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3 **A Phenomenological Approach to Diagnosing Psychosis in Autism Spectrum Disorder**
4 **and Intellectual Disability: A Case Series**
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7

8 **Abstract**
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10 **Purpose:** The diagnosis of psychosis in individuals with autism spectrum disorder poses a
11 unique clinical challenge. The presence of intellectual disability further complicates the
12 diagnostic picture. Reliable and timely diagnosis of psychosis in such individuals minimizes
13 the duration of untreated psychotic symptoms and the subsequent impact on the quality of life
14 of the patients concerned.
15

16 **Design/methodology/approach:** The authors present four patients with psychosis, autism
17 spectrum disorder and intellectual disability, who have received care within forensic mental
18 health and intellectual disability settings. These examples demonstrate the interaction
19 between these conditions, as well as issues pertaining to diagnosis and management.
20

21 **Findings:** In all four patients, sustained use of antipsychotic medication was objectively
22 associated with an improvement in psychotic symptoms and quality of life. In instances
23 where autistic phenomena were accentuated upon development of psychosis, such features
24 returned to the baseline levels evident prior to the onset of psychosis.
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26 **Practical implications:** The discussion and related case examples could improve
27 understanding of the possibility of psychosis in individuals with autism spectrum disorder
28 and intellectual disability, and increase awareness of this diagnostic possibility among
29 healthcare professionals.
30

31 **Originality/value:** This is the first published case series illustrating the challenges of
32 diagnosing psychosis in individuals with autism spectrum disorder and intellectual disability.
33

34 **Keywords:** Schizophrenia, Autism spectrum condition, Learning disability, Mental disorder,
35 Mental health, Comorbidity
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37 **Article classification:** Case series
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A Phenomenological Approach to Diagnosing Psychosis in Autism Spectrum Disorder and Intellectual Disability: A Case Series

Introduction

Autism spectrum disorders (ASD) and psychotic disorders have historically been considered as related diagnostic entities (Sugranyes, Kyriakopoulos, Corrigan, Taylor, & Frangou, 2011). However, the nature of this relationship has been the subject of extensive debate (Padgett, Miltsiou, & Tiffin, 2010), alternating between the view that ASD is an early manifestation of childhood schizophrenia on the one hand (Kanner, 1949), and that people with ASD could not be diagnosed with schizophrenia on the other. It is now widely believed that ASD and psychosis are two distinct clinical entities. Kolvin and colleagues (1971) highlighted that children whose abnormal behaviours were apparent before the age of three years fitted with Kanner's description of 'early infantile autism' (Kanner, 1968). In contrast, those children whose development was essentially normal until school years, but then later developed hallucinations, delusions or other behavioural abnormalities, were felt to be more in keeping with a diagnosis of schizophrenia.

A number of studies have examined whether schizophrenia is significantly more prevalent amongst people with ASD, in comparison to the general population (Billstedt, Gillberg, & Gillberg, 2005; Ghaziuddin, Weidmer-Mikhail, & Ghaziuddin, 1998; Volkmar & Cohen, 1991). A recent systematic review examined the rates of psychosis in individuals with ASD, reporting a prevalence which ranged from 0-53% (Padgett et al., 2010). However, the authors noted marked differences and heterogeneity in terms of the methodological approaches of the included studies, which precluded a meaningful pooling of the findings. For example, the prevalence of psychosis in adults with ASD differed greatly between studies. Joshi and colleagues (2013) found a lifetime prevalence of 13% and point prevalence of 8% of psychosis in adults with ASD, whereas a study by Volkmar and Cohen (1991) found only

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3 0.6% from a sample of 163 patients with ASD. Stahlberg, Soderstrom, Rastam and Gillberg,
4 (2004) reported that 7.8% of participants with diagnosed ASD had comorbid schizophrenia,
5 which is higher than the 1% prevalence of schizophrenia in the general population (McGrath
6 et al., 2004). A preliminary study reported a prevalence of 2.4-5.3% across three secure
7 hospitals, depending on whether equivocal cases were considered within the estimate (Hare,
8 Gould, Mills, & Wing, 1999). A meta-analysis highlighted that childhood-onset
9 schizophrenia is preceded by and comorbid with ASD in 30-50% of cases (Rapoport, Chavez,
10 Greenstein, Addington, & Gogtay, 2009). Likewise, it has been noted that in a population of
11 people with childhood-onset schizophrenia, 25% met the criteria for childhood ASD (Sporn
12 et al., 2004).

