Improving Outcomes for People with Autism Accessing Psychological Support

A report for the Winston Churchill Memorial Trust

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Finally, perhaps the biggest thanks needs to be to **The Winston Churchill Memorial Trust** for their funding and support for this project. Without them this would still be an idea sitting at the back of my brain gathering dust. It has been am amazing experience, and one I will endeavour to share and spread as widely as possible.

Introduction

I can't remember the first time I heard the word Autism[1], but it was probably when I was about six years old, when my younger brother, Jack, was diagnosed with the condition. At the time, I didn't really pay much attention to it. I knew my brother was different, but I didn't really know how or why, and to be honest, I wasn't that interested. He was my brother, and it didn't really matter. However, six years later while in the car, my dad put on a recording of a lecture by Professor Tony Attwood, one of the leading figures in Autism Spectrum Disorders. I was going through a lot of my own problems at school – I was being bullied, I wasn't attaining as high as I knew I could, and I just didn't feel like I was fitting in. Therefore, at the start of the journey I didn't really pay much attention. However, it was a long drive, and as I listened, I started to recognise a lot of myself in what he was talking about. At around age twelve I diagnosed myself with Asperger's Syndrome.

It wasn't until my diagnosis was officially confirmed some three years later, when the difficulties I was having at school led to a rapid deterioration of my mental health, that I started to take an interest in Autism. Part of this was thanks to my psychologist, who realised that I needed to learn to understand my own way of thinking if I was going to learn to cope with the world. However, I also took a more academic interest. Soon after my diagnosis, I was asked to present to a group of teachers about my experiences as a young person with Asperger's Syndrome in mainstream education. I therefore

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[1] I use the word 'Autism' here, and through the document to refer to the whole of the autistic spectrum, including Asperger's Syndrome, unless otherwise specified

thought that if I was going to tell teachers about this condition, I should probably read up on it. Over the next few years, I was asked to do more and more presentations on Asperger's Syndrome, and so my research into the field increased to match. One of the perks of speaking about the condition is that you get to hear other (better informed) people speak about it, and learn from them for free!

At age 18 I discovered my niche. I found a love and a passion for psychology, which fused well with my curiosity about Autism. I decided to pursue a career in Clinical Psychology, as it not only gave me the chance to help other people, but also allowed me to try and answer the questions I had about Autism Spectrum Disorders (ASDs). While at university, I received the contract for my first book, *Raising Martians,* which I wrote in my free time at university. I was also keen to get experience in Clinical Psychology, and managed to secure a part time job as an Assistant Psychologist to Dr Louise Connor, an independent Clinical Psychologist who specialized in Autism.

The summer before my final year at university, I was again working for Dr Connor. I spent much of my time observing her work with clients with Autism; looking at the strategies she used, and how she interacted with the clients. One day, she came back into the therapy room after seeing her last client out, collapsed onto the chair in exhaustion, and said "that was not CBT". She was right. I had been reading about CBT (Cognitive Behavioural Therapy[2]), and

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[2] Cognitive Behavioral Therapy is one of the dominant models of psychotherapy in the UK. Very simply, it is about challenging our thoughts by looking for evidence, and learning or re-training the body's response to certain stimuli.

while I had seen that what she was doing was clearly grounded in CBT, it was applied in a very different way. We talked, and she explained that CBT usually had to be adapted for people with an Autism Spectrum Disorder. This piqued my curiosity, and led me to research how therapy can be adapted for people with Autism Spectrum Disorders. There was very little written on this. As a result, it's not surprising that many of the people I met doing my talks had the same story: 95% of therapists they had seen had tried using CBT and it hadn't worked. For those where it had worked, the common factor was that the therapists had worked with Autism for decades, often almost exclusively, and had developed their own approach (based on theory and good practice) on how to apply psychotherapy for people with Autism. That being the case, how was an NHS Psychologist who had minimal experience of Autism to know what to do? Clearly, there was need for guidance on this issue, and for people to start sharing what works.

It was not like this was a small problem either. The number of people being diagnosed with Autism is currently at 1 in 100 (although more recent research suggests the number of people with Autism could actually be much higher). However, people with an Autism Spectrum Disorder are far more likely to have a mental health problem than people without Autism. In a sample of 112 children with Autism, Simonoff et al (2008) found that 71% had at least one mental health condition, with 41% having two or more. Extrapolating this, within the UK there are almost half a million people with Autism and a comorbid mental health condition, requiring specialist support (0.71%). However, in Child and Adolescent Mental Health services, for example, only

16% of services had any targeted provision for young people with Autism (Wistow and Barnes, 2009), and people with Autism only made up 9% of their case load.

Around this time, my book was almost ready for publishing. The owner of my publisher, Jessica Kingsley, was keen to get Tony Attwood to write the foreword to my book. Tony is generally considered the world expert on therapy and interventions for people with Autism, and so having his name on my book would be a big boost. When he sent me his draft, I took the opportunity to ask him about how CBT needed to be adapted for Autism. The ensuring discussion led to him suggesting that I come out to Brisbane, Australia, to observe the work he and his colleagues do. Unfortunately, the cost of travelling and living out in Australia for any length of time was prohibitively expensive for a final year undergrad with heaps of student loans and planning on using what was left of my savings for a Masters Degree.

A year later, while preparing a joint talk with an old friend, Jane Vaughan, I mentioned Tony's offer, and that I was unable to afford to take him up on it. She immediately thought of her friend, who had just got back from a trip abroad, funded by the Winston Churchill Memorial Trust (WCMT). After doing a bit of research, it seemed like I had the perfect question and project to apply for a WCMT scholarship. A few weeks later I applied, and the rest, as they say, is history…

Disclaimer

Disclaimer (professionals): This document is not a substitute for professional training. I hope that professionals will find useful information and ideas on how they may adapt or improve their practice. However this needs to be done under appropriate supervision, backed up by additional research, <u>and prioritising sound clinical judgment</u>. Reading and applying this document does not make a clinician an expert in working with people with Autism, nor qualify them to do so. This document is purely a resource to support existing good clinical practice.

Disclaimer (non-professionals): This document is not a substitute for professional advice, and should not be prioritized over it. The mental health issues co-morbid to Autism can be profound and highly complex, and require specialist support from an appropriately qualified professional. If you are reading this with reference to a person with Autism with a suspected mental health issue, I <u>strongly</u> urge you to talk to your GP. However, some of the ideas and techniques included in this document may be useful for supporting people with Autism with <u>non-clinical</u> mental health issues.

The Project

Aims

The main aim of this project was to learn how psychotherapies (predominantly CBT) can be successfully adapted and applied for people with an Autism Spectrum Disorder. The idea is that this report will be useful for both parents and professionals in providing ideas and suggestions to improve the wellbeing and mental health of people on the spectrum. It should be remembered that at the time of writing, I am only an Assistant Psychologist, and so much of what I have gained from this trip is experience based. It is therefore impossible to provide you with a manual of how to approach psychotherapy with people with Autism. However, I hope that professionals and parents alike will find within this report a collection of ideas, strategies, tips and resources that will help them in working with people with Autism.

Schedule

On the 17th of January 2014, I arrived in Brisbane, Australia, and three days later, my project commenced. For eight weeks, I followed a reasonably regular schedule.

Mondays

Most Mondays, I left Brisbane and commuted out to Petrie, to Tony Attwood's private home clinic. This was where I observed the broadest range of clients, often with the most complex histories or presenting issues.

Tuesdays

Tuesday mornings I would sometimes again be observing Tony, this time at the Minds and Hearts clinic, but with a similar client group to Monday. Tuesday afternoon would start with the team meeting. This would either be a case or research presentation from one of the clinicians, or a presentation from an outside group with whom the clinic often interacts (such as assisted employment agencies). Following this, I would spend the rest of the afternoon observing Dr Louise Ford, a Clinical Psychologist with many years' experience working at Minds and Hearts, and a real passion and gift for working with children, who we predominantly saw. Finally, in the evenings, I observed Tony Attwood and Michelle Garnet (the director of Minds and Hearts) conduct a new group therapy programme for adults with Asperger's Syndrome and comorbid depression.

Wednesdays

Wednesdays I observed Sally Williams, another highly experienced Clinical Psychologist who has worked for years in the area of Autism, both in Australia and Ireland. She is an exceptional clinician, who really 'gets it' when it comes to Autism, and has a wealth of simple, concrete strategies which she expertly applies, some of which I hope I have captured in this report. On Wednesdays, I observed Sally with children, adults and couples, presenting with a range of issues. These sessions tended to focus on ongoing skill building and problem solving, although several clients came for more intensive work on a specific chronic issue, such as social anxiety.

Thursdays

I spent most Thursdays with Elizabeth Elliot, a Clinical Psychologist who was particularly experienced in Mindfulness [3]based therapy. Because of this, she often saw clients who were extremely anxious, meaning my opportunities to observe clients were limited, due to our need to put the client and their needs first. However, I did get to observe a range of adult clients with her, and therapy ranging from classic CBT to an entire hour dedicated to mindfulness meditation.

Fridays

I spent Fridays with Sally Williams, this time focusing on diagnosis of both children and adults. Here I got opportunities to assist in parts of the diagnostic assessment, as well as discuss and debate the formulations and diagnosis with Sally.

Saturdays

On Saturdays, I assisted in facilitating three groups, Friends Club (4-6 year olds), Exploring Friendships (7-9 year olds), and Exploring Feelings: Anger and Anxiety (8-12 year olds). I will go on to talk about these groups in more depth later in this report.

Sundays

Sundays were my day off, which I used for exploring Brisbane, as well as talking to two parent groups about my experiences in the UK.

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[3] I talk more about mindfulness later. In short, Mindfulness is about accepting thoughts and feelings, but not analyzing them; letting them pass without any judgment or elaboration

Minds and Hearts

The following is a summary based on "Minds and Hearts: Best Practice Guidelines for Supporting Adults with Asperger's Syndrome", a report written by Dr Michelle Garnett, the director of Minds and Hearts. This document is available for free from the Minds and Hearts website resources section (http://www.mindsandhearts.net/index.php/resources/referral-list-and-useful-articles). I strongly recommend this article to any clinicians wanting to know more about best practice service provision for people with an Autism Spectrum Disorder. This includes the structure of service provision, and recommendations for diagnosis and ongoing support.

Also available at the above address are articles on how to manage an angry episode, how to address bullying in individuals with Asperger's Syndrome, an article explaining Asperger's Syndrome, and an article to assist with explaining the diagnosis. While these articles are primarily aimed at clinicians, they may also be of use or interest to parents of children or adults on the spectrum.

About Minds and Hearts

Minds and Hearts: A Specialist Clinic for Asperger's Syndrome and Autism, is located in Brisbane, Australia. It is staffed by 13 Clinical Psychologists, many of whom have extensive experience with Autism Spectrum Disorders, and all of whom receive regular training and supervision from world leaders in delivering psychological services for people with Autism. In addition, the

service regularly has clinicians come to observe the practice, and provides placements for those undergoing training as a Clinical Psychologist.

