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decp debate

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DECP Debate has the following purposes. It acts as:

- The voice of the DECP;
- An organ for the exchange of ideas, interests and views;
- A vehicle for communicating the concerns of the profession; and
- An instrument for two-way communication.

Unsolicited articles or other items for publication are welcomed. Please send these to a member of the Editorial Team. The Editorial Team reserves the right not to publish, for whatever reason, or to suggest amendments. Account should be taken of house style, particularly regarding length. Submissions on disk would be especially helpful but in that case hard copy should also be sent. Disks can be either PC or Mac format, and articles should be saved as an ASCII file as well as in their original word-processing format.

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Guest Editorial

Anne Peake

THE one-day Conference on Anxiety, Autism and Attachment, held at Woodeaton Manor School in Oxfordshire on Saturday 16 June 2012, was a new venture for the Division of Educational and Child Psychology. It came from the suggestion of a member of the Division and took place in a Local Authority School with the support and hard work of the staff, parents and carers and children of the school. We were delighted to be offered this special edition of *Debate* to provide a record of the proceedings. The edition contains articles by the keynote speakers and workshop presenters, with insights and drawings by the young people we all serve.

Key concepts for the conference

Child development unfolds in all its complexities in the same, and for every child, different ways. A brief overview of the life skills children need to start school shows the complex and subtle resources children need to be successful in school. These include:

- Secure self-esteem.
- The capacity to manage feelings.
- Accepting boundaries and rules in the classroom and in the playground.
- Being able to wait, queue and turn take.
- An ability to focus on the task in hand and concentrate.
- Being prepared to try difficult tasks and risk failure.
- Accepting praise and criticism.
- Recognising the needs of others and the need to be helpful for the greater good.

Woodeaton Manor School, Oxfordshire

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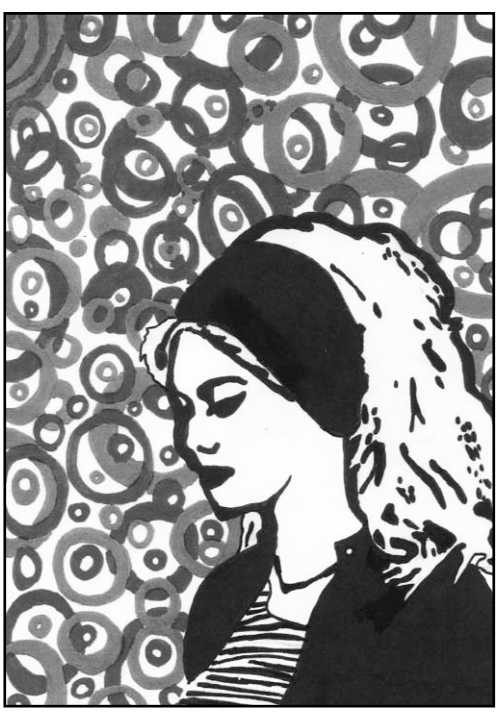
When a child doesn't develop as families and/or schools hope they will, there is a need for advice, support and resources. Educational and Child Psychologists have a great deal to contribute to understanding a child's problems and in being part of a multi professional network response to families and schools. As our understandings develop, there has been an increasing recognition of the nature of children's difficulties, and in particular the part that anxiety plays in the lives of children who present with social, emotional and behavioural difficulties. The causes of debilitating anxiety in children can be constitutional as in autism; the result of mistreatment as happens when children are abused and their lives are disrupted; or the result of shocking and upsetting events.

The one-day conference was an opportunity for those attending to look again at anxiety in the lives of some children, and how we can make significant contributions to the children, their families and schools. We hope that by sharing aspects of the conference with a wider audience, through this special edition of *Debate*, others will be able to access the learning.

Anne Peake
Guest Editor, Edition 144.



Anxiety *– Jane (aged 17 years).*

Chair's Notes

Chris Arnold

LAST SATURDAY my normal weekend routine changed. Rather than mow the grass, fix the plumbing or other domestic tasks, I, along with over 100 others got up early and went to the one-day conference on Anxiety, Autism and Attachment at the Woodeaton Manor School near Oxford. It was probably the best one-day event I have ever been to. The keynote speakers came from a wide range of backgrounds including academics, practitioners alongside those with first-hand experience of autism and being brought up in the care system. I came away enthusiastic, feeling that I had learned a lot and somewhat humbled by the courage of some of the presenters. I was not alone.

The professional landscape for EPs is changing. The new Bill is due out in the autumn and this is expected to increase the range of setting for young people who will be accessing educational psychologists. The changing role of the British Psychological Society and the DECP in the post-Health Professions Council era is encouraging change and development, so we are increasing the range of services offered to our members. Contributions to CPD opportunities are seen to be central to this. To this end the Division is organising a number of one-day events through the Society's Learning Centre in 2012, including the day I attended last week, and we are planning for the 2013 programme. Suggested topics include improving numeracy and literacy outcomes, working with students post-16, supporting families of young offenders and managing violent behaviour. There are many others. The full programme will be circulated soon by the Learning Centre.

Your committee is very actively working on guidelines for ethical trading. This is a key issue for our profession as many services are now having to trade their services to survive. Ensuring that we are ethically secure is a matter that the Society is keen to promote and the Division will be publishing the guidance when it is ready. We also have a working group preparing guidelines for EPs about the medicalisation of children. This is a very hot topic at present and members can expect to see much more coverage of this area in the press and from the Society.

The wider functions of the Society cover many different practitioner groups. We are promoting collaborative links with colleagues in other Divisions and finding much in common. The Special Group in Coaching Psychology is fast growing and is finding a role in schools. A number of EPs are already members and offering courses in coaching to staff in secondary schools. The Forensic Psychologists are providing information about the rules of evidence for expert witnesses. It is vital that we continue to work within our competence. If our work helps in legal proceedings, we must be secure that the evidence we supply is appropriate and ethical.

The Division continues to support research through a small fund. Please do consider applying if your work would benefit from some additional financial support. The criteria are available from Susan.Eppel@bps.org.uk. Similarly, please look at the CPD events for the remainder of this year and from January 2013. The Annual Conference/CPD event is in the planning stage. Applications for members to offer seminars, symposia, workshop or poster presentations are welcome. The Society's website has the details of how to submit proposals.

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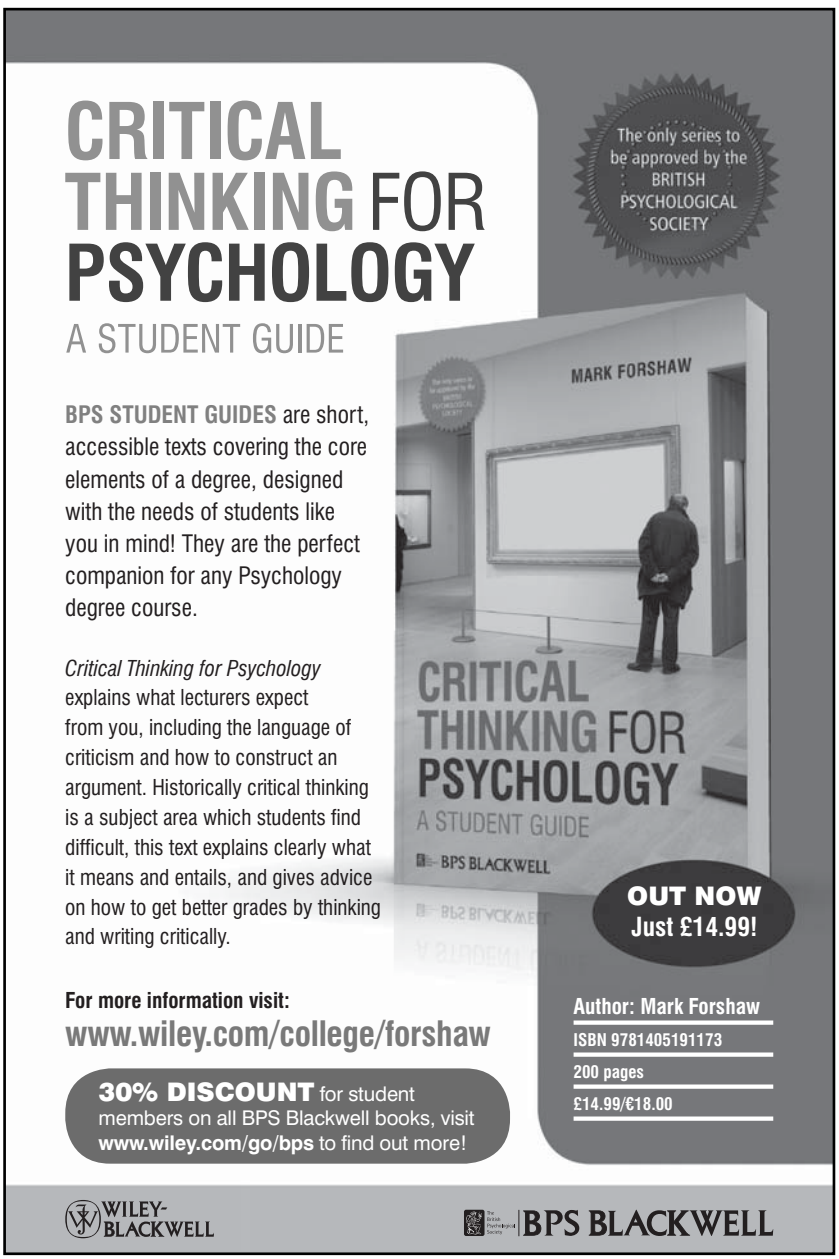
The future is exciting and challenging. My professional practice continues to develop and change as I respond to new circumstances. If this includes getting up early on some Saturdays to attend conferences of the quality that I enjoyed last weekend, so be it. The grass and plumbing can wait.

Chris Arnold
Chair,
Division of Educational and Child Psychology.



Autism and the brains working: How far have we got?

Andrew Curran

Dr Andrew Curran's specialist interests within his field of paediatric neurology include autistic spectrum disorders, epilepsy, long-term neurological disability and traumatic brain injury. He is particularly interested in the sociological aspects of learning as it relates to neurobiology, emotional literacy in education and the impact of disability on individuals, carers and society.

IT IS EXTRAORDINARY TO ME that in the last 15 years of brain research, all those billions of dollars spent in laboratories has shown to me one single important message. It can best be set out as follows:

- If a child is in an environment where they are *understood* as an individual human being then,
- Their *self-esteem* will be improved, and
- If their self-esteem is good they will gain *self-confidence*, and
- If they are in an environment where their self-esteem is good and they have self-confidence, they will feel *engaged* with that environment.

And what does all that add up to? Well, love as it happens.

The billions of dollars of research have shown some central points about brain functioning during learning which feeds directly into this thought. Firstly our main learning neurochemical, dopamine is controlled predominantly by the limbic system. What is the limbic system? Why, our emotional self in its broadest sense. Our limbic brain evaluates what is going on all the time and decides what we will pay attention to and what we will ignore. The more emotionally engaged we are with something, the more attention we will pay it. Attention as a function is also part of the dopamine system.

So now we are paying attention to something, how do we learn from it? Again dopamine comes to the fore as the main learning neurochemical in the brain (which makes sense really; if you use the same neurochemical to pay attention to something as you use to learn with, then you are killing two birds with the one stone!). Dopamine gets a helping hand from a couple of other neurochemicals, glutamate (which is all to do with excitation!) and a very long named chemical called gamma amino butyric acid (GABA for short) (which is to do with inhibition), but without dopamine learning cannot occur.

Dopamine sets in motion the processes that grow connections between nerve cells in the brain. These connections are called synapses and they allow signals to pass between nerve cells. These connections build up into patterns of nerve cell firing called Hebbian assemblies or templates and it is these templates that are the underlying fact behind everything we do with our brains.

So if we get someone emotionally involved in what we are doing, we get their attention. If we get their attention, then they will start to learn. So far so good. But how can we start that initial process of dopamine release that produces the results we want?

The answer to this is surprisingly easy (and obvious to every village wise woman since the dawn of time). As I have said dopamine release in the brain is predominantly under the control of our emotional system, the limbic system. So what turns on our emotional system? Well, stress will do that, but stress also turns on things that interfere with expansive learning such as steroids (that actually can destroy the nerve cells you

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learn with in the hippocampus, a brain structure essential for learning) and the big stress hormones, adrenaline and noradrenaline (which, through their action on the amygdala, will drive memory into unconscious memory through the corpus striatum). So learning through high levels of stress is not fundamentally a good thing.

So how can we get our limbic system to produce dopamine exactly where we want it in the brain, and without too much adrenaline, noradrenaline and steroids? The answer is through reward and the anticipation of reward. Nature has set our brains up so that these simple concepts will optimise our brains for learning (which makes lots of sense in evolutionary terms – it is a good idea to learn well things that bring reward!).

Reward in us humans is a complex thing. What rewards me may not reward you. And this is why models of learning such as Multiple Intelligences are so important. Find out what a person's intelligences are, and you immediately have an in into what will get their attention and optimise their learning.

So we have now come full circle. If you understand someone, they have good self-esteem and good self-confidence when they are with you. They are then perforce emotionally engaged with you and what you are doing. Learning will then be optimised for that individual (which doesn't mean that everyone can be an Einstein, but it does mean that an individual human can better reach his or her maximum potentials). It all comes back to that simple four-letter word. Love an individual human for themselves, and they will learn from you.

The final question that I would ask you is this – what are you taking into the classroom that is preventing you and your pupils making good emotional contact? Change that, and you will immediately have improved your pupils' potential to learn.

And, perhaps most importantly, you will be having fun (and there's nothing wrong with that!).

Correspondence

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Reference

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'When I'm anxious I feel down and scared. I don't want to socialise. I take it out on other people without realising it.

I put my hands on my head, I touch my nose a lot – and sometimes I pick it when I get really anxious. It has a massive impact on me. When people point it out it makes me feel worse and makes me angry. They have to leave it till I'm calm – then point it out to me. Then I'm really sorry and I know they are only trying to help.

Yesterday when this happened I could see the expression on B's face. I could tell he wasn't happy. At the time I didn't care. It was only afterwards that I realised I shouldn't have said the things I did to him – but then it was too late. I started to regret what I'd done – and then I started to get anxious again.'

Andrew (aged 14 years)

Psychopharmacology in Autistic Spectrum Disorder

Marian Perkins

Dr Marian Perkins is a Consultant Child and Adolescent Neuropsychiatrist heading a specialist service for children and families where autism is a concern. She is also a Honorary Senior Lecturer (Oxford University).

THE USE OF psychopharmacology in children with mental health difficulties has always been the subject of debate, sometimes contentious debate, between mental health professionals. This debate continues and may be particularly acute in the field of neurodevelopmental disorders, in particular autistic spectrum disorder. There are a number of general issues that need to be considered prior to discussing the specifics of the possible appropriate medications for different aspects of the disorder.

Very stringent observations with respect to clinical trials on children with these difficulties, particularly in the UK, has made good evidence-based information from adequate research methodology, for example, double-blind crossover trials, hard to generate. The broad range of the autistic spectrum has also made it difficult to generalise the potential efficacies of some of these interventions from some of the studies, which have tended to have been conducted on more severely affected individuals. Another significant problem is the general difficulty in being able to measure the effectiveness of medications due to paucity of sensitive and validated assessment instruments. The limited length of many studies makes it hard for a clinician to extrapolate on longer-term efficacy but also limits the information that we have in terms of side effect profile and potential longer term adverse sequelae.

Clinicians also need to be cognisant of the technical aspects of paediatric prescribing. The Medicines Act 1968 and European legislation make provision for doctors to use pharmacological approaches in off-label or out of licence capacity, or to use unlicensed medicine. This, however, rides on the presumption that there is adequate information to support the quality, efficacy, safety and prospective use of a particular drug prior to its prescription. Many of the pharmacological approaches in autism spectrum disorder will fall within this domain. Whilst this is entirely appropriate, on the other hand it may mean that certain clinicians are extremely reluctant to consider this approach even when it may be clinically appropriate.

There are several key aspects when considering medication. Firstly, there must be a rigorous risk benefit analysis and both clinician and family, and young person if appropriate, accept the limitation of the knowledge we have. Very detailed communication and discussion with the family are paramount, not only so that they are fully availed of the information to make an informed choice, but also so that it is very clear what aspects of the child's behaviour one is attempting to alleviate. As ever, therefore, a very detailed neurodevelopmental assessment including physical assessment will be crucial to delineating any plan for pharmacological intervention. This may well include pre-treatment baseline investigations and a plan for surveillance, evaluation and review once medication has been initiated. In general one can attempt to alleviate target symptoms, for example aggression, hyperactivity, rigid and ritualistic type behaviours or anxiety and affective symptoms.

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The detailed assessment of possible comorbid disorders that may warrant intervention in their own right, for example, ADHD, Gilles de la Tourette syndrome, epilepsy or Delayed Sleep Phase Syndrome, is crucial. Currently there is no single medication for autistic spectrum disorder that alleviates symptoms in all three domains simultaneously…it is essential that pharmacotherapies are viewed as an adjunct to appropriate and adequate psychological and educational interventions. There are a range of different medications to be considered. As currently there is no overarching neurochemical theory that encompasses all aspects of the range of symptomatology within autistic spectrum disorder, the medications used tend to focus on certain neurochemical pathways, most notably the dopaminergic, seratonergic and peptidergic pathways.

