GAP

CELEBRATING THE FIRST 10 YEARS OF THE JOURNAL

Edited by Glenys Jones
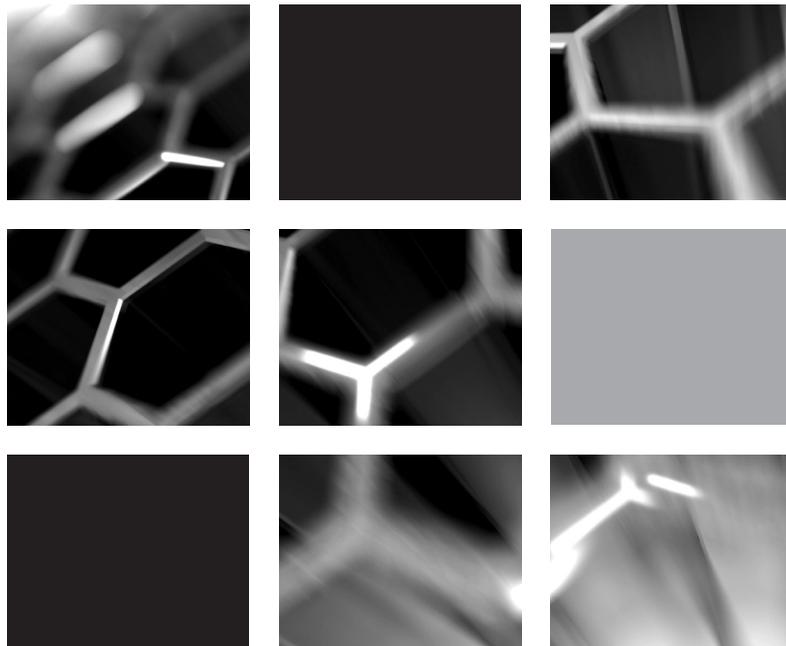
Clinical observations of the differences between children on the autism spectrum and those with attachment problems: the Coventry Grid

Heather Moran

Editorial comment

It is often problematic when a child has experienced a very difficult early life or serious abuse or trauma to determine whether the child has attachment problems or is on the autism spectrum or both, as the presenting problems may appear very similar on referral. Heather Moran is a Consultant Child Clinical Psychologist who works within a Child and Adolescent Mental Health Service (CAMHS). Over the last few years, she has met with other professionals in the West Midlands to discuss the similarities and differences between children on the autism spectrum and children with attachment problems and their response to interventions. This paper is a work in progress and presents the thoughts and ideas generated to date. It is presented here as others also ponder the same questions and Heather would welcome readers views on this.

When one is unsure about the underlying explanation for a child's difficulties, it is advisable to continue diagnostic assessment and discussions during the interventions, using the child's response to strategies as evidence on the nature of his or her difficulties. There is a danger that if a child is placed in a specific diagnostic category, s/he may be excluded access from services or interventions that might help (if services are only given when a particular diagnosis is made). As the diagnostic process is a subjective one, in the absence of definitive tests, then there will always be some children who are inappropriately diagnosed. If more detailed criteria are created to help in the diagnostic process – as is attempted in this paper, then potentially fewer children will lose out. Of course, if clinicians believe that both sets of children – those with attachment problems and those on the autism spectrum – benefit from the same services and strategies, the diagnostic category in which they are placed may be deemed less important. The need for clarification and for papers such as this, is clear.

Introduction

This paper raises the issue of differential diagnosis in children who present with social, emotional and behavioural difficulties. Some of these children will be on the autism spectrum and some will not, their difficulties being explained by attachment problems. There will be a very small number of children who will have both autism and attachment problems. More is now known

about attachment disorder and the treatments being developed focus on developing and strengthening emotional relationships. Treatments for children on the autism spectrum may also have this as a goal, but would also address their needs in relation to communication, social and emotional understanding and flexibility.

Coventry Child and Adolescent Mental Health Services (CAMHS) has developed the Coventry Grid: ASD vs Attachment Problems to try to identify differences between the two groups and so assist in differential diagnosis.

