

Mental Health Problems  
and  
Children with Social, Emotional and Behavioural Difficulties.

*What communication strategies can be used to support the mental health of children with classical autism?*

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## **Aims/Introduction**

There is no one identifiable cause of mental health problems. Some causes may include biological, biochemical, hereditary and psychological factors although this is part of a much wider debate (MIND, 2012). Following diagnosis there is a vast array of support therapies available to support people with mental health issues; some of these therapies support the psychological causes of mental health problems (British Association of Behavioural and Cognitive Psychotherapies, 2005) and will be explored in this paper. Although it is recognised that all children are individually resilient, it is fair to assume that during a stressful incident most children will feel anxious or upset. Talking to someone about how we feel can often make us feel better and we are able to continue with everyday life. If we do not talk about how we are feeling and keep things locked inside, feelings often become amplified and overtime we could develop mental health problems. Autistic spectrum disorder (ASD) is a spectrum of developmental brain disorders characterized by impaired social interaction and communication skills and a limited range of activities and interests (Kanner 1943). This paper will focus on individuals with classical autism. Although autism is not a mental illness (NHS, 2010) over 70% of children with autism have at least one mental illness / comorbid disorder (Simonoff, 2008 compared with 9.6% of children who do not have autism (The Office of National Statistics 2004). Classical autism or low functioning autism is classified by impairment in social interactions and communication. If children who have classical autism have difficulties in communicating (Kanner, 1943) and talking therapies involve talking and

listening, (DoH, 2001) how can these individuals access these therapies? It is my assertion in this paper that improved communication when supporting autistic children both pre and post diagnosis could go some way towards reducing the high comorbidity rates within this group. In an effort to explore this assertion I have undertaken a review of the available and current literature, explored some of the latest available standard talking therapies that can support the autistic child following diagnosis of a mental health condition and then, through whole school training sessions, explored how two special schools proactively support the mental health of their pupils.

Mental health conditions can be supported both proactively and reactively. Proactive mental health support is concerned with how we support individuals following serious or stressful incidents. Reactive mental health support is concerned with how individuals are supported following the diagnosis of a mental health condition; this paper aims to explore how the autistic child can access support in both proactive and reactive areas. The paper goes on to offer some observations and techniques that could be employed to improve the way practitioners communicate with low functioning ASD children.

### **Research Question**

*What communication strategies can be used to support the mental health of children with classical autism?*

## **Literature review**

Mental health conditions in children are widespread. The number of incidents and the far ranging implications of such conditions are being reported nationally and successive governments have approached the support, care and treatment of these conditions in various treatment programmes. Reports published by Action for Happiness (2012) show that there is huge opportunity for improving well-being with between 21% and 28% of people nationally reporting low and very low life happiness. With children and adolescents we know that this figure is notoriously difficult to predict and to measure (Action for Happiness, 2012), but within this overall category this paper identifies a sub-set of children measured on the autistic spectrum who, for many different reasons, appear to have difficulty accessing therapies.

The National Health Service (NHS) describes autism as a lifelong developmental disability, not a learning disability or mental health problem. The International Classification of Diseases (ICD) categorised autism in ICD-10 as belonging to the group of “Pervasive Developmental Disorders”. Meehan (2011) found three main difficulties in identifying and diagnosing mental health difficulties. These are that people with autism often have difficulties expressing and communicating emotion (Lainhart and Folstein, 1994; Perry, Marston, Hinder, Munden and Roy 2001). There are only limited standardized instruments for the diagnosis of psychiatric disorders in children with autism (Helverschou, Bakken and Martinsen, 2009) and there is substantial overlap between the behaviours displayed in autism and some

symptoms of some mental health problems (Helverschou et al, 2009; Gould, 2010).

In 2004 The Office of National Statistics (ONS) survey found that 9.6% of children aged between 5 and 16 suffer from a diagnosable mental health disorder, this included 1% of children with autism. In 2008 Simonoff found that 70% of children with autism have at least one comorbid disorder, 41% had two or more. Meehan, (2011) suggested that although mental health difficulties may have a devastating impact on the lives of those with autism, mental health promotion has been generally overlooked within this group. In 2008, Jones, English, Guldberg, Jordan, Richardson and Waltz found that many autistic children are managed in primary school but often find secondary school very difficult and can develop significant mental health and behavioural difficulties.

Madders (2010) described autism as a complex disability making co-morbid mental health problems harder to recognize, harder to evaluate and harder to treat. Atkinson and Hornby (2002), Music (2007) and Tyler (2010) found that staff in schools often felt that supporting children's mental health was outside their remit. Other reports suggest a lack of teacher knowledge in this area (Atkinson and Hornby, 2002; Weare and Gray, 2003; Department of Health, 2006. Other barriers against supporting mental health issues in schools include the role of the National Curriculum (O'Hanlon, 2000) and testing and league tables (Finney, 2006).

There are many conventional approaches to treating mental health problems with an important set being talking therapies. Talking therapies cover a range of interventions that help people deal with negative feelings (The Mental Health Foundation, 2012) The MHF also believe that talking about your problems is an important factor for good mental health. The National Institute for Health and Clinical Excellence (NICE) in 2005 recommended talking therapies rather than medicine for children who have depression. NICE guidelines state that good communication between healthcare professionals and children is essential and that the support provided should be tailored to the needs of the individual and the physician to be fully informed of the usual communication style of the individual (Howlin, 1997).

