The Coventry Grid for adults: a tool to guide clinicians in differentiating complex trauma and autism

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Editorial comment

In this paper, the authors discuss the need for an instrument to help distinguish between autism and the effects of complex trauma in the diagnostic assessment of adults. They chose to adapt the Coventry Grid (Moran, 2010) for this purpose and developed the Coventry Grid for Adults (CGA). It is widely accepted that autism presents differently in each individual with the diagnosis and so too in trauma. Diagnostic assessment tools are necessarily limited in that they have to use general descriptors and can not account for every individual seen with the condition. There is also often a focus on difficulties and a tendency to view difference as a deficit, when such differences can convey strengths and/or may not be viewed as a problem by the person concerned. The authors acknowledge that the CGA is in its infancy and welcome feedback from readers.

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Introduction

Identification of autism in adulthood is not always straightforward. Many traits characteristic of autism can also indicate a complex trauma (CT) history. In fact, the developmental impact of early trauma in some institutionalised babies has so clearly mirrored autism that it has been considered a type of 'quasi-autism' (Rutter et al, 1999). Like autism, CT is usually experienced as pervasive and can have a lifelong impact on an individual (Van Der Kolk, 2014). It is often unclear whether a person's difficulties should be best understood through the lens of autism or CT or both (Lai and Baron-Cohen, 2015).

A significant number of adults are thought to have undiagnosed autism, many of whom have been mistakenly understood as experiencing mental health problems (Lai and Baron-Cohen, 2015). Concurrently, individuals with a history of feeling different from others and struggling to manage social interaction have queried whether they may be autistic, and requested formal assessment. The interactions between autism, poor attachment and vulnerability to trauma mean that there will also be a group of people who have both autism and CT (Perry and Flood, 2016).

Diagnostic criteria for autism specifically require that difficulties cannot be explained by 'another mental disorder', acknowledging that the same symptoms could have different origins (*Diagnostic and Statistical Manual of Mental Disorders,* 2013). Accordingly, gold standard diagnostic tools, such as the Diagnostic Interview for Social and Communication Disorders (DISCO; Wing, Leekam, Libby, Gould and Larcombe, 2002) and the Autism Diagnostic Observation Schedule (ADOS-2; Gotham, Risi, Pickles and Lord, 2007), should be used as a part of a comprehensive assessment undertaken by experienced clinicians who can also rule out other

reasons for the development of apparently autistic traits (see National Institute for Clinical Excellence guideline 142, 2012). Despite the increasing commitment to comprehensive assessments, diagnosis is not always clear cut, with clinicians sometimes practising diagnostic 'upgrading' when there is a lack of clarity (Rogers, Goddard, Hill, Henry and Crane, 2016).

The authors acknowledge and do not dispute established arguments against the usefulness of diagnostic labels (eg Bentall, 2006). That said, we believe that disentangling autism from experiences of trauma (or recognising where both are present) is important, not because of any inherent value in giving a person the correct label(s), but to develop a better understanding of the person and the origins of their difficulties. From a good formulation follows the best person centred support, treatment or management plan (Johnstone and Dallos, 2013).

Where CT and autism are misdiagnosed, this can have negative implications for both the person themselves and also on the systems that support them. Someone with autism understood to have CT, or vice versa, may find themselves poorly understood by themselves and others, and could therefore be offered inappropriate support or interventions. Accurate identification of autism, for example, allows the clinician to adapt their therapeutic approach to increase suitability for the autistic individual (eg Bulluss, 2019; Gaus, 2011), facilitating treatment responsivity. When interventions are not effectively tailored and likely to lead to an improvement in well-being, an individual may be apportioned blame or dismissed as being 'non-compliant', which can serve to maintain or exacerbate distress.

The Coventry Grid

The problem of disentangling autism and CT has begun to be addressed in children's services, most notably with the Coventry Grid (Moran 2010; 2015; see also Flackhill, James, Soppitt and Milton, 2017). This is a tool developed to assist professionals in noticing the often subtle differences between children on the autism spectrum and those with attachment difficulties. There is no equivalent tool for working with adults, although the authors have anecdotal evidence of clinicians in adult services using the Coventry Grid in its original form. Given the Coventry Grid is a tool designed for understanding difficulties in children, this approach has obvious limitations. The authors therefore used the Coventry Grid as a starting point to develop an equivalent tool for use in adult services, The Coventry Grid for Adults (CGA), see *Appendix 1*.

