Question Report - Session 1 9.30 - 10.45		
#	Question	Answer(s)
1	please could you elaborate- increase in prevalance as intellectual functioning decreases?	Research shows that about 50% of autistic individuals have a coexisting intellectual disability, compared to 3% in the general population. While it is likely that autism is under recognised in high functioning individuals, there is nevertheless a huge overrepresentation. It is clear that underpinning impairments in brain structure and function lead to problems with both learning (intellectual functioning) and social communication.
2	Have you had any involvement with the Spectrum 10K research project? Can you say anything about that?	
3	For those patients who fall just short of the ASD diagnostic criteria, should they be considered to have traits of ASD, or should alternative psychiatric diagnoses be sought for their presentations, or both? Thanks	I think consider on case by case- certainly exploration of whether an alternative diagnosis could be contributing to impairment is central to diagnosis but for some people discussion about 'traits' can be helpful and help them to think about their own strengths and weaknesses
4	It would be helpful if you could touch upon ASD and EUPD co-morbidity, their co-existence, prevalence, approach to management etc. Thank you	
5	What has happened to the Schizoid PD diagnosis?	
6	Why are ASD pts. not in the vulnerable/priority group for Covid Vaccination. Most GPs are not sure of this vulnerable group.	They are if they have an additional learning disability. There is a question whether this group is sifficiently prioritized given their great vulnerability.
7	How is presentation in women different?	
8	Could you Please elaborate ASD in women different from male with an example. Thank you	
9	In women, the differences often become more apparent in their teenage years, and v well masked or managed in primary school. is it possible to recognise what seems to be ‘adult onset’ ASD?	
10	what do you think of the necessity of assessment tools like ADOS, ADI? can diagnosis be made on clinical assessment only?	
11	Diagnostic tools like ADOS and rating scales rely heavily on age of onset and communicaton difficulties, among other things. Do these scales become obsolte with the change in criteria	
12	What pre-assessment questionairre you use in your clinic ? Is it valid to be able to give a provisional diagnosis or a confirmed diagnosis in one standard psychiatric community mental health interview in a clinic for one hour in busy general adult community settings ? thanks	
13	Could you please discuss differential diagnosis/comorbidity of ASD and psychosis. Sometimes unusual or repetitive behaviours can be difficult to distinguish.	

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14	do you see much ASD comorbid with social phobia? How do you manage it? DO you see much 22Q deletion causing ASD? How do you treat it?	
15	Thank you for such a helpful presentation. Could you comment on how we manage the issue of long waiting lisits for diagnostic assessments and the way in which we enable practitioners to diagnose ASD- I am thinking particularly about children and adolescents and I am aware you work with adults, but would value a further conversation on this- what is a reasonable method for diagnosis- does it need to be ADOS and ADI apraoches- whoshould it be- thanks for touching on this and the pragmatism too	
16	Yes he liked to watch the same or similar programs. I Can't remember him listening repetitively to the same song, it was more TV that he watched a lot of. There was an incident I do remember when he wanted a 3rd biscuit and I had said no = he was about 3 or 4years old, but he did not give up and became very upset and angry and in the end I took him to his bedroom and left him there crying and saying over and over again...'I want another biscuit'...I left him in his room for a long time until I heard that he had stopped crying. I went upstairs to get him and he was sobbing still quietly and I brought him downstairs and he then said again 'I want another biscuit'...it was like he was obsessed with wanting another biscuit and was absolutely not going to let it go.	
17	I assume we assess for strengths too	
18	could you elaborate on "Atypical Autism" and how it is suspected/diagnosed	
19	Shyness is intuitive as an ASD feature- but bossiness- is that alos common in people with ASD?	
20	Is there any evidence of an increased prevelance of medically unexplained symptoms/persistent physical symptoms in those with ASD?	
21	Where is Aserger's Syndrome standing in new diagnostic criteria?	there are no subtypes described in DSM-5/ICD-11 so AS is folded into umbella term of ASD
22	Does a significant early trauma history rule out an ASD diagnosis?	
23	I have noticed that there is increasing use of the term autistic spectrum condition (ASC) in place of autistic spectrum disorder (ASD). I presume this is to reduce stigma and links to embracing differences rather than highlighting impairments. What are your thoughts on this?	Yes, my understanding is just that. I tend to use ASD/autism/autistic people as it is in line with DSM/ICD language and hopefully then reduces confusion
24	Bleuler coined Autism as a basic symptom of schizophrenia; at the same time we are seeing many autistic people with psychosis - is this a continum; could you please expand on this?	