It is not possible within the format of this debate to cover a comprehensive list of medications, indications and side effect profile. I therefore wish to highlight some general principles and areas for clinicians to consider. One of the commonest requests from families for the use of medication is for severe aggression. Atypical neuroleptic medication is often considered and more latterly there has been an increasing range of atypical medications that have been used, for example, aripiprazole. This has largely been generated by the desire for better side effect profile, often wishing to limit the significant weight gain that can be associated with these medications. Other medications considered are mood stabilisers or anticonvulsants, however, one awaits research data regarding the comparative efficacies of these approaches. Children with autistic spectrum disorder also have high rates of inattention, overactivity and impulsiveness. If in addition to the autistic spectrum disorder the profile would meet criteria for attention deficit hyperactivity disorder, then a trial of methylphenidate or atomoxetine may be warranted. The restricted repetitive behaviours and interests domain can also be another area that may warrant intervention. SSRIs have been studied in this context, most notably fluoxetine, fluvoxamine, sertraline, citalopram and ecitalopriam. Side effects tend to be relatively mild, for example increased agitation. Atypical neuroleptics may also have a role in this domain. The other two areas for which it is worth considering pharmacological interventions are excessive anxiety and affective symptomatology, usually to be targeted with SSRIs, mood stabilisers or atypical neuroleptics. Sleep disorders in children with ASD are a very significant problems and melatonin has been shown to be beneficial to children in this area in seventeen studies. This intervention is most efficacious for Delayed Sleep Phase Syndrome as these children may well have other sleep disorders.

Hence, while the use of pharmacology in children with autistic spectrum disorder is an extremely complicated consideration, I would moot that not only from the research evidence but from my clinical experience and families and children whose lives I have seen transformed by such interventions, as an adjunct to the psychological therapies in very particular circumstances these approaches can be invaluable.

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The Shadow Spreading *– Danielle (aged 17 years).*

Autism, Anxiety and Mental Health

Paul Isaacs

Paul Isaacs is an adult diagnosed with High Functioning Autism (HFA). He had Classic/Kanner's Autism as a infant and didn't gain functional speech until he was 7- or 8-years-old.

Paul works as a member of Autism Oxford's Training Team and also as an Autism Training Consultant for MacIntyre Care. His autobiography, Living Through The Haze*, has just been published, and his second book is well on its way!*

FROM AN EARLY AGE my mum knew there was something 'different' about me, although I was initially a seemingly happy and smiley baby. My birth had its complications due to an emergency caesarean section as my mum and I were in distress.

Paul and his father Peter in 1989, when Paul was a severely Autistic infant.
©Isaacs Family

As my development progressed, it can be observed in family photographs that my body language changed; I seemed distant. I was a late walker (18 months) and a late talker. It took me until 7- or 8-years-old to gain functional expressive language and it took me until I was about 12 or 13 to gain a reasonable amount of functional receptive language. This made it very hard in a mainstream school environment and I was prone to being bullied by teachers and students because of being 'odd'. This caused great anxiety for me as I was growing up.

I have visual fragmentation which means I'm both object blind and meaning blind. As a young child with severe autism, I was constantly working out the world from my senses. I would use my tongue, lips, bare feet, hands, fingers, face, arms, legs to gain

Peter, Paul's Dad, was diagnosed with Asperger's Syndrome, and Belinda, Paul's Mother, was diagnosed with Atypical Autism.
©Isaacs Family

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Paul's Grandfather, Gilbert Harpwood, was diagnosed with Asperger's Syndrome in 2011. ©Autism Oxford

meaning of my visual scope and surroundings. I also used to mouth things and lick my palms to 'get a sense' of what the object 'felt' like. I'm about 80 per cent to 90 per cent face blind, so I rely on hair on the head and voices of the individuals to recognise people. I don't, however, process tone of voice, body language or facial expressions. I have poor emotional recognition called alexithymia which causes me to get confused about my own emotions causing a lagging effect. It once took me once up to two years to process that I was being bullied at my place of employment.

I had many failed jobs as a result of being undiagnosed at the time. I was misdiagnosed in 2008 with 'Asperger traits with a complex personality' by a mental health professional, along with other inaccurate mental health personality disorders, two of which were correct while the rest weren't happening at all! It was through Autism Oxford and Kathy Erangey that I was formally diagnosed with High Functioning Autism by a specialist in ASD in Headington, Dr Michael Layton, in 2010. Dr Layton was very kind and supportive over the many months diagnosing my father with Asperger's Syndrome, my mother with Atypical Autism (PDD) and my grandfather with Asperger's Syndrome. I thank Kathy Erangey for giving me the chance to be a speaker and member of the training team at Autism Oxford; I have found my niche in life at last!

As a result of anxiety, I was having dissociative episodes in my later infancy. This caused me to detract and create other 'alters' to deal with situations that my core self couldn't deal with. I have three alters that all have their own personalities and functions for me to deal with certain situations. This was result of abuse and bullying. These dissociative symptoms were finally recognised by a mental health professional in early 2012.

Paul Isaacs in 2011. ©Thames Gazette

My presentation at the Autism, Anxiety and Attachment Conference was about my personal journey of being misdiagnosed, judged and bullied over many years of my life. However, it is a story about remaining positive, true to yourself, being accepted and enlightened. I hope it inspires and helps

others to believe in themselves as people and go forward on their on their own positive journey!

The key is to be around people who make you feel valued and make you feel like you're worth something, that is what has helped me fulfil my potential as a person, I believe this ethos is key to helping people all across the autism spectrum.

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'I'm anxious when it's not like I'm used to everything being. Then it's stressful. It comes when you don't have any choice – when you don't have any control over the situation. On the other hand it's when you have too many choices – too many decisions to make.'

Ella (aged 14 years)

Developing an ASD Assessment Protocol for adolescent girls with attachment difficulties

Katie Adolphus & Rachel Smith

This article describes the challenges and tools chosen when developing an assessment protocol for adolescent girls at Tumblewood Therapeutic Community.

MOSAIC ASD Service includes a Clinical Psychologist (KA) and Specialist Speech and Language Therapist (RS) with experience working in several ASD Diagnostic Services and working with young people who have experienced early trauma and disrupted care. Tumblewood Therapeutic Community (TW) asked us to conduct ASD Diagnostic Assessments for four of their residents.

Our typical assessment package, informed by the National Autism Plan for Children (NIASA, 2002) and NICE guidelines (2011) needed expanding to reflect the complexity of these girls' histories and current circumstances. We also wanted to involve other disciplines and were able to read reports from and/or have discussions with a Consultant Psychiatrist, Educational and Forensic Psychologists who had worked, or were still working with the girls.

Challenges

Gender and Age: Understanding of girls with ASD is developing (see references). We find, however, that standard assessment tools are better at identifying the male phenotype. We used the Autism Spectrum Screening Questionnaire – Revised (ASSQ-Rev) (Ehlers et al., 1999, and Kopp & Gillberg, 2011). This is a 45-item carer-report questionnaire specifically revised to include items targeting this newly understood female presentation. The NICE guidelines note research indicating that the original ASSQ has equal sensitivity and better specificity than the commonly used Social Communication Questionnaire. We adapted the questionnaire for TW staff asking them to rate whether: 'This child stands out from other children in this setting, rather than other children 'of her age''. This was an attempt to understand differences in social functioning compared to other girls with similar backgrounds. We also used the Adolescent Autism Quotient (Baron-Cohen et al., 2006), to capture the adolescent presentation. This is a 50-item carer-report questionnaire. A member of the TW care team, a teacher and parents were asked to complete these measures.

History Gathering: The girls all had extensive social work files. We reviewed the information held by TW and requested copies of other reports and spoke to their authors if necessary and possible. This process was time intensive but absolutely necessary. For one young person we were able to gain an understanding of the significant life events in her early history but not early social functioning or behaviour. Health Visitor records may have been helpful but it was not possible to access them within time constraints. This influenced the diagnostic decisions we ultimately reached in one case.

We used the Developmental, Diagnostic and Dimensional Interview (3Di; Skuse et al., 2004) and interviewed parents (birth or adopted), when possible.

For one girl, parents were not available and we considered asking her Guardian Ad Litem. Funding became an issue and this

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particular assessment did not take place. We included most of the 3Di but excluded section 15 and beyond. These are questions regarding aspects of the girls functioning already well assessed by the TW team. We were mindful of the fact that parents had not lived with their daughters for some time and, therefore, questions about current functioning would be more difficult to answer.

Current Functioning: The girls routinely see an Educational Psychologist at TW. We had access to reports about recent (and, at times, historical) testing using the WISC IV, WORD and WIAT. RS worked at TW prior to these assessments and we reviewed the girls performance over time on the 'Clinical Evaluation of Language Fundamentals-4' (CELF-4), 'Understanding Ambiguity' and the 'Test of Language Competence' (TLC-E). These assess understanding of unambiguous, ambiguous and pragmatic language. TW teaching staff also provided reports. We conducted a 3Di interview with a senior member of the care team for each girl omitting questions about early functioning. This impacted the possible 'total score' each interview could achieve and, as such, the meaning of the scoring thresholds used by the 3Di.

We used the Autism Diagnostic Observation Schedule (ADOS) (Lord et al., 1989). We would have preferred to have videoed this for consideration at a consensus meeting. The girls refused and so we were both present and the score agreed between us. Lastly, we would have liked to have been able to observe the girls around the community. TW felt it was important that the young people knew the specific reasons for the observation (to watch their social interactions with peers). We felt that this would potentially influence their behaviour in unknown ways and make our observations difficult to interpret. We decided not to pursue this element of the assessment. RS has known the girls for some time and has seen them in other contexts.

Competing Explanations: The girls' needs are understood in terms of attachment difficulties by the experienced team at TW. Introducing another way of understanding some of their needs had the potential to be challenging. The Coventry Grid (Moran, 2010) helped us unpick differences between ASD and Attachment presentations. We reviewed the grid and gave each element a tick if we had evidence it fitted, a cross if we had evidence that it did not and a '?' if we had no evidence. Noting patterns informed interpretation of our assessment. We found that a number of grid elements were not covered by our chosen assessment tools and so began generating a questionnaire based specifically upon the grid. We aim to trial this soon.

Reflections

None of the tools used are themselves diagnostic and scores alone do not an accurate decision make. Gathering information from multiple people was overwhelming at times but essential. Acknowledging differences of opinions, concerns about the veracity of some reports and the interaction of ASD and Attachment issues was very important.

We worked hard to balance the time needed with the sense of urgency often surrounding these girls. Indeed, one girl left the community before our conclusions had been discussed with her. As such, it is important to have agreements about the time frame for the work and how to communicate the conclusions. We found that recommendations that were future focused and/or specifically addressed issues of risk were thought particularly helpful.

We are not purporting to have perfected the process. We would welcome feedback.

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'Anxiety – It's like a prickling – a fear. It's like you're not there at the scene – like you're in a dream.'

Danielle (aged 17 years)

Distinguishing between the behaviour patterns of ASD and significant attachment problems: The Coventry Grid

Heather Moran

Heather Moran's path to clinical psychology was a long one. Initially, she was a residential social worker and then a teacher in a residential school for children with social, emotional and behavioural difficulties. She trained as educational psychologist on the Birmingham course and worked in Leicester and then in Coventry for about seven years. She transferred to clinical psychology via the British Psychological Society and she has worked in Coventry CAMHS for the past 14 years. Heather and her husband were specialist foster carers and have four adopted children. She specialises in work with children with ASD and also with children who are adopted. She runs a therapeutic group for girls who are depressed and self-harm and work with children who have had traumatic and emotionally abusive experiences. Her interest in attachment and ASD arose from elements of work in all these areas and from life experiences living with her children and foster children.

ONE OF THE DIFFICULTIES with assessing for ASD is that there are always children who are referred who sound to have ASD in the referral, but who clearly do not have ASD when they are face-to-face with an assessor and their symptoms are explored. The quality of a referral has a significant impact upon what happens to a 'case'. If it lists many of symptoms of ASD, the child will wait for an autism assessment only to be discharged without a diagnosis. This frustrates parents, carers and professionals and can only be reduced by more thought going into the referrals which are made.

This can be very serious issue is the case of children who are Looked After. Their plans for a placement may be delayed pending the outcome of their assessment. This is the right thing to do if the child probably has autism because the potential adopters will need to know before making a commitment, but otherwise it will merely delay their move to a permanent family. Our own adopted daughter was in exactly this position. The adoption plan was made but we were warned that we would need to wait for an autism assessment to be completed before she moved. We saw the referral and it did present symptoms which could have indicated ASD. However, we had already met her foster carer and explored the nature of her difficulties and knew that they indicated attachment problems not ASD. The difficulty was that the referral was not detailed enough to show that she did not have ASD and that her problems were related to her very poor early start. We went ahead with the adoption plans and she was able to move into our family without a further six-month wait for an assessment. This would have meant that she had been placed for adoption at 4-years-old rather than 3½, and that her brother would have waited too, making him 5½. Fortunately, the delay was avoided. It was clear that the referral would not have been made if the understanding of her behaviour patterns had been more complete.

In my daughter's case, the cause of her difficulties was known. In the case of other children, the cause more usually goes unreported. There are children who are severely mistreated by their carers and whose parents present them to services with concerns about their behaviour. Some of these parents will be unaware of the fact that their parenting is so bad. Most will probably disguise their

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poor parenting by simply not reporting it. Parents very rarely report their own mistreatment and neglect of their children to authorities. Cases such as Baby Peter show that the child may be taken to see professionals but the extent of the child's mistreatment can easily be masked.

Relatively few children are severely abused but there are children who have problems due to their parents' problems. For example, a parent who is unavailable because of their own mental health problems or learning disability is likely to affect their child's relationships with them and, therefore, with other people. These children may present unusual levels of anxiety and have poor social interaction, symptoms which are key to an ASD diagnosis.

The nature of ASD is that the problems are pervasive, evident across situations. The defining feature of ASD is a strong inclination to notice patterns and seek out order and routine, along with a strong preference for sameness. We know that the effects of the social environment are significant, either in a supportive or a negative way, so ASD symptoms may be more or less evident in a setting. Often the symptoms can be reduced in severity by a sensitive and caring approach based upon the child knowing and trusting those supporting him. The carer or teacher can recognise triggers for increased anxiety and avoid or minimise them. This usually has significant benefit for the child. Most often, the people who are best at supporting the child are those who have these closer relationships with him. Attachments with parents have been found to follow largely normal patterns in children with ASD, modified by their cognitive ability. The child is often able to use their close relationships to modify their moods or to deal with the 'fall out'.

In attachment difficulties and disorders, the very nature of the problem is most evident in the closest relationships and difficulties may be far less apparent outside those relationships. Often carers report that the child seems to sabotage relationships as they become closer. This negative construction suggests that the child does not want intimacy. An alternative construction is that the child's lack of understanding of what intimacy has to offer and how to use it which is the underlying problem. When children who have had very poor and/or abusive care, they may have a poorly developed understanding of how emotional closeness will offer protection, love and better support. There has been a lot of development in psychological therapies recently with newer approaches being designed to to tackle this poor construction head on with the child and carers receiving therapy together in order to understand the child's unhelpful constructions and to develop healthier ones (for example, in the work of Dan Hughes).

The way we might try to help a child will depend heavily upon our professional construction of their difficulties, with diagnosis being a signpost rather than a destination. The best way to start intervening will be quite different for a child with ASD compared with a child with attachment problems. For both, an important aspect will be to reduce the social demands and to increase the structure in their day. For the child with ASD, they may have a key worker to mediate between them and the other people in their daily experiences. It will not usually need to be based upon a closeness because most children with ASD will have other people they have close relationships with. The relationship will have a more practical focus, as an enabler rather than a therapist. For a child with attachment difficulties, the arrangements will usually involve a key worker who will try to offer unconditional regard. This is often extremely difficult to do because the child will probably be inclined to blame their best supporter for their difficulties. The task will be to try to demonstrate through the development of that relationship that staying in relationships can be a very good thing.

Children who are Looked After have been found to be more likely to have ASD than the general population. This means that they are more likely to have parents with ASD (who may well be misdiagnosed as

having personality disorder or schizophrenia). If a person has ASD and experiences very poor parenting, they will probably find it far harder to be a good parent, even more so than for people without autism because the core difficulties in ASD affect a person's potential to attune to another's needs and to empathise. Where a child has both ASD and attachment difficulties, the task of support will be very challenging because the child's ability to empathise and to develop healthy relationships will be more severely compromised.

Within the Coventry CAMHS team we had become increasingly concerned about the issue of referrals and of potential misdiagnosis of attachment problems as ASD. Some of the children being referred might fit with a diagnosis under the extreme of the autism spectrum, meeting the criteria for PDDNOS. As more children were referred for autism assessment, we met more who had some problems similar to those of autistic children but those problems were of a different quality. We decided to pull together what we had noticed about the differences through meetings of the CAMHS attachment interest group. This was a multidisciplinary team which had representation from social work, clinical psychology, nursing, speech and language therapy, psychiatry and occupational therapy. After a number of meetings we had the first version of the Coventry Grid.