Aims of this paper

The aim of this paper is to provoke more discussion and research amongst clinicians who are concerned with the assessment and diagnosis in more socially able children on the autistic spectrum. Such children may have subtle social communication problems and be quite sociable, especially girls (Attwood, 2007). Social difficulties are independent of sociability or social interest, as Wing (1996) pointed out, so that children can be very socially interested and sociable, but have major social difficulties and vice versa. Often a referral into Coventry Child and Adolescent Mental Health Services (CAMHS) for further assessment with regard to the autism spectrum will highlight only the main features of autism (eg insistence on routines, friendship problems, poor social understanding, anxiety about change, difficulties with the social use of language), all of which may also be seen in children with attachment disorder (Golding, Dent, Nissim and Stott, 2006). As yet, diagnostic interviews for autism do not make this differential diagnosis, although they might differentiate between subgroups within the autism spectrum (Skuse, Warrington, Bishop, Chowdhury, Lau, Mandy and Place, 2004) Lord, Rutter and Le Couteur; 1994; Leekam, Libby, Wing, Gould and Taylor, 2002). This paper suggests that looking closely at the child's behaviour patterns may help to differentiate between autism and significant attachment problems.

Background

According to the diagnostic criteria, both autism and attachment disorder affect social skills and relationships significantly (Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 2002; International Classification of Mental and Behavioural Disorders (ICD-10), 1992) so it can be difficult to be certain of the diagnosis in some children, especially when they have had adverse early

lives (Rutter, Kreppner, Croft, Murin, Colvert, Beckett, Castle and Sonuga-Barke, 2007).

The diagnostic criteria for attachment disorder are very specific and there is an argument that there are more children with significant attachment difficulties than are identified and diagnosed (Howe, 2006). Perhaps the criteria are too narrow. So, the term 'attachment problem' is used in this paper as a shorthand for all kinds of significant attachment difficulties, severe enough to affect the ability to develop mutually supportive relationships with family and friends. There is limited research in this area, and much has focused on identifying different attachment types (Bowlby, 1999; Crittenden, 1992). Secure attachment develops through patterns of interaction with parents and carers who are more or less able to display warmth and soothing to their child in a way that satisfies their child's temperament and needs, and through the child's experiences of care, trust and love (Gerhardt, 2004). These attachment patterns seem to provide a template for intimate relationships.

The diagnosis of borderline personality disorder is used for adults with poor attachment history and ongoing severe relationship problems (Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 2002), so it appears that disturbed relationships with carers can have a long term, negative effect upon children's development, even when the children have not had hugely disrupted care history or been severely physically deprived (Glaser, 2000; Herman, Perry and van der Kolk, 1989). However, confusion also exists in the diagnoses on the autism spectrum in adults coming for a first diagnosis, particularly where parents are not available to give a detailed history of their early development, so it is not clear how accurate such a diagnosis is. In the UK, those children growing up with parents who have psychiatric disorders and/or personality disorders might be at the most risk of developing significant attachment problems. Not all of these children will develop such difficulties though and there is much research to be done in identifying factors affecting resilience.

A key feature in all attachment problems seems to be a persistence in behavioural patterns which 'push' other people into responding clearly and taking a position in relation to the child's behaviour. These children have often experienced intermittent, inconsistent and disruptive care and contact with their parents and they can lose their trust in adults. They might be testing the

boundaries to see how strong their relationship with others really is. Another common feature is that these children draw much more attention to themselves than do others of the same age. They can be over-vigilant, picking up on the non-verbal behaviour of others and mistakenly thinking that this was directed at them. It is suggested that patterns of interaction that were adaptive in the adverse circumstances of their early development can, in some children, become quite resistant to modification (Howe, 2005). These patterns of behaviour are less useful outside the immediate environment in which they were developed, so children who are removed from their birth family may need help to understand and adapt their behaviour and to develop healthier relationships (Golding, Dent, Nissim and Stott, 2006; Howe, 2006).

At the present time, clinicians and researchers are working on the development of treatments for children with attachment problems and some of these look promising in their effects on relationships and behaviour (Howe, 2006; Hughes, 2000; Levy, 2000). In attachment therapies, the focus appears to be upon developing social and emotional understanding and physical closeness, with a frequent reference to the feelings of the adults and the child (Howe, 2006). Some treatments are designed to enhance relationships with carers and might also benefit children on the autism spectrum (such as Theraplay (Booth and Jernberg, 2010)).