Structured post incident learning is a technique for learning through reflection, sharing experiences, gathering information, and developing ideas for the future (Gibbs, 1988). A small study into the effect that structured post incident learning has on pupils and schools following serious incidents (Cotton, 2010), found that a structured process for post incident learning reduces incidents by teaching children more socially acceptable ways of expressing their need for support thus improving the mental health of the child (MHF, 2012). However, lack of structure could make post incident learning less effective (Kahan, 1994). Cotton (2010) developed the 3 'L's approach for practitioners. This is a simple set of tools enabling staff to listen to the child's point of view first (Cole, 2009), link their feelings to their behaviour (Faupe, Herrick and Sharp, 1998), and then together learn alternative ways to support the child (see Appendix 1). During the study staff and carers gave their view on post incident learning and

it was suggested that individuals with communication difficulties might find this process difficult due to the perceived limited level of understanding displayed by individuals with autism. Although structured post incident support may be difficult for pupils with classical autism, pupils have a human right to be listened to (Taylor, 2000). The Disability Discrimination Act and the Equality Act (2010) make it a legal requirement for reasonable adjustments to be made to the services provided to people with disabilities, including autism. As well as there being a legal responsibility and duty to do something we need to find some solutions to this problem. The National Autistic Society (2012) stated that communication and interaction do not have to involve the use of language and speech so other methods of communication need to be established. We know that there exist many traditional speech and language tools and communication aids such the Picture Exchange Communication System (PECS) that can be useful in the delivery of talking therapies such as cognitive behaviour therapy (CBT). What is less clear is whether or not these tools are used by therapists and practitioners with children with autism and how effective they are in helping children gain access to therapy. PECS was developed by Bondy and Frost (1994) and is designed to address the needs of children with significant communication deficits. Bondy and Frost's study (1994) showed that 95% of 85 nonverbal preschool children with autism had learned to use the picture symbols for communicating. Other communication aids which could be used to support the delivery of talking therapies could include Alternative and Augmentative Communication (AAC) systems. These systems support or replace spoken communication. The techniques include gesture, symbols, signing, word boards, communication boards, books and



Voice Output Communication Aids (VOCAs) (Scope, 2012). Voice Output Communication Aids (VOCAs) are commercially available, electronic devices designed to support people who are unable to vocalize their needs and exchange information. Communication passports (Miller, 1997) can also be used to support the delivery of talking therapies. Communication passports are a positive way of supporting people with sensory and communication disabilities who cannot speak for themselves. The communication passport includes personal information about the child's needs, such as his/her likes and dislikes. The passport is owned by the child and helps new people understand a child's personal needs (Scope, 2012). Although Goldbart and Caton (2010) could find no formal evaluation of communication passports 30% of practitioners involved in the research reported using communication passports. The research (Goldbart and Caton, 2010) found that the passports were used more with adults than children.

There are many therapeutic approaches for supporting mental health, many of which feature long-term interventions such as counselling. There appear to be some welcome signs that the needs of particularly high functioning autistic children can be met through counselling. Counselling covers a broad spectrum of interventions but provides a regular time and space for people to talk about their troubles. This is done in an environment which is free from intrusion and is confidential so people are encouraged to explore difficult feelings (MIND, 2012). In 2006, Vermeulen and Vanspranghe found that counselling can help to resolve misinterpretations of the world held by those with autism which can lead to anxiety, however, The National Institute of

Deafness and other Communication Disorders (NIDCD) recognise that children with classical autism are often self-absorbed and seem to exist in a private world where they are unable to successfully communicate and interact, making the counselling process difficult with this group.

Other forms of counselling include the Life Space Interview (LSI) and the Life Space Crisis Intervention (LSCI). The Life Space Interview is a classroom counselling system developed by Fritz Redl (1963). The process is used to change behaviour patterns of students. The (LSCI) is an interactive therapeutic strategy for turning crisis situations into learning opportunities. LSCI was developed by Long (2001) and derived from Redl's Life space interview.

The Royal College of Psychiatrists (2012) found that Cognitive Behaviour Therapy (CBT) is particularly appropriate for people with autism or Asperger's syndrome as it can be used to challenge cognitive distortions (Paxton and Estay, 2007). CBT is a way of talking about how you think about yourself, the world and other people and how your actions affect other people. The concept of CBT was developed by Pavlov (1897). This stemmed from applying the principles of learning theory to shape human behaviour, and this in turn, through altering behaviour may help to alleviate psychological disorders. Two examples of Computerised CBT have been approved by the National Health Service (NHS). Evidence suggests that the delivery of CBT using a computer can help with anxiety and depressive disorders, especially when a patient also sees a therapist (NHS, 2010).

Wood, Drahota, Sze, Har, Chiu and Langer (2009) randomly assigned 40 children with autism ranging from seven to eleven years old to 16 sessions of CBT or a three-month waiting list for CBT. Parents and children completed anxiety symptom checklists at baseline and post treatment / post waiting list. The research found that 78.5% of the CBT group met Clinical Global Impressions (CGI) scale criteria, compared with only 8.7% of the waiting list group. The CGI scale is one of the most widely used assessment instruments in psychiatry; the scale offers a readily understood, practical tool that can be easily used by clinicians (Busner and Targum, 2007). The research found that remission of anxiety disorders appeared to be an achievable goal among high-functioning children with autism. Ooi, Lam, Sung, Tan, Goh, Fung, Pathy, Ang and Chua (2008) also found that 16 sessions of CBT was effective in reducing anxiety in high functioning autistic children with a mean age of 11.50 years.

Sofronoff, Attwood and Hinton (2005) also evaluated children diagnosed with Asperger's Syndrome who received CBT and the impact of parental involvement. Parent involvement enhanced the usefulness of the intervention.

Most academics and clinicians consider CBT to be an effective therapy for some individuals but it is not without its limitations,

*“1. The precise role of cognitive processes is yet to be determined. The maladaptive cognitions seen in psychologically disturbed people could be a consequence rather than a cause.*

*2. The cognitive model is narrow in scope - thinking is just one part of human functioning, broader issues need to be addressed.*

*3. Ethical issues: CBT is a directive therapy aimed at changing cognitions sometimes quite forcefully. For some, this may be considered an unethical approach.”*

(McLeod 2008).

In an effort to assess the impact, validity and demonstrate the very particular challenges expressed through the literature review it was possible to develop a small analysis conducted locally with two schools.

