified recent social stressor (Spirito, Stark & Williams, 1988). The strategies (as measured by the KIDCOPE; Spirito et al., 1988) reflect the dimensions of engagement/approach and disengagement/avoidant coping (see Instrument section below).

Methods

Participants and procedures

The sample surveyed consisted of 104 children with HFASDs, aged 7–12 years, recruited from a large social skills treatment study in western New York (institutional review board approved). Each participant met inclusion criteria for the treatment study using a multiple-gate screening procedure (see Lopata, Thomeer, Volker, Nida & Lee, 2008). Inclusion criteria included a prior clinical diagnosis of autism (high-functioning autism [HFA]), Asperger's disorder (AD), or pervasive developmental disorder not otherwise specified (PDD-NOS), a WISC-IV short-form composite IQ > 70 (and a VCI or PRI ≥ 80) per testing done by members of the research team, and evidence of social impairments (at least two) and restricted and repetitive interests and behaviours (at least one per diagnostic criteria; American Psychiatric Association, 2000) as assessed independently by two members of the senior research team (consensus required for inclusion). Studies have shown that IQ does not predict adaptive functioning (such as coping) among children with HFASDs (Lopata et al., in press) and adolescents/young adults with HFASDs (Kenworthy, Case, Harms, Martin & Wallace 2010) and in adolescents with Asperger's disorder (Saulnier & Klin, 2007). Therefore, our inclusion parameters create a highly homogeneous sample.

Parents of children accepted for the treatment study were approached and invited to allow their children to participate in this study, which involved a 10-minute interview (i.e. identification of social stressor and completion of the KIDCOPE). Initially, each child was directed to identify a socially stressful situation that he/she had encountered during the past week, and how the situation made him/her feel (nervous, sad, and/or mad). Next, each child rated each of the 15 items on the KIDCOPE, indicating whether each strategy had been used and whether that strategy was perceived as effective in dealing with the social stressor. A trained research assistant met individually with each child after completion of the interview and survey. Each KIDCOPE item was read aloud to the child to avoid possible problems associated with the presence of unknown reading difficulties. The child provided a response to the item and the test administrator circled the chosen answer on the survey protocol.

Instrument

The KIDCOPE (Spirito et al., 1988) is a 15-item checklist designed to assess ten strategies including distraction, social withdrawal, wishful thinking, resignation, self criticism, blaming others, problem-solving, emotional regulation, cognitive restructuring and social

support. There are two versions of the KIDCOPE – one for ages 7–12 years and the other for ages 13 years and older. The 7–12-year-old version consists of 15 items that can be collapsed into ten coping categories. In addition, two total scores can be derived including a frequency score and an efficacy score. Consistent with the standardised procedure, frequency items (How often did you do this?) were converted into dichotomous scores, indicating whether one had used (1) or had not used (0) the coping skill. The efficacy scale (How helpful was it?) consisted of three-point Likert items (0 = not at all; 1 = a little; and 2 = a lot).

Moderate test-retest reliability was reported (Spirito et al., 1988; Spirito, Stark, Grace & Stamoulis, 1991) and concurrent validity was supported in moderate to high correlations with other commonly used coping scales (Spirito et al., 1988). While the 15 items can be collapsed into 10 coping strategies (Spirito et al., 1988), the author recommended that analysis can be conducted by each item level, especially "in the case of the KIDCOPE, as well as other screening measures that have a small number of items" (Spirito, 1996, p. 574). The authors also noted that other studies have found that items may be grouped into broader categories including either positive/engagement or negative/avoidant/disengagement coping strategies. Preliminary factor analyses have supported the existence of these two main categories (i.e. positive and negative; Spirito et al., 1988). Positive/engagement strategies include cognitive restructuring, problem-solving, social support and emotional regulation (calming self down) and negative strategies include blaming others and self-criticism. Negative strategies also encompass avoidant coping which includes distraction, blaming others, wishful thinking, and resignation. Finally, in an independent factor analysis study (exploratory and confirmatory) on the KIDCOPE, Cheng and Chan (2002) reported that negative coping (escape-oriented or avoidant) included distraction, social withdrawal, self criticism, blaming others, wishful thinking, resignation and negative emotional regulation. Positive strategies (control-oriented) included cognitive restructuring, problem-solving, social support, and positive emotional regulation (Cheng & Chan, 2002). Based on the preliminary nature of this exploratory study and need to document a range of strategies, the current study examined each of the 15 individual items.