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24 Furthermore, Larson et al. (2017) conducted a study whereby 116 individuals with
25 ASD and psychosis were compared with a group with psychosis only. They found that a
26 diagnosis of atypical psychosis was more likely in individuals with ASD relative to those
27 with psychosis only, who were more likely to receive a diagnosis of schizophrenia. This
28 suggests that there may be a specific manifestation of ASD linked to comorbid psychosis,
29 yielding an atypical clinical picture, especially with regard to affective disturbance.

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Phenomenological overlap is a likely contributory factor to the wide variability in the
reported rates of schizophrenia in people with ASD (Skokauskas & Gallagher, 2010). The
neurodevelopmental hypothesis of schizophrenia suggests that its origins in adolescence are
partially explained by the consequences of events in early development (Owen, O'Donovan,
Thapar, & Craddock, 2011). Evidence suggesting a genetic overlap between
neurodevelopmental disorders such as ASD, attention deficit-hyperactivity disorder (ADHD),
bipolar affective disorder and major depressive disorder are emerging (Cross-Disorder Group
of the Psychiatric Genomics, 2013). Such findings suggest viewing these functional

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3 psychoses as a group of related and overlapping syndromes, with origins partially based in
4
5 the early developmental period.
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8 9 **Diagnostic Issues**

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11 The diagnosis of a psychotic disorder in an individual with ASD poses a clinical
12
13 challenge. In fact, numerous cases of misdiagnosis of psychosis and schizophrenia have been
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15 reported, especially in instances where the ASD was not previously diagnosed (Tantam,
16
17 2003). Through their ASD presentation alone, some people with ASD may meet the criteria
18
19 for schizophrenia on clinical interview schedules, such as the Structured Clinical Interview
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21 for the Diagnostic and Statistical Manual of Mental Disorders (SCID) (Konstantareas &
22
23 Hewitt, 2001). More specifically, the negative symptoms of schizophrenia have an overlap
24
25 with the symptoms of ASD (Frith, 1991). Carpenter et al (2007) reports that it is relatively
26
27 common for more able individuals with ASD to be erroneously diagnosed with
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29 schizophrenia, and cited examples of how some common features of ASD may be
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31 misinterpreted, as summarised in Table 1.
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38 *Table 1: Common reasons for the misdiagnosis of schizophrenia in ASD (Carpenter, 2007).*

39 40 ASD feature	Reason for potential confusion with schizophrenia
41 42 Imaginary friends	Can be interpreted as thought broadcasting and insertion.
43 44 Preoccupation with 45 46 control	Can lead to a person being said to have delusions of control or 47 48 influence.
49 50 Obsessional thoughts	Can also have a quasi-hallucinatory, inserted quality.
51 52 Internal dialogue	Can be interpreted as hallucinatory voices giving a running 53 54 commentary or discussing amongst themselves.
55 56 Bizarre ideas	Can be held in such a fixed manner, that it has the quality of a

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	delusion.
Fleeting visual hallucinations	If such hallucinations are rare and fleeting, they do not merit a diagnosis of schizophrenia.
Oddities of speech	The way that people with ASD may speak – with tangential comments and abbreviated explanations can mimic thought disorder.
Stereotypes and catatonic symptoms	Can also lead to an erroneous diagnosis of schizophrenia.
Social isolation	When undergoing time of change, social isolation can become more evident.
Proneness to psychotic reactions under stress / anxiety	When stressed, internal experiences can become ‘out of control’ and appear to merit the diagnosis of psychosis.
Concrete thinking	May be present in both ASD and schizophrenia.

Conversely, there is also a risk that the diagnosis of schizophrenia can be missed among those diagnosed with ASD. It is therefore essential to carefully elicit the content and form of the person’s thoughts, which will help identify a change from the usual preoccupations/ meanings attached to these thoughts. A thorough exploration of phenomenology can minimize the risk of psychosis being missed in people with ASD.