## **Method**

For this paper two schools offering education for children with a wide range of special educational needs, including children with autistic spectrum disorder (ASD), profound and multiple learning disabilities (PMLD), severe learning disabilities (SLD) and complex medical conditions were approached and asked to be take part in this study. During initial meetings a willingness to be involved in the research was expressed and the process was explained. The whole staff team in each school was trained in providing structured post incident support for children with ASD in order to proactively support the children's mental health. With support in staff meetings the two schools then developed a range of strategies to communicate with this group. The staff then presented these strategies to the whole of their team. The strategies were then trialled with children for one term and the views of the staff were then recorded via whole school staff meetings. The age and performance levels (P-Levels), (Qualifications and Curriculum Authority, 2005) of the children involved in this paper were collected to give an idea of the childs level of communication. (Details of performance levels are explained in Appendix 2).

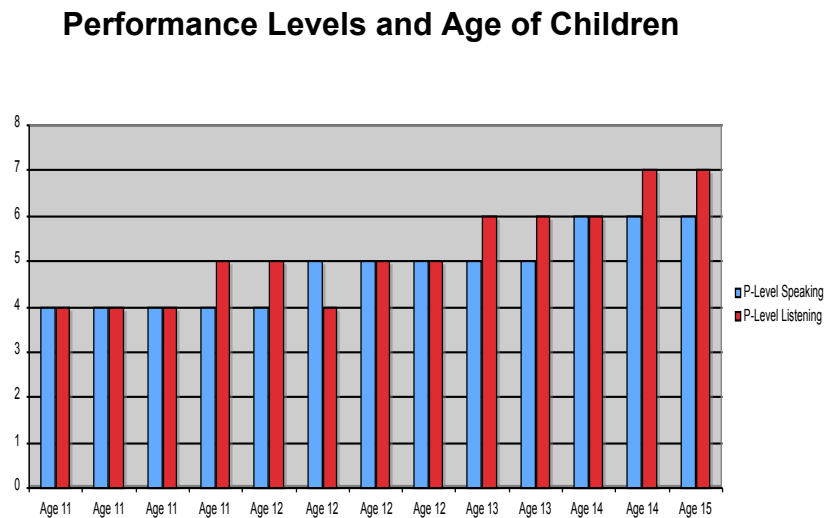
Alongside the development of these strategies I explored a range of reactive strategies in the form of talking therapies that are currently available such as counselling and CBT. For this paper I am going to focus on the behavioural approaches used in CBT. Fifteen CBT Practitioners were randomly selected from the British Association for Behavioural & Cognitive Psychotherapies (BABC) website. The website lists the contact details and specialisms of the

practitioners who are registered with the organisation. The 15 practitioners were initially contacted via email, all of the practitioners who were contacted specialised in working with children with autism. Interviews were then used, as the aim was to gain the opinions of the CBT practitioners rather than to collect measurable facts (Bell, 2005). The “guided or focused interview” (Bell, 2005, p.161) was used because it would allow the writer to follow lines of argument and discussion. Although the writer was aware that this is a time consuming and difficult to analyse method (Bell, 2005), it was chosen because benefits outweighed the potential difficulty. The starter question (see Appendix 3) helped to initiate discussion and allowed the practitioners to explore their perceptions in more depth.

## Results

### Combined results from two staff teams

The age and performance levels in speaking and in listening of the children the structures were used with are as follows:



Appendix 2 shows level descriptors for the P-Levels (QCA, 2005).

The staff teams all discussed the importance of building positive relationships with the children that they support. The staff believed that the key to building positive relationships was to share positive experiences with the children.

Building positive relationships enabled staff to spot signs of anxiety and intervene early. The use of communication passports enabled staff to react to each child's needs in a personalised way. The communication passport from one of the schools is detailed in appendix 4. These were completed with the children and shared among the staff team, parents and other professionals.

One school used a communication dictionary to record how children communicate and ways in which staff can help children to feel better.

The worksheets in appendix 5 were used following an incident where a child had become upset. The worksheets were completed by staff and children and used as evidence of how staff have tried to rebuild a positive relationship following an incident. The pupil or staff can draw what happened during the incident. The worksheet is laminated so that when the pupil has given as much information as s/he feels s/he can manage it can be photocopied and the pupil wipes the worksheet clean.

The green and red faces in appendix 6, were used in one of the schools to teach children basic feelings such as happy and sad. The teacher would show pupils the different coloured faces depending on the situation for example if a child did a good piece of work or was particularly helpful, the child would be shown the green face. If a child showed unacceptable behaviour eg violence towards another child, the child was shown the red face. Staff tried to ensure that the green face was shown more than the red face.

Appendix 7 shows symbols used by one of the schools to teach children about different feelings. In one of the schools involved in this paper the symbols accompanied stories and were also used for post incident support. Some children found the coloured symbols over stimulating so the colour was removed for such children.



One of the schools developed feelings diaries (appendix 8). The diary was completed by children and staff at the end of each day and would go some way towards helping staff recognise how individuals are feeling.

The experiences, feeling, behaviour worksheet in appendix 9 was completed with a child post incident and then wiped clean by the child.

The listen, link, learn worksheet in appendix 10 is another example of the experiences, feelings, behaviour worksheet.

Following the implementation of the above strategies, the staff from one of the two schools involved in the research reported that none of the strategies implemented seemed to have had any effect on the pupils' behaviour in the short space of time the strategies were implemented. The schools recognized that the strategies might have an impact on the mental health of the child in the long term but felt that before pupils can try to manage their emotions they need to actually know about what they're feeling and when. The school believed that if children know how they are feeling the strategies would be more effective and stated that more work in teaching children about their feelings is going to be implemented in the school immediately. The school reported that trialing the strategies made it even more obvious how little, if anything, the pupils they work with know about their emotions. The school stressed that they will continue to implement the strategies and aim to reassess the impact in 12 months.