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25	Are Addictions included in mental health disorders ?	
26	How is presentation different in older adults?	
27	You have discussed sensory sensitivities and atypical presentation with eating disorders. Do people with ASD present to pain clinics?	
28	ASD and EUPD symptoms sometimes overlap how to differentiate ?	
29	Typing mistake correction- Asperger's Syndrome in new diagnostic criteria	
30	Will there be mention of Pathological Demand Avoidance in today's conference? This seems to be an area that carers know a lot about, possibly more than some health professionals. I would like to better understand what the term means and what is the clinical significance	
31	Very keen to hear the speakers view on the role of sertraline for anxiety in children with ASD. I find it enormously helpful for many but it doesn't seem to feature much in some literature. Thanks.	
32	Do the SNAP cohort receive treatment? If so, follow-up data show little effect - or things might be a lot worse without treatment.	
33	any comment on the the interplay between ASD and schiziod and schitypal disorder . Also the prevelance of LD in ASD , thank you	
34	Is the RAADS R questionaire good for diagnosis of ASD?	
35	What are the rates of psychosis in adult ASD and treatment considerations?	
36	With the evidence of emotional difficulties persisting until older age, should we be reviewing the culture of community services advising "Your daughter is still under 5 years and we only accept referrals over"; also, should we be increasing commissioning of community diagnostic services? Thank you.	
37	Do those who are diagnosed with social (pragmatic)communication disorder have similar comorbidity profiles?	
38	Further to my question- does it mean we do not use Asperger's Syndrome term any more? ASD- Autism Spectrum Disorder- does itself say anything about low or high or normal IQ.	
39	Could Prof Simonoff comment on any links between ASD and gender dysphoria in adolescents and the management of gender dysphoria in adolescents with ASD?	
40	Is it possible to send us all the presentation slides after the training session	
41	Any thoughts about the association of ASD and obsessive thoughts and how to manage it effectively	

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42	Are we seeing diagnostic overshadowing in the opposite direction too? i.e. diagnosis of ASD where there may be a treatable disorder or where the difficulties represent normal adolescent social/emotional learning?	
43	Is there any evidence regarding Sertraline? Fluoxetine and Citalopram generally do not work in my view. However, I have had a number of good responses to Sertraline. I have used it to treat anxiety symptoms as opposed to depressive symptoms.	The, RCT evidence provided in the slides, with relevant references.. For anxiety and depression, there is no gold standard evidence for their efficacy and the evidence for their role in reducing core symptoms suggests the not lead to improvement. There is currently unpublished evidence for escitalopram suggesting small possible benefits, but again, not significant. Therefore the evidence in favour of CBT, but where pharmacological intervention is required, it is still reasonable to try an SSRI, with suitable caveats given to patients and families.
44	What does Prof Siminoff think about the potential for using video-feedback based interventions in the early years for children with a diagnosis/considered genetically 'at risk' for autism?	I am assuming that the focus of this intervention would be for improvement in social communication? There is some, limited, evidence in favour of-or teacher/other-interventions aimed at improving social communication. The evidence for long-term benefits is very slim, but there is some student that this could be the case. The mechanism of delivery has not been formally tested but I suspect it is less likely to be important than the active ingredients of the intervention as well as its intensity. Presently, there is no evidence for what is being suggested.
45	I have found some benefit using Tricyclics both in terms of Mood and Obsessive features particularly as a means to helping people access CBT. Any comments?	It is certainly plausible that try cycling antidepressants would be helpful and should be one of the pharmacological interventions considered, probably however after trying an SSRI. Certainly the joint use of pharmacological and psychological interventions should be considered, as indicated particularly when patients can't immediately access psychological intervention
46	Could SSRI dose be critical in managing emotional disorders in ASD. Do we need maybe- higher doses?	SSRI dose could be critical. The key studies try to examine effects at different doses, starting with a lower dose and increasing higher dose. However, the main point is that the studies were dose to treat autistic restricted and repetitive behaviours, not anxiety or depression, so we don't know what dose might be optimal for these conditions.
47	Will catatonia be covered anywhere during the day ?	