The presence of intellectual disability (ID) adds a further layer of complexity to the aforementioned difficulties of misdiagnosing ASD as schizophrenia, or vice versa, as well as establishing cases where there is a dual diagnosis of ASD and schizophrenia. This is further discussed in Box 1 (Fletcher, Loschen, Stavrakaki, & First 2007). Such cases are rarely described within the literature, and thus there is limited understanding of the prevalence of

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2
3 coexisting ASD and schizophrenia within the ID population. Esan et al (2015) assessed a
4 sample of 138 patients treated over six years within an inpatient forensic ID service, finding
5 that six of these patients had both ASD and schizophrenia. However, it is difficult to make
6 assumptions of the representativeness of this single study (Esan et al., 2015).
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13 *Box 1: Factors complicating establishing an accurate diagnosis of mental disorder in*
14 *individuals with ID (Fletcher et al., 2007).*
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| <ol style="list-style-type: none">18 1. Difficulties with the patient articulating their symptoms to professionals owing to
19 communication deficits.20 2. Propensity for some individuals with ID to attempt to hide their difficulties in order to
21 be perceived as ‘competent’ by others.22 3. Some individuals with ID may provide false reassurance out of a desire to appease the
23 professional evaluating them.24 4. Diagnostic overshadowing, whereby professionals may be inclined to attribute
25 symptoms of mental disorder to the individuals ID. |
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37 It has been suggested that the reliability of diagnosing psychosis in people with ASD
38 who also have ID is poorer than in those in the general population (Dossetor, 2007). This is
39 unsurprising given that there is no consensus on the best way to assess psychopathology in
40 adults with ASD and ID (Underwood, McCarthy, & Tsakanikos, 2010). There is no guidance
41 for the clinician on the diagnosis of psychosis in ASD in the 10th revision of the International
42 Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health
43 Organization, 1992). The 5th edition of the Diagnostic and Statistical Manual of Mental
44 Disorders (DSM-V) specifies that in individuals with a history of ASD, the diagnosis of
45 schizophrenia can only be made if there is a presence of hallucinations and delusions for at
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3 least one month duration (American Psychiatric Association, 2013). However, this seeming
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5 lack of guidance and literature on psychosis and ASD should not prevent consideration of the
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7 diagnosis in patients where such clinical suspicion exists. Failure to correctly identify
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9 psychosis in individuals with ASD would mean lack of provision of antipsychotic treatments,
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11 prolonging psychotic experiences and further compromising quality of life. Conversely,
12
13 failure to identify ASD in individuals with comorbid psychosis would lead to individuals
14
15 receiving inadequate treatment for their actual clinical needs (Larson et al., 2017).
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18 In this case series, we present four patients with mild ID who illustrate the clinical
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20 challenges of differentiating between diagnoses of ASD and psychosis, or may indeed have
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22 both conditions, with the overall aim of improving recognition, understanding of the interface
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24 between these conditions, as well as issues pertaining to diagnosis and management.
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27 **Method**

28 **Design**

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30 In this case series, four patients with psychosis, autism spectrum disorder and
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32 intellectual disability, who have received care within forensic mental health and ID settings,
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34 are presented.
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39 **Procedure**

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41 Clinicians working within two forensic ID services (one National Health Service and
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43 one independent sector) in the East of England were invited to submit cases to the project,
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45 and provided with the procedure to adhere to. The clinicians were asked to provide key
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47 information which included the apparent age of onset of psychosis, relevant family history,
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49 clinical diagnoses according to diagnostic manuals, any diagnostic tools to assist in their
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51 decision making, evidence of impairment due to symptoms, and the patient's response to
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53 described treatment. All participants had diagnoses of intellectual disability and autism
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spectrum disorder according to established diagnostic criteria, made by Consultant Psychiatrists during their care.

Ethical considerations

Case studies are presented according to principles established by the British Medical Journal Ethics Committee (British Medical Journal, 2018). These include obtaining informed consent and removal of patient identifying details. Informed consent was obtained from all patients included as case studies within the paper.

Case Series

Four case studies are presented, cases A, B, C and D. Cases A and B are described in Tables 2 and 3, and cases C and D are described in Tables 4 and 5.

