The ADHD Clinic

Autism in Adulthood: Diagnosis, Treatment and Life Impact

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Expert in Mind
Essential in uniting professionals

We Will Cover:

- ASD Diagnostic Criteria
- ASD Core domains
- Comorbidities and differential diagnoses in adults
- ASD as a spectrum (Symptom severity, language, IQ)
- ASD diagnostic assessment and NICE Guidelines
- ASD and medicolegal issues
- How to effectively communicate with people with ASD
- Aetiology of ASD
- Management of ASD in adults

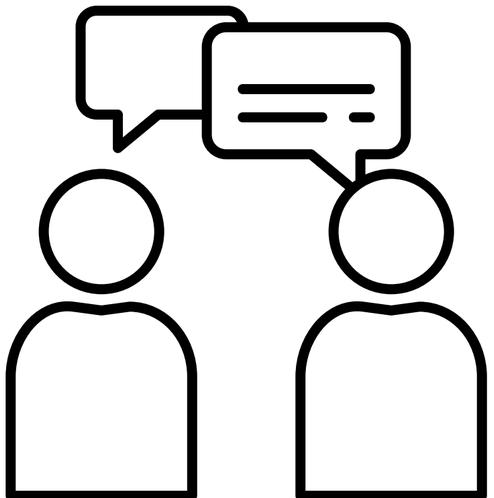
ASD Prevalence in Adults - UK

- Estimated prevalence: 1.0%–1.1% of UK adults
- Brugha et al. (2011): ~1% of adults met criteria for ASD
- Data from 2007 - Higher in men (~1.8%) than women (~0.2%)
- Data from 2021 - m:f ration 3:1 to 2:1
- Many adults remain undiagnosed, especially women and minorities
- Females underdiagnosed because they are better able to adapt and hide ASD difficulties

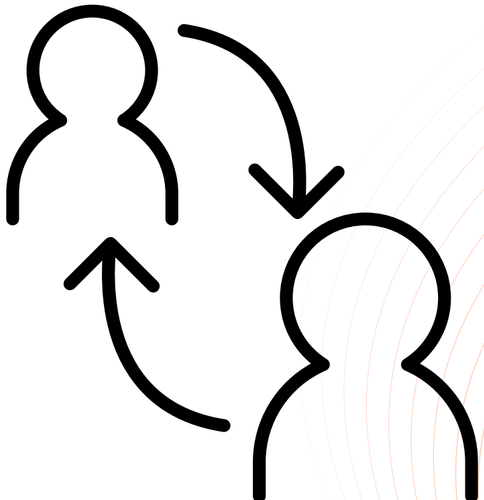
Autism Spectrum Disorder (ASD)

ASD is a lifelong developmental disability that affects:

the way a person
communicates
with others



the way a person
relates
to others



the way a person
makes sense
of the world around them

ASD Diagnostic Criteria

Core Features (DSM-5 Criteria)

ASD includes two major domains:

A. **Persistent deficits in social communication and interaction**

B. **Restricted, repetitive patterns of behaviour, interests, or activities**

Core Features (DSM-5 Criteria)

Criterion A: Social Communication Deficits

Must meet **all 3** of the following:

- Deficits in social-emotional reciprocity

  Abnormal social approach, failure of back-and-forth conversation, reduced sharing of interests/emotions
- Deficits in nonverbal communicative behaviors

  Poor nonverbal communication (eye contact, gestures)
- Deficits in developing and maintaining relationships

  Difficulties in developing, maintaining, and understanding relationships

Criterion B: Restricted and Repetitive Behaviours

Must meet **at least two** of the following:

- Repetitive motor movements or speech (e.g., echolalia)
- Insistence on sameness, rigid routines
- Intense, fixated interests
- Hyper- or hypo-reactivity to sensory input

Additional DSM-5 Criteria

- Symptoms present in early developmental period
- Cause significant functional impairment
- Not better explained by intellectual disability

Severity Levels (DSM-5)

ASD is classified into 3 levels:

Level 1 – Requiring support

Level 2 – Requiring substantial support

Level 3 – Requiring very substantial support

Severity Level	Social Communication	Restricted/Repetitive Behaviours
Level 1 May live independently and hold employment	Needs support; difficulty with initiation and recipocity but can speak in full sentences	Inflexibility noticeable; trouble switching tasks
Level 2	Substantial support; marked social deficits. Can only speak in simple sentences	Obvoius RRBs; difficulty coping with change
Level 3	Very limited interaction; severe deficits. Very limited speech or non-verbal	RRBs severely interfere with daily life

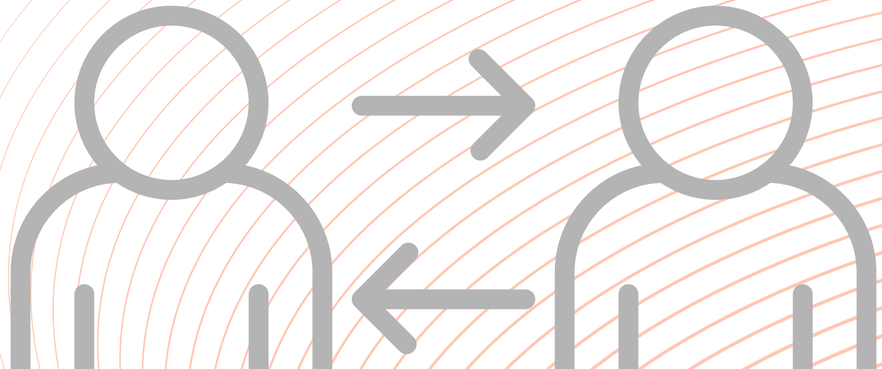
Adult-Specific Considerations

- Symptoms may not be noticeable until later in life when **demand exceeds** capacity or when the person is going through stress
- May have developed compensatory strategies and therefore presentation may differ due to masking or coping strategies especially when have normal or above normal intelligence
- Retrospective history often used (family, school, self-report)
- Focus on current functional impairment