It is known that there are high rates of mental health disorders in children who are 'looked after' by the local authority but that these children are under-represented in CAMHS populations (Richardson and Lelliott, 2003). In relation to the autism spectrum, Meltzer, Gatward, Corbin, Goodman and Ford (2003) found that 8 per cent of boys aged 11–15 years met criteria for a diagnosis within the autism spectrum in their sample of 'looked after' children, higher than the prevalence rate in the general population of children at 1–1.5 per cent (Baron-Cohen and Scott, 2009). As well as problems related to a lack of access to CAMHS, perhaps part of this may be because there is a bias against understanding their behaviour through attachment theory. Some children who are permanently looked after by the local authority or adopted might be expected to be particularly vulnerable to developing serious and multiple mental health and behavioural problems during their lifetime, if they experienced severe adversity in their family relationships which led to their permanent removal. A

key criteria in the diagnosis of autism is that evidence of autism should be present within the first three years of life. Where it can be shown that children have been typically developing from birth to beyond the age of three years, then it is more likely that a diagnosis of attachment disorder will be given to explain their difficulties. Doctors providing medicals for looked after children will consider the need for further psychiatric or psychological assessment and can ask for information from those working with the children on a daily basis to clarify the usual behaviour patterns of the child and make decisions about the need for a referral for autism assessment. Some of those children may well have both autism and attachment problems and might require a very careful consideration of the kind of support they need and can use.

Services for children on the autism spectrum in Coventry

Coventry has a long tradition of active work with children and families on the autism spectrum over the last 15 years, during which the team has been involved with about 700 families. The team offers diagnostic assessment and treatment and support for children without learning disabilities. The majority of therapeutic interventions and supports have been in operation for 12 years now and this includes individual therapies as well as group work with children and parents. The team has worked with a significant minority of families over the longer term, with periods of intervention, as required, throughout childhood. Alongside this work, the Coventry service had been developing more targeted services for children and adolescents with attachment difficulties. Many of the same professionals have worked with both groups of youngsters, finding that intervention could be similar in some respects, but needed to be quite different in others.

Differences noted by therapists working with children on the autism spectrum and children with attachment problems

Children with attachment problems
One of the key differences noted by clinicians related to the way a therapeutic relationship was used by the child. Professionals described a much more 'emotional feel' to therapeutic relationships with children with attachment problems and a more 'matter-of-fact feel' to therapeutic relationships with those on the autism spectrum. The clinical issues of limiting emotional

dependence and maintaining appropriate interpersonal boundaries were highly significant when working with children with attachment problems. Therapists reported that relationships with this group often developed quite quickly, but that they had to work hard to develop and maintain more appropriate relationships. Therapists often reported emotional challenges to therapists and resistance to the relationship boundaries they were establishing and maintaining. The children generally arrived with some ability to make a relationship with another person, albeit often in an idiosyncratic and inappropriate way. Part of the therapeutic intervention was to directly address these issues, helping the youngsters to understand their own construction of relationships, the way they may have been developed and become unhealthily skewed, and how they might change things so that their future relationships could be more successful and healthy. The relationship between the child and therapist was the vehicle for therapy.

Children on the autism spectrum
In contrast, the therapists working with youngsters on the autism spectrum described making great efforts to make the beginnings of relationships work in order to reach a point of engagement. They were actively trying to develop the children's construction of a relationship with a professional so that they might view the contacts as being relevant and useful to them. The maintenance of appropriate emotional boundaries was far less of an issue because the children were not usually setting out to test those boundaries, although appropriate behaviour for the room or for the situation could be an issue. The task was to make therapy relevant, often by involving children's interests or obsessions because the relationship with the therapist was unlikely to be a significant motivator in the early stages of therapy.

Development of the Coventry Grid: Autism vs Attachment Problems

The development of the grid arose from concerns of clinicians at Coventry CAMHS who were involved in the assessment and diagnosis of children on the autism spectrum. None of these clinicians only worked with children on the autism spectrum. Their assessments found that a child might at first appear autistic (especially 'on paper') but that an exploration of the child's early and later development, the family's mental health and experiences often indicated fairly typical early development, but significant trauma, mental health problems, and a lack of stability in relationships. Like

children on the autism spectrum, these children also had problems with the social use of language, emotional regulation, social skills and repetitive and routinised behaviours. As these were investigated, what usually emerged was a rather different picture of the problem, with a high dependence upon emotional relationships, even when a child appears very rejecting of the attachment figure. These children made more connections with the clinicians and then used that relationship to face things that were difficult for them. In some cases, a formal diagnostic interview with parents or carers would have placed the child in the Pervasive Developmental Disorder or autism category, in contrast to information from other sources such as school and clinical contacts. Clinicians were concerned about the long-term accuracy of any diagnosis they might make and that this might lead to the child being offered less effective support and treatment. It was not only a problem in Coventry; this dilemma was also discussed regularly at the multidisciplinary West Midlands Regional Partnership working group which was looking at the assessment and diagnosis of children on the autism spectrum and aiming for some consistency across the region.