The grid summarised what we had seen and heard in our clinics and in our experiences of working with children with attachment problems. For example, the referral headlines for a child with ASD and for a child with attachment problems might include repetitive questioning but we found that the subjects of their questions were different. Those with attachment problems seemed to ask about what they would be doing and where, or what was for dinner but not really about their particular interests (like the order of the planets or the previous football teams a player had played for). The general rule seemed to be that the children with attachment problems wanted reassurance that they would be looked after or that they would be allowed enough control. Those with autism had a more intellectual interest in the question and answer, not really an emotional one. Not answering their questions might irritate the children with autism but would not signify to the children with ASD that they were uncared for. The children with attachment problems would interpret the non-responder's behaviour in the light of their view of themselves or worry about the emotional meaning of the non-response.

We distributed the Coventry Grid to anyone who asked for it and we invited comments to professional colleagues in the West Midlands regional autism group, through the CCPLAC network and on EPNET. This was a useful process because we discovered that we were in good company in our worries about referrals and potential mis-diagnosis. The Coventry Grid was published in 2010 in *Good Autism Practice* with a view to people joining in the debate.

We have had a great deal of interest from clinicians across the country and in Australia. We hoped that there would be interest and that we might stimulate the academic world into wondering whether the patterns we had noticed in Coventry could be properly researched. We are interested in whether other clinicians find the things we highlighted in the Coventry Grid to be the case in children they see. We are also very interested in whether diagnostic instruments can be developed which distinguish between ASD and attachment disorders and can diagnose both if appropriate.

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Ignored Help *– Liam (aged 18 years).*

Developing an 'Attachment Focused Clinic' for young children with complex neurodevelopmental difficulties in Community Paediatrics

Suzanne Thompson & Mariana Giurgiu

Dr Suzanne Thompson and Dr Mariana Giurgiu are Clinical Psychologists working in an Attachment Focused Clinic which is part of the Child and Families Psychological Therapies Service, Suffolk Community Healthcare.

EARLIER THIS YEAR, the 'Attachment Focused Clinic' was successfully launched, across Suffolk. It forms part of the Child and Families Psychological Therapies Service, and is designed for children presenting with complex neuro-developmental difficulties where there appear to be either underlying or contributory attachment difficulties in the child-parent/carer relationship. Such difficulties may also have arisen in response to the child's medical condition or other developmental delays. Common referrals include children with developmental trauma and autistic features, children with severe feeding difficulties in the context of attachment problems and complex physical conditions (i.e. not meeting CAMHS criteria for eating disorder); and children with significant behavioural and emotional difficulties in the context of language disorders, physical disabilities, and/or developmental delay.

The clinic is run by three Clinical Psychologists and a Child & Family Practitioner making up two full-time posts. The services offered by the clinic consist of Training and Consultation for Community Paediatric Professionals and Specialist Attachment Focused assessment and interventions for children aged between 3- to 8-years-old.

Training sessions aim to increase professional awareness in recognising possible attachment related issues and to incorporate this knowledge in their assessments and interventions. In particular, where there are behavioural and cognitive difficulties that can be interpreted both as attachment difficulties or an autistic spectrum disorder. We also hope to promote greater psychological understanding of the child's problems within the family context, in a medically oriented environment.

The consultation process is designed to:

- Create an opportunity for reflection.
- Explore systemic factors that might contribute to the child's presentation.
- Clarify expectations about a potential referral, and identify situations where parents may have formed an 'attachment' to the health system, for example, by persisting in seeking ongoing referrals.

The third component of the clinic is the provision of attachment focused based assessments and interventions for children. Interventions aim to increase parental responsiveness and sensitivity to the child's needs. We draw upon attachment focused models, including the Solihull Approach, Circle of Security, and the PACE model, in conjunction with principles of social learning theory, systemic and cognitive behavioural approaches. A workshop on Attachment Focused parenting has been developed and is currently being piloted, along with a guided self-help programme for parents that are able to use it.

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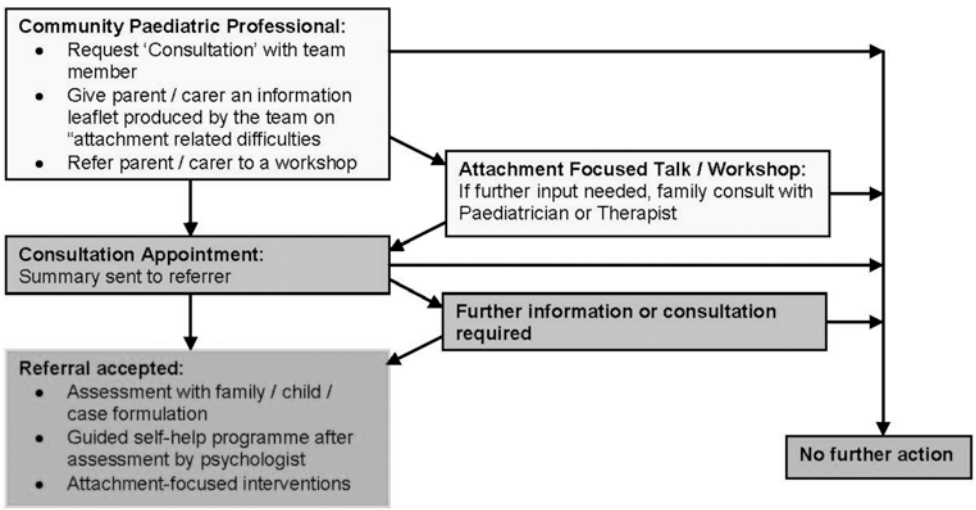
Figure 1: The Referral Pathway Process.



The first meeting usually takes place without the child as in our experience, parents and carers are able to concentrate and speak more freely and the child is not exposed to further potentially damaging negative descriptions of themselves and their behaviour.

A range of measures and questionnaires are administered including the Strengths and Difficulties, Parenting Stress Index, and Connors Early Childhood Scales, and the child may be observed at home, or nursery/school. A structured child-parent assessment may be undertaken and video analysed using coding systems (e.g. Mellow Parenting; Marschack Interaction Method). The MIM assessment in particular, 'enables us to see both strengths and problem areas within patterns of interaction that parents are unaware of, and so cannot tell us' (Booth & Jerberg, 2010). Depending on the child's age and cognitive ability, their views of self and others are sought through attachment based analyses of family drawings (Fury, Carlson & Sroufe, 1997), and doll-play tasks using MacArthur story stems technique (Emde, Wolf & Oppenheim, 2003).

Experience and reflections

Knowledge about attachment has varied widely across and within professional groups. Therefore staff training sessions have been designed to be highly clinically applicable and demonstrate the relevance of attachment theory in the day to day situations therapists encounter in their work with children and families. For example, for physiotherapists and occupational therapists, one of their challenges can be how to carry out therapy when working with a child who is clingy or a parent who is 'over-protective'. Exploring how a child's and parent's behaviour in a therapy session may reflect activation of attachment safety behaviours in the context of anxiety, and sometimes previous trauma as a result of illness/condition; has been helpful in achieving a different understanding of the dynamics involved and removing blame.

Training provided to date has been described by participants as 'relevant, essential, informative, and applicable to clinical practice'. Clinicians have frequently commented that the training has made them 'think' both about their practice and diagnostic decision making. Whilst this opportunity to reflect has been welcomed, it has also

generated feelings of anxiety and uncertainty about the conclusions reached in some cases. For others, the training has offered the opportunity to reflect on their own experiences of parenting/being parented, sometimes stirring mixed emotions. Interestingly, training appears to have been best received when delivered within professional disciplines, for example, during a team meeting. Clinicians have been more able to reflect on their own practice and anxieties, which might be connected with the safety and security of being within their own professional group. The consultation process has helped our colleagues with thinking about readiness for change and the extent to which a parent or carer may be psychologically available or have sufficient reflective capacity for our intervention to be helpful to them.

Interventions with families so far have also varied enormously with some parents being highly receptive to thinking about the child's emotional needs for safety and security as underpinning or contributing to their child's behavioural and/or developmental difficulties. In other cases, improving parental reflective functioning is harder where parents themselves have mental health issues, or difficulties with flexibility of thought and imagination due to their own social communication difficulties. Micro analysis, when reviewing video with parents allows them to see for themselves where there may be difficulties with synchronicity and how the parent and child may be 'miscueing' each other resulting in difficult interactions or unwanted behaviours. Often the process of reviewing the video with parents opens up new perspectives and ideas about how to manage the child's difficulties.

Obstacles and issues

The name 'Attachment Focused Clinic' has been much debated both within and outside the team. At training sessions our colleagues often ask us about how to raise this 'sensitive' issue with families, and sometimes express concern that it might jeopardise the therapeutic relationship if parents' feel negatively evaluated or disbelieved. There is also uncertainty about what to do if they identify a relationship issue but the parent denies this, or is wedded to their own beliefs about the problem.

Outcomes and future

Future challenges for the service include managing demand and capacity, and evaluating the impact of each component on the child, family and paediatric service. Quantitative and qualitative outcome data is routinely being gathered. Encouragingly, there has already been an increase in awareness, and recognition of attachment related difficulties. In some cases we have been able to provide a short intervention and discharge children whose parents had previously been pursuing an ASD diagnosis. Increasingly we are being invited to bring an attachment perspective into multi-disciplinary assessments of social communication issues at an earlier stage, and it is apparent that the attachment model is permeating professionals thinking and influencing diagnostic decision making.

Acknowledgements

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'What makes me anxious? Being in uncomfortable social scenarios – talking to people I don't know very well. I feel nervous, start looking around, fidgeting and moving my fingers. I clam up. I only speak when I'm spoken to directly. I avoid eye contact so it feels less awkward. If they stare at you – hold eye contact – then I feel really uncomfortable.'

Jake (aged 15 years)

Looking behind the behaviour – understanding early experiences

Lynne Hipkin

Lynne Hipkin runs her own private practice, but is also contracted to provide assessments of attachment for LAC, and training and consultation for foster carers and social workers who are part of Kent Social Services Therapeutic Reparenting Programme (TRP) via Ashwood Associates (based in Surrey).

AS A TRAINEE and newly-qualified clinical psychologist in the 1990s I always had my checklists and crib-sheet close to hand. I knew all the right questions to ask about a child's early development and was able to take a good account of current behaviour and social relationships. However, experience and wise supervision have taught me that understanding a child's world is a complex task, and many meetings with looked after children of all ages have provided valuable insight to the impact of early experiences on ways of relating, learning and managing feelings. 'Developmental milestones achieved at appropriate times' or 'placid baby' no longer appear in my notes; I want to know what that *meant* for the parents, how they understood their child's progress and communications, and what was going on in their lives at the time. Family life, in whatever form it takes, does not follow a predictable pattern. We are all affected every day by our interactions with those close to us, and respond both within and outside the family according to our interpretations of these relationships and the external events that impact upon them. Our behaviour stems, according to the CBT model, from our beliefs and assumptions, but those beliefs run deep, finding their roots in our early years. Developmental assessment, therefore, is not just about the acquisition of skills, but the fundamental development of *self*. How did *this* child experience himself in this family, and how did *this* family interpret, respond and react to their newest member?

A child's developing brain depends largely upon feedback from external sources to evolve emotional, social and physical control, and to assimilate knowledge via opportunities offered for exploration, play and stimulation. When conditions are right, learning, self-esteem and confidence can build steadily, but where adult care is interrupted, unpredictable, or anxiety-provoking, the impact for the developing self can be significant. Attachment theory is not just relevant where relationships have been abusive or neglectful. Mental health, family events, loss, illness and changes of family structure can all affect expectations and understanding of the child, and organise both the child's and the parents' coping style. The behaviours a child displays can represent attachment 'strategies' designed to maximise

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contact with attachment figures or decrease feelings of fear or vulnerability. However, it is common for these strategies to appear inappropriate to others and provide obstacles to learning and friendships. A pre-occupation with self-protection and preservation also means that the child may fail to recognise others' feelings and expressions, or may misinterpret these. The behaviours a child learns to use in early childhood can persist or re-emerge at times of stress, despite restoration of benign emotional care.

The power of early experiences often extends throughout childhood and into adolescence and adulthood. Lack of conscience, poor impulse control, aggression and antisocial behaviour can all be the result of early attachment difficulties that have not been addressed.

The pattern and intensity of attachment behaviours can sometimes mimic recognisable profiles or syndromes such as autistic spectrum disorders, attention problems, or conduct problems. Delay of particular milestones may be the result of inherited or inherent neurological make-up, but can also be due to lack of appropriate stimulation or early trauma. The psychologist has a crucial role to play here, in terms of exploring and interpreting both history and present observations. Lack of empathy, poor social skills and controlling behaviours are a constant feature of my assessments of children in care, some of whom have received very early diagnoses of ASD. However, in considering their chronologies and how they may have perceived and protected themselves from what was going on around them, it becomes apparent that these are complex behavioural defences. These are children who have not had their needs or emotions adequately reflected and, therefore, struggle to either know themselves or imagine the internal states and intentions of others. Their ideas about caring relationships are full of threat and resulting hyper vigilance leaves little space for concentration and learning. Their behaviour can raise anxieties such that school exclusions are not uncommon.

Within my general clinical practice, I see other cases where early relationships and family history can shed light on otherwise 'obvious' cases of attention-deficit disorder or social and communication problems. A mother who had been severely depressed during her daughter's first two years of life was able, with gentle encouragement, to talk about how this had impacted on their relationship and her feelings of guilt, leading to a later intensity of their bond to the exclusion of others. This went some way to explain the little girl's lack of response to nursery staff, her avoidance of eye contact and lack of interest in other children – all of which had been taken as signs of possible ASD. This mother was reluctant to speak about her own mental health and had therefore not revealed this crucial information to the paediatrician.

In another case, a 9-year-old boy was showing signs of anxiety at school, hiding under tables, refusing to join group activities and constantly needing to know the time. He hummed to himself, had a small toy with which he fiddled constantly, and his temper would flare when he perceived he was being coerced to do something. He was not tolerated by his classmates who were confused by his changing moods and his wish to control all their games. The family chronology, despite a settled current picture, revealed a troubled marital relationship with incidents of domestic violence, and then a messy separation during which there had been changes of home and caring figures. Some of this boy's behaviours were old strategies for managing anxiety, and some were communicating his sense of confusion and self-blame. He needed to convince himself and others that he was in control, because in his family it had been dangerous to be vulnerable. With this alternative context for his behaviour, school staff were able to respond sensitively to his challenges and provide the reassurance and containment he required. His trust grew, and he was also able to engage in some therapeutic work with his mother, designed to process the past and

establish safety in the present. He was also a child whose profile had been initially thought by others to fit an Asperger's diagnosis.

The consequences of missed historical information for children whose attachment relationships have not run smoothly are serious. Attachment difficulties and ASD can of course co-exist, but therapeutic intervention and management for each is different. One accepts a barrier to fully reciprocal relationships and concentrates on support for managing behaviours and teaching coping skills, whilst the other actively encourages efforts to build reciprocity and often allows some regression to dependency. It matters that we have a full understanding of the context (past and present) for a child's behaviour before describing its meaning with any confidence. It is well documented that symptoms of attachment difficulty and autistic spectrum disorders can appear very similar. In order to differentiate the two, there needs to be exploration of early emotional experiences. Curiosity is the key to a thorough developmental history.

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'When I get anxious, it's like a road curving away from what I'm supposed to be doing. In other words it goes off at a tangent and I'm not putting the effort in that I normally put in. I'm being distracted by something else.'

Bradley (aged 15 years)

Video Interaction Guidance (VIG)*: Anxiety, attachment, autism

Hilary Kennedy & Miriam Landor

Hilary Kennedy is a freelance chartered educational psychologist and national trainer and supervisor for the Association for Video Interaction Guidance uk™ (AVIGuk). She is a key developer of Video Interaction Guidance (VIG) in the UK. Her recent book on the subject of VIG has the sub-title 'A Relationship-Based Intervention to Promote Attunement, Empathy and Well-being'. She is currently a freelance VIG trainer working on projects around the UK including the Family Drug and Alcohol Court, Camden, Tower Hamlets, safeguarding, NSPCC Neglect, and works supporting projects in the Czech Republic, Finland and Mexico. She is also an honorary senior lecturer at University College London, an associate fellow of the British Psychological Society, and is involved in supporting research in the effectiveness of VIG as an intervention.

Origins of VIG

THE APPROACH stems from work done by psychologist Harrie Biemans in the Netherlands. He based the intervention in intersubjectivity theory and on Trevarthen's principles of 'attuned interaction' which underpin earliest parent/infant relationships (Biemans 1990, cited in Simpson, Forsyth & Kennedy 1995). Interestingly, some of Biemans' earliest VIG work in the 1980s was with families where the children were on the autistic spectrum or were living in care because of a breakdown of attachment relationships.