Table 2: Case study A

<i>Age of onset of psychosis</i>	20 years
<i>Family history</i>	A has a family history of schizophrenia in his brother, anxiety and depression in his mother, and harmful use of alcohol in his father.
<i>Diagnoses</i>	<ul style="list-style-type: none"> • Mild Intellectual Disability (F70.1) • Autism Spectrum Disorder (F84.0) • Schizoaffective Disorder (F25.1) • Harmful use of alcohol, cannabis, and solvents (F10.1, 12.1 and 18.1) though currently abstinent in a forensic setting.
<i>Diagnostic tools used</i>	<ul style="list-style-type: none"> • WAIS-III (Wechsler, 1997): full scale intelligence quotient = 61 • ICD-10 (consensus of diagnosis established between two psychiatrists) (World Health Organization, 1992)
<i>Brief description</i>	<p>A is a 33 year old male with mild ID. He experienced sexual abuse during his childhood. Though he attended mainstream school, he struggled with lessons and left school aged 14 years, with no formal qualifications. He was described as a loner, having only one close friend. After leaving school, he began work at an animal shelter. He struggled to understand instructions, often interpreting them in a concrete manner.</p> <p>In his teens, A felt that he was homosexual, and also developed a sexual interest in animals. He fantasized about the latter, and occasionally acted on such fantasies, though after such encounters, he would ruminate and become distressed. At around 20 years of age, A started hearing voices commanding him to carry out bizarre sexual acts</p>

	with animals. He firmly believed that if he did not comply with these commands, either he or his mother would be killed by the voices. A also experienced unpleasant bodily sensations, and was convinced that the individuals responsible for the voices were imposing these experiences on his body. Along with these symptoms, he had episodes of mood disturbances alternating between low mood and elation/ irritability, lasting for few weeks at a time.
<i>Evidence of impairment due to symptoms</i>	<ul style="list-style-type: none"> • Subjective distress • Risks of self-harm (alcohol abuse) • Risks of sexually inappropriate behaviors (sexual acts against animals) • Vulnerability (deterioration in level of functioning related to onset of symptoms)
<i>Response to treatment</i>	While on antipsychotic medication, the intensity of A's hallucinatory experiences reduced considerably, alongside a subsequent reduction in distress, and sexually inappropriate behaviour towards animals.

Table 3: Case study B

<i>Age of onset of psychosis</i>	19 years
<i>Family history</i>	B had no known family history of mental illness or intellectual disability.
<i>Diagnoses</i>	<ul style="list-style-type: none"> • Mild Intellectual Disability (F70.1) • Autism Spectrum Disorder (F84.0) • Paranoid Schizophrenia (F20.0)
<i>Diagnostic tools used</i>	• ICD-10 (consensus of diagnosis established between two psychiatrists) (World Health Organization, 1992)
<i>Brief description</i>	<p>B is 44 year old male with mild ID. In his pre-school years, he was found to have a general delay in attainment of his major developmental milestones. Aged five years, he was assessed and subsequently attended special educational needs schooling. At school, B's deficits in reciprocal social interaction were clearly evident. Humour and teasing seemed to play a major role in his peculiar interaction style with his peers. He needed to adhere to a strict routine, and experienced significant anxiety when this was disrupted. Additionally, B had a tendency to interpret things in a concrete manner.</p> <p>His first contact with psychiatric services was at age 19 years, when he was observed to be increasingly withdrawn. B's inappropriate social interactions and eccentric beliefs, including delusions that he is of superior intelligence, became more prominent. He began making bizarre statements like experiencing 'standing outside of himself.' By the age of 23 years, he had developed firm convictions that his neighbours were poisoning his food, and ceased eating and drinking as a result. B was also depressed in mood, with significant feelings of guilt.</p> <p>Though B demonstrated an initial improvement with antipsychotic medications, full remission was never achieved. By 28</p>

	years of age, his persecutory beliefs were more elaborate, and he believed that his mother was tampering with his tablets and was trying to poison him.
<i>Evidence of impairment due to symptoms</i>	<ul style="list-style-type: none"> • Subjective distress • Risks of self-harm (related to hallucinations) • Risks of harm to family (related to hallucinations/delusions) • Risks of damage to property (related to hallucinations/delusions) • Vulnerability (deterioration in level of functioning related to onset of symptoms)
<i>Response to treatment</i>	After several trials of different antipsychotics without lasting success, B was commenced on Clozapine, which brought about sustained symptomatic improvement. Even during periods of relative remission, B continued to express odd beliefs and demonstrated inappropriate social behaviours, which are likely to be attributable to his ASD diagnosis. However, these were less pronounced compared to periods of active psychosis.