Results and discussion

Table 1 reports the demographic characteristics – including the age, gender, ethnicity, diagnosis, and IQ – of the child participants. A majority of the participants were male (91%) and Caucasian (89%), with an average age of 9 years and average IQ of 104. A majority had a prior clinical diagnosis of Asperger's disorder. Additional data on parent education level indicated that the highest percentage reported a bachelor's degree (38%).

Ninety-eight participants each identified a recent socially stressful situation they had encountered. The content of the social stressors were as follows: teased verbally by others, e.g. being called weird ($n = 21$); getting into a physical fight with others ($n = 18$); physically pushed by others, e.g. tripped ($n = 18$); and feeling angry or annoyed as a result of what others did/said or what others asked the child to do, e.g. mother asking child to do something, or when others took the game or changed the TV channel ($n = 59$).

TABLE 1
Demographic characteristics

Variables	Percentage	Mean (*SD*)
Age	–	9.04 (1.61)
IQ	–	104.04 (13.40)
Gender		
Male	91.3 ($n = 95$)	–
Female	8.7 ($n = 9$)	–
Ethnicity		
White	88.5 ($n = 92$)	–
African	3.8 ($n = 4$)	–
Hispanic	2.8 ($n = 3$)	–
Others	2.8 ($n = 3$)	–
Native	1.0 ($n = 1$)	–
Asian	1.0 ($n = 1$)	–
Diagnosis		
Asperger disorders	66.3 ($n = 69$)	–
PDD-NOS	26.9 ($n = 28$)	–
Autism	3.8 ($n = 4$)	–
High functioning autism	2.9 ($n = 3$)	–
Parents' education		
Bachelor's degree	37.5 ($n = 39$)	–
Master's degree	18.3 ($n = 19$)	–
Technical school	15.4 ($n = 16$)	–
Others	14.4 ($n = 15$)	–
High school	11.5 ($n = 12$)	–
Doctorate	2.9 ($n = 3$)	–

PDD-NOS: pervasive developmental disorder not otherwise specified

Table 2 reports on the types of coping strategies used and the effectiveness of those coping strategies as endorsed by participants.

Data in Table 2 indicate the percentage of participants who reported using each of the 15 coping strategies in dealing with the socially stressful situation and the percentage who endorsed each strategy's effectiveness. It is important to note that there are several coping strategies (i.e. distraction, social withdrawal, problem-solving, emotional regulation, and wishful thinking) which contain two items. For the current sample, these coping strategy items often did not yield a similar percentage within the same coping strategy. Given the small number of items in the KIDCOPE, each item was analysed individually (Spirito, 1996).

Results in Table 2 are descriptive in nature. To facilitate, preliminary interpretation items were examined according to whether they were endorsed by the majority (more or less than 50%) of the participants. This basic guideline was applied for both the percentage who endorsed using the

TABLE 2
Types of coping strategies and their effectiveness

Types of coping strategies used	% Endorsed Used	Effectiveness: Not at all (%)	Effectiveness: A little (%)	Effectiveness: A lot (%)
> 50% use and > 50% effective				
Emotional regulation (calm down)	75.0	9.1	41.6	57.1
Cognitive restructuring	68.3	7.0	42.3	50.7
Problem solving (doing something)	68.3	14.1	35.2	50.7
Social support	62.5	6.3	34.4	59.4
Distraction (do something)	59.6	3.2	32.3	64.5
Problem solving (think of something)	53.8	10.7	39.3	50.0
<50% use and <50% effective				
Blaming others	40.4	31.7	41.5	26.8
Emotional regulation (yelled)	37.5	63.2	15.8	21.1
Social withdrawal (stay by self)	36.5	13.5	45.9	40.5
Resignations	26.9	25.9	37.0	37.0
Self criticism	17.3	11.1	72.2	16.7
>50% use and < 50% effective				
Wishful thinking (wish problem never happened)	85.6	16.9	38.2	44.9
Wishful thinking (wish I could make things different)	76.9	25.3	31.6	43.0
Distraction (forget it)	61.5	12.5	48.4	39.1
Social withdrawal (keep quiet)	54.8	14.0	36.8	49.1