What is VIG?

The VIG guider films the client and interaction partner (e.g. mother and child; teacher and pupil; nurse and patient, etc.) in a brief everyday session together. This video is then analysed and edited into a few micro-clips exemplifying 'better than usual' instances of attunement, where the client is following their partner's lead by receiving and responding to their initiatives. Together the guider and client then review the clips, discussing what they see in the film, what the client did which led to harmonious interaction and how they can build on this in future. Generally only a few sessions are required to bring about positive change. Trainee guiders take video of themselves conducting shared reviews to their supervision sessions, where the VIG principles of attuned interaction underpin the process at every level.

How does VIG relate to attachment?

From the beginning, parental sensitivity and responsiveness to their infant's signals were recognised as providing the 'secure base' from which healthy development stems (Ainsworth & Bowlby, 1965). Recently an attachment theorist has proposed a 'transmission model' (van IJzendoorn, 1995) whereby attachment is understood to be a two-way process, from parent to child – through parental sensitivity and responsiveness, and their 'attachment representation' or beliefs – and from child to parent – through the infant's behaviour and state of secure attachment. A parent's 'mind-mindedness', or their ability to infer their child's

* Video Interaction Guidance (VIG) is a relatively new intervention approach in the UK whose methods, quality and standards are specified by the Association for Video Interaction Guidance UK. (See www.videointeractionguidance.net for more details)

mental state, has been shown to predict secure attachment, along with parenting reflectivity (Rosenblum et al., 2008). VIG has been shown to increase the key transmitters of secure attachment: parental reflective function; mind-mindedness; increasing parental sensitivity and emotional attunement to their infant or child. What is important therefore in bringing about change is to focus not so much on the behaviours of child or infant, or on the parent's internal understanding or representation of attachment, but rather on the *interactional relationship* between them; the intervention is indeed named 'Video Interaction Guidance' (Kennedy, Landor & Todd, 2010).

Evidence for effectiveness for VIG in promoting sensitive parenting

There is growing evidence that VIG is a highly effective intervention for improving relationships in a wide range of contexts and in particular for developing sensitivity between parents and their children (Fukkink, 2008; Kennedy, Landor & Todd, 2011).

At Leiden University, 'Video-feedback Intervention to promote Positive Parenting' (VIPP) (Juffer et al., 2008) was developed with the aim of enhancing sensitivity and exploring whether in turn this could move children to more secure attachment patterns. In a randomised intervention study, Juffer et al. (1997) showed that VIPP significantly lowers the rate of disorganised attachment.

Long-lasting impact on parent sensitivity was shown by Klein Velderman (2005). Eighty-one first-time mothers were selected on the basis of insecure attachment representation and were randomly assigned to VIPP, VIPP-R (i.e. VIPP with an additional representational focus, intervening in the mother's understanding of her own attachment) or a control group. In the short-term the mothers in both intervention groups were significantly higher in maternal sensitivity than in the control group. The rate of disorganised attachment was significantly reduced. Three years later the children in both intervention groups exhibited fewer externalising behaviour difficulties. Interestingly the group who received VIPP-R showed significantly fewer gains than those receiving VIPP alone.

Moss et al. (2011) demonstrated clearly the effect of a VIG-type intervention for parents reported for maltreatment of their children (1- to 5-year-olds) alongside a randomised control group. The intervention group showed significant improvements in parental sensitivity and child attachment security, and a reduction in child disorganisation. Older children in the intervention group also showed lower levels of internalising and externalising problems following the intervention.

Following an EU-wide search for evidence of interventions (Stewart-Brown & Schrader McMillan, 2010), a review of what works in preventing emotional maltreatment from occurring and reoccurring provides a strong endorsement of the use of VIG (Barlow & Schrader McMillan, 2010).

VIG has recently been recommended in the draft NICE Guidance (National Institute for Health and Clinical Excellence, 2012) as an evidence-based intervention for all those involved in promoting social and emotional wellbeing in young children (0 to 5).

How does VIG work in ASD?

VIG is an intervention of particular interest for those involved in the world of autism, either for families or for those who work with them. In Vygotskian sociocultural theory, successful learning and development take place through relationships, which are often an area of specific difficulty for those on the autistic spectrum. As demonstrated above, VIG has been shown to increase attunement and attachment in relationships. In addition VIG is an approach which uses the visual medium, generally an area of strength in ASD. The micro-analysis of communication allows parents and others to notice the emerging initiatives of children with autism and to build on these (Forsyth & Sked, in Kennedy, Landor & Todd, 2011).

There is a growing body of research evidence of the effectiveness of VIG intervention in autism. For her doctoral dissertation, Short (2010) explored how VIG had been used for children with ASD. She described two VIG studies which focused on the quality of the interaction, that is, intersubjectivity. These showed that 'adult initiatives decreased, child initiatives increased and at the same time interactions which demonstrated intersubjectivity or attunement increased'.

Sked carried out a project using VIG and an imitative intervention with teaching auxiliaries who worked with children on the autistic spectrum; she found that the children, who were previously not engaging in social interaction, began to do so (Kennedy & Sked, 2008)

Loughran (2010) was interested in the sibling relationships of children with autism, as research from family systems theory shows that sibling relationships form a lasting template for other relationships through life; they can be particularly compromised if one child has ASD through their negative behaviours and lack of reciprocity. Her doctoral project showed positive effects from using VIG to improve the interaction behaviours of siblings of children with ASD and to support these siblings in their experience of the sibling relationship.

Nelson (in Forsyth & Sked, in Kennedy, Landor & Todd, 2011) describes a case study in which a boy with ASD was the client; he had a poor relationship with a deaf sibling. The VIG shared reviews were conducted in an 'autism-friendly' way; the VIG guider used simplified language and visual prompts to signify the attunement principles, and gave additional time for processing information. Both the child and his parents reported improved interaction and relationships between the siblings.

Conclusion

The authors are struck by how powerful VIG can be to reduce anxiety for the child, parent and professional, whether the presenting difficulty is around attachment or autism or both. This decrease in stress can be observed in the videos of the shared reviews between the parent and the guider. The guiders experience the parents relaxing when they see visual images of their attuned interactions. It is impressive to watch these joyful moments when hope for future change emerges.

We propose that using VIG as part of an assessment process for youngsters who may have attachment difficulties or autism would give parents a supportive experience where they are given the chance to understand the nature of their child's differences and what they can do to support their development, and perhaps most importantly, decrease anxiety all round so they can enjoy spending time together.

The Authors

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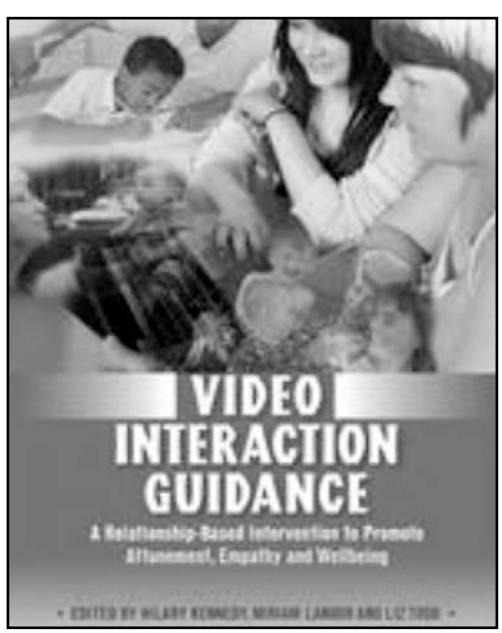

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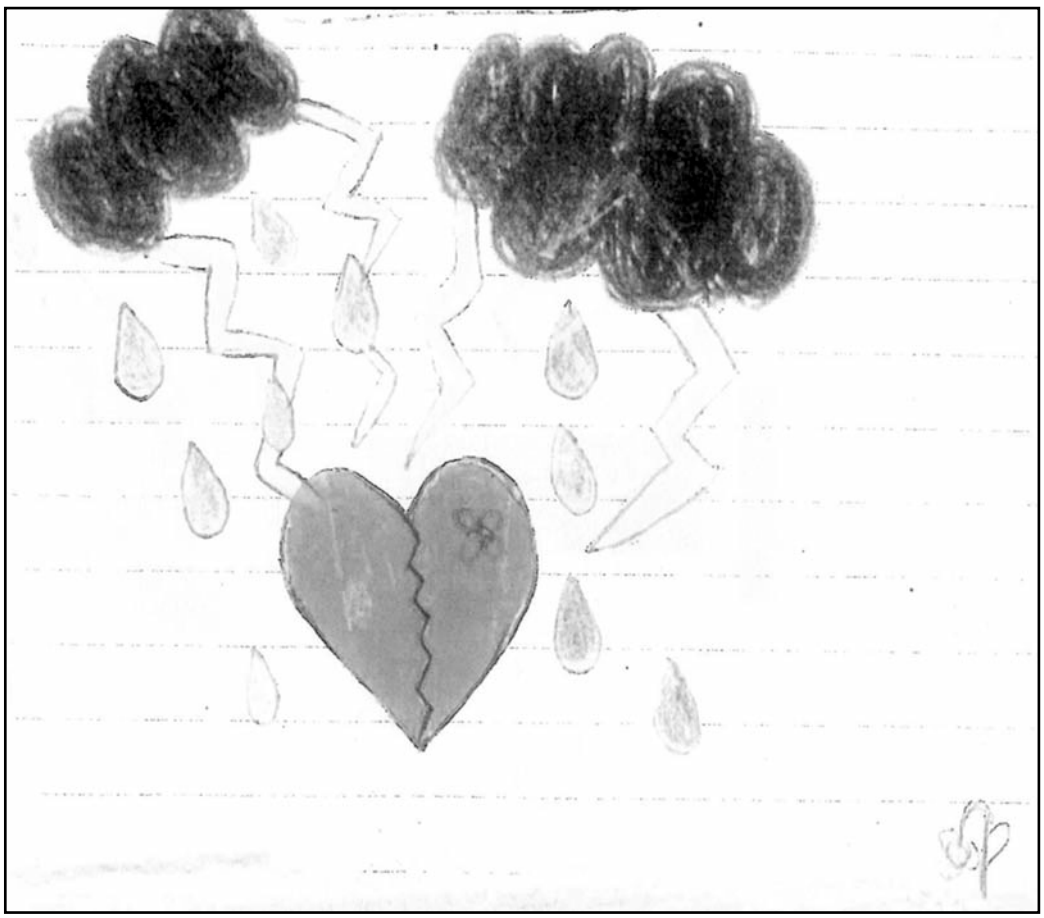

Anxiety *– Annie (aged 15 years).*

Bring back orphanages – bring back attachments

Phil Frampton

Phil Frampton was born in 1953 in a 'Magdalene laundry' in Cornwall and abandoned to the care system until the age of 18. His memoir The Golly in the Cupboard *(2004) on being mixed race and brought up in care, was followed by his BBC programme of the same name, which won the 2005 Race in the Media Award for radio documentaries. An experienced keynote speaker and author of three travel books, Phil is a freelance journalist, broadcaster and research consultant. He has written for The Independent, The Guardian, The Daily Mail, Big Issue, and journals around the world. Phil was a member of the Cabinet Office Advisory Group on the Education of Young People in Care, a Parliamentary Select Committee Witness regarding Abuse of Children in Care, founding Chair of Care Leavers Association (2000–2003) and in 2008, was shortlisted to become a national Director of OFSTED.*

THE MOST APPALLING STATISTIC about our modern care system is that 85 per cent of siblings are split up in care. Most parents hearing this are horrified to think that society could be so systematically cruel. The sad reality is that those managing the care system no longer provide residential accommodation that can viably keep siblings in care together or provide stability for young people. Climbie Report author, Lord Laming, like others defending our fostering-based care system, argues that 'Every child ought to have the experience – a good experience – of living in a proper functioning family.' (Channel 4)

However, Professor Juliet Mitchell, a leading authority on siblings, told me:

> 'Sibling relationships are absolutely crucial. The majority of siblings in care are split up. I'm horrified, it illustrates the fact that we underestimate the deep meaning of sibling relationships. It's a double whammy. You've lost your family home and your parents and then you go and lose your siblings. Children form enormously important sibling bonds in the absence of parents.'

Simplistic explanations of the importance of attachments and applications of attachment theory focus on the relationships between children and their parents or adult carers. So, when Cairns (2002) observes that attachment can be expressed through an intimate persisting affectional relationship, which between the dependant infant and their attachment figure, has a primary status and a biological function in development, the norm is to consider child-adult relationships.

The assumption is that, where a caring adult fails to fulfill the attachment function, the child will simply to fall into an attachment void. However, in the case of sibling

groups, observations show this does not have to be the case. For example, Goldstein (1999) accepts that in many parts of the world, economic circumstances require that older siblings may play a caretaker role in the family and be an attachment figure to their younger siblings.

So too, where sibling groups have been subject to serious neglect or abuse, then one sibling may take on the caretaker role and become the primary attachment figure, a process reflected in my casual reflections in *The Golly in the Cupboard* on my growing up in children's homes. Sadly, the important attachment and dependent bonds between siblings are generally disregarded in our care system. Many social workers use attachment theory to prioritise the child being placed with an adult over and above their siblings. Sibling and primary attachments are destroyed in the name of attachment theory, leaving the children to suffer.

It is my contention that sibling children are treated as individuals and atomised rather than considered as sibling units. This is not to meet the young people's needs but to fit in with the inadequacies and lack of investment in the care system. In particular, there has been a systematic stripping away of placement options that can accommodate sibling groups of more than two children. Consequently social workers see themselves faced with no option but to sanction the separation of siblings.

English children's homes today account for only 10 per cent of care placements and can rarely take more than six young people. Over 20,000 places in children's homes have disappeared over the last 30 years, resulting in placement shortages that no amount of government campaigns on adoption and fostering have resolved. Most of today's homes are privately owned and cannot afford to sit half empty on the off chance that a group of siblings may arrive.

The Fostering Network reported a shortage of 5250 fosterers in 1998, but now they say the figure has risen to 10,000. Acute fostering shortages mean each child is put wherever a placement can be found. This shortage is bringing about so many temporary and inappropriate placements that, on average, young people in care are damagingly moved every two years, often to a different town, losing their home, siblings, friends and schooling.

In recent years, I have met young care leavers who have had 30 placements moves, 54 placement moves, up to 72 moves. The impact of such moves on a young person's development is staggeringly ignored by the likes of Laming who have systematically refused to put in place alternative systems to ensure that a child in care can feel they are in a safe permanent place for the duration of their time in care, let alone the other damaging effects of placement moves.

In the 1950s and early 1960s, the children's officers (lead children's social workers) operated under a guiding policy of 'one strike and they are out' whereby a young person suffering one foster placement breakdown would then be given a long-term placement in children's homes. The clear policy was to avoid further damage to the young person's self-esteem. The children's officers were so convinced of this policy that the early 1960s saw them in almost full scale revolt against Government pressure to end the one strike rule.

Today, social work managers under budget pressure are more likely to press a child suffering a foster placement breakdown back into a new foster family as the cheaper option to a long-term placement in a residential home. They seem more concerned about the short-term damage to their performance targets than the long-term damage done to a child's ability to form attachments. What does the young person learn from continual placement moves?

- 'It doesn't matter whether I like a place or not, they'll still move me.'
- 'There's no point in my trying to get on with this family because I'll get moved anyway.'
- 'I don't want to go to my new school because I've missed so much that other

kids will think I am thick and laugh at me.'

- 'Nobody wants me, so there must be something wrong with me.'

'I gave up making friends when I was moved to my 13th school', is the haunting comment of one young person who had left care. The current fostering based system completely undermines the prospects of young people forming attachments, whether with adults or their siblings.

Meanwhile, following the outcry over the tragic fate of Baby P, care order applications have risen to over 10,000. The current Government-imposed cuts are being used by local authorities to close more children's homes, with a result that the shortage of available placements is at breaking point. Sadly, what Baby P represents is that it is the children that break, the social workers that get the blame and the national and local Government that wring their hands.

Born in 1953, I was raised in 'orphanages' that were home to between 20 and 40 children. In my time there, at least five biologically-related sibling groups passed through, being able to share most of their childhood together, as was the case for thousands of others. I have no need to romanticise on life in those children's homes. On the contrary, *The Golly in the Cupboard* points to the casual neglect, cruelty and abuse that prevailed in many orphanages/children's homes of the time. Nevertheless what I pointed to in my autobiography is that, given the time we children spent living together during my 11 years in one 40-bed and one 20-bed children's home in Southport, Lancashire, we forged 'sibling' relationships even though we might not be siblings related by blood. Elgar and Head in 1999 wrote that 'Broadly speaking, siblings can be defined as any other child with whom a child has either lived for an extensive period of time or to whom a child is biologically related.'