The Coventry Grid for Adults (CGA)

Like the original Coventry Grid, the CGA was developed by a group of interested clinicians working in services supporting people with autism and/or complex trauma. The group was made up of Clinical Psychologists and a Speech and Language Therapist, all of whom had at least two years' post qualification experience in these fields and were trained in the administration of at least one of the gold standard tools for the assessment of autism (eg DISCO or ADOS). The initial working group mostly comprised clinicians employed by Mersey Care NHS Foundation Trust, a mental health trust in North West England, but also included a Clinical Psychologist from Adelaide, Australia who attended meetings via Skype and a Clinical Psychologist working for the University of Liverpool Doctorate in Clinical Psychology training programme.

The children's Coventry Grid contrasted autism with attachment problems, which it defined as "all kinds of significant attachment difficulties, severe enough to affect the ability to develop mutually supportive relationships with family and friends". The CGA is designed to map onto how these difficulties might manifest in adulthood, however the term complex trauma has been used as this is a widely accepted term capturing the adult experience of attachment difficulties while avoiding the pitfalls of diagnostic categories such as Borderline Personality Disorder.

The first step involved reviewing each item of the Coventry Grid and agreeing whether or not it could be usefully applied to an adult population, or whether it needed amending or deleting. As individual items were reviewed, it became clear that some broader sections and their titles also required amending or deletion (for example, an item was added pertaining to forming and maintaining intimate relationships).

Existing networks and a conference presentation were used to invite interested professionals with two or more years' post qualification experience working with these populations to assist in reviewing the CGA. Prior to review, the draft grid was amended so that the proposed 'Autism' and 'CT' items were mixed together and randomly listed under the section headers. Reviewers were asked to indicate whether each item was likely to be a feature of autism, CT or both. Seven reviewers provided feedback which was used to refine the grid, with a number of items removed or adapted where there was a lack of consensus, or the items did not reliably differentiate autism from CT.

Purpose of the CGA

Like the original Coventry Grid, the purpose of the CGA is to assist qualified clinicians to better understand individuals who present with difficulties common to both autism or CT, enabling more refined assessments for those individuals and informing multidisciplinary team discussions. The CGA is not intended to be used as a checklist, and it should not be used in isolation from other formulation work with an individual.

Limitations of the CGA

Whilst the CGA is not a diagnostic tool, the very act of grouping experiences and behaviours into two relatively broad categories means that important subtleties may be lost. Further, the focus of the CGA on 'difficulties' is inherently aligned with a problem focused approach to working, even if the explicit intention is to use it to increase understanding.

Autism is experienced and observed in an enormous variety of ways, and this may be especially true in adulthood when individuals have developed idiosyncratic ways of managing their differences (Lai and Baron-Cohen, 2016). In addition, autism and CT may have different presentations in men and women (Trubanova, Donlon, Kreiser, Ollendick and White, 2014) which the CGA is not able to directly address. However, it may be that the CGA is indirectly useful here, for example helping to correct the disproportionate misdiagnosis of Borderline Personality Disorder in autistic women (Trubanova et al, 2014).

Like the CG, the CGA does not distinguish between attachment styles and therefore the range of CT presentations. In particular, it may not be sensitive to an anxious avoidant pattern, where some behavioural features may mirror those commonly associated with autism (Mackenzie and Dallos, 2017).

As yet, the CGA remains an unvalidated tool with items assembled through the anecdotal experience of clinicians. There is a potential weakness in relation to the formulation of items, in that the overall experience and post qualification training within the group was skewed in favour of autism. While all members of the group had been trained in at least one formal diagnostic tool for autism and had clinical experience working with CT, only one person had been trained to administer a structured assessment of attachment relationships. This perhaps reflects the relative emphasis on formulation over diagnosis in CT.

In addition, although over 100 experienced clinicians were invited to participate in the review process, many reported insufficient confidence in their knowledge of autism and CT to do so and only seven were eventually involved. This smaller than anticipated number speaks to the need for the development of a tool to support clinicians in this complex area.

Concluding comments

The CGA is a working document and we plan to continue to improve it based on feedback. Further work is required to develop its sensitivity to a broader range of attachment styles. Future research will investigate the usefulness of the CGA to both clinicians and the individuals who have been assessed using the CGA. There is also scope to explore the link between the behavioural observations and the functions underpinning these.