Autism Core Demains

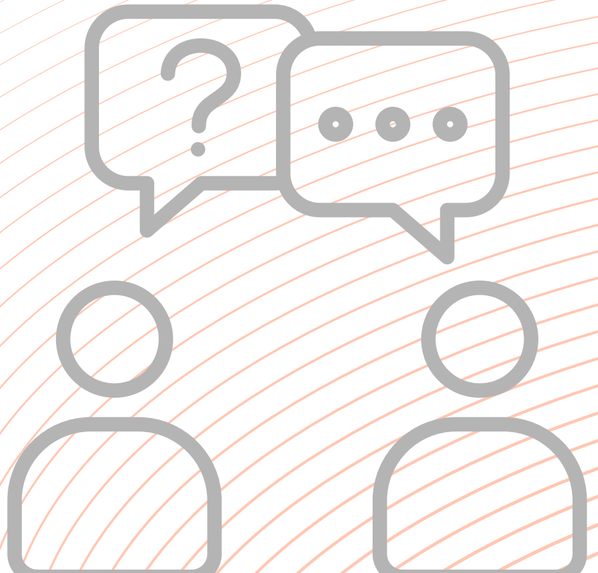
Deficits in Social Interactions

- Failure to establish age appropriate peer relationships or friendships
- Lack of interest in sharing enjoyment, interests, or achievements with other people.
- Deviant response to others emotions
- Lack of modulation of behaviour according to social context
- Altered empathy (find hard to comfort others)



Deficits in Verbal Communication

- Delay in speech development i.e. Not able to speak in sentences before the age of 3
- Speech unusual in rate, volume tone (too fast or too slow), intonation
- Inability to understand others speech/complex two or more step instructions
- Pronoun reversal
- Echolalia
- Intonation

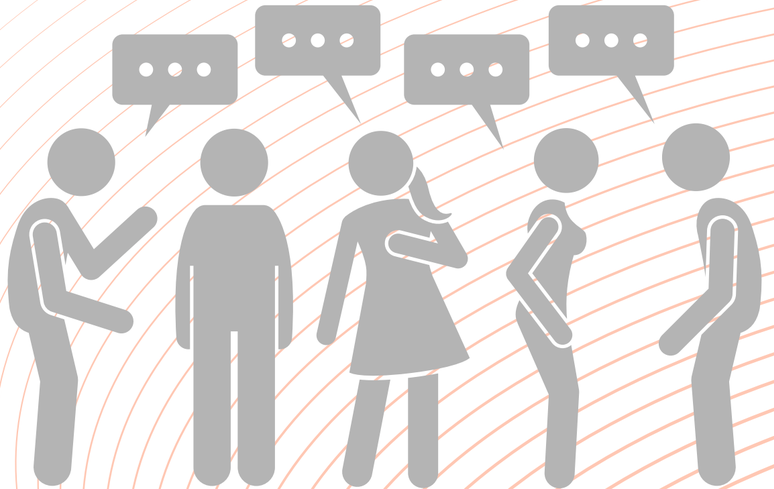


Deficits in Non-verbal Communication

- Lack of eye contact
- Lack of facial expression/social smile when speaking to others
- Lack of social gestures e.g. waving good-bye
- Inability to understand others' body language
- Abnormal body posture

Social Communication

- Lack of reciprocal to and fro communication
- Difficulties in having group communication
- Better at emails/texts compared to face to face/phone communication
- Socially naïve, not diplomatic, say without holding back, can come across as rude
- Cannot do small talk or social chit chat

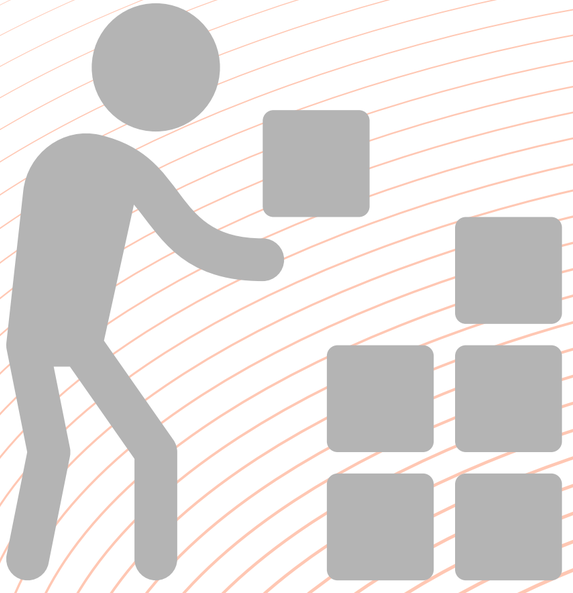


Social Imagination

- Inability to understand abstract concepts/jokes/sarcasm
- Inability to understand others' emotions or intentions
- Difficulty in foreseeing the consequences of their actions
- Difficulty to imagine or empathise with another person's point of view

Restricted & Repetetive Patterns of Behaviours

- Highly-focused interests (interests unusual in focus or intensity)
- Repetitive behaviour and routines
- Sameness of routines
- Resistance to change
- OCD like symptoms
  - Rituals, checking, cleaning repeatedly etc.
  - Does these as a habit, not distressed
- Sensory sensitivities



Sensory Sensitivities

- Over or under sensitivity to sounds, touch, tastes, smells, light, colours, temperatures or pain.
- People with ASD may find certain background noises unbearably loud or distracting, which others are able to ignore or block out.
- Fascination with lights or spinning objects.

Meltdowns and Shutdowns in Autism

Understanding Emotional and Sensory Overload in ASD

What is a Meltdown?

- Externalised response to overwhelming stress
- May include crying, yelling, hitting, or fleeing
- Often triggered by sensory overload, social stress, or unexpected changes
- Misunderstood as aggressive or attention-seeking

What is a Shutdown?

- Internalised response to stress or overload
- May appear mute, withdrawn, frozen or dissociated
- Often mistaken for depression, defiance or mutism
- May last from minutes to hours

Common Triggers

- Sensory overload (noise, light, crowds)
- Unexpected changes in routine
- Social stress or confrontation
- Masking fatigue
- Communication breakdowns

Support Strategies - Meltdown/Shutdowns

- Provide low-arousal environments
- Allow predictable routines and transitions
- Offer sensory breaks
- Avoid punitive responses—use empathy
- Support self-advocacy and emotion regulation

Adult ASD and Comobidity

People with ASD are more likely to have:

- Anxiety disorders (40–50%)
- Depression (39-50%)
- OCD (15 – 20%)
- Social anxiety (11-76%)
- ADHD (20-40%)

Differential Diagnosis

ASD can present similar to various other mental disorders

In females

- Emotionally unstable personality disorder (EUPD)
- Eating disorders

In males

- Psychosis with vague psychotic symptoms.
  Due to ‘meltdowns’ or ‘imaginary friends’