The second school involved in the research felt that the strategies they implemented went some way towards enabling the staff to build positive relationships with the children they work with. The school believed that the consistent implementation of the strategies would support the mental health of their children in the long term. The staff stated that they will continue to implement the strategies and reassess the long-term impact in the future. The head of this school stated that implementing these strategies has had a positive impact on the ethos of the school.

Both schools involved in the research stated that they need to improve how and what they communicate with mental health practitioners. The two schools stated that as a result of this work they would share the communication passports they had developed with other professionals and parents.

Fifteen CBT Practitioners taking part in this study responded as follows:

**Q. How are children with classical autism supported through CBT?**

Twelve out of the 15 practitioners stated that they only worked with autistic children if the individuals had some level of language. Ten out of the 12 practitioners stated that they had used some form of communication aids in the delivery of CBT with this group in the past such as Alternative and Augmentative Communication (AAC) systems. Fourteen of the 15 practitioners stated that they find the process of CBT difficult with this group due to the perceived level of communication such children display (Hall, 1996). The three practitioners who worked with children who have classic autism explained that they often need to be more creative in their approach but did not explain how they were creative and what this involved. Ten practitioners stated that if they were unable to communicate effectively with the individual they would work closely with parents and schools to support the child. One of the practitioners stated that, in his/her experience, when asked to assess autistic children for mental health conditions by parents and schools, 90% of the children, when assessed, do not have mental health issues. One of the practitioners believed that there are higher comorbidity rates exhibited in children with Asperger's rather than in those with classical autism due to misinterpretations in communication, further research would be necessary to support this view. Three of the practitioners believed there was a huge deficit in supporting the autistic child's mental health and a lack of guidance, support and training is a major problem.

## Discussion

The central premise of this paper is simple and has led to some surprising insights and conclusions. Mental health conditions in children are widespread (Action for Happiness, 2012 and ONS, 2004) and although there is no one identifiable cause of mental health problems, it is generally accepted that talking about problems can go some way to ensuring improved and hopefully more manageable mental health (MHF, 2012). Children with classical autism often have difficulties in communicating their problems and research suggests that 70% of autistic children exhibit one or more comorbid disorder (ONS, 2004). One reason for such high rates of comorbidity within this group could be due to the difficulties autistic children have in communicating. If a child is unable to communicate how they are feeling, how can they get the support they need? Personal Communication Plans (PCP's) could be used so that parents, teachers and other professionals know the child's individual style of communication enabling more effective support for the child. The children involved in this study were all aged between 11 and 15 and were between P-Level 4 to 6 for Speaking and P-Level 4 to 7 for Listening (see appendix 2). Further research could be carried out to assess the impact of the strategies on younger children and children with lower P-Levels. The two schools involved in the research managed to implement several strategies aimed at improving communication with children with classical autism. Although the impact of the implementation of the strategies is difficult to assess (Action for Happiness, 2012), both schools reported positive outcomes though implementing the strategies such as enabling the staff to build more positive relationships with the children. Completing the work sheet with the child could go some way

towards building relationships. The staff all recognised that building positive relationships with the children would enable them to spot early signs of anxiety and intervene appropriately. One school also commented on an improved ethos within the school as a direct result of the implementing the strategies. This could be because the strategies encouraged the staff and children to share positive experiences. External therapists may not have the opportunities or time to share positive experiences and build positive relationships with the child. The literature review shows that communication passports could be effective in the delivery of therapy but Goldbart and Caton (2010) found that communication passports are only used by 30% of practitioners and they were used more with adults than children. This could be because communication passports have not been developed for many children or they are not being readily shared. More training for practitioners in the use of communication passports could also increase the number of practitioners using such strategies. Both schools involved in this study stated that they need to improve how and what they communicate with mental health practitioners and parents.

A major obstacle to supporting mental health could be that autism is a complex disability. The limited standardized instruments for diagnosis (Perry, 1994) also make mental health problems difficult to assess (Action for Happiness, 2012). However Atkinson et al, (2002) explained that the everyday pressure of work for teachers combined with a lack of teacher knowledge and teachers often feeling that mental health promotion is outside their remit is also a major disadvantage in supporting the mental health of the children with autism. This could be one reason why mental health promotion has been

generally overlooked within this group (Meehan, 2011), but research shows that if these obstacles could be overcome the mental health of the autistic child could be supported (MHF, 2012). More support for teachers and quality training in recognising and supporting mental health issues in children along with the development of more instruments for diagnosis could go some way towards reducing the high rates of comorbidity in this group. There are a number of communication aids that are available to support communication; these methods could be used to support the mental health of the autistic child both pre and post diagnosis. Following diagnosis of a mental health condition CBT and other talking therapies, could go some way towards reducing comorbidity in autistic children (Ooi et al 2008). CBT was highlighted by Paxton and Estay, (2007) as particularly appropriate for people with autism.

During interviews with 15 randomly selected CBT practitioners who specialized in children with autism only three of the practitioners worked with children with classical / low functioning autism. This could be because children with classical autism are not accessing CBT or there is a lack of CBT practitioners trained to work with this group. This could emphasise a need for more CBT practitioners to be trained to work with this group or the profile of CBT should be raised for children with classical autism. The practitioners who did work with children with classical autism talked about being creative with the delivery of CBT but did not explain how they were creative and what this involved. Further questioning would have clarified this. If the practitioner is not trained in this area the effectiveness of the therapy would rely on the practitioners ability to effectively adapt the process; this could create inconsistencies in the impact of the therapy. Ten of the practitioners talked

about the importance of the role of parents and schools but if teachers often see supporting mental health as outside their remit (Atkinson and Hornby et al 2002) further training may be necessary to improve awareness of the support available for both teachers and parents. One CBT practitioner explained that approximately 90% of the children they are asked to assess by schools do not have mental health issues which maybe because schools need better practical skills to help these children to communicate, further training could also go some way towards supporting this theory. Three of the CBT practitioners felt that there was real deficit in supporting the autistic child's mental health but more research is needed in this area. Improved communication with children, teachers, mental health practitioners and parents when supporting autistic children, both pre and post diagnosis, could go some way towards reducing the higher comorbidity rates within this group.