Table 4: Case study C

<i>Age of onset of psychosis</i>	24 years
<i>Family history</i>	C has a family history of schizophrenia in a second degree relative.
<i>Diagnoses</i>	ICD-10 (World Health Organization, 1992) <ul style="list-style-type: none"> • Mild Intellectual Disability (F70.1) • Autism Spectrum Disorder (F84.0) • Schizophrenia (F20)
<i>Diagnostic tools used</i>	Psychometric assessment when aged 18 years, as well as ICD-10 (World Health Organization, 1992) criteria used by experienced psychiatrists.
<i>Brief description</i>	<p>C is a 32 year old male with mild ID. With regard to his early development, his speech was delayed, and he received speech and language therapy input. During his childhood, he was also noticed to have flapping hand movements as well as jerking movements of his trunk. Additionally, he had ritualistic behaviours and difficulty in adjusting to change. C attended special educational needs schooling followed by a brief period in college. He was employed once, at a shop briefly, but this was terminated due to his difficulties in coping with changes within this setting.</p> <p>Aged 22 years, C was detained under the Mental Health Act after he presented with weight loss, self-neglect and disengagement from his carers, refusing them entry into his flat. Two years later, he was hospitalized for the second time with gradual deterioration and self-neglect over several months. During this time he held a firm belief that he was both infected with HIV and had leukaemia. He also believed that he was an internationally renowned surfer and a football player for Manchester United, married to a famous actress. He was convinced that his leg was sewn back after a shark attack and that his wife had been killed during this same attack. He was non-compliant with his</p>

	<p>medication throughout this period.</p> <p>C was later transferred to a rehabilitation unit, where he remained for around a year before being discharged into supported living in the community. He stayed in this placement for one year. He was then placed in a different flat in order to support him living more independently. C was ambivalent about this change and after a few months, he developed suicidal thoughts and was non-compliant with his medication regime. He seemed to settle with repeated reassurances, and continued to routinely visit his parents every week for a meal. During one of these visits, C stabbed his mother in the head, with the intention of murdering her. In subsequent interviews, he said that the thoughts of killing his mother started around the time of moving accommodation. These thoughts intensified when his belongings were moved to the new flat. C said “it seemed so final”, “I just couldn’t take it any more” and “I just had to get it done and she (his mother) was the right person”. He also stated “they are messing with my head”.</p>
<i>Evidence of impairment due to symptoms</i>	<ul style="list-style-type: none"> • Subjective distress • Risks of harm to family (related to delusions) • Vulnerability (deterioration in level of functioning related to onset of symptoms)
<i>Response to treatment</i>	<p>Following the assault on his mother, C was recommenced on antipsychotic medication. At this point his mental state improved, and he did not display any further aggression or self-neglect.</p>

Table 5: Case study D

<i>Age of onset of psychosis</i>	15 years
<i>Family history</i>	D had no known family history of mental illness or intellectual disability.
<i>Diagnoses</i>	<p>ICD-10 (World Health Organization, 1992)</p> <ul style="list-style-type: none"> • Mild intellectual disability (F70.1) • Autism Spectrum Disorder (F84.0) • Hyperkinetic Conduct Disorder (F90.1) • Paranoid schizophrenia (F20.0)
<i>Diagnostic tools used</i>	Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (World Health Organization, 1994).
<i>Brief description</i>	<p>D is a 32-year-old male with mild ID, ASD and paranoid schizophrenia. His family reported that his early developmental milestones were delayed, particularly his speech. He attended special educational needs schooling and came to the attention of mental health services at around the age of 5 years. He was diagnosed with ADHD and conduct disorder during his childhood. Later on he was diagnosed with paranoid schizophrenia during his adolescent years, at a time when he had been experiencing difficulties in affect regulation, an intense preoccupation in death, poor relationships with his peers, and a history of fire setting. D was first admitted to hospital at the age of 15 years and had multiple subsequent readmissions. Most readmissions were due to</p>