In both males & females

- Sexual abnormalities including asexuality, gender identification, homosexuality or physical contact
- OCD
- Social anxiety disorder

Similarities Between ASD and EUPD

- Troubled relationships and intimacy issues
- Anger, rages, meltdowns, and mood instability
- Self-harm and high suicidal ideation
- Poor attachment in early life
- Feelings of emptiness and issues with identity
- Black-and-white thinking (splitting)
- High rates of childhood sexual abuse and bullying

Key Differences Between ASD and EUPD

Feature	ASD	EUPD
Onset and Developmental History	Symptoms evident in early childhood	Develops in early adulthood
Sensory Issues	Heightened sensitivity to noise, light, touch, etc	Sensory sensitivites not present
Coordination	Poor coordination, clulmsiness, dyspraxia	Typically no coordination issues
Language Processing	Literal, slower, difficulty with jokes/metaphors	Normal language function
Non-Verbal Behaviour	Poor eye contact, limited expressions	Normal non-verbal communication
Systematising and Organising	Prescise, detail-oriented	Often chaotic
Openness to New Experiences	Low openness, dislikes change	Seeks stimulation and change
Sociability	Comfortable being alone	Uncomfortable being alone
Rules and Structure	Follows rules, routines, blunt honesty	Rebellious, manipulative
Self-Harm	Methodical, due to sensory overload	Impulsive, triggered by rejection
Sensitivity to Rejection	Less sensitive, misses social cues	Extreme sensitivity, imagines rejection

ASD as a spectrum

Symptom Severity

Severity of condition

- It can encompass a wide range of presentations, severities, and functional abilities
- Diagnostic skills lie in getting the right cut off whilst accounting for masking or coping strategies
- Deeper exploration is required for those with normal and above normal intelligence

Spectrum in Disorders

Disorders Included in Autism Spectrum Disorder (ASD)

DSM-5 consolidates several previously separate diagnoses under a single umbrella: Autism Spectrum Disorder (ASD) including

- Autistic Disorder (Classic Autism)
- Asperger’s Syndrome
- Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)
- Childhood Disintegrative Disorder

1. Autistic Disorder (Classic Autism)

- Language delays and social communication impairments
- Repetitive behaviours and restricted interests
- Symptoms usually evident before age 3

2. Asperger’s Syndrome

- No significant language or cognitive delays
- Marked difficulties in social interaction
- Restricted and repetitive behaviours
- Often average or above-average intelligence

3. PDD-NOS (Atypical Autism)

- Milder or atypical symptoms
- Does not meet full criteria for other subtypes
- Variable onset and presentation

4. Childhood Disintegrative Disorder

- Normal development for at least 2 years
- Significant regression in language, motor, and social skills
- Rare and severe form

Rett Syndrome (Now Separate)

- Previously included in PDD
- Now excluded from ASD in DSM-5
- Genetic disorder (MECP2), mainly in females
- Regression in hand use, speech, and motor skills

Spectrum in IQ Variability

Spectrum in IQ Variability

IQ Distribution in the General Population

Follows a normal distribution (bell curve)

Mean IQ = 100 SD = 15

~ 68% score between 85–115

~ 95% score between 70 to 130

~ 2.5% score below 70 (Intellectual Disability)

~ 2.5% will score above 130 (exceptional intelligence)

IQ Distribution in Autism Spectrum Disorder

Skewed or bimodal distribution

~ 30–40% have Intellectual Disability (IQ < 70)

~ 25–35% have Average IQ (85–115)

~ 20–30% have Above Average IQ (>115)

Key Differences Compared to General Population

- Greater variability and wider spread in ASD
- More individuals at both low and high ends
- Greater discrepancy b/w IQ domains (Verbal Comprehension Index, Perceptual Reasoning Index, Working Memory Index, Processing Speed Index) on WAIS
- Non-verbal IQ may differ significantly from verbal IQ
- Standard IQ tests may underestimate abilities in ASD

Special Considerations in ASD

- Splinter skills or islets of ability may be present
- Communication and sensory issues can affect test performance
- Adaptive functioning may not align with IQ scores

Spectrum in Language Variability

Understanding the Spectrum of Language Abilities

Overview

Language abilities in ASD range from no functional speech to exceptional verbal skills.

Variability exists in both receptive and expressive language

1. Non-verbal or Minimally Verbal

- ~25–30% of individuals may remain nonverbal or minimally verbal
- May use gestures, PECS, or AAC devices
- Communication often occurs through alternative means

2. Delayed Language Development

- Late onset of first words and phrases
- Speech may be atypical in quality, not just delayed

3. Echolalia

- Repeating words or phrases (immediate or delayed)
- May serve communicative or self-regulatory functions

4. Literal or Concrete Understanding

- Difficulty understanding metaphors, idioms, jokes, and sarcasm
- Preference for precise, literal language

5. Pragmatic Language Impairments

- Difficulty using language in social contexts
- Issues with turn-taking, topic maintenance, and interpreting nonverbal cues

6. Advanced or Unusual Language

- Some may have rich vocabulary and formal speech
- May use pedantic or idiosyncratic language

Empathy in Autism Spectrum Disorder

Understanding Cognitive and Affective Dimensions

Types of Empathy

1. Cognitive Empathy (Theory of Mind)

- Understanding what others are thinking or feeling
- Often impaired in autism

2. Affective (Emotional) Empathy

- Feeling and sharing others' emotions
- Often intact or heightened in autism

Empathy in Autism: Key Features

- Cognitive empathy is often reduced or delayed
- Affective empathy is often preserved
- Social expression may be atypical
- Misreading social cues is common
- Emotional overwhelm can occur