In those children's homes, we formed sibling attachments, which assisted our development. At best, the adult care regime was rigid and self-centred. Our care regime was dominated by rules, punishments, timetables and rotas. In effect, the staff were the crocodiles that patrolled the waters of our Neverland. The loveless regime, however, left us to our own devices and hence from dawn till the dormitories were silenced by tiredness, we occupied a children's world. We may have on occasion fought one another but, given the blessing of stability, most of the conflict which arises from continually having to establish peer status structures was absent and bullying minimal. Instead we generally played with each other, nurtured and protected our young and learned from each other, protected one another and even went shoplifting and pilfering together as would a gang, but we had Artful Dodgers rather than Fagins to lead us.

This is no wistful look on a bygone age. These homes were disgracefully managed leading to the neglect and serious abuse that we suffered. Nevertheless, we children were able to form attachments to a level almost unthinkable in today's era of the systematically atomised child in care. Governments, which had since the 1950s been pressing to hugely reduce residential care and orphanages on the grounds of cost, found their excuse during the Thatcher era with the revelations of widespread sexual abuse by adult carers.

Such revelations did not lead Government to demand closure of fee paying boarding schools (to which 55 per cent of Cameron's Cabinet were sent). More significantly the revelations did not lead Governments to put in structures and young people's empowerment procedures to enable whistleblowing for children's protection and flagging up bad management practices. On the contrary, care has been sent down the road where children's and young people's attachments are secondary to short term budgetary and party political constraints. Former Barnardo's Chief Executive, Martin Narey stated before the last Government White Paper:

'Our society spends £1.9 billion a year on doing a pretty awful job. I think that if we take this opportunity to look afresh at how and where we spend that money, and possibly putting some more of it into a different form of residential care, then I think we can make a big change to the life chances of the children we're talking about.'

There is an alternative

In Europe there are care systems that have hugely better outcomes. A Commons Select Committee in 2009, having visited Germany, where care homes account for 50 per cent of care placements, echoed Narey's call. In 2010, I revisited Kinderhaus in East Berlin. Kinderhaus currently houses 280 mainly local children, aged 6 months to 18 years, many of whom reside with their siblings in family group apartments (akin to the past Barnardo's villages). By chance, I came across a sibling group of five who'd been there since my visit four years ago, something almost impossible in our system.

German child protection expert, Professor Reinhart Wolff, proudly told me that 100 per cent of Kinderhaus teenagers achieve the German equivalent of five A-C GCSE's (Berlin schools' average 85 per cent, British care 11 per cent). Moreover, 20 per cent go on to achieve the equivalent of three A-Levels. He explains:

> 'What we find is important is that you do not sever the links of a child to his or her local environment, so it's fairly important that most of the kids, more than 80 per cent living here, come from the area. And they still keep their links to their schools and friends.'

The stability afforded also allows staff to concentrate on the children's development using social pedagogy:

> 'If the child has an assurance that this situation will not be broken up by the school, or by the child welfare department, then, of course, the child can settle down and muster his or her resources and develop.'

Larger homes find it easier to have the slack to bring in sibling groups but also to take advantage of economies of scale. The complex has a residential family intervention unit, a mother and baby unit, a child protection assessment unit and a day care centre catering for 200 children. All aspects of the care experience are catered for. Specialist staff based at the project benefit the local community as they provide services for the surrounding area whilst the young people are at school. Yet Kinderhaus's weekly costs per child are just 700 euros, a stunning 20 per cent of the British average, and less than charged by our fostering agencies.

Another crucial advantage is that Kinderhaus children are sufficient in number to elect their own youth council, which has powers to summon and reprimand staff and children and to call for management to act. This is a key factor in both protecting children from abuse and correcting bad management practices. Just before I arrived a member of staff had been reprimanded by the youth council for levying fines on young people as a form of punishment. The youth council, aware that the carer's actions contravened the rules of the home, reprimanded her and called on the Kinderhaus board of directors to take action. She was sacked.

Many UK 'corporate parents' such as local authorities and fostering organisations talk of empowering and listening to the young people but none have a clear mechanism established. Consequently, the lip service paid to Paolo Frere's 'service user empowerment' damagingly undermines and disempowers service users. The recent imprisonment of pimps who prayed on young people in Rochdale's children's homes, forcing the young girls into prostitution for the paedophile market, has focused on the fact that the pimps were Asian. The actual focus should be on the fact that these mainly privately run homes had no watertight procedures whereby the young people were able to come together, voice their concerns and be reassured that their issues

would be acted upon by the local authority and the police.

Visiting Kinderhaus, I was acutely aware of the confidence and relaxed attitude demonstrated by the young people. This not only reflects good relations with the staff, it is also a feature of having a settled environment. However, it particularly demonstrates the sense of empowerment shared by the young people, achieved through not only stability but also collective, democratic control. In our budget constrained care system, a programme of recreating large complexes of homes (such as past Barnardo's villages) or apartments to not only eliminate the placement shortage, but to keep sibling families together and allow others to freely form new sibling attachments, is entirely practical. Britain has one million empty properties, including tower blocks akin to Kinderhaus, many of them owned by the local authorities. It makes more sense to look to a new advanced model of empowered stable care for our young people than a care system where so many leave care in a worse condition than when they entered.

It is worth visiting Germany to see inspiring alternatives to our broken system. www.kinderhaus-b-b.de/start.php

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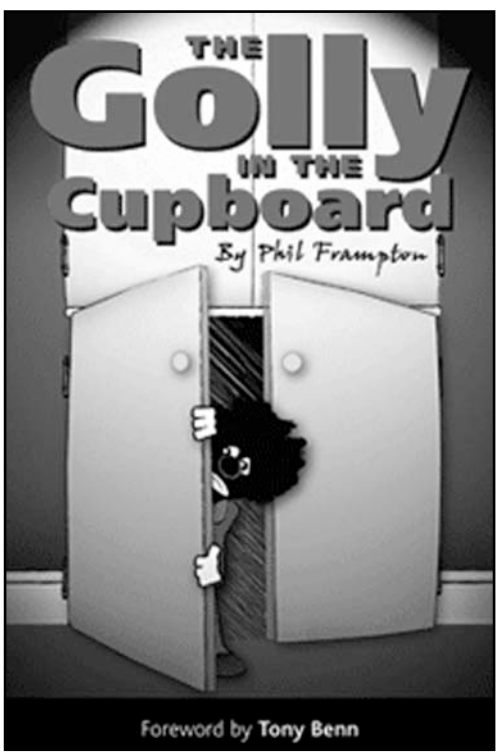

Anxiety *– Jane (aged 17 years).*

Tell it like it is: Using life story work for some anxieties

Anne Peake

Anne Peake is an Educational Psychologist working for Oxfordshire County Council. Her professional interests are safeguarding children, children in the Looked After system/adopted, attachment difficulties and autism. She has produced a booklet on Life Story Book Work, copies of which can be obtained by contacting her directly.

ANXIETY is a part of everyday life and most children are anxious sometimes. They are usually successfully helped by parents, teachers and friends to deal with their anxieties. Over time, they build up a repertoire of strategies which can serve them well in life. Sadly, some children are not so fortunate. They have severe difficulties with anxiety, which are routed in their disrupted childhoods, the histories of being abused, and/or traumatic events in their lives. As a result of these severe difficulties, they can be so suffused by anxiety that it pervades their being and adversely affects everything they do. In addition, they may have neither the information they need to think about what has happened, nor the support to manage to do so.

Life story work has proved to be a valuable resource to help children in the Looked After system/adopted to record their lives in a way which makes sense to the children. This process of making a record in which the content of the work is a basis for talking and listening to children can be used to help children with severe difficulties of anxiety. When children are anxious, their capacity to deal with what is happening around them with regards to their family, school, and friends, is undermined. As Bradley (p.26) so helpfully explains, they can become preoccupied within a world. Then, they need support and time to think about their anxieties and the way in which they can manage these. Often, their anxieties are a consequence of their histories. Children's histories are usually written by others, not by the children themselves. The truth is that only the children know the real details of their histories, they are often not able to have the insight or feel they have the permission to recount these details, sometimes even to themselves. The anxieties around their histories/experiences become a further disruptive event which only contributes to their vulnerability. It is really essential that any life story work is not viewed by the child as an extension of work or pressure. It is work that can touch on difficult issues, and it can be a means of helping children come to terms with things that have happened to them previously or are a problem for them currently. It is not a way of probing what the child knows, remembers, and is willing to say, but rather a way of helping a child link the past with the present and the future. The process of doing life story work provides the following opportunities:

- A structured, safe routine for talking and listening to children.
- Regular opportunities to articulate memories and worries at a pace which is child centred and contained.
- The work is a basis for providing a child with additional information to help them understand what has happened previously. The provision of additional information can often be useful to correct misconceptions.
- Most of all, the work provides for a space and time for the child to remember with a supportive adult and this is the basis for understanding.

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Life story work is not an end in itself. It can be a helpful way of intervening and working with children with regard to their anxieties. It is one way of enabling a child to speak about what might previously have been unspeakable. For professionals thinking of planning this work with children, it is vital to contemplate the barriers that can be set up to doing life story work. While most, if not all people would agree that children who are suffused with anxieties about their history/experiences need help, there are often barriers. In the workshop we briefly looked at these. They may come from different points in the child's network of family and support. They are always there and should not be underestimated. If we as professional are daunted by these barriers, then how much more so will it be for a child. If we as psychologists are to be advocates for children with anxieties who need our help, then we need to be mindful of the barriers, address the specifics that are raised and overcome them to provide children with the support they need.

Vulnerable children with severe anxieties are unlikely to refer themselves. Identifying the need for life story work with particular children will initially depend on psychologists as professionals being open to doing this work and the conversations we have with people concerned about a child. In my experience, it is often people who have frequent contact with a child who are best placed to identify what they imagine are the dilemmas for the child. Whenever a need is identified for this kind of work, the planning and preparation needs to include what the child/young person thinks, wants and needs. In addition, there is a need to consider what the parents/carers and the other professionals in the network around the child think and there needs to be an assessment of their capacity to support this work with the child. What children need is a familiar, trusted, reliable adult who is able and available just for them.

There is a need for research and preparation before the sessions with the child. This involves establishing the aims of the work, being clear what the child knows and can know, and collecting relevant information. There needs to be a session with the child whereby an agreement is reached with regard to the parameters of the work. Given that many children who are anxious have had very difficult histories/experiences, it is particularly important to ensure that the agreement with regard to the work is clear and unambiguous. It can be useful to agree with the child the topics that will be covered. It is helpful to have a degree of flexibility about the order of the topics such that the child can use the start of each session to choose a topic that feels manageable to them and within their capacities on that day. Building in the flexibility to choose an easy and/or largely positive topic as opposed to a difficult one, with the option of also not choosing a topic at all and perhaps rearranging photographs or discussing layout, means that the work undertaken can be sensitive to a child's moods and feelings on the day. Given the context of the work is about anxieties, a child is more likely to feel reassured if she/he feels some sense of control with regard to content and pace. The final order of the topics as the book is assembled can be jointly decided at the end of the work.

Decisions need to be made about the venue which must be private, comfortable and uninterrupted. Negotiations about the start date, frequency and duration of the sessions, can take time given the other demands on the child's time and on the network around the child. The child will be helped by a discussion about what will be said to adults and peers about the work as it is ongoing, so that any social pressures on the child are minimised.

Anxieties are often fuelled by the unexpected. Anxious children are best helped by routine processes which in their predictability, bring a sense of security and safety. Sessions can be structured to be predictable, for example, a greet and news time at the beginning, a time to choose a

topic with the reassurance that the child can talk, ask questions and be listened to. Having the adult write, stops literacy levels 'getting in the way'. The adult writes and asks thought provoking questions from which discussions flow. During the discussions, the adult can make an input which helps the work and the child, for example: giving additional information, affirming the child's expression of their experiences and feelings, and adding when appropriate additional comments. All sessions should end with the adult checking 'what are you going back to now…how do you feel' and most importantly, accompanying the child to reassure the child and witness the transition from an individual session to the cut and thrust of daily life.

The content of the work will vary with the identified needs for the work. The content can touch on: significant people in the life of the child (past and present), moves/reasons for moves, schools attended, losses/bereavements, the present, and the themes that emerge. What is important is that it isn't work which solely focuses on difficult histories/experiences. The work needs to be woven through with a balance of the positive alongside that which is difficult. Learning to see the silver lining round the darkest of clouds is a positive strategy and especially so for children who are anxious. As one girl aged 15 said on reflection about being sexually assaulted by a lodger in the house,

> 'When I make friends with other girls, I think that what I've been through makes me sensitive to them and what they've been through. I feel sometimes I can recognise it when somebody else has been through the same think. I think that I've been there, had that happen, the same with drinks and drugs, and I've got the T-shirt and I'm moving on.'

Evaluating the outcome! This could seem an insurmountable task. Can we ever plum the depths a flood of anxiety in another person, especially a child and then measure what impact we have had on the waters? The focus has to be on the quality of the relationship and the observable impact on the young person, the network, and ourselves. There are some measures. Firstly, the child has had more information and the undivided attention of a supportive adult. Their presence in the sessions, their contributions and the relationship that has been established, are key outcomes. Secondly, for children who have had disrupted childhoods, the process of the work may have given them an experience of starting and finishing a relationship, unrelated to a crisis/problem. Many of the children will have in the past had disadvantaged and/or history and create something special for a period of time. Thirdly, and most importantly, the child has the book. So the child has ownership and makes decisions about what to do with it. My own experience has been that children often say that the book will be very private, but when they have it in their possession, they often want to share it with significant adults in their life. This can be a whole new beginning for a child in terms of sharing their worries and anxieties. Fourthly, the insights gained by the adult to doing the work, are an invaluable source of understanding about the child. If the adult can play a significant part in a professional network around the child, the insights gained will help the decision making about that child in the future, much more child centred. Finally, adults who do this work gain so much, personally and professionally, with regard to their understanding of the inner world of the child. Speaking for myself, I am indebted to the young people with whom I have done life story work for the opportunity to listen to them.

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THE STORY SO FAR

So this is my story so far. I have enjoyed telling my life story, meeting up with people to hear what they think, and having my photograph taken – even though I said I hated it. Anne asked me what I've learned from doing the work and I said:

'It helps to see what happened to your parents. If they didn't have enough love, you won't get enough love. I did off my Nan.'

'I learned, don't judge a book by its cover, he (my dad) didn't have a good life.'

'I have learned, don't hit women, it is wrong.'

'My Nan is my life.'

'My mum is a big person in my life.'

'Thinking about drugs…never take em ever, ever, ever again. My Nan says she will slap me if I do.'

'I want to go in the Army, if my Nan lets me.'

By Sam, aged 16 years

Connectedness to school: A vital link for young people with autism?

Louise Meehan

Dr Louise Meehan works as an Educational Psychologist for Leeds City Council. *She reports on the results of a study which investigated the mental health of young people with an autistic spectrum condition in three mainstream secondary schools.*

THERE IS GROWING AWARENESS that the positive relationships young people build with peers and teachers help them to develop a sense of belonging to the school community. In turn, this belonging or connectedness impacts positively on their well-being and academic success (McLaughlin & Clarke, 2010). However, there has been limited exploration of the importance of connectedness to school for young people with autism. Given the difficulties that young people with autism have with social interaction and forming relationships, it could be hypothesised that they have less interest in connectedness. This brief article considers the relevance of the concept of connectedness to school for those with autism and ways in which it can be developed.

Connectedness and autism

Despite the apparent counter-intuitiveness of the concept of connectedness to school for those with autism, in my own case study research (to be published in more detail elsewhere), it emerged as a prominent theme with close links to mental health. Semi-structured interviews with young people, parents and school staff, investigated the well-being of 11 Key Stage 3 young people with an autism diagnosis from three mainstream secondary schools, along with school-based factors that promoted or demoted this. Positive peer friendships promoted well-being for a few, but their absence caused many considerable anxieties. Being understood and listened to by teachers had a positive impact on well-being and lack of empathy from staff the opposite effect.

These findings are supported by other research regarding young people with autism in mainstream schools. As adolescence approaches many strongly desire peer friendships, despite difficulties establishing and maintaining these (Daniel & Billingsley, 2010; Dann, 2011). For some, positive relationships with peers promote social inclusion and well-being (Humphrey & Lewis, 2008). More often, young people with autism are peripheral to or isolated from friendship networks, and experience loneliness (Locke et al., 2010) and bullying (Humphrey & Lewis, 2008; Tobias, 2009). They can be distressed by teasing, ignoring or scorn from peers, showing awareness of their lack of connectedness (Ochs et al., 2001) and sometimes withdraw from others to avoid further pain. Accounts of schooling provided retrospectively by adults with autism also focus on wanting to belong but experiencing a lack of connectedness, bullying and isolation, often resulting in mental health difficulties (Portway & Johnston, 2003; Beardon & Worton, 2011).

Less research exists on relationships between school staff and pupils with autism, but results from my study and Tobias' (2009) focus groups indicate that young people appreciate individual meetings with an adult to discuss their concerns and often build strong bonds with him/her. There is also evidence that those with autism value characteristics in school staff that promote

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connectedness (Willliams & Hanke, 2007; Dann, 2011); although it is often harder for teachers to build relationships with them (Barrett, 2006).

To summarise, research indicates that connectedness to school is much desired by many young people with autism, although, as a result of their difficulties and others' reactions to them, it is often hard for them to achieve. Instead, feelings of isolation frequently affect well-being.