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Appendix 1: The Coventry Grid for adults: a tool to guide clinicians in disentangling complex trauma and autism

Please note: The purpose of this tool is to assist qualified clinicians to better understand individuals who present with difficulties common to both autism or complex trauma, enabling more refined assessments for those individuals and to inform multidisciplinary team discussions. The CGA is not intended to be used as a checklist, and it should not be used in isolation from other formulation work with an individual.

1 Inflexible thinking and behaviour

People with autism and people with significant attachment difficulties (here termed Complex Trauma, CT) present with difficulties with flexible thinking and behaviour. This can present as behaviours which are demanding, .

Presentation observed in both	Autism	Complex trauma (CT)
1.1 Preference for predictability in daily life		
	a. Repetitive questions related to own focused interests.	i Looks forward to new experiences but may not manage the emotions they provoke (eg may not cope with excitement or disappointment).
	b. Ritualised greetings (including specific 'scripts' for 'small talk').	ii Seeks to keep relationships close, driven by fear that changes in caring behaviour indicates potential for abandonment.
	c. Becomes anxious if routine is removed and may seek to impose usual routine (eg difficulties transitioning between work and holidays; becoming distressed if usual appointment times are changed).	
	d. Inclined to try to repeat experiences and therefore day to day repetition becomes routine (eg becomes distressed if asked to sit somewhere else in a work office).	
	e. Distressed when a routine cannot be completed (eg when cannot follow the usual route because of road works).	
	f. Adhering to strict and inflexible routines, and possibly becoming distressed when these are disrupted. (eg categorising and organising household items: 'everything has its place'. Refusal to let others in household use certain items).	

Presentation observed in both	Autism	Complex trauma (CT)
1.2 Difficulties with eating		
	a. Limits foods eaten according to unusual criteria such as texture (sensory), shape, colour, brand, situation, rather than what that food is (eg will eat chicken nuggets but not chicken, will only eat Fray Bentos steak pies). May also become distressed if packaging changes.	i Aversion to specific foods due to textures, tastes etc. which trigger traumatic memories.
	b. Food neophobia, showing fear for new foods, causing a very limited diet.	ii Person describes binge eating and restrictive eating as comfort seeking, gaining a sense of control, and coping with emotional stimuli. Eating difficulties may fluctuate depending on emotional state.
	c. Preferences for standardised/processed foods related to their predictable nature.	
1.3 Repetitive use of language		
	a. Immediate/delayed echolalia. This can be repeating what a communication partner has said, or in the form of stereotyped language (eg speaking in quotes from books or movies).	i Uses repeated phrases in close relationships (eg 'I can't bear it anymore') expecting predictable responses from others (eg 'I'm here for you').
	b. Repetition of 'favoured' words which are chosen for their sound or shape, rather than for their use in communication or emotional content.	ii Language used to elicit caring response from others but is not experienced as a comforter in its own right.
	c. Uses formal, pedantic or inappropriate language. This may be in context but also may be using words/phrases the person does not understand.	
1.4 Unusual relationship with possessions		
	a. Makes collections of objects. Collections often carefully arranged (eg alphabetised).	i Interested in showing possessions to others and gaining a response, including social approval or envy.
	b. Has a collection of items (that may or may not be socially appropriate) and does not seek social approval for the collection or for its care.	ii Ambivalent attachment relationships with objects: may deliberately destroy emotionally significant possessions when angry.
	c. Will often be able to say where most treasured possessions are and recognise if they are moved.	iii Hoards items due to previous experiences of deprivation or loss.
	d. Preference for certain belongings due to sensory features (eg crystal glass figures).	
	e. Hoards items due to inability to discriminate between useful and useless items.	

2 Intense and restricted interests

Adults with both autism and CT often display patterns of intense and restricted interests. In childhood, this may have been most evident in the way they played (for example lining up toys or struggling to engage in imaginative play). As adults, this may manifest itself in choice of hobbies and behaviour in informal social situations.

Presentation observed in both	Autism	Complex trauma (CT)
2.1 Unusual choice of hobbies or interests		
	a. Preference for logical, predictable interests (eg train timetables, stamp collecting).	i Choice of interests often linked with specific group identities (eg music scenes, tattooing). Sudden change in interest appears to be related to unstable sense of identity.
	b. Collects facts rather than showing interest in more general aspects (eg knows football scores but does not show a real interest in the match).	ii Intense interest may relate to a personal experience, an emotional weighted event or an interpersonal relationship (positive or negative).
2.2 Social interaction related to interests		
	a. Prefers to pursue interests alone, or only alongside others, in a parallel fashion.	i Quickly forms friendships or sense of belonging with others who share the same interest. Interest could be superficial.
	b. Where interests are pursued in groups this tends to be in settings with clear social rules that may have been taught (eg going out for a meal, role play).	ii Creates an ideal self through emulating an idealised other's interests.
	c. Even when interests are shared, discusses own knowledge, rather than gaining knowledge from others and will rarely ask others for their opinion on interest.	

