Help for Autism and PDA

Advice and guidance for families with children on the Autism Spectrum, including PDA.

Friday, 2 March 2018

Watch this space ...

In the course of my clinical work, I meet with many parents who are seeking an explanation for their child's difficulties. I am also privileged to have been allowed to join a number of closed Facebook groups where parents share their experiences of bringing up children with Autism and PDA. Without exception, these parents have been strong, resilient and determined to achieve the best possible outcomes for their children. Many have had their parenting repeatedly questioned and report feeling 'lonely, isolated and full of self-doubt'.

I wanted to write this particular article to try and clarify once and for all why many clinicians may consider the possibility of a child's difficulties being due to an attachment disorder rather than Autism or PDA.

Brain development in babies starts in week four of gestation. The earliest part of the brain to develop is the brain-stem. This part of the brain deals with hunger, thirst and respiration. Next to develop is the mid-brain, which controls sensory processing, pain modulation and motor functions.

A little later what is known as the diencephalon (including the thalamus and hypothalamus) starts to develop. This part of the brain manages the 'fight, flight or freeze' response to threat or perceived threat. It also serves to process and relay sensory information.

About Me

Help for Psychology

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(the fight, flight or freeze response).

Chronic stress (and note the use of the word ‘chronic’) can lead to structural changes in the higher regions of the brain associated with emotion control, problem solving, and learning.
An overactive ‘fight, flight or freeze’ response can also leave the child fearful and hypervigilant.

Children exposed to early ‘trauma’ often have digestive issues, sleep issues, sensory motor issues, hyperactivity, and are impulsive and irritable. They frequently display difficulties with emotional regulation and experience cognitive difficulties, such as in problem solving, planning and sequencing. They will also display cognitive rigidity and difficulties with play. They are also likely to experience ‘sensory over-responsivity’ and will react badly to touch, light and loud noises. They may also have problems with proprioception – knowing where their body is in space.

It is easy to see how this kind of difficulty – known as developmental trauma – and Autism and PDA can easily be confused.

However, a great deal of research and work has been carried out in an attempt to put together diagnostic criteria for, what is now being referred to as, Developmental Trauma Disorder, and it is vital to get the message out to clinicians who are assessing children that the proposed criteria are VERY clear. There must be evidence of exposure to ‘**multiple** or **prolonged** adverse events over a period of at **least one year’.** This means **repeated** and **severe** domestic violence; **significant disruption of caregiving, repeated** changes of caregiver, or exposure to **severe and persistent** emotional abuse.

Some children do, sadly, experience this level of trauma – I have seen it many times in my own clinical work. Children who have had an unfortunate start in life do display behaviour that looks very much like Autism, and more particularly PDA. But, it **IS** different.

Many people, particularly clinicians and social workers, will have come across the Coventry Grid. The Coventry Grid was initially put together by a group of clinicians in Coventry CAMHS in the early 2000’s and subsequently discussed with the West Midlands Regional ASD Working Party (which I was a part of) before being written up by a Clinical Psychologist called Heather Moran and published in Good Autism Practice in 2010. It was revised in 2015, following Heather’s involvement with a group of Speech Therapists working in the youth justice system. It provided a have recently published a questionnaire (also in Good Autism Practice) in 2017 which aims to take this work further.

As much of our clinical work focuses upon the PDA profile, we are currently working on a further version of this which will include PDA. We hope that this will help clinicians to unpick the differences more easily.

In the meantime, though, I would urge any parent who finds themselves in the situation of having to defend their parenting, or is faced with the suggestion that their child has an 'Attachment Disorder', to quote the extracts above from the proposed criteria for Developmental Trauma (because this is basically what is believed to lead to an attachment disorder), and ask for the evidence of 'prolonged and severe' difficulties. I am not a neurobiologist but given that an over active stress (fight, flight or freeze) response can develop following trauma, is it not entirely possible that some children with Autism, and more specifically PDA, may be born with a heightened stress response, without the trauma? The resulting sensory and behavioural difficulties may at first glance appear very similar until the Autism is explored further.