Promoting connectedness

Young people's views must always be sought in planning any intervention, as viewpoints and experiences differ markedly. However, research indicates various strategies may promote connectedness to school for those with autism. These are listed below:

- School staff understanding the young person is key to building relationships. Training for secondary school staff has been linked with higher rates of school belonging in those with autism (Osborne & Reed, 2011). Effective training seeks to develop empathy amongst staff (Barrett, 2006).
- Support staff should be used carefully; high levels of contact with support staff negatively affect peer relationships (Osborne & Reed, 2011).
- Mentoring or personal tutorial sessions help young people to manage peer relationships, whilst building connectedness with the adult involved (Christie et al., 2008; Tobias, 2009).
- Disclosure of diagnosis to peers and peer support training can increase peer empathy and levels of social support, reducing isolation and anxiety (Ochs et al., 2001; Etherington, 2010). Disclosure needs careful handling and the agreement of young people and their parents.
- Adult support and guidance to develop friendships with pupils with similar interests or difficulties can promote connectedness (Dann, 2011) and was linked to improved well-being by young people in my study.
- Ethos of a school and attitudes towards difference significantly impact on the well-being of those with autism (Humphrey & Lewis, 2008; Tobias, 2009).

Conclusions

Despite the difficulties that young people with autism have with social interaction, connectedness to adults and peers in schools can promote their well-being. Although further research is needed regarding ways to develop this connectedness, I propose that many with autism would benefit from a 'web of connectedness', involving support to establish positive relationships with peers and teachers.

Interestingly, many strategies for building connectedness involve building empathy not in those with autism, but in those around them. Autobiographical accounts written by those with autism criticise others for their lack of empathy, which leads to pressure on the person with autism to conform and subsequent mental health problems (Beardon & Worton, 2011). If connectedness to school is to become a reality for more young people with autism, staff and peers must move more than halfway to build connections. Developing these connections is challenging, but will have a positive impact on the mental health of many with autism, both in school and into their adult lives.

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THE ANGER INSIDE

The boy sits in his english leson doing his work unwilingy he sits lising to his music as the anger burns inside of him the rage that has built up inside is enuf to send a purson insane. The yers of bulleing and hate for him has distord any emotion he my have had for enyone that he may have loved or liked as a friend. All the emotion he nows is hate anger and vile discust for all over members of the human race. If you met him you may think he is a nice purson and he is on the outside but inside is mined he is thinking about the meny ways he coude kill you. He has friends well more like alliys he probuly will kill them to. This boy this demonic child is the one purson that you shoude be scared of because over yares of bulleing the anger has built up.

Lets say for instance everyone has a balloon and this balloon gets filld up with all your anger and hate and stress. Difrent people have there own ways of letting the balloon deflate to relax but this boy hase not foun a way to relax and his balloon just keeps getting bigger. He has littal out brakes he gets in a small fight at school thay are stress markes in the balloon. Wen that balloon finally pops now won now swat will happen. He may go insane he may have a brake down but the most probubell will be that he gose a rampage and nuffing will stop him unlles thay KILL HIM!!!

By Tanis, aged 15 years.

Features of an autism-friendly school

Anne Pearce

Anne Pearce is the Headteacher of Woodeaton Manor School which is a special school for children in Key Stages 2/3/4/5, with severe emotional and social difficulties, including attachment difficulties and autism. The school has been judged as 'outstanding' by OFSTED.

WOODEATON MANOR SCHOOL is a Local Authority Special School for pupils in Key Stages 2, 3, 4, and 5 with severe emotional and social difficulties, including attachment difficulties and autism. The school is housed in Woodeaton Manor House which was built in 1775. Many of the buildings are Grade II Listed. In many ways, the building is one of our assets, particularly for parents who are adjusting to the suggestion that their child needs special education. There is no doubt that a grand building in extensive grounds is attractive. In other ways, the building imposes some limits: steep stairs, an ancient fabric, and definite limits to the nature of adaptations that can be made.

The profile of the school population

In 2004, the prime need of the pupils was variable. Despite having admission's criteria, it did seem there was a lack of clarity with regard to children with social and emotional difficulties, with education officers, Headteachers, and Educational Psychologists, all having different understandings of an emotional and social difficulties profile. Over time, we have been able to more clearly define the group of children whose needs we feel we can best meet. We have revised our admission criteria to take into account our experiences of which children do well here, the need of families, and even, the proposed changes to the *Diagnostic Statistical Manual V* due out in 2013.

Every now and again, the Government publishes a press release that accompanies a new development, programme or initiative. These statements usually start with a punchy first sentence, for example, 'The National Curriculum should be broad, balanced and relevant'. In the main, these words pass me by. However, one word has stayed with me and is at the very core of everything we promote in our school. One such press release said that proposed revisions to the National Curriculum had to promote skills, knowledge and understanding. For us in our school, understanding is the absolute key. We have developed ideas based on understanding and created 'The Woodeaton Way'. All the children, their parents, staff and visitors to the school understand this. Put simply it is *'What can I do to make life better for everyone including myself?'*.

We see our main function and purpose, in order of importance, to secure emotional stability, to increase social skills and experiences, and to maximise academic potential. There is no point in supporting children to get GCSE examination passes, if they can't stand in a bus queue and manage the disappointment of someone else sitting in their favourite seat. The principles supporting our function and purpose are: enrichment, entitlement, and equal opportunities.

The features of an autism-friendly school

Daily routines

- Meeting and greeting the children every morning sets the tone. All of our children have sensory issues. We work to minimise the impact of these. All staff meet and greet all pupils every morning. This gives opportunities for eye contact, physical contact and for measuring anxiety levels.

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- There are twice-daily whole school circle times. These facilitate modelling talking and listening, being alongside each other, open discussions about diagnosos and difficulties, resolving issues, celebrating successes and helping the children cope with the day ahead in school. We are a community of children who don't like shocks and surprises.
- Classrooms are arranged in ways which allow for working separately alongside people, there is always flexibility to cater for individual sensitivities. Our children don't like to sit in rows.
- Mealtimes are an important part of our provision. Food is an issue for all of our children in terms of taste, texture, presentation and smell. All can create challenges, and, of course, opportunities. As Headteacher I take charge of the menu and we have the minimum of e-numbers and added chemicals. No child is allowed to bring food into the school. A menu is posted a week in advance, so again there are no shocks and surprises. At every meal time, there is a range of food available to cater for sensitivities: a salad bar, wet food and dry food, even preferences about the containers for Marmite are all part of our flexibility. We have three dining rooms, which offer, a large busy room, a smaller room where there is less movement around the room, and a quiet room. Children are asked to reflect on their levels of anxieties and to choose the room that best suits how they feel. We queue for meals. This great British tradition means feelings of anticipation and expectation emerge and have to be managed. Queues also offer the opportunity for further social contact with a greater range of people. All staff eat with the children and model emotional and social aspects of sharing food together.

A focus on learning

- The children are grouped in classes mainly by age, but also by emotional and social functioning which leads to some mixed age groups. The classes of younger children spend most of their time with a class teacher with supported excursions for some specialist teaching, for example, PE or Art. As the children get older, the secondary model of different specialist teachers for the different subjects operates and the children grow in to this model.
- We are always looking to maximise the academic achievements of the children. With regard to examinations, we use the widest variety of opportunities possible from online literacy and numeracy assessments, to Certificates of Educational Achievement, ASDAN awards, GCSE and BTech. We have a policy of 'catching children when they are ready' with regard to sitting exams, rather than being tied to certain exams being sat by children at certain ages. Applications are made for Access Arrangements for all the children such that they have bespoke concessions which cater for their complex difficulties and sensitivities.
- In addition to the teaching staff, the school has Teaching Assistants, many of whom are taking a gap year after leaving a nearby secondary school with which our school has close and positive ties. The majority of these Teaching Assistants are young men who bring high levels of physical activity, street credibility and fun, into our school.
- There is annual training for staff on key issues such as identifying and supporting children with special educational needs, autism theory and support strategies, attachment difficulties, alongside other training initiatives such as Team Teach and Mental Health first aid for schools.
- All visiting professionals to the school who make a regular contribution with regard to staff and children, are asked to maintain a professional network log

which is stored on the shared drive which can be accessed by all members of staff.
- The Psychologist to the school has set up an e-library where articles, handouts and reports, can be found in a variety of folders for the benefit of all staff.
- There is a staff meeting at the end of every day where staff can debrief with regard to issues about individual children/classes, discuss arrangements, and support each other.

Work with parents and carers
- For every child who starts in our school, we hold a Placement Planning Meeting with the parents of the child, the Educational Psychologist, and myself. The focus of this meeting is to look at who is in the child's family, the history of the child and family, the parents' view of the child's strengths and difficulties, and it is the place where we make joint plans for early targets for the child starting the school. The aim is to produce a holistic assessment of the issues with regard to a child and family which is written up in detail and with the parents' permission, made available to the staff and on occasions, becomes a basis for seeking further assessments and resources for an individual child.
- All parents are telephoned on a weekly basis by the class teacher of their child. These calls are about celebrating the successes of children, sharing ideas for strategies of support, and being in touch with parents in a regular and positive manner. When needed individual parents are given support. This can include: help to make applications for financial support, being provided with transport and a supporter to attend appointments with professionals, advice about management at home.
- There is a parent/carer support group which meets in the school in the evenings, six times a year. The sessions are varied including outside speakers, for example, DLA funding, talks on topics such as autism and attachment, discussions about issues of common interest, for example, e-safety.
- In order to support the families of our children, the school has an out-of-school liaison officer (Oslo) who distributes an electronic newsletter with information about community groups, activities, holiday schemes, and funds for supporting children and families.

The residential experience

The school is not a residential school, but rather a school with residential opportunities. There is a facility to offer a night in residence to children and families who would benefit from this and who want it. The families who take up this offer, have the opportunity of a night in residence for their child on a regular weekly basis. Care is given with regard to the groupings of the children on each of the four weekday nights when residence is available. Often it is the case that our children and families are isolated sometimes from their own extended families and more often than not from their local communities on account of the special needs of their child. We find that it is frequently the case that our children don't get invited to parties and sleepovers and we see a regular residential experience as the opportunity to plug that gap. A weekly night in residence becomes an opportunity to consolidate the experiences of the daytime with a small group of children and a different set of staff. The emphasis is always on sharing the experience of living together, planned activities, new experiences and most of all, fun.

School trips, holidays and ventures
- All of our staff work hard to generate funding for trips and holidays. In this way we create opportunities for our children which they otherwise wouldn't have. They may well not have these opportunities on account of the limited resources of the family, the complex special needs of the child, and the

difficulties of catering for children who are extraordinarily anxious in new settings. We have managed scuba diving in Egypt, an adventure plus holiday in Spain, the onslaught of Disneyland Paris and we are all looking forward to a week in Tunisia this summer.

- We are always seeking to extend the experiences and capabilities of our children. Whole school outings are points of excitement and challenges. We have taken over a cinema for the whole school to see *War Horse*, visited a local wildlife park, the inevitable trip to Thorpe Park, a day out in a very classy restaurant, 'Le Manour Aux Quatra Saisons', where children had opportunities to work alongside Raymond Blanc. We have had catering expertise which we know is impressive.
- We make our own produce: chutney, cupcakes, flans, and do a roaring trade at a local farmer's market. The amount of emotional and social learning that goes on when the children don their aprons to serve the public with the things they have made, is fantastic.
- We also see that school holidays, trips and ventures, are ways in which we educate the community around us while we help our children take their place in that community. We can now add a conference of Educational and Child Psychologists to our list of achievements. The delegates were served by staff, parents and children and we were very proud of them all.

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Conference Book Stall

Book Reviews

Edited by Peter Lloyd Bennett

Resources reviewed in *Debate 144*

Understanding 10–11-year-olds
Rebecca Bergese
Jessica Kingsley Publishers

The New Teacher's Survival Guide to Behaviour
Sue Roffey
Sage

Managing Exam Anxiety. A toolkit of exam stress busters
Astrid Gregor
Toolkit@eppl.co.uk

The Imprinted Brain
Christopher Badcock
Jessica Kingsley Publishers

Best Practice in Professional Supervision
Alison Davis & Liz Beddoe
Jessica Kingsley Publishers

Social Skills Training for Adolescents with General Moderate Learning Difficulties
Ursula Cornish & Fiona Ross
Jessica Kingsley Publishers

Explaining Inequalities in School Achievement: A Realist Analysis
Roy Nash & Hugh Lauder
Ashgate Publishing

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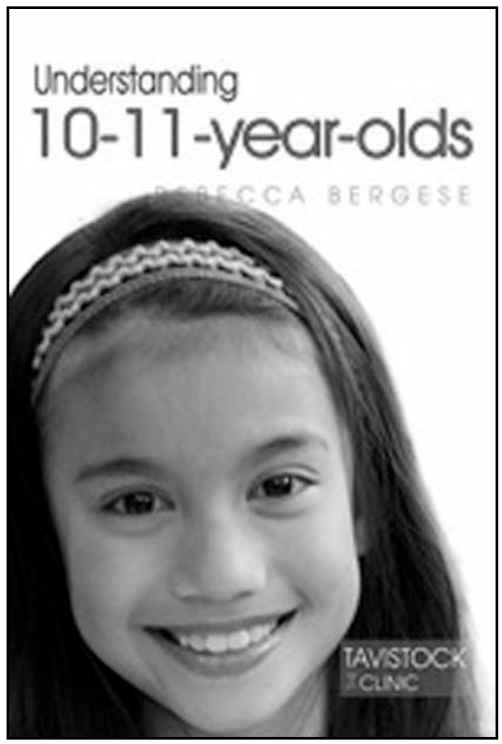
Understanding 10–11-year-olds
Rebecca Bergese
Jessica Kingsley Publishers, 2008
ISBN: 978-1-84310-674-6;
76 pp; Paperback; £8.99.
Reviewed by Alison Bray



This short, easily accessible book is one of a series of guides written by a group of professionals from the Tavistock Clinic's Child and Family and Adolescents departments. The series of books are written in the main for parents, and are intended to support, guide and offer advice to parents about key developmental stages from birth to adolescence, taking the role of supportive friend, offering parents an insight into the emotional world of the child and the challenges faced by their children and themselves as parents. The author draws mainly upon the psychoanalytical perspectives of Freud, Klein, Winnicott among others, and aims to demonstrate how the emotional developmental stage of the child impacts on their understanding of and interactions with the world around them.

The book provides snapshot portraits of situations and scenarios which are common experiences for parents of children who are reaching the end of primary school and about to enter puberty. Topics covered include family dynamics, dealing with loss through bereavement or family disharmony, understanding the social world of the child, supporting children of both sexes through puberty and managing school-based issues and planning for transition to secondary school. As a parent myself I found myself nodding in reassured agreement at several stages throughout the book!

The book's relevance for Educational Psychologists (EPs) is a friendly text to recommend to worried parents of children of this age. It might also be a useful introductory text to EPs in training or newly-qualified EPs who are not parents themselves to familiarise themselves with the everyday issues faced by the children and families they are working to support.

Alison Bray
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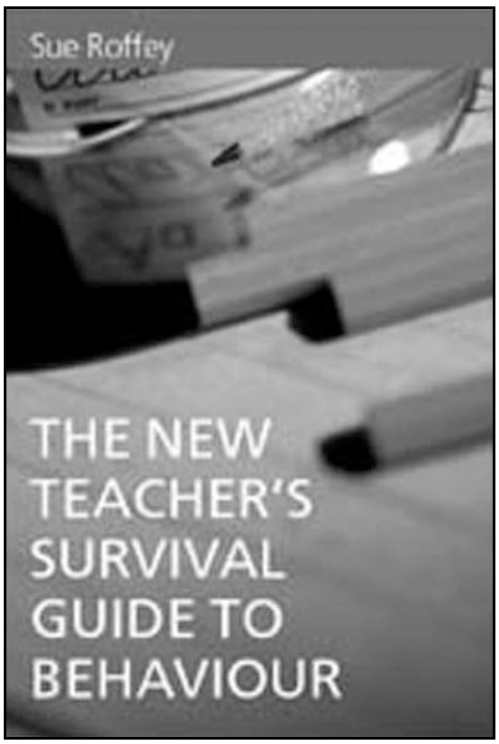
Warwickshire Educational Psychology Service.

The New Teacher's Survival Guide to Behaviour (2nd ed.)
Sue Roffey
Sage, 2001
ISBN: 978-1-84920-744-7;
148 pp; Paperback; £20.99.
Reviewed by Louise Meehan



Taking an eco-systemic approach, this book is about behaviour in its widest sense including, in large part, the teachers' own. Written by an educational psychologist and intended for an audience of recently qualified teachers, the foundations of the text are ones that many educational psychologists (EPs) are likely to be comfortable with including being solution-focused, developing the emotional literacy of all connected with schools, building positive relationships and searching for the meaning of underlying behaviours. Throughout there is acknowledgement of the impact of school culture on both teachers and students.