strategy and the percentage in the effectiveness categories. To further assist in interpretation, the coping strategies were categorised into one of three different groups based on the percentage of respondents who used the strategy and the extent to which the strategy was considered effective (i.e. coping strategies endorsed by >50% of respondents and identified as effective [i.e. endorsement of "A lot"] by >50% of respondents; coping strategies endorsed by <50% of respondents and identified by <50% of respondents as effective; and coping strategies that were endorsed by >50% of respondents but rated by <50% as effective).

Positive/engagement coping

The first group consisted of coping strategies that were reported to be used frequently (endorsed >50%) and perceived to be effective (endorsed >50%) in dealing with the social stressor. Six coping strategies comprised this group: (1) emotional regulation/calming down, (2) cognitive restructuring, (3) problem-solving (fix problem by doing something), (4) social support, (5) distraction (do something), and (6) problem solving (fix problem by thinking something). In the cluster of coping strategies that comprise this category, all but one (distraction) is consistent with the coping strategies considered as positive/engagement coping (Cheng & Chan, 2002; Spirito et al., 1988). In addition, this cluster of strategies is consistent with the broader literature indicating that typically developing children tend to use positive/engagement coping strategies such as problem-solving, social support, cognitive restructuring, and positive emotional regulation when dealing with daily stressors such as interpersonal and academic stressors (Band & Weisz, 1988; Campbell, 1995; Compas, Malcarne & Banez, 1988; Donaldson et al., 2000; Weisz, McCabe & Denning, 1994).

Disengagement/avoidant coping

The second cluster comprised coping strategies that were not used frequently (endorsed <50%) and were also not rated as effective (endorsed <50%). The five coping approaches that fell into this category included (1) blaming others, (2) emotional regulation (yell, scream), (3) social withdrawal (stayed by myself), (4) resignations, and (5) self criticism. Based on the literature, the coping strategies of negative emotional regulation, blaming others and self criticism are considered negative coping strategies (Cheng & Chan, 2002; Donaldson et al., 2000; Spirito et al., 1988). Social withdrawal and resignation are considered avoidant/disengagement coping strategies (Cheng & Chan, 2002; Spirito et al., 1988). Donaldson and colleagues (2000) also report that blaming others, self criticism and resignation were used less frequently and were less effective in dealing with major life stressors such as family issues and interpersonal issues. Regardless of the different labelling of those coping strategies, these researchers consistently acknowledged that they are coping strategies that are not conducive in helping the individual to alleviate any negative behaviours, cognitions or emotions associated with the stressor.

Frequently used but ineffective coping

The final cluster consisted of coping strategies that were used frequently (endorsed by >50% of participants) but were rated as not effective by the majority of participants (endorsed by <50% by participants). This group included (1) wishful thinking (wish problem never happened), (2) wishful thinking (wish I could make things different), (3) distraction (forget the event), and (4) social withdrawal (keep quiet).

While these strategies appear to reflect negative/disengagement coping (Cheng & Chan, 2002; Spirito et al., 1988), the broader literature is less clear as to the extent to which these strategies are effective. For example, orienting away from the stressor may assist in decreasing the emotional intensity of the stressor (Compas et al., 2001; Spivach & Shure, 1982) and some evidence suggests that withdrawal, distraction, and wishful thinking are common strategies for typically developing children and adolescents (Donaldson et al., 2000; Pereda, Forns, Kirchner & Munoz 2009; Roecher, Dubow & Donaldson, 1996; Spivach & Shure, 1982; Wertlieb, Wiegel & Feldstein, 1987). However, these avoidant and disengaging types of coping techniques may occur for different reasons and have different consequences for children with HFASDs.