Of course, I am not saying that some children, with or without Autism and PDA, don't have attachment DIFFICULTIES. This, for me, is different from an attachment DISORDER or developmental trauma. Life happens. Some parents struggle to manage their children for a variety of reasons; poverty, deprivation, poor role models of their own, depression and substance abuse being just a few. In these cases, there is no doubt that parenting courses and support to parent more effectively can be very helpful, and more importantly, often brings about a change in both the child's behaviour and the relationship between the parents and the child. However, this for me highlights the need for clinicians who are working with families to adopt a more 'systemic' approach. By this I mean they take account of the whole family situation when arriving at the most appropriate treatment or assessment for a child who is experiencing difficulties. They need to listen to the parents. If the child's behaviour is so challenging and so disruptive to the family, other children in the family are well behaved and well-adjusted and, most importantly, there is NO evidence of trauma, then sending them on a parenting course, or telling them they do not 'understand their child's needs', is not very helpful.

Posted by Help for Psychology at 02:23 7 comments: G+

It is the beginning of September again and parents all over the country are preparing for the start of the new school year. For some parents though, this is a time of increased stress, or even weary resignation, that once again they will have to face the daily battle of encouraging their child into school. For others, getting their child into school is a distant memory. These are the parents who have either made the difficult decision to home school their son or daughter, or have children who have voted with their feet and become 'school refusers'.

Some of these families will have a diagnosis of Autism or PDA for their child, and others will not. The issue of a PDA 'diagnosis', or even a description of PDA as a distinct behavioural profile, remains contentious. Parents over the summer have reported that their local CAMHS team, or Local Authority, have 'not accepted' the PDA description given to their child because 'it does not exist' or 'it is not in the manuals'. Autism was not included in the DSM until version 3 which was published in the 1980's! That certainly did not mean that prior to 1980 Autism did not exist.

Unfortunately though, this rigid sticking to 'what is in the manual' is potentially very detrimental to children and their families. What may have been stated as a difficulty in formally diagnosing a condition which has yet to be full researched, by a perfectly well meaning CAMHS clinician, is often interpreted, Chinese whisper style, as 'PDA does not exist'. When this then feeds through to school teachers and SENCO's it can lead to tense situations between school and parents. This can leave many families facing a struggle to ensure that their child is appropriately supported in the classroom.

But what about those children and young people with PDA who are home educated, or simply refuse to go to school? Clearly some thrive and do very well away from the social pressures, and sensory overload, of school. Others do less well. I have become aware of an increasing number of young people, who are effectively 'un-schooled' to the point that they spend all day, every day, in their bedrooms, playing computer games or watching YouTube. Some become so socially anxious that they rarely go out of the family home. This can, and does, continue well into young burned out, unable to work or access any kind of social life.

Maybe the first step is for early recognition of the potential difficulties that children and young people with PDA face. Early recognition by both mental health teams and school staff. It is not good enough to simply dismiss parents and send them away on a parenting course, or label them as ‘anxious’ or ‘fussy’ parents. This is not going to help the child, or go any way towards supporting them through school. As stated, home schooling does suit some children very well, and for some is the best option. For others, though, particularly those with very rigid thinking and high levels of social anxiety, it may not be helpful at all.

Many children with PDA do want friends. They want to socialise and deserve the opportunity to learn, not just academic skills, but also the social skills that they will need in adult life in order to function in the world.

PDA does exist. The research evidence is growing and a much clearer picture is beginning to emerge about what PDA looks like, how it presents in both girls and boys, what kind of features distinguish PDA from other difficulties. I can wholeheartedly reassure any clinician or teacher reading this article that PDA occurs all over the country (and probably all over the world) in many different types of families. These families have NOT had the opportunity to talk to each other and come up with the same story to convince a clinical team. Neither have their children, who present in a remarkably similar way.

