The Coventry Grid Version 2 (Modified Jan 2015)

The Coventry ASD vs Attachment Problems Grid

Differences between Autistic Spectrum Disorder (ASD) and attachment problems based upon clinical experience and observations

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The Coventry Grid is an attempt to summarise the differences between the behaviour of children with Autistic Spectrum Disorder and those with significant attachment problems. It is based upon clinical work with children rather than research.

There is an emerging body of research which is clarifying the range of social and communication difficulties seen in children and young people who have experienced early adversity (particularly the work of Prof. Sir Michael Rutter; Dr. Helen Minnis; Prof. Jonathan Green; Prof. David Skuse).

The Grid is particularly thinking about children with ability in the mild learning disability to above average range and those who are interested in connecting with people. It is less useful for the more severe learning disability range and those children who are withdrawn and very avoidant of social contact.

This version of the Coventry Grid was added to by a London/South of England group of speech & language therapists who work in youth justice, and after discussions with professionals at CPD sessions about particular parts of the grid. There are no major revisions but there are additional descriptors added to some sections and some small changes to descriptors.

1. Flexible thinking and behaviour

Children and young people with Autistic Spectrum Disorder and those significant attachment problems and disorders present with difficulties with flexible thinking and behaviour. Their behaviour can be demanding and ritualistic, with a strong element of control over other people and their environment. The different 'flavour' seems to be about personality style, a strongly cognitive approach to the world in Autistic Spectrum Disorder, and a strongly emotional approach in children with problematic attachment. The need for predictability in in children with problematic attachments suggests that the child is trying to have their emotional needs for security and identity met. In Autistic Spectrum Disorder, the emphasis seems to be on trying to make the world 'fit' with the child/young person's preference for order and routine.

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Typical presentation in Attachment Problems
1. Lack of flexibility of thought and behaviour	1.1 Preference for predictability in daily life	• Repetitive questions related to own intense interests • Repetitive questioning re changes in routines and new experiences • Ritualised greetings • Becomes anxious if routine is removed and may seek to impose usual routine (e.g. wants same bedtime routine when away on holidays; won' accept the supply teacher) • Inclined to try to repeat experiences and to interpret any repetition as routine (e.g. asks/demands repetition of following the same route to school; cannot cope with a change to appointments) • Distressed when a routine or ritual cannot be completed (e.g. when cannot follow the usual route because of road works)	• Preference for ritualised caring processes (e.g. bedtimes, meals) • Repetitive questioning re changes in routines and new experiences • Copes better with predictability in daily routines but usually enjoys change and celebrations • Looks forward to new experiences but may not manage the emotions they provoke (e.g. may not cope with excitement or disappointment) • Takes time to learn new routines • Routines tend to be imposed by adults in order to contain the child's behaviour more easily
	1.2 Difficulties with eating	• May limit foods eaten according to unusual criteria such as texture, shape, colour, make, situation, rather than what that food is (e.g. will eat chicken nuggets but no other chicken)	• Anxious about the provision of food and may over-eat (or try to) if unlimited food is available • May be unable to eat when anxious • May hoard food but not eat it