At the time of opening, in late 2005, there was a wait of approximately two years to access specialist services for people with Autism. It was therefore hoped that Minds and Hearts would not only cut waiting times for Autism specific services, but also provide a hub from which experts in Autism can share knowledge, collaborate on complex cases, and devise new therapeutic programmes. In practice, it has also aided in the identification of high quality Autism friendly services whom they can refer to (e.g psychiatrists, speech and language therapists, employment services, etc). Since it's opening, it has expanded greatly to its current state, and maintains a rolling waiting list of clients.

It is worth noting at this point that Minds and Hearts exists within a very different health service to that of the NHS, or even private practices in the UK. While public hospital service is free, within Australia out of hospital treatment is not free (with the exception of those on low incomes). Instead, patients without private healthcare insurance are free to choose their healthcare provider. If that healthcare provider is registered with Medicare, then 85% of the cost of treatment will be charged to Medicare, with the remaining 15% of the balance covered by the client. Within Minds and Hearts, Medicare covers the cost of six sessions per year. This can be extended by GPs to 10 sessions per year in total. These sessions can be used for diagnostics, group sessions, or ongoing therapy.

Overview of services and frequency of contact

The core work at Minds and Hearts is undoubtedly individual therapy. However, the scope of individual therapy goes beyond the treatment of co-morbid mental health conditions (such as depression or anxiety) and includes areas such as:

1) General emotion management

2) Developing daily living skills

3) Developing self identity

4) Management of central issues within AS, such as

     a. Sensory processing difficulties

     b. Executive functioning/problem solving difficulties

     c. Social skill development

Following on from this, therapeutic work at Minds and Hearts can be broken down into three main categories.

1) Problem solving or crisis appointments. These are offered on an as-needed basis, with clients being pushed to the top of a clinician's cancellation waiting list. In the case of a crisis, clinicians would occasionally extend their hours in order to see the client. These sessions would aim to either provide an immediate resolution or strategy to solve a problem, or if this could not be done, ongoing regular therapy in the next available regular slot. These sessions would typically be triggered due to an unpredicted change in the client's environment, where existing coping strategies failed.

2) Ongoing therapy stream. These were regular appointments every one, two, three or four weeks. In practice, I observed that these can be broken down into two further categories

    a. Weekly and fortnightly appointments would usually focus on a specific, current, pervasive and/or disruptive issue that required intensive work. Often this was a comorbid mental health issue or emotion management. Therapy was therefore focused on this specific issue.

    b. Appointments every three or four weeks (and, to an extent, some fortnightly appointments), tended to be focused on ongoing support. This included building skills (including social skills, life skills, and emotion management skills) and strategies (for executive functioning or sensory processing difficulties), identifying and solving problems before they occur, improving family communication and understanding, and developing self-identity and self-esteem. These sessions were therefore often less focused on a specific issue, and while some work may have a current objective (such as building social skills), a much broader approach was taken. This allowed clinicians to work on a number of skills, and adopt a more person-centred rather than problem-centred approach.

    Note: While therapy was not originally designed to follow this format, because clients could often only have up to ten sessions

subsidised, they often opted to spread these over the year, as

this allowed them to have the security of always having another

session coming up. In addition, staff found this to be of

therapeutic benefit, as it allowed clients more time to think

about, internalise and generalise what they had discussed in

therapy. It also provided greater material for the therapist to

identify problems needing solving and skills needing building.

3) Monitoring. These tended to be one to four times a year, but could also be 'as needed'. For example, a client may not come to the clinic for several years, until they are due to change school, and the parents want some support strategies for this transition. These sessions can be thought of as an MOT test, and would focus on charting progress over the years, identifying the major, predictable upcoming challenges (such as moving school, finding work, making friends, romantic relationships etc), and providing strategies for preparing for or tackling these issues. These often had a small therapeutic component, focusing much more on psychoeducation[4] and practical suggestions.

This flexible, client centred approach to the timing of therapy is arguably similar to rehabilitation models used in psychological and occupational therapy. This is a stepped approach to psychological care aiming first to provide intensive, reactive support for specific issues when needed, but reduce to proactive skill building, and eventually long-term monitoring. The

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[4] Psychoeducation is a psychology term, which just means teaching people about psychological theory, and how it applies to their daily life.

environment in which people with Autism find themselves is based on non-autistic needs and wants. It is therefore by definition not an environment to which they are automatically adapted. As such, people with Autism will require ongoing support to adapt to this environment as both they and their environment change both second to second, and year to year. Arguably, this is habilitation, rather than rehabilitation, as a person with Autism was not originally well adapted for a non-autistic environment, but is able to cope, contribute and flourish given the right support.

Although the content of sessions may progress in the same fashion for younger children (i.e. crisis, ongoing therapy, then monitoring), younger children tended to have more frequent appointments than adults

People with Autism have difficulty with generalizing what they have learned. Giving them more time between sessions gives them greater opportunities to understand and apply these skills. However, it is worth noting that for generalization to occur, they may need prompting, and reminding of what they have been taught between sessions. This can often be achieved through a parent, partner or mentor who is involved in therapy. It is also important to ensure the client has notes from therapy to take away with them, to remind them of what they have learned, and help them to apply it.

Just because a client with Autism no longer suffers from, for example, depression, does not mean that they no longer require psychological support – whether that is emotional support, or more autism specific support. As

previously discussed, people with Autism may require intermittent, regular or constant help to adapt to an environment that is not suited to them. I would therefore suggest clinicians consider, **where clinically appropriate**, offering ongoing, less regular sessions to clients without a comorbid mental health problem (i.e. depression or anxiety). This would allow clinicians and clients to build valuable skills and self-support strategies. This has the potential to reduce stress and improve quality of life for both the client and those around them. This would reduce the likelihood of relapse of mental health problems, and may mean the client requires less support from other services in the future. Finally, once skills and self-support strategies have been acquired and are being generalised, once or twice yearly appointments to 'check in' may also be of significant clinical and personal benefit. This would allow the clinician, client and loved ones to identify upcoming issues and strategies, thereby preventing crises forming, which may require more intensive support.

Structure of individual therapy

It is worth noting that while I have called this "individual therapy", often children and young adults would be accompanied by parents, and adults accompanied by partners. This had several benefits:

1. It provides an alternative opinion or way of seeing a situation, which can be used to help the client understand alternative perspectives, either as social skills training, or as part of a CBT intervention

2. It provides a chance for parents or partners to understand their child/partner, and their way of thinking

3. It provides a second person who can remember what was talked about, and prompt the client to use these strategies between sessions.

4. Often parents or partners were seen separately for 15-30 mins before or after the session. This allows them to bring any worries or concerns they have that they were uncomfortable voicing in front of the client, and in the case of children, information about the broader family/work context. Perhaps most importantly, during this time therapists would often provide containment[5] for parents/partners, validate feelings, and suggest strategies specifically designed to help them.

5. It enables the person to attend and engage in therapy. This could be due to practical reasons (such as providing transport) or emotional reasons (such as providing confidence)

In addition to 'individual' therapy, Minds and Hearts also conducted specifically designed couples and family therapy, as well as diagnostics. However, I am assuming that the reader is looking for strategies to help with ongoing therapy with a person with Autism. Therefore, as diagnostic tools already exist for Autism Spectrum Disorders, I will not be going into detail on this area. Equally, I will not go into depth on couples or family therapy as this is a more specialized area, and one which I have less experience of. However, I hope that much of what I discuss later with regards to individual therapy will transfer well to both these settings.

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[5] Containment is another psychology term. This just refers to providing an empathetic safe space for a person to express their thoughts and feelings, without judgment. The idea is that a person should feel their feelings are being "contained", validated, and understood.

Groups

Minds and Hearts regularly develops and runs groups. While some of these are designed to tackle already present issues (such as depression), many are preventative, such as social skills groups for young children. This is another example of the clinic's dual focus on both restorative and preventative work. Groups are discussed in greater depth later in this report.

Non-therapeutic services

While the core of the work at Minds and Hearts is undoubtedly ongoing therapeutic and diagnostic work, the clinic is active in providing training and psychoeducation. For professionals, the clinic runs a four-day intensive course for doctors, psychologists and other allied health professionals. This is in addition to regular, smaller training events around Australia. For parents and people on the spectrum, it provides monthly information nights, presented by staff on a number of topics, from diagnostics to moving to employment. Finally, the clinic also produces a quarterly newsletter with information and a reader friendly digest of recent research, as well as information about their upcoming information nights.

Self Identity, Motivation and the 'This is Me' book

Autism and Self-Identity

Several clinicians, including those at Minds and Hearts, have observed a tendency for people with Autism to have a poor sense of self-identity. Often when asked to define themselves, people with Autism use a job title, or words others have used to describe them, as opposed to a defining set of beliefs about oneself. Tony Attwood suggests this is a reason why many people with Autism are susceptible to low self-esteem through teasing. People without Autism may attribute being called "gay", "psycho", or "stupid" as being a malicious attempt to insult them, or put them down. However, if someone has a poor self-identity, as suspected in Autism, then there is no pre-existing, well-defined identity or set of beliefs with which to counter what this person says. Combined with difficulty understanding why someone would lie, this can lead to people with Autism questioning their sexuality[6], believing they are mentally unbalanced, or not intelligent.

There is research to support these observations. Crane and Goddard (2008) found that people with Autism appeared to lack a reminiscence bump. The reminiscence bump is a marked increase in the number of autobiographical memories (memories for past events that happened to us), which occurs from mid adolescence through to early twenties. Since autobiographical memories play an important role in self-identity (Wilson and Ross, 2003), the

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[6] It is worth noting that this works both ways. For a people with autism who identify as homosexual, lack of acceptance from others can also lead them to question their sexuality, again leading to a negative self-identity

reminiscence bump is theorized to be important in the construction of self-identity (Erikson, 1980). Its absence in Autism could therefore support the suggestion that people with Autism have difficulties forming a self-identity, or are delayed. Equally, Milward (2000) found that children with Autism appeared to better recall events that happened to other people (other referent), than events that happened to themselves (self referent). This again could cause difficulty for a person with Autism in creating a self-defining narrative of their life, and who they are.

Impact of lack of Self-Identity

Self-identity may also have an impact on motivation. Motivational Interviewing (Miller and Rollnick, 2002) argues that for a person to change, they have to want to change (which involves imagining the future, potentially another issue for people with Autism), and self-efficacy – the belief that they can change. However, if a person with Autism has a poor self-identity, then how are they meant to believe they can change the person they are, when they don't know who they are to start with? If they have difficulty recalling past successes (due to poor autobiographical memory), where is the evidence to give them the confidence that they can succeed at this? It may therefore be necessary to do some work on self identity, before any 'standard' CBT work can begin.

The "This is Me" book: Introduction

To try and improve self-identity, Tony Attwood and colleagues devised the "This is Me" book. This is a short exercise that can be done in a clinic setting (lead by a psychologist as facilitator, with input from the client and one or

more family members/friends), but can be accomplished at home, with another family member acting as the psychologist.

The "This is Me" book: Phase 1

The first phase of the exercise is a piece of collaborative work between client, facilitator, family and friends. On a large piece of paper (or some other format which allows everyone to see what they are writing), the facilitator divides the page into two vertically. One side is labelled "Qualities" and the other "abilities". Working together, the group comes up with ideas for different *positive* qualities and abilities to fill each column. Some clients (in particular those with depression) may find it difficult to come up with examples. Here it is particularly useful to have a parent, partner or close friend in the session, so that they can help find examples that the facilitator may not be aware of.