So maybe the best reception any parent going back into school after the summer holidays could have is for staff to say ‘I believe you, we will do what we can to help support your child’. Whether or not their child’s particular profile of difficulties currently appears in a manual is irrelevant.

For those interested in the research mentioned above, watch this space for future updates.

Thursday, 11 May 2017

Autism, anxiety and the impact upon parents

This article is about Autism and anxiety. Research suggests that up to 85% of individuals with Autism will suffer from anxiety. A child with Autism is twice as likely as a neurotypical (non-autistic) child to experience anxiety. A significant number will suffer from extreme anxiety – to the point that it affects not just their life but their family's too. Some children are too anxious to attend school or social events. I am not talking here about reluctance to go to school, or a mild feeling of anxiety about a new challenge or situation, I am talking about complete meltdown and panic attacks at the thought of whatever is asked of them. In our clinic we have even seen children who are so anxious that even the mention of school sends their anxiety levels off the scale. This type of anxiety is debilitating. We always say to people, visualise the worst situation you can possibly imagine being in; one where you feel under threat or completely overwhelmed. Luckily, for most of us this only happens from time to time. For children (and some adults) with Autism this can happen every day of their lives. It is no wonder, therefore, that some will do anything (including hitting out or trashing the house) in order to escape from this feeling.

However, in this article I want to talk specifically about the impact of this anxiety upon parents who are often struggling to deal with the fallout. On a daily basis, we see, and receive emails and telephone calls from parents who are quite literally broken. Loving and caring parents who are experiencing what amounts to domestic abuse every day of their lives, parents who report symptoms of trauma (flashbacks, panic attacks and intrusive thoughts). Very often these are mothers who have had to give up everything – career, friends, dreams of their own, in order to provide care and support (and quite often schooling) for their children. There is no easily accessible support for these parents. In desperation they visit their GP (sometimes repeatedly) and ask for a referral to anyone, anywhere, who might be able to help.

Instead of support though, they find that they are criticised and talked about in the classroom and by other mothers in the playground and, sadly, even some professionals. 'I don't know what the problem is, he/she is fine at school', 'if he/she meltdown which goes on for hours? 'Leave him to cry, he will soon get over it'. What if he or she doesn't just 'get over it' and what if crying becomes a full-blown panic attack where the child threatens to stab him or herself with a knife, or ties a ligature round his or her neck, or where the only way to escape from this ball of fury is to lock yourself (and your other children in the bathroom) while your child launches him or herself at the door armed with a knife?

It is no wonder that these parents arrive at our clinic quite literally shaking. They are constantly on the alert at home, waiting for the next explosion. Many describe it as 'walking on a knife edge' or 'walking on eggshells'. They try and put on a brave face, tell us how much they love their child and how they want to make sure he or she has the best possible future, but they are often exhausted, burned out and, not unsurprisingly, depressed. Most are untreated and unsupported and simply left to get on with it as best they can.

It is important to note that these are not isolated incidents or confined to one particular group of parents. We have seen parents from as far afield as the Middle East, all parts of Europe and the United States of America and what is so compelling is that their stories are unbelievably similar. These are not parents who have read something on the internet, or seen a programme on the television. They are reporting EXACTLY the same behaviour and reactions in their children.

In addition, they are stumbling about in the dark in terms of what to do for the best. If your child is anxious and wants to spend every waking hour on the x-box or has a complete meltdown every morning about going to school, what should you do? Accept that a child on the Autistic spectrum needs time to unwind and effectively re-charge their social battery, so you let them play for hours in a darkened room, alone apart from online 'friends'? Accept that for some children, formal schooling is not working, so you home school? What will happen to that child when they become a teenager or an adult? Will they ever come out of their bedroom and engage in a 'normal' life? What does 'reducing demands' mean?

there was no TV or social media. There is also little research about what happens to adults on the spectrum, particularly those with PDA.