	1.2 Difficulties with eating cont.	• May adjust eating because of literal understanding of healthy eating messages (e.g. sell-by dates, avoidance of fat) • Restricted diet seems to be about maintaining sameness and the child is not easily encouraged by people the child is attached to • Connection between high functioning ASD and eating disorders during adolescence	• May be unable to eat much at a sitting • May 'crave' foods high in carbohydrate • Eating is transferable from situation to situation and the child can be persuaded by close adults • Children tend to have a range of eating disorders
	1.3 Repetitive use of language	• Echolalia • Repetition of 'favoured' words which are chosen for their sound or shape, rather than for their use in communication or emotional content • Children's repetitiveness is out of synch with their developmental stage • May use formal or inappropriate language which they don't understand (incorrect use of words/phrases.	• May develop rituals for anxiety provoking situations (e.g. says same things in same order when saying goodnight or leaving for school) • Older young people's self comforting may take form of substance misuse/self harming • Children's repetitive seems to be like that of a younger child – learning and playing with language
	1.4 Unusual relationship with treasured possessions	• Often uses possessions as ornaments, especially making collections of objects, but does not seek social approval for the collection or for its care • Will often be able to say where most treasured possessions are and recognise if they are moved • May be unable to dispose of old toys/papers/books even though they are not used • Shows a preference for old, familiar items (or toys/items which are part of a series) rather than new and different toys • Can be a mismatch between the amount of theoretical knowledge they have and their social use of that knowledge e.g. aware of football facts but doesn't share it socially.	• May seek social approval/envy from others for possessions • May not take extra care with possessions which have been given an emotional importance • May be destructive with toys, exploring them and breaking them accidentally • New and different toys are appreciated • May lose things easily, even most treasured possessions, and may be unable to accept any responsibility for the loss • May deliberately destroy emotionally significant possessions when angry

2. Play

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

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
2. Play	2.1 Poor turn-taking and poor losing	• May try to impose own rules on games • May see eventually losing a game as unfair if was winning earlier in the game • Preference for playing alone or in parallel with others • Interests may be not be age appropriate and narrow.	• May try to impose own rules on games so that they win • May be angry or upset about losing games and blame others or the equipment for their failure (there is a sense of fragile self-esteem in the style of reaction) • Preference for playing with others who can watch them win • Interests are more usual/age appropriate but response to the activity is emotionally driven.
	2.2 Poor play with toys	• Plays with toys as objects rather than personifying them • May spend all time organising toys and arranging in patterns (e.g. ordering by size, colour) • May 'play' with unusual things (e.g. reading the telephone book, watching water run down the drain) for long periods from a young age	• Uses possessions & actions to engage the attention of other children • May play games which include own experience of traumatic life events and difficult relationships • May have poor concentration on activities and be able to play alone only for very brief periods (or be able to be alone briefly)
	2.3 Poor social play	• Dislike and avoidance of others joining in play • Lacks interest in social play with parents/carers	• Relies upon adults to provide play opportunities and/or to direct play • May prefer to play with adults (esp. carers) rather than children

	2.4 Repetitive play	• Lack of interest in developing a range of play • Strong preference for the familiar and tendency to play alone for long periods	• Plays repetitively with adults much as a toddler likes to play such as hide and seek, lap games • Plays out past experiences and preferred endings repeatedly (e.g. escaping from danger, saving siblings)
	2.5 Poor imaginative play	• Difficulty playing a variety of roles within games • Difficulty incorporating a range of toys into the same game (e.g. using both Dr Who and Spiderman toys in a game) • Preference for toys which have a mechanical rather than emotional nature (e.g. cars, trains, Lego) or which require logic and order (e.g. reviewing and organising collections of objects) or examining objects (e.g. watching spinning objects)	• Difficulty ending role play games • May be able to take various roles but may show a strong preference for a kind of role (e.g. always the baby, always the angry father) • May not seem to enjoy solo imaginative play and lose interest but can play imaginatively with another person

3. Social interaction

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

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
3. Poor social interaction	3.1 Difficulties with social interaction 3.2 More successful in interactions with adults than peers 3.3 Own needs drive interactions 3.4 Lacks awareness of risk and personal danger in interactions with adults	• Interaction is usually one-sided and egocentric with little regard for the response of the audience • Does not often manipulate others emotionally except through angry outbursts (i.e. would rarely ingratiate self with audience) • May perform better in less emotional situations • Poor awareness of own role in interactions • Lack of social imagination – can't imagine what risks might be associated with certain peer /adult relationships (it can look similar to attachment in need to make friends)	• Seeks an emotionally expressive audience for interactions (e.g. seeks to provoke strong reactions in audience such as anger, sympathy, support, approval) • May make persistent attempts to interact with adults or older children rather than with age peers • May initiate interactions with others which allow them frequently to play the same role in relation to self (e.g. as the victim, as the bully). We need to look at the relationships and see what need it meets. In attachment it is likely to be meeting an emotional need, possibly to do with pleasing others.
	3.5 Difficulty sharing and working in a group	• Lacks awareness of the social expectation that the child will share (because the child does not understand or need the social approval of others) • May not realise the needs of others waiting for their turn	• Aware of the social need to share but anxious about sharing (especially food) and may refuse or hoard or hide possessions and food to avoid sharing • May take things which are important to others with awareness that this will be upsetting for the other person

4. Mind reading

Both groups have difficulties taking the perspective of another person and reading intentions.