3 Social interaction/communication

There are key similarities in social interaction/communication: people with autism and CT tend to have an egocentric style of relating to other people and lack awareness of the subtle variations in social interaction which are necessary to develop successful relationships with a range of other people.

Presentation observed in both	Autism	Complex trauma (CT)
3.1 Difficulties with social interaction		
	a. Lacks awareness of the needs of the audience; lack of attunement and reciprocity in social interaction (eg does not turn take).	i Hyper-vigilant and overly sensitive to tone of voice, volume and stance of communication partner; person may appear to be hyper-vigilant to any potential emotional rejection.
	b. Does not knowingly influence others emotionally except through angry outbursts (eg would rarely ingratiate self with audience).	ii No difficulties initiating conversation (unless in an emotional aroused state).
	c. Does not vary eye contact with emotional state, though may still vary at times (eg when effort put in to make eye contact).	iii Eye contact affected by emotional state.
	d. Attempts a logical approach to social interactions (eg rote understanding of body language).	
	e. Person assumes prior knowledge of communication partner (eg limited Theory of Mind). Does not start conversations by addressing the person/context but starts with the subject matter.	
	f. Proximity to others might be unrelated to desire to interact socially (eg close proximity may not signal an intimacy or desire for contact).	

Presentation observed in both	Autism	Complex trauma (CT)
3.2 Difficulty interacting in a group setting		
	a. Lacks awareness of the social expectation of sharing (eg sharing talking time/turn taking when interacting in groups).	i Feels anxiety that other members of the group are not safe.
	b. One-sided social approaches.	ii Hyper-alert to any indications of threat from others, and seen by others to 'over-react' to these. This could include behaving in a hostile way, withdrawing, or making special efforts to ingratiate self with others.
	c. Laughs at jokes but does not understand why they are funny or laughs at the wrong time. Misses subtle or unexpected verbal or contextual associations.	iii Patterns of social relationships develop to meet emotional needs, either with attempts to please others or keep others at a distance.
	d. Manages well in highly structured social interactions (eg appointments).	iv 'Assigns' others (eg professionals) to roles which are familiar to their own past experience of relationships (presenting as transference).
	e. Struggles to keep up with fast moving subtle interactions (eg sarcasm, body language).	v Initiates interactions with others which allow them frequently to play the same role in relation to self (eg as the victim, as the bully).
3.3 Difficulties in intimate relationships		
	a. Difficulties understanding what makes others feel loved and appreciated (eg only buys practical presents).	i Pattern of seeking out attachment and then withdrawing and rejecting attachment figures.
	b. Struggles to understand social rules of relationships. May become fixated on others while unaware or unconcerned that feelings are not reciprocated.	ii Expectation that others will be abusive and punitive.
		iii Hyper-alertness to threats within a relationship and perceived threat of abandonment in intimate relationships.

4 Mentalising/theory of mind

People with autism and CT often have difficulties with mentalising/theory of mind. This refers to both the ability to see the thoughts/perspective of others; to recognise that this may differ from their own; and to read others' intentions.

Presentation observed in both	Autism	Complex trauma (CT)
4.1 Difficulty appreciating others' views and thoughts		
	a. Rarely refers to the views of others.	i Efforts to feel safe by influencing social interactions and evoke desired emotional responses in others. This may be perceived as controlling.
	b. Uses logic or rules to work out others' intentions.	ii Overly compliant and ingratiates self with others in order to feel safe.
	c. Fails to take into account how others will feel when making decisions about behaviours.	iii Acutely interested in others' thoughts or views but ability to accurately assess these is disrupted by schemas (eg early experiences leading to the belief 'I am unlovable' result in suspicious interpretation of loving behaviours).
	d. Fails to acknowledge or offer comfort when someone has been hurt.	
	e. Obsessively reviews previous interactions and applies logical thought patterns to previous events.	
4.2 Lack of appreciation of how others may see them		
	a. Has unusual logic or lack of awareness about personal responsibility (eg fail to take responsibility for unintentional mistakes).	i Avoids personal responsibility by blaming others for own mistakes, but fails to take into account context, others' perspectives, others' knowledge of events, or the consequences of avoiding responsibility, regardless of impact on people or relationships.
	b. May lack awareness of others' views of self, including lack of awareness of 'visibility' of own difficulties.	ii Tries to shape others' views of self by biased or exaggerated reporting in line with social conventions.
	c. Does not appreciate need for social convention to elicit positive response and view of themselves from others (eg responds to someone's new hair cut by telling them they don't suit it).	
4.3 Problems distinguishing between fact and fiction, blurring of boundaries		
	a. Does not place value on the distinction between people and objects, fictional characters or events (although may recognise the latter are not 'real').	i Unable to judge whether a threat is realistic. Acts as if all threats, however minor or unrealistic, need to be defended against.
	b. Poor at fabrication or 'white lies', rather misrepresentation may occur due to difficulties understanding and communicating multiple perspectives.	ii Fabrications may be elaborate and also may deliberately be harmful to others' reputations.