Many of the parents of children we see at our clinic often say they recognise features observed in their children in themselves. Some report that life got easier once they were in charge of their own destiny and not subject to endless demands from others. Others simply said that they grew out of the extreme behaviour and found ways to manage their anxiety. Others have not been so lucky and may be the absent parents, and those who have experienced some form of breakdown. What is very clear is that teachers, mental health professionals and those involved in policy making, cannot simply continue to ignore this problem. Parents cannot just be left with no support for themselves or their children. Without appropriate diagnosis and intervention strategies, the problems experienced by these families can only get worse. There is no point in trying to sweep this problem under the carpet, continue to blame parents or question their stories when they do seek help. There are some children who simply cannot respond to a 'Supernanny' approach to discipline and child-rearing, and they, and their parents, need support and understanding now.

For details of our services surrounding anxiety please head to our website at https://help4psychology.co.uk/anxiety.html

Posted by Help for Psychology at 02:51 5 comments: G+

Thursday, 30 March 2017

Missed or delayed Autism and PDA diagnoses

This article is equally applicable to both boys and girls. In the course of many years of clinical experience I have learned that boys can be just as good as girls at 'masking' their difficulties (particularly those who have the Pathological Demand Avoidance profile).

The guidelines recommend that any assessment should start within three months' of a referral being made. However, this is usually not the case. In 2015 the National Autistic Society carried out a survey of parents who had been through the diagnostic process in the UK. This survey found that the majority of parents were aware that their child had a difficulty from a very early age. The average wait time between parents first noticing a problem and getting a final diagnosis, was reported to be around three and a half years!

The NICE guidelines also recommend that every child who receives a diagnosis should be given a personalised plan, an allocated key worker and 'the opportunity to take part in age-appropriate psychosocial interventions'.

This clearly is not the case for the majority of young people. Parents often report that they have tried to access support for their children from their local Child and Adolescent Mental Health Services (CAMHS) without success. Some state that they have been told that their child is not presenting with 'serious' enough difficulties and that teams only have capacity to see children with very significant mental health issues. The trouble is, that without any post-diagnostic support, children and young people can go on to develop more serious problems.

Also, what a lot of people fail to understand is that there is no 'quick fix'. Children with Autism and PDA are not going to be 'fixed' by a few sessions of support around managing anxiety, or anger. They are likely to need specialist input from clinicians who really 'get' Autism and have the expertise to modify standard CBT (Cognitive Behavioural Therapy) and other approaches. In addition, when working with children with Autism, it often takes a significant amount of time to build a therapeutic relationship.

In addition, with Autism and PDA, the issues that families and young people do have, tend to wax and wane. There may be periods where everything is going well, followed by a 'crash' when problems become more significant and troubling. This is sympathetic towards the difficulties they face. I know how stretched they are and I am fully aware of the number of children (with and without Autism) who have very serious mental health difficulties. It is a constant challenge to juggle available resources and time. Prioritising who to see is a nightmare.

How can this be done fairly? What may not appear to be a 'serious' mental health condition or a 'serious' level of challenging behaviour can change in a moment, and can quickly become a crisis, leaving parents and young people, struggling to cope.

Also, another argument for the benefit of providing intervention and support before crisis point is reached, is the huge cost (both financial and emotional) of managing a young person in inpatient services. There is a national shortage of adolescent beds throughout the country and young people often have to be accommodated in units many miles from home. By this point, things may have got so bad for them that they are self-harming, presenting with extremely challenging behaviour or are even suicidal.

Once in hospital, there is also no guarantee that they will be lucky enough to be treated by staff who understand Autism or who have the expertise to provide the modified intervention approaches needed by young people on the Autistic Spectrum. On top of this, once discharged from hospital, it can be very difficult to arrange follow-up support.