The Coventry Grid was developed by the Coventry CAMHS attachment interest group and the Coventry CAMHS neurodevelopmental team. Both were multidisciplinary groups of professionals who work with children with all kinds of psychological and psychiatric difficulties but who have a specialism in autism or attachment problems (and a number of individuals who have specialisms in both). The group included representatives from the professions of speech and language therapy, clinical psychology, social work, mental health nursing, occupational therapy, art therapy and psychiatry. The group worked through the symptoms of autism, identifying the day-to-day, real life problems reported by parents and carers. Then, the group considered how those symptoms presented in children with attachment problems.

There was lively debate about the similarities and differences in the expression of difficulties shown in children's behaviour. For example, problems with eating are often mentioned in referrals for both groups of children with temper tantrums and rigid, obsessive behaviours around eating. However, careful elaboration of the nature of these problems showed considerable differences in how, when and where they occurred. The

problems related to eating in children on the autism spectrum were often about the strong preferences related to physical sensations (such as texture and taste), the way food is organised on the plate, or its place in the child's daily routine. Problems with food were pervasive, occurring wherever the child was invited to eat, regardless of who was offering the food and where it was being eaten. Denial of offered food seemed to be related to taste and texture preference and not to who was offering it. In contrast, for children with attachment problems, the provision of food often had strong emotional significance and was associated with relationships. Problems were most evident in relation to parents or carers, with more typical eating habits in situations with other adults. Parents and carers often reported concerns about abstinence and gorging and these behaviours tended to be associated with deliberate (and planned) deceit such as throwing or giving away food, or hiding food and wrappers. Denial of offered food seemed to be with the intention of emotional hurt or emotional defense, something which requires an understanding of emotional relationships. The devil was in the detail: differences between the two groups were considerable, even though the headline in referrals could be "*obsessive and rigid patterns of eating behaviour*".

The resulting Coventry Grid: ASD vs Attachment Problems is provided in *Appendix 1*. The paper was then distributed within the wider CAMHS team for consideration and comments and to other local professional groups that were also engaged in the debate about whether or not a child's symptoms suggested autism or attachment problems. A key group was the West Midlands Regional Identification Working Party: a multidisciplinary group of experienced professionals (from education services, paediatrics, CAMHS) all of whom are closely involved in delivering services to children with autism and many of whom were faced with similar issues around differential diagnosis. The document was also posted on two online discussion groups (Educational Psychologists involved in the online forum, Educational Psychology List (EPNET) and the Clinical Psychologists Working with Looked After and Adopted Children (CPLAAC) forum, and to other interested parties who requested it. A number of these people took the grid for discussion within their own services and provided feedback about the views of their groups.

In each case, professionals who responded indicated that the Coventry Grid was timely: they were also engaged in discussions and serious debate about this issue. They have stated that their experience was similar to that of our service. They have also found differences between children on the autism spectrum and attachment problems and were actively seeking advice about what the differences are.

How might the grid be used?
Both autism and significant attachment problems might be construed as developmental difficulties and both groups might be vulnerable to misdiagnosis, especially when they present with depression and anxiety or when they have very good intellectual abilities and relatively poor relationship skills. Although at the point of referral children may look similar, there appear to be important differences in the way their problems are expressed in daily functioning. The differences imply that different assessment and diagnostic pathways and different treatment styles may be needed for the two groups even though there may be some types of intervention from which they would both benefit (eg the use of visual timetables to reduce anxiety).

The Coventry Grid is presented to draw attention to the similarities and differences between symptoms of autism and attachment problems. There is a need for more research in this area and attention could be focused upon children who are looked after by the local authority because they should be screened for mental health problems through their regular medicals. That screening will rely heavily upon the quality of information being presented to medical officers, so a tool such as the Coventry Grid used with the Asperger Quotient -Child questionnaire (Auyeung, Baron-Cohen, Wheelwright and Allison (2008) might aid decision making about referrals for further assessment and treatment (which professional and for what?). The Coventry Grid might also be useful to clinicians making differential diagnoses, especially where there has been known abuse and neglect in early life, even though the child has remained with the birth family.