## **Conclusion**

The evidence whilst far from clear appears to suggest that on the one hand autistic children appear to benefit, as do most children, from therapy (MHF, 2012). Yet there remains the questions about access and relevance in terms of choosing the right therapy in a crowded field and arguably questions of validity and evaluated impact. My initial research, limited in scale, backs up the assertion that there is variable practice, different approaches, a lack of consistency perhaps in application and consequently variable outcomes. But what seems to link practitioners approaches together is a recognition that in fact autistic children seem to struggle to gain access to these services.

This paper has led me to believe that mental health should be supported in education because the simple strategies developed and implemented by the two schools had positive outcomes and could support the autistic child's mental health proactively.

To assess the true impact of the approaches used in this study further research would be necessary. This is because the sample remains relatively small and would need to be accessed over a longer period of time. However, the research has shown some interesting outcomes that may be worth exploring in more detail.

This study as led me to believe that constant monitoring and review of the autistic child's mental health, high quality training for school staff and parents in recognising mental health problems in autistic children, more CBT practitioners to be trained to work with children with classical autism and the development of (PCP's) along with improved communication, both with the child and amongst professionals, could go some way towards reducing the high rates of comorbidity in children with classical autism.

### **Dissemination in the Workplace**

I will feed back the key points of this study during the training I deliver to schools who work with children with classical autism and make the full document available on the downloads section of my website.



## **Wider Dissemination**

I will produce a summary of this research to submit to SEBDA News and the British Institute of Learning Disabilities (BILD) SLD Experience stressing the importance improved communication with children with classical autism, parents and professionals.

## Appendix 1

The 3L's structure

**Listen** to the child's point of view first. (Use listening skills e.g. paraphrasing, summarising, allowing silence and don't make judgments etc).

**Link** the feeling to the behaviour E.g. "how did that make you feel?"

**Learn** alternative strategies for when the pupils feels that way. Staff should explain why staff took the action they did. Consider what staff could do to support the child better. Discuss any consequences (that should be linked to the behaviour) Dreikurs and Grey (1993). Discuss any further actions, e.g. restoring relationships etc.

## Appendix 2

### English

Speaking / Expressive communication

P levels 1 to 3 are common across subjects.

**P1(i)** Pupils encounter activities and experiences. They may be passive or resistant. They may show simple reflex responses, *for example, starting at sudden noises or movements*. Any participation is fully prompted.

**P1(ii)** Pupils show emerging awareness of activities and experiences. They may have periods when they appear alert and ready to focus their attention on certain people, events, objects or parts of objects, *for example, attending briefly to interactions with a familiar person*. They may give intermittent reactions, *for example, sometimes becoming excited in the midst of social activity*.

. **P2(i)** Pupils begin to respond consistently to familiar people, events and objects. They react to new activities and experiences, *for example, withholding their attention*. They begin to show interest in people, events and objects, *for example, smiling at familiar people*. They accept and engage in co-active exploration, *for example, focusing their attention on sensory aspects of stories or rhymes when prompted*.

. **P2(ii)** Pupils begin to be proactive in their interactions. They communicate consistent preferences and affective responses, *for example, reaching out to a favourite person*. They recognise familiar people, events and objects, *for example, vocalising or gesturing in a particular way in response to a favourite visitor*. They perform actions, often by trial and improvement, and they remember learnt responses over short periods of time, *for example, showing pleasure each time a particular puppet character appears in a poem dramatised with sensory cues*. They cooperate with shared exploration and supported participation, *for example, taking turns in interactions with a familiar person; imitating actions and facial expressions*.

. **P3(i)** Pupils begin to communicate intentionally. They seek attention through eye contact, gesture or action. They request events or activities, *for example, pointing to key objects or people*. They participate in shared activities with less support. They sustain concentration for short periods. They explore materials in increasingly complex ways, *for example, reaching out and feeling for objects as tactile cues to events*. They observe the results of their own actions with interest, *for example, listening to their own vocalisations*. They remember learnt responses over more extended periods, *for example, following the sequence of a familiar daily routine and responding appropriately*.

. **P3(ii)** Pupils use emerging conventional communication. They greet known people and may initiate interactions and activities, *for example, prompting another person to join in with an interactive sequence*. They can remember learnt responses over increasing periods of time and may anticipate known events, *for example, pre-empting sounds or actions in familiar poems*. They may respond to options and choices with actions or

gestures, *for example, by nodding or shaking their heads*. They actively explore objects and events for more extended periods, *for example, turning the pages in a book shared with another person*. They apply potential solutions systematically to problems, *for example, bringing an object to an adult in order to request a new activity*

- . **P4** Pupils repeat, copy and imitate between 10 and 50 single words, signs or phrases, or use a repertoire of objects of reference or symbols. They use single words, signs and symbols for familiar objects, *for example, 'cup', 'biscuit'*, and to communicate about events and feelings, *for example, likes and dislikes*.
- . **P5** Pupils combine two key ideas or concepts. They combine single words, signs or symbols to communicate meaning to a range of listeners, *for example, 'Mummy gone' or 'more drink'*. They make attempts to repair misunderstandings without changing the words used, *for example, by repeating a word with a different intonation or facial expression*. Pupils use a vocabulary of over 50 words.
- . **P6** Pupils initiate and maintain short conversations using their preferred medium of communication. They ask simple questions to obtain information, *for example, 'Where's cat?'*. They can use prepositions, such as 'in' or 'on', and pronouns, such as 'my' or 'it', correctly.
- . **P7** Pupils use phrases with up to three key words, signs or symbols to communicate simple ideas, events or stories to others, *for example, 'I want big chocolate muffin'*. They use regular plurals correctly. They communicate ideas about present, past and future events and experiences, using simple phrases and statements, *for example, 'We going cinema on Friday'*. They contribute appropriately one to one and in small-group discussions and role play. They use the conjunction 'and' to link ideas or add new information beyond what is asked.
- . **P8** Pupils link up to four key words, signs or symbols in communicating their own experiences or in telling familiar stories, both in groups and one to one, *for example, 'The hairy giant shouted at Finn'*. They use an extensive vocabulary to convey meaning to the listener. They can use possessives, *for example, 'Johnny's coat'*. They take part in role play with confidence. They use conjunctions that suggest cause, *for example, 'cos'*, to link ideas.