Example

Qualities	Abilities
Kind	Good with computers
Generous	Very good at maths
Funny	Football (not on the team, but enjoys
Trusting	playing it)
Energetic	Good at DIY
…	…
…	…
…	…

Some clients (and friends and family), depending on their ability and mood may come up with a large number of qualities and abilities. Others may only be able to come up with a few. Once the facilitator is satisfied that it is unlikely anyone else will be able to think of any more in the immediate future, this phase of the exercise ends.

The "This is Me" book: Phase 2

The second phase of this exercise involves the clients obtaining a scrapbook. On the first page, each quality and ability is listed, to become a contents page. Each double page spread after that is headed with one of the qualities or abilities, and becomes a page dedicated to examples of this quality or ability.

From this point on, the client (with help/prompting/pointing out from those involved in brainstorming) starts to fill each double page spread with examples of that quality or ability. These could be written, photographs, mementos – anything which reminds the person of an incident where they showed this ability or quality. Over time, more qualities and abilities may be 'discovered', added to the contents page, and given their own double page spread to be filled in. The idea is that the client should end up with a working document, which is constantly updated with examples of their qualities and abilities, that serves to re-enforce a positive self-identity. In addition, given the difficulties people with Autism have in creating self-referent autobiographical memories, this book can help support a narrative of self-referent memories, helping the creation of a self-identity.

The "This is Me" book: Phase 3

The final phrase of the "This is Me" book involves identifying a hero or role model who the person looks up to and admires. This could be a fictional character (e.g Batman, Sherlock Holmes), a person in the media (e.g Bill Gates), or a friend or family member (e.g Granddad). The important thing is that this is a positive role model, who the client admires and aspires to be more like. We then, again as a group, start to brainstorm examples of what qualities and abilities that person demonstrates (with the exception of superpowers!), and how they demonstrate them. For example, Bill Gates is smart because he can programme computers.

Within the "This is Me" book, a separate section is created. In it, there is a list of personal qualities and abilities that this admired person has (ideally, backed up with articles/photos/pictures demonstrating them). In the pages following this, examples are collected of when the client demonstrates these qualities their role model has, and which they are aspiring to. For example, one of Batman's qualities might be that he sticks up for people who need help. Therefore, there could be a double page spread entitled "sticking up for people who need help", which starts to get filled with examples of when the client has done this, such as by telling a teacher when he sees someone being bullied. Some qualities that the role model has may already be qualities the client has demonstrated. In these cases you can either refer back to already created page, or create another, focusing on how each example of when this quality was demonstrated was like something their hero would do.

In doing this, the person is able to get an internal positive view of themselves. The role model may not be relevant to other people, but it is very meaningful for the client, and seeing pre-existing similarities between themselves and that person can provide internal validation of who they are. Equally, seeing themselves progress to be more like this person again provides positive internal feedback, as well as a sense of control over themselves, as they are choosing who they want to be like.

Emotional Thermometer

Theoretical Background

For me, one of the most exciting series of papers to come out in the last few years have been by Ami Klin and his team at Yale. One study, published in *Nature* in 2009, showed infants images of Biological Motion.
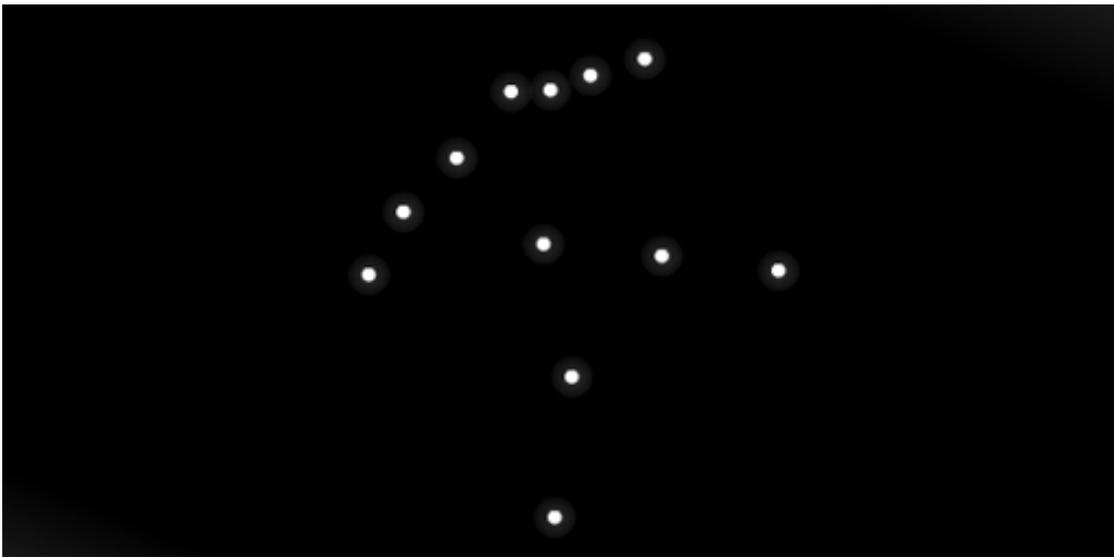
People may be familiar with biological motion from the behind the scenes clips from movies that use a lot of CGI. In short, ping-pong-ball-like objects are attached to various key points in the body. A computer then films the person move around, and records the location of these ping-pong balls, removing all the other information. You end up with a moving image like the one above (of someone balancing on one leg).

The interesting thing about biological motion is that people can naturally put these dots together and make a person. However, when the image is

inverted, our brains don't recognise it as a person, rather a set of randomly moving dots.

Ami Klin and the team showed two year olds with and without Autism a video (with audio) of the biological motion of someone introducing themselves and a teddy bear, and of someone playing patty-cake. At the same time, they showed the children the same video, but with the image of biological motion inverted (so it wouldn't look like a person), and played backwards, so it wouldn't sync up with the audio being played. They then used eye-tracking software to see if the children looked at the upright biological motion, or the inverted biological motion.

Neurotypical children spent more time looking at the upright biological motion than children with Autism – suggesting that children with Autism either had difficulty seeing the biological motion as a representation of a person, or it didn't matter to them that it was a person. However, on one video – the one of the game patty-cake, this changed. Suddenly, the children with Autism spent a lot more time looking at the upright video.

The team, rather perplexed, went away and started to run some fancy statistical analysis. What they found was that people with Autism were looking at the clapping. When the person clapped in the game of patty-cake, two dots collided, and this coincided with the sound of a clap. They suggested from this that children with Autism look for audiovisual contingencies – things where

visual and auditory things happen at the same time (in this case, two dots colliding and the sound of a clap).

A good every day example of this is mouths. When our mouths move, we are usually making sounds with them. Therefore, we might expect people with Autism to spend a lot of time looking at a person's mouth. An earlier study by Klin et al (2002) found exactly this. They showed 15 young adults with Autism, and 15 matched controls (people without Autism, but with similar IQs and ages) a movie, and used eye-tracking software to record where they looked. Consistently, they found that people with Autism tended to look more at mouths, as opposed to eyes.

The tricky thing is, so much of what we communicate about our emotions is done with our eyes. Simon Baron Cohen and the team at the Autism Research Centre, Cambridge (www.autismresearchcentre.com), created the RMET – the Reading of the Mind in the Eyes Test. Here, people are given a set of images of people's eyes, and four words describing their emotional state. They are then asked to choose which word matches the emotional state. Neurotypicals are able to do this with surprising accuracy, given that they only get a very small area of a person's face to pick up on emotional cues. However, people with Autism find this task much harder.

jealous   panicked

arrogant   hateful

If people with Autism are looking for audio-visual contingencies (i.e mouths) then they are going to spend less time looking at eyes. Because of the amount of emotional information within the area round the eyes, people with autism may pick up on significantly fewer emotional cues. This may not only make it hard to understand other people's emotions, but also their own.

Lisa Barrett (2006) uses the analogy of learning to see colours to understand how we learn about emotions. I might say to you that this piece of paper is white, and we might both call it white, but the qualia – the experience of whiteness – may be very different for me. What I see as white, you might see as blue, however we have labelled the colour of the page 'white' so we call it that.

Just like colour, there is no way to know that someone else experiences 'happy' the same way as you do. However, rather than using our eyes to detect colour, we read other peoples facial expressions. When we see a person have a smile on their face, we might recognise that in ourselves, hear them talk about being happy, and we start to build up a mental sense of what 'happy' is. We still don't know that what I call happy is what you call happy, but we know that they are probably similar experiences.

But what happens if you are looking at mouths, rather than eyes? Since so much of our emotional expression is through our eyes, rather than mouths, then this person is going to pick up on a lot less emotional information. They may therefore find it harder to understand exactly what another person feels. This would create the difficulty in picking up and understanding emotions in others that we commonly associate with Autism, but it will also make it harder for that person to build up their own emotional vocabulary to describe and understand how they feel.

Emotional recognition in clinical contexts

During my time at Minds and Hearts, and with Dr Connor, I frequently observed that a significant amount of work was done to develop an emotional vocabulary, before any sort of Cognitive Behavioural Therapy could be done. CBT relies on understanding how a thought triggers a feeling. However, if you have difficulty defining (and therefore recognizing) that feeling in yourself, then it will be impossible to engage in CBT, let alone communicate how you

feel feeling. Indeed, I have frequently heard people with Autism say "I don't know how I feel". Because of this, developing emotional recognition, and therefore an emotional vocabulary is important, not just as a prerequisite to CBT, but also for personal growth.

The CAT-KIT

Tony Attwood, Kirsten Callesen and Annette Moller Nielsen developed the Cognitive Affective Training Kit. This is an extremely well thought out and well validated resource for developing an emotional vocabulary, and I would highly recommend it for clinicians working with children or adults with Autism. Because this is a proprietary piece of equipment, I cannot go into the specifics of the CAT Kit, other than to recommend you go to www.cat-kit.com. However, the underlying principles behind the CAT-KIT were used extensively in Australia (and in some clinical work I have done in the UK), often without the CAT-KIT itself. Therefore, it is these underlying principles I will focus on my discussion.

Defining emotions: the components

How do you go about teaching someone to label and identify emotions? As discussed, ordinarily, someone would look at facial expressions to identify how other people feel, and then use that as a reference point for their own emotions. Therefore, can we do something similar in a structured, concrete, clinical context?

A good place to start is looking at different situations and the emotions they create. This is not only useful for gaining an understanding of ones own emotions, but also of the sort of things that can trigger those emotions. So, for example, you might go through a (written!) list of twenty or so scenarios for 'happy". These may be made up, but several may be real life situations that the person has encountered. The person may also have their own examples they want to use, which is even better!