	<p>relapses resulting from non-compliance with medication, as well as alcohol and illicit substance abuse.</p> <p>When initially admitted to hospital, D would typically report hearing the tweets of birds, with the conviction that they were directed specifically to him. He believed that such experiences represented warnings that people intended to harm him. D had previously worn a stab proof vest and carried a knife in order to protect himself from such perceived harm. D also complained that he was able to see small lights on walls and lights coming through windows, which he interpreted as an indication that there were men outside using torches, awaiting an opportunity to murder him. He additionally reported that women were communicating to him through the television to warn him of forthcoming danger. D specifically mentioned a well-known British television presenter doing this repeatedly. D also reported other firmly held beliefs consistent with a clinical picture of Capgras syndrome, stating that his family, and the nursing staff, had been taken and replaced by clones, who were intent on murdering him. He believed that they were talking exclusively about him into a recording device. He believed staff were ‘wearing wires’ and spying on him and planned to murder him. D also disclosed that he thought these individuals were part of the mafia.</p>
<i>Evidence of impairment due to symptoms</i>	<ul style="list-style-type: none"> • Subjective distress • Risks of harm to others (related to hallucinations/delusions) • Risks of property damage/ fire-setting (related to hallucinations/delusions) • Risks of substance misuse (as a means of managing his distressing experiences) • Vulnerability (deterioration in level of functioning related to onset of symptoms)
<i>Response to treatment</i>	<p>D initially responded well to Olanzapine but would frequently stop taking oral medication. His periods of non-compliance correlated with increases in illicit drug and alcohol abuse. Commencement of Olanzapine in depot form led to sustained symptomatic improvement.</p>

Discussion

This paper has described the phenomenological approach to diagnosing psychosis in individuals with both intellectual disability and autism spectrum disorder. The paper has a number of drawbacks, including all of the associated difficulties with case studies, such as limited generalisability. Furthermore, all of the relevant cases identified during this study were male, and as such, future research on women with this combination of diagnostic comorbidity is required. Nevertheless, the paper has a number of implications. While there is a growing clinical ability in professionals to recognize and diagnose ASD, and an increasing recognition that mental disorder is more prevalent in people with ID, the differentiation between, and diagnosis of psychosis in ASD remains a clinical conundrum, with further complexity if ID is also present.

Clinical training should place appropriate emphasis on the ability to understand, describe and document the interface between ASD and psychosis. More research, including qualitative research, is needed to support the development and evaluation of reliable diagnostic criteria, and subsequent tools to support clinical practice. There are a number of issues currently affecting practice in this area. There appears to be a reluctance to diagnose psychosis (when clinically appropriate) which poses difficulty in early recognition and treatment (Larson et al., 2017). A delayed diagnosis, or a diagnosis not being made, is likely to result in a poor treatment response, as well as a need for higher doses of antipsychotics. Symptoms not appropriately treated may result in risky behaviour, subjective distress, mistrust in professionals and a poorer quality of life. In some cases, delayed diagnosis may increase the likelihood of being admitted to inpatient or secure placements.

There is currently a lack of guidance from diagnostic criteria, and subsequently tools to assist with the diagnosis of ASD and psychosis. As such, the clinical approach must be based on a phenomenological assessment, including differentiating objective reality, the