So when professionals (as cited in the article by Tracy Elliot entitled 'Why timely diagnosis of autism is important' – cerebra.org.uk) state that reducing waiting times for Autism diagnosis may not be a 'priority' for the NHS, this seems to be extremely short sighted. Surely ensuring that children and young people are assessed and diagnosed in a timely manner would ultimately save the NHS huge amounts of money? In addition, it would also save young people and their families from enormous emotional upset and confusion. The sooner that families know what they are dealing with, the more likely they are to use the right strategies and the young people themselves will know that they are not 'odd' or 'weird'.

can be pre-ordered via Amazon.

Posted by Help for Psychology at 07:04 1 comment: G+

Tuesday, 31 January 2017

Managing the child with PDA in the classroom – Part Two

The second part of this article is aimed at both parents of children on the Autistic Spectrum, and those working with them in a school environment, and examines the impact of the various stresses of the school day for these young people, but also for those who have the job of supporting them, particularly teachers and teaching assistants.

First from the point of view of the young people. We immediately come straight back to anxiety. It is important to note that the level of anxiety for some of these children goes way beyond the everyday anxiety we all experience from time to time. Imagine the worst you have ever felt – that important job interview, waiting for exam results or medical test results or that meeting with the boss which is not going to go well. This is what these children can feel like EVERY SINGLE DAY. Think how you felt in that situation, the thumping heart rate, the sick feeling in the stomach and, more importantly, that desire to run away somewhere safe and get away from the situation. Imagine feeling like that every time you think about going to school. On top of that, imagine that every day you know, at some level, that it is socially unacceptable to show this level of anxiety so you hold it all in – all day, every day. Sometimes you may not manage this and you will end up 'losing it' over something apparently trivial (haven't we all done this at some point?) but also imagine that you are not good at noticing when you are getting to that point, so your explosion of anger and frustration takes you (and everyone else) by surprise. At this point, someone helpfully tries to get you out of the room so that you and the other children are safe. Many children on the Autistic spectrum will have quite significant sensory it is hardly surprising that so many children on the Autistic Spectrum struggle at school.

However, it is not only the young people who find this difficult. Many teachers report feeling helpless and not being sure what to do for the best when a young person is clearly distressed, but at the same time causing havoc in the classroom. Even those who do not visibly show their distress can inadvertently cause disruption, fidgeting, skin picking, interrupting, getting in and out of their chair, refusing to do certain pieces of work etc.

The answer is often to allocate a specific teaching assistant to support a particular child. This can be a very difficult job and it is easy to feel disheartened. With many children, particularly those with PDA, you can feel that, at last, you have made a breakthrough – the child you are working with appears to settle and be doing better, then suddenly, it all goes horribly wrong and you are back to square one. In your darker moments, you may even feel that the child is deliberately sabotaging your efforts. It does not help if you have been physically punched or kicked or been screamed or spat at by a highly distressed child. It is hard not to take this personally.

One issue which is often overlooked is that of burnout. Health professionals have regular supervision (a space in which to discuss with a colleague or manager how a certain situation, child or family has made you feel). 'Projection' is a psychological term used to describe how a child can 'project' all their anger, fear and frustration onto you and make you feel useless and bad at your job.

Without that space to be able to discuss how a situation has made you feel, it is not long before people start to doubt themselves and feel burned out. Also, working with a child with Autism (and even more so with PDA) can be physically and mentally draining. You will pick up on their anxiety levels (even if the signs are not obvious) and may feel like you are 'walking on eggshells' trying to avoid at all costs, saying or suggesting something which will lead to an outburst. Regular breaks and, if possible, also to those parents who are home educating their children. Most find that when their child is away from the situation they found so stressful, they tend to settle somewhat. This does not mean that the stress for parents or the potential for burnout is any less. Many parents still report the feeling of 'walking on eggshells'. There is no easy solution to this. Within a school setting, it may be possible to rotate working with a particular child and take a break. For many parents this is not an option.