For each one, you can discuss that situation, and get the person to assign it a rating out of ten. Some people find this particularly hard, and you may see clusters developing (a lot of 1's and 10s, a few 6's and 4s). While some situations will genuinely 'feel' the same in terms of intensity, it is worth comparing and contrasting these different situations, to try and create a detailed ranking. In the process, you may find there are other emotions at play too – that is fine, and it is worth writing down other emotions that are at play (so that the person feels they are acknowledged), but the rating is for the intensity of the emotion being discussed only (in this example, happy). The idea is that this will help the person not only identify different situations where they feel, in this case, happy, but also that there are degrees of happiness – something that can be hard to explore when you are used to black and white thinking!

Once each example has a rating, you can transfer them to a big picture of a thermometer, with each example placed at the appropriate height. This not only again helps with defining degrees of happiness, but also makes the

process very concrete, and easy to come back to. With the thermometer in place, we can start to attach labels to the 'degrees'. These labels can come in two forms. Firstly, verbal labels that we use in conversation. For example, for happy, we might have 'ok' 'ecstatic' 'elated' 'good' 'happy' ' joyful' 'cheerful', etc. Working together, you and the person can discuss where different verbal labels are best placed. Do these verbal labels match the example we rated earlier and put here? Would they describe themselves as 'elated' there, or is that too strong a word? What does the dictionary say? What does mum think?

We can also apply visual labels – pictures of different emotional expressions, all appropriate to the, in this case, "happiness thermometer". The important thing about applying visual labels here is that they give the person time to study, analyze and remember these emotional expressions. In the real world, they can last for only a moment before they are replaced, which doesn't give time for this process to happen. By providing emotional expressions, you can encourage and engage in an analytical process for understanding emotional expression, and what they might mean.

Now we have defined the stages of the thermometer, it is worth considering the thermometer as a whole. Cognitive Behavioural Therapy talks about "The Human Compass" – Thoughts, feelings, actions, and bodily sensations. So far, we have talked about the feeling (happiness), but what thoughts, actions and bodily sensations accompany it?

In the process, you may have already started to discuss the sort of thoughts that make that person happy – getting a new toy, getting 100% on a test, etc. This can be useful to help identify the types of situations where they feel happy, as well as help them to recognise the link between thoughts and emotions. To explore bodily sensations, you can draw an outline of a human body, and discuss and draw on different sensations that are associated with emotions. For example, speaking more softly, having lots of energy, smiling, butterflies in the stomach, feeling relaxed, etc. Like with thoughts, identifying bodily sensations can help the person pick up on more concrete cues about their emotional state. Finally, you can do the same for Behaviours – things like jumping up and down, running around, hugging people, eating more, etc.

General points

Throughout this section, I have used the example of happiness, as this is a good, positive emotion to build on first. This helps build motivation for the task, and aids in the creation of a therapeutic relationship. It also helps the person to relax, and understand what the process is getting at, which will help when talking about more difficult emotions.

When doing this, it is important to remember to make everything as concrete as possible. This involves writing things down, using pictures, images, diagrams, etc to create something which can be referred back to. This process does not automatically create an emotional vocabulary, rather it provides a starting point, a reference book, which will need to be used,

referred to, and updated as the person develops their emotional understanding.

It is important that the guide to this process is open and able to discuss their own feelings, thoughts, bodily sensations and behaviours. This is not only helpful in getting the person to understand the process and what is expected, but also provides ideas about the sorts of things they may need to consider for themselves.

Finally, as I said earlier, the CAT-KIT provides a much more structured, manualised process for doing the work described here and more. I would strongly advise referring to the CAT-KIT website for information, and consider whether the CAT-KIT would be of benefit when going through this work.

The Emotional Tool Box

Introduction

Throughout my time at Minds and Hearts, one of the core practices running through therapeutic and psycho-educational work was the use of the Emotional Toolbox. The underlying principles behind the emotional toolbox are not new. For example, Carr and McNulty (2006) outline Behavioural strategies such as exercise, social support, and distraction as strategies within the cognitive Behavioural framework. However, the Emotional Toolbox expands on these principles in a way that makes use of the autistic mindset and profile, while also making sometimes very abstract concepts concrete and therefore more accessible to people with Autism.

The number of tools in the tool box varied during my time in Australia, depending not just on the practitioner, but most importantly with the client, and what tools they engaged with and found helpful. Below is a list of tools.

- Physical Tools

- Relaxation Tools

- Pleasure Tools

- Thought Blockers *

- Special interests *

- Thinking Tools

- Social Tools

- Self Awareness Tools

Note: As will be expanded on later, Thought blockers, and to a lesser extent, Special Interests need to be used with care.

It is important to note that each tool is not a specific technique. For example, physical tools (often represented by a hammer) may be talked about as "one tool in the tool box", however, there are lots of ways to use this tool. For example, both jumping on a trampoline and playing football are physical tools. Clients were encouraged to brainstorm several techniques for each tool with the therapist, and try out a subset of these techniques. The aim is that, in the end, the client will have a list of tools. Under each tool are a few, proven, effective techniques for that individual, which can be used in different situations (for example, a physical tool for work, and a physical tool for home). This makes it concrete, provides a prompt, and also allows other people to remind and prompt the person to use their tools.

When to use tools

It is also important to choose the right emotional tool for the job. Just as you shouldn't hammer a screw, there are some tools that will only be effective at certain times. Negative emotional states, such as anger, anxiety and sadness, can be thought of as being on a thermometer with a scale of 0 to 10. Generally speaking, for scores of 0-3, tools such as Self Awareness Tools, social tools, and thinking tools (such as the cognitive side of Cognitive Behaviour Therapy) are appropriate. These tools are great at improving resilience; helping people to prepare for future emotional difficulties. However,

these require the person to be calm, relaxed, and rational, and therefore won't work when someone is feeling more emotional.

For scores of 4-7, people may still be calm, but are clearly not relaxed, and are likely to be thinking less clearly. Therefore, tools designed for this emotional state are designed to de-escalate the situation. Things like relaxation tools, pleasure tools, thought blockers and special interests are all good at this.

When a person is feeling highly emotional, 8-10, rational thinking is often hard, if not impossible. For people feeling highly anxious or angry, they will have a large amount of adrenaline in their system, which is causing them to fight (anger), flight (run away) or freeze (shutting down). When we lived in caves and had problems like "Mr Ugg has a bigger mammoth tusk than I do – I should really try and fight him for it" and "gee, that Sabre Toothed Tiger looks hungry", adrenaline was very useful. It increases our heart rate, primes our muscles and pours glucose into our system so we are at our physical prime, so we can fight Mr Ugg or run for our lives from the Sabre toothed tiger. However, in the modern day, neither of those responses is socially acceptable. So we end up sitting there and stewing. This isn't good for us physiologically (as all that glucose going around unused is bad for our bodies), but it is also awful for us psychologically, as it keeps us anxious, but unlike the caveman, we can do nothing to change the situation (i.e. We can't fight or run away). At times like this, the best thing we can do is use our physical tools – stuff that burns off that excess glucose, gets our body moving,

and uses up that adrenaline. The exception to this is, of course, sadness. Unlike anger or anxiety, depression is not accompanied by an excess of adrenaline. However, exercise does release endorphins that help to elevate mood, and so can still be a helpful tool in combating sadness.

It is important to note that with all of these tools, there is no 'lower limit' to when they can be used, only an 'upper limit'. For example, while I have suggested that relaxation tools are best between 4-7 on our emotion thermometer, they can be used from 0-7. This is because below 4, a person probably doesn't need to be any more relaxed, and you might be better off using a cognitive or self-awareness tool to build resilience. However, because relaxation tools require a certain degree of control, they aren't suitable beyond about 7. Physical tools on the other hand, can be used anywhere from 0-10, whereas cognitive tools are only between 0-3.

Physical tools

Physical tools can be used in two ways. The first is, as indicated above, to use up that excess adrenaline. This can be through anything active – running, playing sport, going to the gym, hitting a punch bag, etc – anything that uses up energy – even just going for a walk.

There are, however, some caveats. Firstly, it is important to remember that while sport can be a good example of a physical tool, it is competitive by nature, and losing a game, or following rules may not be something that this

person can handle, particularly if they are at 7 or more on their emotion thermometer.

Secondly, sometimes, particularly with anger, people find that standard forms of physical activity are not effective, as they lack a destructive element. For people who need a sense of destruction, crushing cans, ripping up a phone directory or old clothes, or destroying an old cardboard box can be helpful.

The second way to use physical tools is as part of a routine. Regular physical exercise is highly effective at improving long-term low mood, burning off anxiety before it gets to crisis levels, improving energy levels and improving resilience. However, unlike the first use of physical tools, which is a crisis solution to regulating mood, this is a long-term measure. As such, it requires physical exercise to be built into a routine. This might start at two thirty-minute periods of exercise per week, which get your heart pumping and make you break a sweat. Ideally, the frequency (and to a lesser extent, the duration) of physical activity would then be slowly increased up to a comfortable (but most importantly) sustainable level over a period of months.

As with any exercise, the user needs to enjoy the exercise (or at least, not dislike it). Getting an assessment by a professional personal trainer can be a great way to identify your personal physical strengths and weaknesses, and the sorts of exercises you may enjoy, and be able to build into your daily routine.

Relaxation tools

Relaxation tools, as with all the tools in the 4-7 area of the thermometer, help you relax. However, while most other tools in this area are somewhat unique and individualized, relaxation tools are techniques specifically designed to help you relax. Three of the most common techniques are listed here.

The first tool, breathing, is a technique people regularly talk about, but few do effectively. The idea of slow breathing is to tap into the body's physiology, and use that to tell your brain to relax. Slow, relaxed, deep breaths that expand your midriff, rather than your ribcage, do this. However, often people take deep breaths, and in doing so focus on expanding their ribcage. Breathing using our ribcage allows us to get air in and out faster, and so is great for when we are physically exerting ourselves. However it is terrible when we are trying to trick our body into relaxing, as it uses more energy, and is the sort of thing we do when we are anxious!

Another common mistake is breathing too fast or too slow. Regulating your breathing should not feel like holding your breath, rather, it should not feel rushed. Conversely, it should be slower than your standard breathing rate, and certainly not open-mouthed panting. Both starving your body of oxygen and panting will again push your physiology into being active, rather than relaxing it, and therefore the brain.

One good technique to practice breathing is to lie down, and place an (empty) plastic cup on your stomach, open side down. As you breathe, focus on

moving the top of the cup up and down through your breathing (this can also help focus the mind, and get it off spiraling thoughts!). It should move slowly but steadily, before pausing briefly at its maximum rise and fall. Be careful to make sure that the cup rises when you breathe in, and falls when you breathe out. It is surprisingly easy to 'breathe in' like you are about to take off your shirt in front of people. This lowers your midriff by pushing the diaphragm up into your rib cage, and expanding your rib cage. This leads to short, shallow breathes and isn't helpful.

The next tool is Progressive Muscle Relaxation. This involves slowly working through groups of muscles, tensing all the muscles in that area as much as you can (without causing cramp/physical discomfort/damage) for a moment, before relaxing all of those muscles. When doing this myself with clients, I usually work through 10 muscles groups (toes, lower leg, upper leg, stomach, chest, hands, arms, shoulders, neck, face), and hold each group for about three to five seconds. This is best done with eyes closed, when either lying down, or sitting upright on a chair, with both feet on the floor. As you go through each muscle group, try and focus on the feeling of tensing, but importantly the feeling of relaxing in each muscle group after tensing.