## Listening / Receptive communication

P levels 1 to 3 are common across subjects

- . **P1(i)** Pupils encounter activities and experiences. They may be passive or resistant. They may show simple reflex responses, *for example, starting at sudden noises or movements*. Any participation is fully prompted.
- . **P1(ii)** Pupils show emerging awareness of activities and experiences. They may have periods when they appear alert and ready to focus their attention on certain people, events, objects or parts of objects, *for example, attending briefly to interactions with a familiar person*. They may give intermittent reactions, *for example, sometimes becoming excited in the midst of social activity*.
- . **P2(i)** Pupils begin to respond consistently to familiar people, events and objects. They react to new activities and experiences, *for example, withholding their attention*. They begin to show interest in people, events and objects, *for example, smiling at familiar people*. They accept and engage in co-active exploration, *for example, focusing their attention on sensory aspects of stories or rhymes when prompted*.
- . **P2(ii)** Pupils begin to be proactive in their interactions. They communicate consistent preferences and affective responses, *for example, reaching out to a favourite person*. They recognise familiar people, events and objects, *for example, vocalising or gesturing in a particular way in response to a favourite visitor*. They perform actions, often by trial and improvement, and they remember learnt responses over short periods of time, *for example, showing pleasure each time a particular puppet character appears in a poem dramatised with sensory cues*. They cooperate with shared exploration and supported participation, *for example, taking turns in interactions with a familiar person; imitating actions and facial expressions*.
- . **P3(i)** Pupils begin to communicate intentionally. They seek attention through eye contact, gesture or action. They request events or activities, *for example, pointing to key objects or people*. They participate in shared activities with less support. They sustain concentration for short periods. They explore materials in increasingly complex ways, *for example, reaching out and feeling for objects as tactile cues to events*. They observe the results of their own actions with interest, *for example, listening to their own vocalisations*. They remember learnt responses over more extended periods, *for example, following the sequence of a familiar daily routine and responding appropriately*.
- . **P3(ii)** Pupils use emerging conventional communication. They greet known people and may initiate interactions and activities, *for example, prompting another person to join in with an interactive sequence*. They can remember learnt responses over increasing periods of time and may anticipate known events, *for example, pre-empting sounds or actions in familiar poems*. They may respond to options and choices with actions or gestures, *for example, by nodding or shaking their heads*. They actively explore objects and events for more extended periods, *for example, turning the pages in a book shared with another person*. They apply potential solutions systematically to problems, *for example, bringing an object to an adult in order to request a new activity*.

- . **P4** Pupils demonstrate an understanding of at least 50 words, including the names of familiar objects. Pupils respond appropriately to simple requests that contain one key word, sign or symbol in familiar situations, *for example*, 'Get your coat', 'Stand up' or 'Clap your hands'.
- . **P5** Pupils respond appropriately to questions about familiar or immediate events or experiences, *for example*, 'Where is the ball?', 'What are you doing?', 'Is it yellow?'. They follow requests and instructions containing at least two key words, signs or symbols, *for example*, 'Put the spoon in the dish', 'Give the book to Johnny'.
- . **P6** Pupils respond to others in group situations, *for example*, taking turns appropriately in a game such as 'Pass the parcel'. They follow requests and instructions with three key words, signs or symbols, *for example*, 'Give me the little red book'.
- . **P7** Pupils listen to, attend to and follow stories for short stretches of time. They follow requests and instructions with four key words, signs or symbols, *for example*, 'Get the big book about dinosaurs from the library'. They attend to, and respond to, questions from adults and their peers about experiences, events and stories, *for example*, 'Where has the boy gone?'.
- . **P8** Pupils take part in role play with confidence. Pupils listen attentively. They respond appropriately to questions about why or how, *for example*, 'Why does a bird make a nest?', 'How do we copy this picture?'.

### **Appendix 3**

Questions asked to 15 CBT Practitioners who specialise in supporting children with low functioning autism.

Q. Did you know that those with ASD often have one or more other disorders as well?

Q. Why do you think this is?

Q. Do you think that talking therapies could be used with children with ASD?

Why/why not?

Q. If talking therapies have proved useful in people with depression, anxiety, OCD and other disorders, couldn't they be used to help those who have a comorbid disorder with ASD?

Q. Why/why not?

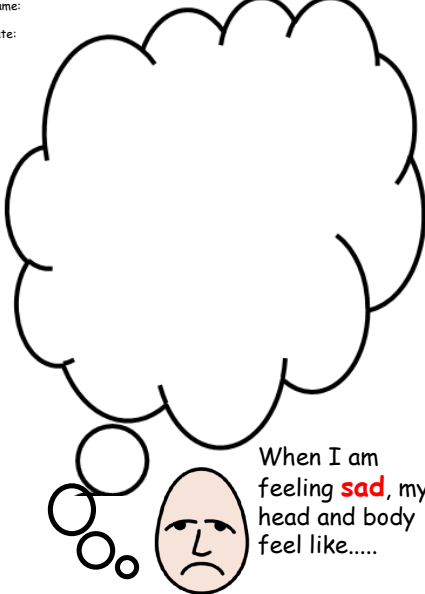
Q. Do you think they would be useful in reducing the rates of comorbid disorders in ASD?