I suggest the overall message of this article is the need to appreciate the effort involved in supporting a young person with high anxiety levels. It is not just a case of providing clear boundaries, or adopting a consistent approach which is the advice given to many parents (and teachers) struggling to manage challenging behaviour. What is needed is a sympathetic and joined up approach which aims to understand the underlying challenges for these children.

Finally, we do offer training courses for schools, and further details can be found on our website - http://www.help4psychology.co.uk/pdacourseschools.html

Posted by Help for Psychology at 06:04 3 comments: G+

Sunday, 15 January 2017

Managing the child with PDA in the classroom – Part One

The previous two articles have touched upon the challenges faced by parents when their children 'mask' or hide their difficulties in the classroom. In the course of assessments and therapy with families, many parents have reported feeling blamed and judged when it appears that whatever they seem to try with their children does not work, whereas at school they perhaps behave like the model child.

parents and ultimately on their ability to hold down a job – how many employers are able to be sympathetic and that flexible?

A high number of children on the Autistic Spectrum, particularly those with PDA, will be temporarily (and sometimes permanently) excluded from school. To be fair, if the child is so distressed that they are putting themselves, or others, in danger as a result of their behaviour, this is probably the only option schools have.

However, all behaviour is a form of communication. Children on the Spectrum who are throwing furniture around or hitting their teachers and peers are not 'naughty', they are distressed. They often do not have the words to express how they are feeling, or the social imagination to predict the consequences of what they are doing.

School staff often feel at a loss to know what to do for the best. Children with Autism struggle with change and will often find a change of routine, or teacher, unbearably anxiety-provoking, but often with the support of visual timetables and clear structure, many can cope. Those who appear to experience the greatest difficulty are the children with PDA. Everyday demands are often unbearable and they can quickly escalate into full 'meltdown'. This can include screaming, punching, kicking and biting or running out of the class. Some children might need to be restrained for their own safety which is distressing for both the child and the staff, who even if they have received appropriate training, often feel uncomfortable.

The following strategies may help some of these children to succeed at school. They are taken partly from the National Autism Standards, 'The Distinctive Clinical and Educational Needs of Children with Pathological Demand Avoidance: Guidelines for Good Practice', produced by Phil Christie, who was formerly the Director of Children's Services at the Elizabeth Newson Centre in Nottinghamshire, and partly from advice and guidance from the staff at the Robert Ogden School, a National Autistic Society School in Doncaster who have experienced good outcomes with children with PDA.

Children with a demand avoidant profile tend to under-perform in terms of their potential, due to their anxiety and need for control. Key issues for any school will be way' and being given privileges the other children are not. Simply, trying to make them comply is unlikely to work – schools have to work to find a balance and this is often a challenge. Help for Psychology run courses for both parents and teachers and we are well aware of how hard it can be to accommodate the needs of a very distressed and anxious child. (Full details of our training courses are on our website.)

The guidance states that teachers need to be 'flexible and adaptable'. Children with PDA find direct instructions and demands difficult. Again this can be a challenge if you are a teacher, working within the confines of the National Curriculum with 30 other children in the class. However, they often can cope if they are provided with options – 'would you like to do X first or Y?' The expectation is, of course, that they need to do something but at least giving them a choice can reduce the demand somewhat.

Also, unlike children with more classic forms of Autism, providing lovely visual timetables and schedules are unlikely to be effective for children with PDA. Quite often the anxiety provoked by worrying about what is going to happen leads the child to sabotage the activity rather than deal with those uncomfortable feelings. This can be very difficult for both parents and teachers to understand, particularly if the activity is something you know they would enjoy, but talk to any adult with PDA and they will confirm that the stress of expectations (both their own and those of other people) can be simply unbearable. Rewards and positive reinforcement for appropriate behaviour can often provoke the same reaction because if you do well once, the expectation (and therefore the demand) to do the same next time is also a challenge.