The last tool is guided imagery. This is very simply an external voice (such as a therapist or CD) talking a person through a guided story. This could be something as simple as lying in a meadow, or an elaborate psychedelic fantasy. However, both focus on small details (things you might not think of automatically, such as the changing colour of the sky, the sound of rabbits

nibbling grass), and are (most importantly) relaxing, rather than exciting or scary. There are a lot of guided imagery audio CDs and transcripts of audio CDs available online.

Pleasure tools

These will, as you would expect, vary hugely from person to person. For me, a pleasure tool is looking at the stars at night, breathing the cool night air, riding horses, etc. The key thing is to remember that this is a tool. Therefore, it is not enough just to say to someone who is stressed to "use your pleasure tools" or "do something you enjoy" – that is obvious. What makes this a tool is that it is a list of pleasure tools, which have been tested, and there is at least one tool for each common environment the person might find themselves in. For example, there is no point telling someone who doesn't like cats to stroke a cat. Equally, there is no point telling someone at school who likes cats to stroke a cat when there are no cats around!

Thought Blockers

Thought blockers are arguably a type of pleasure tool. However, these act a bit differently to other pleasurable activities. Whereas most pleasure activities might be a pleasant distraction, they are not a permanent block on negative thoughts. Thought blockers, on the other hand, are forms of escapism. These work by filling up our attention with the thought blocker, stopping anything else (such as worries) getting in. It is a bit like putting a plug or bung in to stop water – nothing else can get through to our attention because this completely consumes our attention.

The escapism thought blockers provide isn't always bad. Everyone enjoys some escapism – you only need to see the commuters on the London underground with their nose in a book, or with headphones in their ears, to see that. The difficulty is that when used too much, they stop being a temporary measure, and start to become avoidance of a problem. However, by avoiding the problem, the problem is highly unlikely to go away, meaning you will have to keep avoiding the problem, and completely disappear into a thought blocker. Therefore, while in the short term (i.e. minutes to hours) thought blockers can be a functional coping strategy, allowing you to get yourself in a better frame of mind, in the medium and long term, they are highly dysfunctional.

Thought blockers can even become so dysfunctional as to become an addiction. If the only way you have ever solved problems is to ignore them, and disappear into a fantasy world, then they will become the only mechanism you ever use. Problems will build up higher and higher outside this fantasy bubble, causing someone to retreat further and further into it until it eventually collapses, and a person is left unable to find an alternative coping mechanism for all the problems they find themselves in. Thought blockers can also be expensive, and lead to a very disrupted sleep-wake cycle.

So what are thought blockers? One of the most common examples of these is computer games. These games usually employ psychologists to make the games highly playable. They do this by using the same principles as are used

in casino gambling machines, except rather than spending your money, you are spending your time. Whereas a casino game makes you think "maybe next time it will pay out" "I'm due for a big pay out soon", etc, a computer game is designed to make you think "five more minutes and I will have finished this achievement", "if I spend another hour, I'll finish this quest", etc. Internet browsing and TV are two other common examples of thought blockers. Again, here, there is an element of "just a little bit more" of something that fully consumes your attention.

It is important to note that I am not saying that thought blockers should not be used, or that you need to stop your children playing computer games. However, **if** someone has difficulty disengaging from such activities (remember – what might be a thought blocker for one person might not be a thought blocker for someone else), then strategies may be needed to help someone disengage and move onto the next task. One good strategy to help with moving on are Time Timers. These are available both as a physical product, and as an app. However, both versions provide a countdown timer, which provides a visual representation of how much time is left, and alerts the user when the time is up (and can provide a warning if needed). This is helped when there is an engaging task to move onto, which can help the person stop thinking about how they were *almost* at the next level. Equally, having a visual schedule showing how long the thought blocker can be used for, and what the next task is, can be very useful. Finally, given thought blockers require little to no effort to engage in, scheduling a difficulty to engage in task (such as homework) after a thought blocker is unlikely to be

successful. You may need to wean that person off the thought blocker with an engaging, but less fun task first.

Special Interests

Special interests, like thought blockers, are arguably a type of pleasure tool. Like pleasure tools, these are a pleasurable distraction. However, unlike other pleasure tools, special interests often provide a sense of security or control. Speaking from my own experience, there is something very comforting about knowing the answer, knowing how something will work, and being the smartest person in this particular area.

Special interests can, at times, function as thought blockers, as they are very distracting and pleasurable, and can prevent us thinking about the demands of the world. However, unlike thought blockers, I would argue that special interests do not have the same 'casino psychology' behind them, or at least not to the same extent as, say, a computer game. However, they can still be harder than most other pleasure tools to disengage from, and similar strategies to those used for thought blockers may need to be implemented.

Thinking tools

Technically, all of the tools described within the toolbox are established parts of the menu of Cognitive Behavioural Therapy. However, this section is arguably the bit that people will tend to think of when they think of "psychological therapy". It is important to recognise that while many people with Autism Spectrum Disorders are highly intelligent, they are often visual,

concrete, and very exacting thinkers. The cognitive part of thinking tools is rhetorical, often more metaphorical or philosophical, and works in shades of gray. As such, this can be harder to use therapeutically with people with Autism, but certainly not impossible.

Thought needs to be given to the individual's strengths and weaknesses. In particular, I have frequently observed (and come into contact with) clients who have learned how to appear as if they 'get' what you are saying, but in fact don't understand. This is a common coping strategy for people with Autism (and one I have used myself). Therefore, it is vitally important to check understanding regularly, for example, by asking a question based on the information just given.

It is also important to remember that people with Autism have difficulty generalizing learning. Therefore, a client may leave you thinking they are going to be able to successfully apply a piece of learning, but may come back having not used that learning because they didn't know how to apply it. Therefore, you may have to regularly revisit old topics – two steps forward, one step back. Equally, while homework is an important part to CBT many programmes, these are especially important in clients with Autism, given their difficulty generalizing.

Finally, it is worth remembering that many of the thinking tools used in this section require some emotional self-awareness and understanding. Often, this

is lacking in individuals with Autism, and so preparatory work may need to be done to understand emotions better, and build a vocabulary.

At its heart, Cognitive Therapy (i.e, the C bit of CBT), is about changing your perception. Philosophically, it argues that it is not events themselves that make us happy or sad, that make us jump for joy or run out in a rage: it is our perception of those events. You may look at a split bin bag with disgust, but for a fox or a fly, it's dinner. You may be angry that your flight has been delayed, but the passenger running up to the gate who thought he had missed the flight is probably delighted.

Let's imagine your New Year's resolution has been to lose weight, and so you have maintained a strict no chocolate diet. However, come Easter, the urge becomes too great, and in a moment of pure oral ecstasy, you demolish an entire Easter egg. From this, you may have many very different interpretations. Here are two

> *"Oh god, I've broken my diet. How could I be so weak and stupid –*
> *I've probably gained four pounds already, and I worked so, so hard*
> *to burn them off. All that work for nothing. I'm a complete failure, as*
> *clearly I have no willpower. Well, since I'm fat anyway, I might as*
> *well go to the supermarket and buy up all the post-Easter*
> *discounted Easter eggs – it's not like it's going to make any*
> *difference now.*

"aaah, that was amazing. I've not had chocolate in four months! I think I earned that little treat. Back to the diet now of course – I wonder how many other people from Weight Watchers *will have given themselves a treat over Easter? Maybe I won't be the only one who has gained a pound or two this week!*

These are two very different interpretations of the same event, each of which leads to very different emotions and actions. The tricky thing is, our interpretation of events is usually instantaneous and unquestioned. The world around us is so complex, our brain has evolved shortcuts that help us quickly make judgments about the world, so we can respond faster, and therefore survive. Annoyingly, these judgments aren't always correct. Our brains use past experience to make these judgments. However, sometimes bad or difficult past experiences can lead to an unhelpful view of the world, self or others. When this happens, and these past learning experiences are used to make a quick appraisal of something, that appraisal can be contaminated, and be very unhelpful.

For example one unhelpful way of thinking is catastrophising. In the case of our would-be dieter, they are catastrophising because they believe that one little lapse in a diet has ruined all the hard work they have done, and so they may as well go on a chocolate binge.

Because our brain can be a little too ready to unquestionably accept these thoughts as the truth, CBT tries to train us to first *notice* our thoughts, and

then *evaluate* the evidence for and against these thoughts. This might involve coming up with alternative interpretations for the evidence and testing them out. For example, our lapsed dieter might recognise that their interpretation is only one interpretation. They might think that other people might interpret it as just a small lapse, and not beat themselves up over it. They might then go and ask some friends about their success with dieting, and if they have ever had lapses, and how they felt about them. She could also test her assertion that she will have gained four pounds and ruined her diet. She could weigh herself in a couple of days, and see a) how much weight she has gained, and b) how much time did it take for her to lose that weight last time. Has it really ruined four month's work, or just a few weeks work?

You may have noticed that I have not given you any specific tools for this bit. There are several reasons for this. Firstly, while the underlying principles of CBT are the same, these are applied very differently, depending on the person. Therefore, it is very hard to give specific concrete strategies briefly enough to cover most issues. However, I hope that by giving you an understanding of the underlying principles of the thinking bit of CBT, you will be able to get an idea as to whether this is something which may or may not work for you, and from that, research it further. In particular, if you think CBT may be helpful, I would recommend the book CBT for Dummies, which will also provide you with structured resources and work sheets to help you. The second reason why I have not gone in depth into CBT is that for those with clinical or complex presentations, it is important that you have a qualified CBT practitioner to guide you through the process. Therefore I don't want to create

confusion by presenting CBT in a different way, nor delay seeking help. Finally, while I have used CBT in supervised practice, I am not a qualified CBT therapist, and I feel others could inform you of specific cognitive tools better than I can.

What I can say is that common to all the applications of thinking tools I saw was that the education and use of thinking tools was made very concrete. People were guided through the process in very small steps, often using worksheets which a) stated the question, b) provided prompts/ideas for the sort of responses people sometimes have, and c) could be referred back to. Equally, progress through cognitive therapy was often very slow, often repeatedly going over the same material in different ways and applying it to different situations in order to ensure comprehension and generalization. Finally, thinking tools were only employed after significant preparatory work on emotions and self awareness had already been done, as discussed elsewhere.

Social tools

Human beings are inherently social creatures. Indeed, primates are known for being one of the most social animal orders there are. This has been such a defining characteristic for us that our brains have evolved to help us live in social groups even better. For example, we have evolved the neural engineering to be able to understand what another person knows (or think they know, even if I know that what they think they know isn't true). We owe our exponential technological progress to our social brains too – it is these

that allow us to imitate other people, communicate using language, and in doing so transfer knowledge onto the next generation. If it wasn't for this, we would quite literally still be re-inventing the wheel over and over again, generation after generation.

There is often a misconception that those with Autism are not social. This is not true. We are still human, and while some of our social circuitry may be misfiring, or working in a different way, there is often still the desire to be social. However, people with Autism may not need as much social contact to get their 'social fill'. A term frequently used at Minds and Hearts is that a person without Autism may need a bucket of socialization, where as someone with Autism might just want an egg cup. However, just as socialization can be a helpful tool for people without Autism, so can it be for people with Autism.