Q. Why/why not?

Q. How are children with classical autism supported through CBT?

## Appendix 4

Name:  
Date:



When I am feeling **sad**, my head and body feel like.....

This form features a large thought bubble with three smaller bubbles leading to a sad face icon. The sad face has a downward-curving mouth and slanted, downward-pointing eyes. The text prompt is positioned to the right of the sad face.

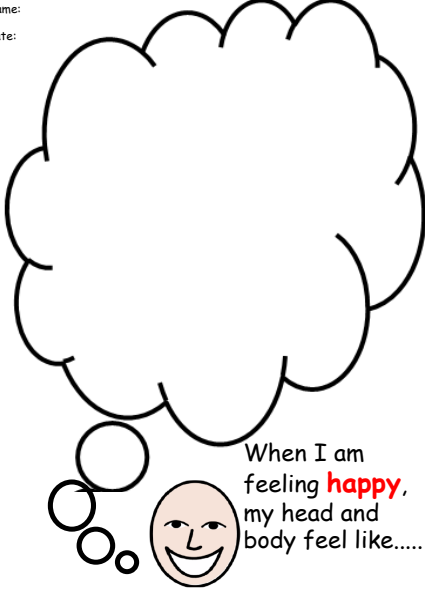
Name:  
Date:



When I am feeling **angry**, my head and body feel like.....

This form features a large thought bubble with three smaller bubbles leading to an angry face icon. The angry face has a straight, downward-curving mouth and slanted, upward-pointing eyes. The text prompt is positioned to the right of the angry face.


Name:  
Date:



When I am feeling **happy**, my head and body feel like.....

This form features a large thought bubble with three smaller bubbles leading to a happy face icon. The happy face has an upward-curving mouth and slanted, upward-pointing eyes. The text prompt is positioned to the right of the happy face.

Name:  
Date:



When I am feeling **calm**, my head and body feel like.....

This form features a large thought bubble with three smaller bubbles leading to a calm face icon. The calm face has a straight, upward-curving mouth and slanted, downward-pointing eyes. The text prompt is positioned to the right of the calm face.

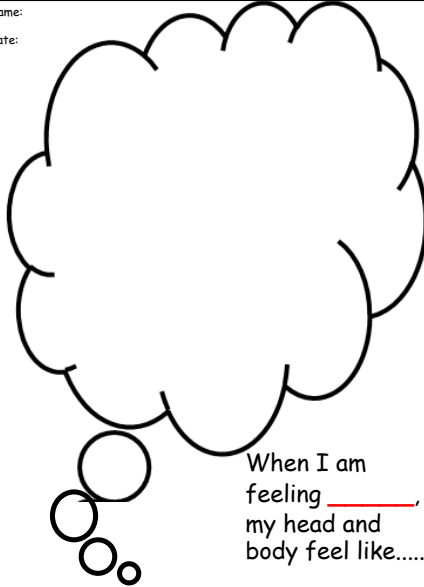


Name:  
Date:





When I am feeling **relaxed**, my head and body feel like.....

Name:  
Date:



When I am feeling \_\_\_\_\_, my head and body feel like.....

## Appendix 5


 **Comic strip!** 

Me


This happened...

I felt...

If I feel like this again I will...




Pupil: \_\_\_\_\_  
Staff: \_\_\_\_\_  
Date: \_\_\_\_\_

When I was feeling sad or angry 


I showed this by \_\_\_\_\_

This was because I felt \_\_\_\_\_


If I feel sad or angry again I will \_\_\_\_\_  
(strategy to de-escalate)

To help others know and to help make me happy 

Pupil: \_\_\_\_\_  
Staff: \_\_\_\_\_  
Date: \_\_\_\_\_



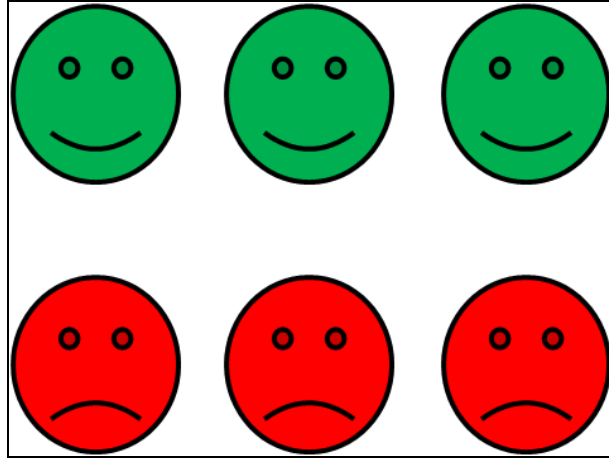
Any info regarding situation e.g. triggers:



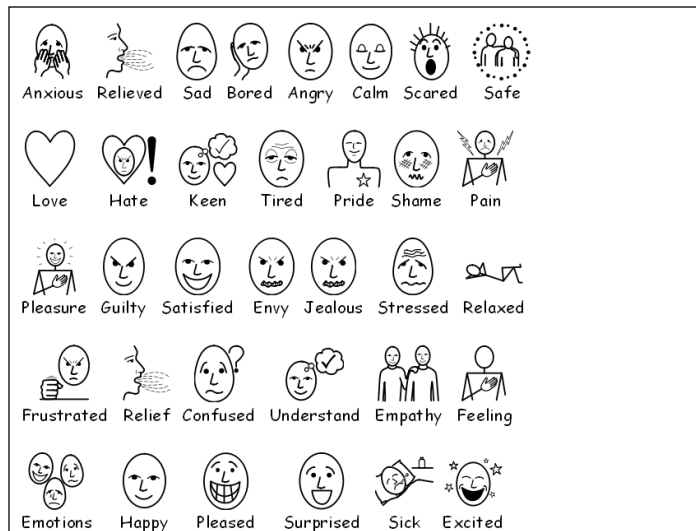
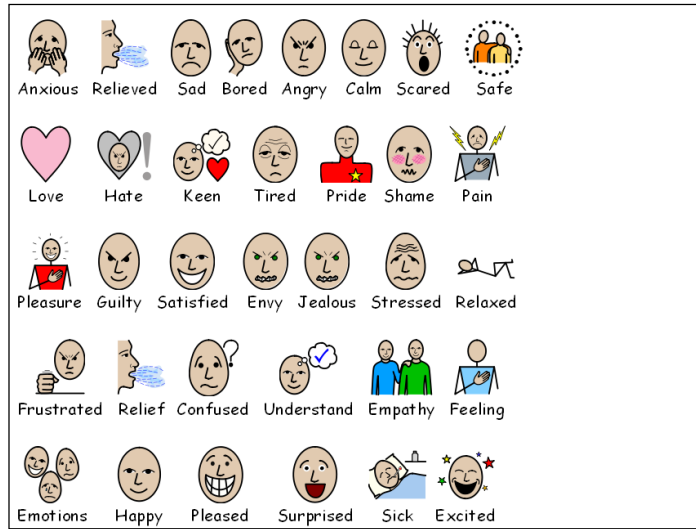
What we did to rebuild our relationship