Social deficits contribute to the core social difficulties that interfere with the daily functioning of children with HFASDs (American Psychiatric Association, 2000). It is plausible that children with HFASDs merely used this technique, through being socially withdrawn, because they feel comfortable. Taking a proactive strategy in dealing with challenges such as academic and interpersonal stressors is considered adaptive coping for typically developing children (Band & Weisz, 1988; Campbell, 1995; Compas et al., 1988; Donaldson et al., 2000; Weisz et al., 1994). However, this requires tactful and skilful social skills. Individuals with autism, due to the deficits in the developmental capacities for joint attention and symbolic use, may face challenges in taking perspectives and reading social cues from others during social interactions (Marans, Rubin & Laurent, 2005). The unusual and/or lack of social overtures of people with autism may solicit negative or avoidant interaction by others. The potential negative reactions of others to the communicative styles of people with autism may hinder further interaction and/or practicing effective and socially appropriate coping styles (Marans et al., 2005). Klin et al. (2005) contended that individuals with HFASDs are capable of learning and improving their joint attention and symbolic use. It is therefore imperative that children should be taught to expand effective and socially appropriate coping strategies in dealing with social stressors (Marens et al., 2005).

Children in this sample also rated "wishing thinking" and "distraction" (forget it) as coping strategies that are utilised frequently but are not effective. As discussed above, individuals with autism have difficulties in joint attention and symbol use, which are also prerequisites of emotional regulation (Marens et al., 2005). Individuals with HFASDs may have challenges in taking perspective and imagination (Craig & Baron-Cohen, 1999). Having to use cognitive strategies to imagine, for instance, may be challenging for people with autism. Therefore, unless individuals with autism are taught properly how cognition could alleviate any negative emotionality associated with stressors, they may not understand how to utilise this coping strategy effectively.

These results may imply that concrete, behaviourally oriented coping strategies may be easier for children with autism to learn, execute and see the positive outcomes in dealing with stressors, and are likely to be the preferred skills they can focus on in dealing with social stressors. Coping strategies that involve emotionality, imagination and perspective taking may not be as effective in dealing with social stressors until those strategies are taught properly to the children with HFASDs, and that the skills are processed and understood by the children with HFASDs. Such tentative conclusions, however, would require further research.

Strengths, limitations and implications for future research

While a major strength of this study included documentation of the coping strategies of children with HFASDs in response to social stressors using a fairly large sample size, future studies can be strengthened in several ways. First, a comparison group with typically developing peers of the same age group will allow a comparison to delineate if/how children with HFASDs may use different coping strategies to deal with social stressors due to the nature of their disability condition. Second, future studies examining whether certain coping strategies lead to more positive adjustment for children with HFASDs (e.g. psychological well-being, academic and social competence) would allow researchers and clinicians to understand the effect of different coping mechanisms on specific outcomes, thus assisting with intervention development (Compas et al., 2001). In addition, there are inconsistencies in the literature about the basic construct of coping and the multi-dimensionality of coping. For instance, there are various conceptualisations of coping that exist in the literature – such as positive/negative engagement or approach/disengagement or avoidant, cognitive/behavioural, problem-focused/emotional focused (Compas et al., 2001). Further, the existing literature currently lacks consensus regarding the construct of coping resulting in some coping strategies falling into different dimensions. Examples that fell into the last cluster in this study, including wishful thinking, social withdrawal, and distraction warrant further investigation as to whether they are effective for children with HFASDs in dealing with social stressors. While coping strategies that require proactive social interactions and cognitive ability to deal with stressors are generally considered adaptive coping strategies, further research needs to be conducted in order to understand how the unique social deficits (i.e. joint attention, emotional regulation,

symbol use, perspective taking) may affect how a person with HFASDs can use those coping strategies. Another limitation of this study involved the conceptualisation of coping according to a more narrowly defined dimension (i.e. positive/engagement and negative/disengagement/avoidance). While this allowed for examination of coping according to these dimensions, there are a number of conceptualisations of coping described in the literature. Future studies may contribute by examining coping using different conceptualisations of coping and measures that capture different strategies for coping. Lastly, the use of multiple informants through a combination of interviews, questionnaires (parent, child, and/or teacher ratings), and observations (Compas et al., 2001) will assist in cross-validation of the results involving strategies used by children with HFASDs.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev). Washington, DC: American Psychiatric Association.