Talking to someone, particularly if they are removed from the problem, can be a great way of working through a problem. They can help us see it in different ways, often just by reflecting back to us their understanding of a problem. They might be able to offer up some of their own experience to help solve a problem, or guide you through thinking about the problem in a different way. This might help you solve a problem, or it might help you both identify faulty thinking (such as was discussed in the Thinking Tool section), helping you feel better. If nothing else, talking to someone can offer validation and unburdening of feelings, or distraction from the problem.

However, people with Autism can have difficulties accessing social tools. One of the biggest problems is having a limited number of people whom they feel they can talk to. Some people with Autism are very socially motivated, and while they may not have a large group of friends, they will have a small group of close friends, many of whom might be a suitable 'social tool'. Others with Autism might not have any "friends" they feel they can call on. In this case, the social tool might be a partner, a friendly colleague, a teacher, or a parent. The important thing is that whoever is being used as a social tool is someone who is available, trustworthy, and understanding.

Availability may be difficult, and require a list of different people who can be called on as social tools in different social situations. For example, Clive, your friend from work might be a suitable social tool at work, but might be less available after work hours. Similarly, calling your parents while they are at work might mean they are unable to give you their undivided attention. Therefore, as with all tools, it is worth creating a list of different people who can be used as social tools in different situations.

Trust can be a big issue with people with Autism. Firstly, some people with Autism have difficulty trusting anyone, particularly given the high rates of bullying people with Autism often endure during school. However, others have the opposite problem, and are too trusting. This can lead to people taking advantage of privileged, sensitive information. Equally, being too trusting with even the trustworthiest of friends can have problems. Over disclosure can lead to boundaries being broken, causing a friend to back off or refuse to

engage in a topic in order to re-establish a boundary they are comfortable with. This can be mystifying for a person with Autism, who may not realise that any boundaries have been broken. It is therefore important that people with Autism who plan on using social tools know *how* to use them, and, if appropriate, receive help in identifying who to approach, and what sorts of things may not be appropriate to talk about.

Finally, it is important that the person being used as a social tool is understanding. People do not normally disclose all their problems to a complete stranger, as it is seen as socially inappropriate. I would argue that one of the reasons for this is that we don't know how that person will react – they don't know us and we don't know them. What if they make it worse? What if they think we are weird? When we disclose to a friend, we can often predict how they will react. We will also feel more confident that they will understand. This is also the case for people with Autism. However, in addition to understanding Jim as a person, you also have to understand that Jim has Autism. It may not be called Autism, and indeed the person being used as a social tool may know nothing about Autism, but they will know just through experience that Jim is a little quirky, and might sometimes get things wrong without meaning to, and feel comfortable with this.

Finally, it is worth noting that one of the best candidates for social tools are animals. Unlike humans, animals are more predictable, don't say you've done something wrong, will always listen, and can often be a calming influence. Indeed, in terms of availability, trustworthiness and understanding, animals

tick all three boxes better than many humans. Of course, there are some things they can't do, such as reflect back, or suggest solutions. However, they can be a very useful social tool, particularly for people with Autism.

Self-awareness tools

One (comparatively) recent development to CBT is the use of Mindfulness. Mindfulness itself is a meditation with its origins in Buddhism. The idea is that rather than constantly judging and analyzing thoughts, feelings and sensory perceptions, they are treated as transitory. They are welcomed, but not judged, and left alone to pass quickly. Mindfulness is about being truly in the moment, in a state of being, as opposed to a state of doing, where we are fretting about the past or future and aiming to control everything around us.

While some (including me when, back in my undergraduate days, I was first taught about mindfulness) will think of this as rather religious/airy-fairy/philosophical/new-agey, there is actually good research behind it. Indeed, Buddhist monks who regularly practice mindfulness over an extended period show differences in neural activation.

Mindfulness based CBT has been found to be an effective treatment, particularly for regularly relapsing depression. This is perhaps unsurprising. Cognitive Behavioural Therapy would suggest that people who have a reoccurrence of depression experience a negative event, which is negatively appraised (i.e. we have negative thoughts about it), which leads to a negative emotion, and ultimately to behaviours which reinforce the negative thoughts or

effect, or lead to further depressive events. For example, a death in the family causing someone to retreat away and avoid social contact, meaning they have poorer social support to cope with both the death, and other minor negative events that happen in life. Traditional CBT says you need to try and catch these negative automatic thoughts when they arise, then question them, and re-evaluate them. Mindfulness, however, encourages an awareness of these negative automatic thoughts. Rather than evaluating these thoughts, Mindfulness, teaches you to let them go, without judging them or ruminating (over-thinking) on them. This makes it harder for a negative thought to lead to a negative emotion, and for a negative emotion to lead to negative behaviours that may reinforce the negative mood.

While you can practice mindfulness for extended periods, going into deep meditations, this is often not what is used therapeutically. Instead, clients are encouraged to engage in short, five to ten minute Mindfulness sessions every day. This has been found to be particularly effective, while also being manageable for clients, not requiring a major lifestyle change.

I cannot claim to be an expert on mindfulness, however if this sounds like a tool that might be useful, I would recommend Chris Mitchell's book, *Asperger's Syndrome and Mindfulness*. Chris has Asperger's Syndrome, and has found mindfulness particularly helpful for him. I would recommend this over other mindfulness books simply because often people with Autism have difficulty in disengaging all evaluation of everything around them

Groups

Introduction

Minds and Hearts runs a whole series of groups on a rotating basis, covering a range of issues from emotion management to relationship counselling. The groups last 8-10 weeks, and are usually run to coincide with the school terms. Children's groups typically take place on a Saturday to avoid interrupting school, whereas adults groups are often in the evening on weekdays. The groups typically consist of eight clients, with a minimum of two therapists. The groups last 90 minutes for adults, or for children, one hour followed by a 30 minute information/feedback/advice session for parents.

Before entry to the groups, all prospective participants had to be screened by a Clinical Psychologist at Minds and Hearts (preferably one who had run the group before). This was to ensure that all participants were at a stage in their development where they could access the material with the support offered in the group, and did not need more intensive, one to one support.

The groups are **highly** structured, with a very detailed workbook for clients with weekly homework assignments. This is not just structured in terms of the content that is to be covered, but also breaks tasks down into small, structured parts. For example, rather than "list things that give you pleasure", the handbook provides lots of examples of things that could give pleasure, or for older children/adults, subheadings for the types of things that can give pleasure (i.e. activities, experiences, dreams for the future, etc). This is particularly important, as reflection and self-awareness can be particularly

difficult for people with Autism, and they may therefore need significant guidance in this way during groups.

Both the adults and children's groups start with a review of the content to be covered that day, and in the case of the children's groups, a visual schedule with each part of the sessions represented. These are ticked off as the session progresses. The children's groups also use a star chart, to aid engagement, and help ensure the following of group rules. The aim is for every child to get a full complement of stars by the end, and while some stars may be delayed until disruptive behaviour ceases, they will then be promptly rewarded for good behaviour (i.e, non-disruptive behaviour). When the group session finishes, children are each given a small reward for reaching their full complement of stars.

The group sessions are the intellectual property of their creators, and Minds and Hearts. Equally, it would be unethical to provide treatment manuals to those who did not have appropriate experience or supervision to implement them safely and effectively. However, Minds and Hearts have offered to allow the publication of a brief description of each session of the four group programmes I attended. It is our hope that this provides a template from which therapists can devise their own group sessions, by indicating the issues that need to be covered, and the pace at which they are covered.

The four groups I attended were:

1. Adults with depression group: This was the first run of a 10 session programme for adults with depression, adapted from a previous group for adolescents with depression. The sessions ran on Tuesday evenings from 5:30 to 7:00, and were facilitated by two Clinical Psychologists

2. Friends Club: An eight session group focusing on social skills for 4-6 year olds. The sessions ran on Saturdays from 9:00 to 10:30 (with the last 30 minutes for parents), and were facilitated by two Clinical Psychologists and a trainee Clinical Psychologist.

3. Exploring Friendships: An eight-session group on social skills for 7-9 year olds. This reviews and builds on skills developed in the Friends Club group, but previous attendance at Friends Club was not a requirement. The sessions ran on Saturdays from 11:00 to 12:30 (with the last 30 minutes for parents), and were facilitated by two Clinical Psychologists and a Trainee Clinical Psychologist

4. Exploring Feelings – Anger and Anxiety: an eight-session group on emotional awareness and management for 8 to 12 year olds. This session format draws heavily and elaborates on the emotional toolbox discussed earlier. The sessions ran on Saturdays from 1:00 to 2:30 (with the last 30 minutes for parents), and were facilitated by two Clinical Psychologists and a Trainee Clinical Psychologist.

Adults with Depression

Programme Description: During this 10-session group our initial focus will be self-understanding, particularly into the causes of depression, how to

recognise early and ongoing signs of low mood, and patterns of thinking and behaviour that contribute to depression. Our next focus will be learning how to change these patterns and overcome depression utilising cognitive and behavioural strategies. The therapeutic focus is informed by a deep knowledge and understanding of Asperger's Syndrome and depression. The group is structured and individual difference is embraced and celebrated.

Session 1 – Qualities and Abilities:

After introductions and the establishment of group rules, participants are introduced to a five-minute self-awareness activity. Breaking off into two groups of four, participants use the format established in the "This is Me" book to identify their own personal qualities and abilities, before exploring how they can positively affect their life. The group ends with all group members sharing compliments.

Session 2 – What is Depression?:

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. Participants are asked to identify reasons why they are depressed, before discussing the nature of depression and it's treatment. The remainder of the session continues the psychoeducation of depression, by considering perpetuating factors to depression and how Asperger's Syndrome can affect mood, whilst asking participants to consider the factors that apply to their own depression.

Session 3 – Tools to Combat Depression:

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. Participants discuss the advantages Asperger's Syndrome can bring, and how it benefits them. They are then provided with psychoeducation on how to beat depression, and the emotional toolbox. The remainder of the session focuses on exploring physical tools, and the sorts of physical tools participants could use at work or home.

Session 4 – Art and Pleasure Tools:

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. The group then explores how art can help express emotions, and how emotions provide inspiration for some of the most powerful pieces of artwork. The group then turns to pleasure tools: identifying activities, experiences, dreams, etc that are enjoyed. It also explores special interests, and their value to mood.

Session 5 – Thinking Tools (part 1):

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. The session then introduces thinking tools. First participants are invited to identify positive aspects of themselves, and how it makes them feel. They are then introduced to the idea that situations trigger thoughts, which then trigger feelings. Participants then practice fact-checking thoughts; looking for supporting and contradictory evidence for thoughts, and considering alternative explanations.

Session 6 – Thinking Tools (part 2) and Social Tools:

The session starts by reviewing the last session and the home projects,

before moving into the short self-awareness activity. The session reviews and

continues to explore the idea of fact-checking thoughts, working with

examples derived from the home-task. Participants are introduced to the idea

of cognitive distortions, and guided through identifying them in the examples

from the homework, before reviewing which distortions they use and when.

The remainder of the session explores and identifies social tools.