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
4. Mind reading	4.1 Difficulty appreciating others' views and thoughts	• Rarely refers to the views of others	• May be manipulative (or overly compliant) and ingratiate self with adults/children
	4.2 Lack of appreciation of how others may see them	• Lacks awareness of other's views of self, including lack of awareness of 'visibility' of own difficulties (e.g. may volunteer to perform gym sequence even though child is very poor at gym) • Does not appreciate the information parents would like to hear about successes and enjoyment	• Inclined to blame others for own mistakes • Draws attention away from own failures towards own successes • May try to shape others' views of self by biased/exaggerated reporting
	4.3 Limited use of emotional language	• Rarely refers to the emotional states of self and others	• Hyper-vigilant with regard to particular emotions in others (e.g. anger, distress, approval) and often makes reference to these states • Poor emotional vocabulary

	4.4 Problems distinguishing between fact and fiction	• May not realise that cartoons, toys, animations and science fiction are not real • May not realise that fantasy play is a temporary role • May be easily influenced by fantastic claims and advertising • Lies are often easily discovered and 'immature' in style	• Tendency to see self as more powerful and able to overcome enemies, or as vulnerable and powerless to offer any challenge • May talk repeatedly of how to overcome captors/escape from imprisonment/kill enemies even when these adversaries are obviously bigger, stronger and more powerful than the child • May not be able to judge whether a threat is realistic and act as if all threats, however minor or unrealistic, need to be defended against • Lies may be elaborate and also may deliberately be harmful to others' reputations and designed to impress the audience

5. Communication

There are many areas of similarity in the social communication difficulties because they are about the subtleties of communication.

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
5. Communication	5.1 Pragmatic language problems	• Poor awareness of the purpose of communication • Lacks awareness of needs of audience • Does not repair communication break down • Poor eye contact (may be fleeting, staring, is not synchronised with verbal communication) • Proximity does not signal intimacy or desire for contact • Often does not start conversation by addressing the person • Conversation is stilted • The burden of communication lies with the listener/adult • Assumes prior knowledge of listener	• Lack of attention to the needs of the listener through poor attention to communication (due to poor modeling) • Eye contact affected by emotional state • May be overly sensitive to voice tone, volume and stance of speaker (hyper vigilant to potential emotional rejection) • Better able to initiate conversation • May be overly sensitive to voice tone, volume and stance of speaker (hyper vigilant to potential emotional rejection) • Non-verbal communication may be delayed (this includes reading of facial expressions & gestures) but progress can be good with intervention. This can vary depending on type of attachment difficulties. • Can be hyper vigilant; often described as manipulative because of poor emotional regulation
	5.2 Poor understanding of inferred meaning, jokes, sarcasm and gentle teasing	• Poor understanding of idiomatic language	• Gentle teasing may provoke extreme distress (self-esteem seems to be too fragile to cope) – internalise/assume it is about them • Poor understanding of idiomatic language (and may take misunderstandings personally).
	5.3 Use of noise instead of speech	• Makes noises for personal pleasure (as with favourite words) e.g. barking	• Attention-seeking noises (e.g. screams/screeches/whines under stress) to signal emotional needs and wishes

	5.4 Vocabulary	• May have word-finding problems • Often have unusually good vocabulary (for age, or cognitive ability, or within specific interest areas) • Less use of vocabulary related to emotions	• Often poor vocabulary range for age and ability • May use more emotive vocabulary (to get needs met) • Often poor vocabulary range for age and ability Acute by the time they get to adolescence. • May use more emotive vocabulary (to get needs met) Lots of basic negative vocab around anger, much fewer vocab items known to describe other emotions. • Can be stuck in 'street' style of communication and doesn't know how to change register depending on audience.
	5.5 Commenting	• Provides detail in pedantic fashion and gives excessive information	• Reduced amount of commenting behaviour

6. Emotional regulation

Although the behaviour may be similar, the causes seem to be different.