Common Misconceptions

"People with autism lack empathy" – ❌ Incorrect

They may struggle with recognising emotions, not with feeling them

"They don't care about others" – ❌ Incorrect

Many care deeply but express it differently

Clinical Implications

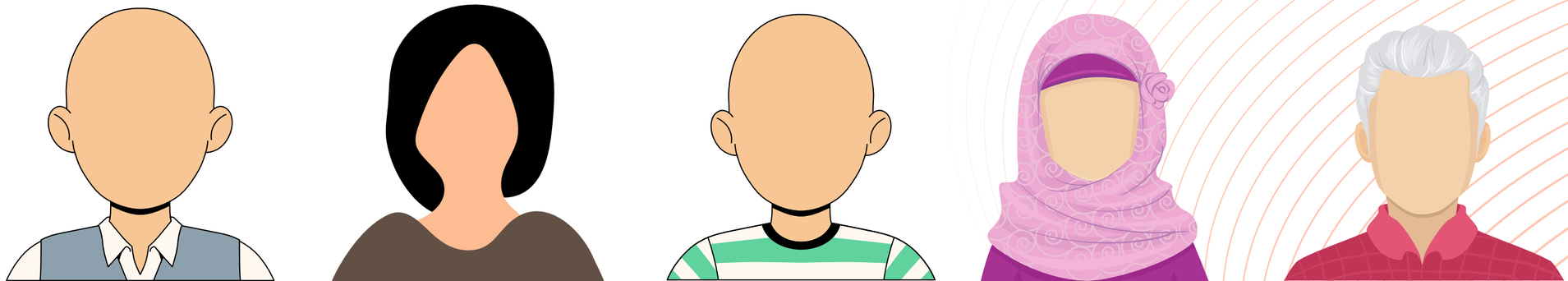
- Empathy-related challenges can lead to social misunderstandings
- May be perceived as aloof or indifferent
- Legal advice should take into account that empathy is not absent in individuals with ASD
- Interventions may include:
    - Social cognition training
    - Emotion recognition strategies
    - Support for navigating social norms

Face Blindness (Prosopagnosia) in ASD

Understanding their relatinoship

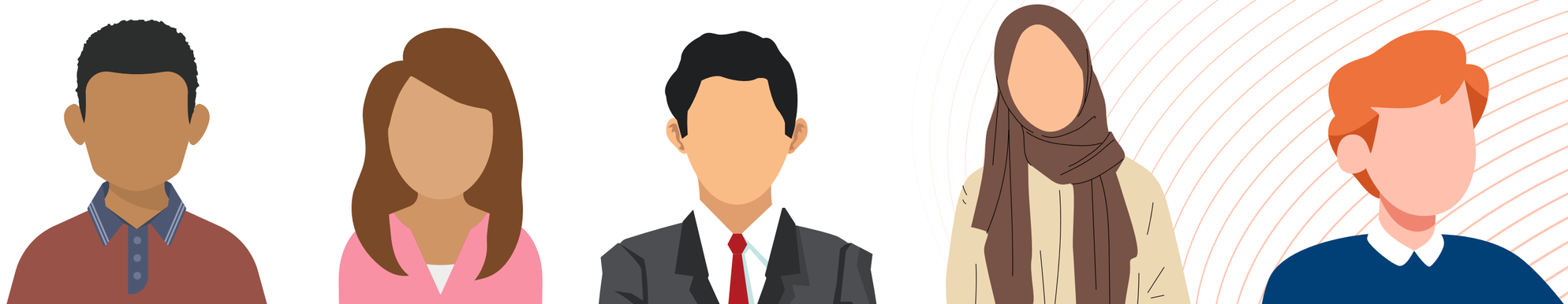
What is Face Blindness (Prosopagnosia)?

- Neurological condition involving difficulty recognising faces
- Can be developmental (lifelong) or acquired (after brain injury)
- Not due to vision or intellectual disability



Face Processing in Autism

- May be due to atypical face processing (e.g., reduced attention to eyes)
- Emotion recognition may also be impaired
- ASD: Face-processing may improve with intervention
- Many autistic individuals do not have prosopagnosia



ASD Diagnostic Assessment in Adults

Diagnostic Assessment in Adults

- Starts with screening tools- informs if a full assessment is indicated
- Clinical assessment - gold standard
- Using one or more diagnostic Tools to complement clinical assessment

ASD Screening Tools

Patient-Based (Self-Report)

- AQ (Autism Spectrum Quotient)
- RAADS-R
- EQ (Empathy Quotient)
- SQ (Systemizing Quotient)

Informant-Based

- SRS-2 (Adult form – can also be self-report)
- SCQ (used in adults when childhood data is available)

AQ- Autism Spectrum Quotient

- 50-item self-report tool
- Measures traits across social skill, attention switching, communication, imagination
- Scores ≥32 suggest high likelihood of autistic traits

RAADS-R - A Screening Tool

- 80-item self-report scale
- Assesses social relatedness, language, sensory-motor behaviour, circumscribed interests
- Helps differentiate ASD from other psychiatric conditions

SRS-2, EQ, and SQ - Screening Tools

SRS-2:
Self or informant-rated tool measuring social responsiveness

EQ (Empathy Quotient):
Self-report; measures affective empathy—often lower in ASD

SQ (Systemizing Quotient):
Self-report; measures interest in rule-based systems—often higher in ASD

Screening Tools

- Screening tools are not diagnostic
- Must be interpreted in clinical context
- May be influenced by mental health, insight, or masking

ASD - Clinical Assessment

- Conducted according to diagnostic criteria
- Excludes other conditions as possible explanation of traits
- Should include developmental history ideally from a parent

NB: Developmental history helps to exclude other differential diagnoses as ASD starts in childhood whilst other similarly presenting disorders (depression, schizophrenia, borderline personality disorder, anxiety disorders etc.) start later in life.

Diagnostic Tools

Diagnostic Tools

- ADI-R
- ADOS-2 (Module 4)
- 3Di – Adult
- DISCO

ADI-R (Autism Diagnostic Interview - Revised)

- Structured interview with caregiver or family member
- Focuses on early childhood development and behaviour
- Useful when reliable developmental history is available

ADOS - 2 (Module 4)

- Observational tool for verbally fluent adults
- Semi-structured interaction tasks
- Assesses social communication and restricted behaviours
- Requires specialist training

3Di - Developmental, Dimensional and Diagnostic Interview

- Computer-assisted structured interview
- Aligns with DSM-5 and ICD-11 criteria
- Conducted with someone who knows the adult well
- Shorter and more efficient than ADI-R

DISCO (Diagnostic Interview for Social and Communication Disorders

- Lifespan-based, clinician-led interview
- Explores full range of social, communication, and behavioural domains
- Time-intensive and used in specialist settings

Diagnostic Assessment - Summary

- A gold standard diagnostic must include a clinical assessment

- Current diagnostic tools like DISCO, ADOS, and ADI each have their limitations and proponents. However, none of them constitute 'gold standard' when used in isolation without a comprehensive clinical assessment."