Concluding comments
It is hoped that this paper will stimulate discussion amongst clinicians and researchers about the need for tools which provide differential diagnosis between autism and attachment problems. It is hoped that interested clinicians will provide feedback on the grid,

clarifying whether the ideas identified so far are relevant to them and whether they think there is a need to develop such work further.

References

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edition) Washington, DC: American Psychiatric Association.

Attwood, A (2006) *The complete guide to Asperger's syndrome* London: Jessica Kingsley Publishers.

Attwood, T and Grandin, T (2006) *Asperger's and girls* Arlington: Future Horizons.

Auyeung, B, Baron-Cohen, S, Wheelwright, S and Allison, C (2008) The Autism Spectrum Quotient: Children's Version (AQ-Child) *Journal of Autism and Developmental Disorders* 38, 1230–1240.

Baron-Cohen, S, Scott, F J, Allison, C, Williams, J, Bolton, P, Matthews, F E and Brayne, C (2009) Prevalence of autism-spectrum conditions: UK school-based population study *British Journal of Psychiatry* 194: 500–509.

Booth, P B and Jernberg, A M (2010) *Theraplay: Helping parents and children build better relationships through attachment based play* (3rd edition) San Francisco: Jossey-Bass.

Bowlby, J (1999) *Attachment: attachment and loss* (Vol 1) (2nd edition) New York: Basic Books.

Clinical Psychologists Working with Looked After and Adopted Children (CPLAAC) available from www.cplaac.org.uk (accessed 8 October 2010).

Crittenden, P M (1992) Quality of attachment in the preschool years. *Development and Psychopathology* 4, 209–241.

Educational Psychology List (EPNET) available from www.jiscmail.ac.uk/lists/epnet.html (accessed 8 October 2010).

Gerhardt, S (2004) *Why love matters. how affection shapes a baby's brain* Hove: Brunner-Routledge.

Glaser, D (2000) Child abuse and neglect and the brain: a review *Journal of Child Psychology and Psychiatry* 41(1), 97–116.

Golding, K, Dent, H R, Nissim, R and Stott, L (2006) *Thinking psychologically about children who are looked after and adopted: Space for Reflection* Chichester: Wiley Blackwell.

Herman, J L, Perry, J C and van der Kolk, B A (1989) Childhood trauma in borderline personality disorder. *American Journal of Psychiatry* 146, 490–495.

Howe, D (2005) *Child Abuse and Neglect: Attachment, development and intervention* Basingstoke: Palgrave MacMillan.

Howe, D (2006) Developmental attachment psychotherapy with fostered and adopted children *Child and Adolescent Mental Health* 11(3), 128–134.

Hughes, D A (2000) *Facilitating developmental attachment: the road to emotional recovery and behavioral change in foster and adopted children* Northvale, NJ: Aronson.

Jordan, R and Jones, G (1999) *Meeting the needs of children with autistic spectrum disorders* London: David Fulton Publishers.

Leekam, S R, Libby, S, Wing, L, Gould, J and Taylor, C (2002) The Diagnostic Interview for Social and Communication Disorders: algorithms for ICD-10 childhood autism and Wing & Gould autistic spectrum disorder *Journal of Child Psychology and Psychiatry* 43 (3), 327–342.

Levy, T M (Ed.) (2000) *Handbook of attachment interventions* San Diego: Academic Press.

Lord, C, Rutter, M and Le Couteur, A (1994) Autism diagnostic interview-revised: A revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders *Journal of Autism and Developmental Disorders* 24(5), 659–685.

Meltzer, H, Gatward, R, Corbin, T, Goodman, R and Ford, T (2003) *The mental health of young people looked after by local authorities in England* Norwich: Her Majesty's Stationery Office (HMSO).

Prior, V and Glaser, P (2006) *Understanding attachment and attachment disorders. Theory, evidence and practice* London: Jessica Kingsley Publishers.

Richardson, J and Lelliott, P (2003) Mental health of looked after children *Advances in Psychiatric Treatment* 9, 249–251.

Skuse, D, Warrington, R, Bishop, D, Chowdhury, U, Lau, J, Mandy, W and Place, M (2004) The developmental, dimensional and diagnostic interview (3di): a novel computerized assessment for autism spectrum disorders *Journal of the American Academy of Child and Adolescent Psychiatry* 43, 548–558.