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48	We usually see a long waiting time to receive psychological support and have to prescribe SSRI to help with anxiety symptoms. Would you advise anything differently?	Ideally, given that there is evidence for psychological but not pharmacological interventions, the latter would be the first intervention of choice for those that are able to access them. It is worth discussing with colleagues, including service commissioners, what scope there is for changing this so that there is greater access to adapted psychological interventions.
49	Thanks Emily for the presentation, CBT has been found to be significant but most of the ASD patint are too anxious to engage in therapy, are there any antidepressant or anxiolytics that has been found significant for treatment of children and adolescence	See above responses. There is no current evidence for efficacy pharmacological interventions. This is, however, partly an absence of evidence, i.e. a lack of studies targeting the group of anxiety. There are ongoing trials both in the UK and US which we hope will illuminate these questions
50	Were people with schizoid PD over diagnosed in the past? Do you think a significant number may be seen as having an AS condition now?	Almost certainly
51	Please comment on treatment evidence on social anxiety in ASD.	Many of those included in the CBT trials that I showed had social anxiety. It's worth remembering that most of the trials look at a decrease in symptoms rather than a complete eradication of these and, logically speaking, we are thinking of how interventions reduce symptoms so that people can manage their anxiety.
52	It would also be helpful to hear your views on other personality disorders particularly schizotypal and schizoid. I have heard you shouldn't diagnosis schizotypal if a person has ASD. What is your view on this? Many thanks	
53	May I make a comment that with regards to behaviour which challenges, it is important to exclude physical health problems first - given that autistic people often experience pain/physical sensations differently, and may have dfficulties communicating with others. Thanks.	This is an important point. Behaviour the challenges can be due to physical health problems, in particular conditions that cause pain or distress, lack of appropriate environmental modifications, inappropriate learnt responses as well as underpinning psychiatric disorders. That is why a comprehensive approach to their assessment and intervention is essential. Even amongst high functioning autistic people, impairments in interception may reduce their ability to observe and report painful conditions.
54	Re: "You require MDT approach" - my understanding is that CAMHS occupational therapy no longer accept referrals for sensory profiling and ongoing therapy. Please could you clarify, or whether budging restrictions are variable dependant on geographical area. Many thanks.	This is a local decision; however, you are correct that there may be insufficient occupational therapy services in many CAMHS serving this population.

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55	I'm an acute medicine consultant - I deal with physical health problems. Patients with MH issues sometimes present to our services. I've never met anyone on guanfacine - do adult patients take it?	It can be prescribed for adults, but less commonly. In general ADHD is both less recognised in adults with autism and also less treated. Finally, many will have had a reduction in the severity of their ADHD symptoms so that fewer need medication
56	Could you please comment on introversion as a tempramental trait (degree of) and whether in absence of other characteristics of ASD is enough (based on impact on functioing) can be considered as due to ASD?	
57	Please could I ask if you know of any strong research evidence for the use of Melatonin in adults with autism? Thank you.	
58	How to switch risperdone to aripiprazole in under 16years the reason being raised prolactin levels.	This will involve tapering down of risperidone while starting aripiprazole, bearing in mind that you always want to use the lowest effective dose of either medication. With aripiprazole, some patients experience akathisia on very low doses may need a slightly higher dose.
59	Any thoughts on pathological demand avoidance and evidence base for treatment?	See this article. The characteristics described by PDA our incredibly challenging to parents and sometimes schools/others. However, we think they can be better explained by characteristics associated with (e.g. rigidity) as well as high levels of anxiety and oppositionality. Given that there are evidence-based interventions for these, we prefer to formulate individual in this way. We find that many of the interventions suggested for PDA may lead to further secondary impairments not insisting the CYP engages in everyday activities. Green, J., Absoud, M., Grahame, V., Malik, O., Simonoff, E., Le Couteur, A., & Baird, G. (2018). Pathological Demand Avoidance: symptoms but not a syndrome. The Lancet Child and Adolescent Health, 2(6), 455-464.
60	what do you think of the necessity of assessment tools like ADOS, ADI? can diagnosis be made on clinical assessment only?	Neither the ADI nor the ADOS is required in all assessments. It is very helpful if some members of the MDT assessment team have trained in one or both measures as they provide a good background and structure for routine assessments. There are likely to be a number of cases in which detailed and highly structured assessment is necessary to confirm/this confirmed the diagnosis. A common clinical error is that of using an ADOS score is a cut-off for/against the diagnosis. ADOS scores are one source of information that should be considered in the context of all other sources are never used as a strict cut-off.
61	If SSRI not beneficial in age 5-18yrs for anxiety, what about the 18 plus adult ages - what does work? we in adult psych use SSRI....this seems now dubious?	The situation is one of an absence of evidence, rather than evidence of a lack of effect. So SSRIs can be used but with caution given that we don't know their efficacy.