The content should be very familiar to EPs. Successive chapters broaden out issues of behaviour, starting from the teacher's own values, skills and resilience, before moving onto the class, school and community. Towards the end, a chapter is devoted to dealing with the most challenging students. This contains sections on various ways forward including restorative practice and behavioural approaches, but these are probably covered too briefly to enable the new teacher to implement them without further information or support. However, there is a practical emphasis throughout and a focus on specifics, such as how to deal with fighting between students and how to handle mobile phones in the classroom. The book also succeeds in sensitively promoting empathy for those young people in difficult situations whose behaviour challenges school staff. In addition there is a well-written section on the role of the EP.

Sue Roffey writes in a readable, modern style. Case studies are used to illustrate the arguments made and activities and reflection points emphasise practical applications. The final chapter includes a summary of key 'Do's and Don'ts' from the preceding chapters listed as bullet points. Despite the book's accessible style it is not short on content and is, at times, very thought-provoking. Relevant research is cited to support key arguments and extensive further reading in terms of both books and websites is signposted.

The New Teacher's Survival Guide to Behaviour is intended for recently qualified teachers who are working with children and young people aged 7 to 18 and EPs could confidently recommend it to teachers in their first few years of practice who work across this age range. It would not (and does not claim to) be as helpful for those teaching in Foundation Stage and Key Stage 1. However, its appeal could be broader, as although some sections are specifically aimed at new (and younger) teachers, this book has much to say to any teacher who wishes to reflect on and develop their skills and confidence in managing their own and other's behaviour.

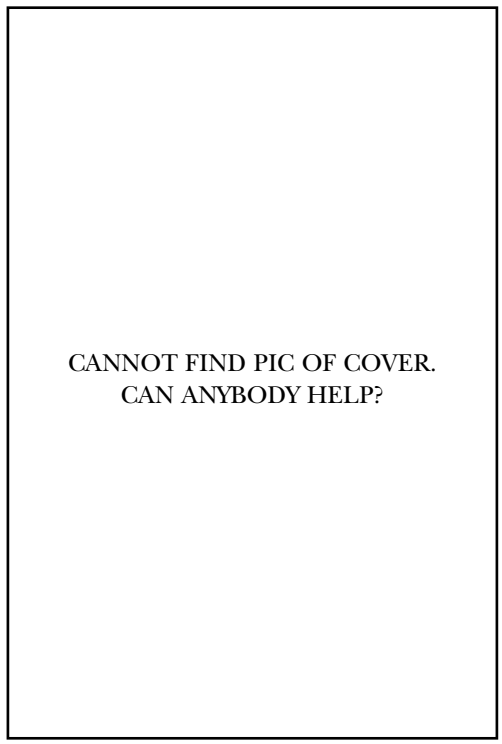
Louise Meehan
Educational Psychologist in West Yorkshire.

Managing Exam Anxiety. A toolkit of exam stress busters
Astrid Gregor
toolkit@eppl.co.uk
69 pp; Paperback; £19.00.
Reviewed by Peter Lloyd Bennett

This resource primarily aims to share practical and evidence based strategies to help students in their preparation and performance in examinations. It comes across as quite brief and succinct but at the same time fairly comprehensive.

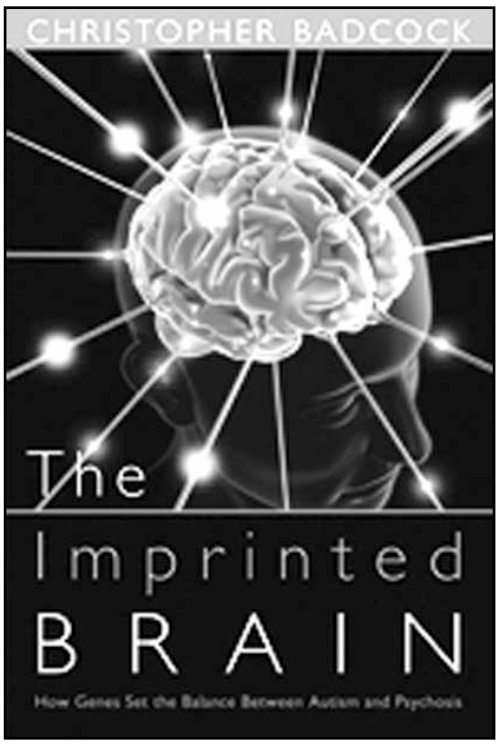
Gregor's scholarly approach covers the nature of examination stress, interventions and strategies for managing it as well as the prevention and self-management of examination anxiety. Photocopiable resources form the materials for a training package of between seven and 10 sessions and draw upon a well established knowledge base.

My suggestions for a second edition of this useful resource would be to include some more details of illustrative case studies. The lay out seemed a little stark with subheadings in bold type for very short paragraphs though this may have helped the easy accessibility. The questionnaires could include a quantitative measure which could help students measure their progress over the training programme and, therefore, contributing towards the evidence base of the effectiveness of the materials. This is a potentially very useful resource which educational psychologists could pick up and run with minimal preparation.



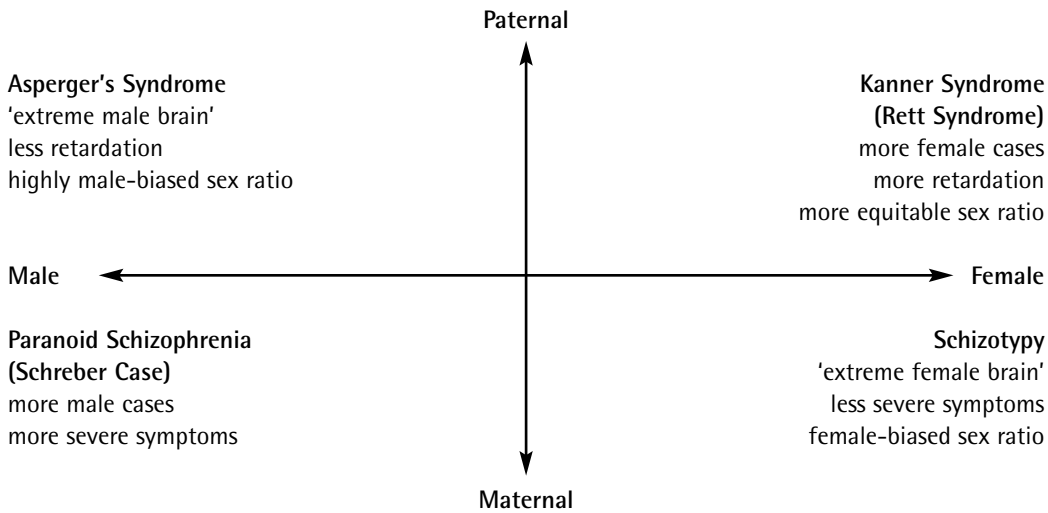
Peter Lloyd Bennett
Educational Psychologist in Peterborough.

The Imprinted Brain
How genes set the balance between autism and psychosis
Christopher Badcock
Jessica Kingsley Publishers, 2009
ISBN: 978-1-84905-023-4;
256 pp; Hardback; £19.99.
Reviewed by Ursula Cornish



This interesting book combines evolutionary biology and neurological and genetic research. It offers a thought-provoking theory about human brain functioning and the genetic impact on its development. It emphasises the importance of imprinted genes, genes that develop differently depending on whether they are inherited through the paternal or maternal line, and how this can develop into autism and schizophrenia. Badcock presents a new way of thinking about mental development and the emergence of mental disorder by drawing on evidence-based research into ttie discovery of genetic effects, involving not just the inheritance of genes, but also their expression. Badcock's imprinted brain theory suggests that a mechanism of genomic imprinting (a balancing act between maternal and paternal genes during gestation) can influence different ways in which gene expression can affect brain development, behaviour, physical side-effects and other symptoms as well as mental development and disorder. Enhanced effects of paternally expressed imprinted genes, and deficits of effects from maternally expressed genes, or both, underlie autistic conditions. Some genetic underlying factors are already well researched, for instance, Angelman Syndrome, Rett Syndrome and Turner Syndrome, which include autistic behaviour. This is characterised by difficulties in social interactions, communication and language. However, these can be accompanied by enhanced spatial and mechanistic abilities. Badcock convincingly argues that the symptoms of people with schizophrenia (such as the classic case of the psychotic Schreber) show the opposite characteristics to those with autism (absence of gaze monitoring, interpretation of other people's intentions, shared attention and sense of self). Both autism and schizophrenia are inheritable but neither follow Mendel's law of inheritance of dominant and recessives genes. Badcock describes many clinical examples that suggest that autism and psychosis are opposite ends of a continuum: at one extreme the mind blindness (autism) he calls hypo-mentalism, and at the other the bizarre hyper-mentalism of the psychotic person. He and his colleague Professor Crespi developed a two-dimensional model of genetic conflict with the principal psychiatric outcomes: the horizontal axis refers to male/female sex chromosome gene expression, and the vertical axis refers to paternal/maternal imprinted gene expression.

The diagram by Badcock illustrates how he understands the underlying mechanism of the balancing act that can produce various outcomes.



Badcock explains that the imprinted brain with its parallel running cognitive abilities of mechanistic thinking and mentalistic reasoning may have had evolutionary usefulness. The mentalistic being, due to increased maternal gene expression relative to paternal gene expression, may be the source of social and communication skills that allowed people to care for each other and survive despite the adverse effects associated with lower birth weight, intra-uterine growth restriction, and higher incidence of foetal hypoxia (oxygen starvation). In contrast, paternal gene expression results in growth effects associated with autism and mechanistic thinking. Both types of cognitive style are equally relevant for the development of human beings. This theory and its supportive evidence may lead to a different kind of classification of psychiatric disorders and throws light on the possible underlying mechanism that explains how autism and psychiatric syndromes can be understood not only by medical professionals but also by educational psychologists, social workers and therapists.

Badcock also makes pertinent comments about Freud and what is missing in his thinking regarding autism in children and schizophrenia. Of particular interest is the light the theory throws on the genetic make up of geniuses.

It gives a clear picture of autism with references to people with Asperger's Syndrome and schizophrenia. It gives enough case examples to make the reading more enjoyable despite the complexity of the various areas it covers.

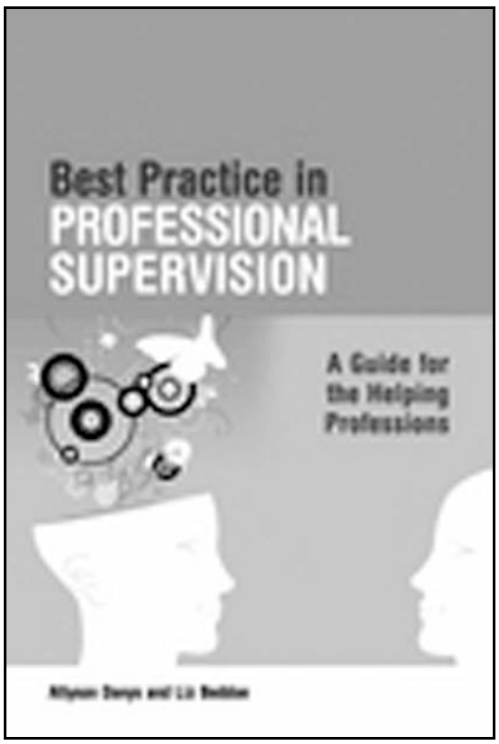
Ursula Cornish AFBPS
Camden.

Best Practice in Professional Supervision: A Guide for the Helping Professions

Allyson Davys & Liz Beddoe

Jessica Kingsley Publishers, 2010
ISBN: 978-1-84310-995-2;
256 pp; Paperback; £19.99.

Reviewed by Richard Parker



The Division of Educational and Child Psychologists (2010, p.3) recently reminded us that '[g]ood supervision has an important role in assuring quality standards of service delivery and supporting service development' through attending to outcomes for children, young people and their families and also to personal well-being and professional development. I know of no educational psychologist who does not take this responsibility (and right) seriously.

So, what might this publication add? There is a set of positives here, but also some noteworthy omissions.

Positives first: this book is from Aotearoa (New Zealand), whose history renders cultural sensitivity and understanding of great importance – whilst Scaife (2009) pays attention to issues of cultural diversity, I had a sense that this is an even more critical issue for these authors; their attention to detail bears helpful fruits.

I was taken by some new (for me) thinking in this book. The authors offer a helpful development in thinking about the functions of supervision; they move beyond the oft quoted functions (see, for example, Hawkins & Shohet, 2006, p.57ff), adding a dynamism to the model that I found fascinating.

Supervision literature is replete with models and this book is no exception. Alongside the functions model, the authors provide an intriguing way to consider the roles supervisee and supervisor can be pulled into – have *you* ever felt yourself to be a victim or perhaps felt asked to rescue someone in supervision? The 'drama' and 'empowerment' triangles (p.172ff) offer interesting insights into how one might attend and respond to such issues. There are further models including four broad supervisory approaches and their own Reflective Learning Model (Chapter 5; developed from experiential learning models and feeling similar to a favourite of mine – Hawkins and Shohet's CLEAR – see pp.61–63 of their text). They also offer interesting sets of questions or considerations that may help in establishing a supervisory relationship or in differentiating practitioner and student supervision. This latter might usefully sit alongside something like Nash's (1999) modes of activity in supervision.

So, there is much that might be of use in developing and maintaining access to good enough supervision. However, I have a couple of concerns.

The authors claim (p.148) that their Reflective Learning Model '…positions the supervisee as the central figure in supervision', but they pay little primary attention to the supervisee's role and responsibilities. To find this, one needs to turn to Hawkins and Shohet's brief but helpful excursion into this

area. Also, I was surprised that little attention was paid to peer, group or team supervision; these are likely vital support structures in many psychology services and do bear attention. Look to either Hawkins and Shohet (op cit) or Scaife (op cit) for helpful coverage.

I believe this book can usefully sit alongside Hawkins and Shohet and/or Scaife in a service library or on the shelves of someone particularly keen on the topic – however, the book will not replace these established texts.

Finally, I have a question for the authors: as the book is aimed at 'the Helping Professions'; I'd like to know why a profession like educational psychology – or its cousin school psychology – does not appear, given the emergence of a literature written by educational psychologists?

Dr Richard Parker
Lead Practitioner Educational Psychologist; Northumberland Locality Inclusion Support Teams.
Academic and Professional Tutor; Newcastle University.

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British Psychological Society (BPS) Division of Educational and Child Psychology (2010). *Professional Supervision: Guidelines for Practice for Educational Psychologists.* Leicester: BPS.

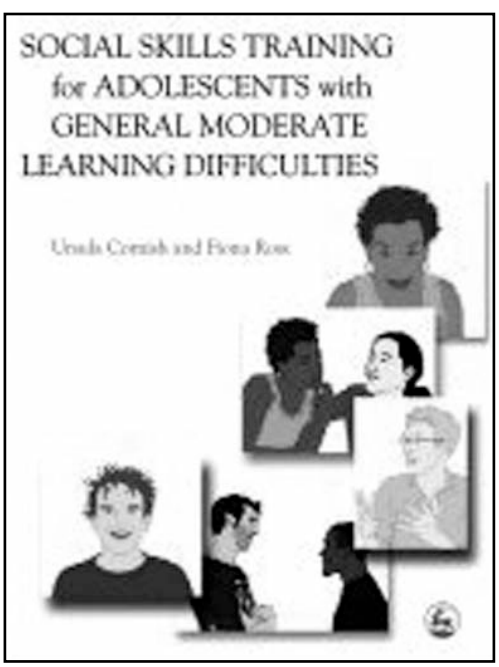
Hawkins, P. & Shohet, R. (2006). *Supervision in the helping professions* (3rd ed.). Maidenhead, Berkshire: Open University Press.

Nash, J. (1999). Developing and refining supervisory skills – an application of solution-focused thinking. *Educational Psychology in Practice, 15*(2), 108–115.

Scaife, J. (Ed.) (2009). *Supervision in clinical practice: A practitioner's guide.* London: Routledge.

Social Skills Training for Adolescents with General Moderate Learning Difficulties

Ursula Cornish & Fiona Ross
Jessica Kingsley Publishers, 2004
ISBN: 978-1-84310-179-3;
128 pp; Paperback; £15.95.
Reviewed by Clare Otter



This practical text, written by educational psychologists, provides a user-friendly resource for setting up and running a social skills training group for young people aged 13 to 17 with learning difficulties. The rationale for the book is that, whilst other social skills training packages may cover age-appropriate social issues, they are often inaccessible to this population due to high literacy demands, a focus on abstract concepts and an assumption of students' awareness of social norms.

The book includes plans for a 10-session programme which the authors have developed in their work with adolescents with learning difficulties and Asperger's Syndrome. Each session plan clearly describes the aims, activities, timings and materials needed, with photocopiable resource sheets provided where necessary and explicit links made with the National Curriculum for PSHE and Citizenship. The activities are varied and provide the opportunities for active engagement and over-learning that this group of adolescents often needs. The authors also include useful

guidance on session format, group size, timings and organising furniture, although more information about group composition and dynamics might have been helpful.