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2
3 ‘normal alternate reality’ of autism and the ‘loss of reality contact’ observed in psychosis,
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5 from one another. The value of establishing a good picture of premorbid and baseline level of
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7 functioning, obtaining information from multiple reliable and consistent sources, conducting
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9 detailed observations in various settings and contexts, and seeking another opinion where
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11 possible to enhance reliability cannot be overemphasized. Until better tools and criteria are
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13 developed, a judicious clinical approach may separate reliable early diagnosis and treatment
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15 with therapeutic benefit, from progressive deterioration and therapeutic nihilism.
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18 All the cases described in our series had a mild level of ID, were capable of adequate
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20 communication and engaged well, allowing independent assessment of their mental states by
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22 at least two psychiatrists. The qualitative change in behavior, new-onset symptoms including
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24 hallucinations and delusions, as well as the alteration or modulation of pre-existing autistic
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26 phenomena coupled with a decline in general functioning all supported the diagnosis of a
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28 psychotic illness. While a treatment response cannot be considered a diagnostic test,
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30 treatment with antipsychotic medication alleviated the new onset symptoms with minimal
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32 effects on pre-existing autistic symptoms.
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35 The patient described in the first case had a pre-existing sexual interest in animals.
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37 With the onset of psychosis, the rationale behind committing sexual acts to animals was to
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39 prevent harm to himself and his mother by a persecutor. The accompanying distress was
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41 reduced after commencement of antipsychotic medications. In the second case, the onset of
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43 psychosis correlated with a clear accentuation of autistic phenomena, as well as the
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45 development of clear cut delusions and affective symptoms. With treatment, the autistic
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47 symptoms returned back to baseline levels.
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50 Similarly, in the third case, there was a clear onset of new symptoms during episodes
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52 of psychosis. Circumstances leading to the committing of a criminal offence may have been
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54 attributable to a combination of autistic and psychotic phenomenology. The patient appeared
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3 to have developed persecutory ideations towards his mother in the context of being
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5 destabilised by changing placement. In the last case of the series, the onset of psychosis was
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7 mistakenly attributed to ASD for a period of time. The clear delusional content and
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9 perceptual disturbances were eventually identified whilst the patient was in hospital
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11 following detailed psychiatric assessments and longitudinal observations.
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14 In all of these cases, the diagnostic difficulty lay in determining if the patients'
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16 preoccupations, thoughts and behaviours were qualitatively different from the features of
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18 ASD. For example, while the "content" of the psychopathology was similar to that of ASD,
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20 the "form" was different. Features suggestive of a comorbid psychosis include the degree of
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22 distress, an increase in the intensity and frequency of preoccupations, the appearance of
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24 morbid themes, new behaviors and a change in functioning. A careful exploration of
25
26 phenomenology to differentiate between the content and form of thoughts is required.
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29 Regarding management, it is important for clinicians to develop a clinically sensible,
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31 sensitive and balanced approach to ensure people with ASD with possible development of a
32
33 comorbid psychotic disorder access the principles of early recognition, intervention and
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35 treatment. Psychosis diagnosed in a person with ASD should be treated in the same way as
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37 psychosis affecting any other individual. This includes prescribing adequate doses of
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39 antipsychotic medication, after ensuring clarity around the target symptoms that need to be
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41 addressed. Non-pharmacological treatments, such as interventions to address maladaptive
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43 assumptions, the use of distraction or masking techniques to treat auditory hallucinations
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45 (Nelson, Thrasher, & Barnes, 1991) and interventions to reduce expressed emotions
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47 (Anderson & Adams, 1996) may also be used as adjunctive measures.
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51 It should also be recognised that the combination of ASD and psychosis may have an
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53 impact on the length of stay in hospitals. Hare et al (1999) reported that people with ASD
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55 stayed in hospital settings for average of 8.5 years, which is 2-3 years longer than other
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3 patients. This may be because people with ASD pose unique challenges in terms of
4 management, treatment and eventual placement (Alexander et al., 2016). When a comorbid
5 psychotic disorder is present, this may potentially increase the length of stay even further.
6
7 However, it is likely that improving the recognition of the needs of patients with comorbid
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9 ASD and psychosis will begin to improve the effectiveness of treatment in this area.
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13 A key area of relevance is risk management of people with ASD and comorbid
14 psychosis. Some of the features of ASD, such as a lack of understanding of social norms,
15 concrete interpretation of rules, misinterpretations of others' intentions, difficulties in
16 expressing emotions, and pursuit of special interests with morbid/ unusual qualities, may pose
17 additional risks on patients when they are diagnosed with psychosis, potentially making them
18 even more prone to offending. Future research should seek to clarify these issues, in order to
19 more effectively assess and treat patients with complex presentations.
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