Appendix 1: The Coventry Grid: Autism Spectrum vs Attachment Problems Differences between the Autism Spectrum and attachment problems based upon clinical experience and observations (Modified July 2010)

Children on the autism spectrum and those with attachment problems both present difficulty with flexible thinking and behaviour. Their behaviour can be demanding and ritualistic, with a strong element of control over other people and their environment. The different 'flavour' seems to be about personality style, a strongly cognitive approach to the world in the autism spectrum, and a strongly emotional approach in attachment problems. The need for predictability in attachment disorder suggests that the child is trying to have their emotional needs for security and identity met. In autism, the emphasis seems to be on trying to make the world fit with the child's preferences.

Symptoms of autism	Present in both autism and attachment problems	Typical presentation in the autism spectrum	Typical presentation in attachment problems
1. Lack of flexibility of thought and behaviour	1.1 Preference for predictability in daily life Repetitive questions related to own intense interests	• Repetitive questioning re changes in routines and new experiences • Ritualised greetings • Becomes anxious if routine is removed and may seek to impose usual routine (eg wants same bedtime routine when away on holidays) • Inclined to try to repeat experiences and to interpret any repetition as routine (eg asks/demands repetition of following the same route to school) • Distressed when a routine or ritual cannot be completed (eg when cannot follow the usual route because of road works) • May cope well with new and unfamiliar experience as no previous routine has developed (eg horse riding; air travel)	• Preference for ritualised caring processes (eg bedtimes, meals) • Repetitive questioning re changes in routines and new experiences • Copes better with predictability in daily routines but usually enjoys change and celebrations • Looks forward to new experiences but may not manage the emotions they provoke (eg may not cope with excitement or disappointment) • Takes time to learn new routines • Routines tend to be imposed by adults in order to contain the child's behaviour more easily

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
	1.2 Difficulties with eating	• May limit foods eaten according to unusual criteria such as texture, shape, colour, make, situation, rather than what that food is (eg will eat chicken nuggets but no other chicken) • May adjust eating because of literal understanding of healthy eating messages (eg sell-by dates, avoidance of fat) • Restricted diet seems to be about maintaining sameness and the child is not easily encouraged by people the child is attached to • May eat inedible substances	• Anxious about the provision of food and may over-eat (or try to) if unlimited food is available • May be unable to eat when anxious • May hoard food but not eat it • May be unable to eat much at a sitting • May 'crave' foods high in carbohydrate • Eating is transferable from situation to situation and the child can be persuaded by close adults • Children tend to have a range of eating disorders
	1.3 Repetitive use of language	• Echolalia (immediate or delayed) • Repetition of 'favoured' words which are chosen for their sound or shape, rather than for their use in communication or emotional content • Children's repetitiveness is out of sync with their developmental stage • Repetitive questioning for reassurance and predictability	• May develop rituals for anxiety provoking situations (eg says same things in same order when saying goodnight or leaving for school) • Children's repetition seems to be like that of a younger child – learning and playing with language
	1.4 Unusual relationship with treasured possessions	• May make collections of objects, but does not seek social approval for the collection or for its care • Will often be able to say where most treasured possessions are and recognise if they are moved • May be unable to dispose of old toys/papers/books even though they are not used • Shows a preference for old, familiar toys (or toys which are part of a series) rather than new and different toys	• May seek social approval/envy from others for possessions • May not take extra care with possessions which have been given an emotional importance • May be destructive with toys, exploring them and breaking them accidentally • New and different toys are appreciated • May lose things easily, even most treasured possessions, and may be unable to accept any responsibility for the loss • May deliberately destroy emotionally significant possessions when angry

Play is a clear problem in both groups of children, with a lack of social imagination and an inclination towards repetitiveness evident in both Autistic Spectrum Disorder and Attachment Disorder. The difference seems to lie inthe way the children play: children with Autistic Spectrum Disorder are inclined to choose toys which are related to their intense interests and to play with those toys by mimicking what they have seen on DVDs and television. They may also choose play that is cognitive and characterised by collecting and ordering information, such as train-spotting or reading bus timetables, and involves little emotional contact with other people. Children with Attachment Disorder may lack play skills but their play interests tend to be more usual.