- No diagnostic tool replaces the need for a proper clinical assessment with a developmental history

- Tools such as AQ10 and AQ50 have some value in screening for those more likely to need a full assessment but are not diagnostic tools

NICE Guidelines

NICE Guidelines

A comprehensive assessment should:

- be undertaken by professionals who are trained and competent
- be team-based and draw on a range of professions and skills
- where possible involve a family member, partner, carer or other informant or use documentary evidence (such as school reports) of current and past behaviour and early development.

NICE Guidelines

To aid more complex diagnosis and assessment for adults, consider using a formal assessment tool, such as:

For people who do not have a learning disability

- Adult Asperger Assessment (AAA; includes the Autism-Spectrum Quotient [AQ] and the Empathy Quotient [EQ])
- Autism Diagnostic Interview – Revised (ADI-R)
- Autism Diagnostic Observation Schedule – Generic (ADOS-G)
- Asperger Syndrome (and high-functioning autism) Diagnostic Interview (ASDI)
- Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R)

For people with a learning disability

- ADOS-G (General)
- ADI-R

To organize and structure the process of a more complex assessment, consider using a formal assessment tool

- Diagnostic Interview for Social and Communication Disorders (DISCO)
- ADOS-G or
- ADI-R.

ASD Traits that can lead to Medico-legal Issues

Meltdowns and Rigidity

- Sensory overload or stress leading to meltdowns and aggression
- Rigidity of thinking and environment leading to aggression.

Example:
A patient became aggressive because another person used his mug.

Obsessive Interests

- People with ASD can have intense/obsessive interests which can lead to law breaking

  Examples:
  A patient hacked into a database of a children's chatting website because he was worried that the security was not good enough .
  Another patient hacked into a prototype of Microsoft office

- Can also get obsessed with litigation

Obsession with People

- People with ASD can also become obsessed with people.

Example:
A patient was obsessed with Holby City star and arrested for stalking

A patient was obsessed with Boris Johnson and was arrested for stalking after campaigning for him for Mayor of London Elections

Another patient became obsessed with a care coordinator and was arrested for following her to her home.

Unusual Interests

- People with ASD can have unusual interests which can lead to law breaking.

Example:
Several cases of possession of indent images of children and extreme pornography

A patient who was son of middle class white Irish parents (mother was GP) because interested in ISIS videos and used to play them on his computer all night.

Rigid Morality and Sense of Justice

- People with ASD have cognitive rigidity and exaggerated sense of justice and fairness.

  Example:
  A university student started to commit robberies in banks and building societies because he felt they exploit the poor. Solicitor advised against having assessment of ASD. Convicted and sent to prison. Assessment in Portland prison.
  *Led to book:**The Unusual Suspect: The Remarkable True Story of a Modern-Day Robin Hood by Ben Machell** (Times columnist and feature writer).*
  ?TV documentary.

Social Naivety and Vulnerability to Exploitation

- People with ASD have difficulty knowing others' intentions and therefore are easily persuaded by them trying top fit in

Example:

A female was persuaded to buy a petrol in a can which her boyfriend used to burn a car that was used in murder charges.

Family Cases

- Resistance to change makes working with social services difficult.
- Agitation and restlessness arise from unplanned social worker visits.
- Social and communication difficulties hinder attendance at social services meetings.
- Tendency to speak without holding back, which can be perceived as rude or abrupt

Fitness to Plea Issues

Fitness to plea can be affected due to functional difficulties such as:

- Rigid and literal thinking
- Communication and comprehension deficits
- Intense anxiety leading to shutdowns in court

IQ is relevant, but not determinative.

Civil Cases

- Assessment of disability as defined by equality act
- Reasonable adjustments
- ?When reasonable adjustments become unreasonable

Civil Cases

- Housing issues such as problems with neighbors due to noise and sensory issues
- Wookey capacity assessment - ASD intense/unusual interests/sensory sensitivities can affect ability to comply with terms of injunction
- Assessment of capacity to conduct proceedings-Rigid and literal thinking and communication and comprehension deficits can affect capacity to conduct proceedings

Strategies for Effective Communication

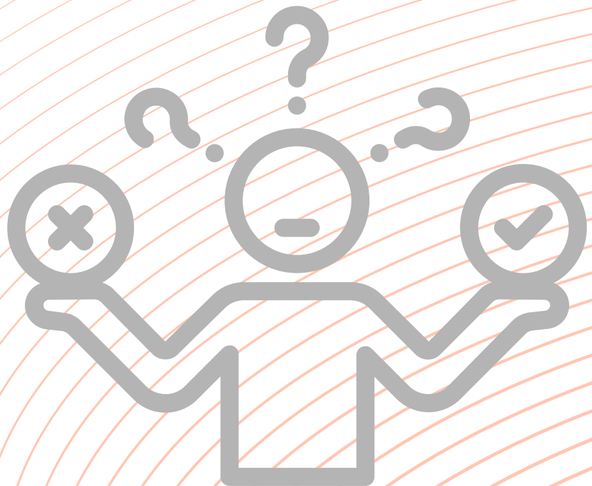
Understanding communication challenges in ASD

People with ASD may take things literally, causing huge misunderstandings.

- Idioms like “Have you changed your mind?” or “You’re pulling my leg” can cause huge misunderstanding.

People with ASD may respond without understanding the implication of what they are saying, or they may agree with you simply because they think this is what they are supposed to do.

- If a person with autism is asked “You didn’t do this, did you?” they may repeat (echolalia) or say “No”
- However, if the question is “You did this, didn’t you?” they may repeat or say “Yes”.



Strategies for Clear and Effective Communication

- Allow extra time to respond to questions as people with ASD may take longer time to process information.
- People with autism often understand visual information better than spoken words. It may be useful to use visual supports/aids, such as drawings or photos, to explain to the person what is happening.
- If they can read, it may be useful to put your information in writing
- Give clear, slow and direct instructions
- Ensure that questions are direct, clear and focused to avoid confusion.
- Prepare the person, explain clearly the situation that they are in and what the professional will be asking questions about.
- Avoid using sarcasm, metaphors or irony.
- Outline ‘next steps’ and advise of any changes in advance to prepare them.