5 Emotional regulation

People with autism and CT often struggle to regulate their emotions. What is often termed a 'meltdown' in autism, looks very similar to some of the extreme experiences of emotion observed in people with CT.

Presentation observed in both	Autism	Complex trauma (CT)
5.1 Difficulties managing own emotions		
	a. Affective instability is not primarily in response to relationships, although may be in response to aspects of relationships (eg a change in others behaviour).	i Responds to others by expressing and rapidly switching between intense emotions (eg love, distress and anger).
	b. Can define feelings or experiences but not in terms of emotional content. May use metaphorical or idiosyncratic definitions of emotions, sometimes related to a specific interest.	ii Prone to exhibiting extreme emotional responses to others known for a short time period.
		iii 'Accelerates' personal/intimate relationships; prone to experiencing quick 'turnarounds' in personal/intimate relationships.
		iv Affective instability is predominantly related to social context and relationships.
5.2 Difficulty appreciating others' emotions		
	a. Explains social relationships/interactions and interpersonal relationships in more of a logical/analytical manner or as related to their own interests (eg an interest in crime or politics would be used to explain how a person can influence another person's behaviours).	i Acutely sensitive to changes in others emotional state with a tendency to perceive these as meaningful to themselves. Hyper vigilant with regard to particular emotions in others (eg anger, distress, approval) and often makes reference to these states.
5.3 Unusual mood patterns		
	a. Sudden mood change in response to external information such as change in the environment, miscommunication or sensory information.	i Sudden mood changes may relate to internal states (eg to PTSD, flashbacks) and perceived emotional demands.
	b. Sudden mood changes in response to a perceived injustice occur primarily when strict personal rules are perceived to have been violated.	ii Sudden mood changes in response to a perceived injustice occur primarily when feeling personally slighted, attacked, targeted or victimised.
5.4 Inclined to sudden extreme anxiety		
	a. Extreme anxiety responses around any changes to routines or to the sudden introduction of unexpected or novel experiences.	i Extreme anxiety as a response to not having perceived needs met (especially comfort, attention, being held in mind). Belief that unmet needs reflect own deficiencies/that others do not care.

6 Executive functioning

Difficulties with executive functioning have been observed in both autism and CT.

Presentation observed in both	Autism	Complex trauma (CT)
6.1 Unusual memory		
	a. Presents with deficits in memory specifically related to interest level (eg difficulty remembering events or stimuli that are not of interest).	i Presents as 'fixated' on certain events but struggles to see how these relate to previous experience of personal trauma or injustice.
	b. Exceptional long term memory abilities; may demonstrate the ability to recall excessive detail for areas of particular interest. Is likely to be able to recall to the same degree regardless of audience.	ii Recall of events may fluctuate, appear confused or change according to the audience.
	c. Less well developed/impaired autobiographical memory processes.	iii Recall of negative memories may be selective in terms of the content.
6.2 Difficulty with concept of time – limited intuitive sense of time		
	a. Strong preference for the use of precise times and/or heavy reliance on external timekeeping (eg uses watch and is unable to guess the time).	i Time has an emotional significance for the person (eg waiting a long time for someone to arrive is quickly associated with a feeling of emotional neglect and rejection).
6.3 Weak central coherence		
	a. Inclined to consider all the information relating to a situation, and have difficulty sorting relevant from irrelevant details to understand how events unfolded. Therefore recounting events or life history may be overly detailed and tangential, without a clear 'storyline'.	i Presents with an 'emotional bias' which then may lead them to omit and/or focus on certain elements of a situation (eg the person's attention may be drawn to elements of a situation which hold an emotional significance to them).