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
2. Play	2.1 Poor turn-taking and poor losing	• May try to impose own rules on games • May see eventually losing a game as unfair if was winning earlier in the game • Preference for playing alone or in parallel with others	• May try to impose own rules on games so that they win • May be angry or upset about losing games and blame others or the equipment for their failure (there is a sense of fragile self-esteem in the style of reaction) • Preference for playing with others who can watch them win
	2.2 Unusual play with toys	• Plays with toys as objects rather than personifying them • May spend all time organising toys and arranging in patterns (eg ordering by size, colour) • May 'play' with unusual things (eg reading the telephone book, watching water run down the drain) for long periods from a young age	• Uses toys to engage the attention of other children • May play games which include own experience of traumatic life events and difficult relationships • May have poor concentration on toys and be able to play alone only for very brief periods
	2.3 Poor social play	• Dislike and avoidance of others directing play • Harder to engage in social play with parents/carers	• Wants adults to provide play opportunities and/or to direct play • May prefer to play with adults (esp. carers) rather than children
	2.4 Repetitive play	• Limited range of play activities • Strong preference for the familiar and tendency to play alone on the same activity for long periods	• Plays repetitively with adults much as a toddler likes to play such as hide and seek, lap games • Plays out past experiences and preferred endings repeatedly (eg escaping from danger, saving siblings)
	2.5 Poor social imaginative play	• Difficulty playing a variety of roles within games • Difficulty incorporating a range of toys into the same game (eg using both Dr Who and Spiderman toys in a game)	• Difficulty ending role play games • May be able to take various roles but may show a strong preference for a kind of role (eg always the baby, always the angry father)

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
		• Preference for toys which have a mechanical rather than emotional nature (eg cars, trains, Lego) or which require logic and order (eg reviewing and organising collections of objects) or examining objects (eg watching spinning objects)	

There are key similarities in social interaction: children in both groups appear to have an egocentric style of relationship with other people and lack an understanding of the subtle variations in social interaction which are necessary to develop successful relationships with a range of other people.

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
3. Poor social interaction	3.1 Difficulties with social interaction 3.2 More successful in interactions with adults than peers 3.3 Own needs drive interactions 3.4 Lacks awareness of risk and personal danger in interactions with adults	• Interaction is usually one-sided and appears self-centred, but can be as unaware of his/her own perspective as of others • Does not often manipulate others emotionally except through angry outbursts (i.e. would rarely ingratiate self with audience), but manipulates others' behaviour so that they do what the child feels comfortable with • May perform better in less emotional situations • Poor awareness of own role in interactions	• Seeks an emotionally expressive audience for interactions (eg seeks to provoke strong reactions in audience such as anger, sympathy, support, approval) • May make persistent attempts to interact with adults or older children rather than with age peers • May initiate interactions with others which allow them frequently to play the same role in relation to self (eg as the victim, as the bully)
	3.5 Difficulty sharing	• Lacks awareness of the need to share and sees no value in sharing in an activity that holds no interest for him/her • May not realise the needs of others waiting for their turn	• Aware of the social need to share but anxious about sharing (especially food) and may refuse or hoard or hide possessions and food to avoid sharing • May take things which are important to others with awareness that this will be upsetting for the other person

Clinical observations of the differences between children on the autistic spectrum and those with attachment problems

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
4. Mind reading	4.1 Difficulty appreciating others' views and thoughts	• Rarely refers to the views of others	• May be manipulative (or overly compliant) and ingratiate self with adults/children
	4.2 Lack of appreciation of how others may see them	• Lacks awareness of other's views of self, including lack of awareness of 'visibility' of own difficulties (eg may to perform gym sequence even though very poor at gym) • Does not appreciate the information parents would like to hear about successes and enjoyment	• Inclined to blame others for own mistakes • Draws attention away from own failures towards own successes • May try to shape others' views of self by biased/exaggerated reporting
	4.3 Limited use of emotional language	• Rarely refers to the emotional states of self and others	• Hyper-vigilant with regard to particular emotions in others (eg anger, distress, approval) and often makes reference to these states • Poor emotional vocabulary
	4.4 Problems distinguishing between fact and fiction	• May not realise that cartoons, toys, animations and science fiction are not real • May not realise that fantasy play is a temporary role • May be easily influenced by fantastic claims and advertising • Lies are often easily discovered and 'immature' in style	• Tendency to see self as more powerful and able to overcome enemies, or as vulnerable and powerless to offer any challenge • May talk repeatedly of how to overcome captors/escape from imprisonment/kill enemies even when these adversaries are obviously bigger, stronger and more powerful than the child • May not be able to judge whether a threat is realistic and act as if all threats, however minor or unrealistic, need to be defended against • Lies may be elaborate and also may deliberately be harmful to others' reputations and designed to impress the audience