Aetiology of ASD

Multifactorial Contributions: Genetics, Brain, Environment

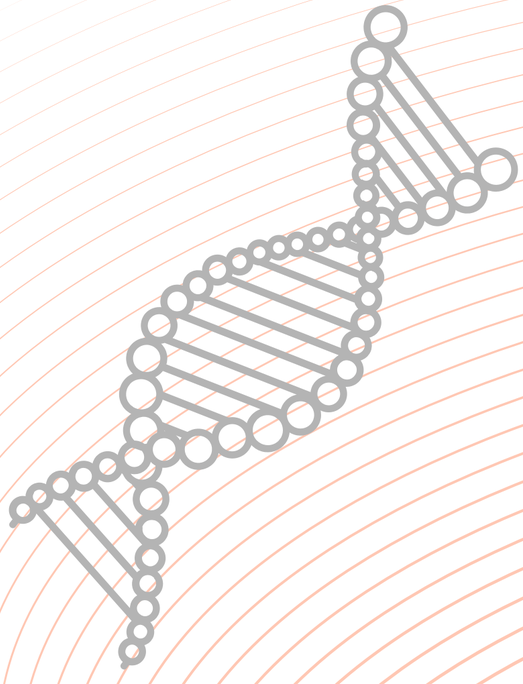
Overview

ASD has a complex, multifactorial aetiology involving:

- Genetic factors
- Neurobiological differences
- Environmental influences
- Gene–environment interactions

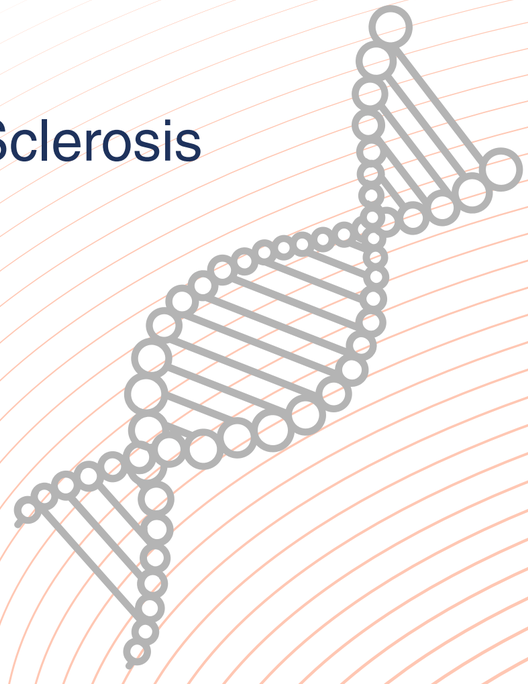
Genetic Factors

- High heritability: ~50–90% of ASD risk
- Twin studies show much higher concordance in identical twins
- Sibling risk elevated (~10–20%)
- Strong evidence of genetic contribution



Types of Genetic Contributions

- Common variants: small effects, additive
- Rare de novo (new) mutations: large effect (e.g., CHD8, SHANK3)
- Copy number variations (CNVs) in various chromosome
- Syndromic ASD: Fragile X, Rett Syndrome, Tuberous Sclerosis



Neurobiological Differences

- Early brain overgrowth (especially frontal/temporal regions)
- Atypical neural connectivity
- Altered function in social brain networks (e.g., amygdala)
- Neurotransmitter imbalances: serotonin, GABA, glutamate

Environmental Factors

- Advanced parental age
- Prenatal infection, maternal stress or illness
- Perinatal complications (e.g., hypoxia)
- Teratogens (e.g., valproic acid)
- Vaccines are NOT associated with autism

Epigenetic & Gene - Environment Interaction

- Epigenetics = changes in gene expression without altering DNA
- Environmental exposures may modify gene expression
- Helps explain different outcomes in genetically similar individuals

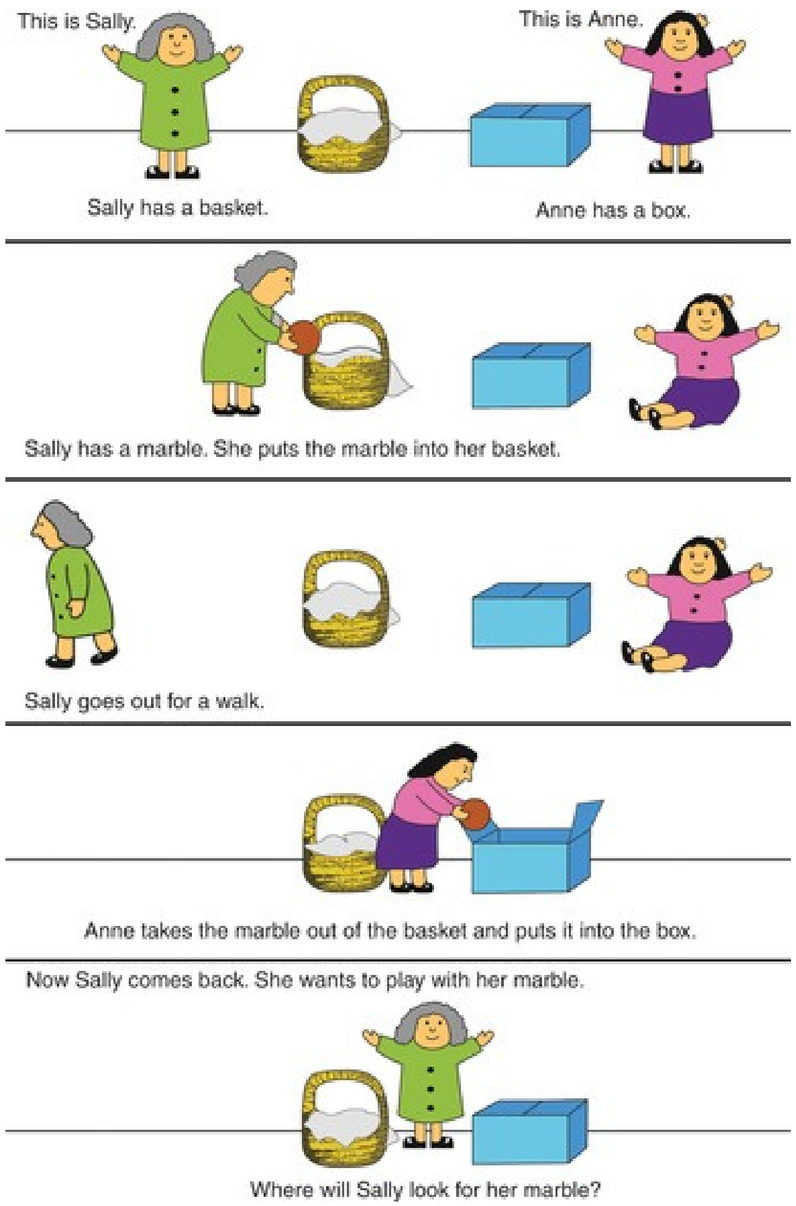
Cognitive Theories in Autism Spectrum Disorder