Session 7 – Thinking Tools (part 3) and Relaxation Tools:

The session starts by reviewing the last session and the home projects,

before moving into the short self-awareness activity. The session continues to

explore how changing our thoughts can change our feelings, and testing out

exactly how much it can change how we feel. Participants are then introduced

to relaxation tools, and identify relaxation tools they can use at home or work.

Session 8 – Relaxation and Helpful and Unhelpful Tools:

The session starts by reviewing the last session and the home projects,

before moving into the short self-awareness activity. The group is then led in a

mental exercise to focus on a time when they felt successful, as an additional

relaxation tool. The group then explores the pros and cons of medication

before identifying tools that are unhelpful for depression (such as alcohol).

Session 9 – A Safety Plan:

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. The rest of the session focuses on identifying times and triggers for very low mood (leading to risk of suicide), how to recognise it, who they can talk to and identifying the most useful strategies for this situation. This session also provides resources for others on how to help with a depression attack.

Session 10 – Your Future:

The session starts by reviewing the last session and the home projects, before moving into the short self-awareness activity. Participants are then invited to think about where they want their life to be in 10 years time – where they will be living, what they will be doing, what will be important to them. They are then invited to consider how they could use their own personal strengths, abilities, and tools to move towards that goal. Finally, participants review the tools they have identified over the past 10 weeks, and rate which are most effective for them and why.

Home tasks:

Each week, participants are set one or more home tasks to complete. This generally consists of three items. First, a weekly planner to schedule in the use of 2-3 physical tools, a daily self awareness exercise, and a few pleasure relaxation and social tools. These are gradually built up over the weeks, starting with physical tools and self awareness tools in week 2. Secondly, a worksheet reviewing the work covered in the session, and providing a structure with which to apply what was learned to a real life example

experienced that week. Finally, a work sheet encouraging participants to think about (or generate) examples of the issue or topic to be discussed next week.

Friends Club

Programme Description: This programme is designed for children who have a diagnosis of Asperger's Syndrome, Autism Spectrum Disorder or PDD-NOS. The programme assists the children to better understand the concept of friendship, and teaches them more about friendly and unfriendly behaviours. The group provides a structured environment within which difference is embraced and celebrated.

Session 1: Through structured activities, the children are helped to get to know each other, develop group rules, and feel more comfortable in a very new environment. They are then introduced to the idea of friendly and unfriendly behaviours with the help of the puppets Eric the friendly Emu, and Kieran the unfriendly Kookaburra.

Session 2: The children are encouraged to think about "what is a friend?"; why we have friends, and what are some of the defining characteristics of friends. They are then taught the Friendly Five: five friendly things to do when meeting someone new. Finally, the children are given examples of friendly and unfriendly behaviours, both acted out through puppets, and are helped to identify them in their lives.

Session 3: Kieran the unfriendly Kookaburra returns to demonstrate unfriendly things to do, and what happens to him when he is unfriendly to people. The children are then supported to identify other activities that are unfriendly, and when they have happened in real life.

Session 4: This session focuses on identifying who might make a good friend, and how some people might not be good friends and get us into trouble. The children are then given strategies for asking to join in with other people, and practice this through role-play.

Session 5: The first half of this session explores compliments and why they are important. With the aid of Eric the Emu and Piper the Possum, the children are taught how to give and receive complements, and then get to practice this with the group. The second half of the session focuses on what happens when we are graceful after losing a game, versus when we get upset at losing, and their effect on friendships.

Session 6: After revisiting the Friendly Five, the children explore conversations, and are provided with strategies and structure for how to have conversations. They then have the opportunity to practice these both with the puppets, and in the group. Next, the children learn about Play Dates, and how the skills they have already learned can be applied in this context.

Session 7: Through three new characters, the children are taught about being bossy, being overly shy, and being appropriately assertive in their interactions

with others. They are encouraged to identify the negative effects that being overly bossy or shy can have on making friends, and the advantages of being appropriately assertive.

Week 8: Using a quiz, the children review and demonstrate what they have learned over the previous weeks.

Exploring Friendships

Programme Description: This programme is designed for children who have a diagnosis of Asperger's Syndrome, Autism Spectrum Disorder or PDD-NOS. The programme explores friendship, is structured to build personal confidence and assists participants to achieve their friendship goals. This group provides a structured environment within which difference is embraced and celebrated.

Session 1: Through structured activities, the children are helped to get to know each other, develop group rules, and feel more comfortable in a new environment. They then think about 'what is a friend?', and use games to consider why friendships are important.

Session 2: Using examples, the children think about how to choose a suitable friend, and the importance of choosing a good friend. They are then given strategies for joining in with others, and rehearse these strategies with others. Finally, the children consider the importance of body language, and what it can tell us about what others are feeling, and whether others are interested.

Session 3: This session provides children with structure and suggestions for initiating and maintaining conversations with others. They observe a modeled conversation and identify what was done correctly and what was not, before breaking into smaller groups to practice conversation skills with each other in different scenarios.

Session 4: This session focuses on demonstrating the importance of showing empathy and compromise in friendships. The children are taught how they can show empathy, and compromise with others, and with support of facilitators, the children practice these skills with each other in different scenarios.

Session 5: The children explore what happens when things go wrong in friendships, such as when they lose a game, receive criticism, or have an argument. The children are helped to think about what these interactions really mean, what other people might be thinking, and to develop their own strategies for dealing with these situations in the future.

Session 6: In the first half of the session children try out a relaxation strategy, before exploring the importance of forgiving others, and how to do so. The second half of the session focuses on how to include others (such as in games), or to invite others to their house. They explore why including and inviting others is important, and who might be appropriate to include, and how to do so safely.

Session 7: This session focuses on bullying and teasing. Children are first helped to identify the difference between friendly joking and mean teasing, and what to do if they are unsure. They then explore why bullies might bully people, and how to stop themselves being bullied.

Week 8: The children review and demonstrate what they have learned over the previous weeks.

Exploring Feelings: Anger and Anxiety

Programme Description: This programme is designed for children who have a diagnosis of Asperger's Syndrome, Autism Spectrum Disorder or PDD-NOS. The programme assists participants to better recognise, express and manage their negative emotions of anger and anxiety. Participants will learn about the emotional tool box, and how this can assist them with better managing their strong emotions.

Session 1: Through structured activities, the children are helped to get to know each other, develop group rules, and feel more comfortable in a new environment. Special emphasis is placed on identifying positive skills, talents and personality traits about themselves. They are then encouraged to think about the sorts of things that make them happy, how we know we are happy (through changes in our body, thinking, and actions), and the different degrees of happiness they have experienced.

Session 2: This session focuses on identifying two opposite emotions: anxious and relaxed. For each emotion, children are encouraged to identify times when they have felt these emotions, and to what degree they felt them. They are then helped to understand why they felt that way, and how they were able to identify these emotions from their mind, body and actions.

Session 3: This session focuses on anger. The children are helped to identify times when they have felt angry, and to identify different degrees of anger they have felt. They are helped to identify cues from their mind, body and actions that they are feeling angry. Finally, they are encouraged to think about times when their heroes have become angry, and how they have coped with that anger.

Session 4: The children are taught about the concept of an emotional toolbox – a set of strategies for managing their emotions. This session focuses on identifying two types of tools that help them express, resolve or cope with their emotions: physical tools (such as running, jumping on a trampoline etc), and social tools (such as talking to family, friends or pets). The children are guided through identifying their own physical and social tools to try out in the coming weeks.

Session 5: Building on the last session, this week the children are taught about relaxation tools they can use. Children are helped to identify personal tools to try out; things they find relaxing that others may not, before practising relaxation tools designed to help everyone relax.

Session 6: The children continue to identify potential tools to add to their toolbox by exploring thinking tools. The children identify the difference between helpful and unhelpful thoughts, and practice how to turn unhelpful thoughts into helpful thoughts. They are also given a four-step plan for how to implement these strategies in real life.

Session 7: Having tested out different tools as homework over the past three weeks, the children are encouraged to review the sorts of physical, emotional, relaxation and thinking based tools they previously identified, and choose which have been the most effective, and deserve putting in their emotional tool box.

Week 8: The children review, demonstrate and consolidate what they have learned over the previous weeks.

Top tips

I spent the majority of my time at Minds and Hearts observing individual therapy work. The majority of this work would not be appropriate for me to relay in this format. However, I was able to observe a lot of practical strategies, top tips, words of wisdom, and other useful bits of information, which I have catalogued here. While these came from all the clinicians I worked with, a high proportion are from Sally Williams, who I observed more frequently, and who had a particularly vast wealth of experience and strategies to pull on during sessions.

Time Timers

These are physical clocks you can buy (but also available as a Smartphone app) that count down how much time is left. By using the visual of a gradually disappearing red area, this provides a visual (not just numerical) cue for how much time is left. This can be particularly useful with younger children, or people who have difficulty disengaging from an activity.

The Emotional Vibe

People with Autism may have difficulty picking up on specific emotions in individuals, but many appear very good at picking up (and very sensitive to) the emotional vibe of the room. In my own personal experience, I found exam halls particularly stressful because I could sense the stress and anxiety in the room, and therefore had to use a private room. It is therefore important to be aware of this ability, and not assume that this is something a person with Autism is oblivious to.

Non-Traditional Formats of Communication (NTFCs)

This is one of my favourite strategies from Sally. In short, traditional formats such as talking face-to-face, facial expressions, gesture, etc are hard for people with Autism to use. Instead, she suggests using non-traditional formats of communication – e-mail, instant messaging, sharing a tablet, writing letters, doing a piece of art, dance, sharing a piece of music – any format which that person finds easier, and less stressful to communicate with. The latter three (art, dance and music) can be particularly useful for communicating emotions, given the difficulty in describing emotions in Autism, already discussed. Therefore, it is always worth considering whether the right form of communication *for that person* is being used, or whether you are using the form of communication you are assuming that person can use.

Doing something else does not mean they are not listening!

Frequently therapists, particularly with young children, would happily keep talking about whatever was being discussed during the session, even while

the person appeared disengaged, and was playing with a toy. Despite this, when asked to give an answer, the children who, on the surface didn't appear to be listening, were often still able to give insightful answers. It is therefore important to remember that just because a person isn't looking at you, and isn't giving you 100% of their attention, does not mean they are not engaged. Indeed, often doing something else while listening actually aids their ability to listen and understand.

Vocalize your thoughts, feelings and why you are doing things.

One of the most common pieces of advice given to parents and partners was to vocalize what they are thinking, how they are feeling, and why they are doing certain things. This helps the child/partner to understand other peoples motivations and point of view, as well as aiding their ability to recognise other people's emotional states. This also helped avoid a lot of arguments that were in fact due to miscommunication.

The Tides of Autism

Tony Attwood had the expression 'the tides of Autism'. In short, people with Autism have good days and bad days, just like anyone else. However, we have to work hard to adapt to a neurotypical world, so when we have a bad day, we may be able to adapt less well, meaning some of our symptoms may become more pronounced. It is important to adapt demands (such as learning) to fit in with these tides. There is no point teaching something hard when the student is having a bad day – save it for a good day, and focus on reviewing stuff they already know and can do.