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
5. Commu-nication	5.1 Pragmatic language problems	• Poor awareness of the purpose of communication • Lacks awareness of needs of audience • Does not repair communication break down • Poor eye contact (may be fleeting, staring, is not synchronised with verbal communication) • Proximity does not signal intimacy or desire for contact • Often does not start conversation by addressing the person • Conversation is stilted • The burden of communication lies with the listener/adult • Poor understanding of communicative gestures • Assumes prior knowledge of listener	• Lack of attention to the needs of the listener through poor attention to communication (due to poor modelling) • Eye contact affected by emotional state • Proximity is an emotional signal/communication • Better able to initiate conversation • May be overly sensitive to voice tone (hyper-vigilant to potential emotional rejection)
	5.2 Poor understanding of inferred meaning, jokes, sarcasm and gentle teasing	• Poor understanding of idiomatic language	• Gentle teasing may provoke extreme distress (self-esteem seems to be too fragile to cope) – internalise/assume it is about them
	5.3 Use of noise instead of speech	• Makes noises for personal pleasure (as with favourite words) eg barking	• Attention-seeking sounds (eg screams/screeches/whines under stress) to signal emotional needs and wishes
	5.4 Vocabulary	• May have word-finding problems • Often have unusually good vocabulary (for age, or cognitive ability, or within specific interest areas) • Less use of vocabulary related to emotions	• Often poor vocabulary range for age and ability • May use more emotive vocabulary (to get needs met)
	5.5 Commenting	• Provides detail in pedantic fashion and gives excessive information	• Reduced amount of commenting behaviour

Clinical observations of the differences between children on the autistic spectrum and those with attachment problems

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
6. Emotional regulation	6.1 Difficulties managing own emotions and appreciating how other people manage theirs	• Extremes of emotion may provoke anxiety and repetitive questioning and behaviour • Does not easily learn management of emotions from modelling (also likely to need an explanation) • Poor recognition of own and others' emotions • Lack emotional control because of lack of awareness and emotional understanding • Different contexts and settings trigger outbursts	• Difficulty coping with extremes of emotion and recovering from them (eg excitement, fear, anger, sadness) • May provoke extreme emotional reactions in others which tend to cast others in roles which are familiar from their own past experience of less healthy relationships • May be able to learn more easily from a non-verbal example than from talking • Shows emotional displays to people child does not know (indiscriminate) and tends to carry on longer (eg temper tantrums occur anywhere and at any time)
	6.2 Unusual mood patterns	• Sudden mood changes in response to perceived injustice	• Sudden mood changes related to internal states and perceived demands
	6.3 Inclined to panic	• Panics about change in routines and rituals and about unexpected experiences	• Panic related to not having perceived needs met (especially food, drink, comfort, attention)
7. Problems with executive function	7.1 Unusual memory	• Poor working memory unless well motivated • Very unusual long-term memory with recall of excessive detail • Difficulties in planning and sequencing actions	• Fixated on certain events • Recall may be confused • Selective recall
	7.2 Difficulty with concept of time – limited intuitive sense of time	• Rigid reliance on using precise times (eg uses watch and unable to guess time • Waiting irritates child because it affects routine and because unable to judge time or mark time	• Time has emotional significance (eg waiting a long time for dinner is quickly associated with feelings of emotional neglect and rejection)

Symptoms of ASD	Present in both autism & attachment problems	Typical presentation in ASD	Typical presentation in Attachment Problems
8. Sensory integration problems	8.1 Difficulty integrating information from senses (eg lack of awareness of heat, cold, pain, thirst, hunger, need to urinate/ defecate)	• May be passive and quiet in acceptance of discomfort or may be distressed but does not communicate the source of distress • May be hyper or hypo sensitive to some sensations	• Physical discomfort may be accompanied by a strong emotional reaction towards carer (eg anger and blame of carer for the discomfort)
	8.2 Unusual physical proximity	• Physical distance is unrelated to intimacy	• Shows awareness that physical closeness is related to emotional reactions (eg increases distance to signify rejection; seeks excessive closeness when anticipating separation)