Band, E.B., & Weisz, J.R. (1988). How to feel better when it feels bad: Children's perspectives on coping with everyday stress. *Developmental Psychology*, *24*, 247–253.

Campbell, T.A. (1995). *Coping and perceived control in older children and young adolescents during three stages of a stressful event.* Unpublished doctoral dissertation. Binghamton University, New York.

Cheng, S.T., & Chan, A.C.M. (2003). Factorial structure of the Kidcope in Hong Kong adolescents. *Journal of Genetic Psychology*, *164*(3), 261–266.

Compas, B.E. (1987). Stress and life during childhood and adolescence. *Clinical Psychology Review*, *7*, 275–302.

Compas, B.E., Connor, J.K., Saltzman, H., Thomsen, A.H., & Wadsworth, M. (1999). Getting specific about coping: Effortful and involuntary responses to stress in development. In M. Lewis & D. Ramsey (Eds.), *Soothing and stress* (pp. 229–256). Cambridge: Cambridge University Press.

Compas, B.E., Connor-Smith, J.K., Saltzman, H., Thomsen, A.H., & Wadsworth, M.E. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Psychological Bulletin*, *127*(1), 87–127.

Compas, B.E., Malcarne, V.L., & Banez, G.A. (1988). Coping with stressful events in older children and young adolescents. *Journal of Consulting and Clinical Psychology*, *56*(3), 405–411.

Craig, J., & Baron-Cohen, S. (1999). Creativity and imagination in autism and Asperger syndrome. *Journal of Autism and Developmental Disorders*, *29*(4), 319–326.

Donaldson, D., Prinstein, M.J., Danovsky, M., & Spirito, A. (2000). Patterns of children's coping with life stress: Implications for clinicians. *American Journal of Orthopsychiatry*, *70*(3), 351–359.

Dubow, E.F., & Tisak, J. (1989). The relation between stressful life events and adjustment in elementary school children: The role of social support and social problem-solving skills. *Child Development*, *60*, 1412–1423.

Eisenberg, N., Fabes, R.A., & Guthrie, I.K. (1997). Coping with stress: The roles of regulation and development. In S.A. Wolchik & I.N. Sandler (Eds.), *Handbook of children's coping: Linking theory and intervention.* New York: Plenum.

Groden, J., Baron, M.G., & Groden, G. (2006). Assessment and coping strategies. In M.G. Baron, J. Groden, G. Groden & L.P. Lipsitt (Eds.), *Stress and coping in autism* (pp. 15–41). New York: Oxford University Press.

Kenworthy, L., Case, L., Harms, M.B., Martin, A., & Wallace, G.L. (2010). Adaptive behaviour ratings correlate with symptomatology and IQ among individuals with high-functioning autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *40*, 416–423.

Klin, A., McPartland, J., & Volkmar, F.R. (2005). Asperger syndrome. In F.R. Volkmar, R. Paul, A. Klin, & D. Cohen (Eds.), *Handbook of autism and pervasive developmental disorders, Vol. 1* (3rd ed., pp. 88–125). Hoboken, NJ: Wiley & Sons.

Klin, A., & Volkmar, F.R. (2000). Treatment and intervention guidelines for individuals with Aspergers syndrome. In A. Klin, F.R. Volkmar, & S.S. Sparrow (Eds.), *Asperger syndrome* (pp. 340–366). New York: Guilford.

Lopata, C., Fox, J.D., Thomeer, M.L., Smith, R.A., Volker, M.A., Kessel, C.M., McDonald, C.A., & Lee, G.K. (in press). ABAS-II ratings and correlates of adaptive behavior in children with HFASDs. *Journal of Developmental and Physical Disabilities.*

Lopata, C., Thomeer, M.L., Volker, M.A., Nida, R.E., & Lee, G.K. (2008). Effectiveness of a manualized summer social treatment program for high-functioning children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *38*(5), 890–904.