The introduction highlights the cognitive and behavioural theories and approaches underpinning social skills training and behaviour change. I found this to be a useful reminder, however, non-psychologists (such as school staff) might benefit from some more detailed explanation. For example, terms (such as 'vicarious learning,' 'self-talk' and 'operant and classical conditioning paradigms') are used as though the reader is familiar with their meaning.

Educational psychologists might be wary about recommending social skills training as a 'standalone' intervention, as we know that combining it with a whole-school and parent-supported approach to young people's social and emotional development is preferable (see Weare & Gray, 2003, for example). A strength of the book is the way that the authors have actively sought to involve parents and family members by setting a homework activity linked to each session, which is supported by a letter to parents and parental feedback form. However, I felt that, although providing guidance on an appropriate school environment was beyond the scope of the book, the introduction could have included more hints on how to support young people to apply their new skills in school situations outside of the training group.

The authors acknowledge that evidence for the success of the programme is limited to anecdotal reports and that more scientific evaluation is desirable, however they do provide some useful tools for assessing the impact of the sessions on group members. This includes guidance on how to conduct pre-and post-intervention measures such as a 43-item social skills checklist, interviews with significant adults, different types of observations and assessments of friendship networks.

In summary, I would recommend this book to educational psychologists who wish to support a school in setting up a social skills group for young people with special educational needs, however it may need to be supplemented with a more accessible introduction to the psychological theory underpinning the intervention.

Dr Clare Otter
Educational Psychologist at Central Bedfordshire Council.

Reference

Weare, K. & Gray, G. (2003). *What works in developing children's emotional and social competence and well-being?* (DfES Research Report 456). Annesley: DfES Publications.

Explaining Inequalities in School Achievement: A Realist Analysis

Roy Nash and edited by Hugh Lauder

Ashgate Publishing Ltd, 2010
ISBN: 978-0-75467-904-2;
265 pp; Hardback; £60.00.

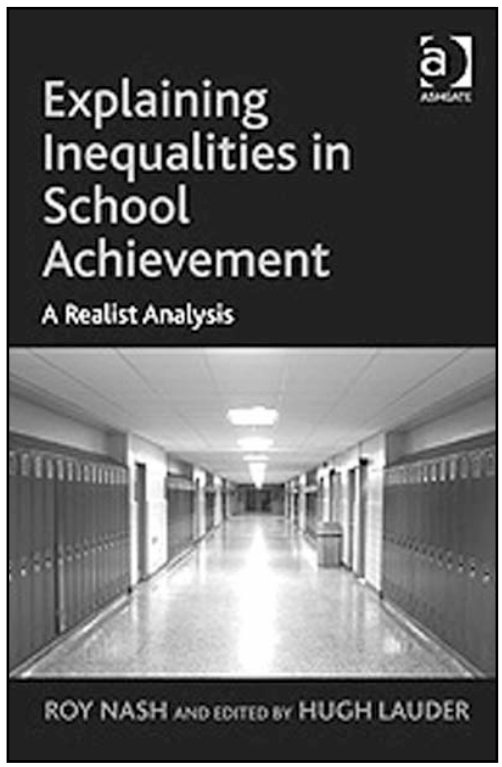
Reviewed by Clare Middleton

The title of this book was instantly appealing to me, and the author did not disappoint as he tackles this complex topic in depth. The author spent the first half of his life in the UK before moving to New Zealand, and the book draws on significant research from both sides of the world. The book was unpublished at the time of Nash's death in 2006, however, Lauder wrote an introductory chapter and ensured its publication. The book is divided into four parts; theoretical foundations, early class differentials in cognition, classed identities in formation, and secondary effects and statistical

modelling. The material in the book is widely researched and each chapter has a clear aim, a conclusion and finishes with extensive references. The book is written in lecture style with the feeling that a theoretical debate is taking place between colleagues.

This topic has challenged sociologists, politicians and educationalists for generations. Despite various strategies and policies being implemented, there remains clear evidence that inequalities continue to exist and have not been ameliorated. Nash reviews research which makes depressing reading for those who believe in social mobility and equal opportunities. It is clear that the prosperous continue to prosper in education, students from richer homes are more likely to have higher scores than those from poorer homes, and even those with similar cognitive ability will have different job expectations as a result of their social class.

Nash reviews and builds on the theoretical perspectives of Bourdieu, Boudon and Bernstein. He clearly supports the view that early childhood is a significant factor in explaining inequalities. He considers issues such as the impact of the number of books within a household, the quality of language used, IQ testing, family expectations, and cultural perspectives. Nash holds the belief that many factors affecting inequalities in school achievement stem from early childhood before children are even exposed to the education system. He also uses some delightful case studies which indicate how crucial a teacher can be to an adolescent. Nash reviews the thoughts of Dewey who believed that successful teachers accept pupils as they are and encourage them to fulfil their individual potential.



This is a complex and mainly theoretical book which would be invaluable to those hoping to extend their knowledge of this area. The extensive references would be useful to doctorate students, and those seeking to carry out further research. I found the book thought-provoking and stimulating, and although it is accessible to all levels of readership, I believe that the reader would benefit from prior knowledge and understanding of the theories that are reviewed.

Clare Middleton
North Somerset Educational Psychology Service.

Resources for Review

Reviewers can keep the resources they have reviewed and it's a valuable part of your continuing professional development so please get in touch. I am happy to give you more information about any of the resources on this list. Not all reviews can be published.
E-mail: peter.lloydbennett@gmail.com

General

Unseen worlds. Kate Adams. *JKP.*
Educational opportunity. Alexander Singleton. *Ashgate.*
Intelligence and how to get it. Richard Nisbett. *Norton.*
International family law. Barbara Stark. *Ashgate.*
Minority rights protection in international law. Helen O'Niorns. *Ashgate.*

Early years

Listening to children in their early years. Hannah Mortimer. *QEd.*
Mathematics through play in the early years. Kate Tucker. *Sage.*
Making the Early Years Foundation Stage work for you (0–36 months).
Helen Rowlands & Hannah Mortimer. *QEd.*

Therapy

Dramatherapy and family therapy in education. Penny McFarlane & Jenny Harvey. *JKP.*
Therapeutic residential care for children and young people. Susan Barton, Rudy Gonzalez & Patrick Tomlinson. *JKP.*
How to incorporate wellness coaching into your therapeutic practice. Laurel Alexander. *Singing Dragon, JKP.*
Creating complex change for children and their families.
Jo Holmes, Amelia Oldfield & Marion Polichroniadis. *JKP.*
Understanding crisis therapies. Hilda Loughran. *JKP.*
Healthy attachments and neuro-dramatic-play. Sue Jennings. *JKP.*
Young people and the curse of ordinariness. Nick Luxmore. JKP.
Therapy to go. Clare Rosoman. *JKP.*
Speaking about the unspeakable. Dennis McCarthy. *JKP.*

Behaviour

A kit bag for promoting positive behaviour in the classroom. Nicholas Morgan & Gillian Ellis.
How to help children and young people with complex behavioural difficulties.
Ted Coles & Barbara Knowles. *JKP.*
Addressing the unproductive classroom behaviours of children with special educational needs. Steve Chinn. *JKP.*
Why do I have to? Laurie Leventhal-Belfer. *JKP.*
Attention seeking. Nigel Mellor. *Sage.*
Managing violence in schools. Helen Cowie & Dawn Jennifer. *PCP.*
Rational emotive behavioural counselling in action. Wendy Dryden & Michael Neenan. *Sage.*

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Autistic spectrum disorders
Autism and Asperger's syndrome in schools. Lee Wilkinson. *JKP.*
Embracing Asperger's. Richard Bromfield. *JKP.*
Making sense of social situations. Albert Cotugno. *JKP.*
Interactive play for children with autism. Diana Seach. *Routledge.*
What autism can be like. Sue Adams. *JKP.*
Brotherly feelings. Sam Frender & Robin Schiffmiller. *JKP.*
Unstrange minds. Roy Grinker. *Icon Books.*

Emotional literacy
How to be angry. Signe Whitson. *JKP.*
Magic circles. Murray White. *Sage.*
Helping children to build self-esteem. Deborah Plummer. *JKP.*
Smart strategies for avoiding classroom mistakes. Carolyn Orange. *Corwin Press.*
What children need to be happy, confident and successful. Jeni Hooper. *JKP.*

Social development
Connecting with kids through stories. Denise Lacher, Todd Nichols & Joanne May. *JKP.*
Social skills games for children. Deborah Plummer. *JKP.*
Fostering a child's recovery. Mike Thomas & Terry Philpot. *JKP.*
What have I done? A victim empathy programme for young people. Pete Wallis. *JKP.*

Learning
Trusting what you're told. Paul Harris. *Belknap Harvard.*
Dyslexia and mathematics. Thomas Miles & Elaine Miles. *Routledge.*
Teaching foundation mathematics. Nadia Naggar-Smith. *Routledge.*
Four in a row. Time and money. Ian Ward. *QEd.*

Schools
Planning, teaching and class management in primary schools. Dennis Hayes. *David Fulton.*
Subject leadership in the primary school. Joan Dean. *David Fulton.*
Primary classroom management. Rob Barnes. *PCP.*

Miscellaneous
The Renfrew Language Scales. Catherine Renfrew. **Speechmark.**
Talkabout game. Developing self-esteem, social skills and friendship skills.
Alex Kelly & Brian Sains. *Speechmark.*
Born together – reared apart. The landmark Minnesota twin study. Nancy Segal.
Harvard University Press.
The psychology of chronic fatigue syndrome/ME and self-management. Paul Gregory.
Hallmark Press International.
Caring for abused and neglected children. Jim Wade, Nina Biehal, Nicola Farrelly &
Ian Sinclair. *JKP.*
The impact of parental employment. Linda Cusworth. *Ashgate.*
Streetwise. Sam Frankel. *JKP.*
Preference organisation and peer disputes. Amelia Church. *Ashgate.*
A guide to classical education at home. *Susan Wise Bauer & Jessie Wise. Norton.*
Chasing ideas. Christine Durham. *JKP.*
Great answers to difficult questions about divorce. Fanny Herlem. *JKP.*

Great answers to difficult questions about death. Linda Goldman. *JKP.*
Breaking free from obsessive compulsive disorder. Jo Derisley, Isobel Heyman, Sarah Robinson & Cynthia Turner. *JKP.*
Overcoming loss. Julia Sorensen. *JKP.*
Getting wise to drugs. David Emmett & Graeme Nice. *JKP.*
Still here with me. Suzanne Sjoqvist. *JKP.*
The expressive arts activity book. Suzanne Darley & Wende Heath. *JKP.*
Leading work with young people. Roger Harrison, Cathy Benjamin, Sheila Curran & Rob Hunter. *Sage.*
Making your words work. Terry Mahony. *Crown House Publishing.*
A new youth. Carmen Leccardi & Elisabetta Ruspini. *Ashgate.*
Chinese youth in transition. Jieying Xi, Yunxiao Sun & Jing Jian Xiao. *Ashgate.*
Contemporary youth research. Helena Helve & Gunilla Holm. *Ashgate.*
Children and social security. Jonathon Bradshaw. *Ashgate.*
Psychotropic drugs fast facts. Jerrold Maxmen, Nicholas Ward & Steven Dubovsky. *Norton.*
Music makers. Music circle times to include everyone. Hannah Mortimer. *QEd.*
Sex, therapy and kids. Sharon Lamb. *Norton.*

Booklets (various)
Trackers 0–5. Colin Gallow. *QEd.*
Disability, disadvantage, inclusion and social inclusion. Policy paper.
Music and play. Hannah Mortimer. *QEd.*
Gifted and talented children in the early years. Hannah Mortimer. *QEd.*
The red beast. Controlling anger in children with Asperger's syndrome. K. Al-Ghani. *JKP.*
The little book of thunks. Ian Gilbert. *Crown House Publishing.*

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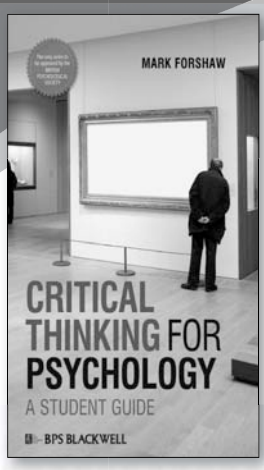

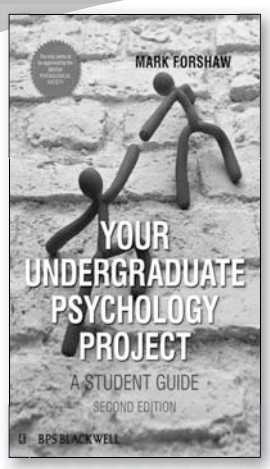

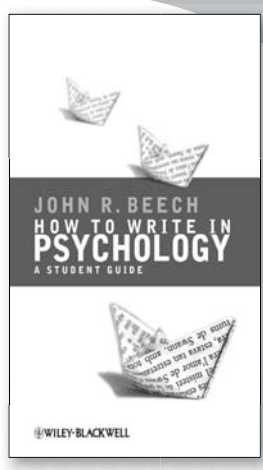

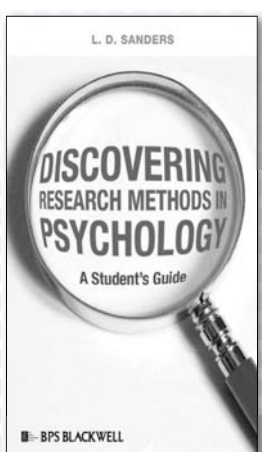

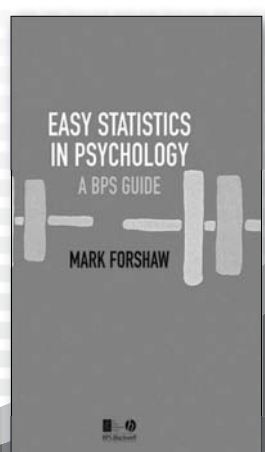

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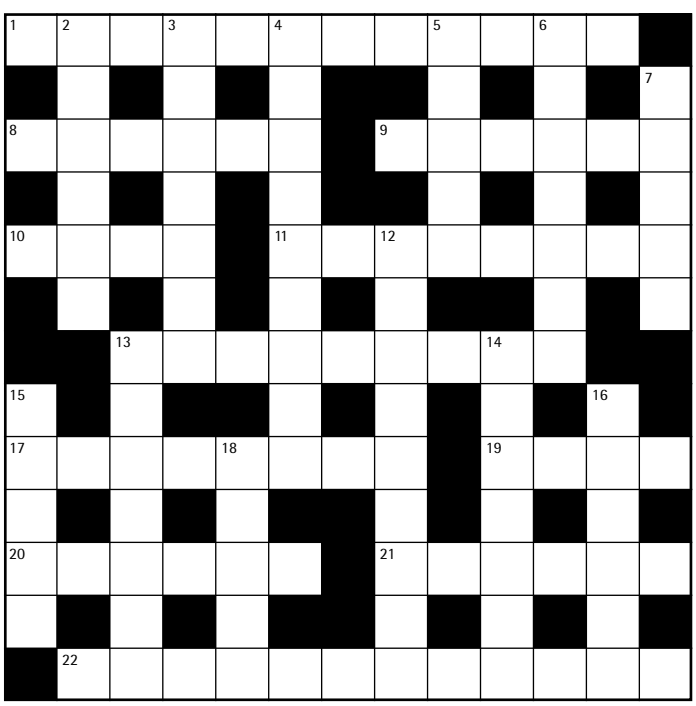
Crossword No. 85 by Psychophilos

ACROSS

1 Vain G&S knight fluffed festival in 22 (12)
8 Awesome sound with slight modification for one season (6)
9 Quiet French street with a silver lining is capital (6)
10 Sacred river's less than first class (4)
11 Far from exclusive – thrillling about the start of 17 – resistance eliminated (8)
13 Yes, the French inter a duck (9)
17 Print worker loses it – Mahler, for instance (8)
19 Transport the sheep in Yorkshire (4)
20 Some blackberry bushes wander about (6)
21 Inherent in some neonates (6)
22 Uninhibited nudes taste it, the home of 1 in 8 (6,6)

DOWN

2 25% of householders stand on the railway 24 times a day (6)
3 Wicked sound of nothing at all on one axis (7)
4 To a smaller extent after feeling foolish (9)
5 Towards French and English poetry (5)
6 Every day, after dark, it sounds chivalrous (7)
7 Silence is part heard (5)
12 London store reported unconstrained behaviour (9)
13 Supplier for 16, we hear, is actually one who lives on charity (7)
14 Round a circular building with a domed roof (7)
15 Nut – something for the chiropodist? (5)
16 Town fight (6)
18 Some crows leave a small bird (5)



Solution to No. 84

ACROSS:
1 Rake 3 Cold snap 8 Arts 9 Clueless 11 Sumertime 14 rarity 15 Nature 17 Cerebellum 20 Open mind 21 Loon 22 Brainbox 23 Snow

DOWN:
1 Reassure 2 Kite mark 4 Oblate 5 Dream maker 6 Need 7 PTSD 10 Weatherman 12 Full moon 13 See me now 16 Leanto 18 Comb 19 Beta

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