Understanding the mental processes behind autistic traits

1.Theory of Mind (ToM) Deficit

- Difficulty understanding that others have independent thoughts and feelings
- Deficits in the ability to attribute mental states (beliefs, intents, desires, emotions, knowledge) to oneself and others
- Deficits in understanding that others have beliefs, desires, emotions, perspectives that are different from one's own
- Key concept: 'Mindblindness' (Baron-Cohen)
- Impaired empathy, sarcasm detection, and perspective-taking
- Explains social misinterpretation and interactional challenges

Sally-Anne Test



Belief question "Where will Sally look for her marble?"
In the Baron-Cohen et al. (1985) study

- 23 of the 27 clinically unimpaired children (85%) answered correctly.
- 12 of the 14 Down's syndrome children (86%) answered correctly.
- Only 4 of the 20 autistic children (20%) answered correctly

2. Weak Central Coherence (WCC)

Proposed by Firth in1989:-
“Central coherence” is ability to derive overall meaning from a mass of details.

Weak Central Coherence leads to

- Cognitive style focused on details over global meaning
- Strength in pattern detection and local processing
- Difficulty integrating context, abstract ideas, or 'big picture' thinking

> ***A person with weak central coherence will see endless expanse of trees rather than “forest.”***

3. Executive Dysfunction Theory

- Impaired planning, inhibition, flexibility, and working memory
- Leads to rigid routines, meltdowns, and poor emotional regulation
- Difficulty switching attention or coping with changes

4. Enhanced Perceptual Functionining (EPF)

- Superior processing in visual, auditory, and tactile domains
- Explains sensory sensitivities and perceptual strengths
- Associated with strengths in music, design, and attention to detail

5. Intense World Theory

- Hypothesis: ASD as hyper-functioning of neural circuits
- Exaggerated perception, emotion, and memory
- Leads to withdrawal and avoidance due to overwhelming stimuli

6. Incredible Systemizers

People with ASD show interest in:

- collection systems (e.g. types of dinosaurs)
- mechanical systems (e.g. functioning of a radio)
- numerical systems (e.g. train schedules, calendars)
- abstract systems (e.g. music)
- natural systems (e.g. meteorology)
- social systems (e.g. dance routine with a dance partner)
- motor systems (e.g. jumping on a trampoline)

Management of ASD in Adults

Multimodal, Individualised Approach

1.Psychoeducation and Diagnosis Feedback

- Provide tailored explanation of the diagnosis
- Involve family/partners if appropriate
- Discuss both strengths and difficulties
- For autistic individuals with normal intelligence,
  - receiving information about ASD and
  - understanding their diagnosis is often the single most important and helpful factor in their lives

2. Environmental and Occupational Adjustments

Workplace:
noise reduction, flexible hours, written instructions

Home:
structured routines, visual supports

Use of assistive technology

3. Psychological Therapies

- Adapted CBT for anxiety, depression, OCD
- Mindfulness for emotional regulation
- Social skills training
- Schema therapy or DBT in select cases

4. Medication Management

- No medication for core ASD traits
- Treat comorbidities as in non ASD but dose may be different
    - SSRIs for anxiety/depression
    - Stimulants/atomoxetine for ADHD
    - Atypical antipsychotics for irritability
    - Melatonin for sleep issues

5. Support Services and Advocacy

- Social care: housing, daily living
- Peer support groups and advocacy
- Guidance for education and career
- Benefits support (e.g. PIP)

6. Crisis Prevention and Safeguarding

- Identify triggers and early warning signs
- Crisis plans and sensory toolkits
- Safeguard against exploitation and harm

7. Legal and Forensic Considerations

- Assess fitness to plead and criminal responsibility
- Provide communication adaptations
- Liaise with appropriate adult or legal support

Cases

Case 1

This case is relevant to those working in primary, secondary and tertiary care settings.

Presentation

Mike is arrested following a serious assault on a colleague at work. The victim explains the assault occurred when he had inadvertently used Mike's mug. He describes Mike as being 'odd' with few friends.

Mike is quiet and polite but makes the police officers feel uncomfortable because of his 'odd' manner.

The police officers contact the on-call GP who arranges for a psychiatric assessment.

Mike is assessed by the on-call psychiatry registrar while in the police station.

The psychiatrist interviews him and Mike does not make eye contact during the assessment.

The psychiatrist is unable to contact Mike's next of kin because Mike will not answer questions. Mike rocks throughout the assessment. Mike stated that he hit his colleague because he does not like to share his things and does not like his things to be moved as he has specific place for everything.

The psychiatrist writes in Mike's notes "no evidence of psychosis, fit for interview"

Case 1

Q1: What should the psychiatrist consider and suspect?

Case 1

Answer:

- Further mental health assessment and assessment for possible autism because Mike has persistent difficulties in social interaction and displays repetitive behaviour in the form of rocking.
- The reason Mike gives for the assault also demonstrates a resistance to change.
- Mike’s colleague’s description may suggest that Mike has problems with sustaining social relationships.
- Consider using the AQ-10 (Autism-Spectrum Quotient – 10 items) to help decide whether referral for an autism assessment is needed.

Case 1

Next steps

The police try to interview Mike without an appropriate adult. Identifying an appropriate adult is difficult when no next of kin has been identified but the police could contact any family member, friend, volunteer, colleague or social/healthcare professional. They could also get information from Mike's workplace. The interview results in little success. When they try to move him to a different cell; he becomes physically aggressive and is remanded into custody (resistance to change).

Mike does not cope well in prison. He finds it difficult to talk to the other prisoners and is verbally abused and bullied. He spends most of his time alone in his cell and although prison officers try to communicate with him, it is clear that he is not looking after himself properly (social interaction and communication difficulties). He repeatedly complains that the fluorescent strip lighting is too bright and keeps trying to cover it with paper (sensory sensitivity).