Marans, W.D., Rubin, E., & Laurent, A. (2005). Addressing social communication skills in individuals with high-functioning autism and Asperger syndrome: Critical priorities in educational programming. In F.R. Voklmar, R. Paul, A. Klin, & D. Cohen (Eds.), *Handbook of autism and pervasive developmental disorders* (3rd ed.) (pp. 977–1002). Hoboken, NJ: John Wiley & Sons, Inc.

Pereda, N., Forns, M., Kirchner, T., & Munoz, D. (2009). Use of the Kidcope to identify socio-economically diverse Spanish school-age children's streesors and coping strategies. *Child: Care, Health and Development*, *35*, 841–850.

Pincus, D.B., & Friedman, A.G. (2004). Improving children's coping with everyday stress: Transporting treatment interventions to the school setting. *Clinical Child and Family Psychology Review*, *7*(4), 223–240.

Portway, S.M., & Johnson, B. (2005). Do you know I have Asperger's syndrome? Risks of a non-obvious disability. *Health, Risk and Society*, *7*(1), 73–83.

Roecker, C.E., Dubow, E.F., & Donaldson, D. L. (1996). Cross-situational patterns in children's coping with observed interpersonal conflict. *Journal of Clinical Child Psychology*, *25*, 288–299.

Rogers, S.J. (2000). Interventions that facilitate socialization in children with autism. *Journal of Autism and Developmental Disorders*, *30*(5), 399–409.

Rudolph, K.D., Denning, M.D., & Weisz, J.R. (1995). Determinants and consequences of children's coping in the medical setting: Conceptualization, review, and critique. *Psychological Bulletin*, *118*, 328–357.

Rutter, M. (1994). Stress research: Accomplishments and the tasks ahead. In R.J. Haggerty, L.R. Sherrod, N. Garmezy, & M. Rutter (Eds.), *Stress, risk, and resilience in children and adolescents: Processes, mechanisms, and interventions* (pp. 354–385). Cambridge: Cambridge University Press.

Saulnier, C.A., & Klin, A. (2007). Brief report: Social and communication abilities and disabilities in higher-functioning individuals with autism and Asperger syndrome. *Journal of Autism and Developmental Disorders*, *37*, 788–793.

Spirito, A. (1996). Commentary: Pitfalls in the use of brief screening measures of coping. *Journal of Pediatric Psychology*, *21*(4), 573–575.

Spirito, A., Stark, L.J., Grace, N., & Stamoulis, D. (1991). Common problems and coping strategies reported in childhood and early adolescence. *Journal of Youth and Adolescence*, *20*, 531–544.

Spirito, A., Stark, L., J., & Williams, C.A. (1988). Development of a brief checklist to assess coping in pediatric patients. *Journal of Pediatric Psychology*, *13*, 555–574.

Spivack, G., & Shure, M.B. (1982). The cognition of social adjustment: Interpersonal cognitive problem-solving thinking. In B.B. Lahey & A.E. Kazdin (Eds.), *Advances in clinical child psychology*, *Vol. 5* (pp. 323–372). New York: Plenum.

Stark, L.J., Spirito, A., & Stamoulis, D. (1991). *Common problems and coping strategies reported by young children.* Poster presented at the Annual Meeting of the Association of Behavior Therapy, New York.

Wallander, J.L., Varni, J.W., Babani, L., Banis, T.H., & Wilcox, K.T. (1989). Children with chronic physical disorders: Maternal reports of their psychological adjustment, *Journal of Pediatric Psychology*, *13*, 197–212.

Weisz, J.R., McCabe, M., & Dennig, M.D. (1994). Primary and secondary control among children undergoing medical procedures: Adjustment as a function of coping style. *Journal of Consulting and Clinical Psychology*, *62*(2), 324–332,

Wertlieb, D., Weigel, C., & Feldstein, M. (1987). Measuring children's coping. *American Journal of Orthopsychiatry*, *57*, 548–560.

■