Visual Schedules: Top tips

Visual schedules are easy in theory, but often aren't done well. Here are a few tips for making them effective

- Make them visual (sounds simple, but often forgotten!)

- Use the same format for each visual schedule

- Show progress – tick off bits of the schedule, remove that part of the schedule, anything to show what has been done

- Give times – don't just say we will do A then B, say we will do A, but at 10:00 we will do B

- Be certain about uncertainty: If at 10 you might do B or you might do C, say it.

- Build in choice – this gives a sense of control, reward, and helps engagement. Rather than give a free choice, a choice from a list of options can avoid arguments or paralysis by analysis

- Generated with the individual, so unique to the individual

Finally, perhaps most importantly, there needs to be motivation to follow a schedule. There is an assumption sometimes that if you give people with autism a visual schedule, they will follow it, because that's what people with autism do. People with autism like the certainty of knowing what is happening, and so yes, schedules are great for that. However, if someone gives you a very unappealing, boring, work heavy schedule to follow, you aren't going to want to follow it. Build in rewards. Get excited about it. Make it a competition. One example was a client who had difficulty motivating their kids to progress through a morning get-up routine. They had a schedule, but it wasn't working

because the children weren't motivated to move from one part to the next – there was nothing in it for them. Therefore, their parents made it into a competition – could both kids get through the morning routine (as a team) faster than they did the previous day? They got really excited and energised about this, cheering their kids on, and at the end, there was a reward of watching their favourite morning show for however much time was left before school.

Paralysis by Analysis

One of the most frequent phrases I heard at Minds and Hearts was "Paralysis by Analysis" – thinking too much, causing the person to stop because they cannot decide, or are having to think carefully about the decision. However, often the response of neurotypicals is to ask more questions, which adds more data and pressure to the analysis, making it harder.

iPhone videos

This is probably my favourite strategy, and is another from Sally Williams. She suggests that when a child is going into a new school/class/has a supply teacher/etc, that the teacher takes out their phone and records a short (60 second) video message to the student. They can introduce themselves, tell them a bit about themselves, and start to build a rapport with the child (for example by talking about that child's interest). They can talk about what they are going to do in class, and reassure the child they are aware of their difficulties, and they know about all the strategies that were in place with the last teacher. This is then sent to the student in advance. This is such a simple

idea, but one that can be so effective in reducing anxiety, and clearly has potential beyond the classroom.

Positive feedback

"You don't keep putting your hand in the cookie jar if there aren't any cookies in it".

Most of the feedback people with Autism get is negative, such as from a failed social interaction, or being told to stop doing some behaviour by a teacher. However, if you want to encourage someone to do something, you need positive feedback. Yet in our culture, we punish any deviance from the rules, but only reward something exceptional. We might reward someone for sticking their hand up and asking a question. However this is exactly the wrong attitude. It may be **incredibly** effortful for a person with Autism to follow the rules, or just keep their hands to themselves in a class. Yet we don't reward them when they do this, only punish when they don't. On the rare occasions when we do reward it, it is after a whole class of this behaviour – that is setting the bar far too high, far too fast for most people. It also doesn't follow findings from psychology – good behaviour needs to be followed quickly by a reward for the good behaviour to be reinforced. This means you might just be rewarding 'following the rules' for the last few minutes, *but you need to reward it nevertheless*. Indeed, intermittent, unpredictable rewards for good behaviour are the most effective, according to Behavioural Theory. Therefore, when you turn around and a child is, in this example, following the rules, reward it. When you keep turning around and seeing the behaviour,

reward it slightly less frequently, and so on until it is the norm. Then you can raise the bar and start rewarding even better behaviour.

Thoughts from the experts

The following is written by Dr Celia Bird, a Clinical Psychologist working at Minds and Hearts. One of the things I was keen to provide was some nuggets of expert advice from Clinical Psychologists, to Clincial Psychologists, which Celia was kind enough to provide. These reflections, based on working with mostly adolescent and adult clients, are of course just one view, but one I felt was incredibly valuable, and wanted to share with you

"I believe providing a safe and validating environment for clients with an autism spectrum condition is crucial. This is the same for any other client of a Psychologist however it is providing a space where what can be a different way to thinking and understanding the world is understood and respected. I have often found that clients have been to therapists before and would like someone who hears what they are saying and can help explain what is happening. This can mean that therapy progresses at a different pace compared to neurotypical clients. Having a strengths-based approach is also part of creating this validated environment. I feel that understanding the strengths of someone with ASD and helping them to apply their strengths to their life is an important part of the therapy process. Furthermore, flexibility with the content and direction of the sessions can reduce the likelihood of getting stuck in the client's rigid

approach. Being flexible and rolling with the client's rigidity and

resistance can also help the clients feel validated."

Dissemination

Plan

A major part of the scholarship is disseminating the findings generated by the project as widely as possible. My initial plan for dissemination was along four pathways:

1) Presentations: I have been giving presentations on Autism Spectrum Disorders for many years, and I am regularly invited to speak at conferences on the subject, providing a platform to spread what I learned

2) Written: I have written a book on Autism Spectrum Disorders, and have a contract to write another. In addition, I often write articles for industry journals and newsletters. This gives me several options for including learning from my project in written materials, with a wide ranging audience

3) Governance: I work closely with a major autism charity, particularly in the areas of governance and campaigning. While the potential to include learning from my project here is perhaps more limited, it has the potential for very high and long-lasting impact

4) Work: At the time of the application, I was working as an Assistant Psychologist specialising in Autism Spectrum Disorders. This presented me with an excellent opportunity to apply my findings in my work, and spread information among colleagues. It also presented me with a chance to embed these findings within a service

March 2014 to July 2014

Since my return to the UK, I have completed six talks, all drawing heavily on my findings from Australia. Although another four talks were booked, these unfortunately fell through. Of the roughly 400 people I have reached through talks, approximately 60% were parents of people with autism, or people with autism. The remaining 40% were professionals, split evenly between healthcare and education backgrounds. I was also asked to write a book chapter for the group *Autistic Intelligence*, focusing on how to improve access to education for people with Autism. While not focused on what I learned in Australia, it does include many strategies that I learned whilst there.

August 2014 to Autumn 2017

In May 2014 I was offered a place to study for the Doctorate in Clinical Psychology at the University of Edinburgh. This is a highly competitive course that qualifies graduates as Clinical Psychologists. This was a long-term goal of mine that I have been working towards for many years, and was an offer I couldn't refuse. During this time, I will be working within the NHS as a Trainee Clinical Psychologist, and will hopefully have opportunities to apply my findings here, where they are most needed. In addition, I will be conducting a major research project as part of my thesis. I hope to use my what I learned from the scholarship (and the questions it raised) as the basis for my thesis. This will hopefully extend the research foundation of these findings, and importantly evaluate how they can be best applied in the NHS setting.

The doctorate course is very intensive. As a result, my ability to disseminate my findings beyond the course will be severely curtailed until the autumn of 2017. For this reason, I have had to postpone the completion of my second book until after the course is completed. In addition, it will be very difficult for me to accept bookings for presentations or writing assignments during this time. However, I would encourage people to visit my website (www.mugsy.org/josh) and get in touch if they are interested in arranging a presentation or piece of writing. While I may well have to decline, I will try and work in as many talks around my studies as I can. Larger conferences (where I can reach more people), events on weekends, and conferences closer to Edinburgh are more likely to be accepted.

Due to my limited availability over the next three years, I have attempted to make this report as comprehensive as possible. My hope is that this report will be all that is needed for anyone to get a full understanding of the project and its findings. Therefore, my aim for the remainder of 2014 is to try and disseminate this report as widely as possible, though a range of contacts within the NHS, Education, and the charitable sector, as well as parents. I will also use any resources available to spread this report further, and I would encourage anyone who wants to publicise or disseminate this report to do so, and contact me if I can be of assistance.

Post Autumn 2017

As a qualified Clinical Psychologist, I will likely be working within an NHS or university setting (or ideally both). Both settings have a strong emphasis on

research and teaching, allowing me to both support the report through research, and spread it further to current and future healthcare staff. Both settings have the potential to broaden out to developing services, but also are likely to include presenting to professionals outside mental health, parents, and those on the spectrum, where I would to continue talking about my findings from Australia. I would also hope to resume my writing at this time, finishing my second book, again drawing on my findings from this scholarship.

Resources

Minds and Hearts

www.mindsandhearts.net

This is the website of the Minds and Hearts clinic, and has many more details on the staff, the groups, upcoming workshops, and a host of resources, links and downloads. In particular, they have information for managing an angry episode, how to address bullying, how to explain the diagnosis, best practice guidelines for people with Autism, and an article explaining Asperger's Syndrome.

Tony Attwood

www.tonyattwood.com.au

In addition to information about Tony's lecture tours, it hosts a number of free to access articles and publications by Tony (including *The discovery of Aspie criteria*) and a paper on modifications to CBT to accommodate the cognitive profile of people with Autism. It also has a database of books by other authors on a range of subjects that Tony recommends.

The National Autistic Society

www.Autism.org.uk

The National Autistic Society is the UK's leading charity for Autism Spectrum Disorders, and has a wide range of information available online. For professionals, I would recommend www.Autism.org.uk/working-with, which has a host of resources for a wide range of professionals, including teachers,

medical professionals, and those working in criminal justice. I am a particular fan of their resources for teachers, in particular their specially designed teacher pack (www.Autism.org.uk/teacherpack). For parents and people on the spectrum, the NAS website has information on employment, benefits, services, and general information about Autism. For both parents and professionals, I would recommend the Autism Helpline run by the NAS, 0808 800 4104

From Like to Love for young people with Asperger's Syndrome or Autism: Learning how to express and enjoy affection by Tony Attwood and Michelle Garnett

This is an excellent book available in two different versions, one for parents, one for professionals. Both guide the reader through a structured CBT based programme to help explore the feeling of like and love, and how to express affection.

Exploring Feelings: Anxiety: Cognitive Behaviour Therapy to manage Anxiety by Tony Attwood

This book won the Teachers Choice Award in 2008, and is an excellent resource for how to tackle Anxiety. While it does not focus on anger, many of the theories, ideas and strategies can be easily transplanted across, due to the similarities between anger and anxiety. While usable by both parents and clinicians, the content is targeted more towards clinicians.

Think Good: Feel Good by Paul Stallard

This is *the* CBT workbook for clinicians working with children and young people. While not remotely targeted at Autism, the highly structured nature of it makes it a very useful tool when working with this client group.

Been There, Done That, Try This! Edited by Tony Attwood, Craig Evans and Anita Lesko

This book came out while I was over in Australia, and was used to good effect in the adults with depression group. The book is written by a host of adults with differing levels of Autism who really have been there and done that, they share their experiences, insights and strategies for dealing with ten of the most common issues faced by people on the spectrum. Brilliant for young adults and adults on the spectrum

CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders, Edited by Angela Scarpa, Susan Williams White and Tony Attwood

This book brings together experts on adapting CBT for people with Autism, tackles both theoretical and practical issues using an evidence based approach. While not exactly light bedtime reading, it provides an excellent scientific basis for clinicians looking to use CBT for Autism, providing knowledge, ideas, food for thought, and a whole host of references for further investigation.

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