Mike only leaves his cell for meal times (**Social Interaction Difficulties**). He always rushes to the food serving hatch and then eats as much as he is able to get. He has to be given a cell to himself because his cellmate reports that Mike kept him awake at night by talking to himself. When the officers go in to clean Mike's cell, they find a pile of papers covered in diagrams of machines **(Interests that are abnormal in focus, content or intensity)**

Case 1

Next steps continued

After about 2 weeks, Mike attempts to hang himself in his cell with sheets. The prison psychiatrist assesses him, and he again does not make any eye contact during the assessment and provides very little information (Abnormalities in verbal and non verbal communications). The psychiatrist is concerned about Mike's mental health and arranges for him to be transferred to hospital under a section to be assessed.

In hospital, Mike keeps himself to himself but takes the antipsychotic medication that he is prescribed because "he was told to". A bank nurse who is new to the ward mispronounces his surname and he becomes very distressed (resistance to change). He tries to cut his arm with a piece of broken glass he finds in the hospital gardens. The other patients on the ward complain that Mike can be heard talking out aloud until the early hours of the morning. He spends the majority of his time in his room, avoiding social interactions. At his next psychiatric review, his antipsychotic is stopped and an antidepressant started.

The psychiatrist is struggling to give a clinical diagnosis for Mike, although autism is considered a possibility. He has improved since being prescribed an antidepressant, but he still says little and appears cold and distant.

Case 1

Q2: The psychiatrist is struggling to diagnose Mike, what should they do?

Case 1

Answer:

- Ask another health professional to assess Mike, to obtain a second opinion.
- Autism should have been suspected earlier, and if unsure the psychiatrist should have contacted the specialist autism team for advice.

Case 1

Next steps

Mike is eventually assessed by a clinical psychologist and his full scale IQ is estimated at 68. The psychologist refers Mike for a comprehensive assessment of suspected autism.

Case 1

Q3: What principles should the staff conducting the assessment adhere to and what should be included in the assessment?

Case 1

Answer:

- Be aware of the adaptations that may need to be made to the assessment to ensure it is effectively delivered. Staff conducting the assessment should be competent and draw on a range of professions and skills.

- Explain the purpose of the assessment to Mike and tell him the outcome. Cover the core autism signs and symptoms, early developmental history, behavioural problems, functioning in employment, past and current physical and mental health and hyper- and hypo-sensory sensitivities, for example Mike’s apparent sensitivity to florescent lighting.

- Consider using a formal assessment tool to structure and aid diagnosis if the assessment is complex.

- Assess for differential diagnosis and coexisting disorders. Do not routinely use biological tests, genetic tests or diagnostic neuroimaging as part of assessment.

- Assess risks. Focus on Mike’s self-harm but also consider: rapid escalation of problems, harm to others, self-neglect and the possible breakdown of the relationship with his mother.

- Develop a care plan for Mike based on the comprehensive and risk assessment.

Case 1

Next steps

Mike is diagnosed with autism. Mike’s social worker manages to track down Mike’s mother via information collected by the police.

Case 1

Q4: How should health and social care professionals involve Mike’s mother?

Case 1

Answer:

- Discuss with Mike whether and how he would like his mother involved in his care. If so, encourage this involvement, and ensure that no services are withdrawn because of it.

- Give Mike’s mother information about autism and its management. Provide details of support groups and her right to a formal carer’s assessment.

Case 1

Next steps

- Mike decides he would like his mother to be involved.

- The social worker talks to Mike's mother about her son, and notices that she avoids eye contact. Mike's mother's house is untidy and she tells the social worker that he had always been as he had presented in hospital since his childhood. She does not consider there is anything wrong with Mike. She wants him at home to support her. She asks if he is entitled to benefits because previously she has been told he was not. Following an occupational therapy, carers and social services assessment, Mike is discharged to his mother's house. Arrangements are made for a package of after-care to be put in place to support him.

- Regarding Mike's criminal charges, the psychiatrist might be successful in making the case that his autism should be taken into account to avoid a custodial sentence. Social support would need to be high to minimise the risk of Mike acting in this way in the future.

- Consider 'supported employment' if it is thought that Mike could work again as he cannot return to his former employment.

Case 2

Presentation

Barry is admitted as an inpatient with an acute asthmatic attack from his nursery.

His mother Sueis reluctant to finish work early and come into hospital. When visiting Barry, Sue keeps closing the curtains around the bed although the staff tell her not to.

She is also found to be adjusting his drip. Healthcare staff feel that Sue behaves a little coldly towards her son, but Barry appears well cared for.

Sue is a 25 year old talkative, anxious woman who is difficult to converse with. She keeps going off on tangents or complaining about specific failings of the nurses: for example, that they had not monitored the drip adequately and that they had not checked on Barry at the prescribed times.

Sue says that she was adjusting the drip because staff failed to do so. She explains that she closed the curtains because she found the ward too distracting and unpleasant. Sue asks for a side room for her and Barry.

Sue is a junior accountant in the local council.

She has little social life and gives the impression of keeping an over-tidy, spotless house. Barry’s asthma is usually well controlled and Sue keeps a diary recording the times he has his inhalers each day.

Sue seems to have a very ordered home and life and has problems making time in it to see the social worker.

Case 2

Q1: What should Sue’s social worker consider and what are the next steps?

Case 2

Answer:

- Suspect autism because Sue is difficult to converse with and seems keen on routine. This is demonstrated by Sue not wanting to interrupt her work routine by coming into hospital to see Barry when he was admitted.
- She also gets upset if Barry is not seen by healthcare staff at the prescribed times.
- Another indication that Sue may have autism is her lack of a social life, indicating she may have difficulty initiating or sustaining social relationships.
- Contact the specialist autism team for advice about whether to refer Sue for an autism assessment

  or
- Use the Autism-Spectrum Quotient – 10 items (AQ-10), to establish whether Sue should be offered a comprehensive assessment for autism.

Case 2

Autism Assessment

- The assessment establishes that Sue, who presents as a well functioning woman with some language problems, has Asperger's syndrome. She demonstrates the following signs and symptoms: difficulties in social interaction and resistance to change.

- At the assessment Sue's mother reveals that Sue was good at school but she had no clear friends other than one girl with whom she went out a lot. Sue is interested in history and maths and has a good head for dates and figures. Sue can add up columns of numbers mentally very quickly. She has a limited social life and tends to be home all the time. She is rather wooden in her non-verbal communication and has lots of routines and problems with change. Sue talks a lot, but is rather concrete and tangential. She interprets many colloquialisms literally and her mother says Sue is not good at sarcasm.

Thank you for joining us.

Do you have any questions?