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
6. Emotional regulation	6.1 Difficulties managing own emotions and appreciating how other people manage theirs	• Extremes of emotion may provoke anxiety and repetitive questioning and behaviour • Does not easily learn management of emotions from modelling (also likely to need an explanation) • Poor recognition of emotions • Emotions take over from logic/knowledge of what one should do (e.g. when losing a game) • Does not show displays of emotion to everyone – discriminating between people and places (e.g. never has a temper tantrum in school) • Difficulties showing empathy even for significant others in life • Cognitive empathy is poor	• Difficulty coping with extremes of emotion and recovering from them (e.g. excitement, fear, anger, sadness) • May provoke extreme emotional reactions in others which tend to cast others in roles which are familiar from their own past experience of less healthy relationships • May be able to learn more easily from a non-verbal example than from talking • Shows emotional displays to people child does not know (indiscriminate) and tends to carry on longer (e.g. temper tantrums occur anywhere and at any time) • Difficulties showing empathy in general but can show better empathy towards a significant other • Highly tuned to non-verbal aspects of emotions
	6.2 Unusual mood patterns	• Sudden mood changes in response to perceived injustice	• Sudden mood changes related to internal states (e.g. to PTSD, flashbacks) and perceived emotional demands
	6.3 Inclined to panic	• Panics about change in routines and rituals and about unexpected and novel experiences	• Panic related to not having perceived needs met (especially food, drink, comfort, attention)

7. Executive function

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in ASD	Typical presentation in Attachment Problems
7. Problems with executive function	7.1 Unusual memory	• Poor short term memory unless well-motivated • Very good long-term memory with recall of excessive detail for areas of particular interest to the child	• Fixated on certain events • Recall may be confused • Selective recall
	7.2 Difficulty with concept of time – limited intuitive sense of time	• Rigid reliance on the using precise times (e.g. uses watch and unable to guess the time) • Waiting irritates child because it affects routine	• Time has emotional significance (e.g. waiting a long time for dinner is quickly associated with feeling of emotional neglect and rejection)
	7.3 Poor central coherence	• Inclined to consider the immediate context (not taking into account past experiences and emotional factors)	• Emotional bias leads to ignoring some elements of a situation (attention drawn to elements with emotional significance)

8. Sensory processing

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation of in ASD	Typical presentation in Attachment Problems
8. Problems with sensory processing	8.1 Difficulty integrating information from senses (e.g. lack of awareness of heat, cold, pain, thirst, hunger, need to urinate/defecate) and lack of physical problem solving skills (e.g. removing coat when hot)	• May be passive and quiet in acceptance of discomfort or may be distressed but does not communicate the source of distress • May be hypersensitive to some light sensations even when pain threshold is high (e.g. labels in clothes irritate but a bitten arm does not)	• Physical discomfort may be accompanied by a strong emotional reaction towards carer (e.g. anger and blame of carer for the discomfort) • Discomfort from basic needs may not be reported to carer (e.g. hunger, thirst) until they are intense • Discomfort connected with physical needs may quickly provoke irritability and distress and provoke the carer to work out and solve the problems for/with the child
	8.2 Unusual physical proximity	• Physical distance is unrelated to intimacy (e.g. they stand too close because they are unaware of social proximity rules)	• Shows awareness that physical closeness is related to emotional reactions (e.g. increases distance to signify rejection; seeks excessive closeness when anticipating separation)
	8.3 Self-stimulation	• Self-stimulation is likely to be related to own sensory needs	• May show sexualised behaviour or present in a sexual way to provoke reactions or to self soothe. • Self-harm is connected with emotional state