Finally for part one of this topic, both parents staff working with children with PDA need to be aware that what works one day may not work the next. Everyone may be congratulating themselves and feeling that they have turned a corner when suddenly – boom, everything explodes and you are back to square one. Everything depends upon the level of anxiety at any given time. The less the anxiety, the more co-operative the behaviour, the higher the anxiety, the more likely you are to see challenging behaviour.

terms of mental health issues, and how to avoid burnout when working one to one with a child with PDA.

Posted by Help for Psychology at 04:54 No comments: G+

Wednesday, 30 November 2016

It's not only girls who can mask

Following on from the previous article regarding masking in children on the Autistic spectrum, this article is going to look at boys who mask. These boys seem to fall into two distinct categories. The first group is those who understand the rules at school and appear to manage the structure of school very well, but who are often struggling socially and academically, and who keep 'below the radar' whilst at school.

When teachers and other staff at school report that they are doing well socially and have lots of friends, sometimes they will need to look more closely at the quality of these friendships – is the young person on the periphery of the social group in the playground, looking for an opportunity to join in? Do they go on 'play-dates' and more importantly, are they invited back for a second or third visit? This can cause stress and anxiety because he will have no idea why this happens or what to do to fix it.

These young people also often have what psychologists refer to as a 'spiky profile' in terms of their IQ. They may be exceptionally good verbally but have much poorer non-verbal skills. This may lead to them being poor at mathematics and/or poor at organising themselves. They may also have difficulties with auditory memory. Basically, information goes in one ear and out the other without being fully processed, so the young person will not be able to follow an instruction given verbally. This will more than likely mean that homework instructions will be forgotten. If you then combine that with poor processing speed (another very common problem for young people with Autism) and the poor child will not even be able to copy information off the board or complete work in time. It is hardly surprising that this apparently well behaved child becomes angry and stressed in the safety of his own home. It is important that teaching staff (and parents) recognise that for some children on the spectrum it is not a case of 'won't do' but 'can't do'.

profile. These were young people, usually boys, where the key impairment is in the area of non-verbal interpretation. This leads to a lack of ability to empathise with the perspective of another person, and an inability to see the potential consequences and impact upon others of certain actions. This can lead to social and behavioural difficulties and social vulnerability. Atypical Asperger's syndrome (as described by Digby Tantam) often co-exists with attention deficit hyperactivity disorder (ADHD), or attention deficit disorder (ADD). These boys will often fail at school, with many being excluded or becoming effectively marginalised from the education system by the age of fourteen.

Although they often manage to form a number of superficial friendships, they will struggle to maintain these, and often suffer from low self-esteem and poor identity. This tends to encourage them to either become the class joker (in an attempt to 'fit in'), or behave in an increasingly outrageous or anti-social manner. At this point, they often become more aggressive - towards people and objects - and frequently they refuse to obey rules of any kind. This can lead to them mixing with other 'troublemakers'. However, there continues to be a naivety about this group with them frequently getting caught or scapegoated.

Quite often, when the police or other authority figures are called, these boys are the ones left standing there, looking around when all the others have run off. They will often mimic the other boys (in terms of clothes, accent or expressions that appear to be 'cool'). However, they very often get this wrong and, to their peers, they can appear odd or an easy target.

The overriding feature of these boys is likely to be, once again, anxiety. Although obsessive special interests tend to be less common in this sub-group (often due to co-morbid ADHD), cognitive rigidity is still present and can manifest itself in the inability to see anyone else's point of view or admit that they may be wrong. In addition, very literal thinking, and a lack of ability to understand and process ambiguous language and metaphors, leads to frequent misunderstanding and this is often coupled with an inability to 'move on' from what they see as 'injustice'.

I hope this week's blog has shown that it is not just girls who mask and sometimes Autism in boys can be just as difficult to spot.

NEXT TIME - In the next article I will be discussing the strategies that schools can use to help manage and support the child with PDA in the school environment.

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