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62	How to manage behavioural difficulties in adults presenting with Aspergers and EUPD	
63	WHY Resperidone why not other antipychotic?	
64	Is it better to avoid first generation antipsychotics for people with ASD and psychosis/challenging behaviour. Is it because they are more prone to develop side effects with first generation antipsychotics? Can these be used at low dose and by titrating slowly when patients do not respond to atypical antipsychotics or develop side effects to atypical antipsychotics and a depot medication is required. Thanks	
65	js	
66	What do you view the core differences between female ASD and female EUPD?	
67	A parent has been asking the role of camel's milk in control of agitation in ASD. Any thoughts would be welcome.	I can't comment on this.
68	please kindly mention on cooccurence of ASD and gender dysphoria in young people	I think this got covered later in the day
69	Could the overlap with PDA-pathological demand avoidance covered?	As above
70	resperidone can give similar side effects as first generation antipychotics js	ues, but this is where the evidence for efficacy in managing challenging behaviours exists
71	What medications are considered most effective for managing anxiety in adults with autism as you mentioned SSRI not very effective?	As above - lack of evidenc rather than evidence of lack of efficacy
72	Can I ask about rates of comorbidity of ASD with eating disorders and indeed disordered eating, in CYP and adults? There's always very little said about restrictive eating from early childhood onwards with ASD.	this was covered - up to 1/3 have autistic traits. You are correct that restrictive eating patterns in autistic individuals for subsequent development of an eating disorder, alongside other characteristics such as rigid, inflexible thinking patterns. Identifying autistic traits and disorders is important because, again, into and is the adaptation.

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73	Supplimentary question to Deepak's would be (particularly to client groups in inpatient forensic settings) is so-morbid diagnosis of disscial PD / and psychopathy.	I think this may be partially covered later in the day. While many children/young people on the autism spectrum appear callous and unemotional, for many this reflects difficulties with emotion rate cognition and communicating their feelings. The latter may be surface manifestation rather than actually due to psychopathy. However, there is evidence that elements in social, in both autistic and non-autistic youth rates of behavioural disturbance. Carter Leno, V., Chandler, S., White, P., Yorke, I., Charman, T., Jones, C. R. G., . . . Simonoff, E. (2020). Associations between theory of mind and conduct problems in autistic and nonautistic youth. Autism Research. doi:10.1002/aur.2346 Carter Leno, V., Charman, T., Pickles, A., Jones, C. R., Baird, G., Happe, F., & Simonoff, E. (2015). Callous-unemotional traits in adolescents with autism spectrum disorder. British Journal of Psychiatry, 207(5), 392-399. doi:10.1192/bjp.bp.114.159863
74	do you think there is between ASD and extreme violence in adolescence, such as involvement with gangs	For the most part, autistic adolescents are less likely to show socialised aspects of conduct disorder, such as involvement in gangs. However, should they get involved in a gang, there probably more likely to behave in a way that harms themselves or others because of their impaired social awareness.
75	is it really relevant or indeed reliable to diagnose EUPD in ASD gievn the overlap of symtopms and the lack of an aetilogical classification system	