Pupil: \_\_\_\_\_  
Staff: \_\_\_\_\_  
Date: \_\_\_\_\_

## Appendix 6

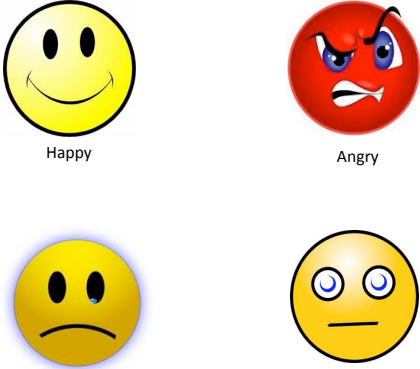


# Appendix 7



# Appendix 8

## My Feelings Diary



Happy

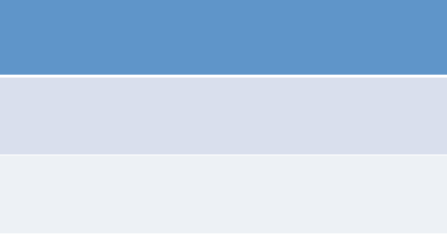
Angry

Sad


Calm

## Day 1

Things that made me feel happy today

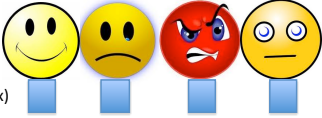


Things that made me feel sad today



## Day 1

Overall, today I felt



(Tick a box)

Because.....

.....

.....

.....

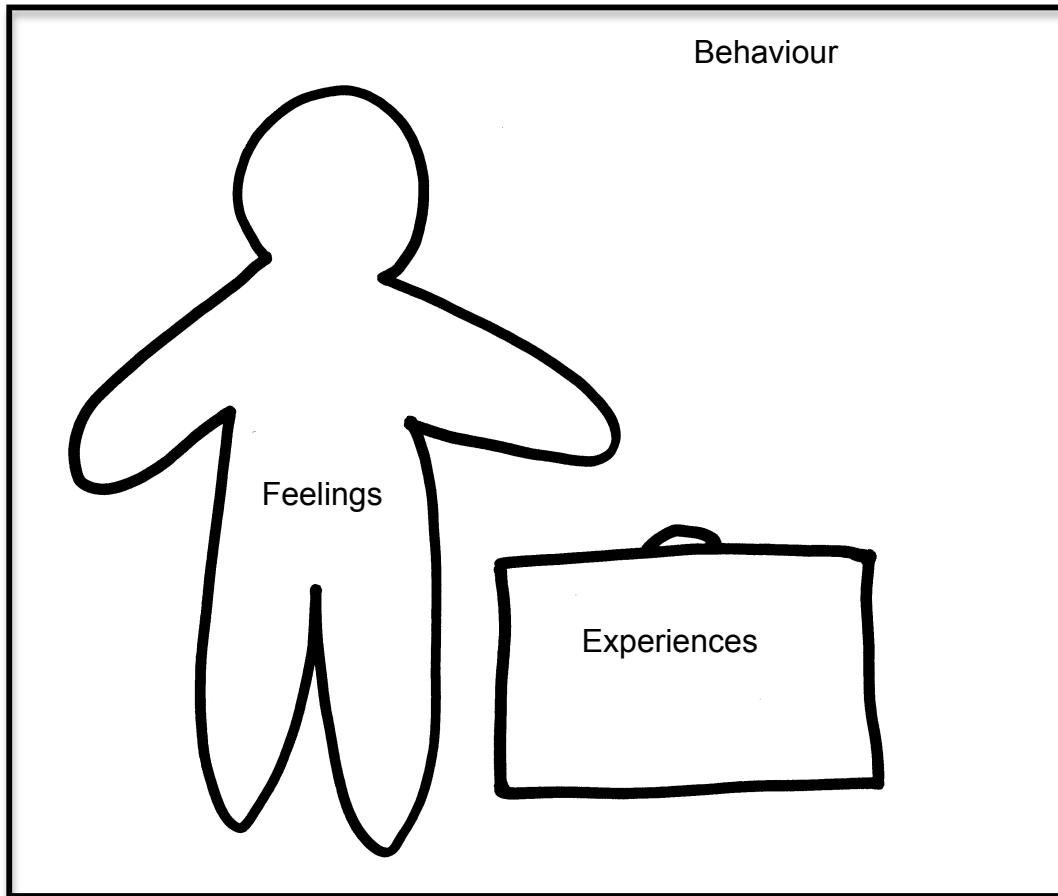
Write here if there is anything else you want to say.....

.....

.....

.....

Appendix 9



## Appendix 10

**Listen** (What happened?)

**Link** (How did it make you feel?)

**Learn** (What could you do if you feel that way again?)

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