Autism, Developmental Disorders, and Related Psychiatric Conditions
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No relevant financial or nonfinancial relationships to disclose.
Objectives:

• Review DSM-IV criteria for Autistic disorder, and changes for Autism Spectrum Disorder (ASD) per DSM-V

• Discussion of comorbid disorders that occur in individuals with ASD

• Review some confounding symptoms and dilemmas in diagnosing comorbid disorders in ASD
DSM-IV Pervasive Developmental Disorders:

Autistic Disorder
Aspergers Disorder
Rett’s Disorder
Childhood Disintegrative Disorder
PDD NOS
Autistic Disorder

A. A total of 6 (or more) from (1), (2), & (3), with at least 2 from (1), &1 ea from (2) and (3):

(1) **qualitative impairment in social interaction**, as manifested by at least 2 of…:

(a) **marked impairment in the use of multiple nonverbal behaviors**, such as eye-to-eye
gaze, facial expression, body postures, and gestures to regulate social interaction
(b) **failure to develop peer relationships** appropriate to developmental level
(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with
other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(d) **lack of social or emotional reciprocity**

(2) **qualitative impairments in communication**, as manifested by at least 1 of…:

(a) **delay in, or total lack of, the development of spoken language** (not accompanied by
an attempt to compensate through alternative modes of communication such as gesture or mime)
(b) in individuals with adequate speech, **marked impairment in the ability to initiate or
sustain a conversation with others**
(c) **stereotyped and repetitive use of language or idiosyncratic language**
(d) **lack of** varied, spontaneous make-believe play or social imitative play appropriate to
developmental level
Autistic Disorder (cont’d)

A. A total of 6 (or more) from (1), (2), & (3), with at least 2 from (1), &1 ea from (2) and (3):

(3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities
as manifested by at least 1 of the following:
   (a) encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest
       that is abnormal either in intensity or focus
   (b) apparently inflexible adherence to specific, nonfunctional routines/rituals
   (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting
       or complex whole-body movements)
   (d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3
   years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or
   imaginative play.

C. The disturbance is not better accounted for by Rett’s disorder or childhood disintegrative
   disorder.
Asperger’s Disorder

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
   (1) marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
   (2) failure to develop peer relationships appropriate to developmental level
   (3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
   (4) lack of social or emotional reciprocity

B. Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
   (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
   (2) apparently inflexible adherence to specific, nonfunctional routines or rituals
   (3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
   (4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific pervasive developmental disorder or schizophrenia.
Rett’s Disorder

A. All of the following:
   (1) apparently normal prenatal and perinatal development
   (2) apparently normal psychomotor development through the first 5 months after birth
   (3) normal head circumference at birth

B. Onset of all of the following after the period of normal development:
   (1) deceleration of head growth between ages 5 and 48 months
   (2) loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (i.e., hand-wringing or hand washing)
   (3) loss of social engagement early in the course (although often social interaction develops later)
   (4) appearance of poorly coordinated gait or trunk movements
   (5) severely impaired expressive and receptive language development with severe psychomotor retardation
Childhood Disintegrative Disorder

A. Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

B. Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:
   (1) expressive or receptive language
   (2) social skills or adaptive behavior
   (3) bowel or bladder control
   (4) play
   (5) motor skills

C. Abnormalities of functioning in at least two of the following areas:
   (1) qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
   (2) qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
   (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, including motor stereotypies and mannerisms

D. The disturbance is not better accounted for by another specific pervasive developmental disorder or by schizophrenia.
Pervasive Developmental Disorder, not otherwise specified

The essential features of PDD-NOS are **severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills; and stereotyped behaviors, interests, and activities.**

The criteria for Autistic Disorder are not met because **of late age onset; atypical and/or sub-threshold symptomotology** are present.

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for **a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypical Personality Disorder, or Avoidant Personality Disorder.** For example, this category includes “atypical autism”– presentations that do not meet the criteria for Autistic Disorder because of late age of onset,
According to the Centers for Disease Control’s (CDC) latest statistics, about 1 in 68 children has been identified with an autism spectrum disorder (ASD).

ASDs are reported to occur in all racial, ethnic and socioeconomic groups, and are almost five times more common among boys (1 in 54) than among girls (1 in 252).
A. Persistent *deficits in social communication and social interaction* across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. **Deficits in social-emotional reciprocity**, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. **Deficits in nonverbal communicative behaviors** used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. **Deficits in developing, maintaining, and understanding relationships**, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior.
B. **Restricted, repetitive patterns of behavior, interests, or activities**, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. **Stereotyped or repetitive motor movements, use of objects, or speech** (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. **Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior** (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly **restricted, fixated interests that are abnormal in intensity or focus** (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. **Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment** (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior.
C. **Symptoms** must be present in the early developmental period (but *may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life*).

D. Symptoms *cause clinically significant impairment in social, occupational, or other important areas of current functioning*.

E. These disturbances are *not better explained by intellectual disability* (intellectual developmental disorder) *or global developmental delay*. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.
DSM-V revision
“Autistic Spectrum Disorder”

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:
With or without accompanying intellectual impairment
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor
(Coding note: Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder
(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].
With catatonia (refer to the criteria for catatonia associated with another mental disorder)
(Coding note: Use additional code 293.89 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)
Levels of Severity:

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>‘Requiring support’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Communication</strong></td>
<td>Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.</td>
</tr>
<tr>
<td><strong>Restricted interests &amp; repetitive behaviors</strong></td>
<td>Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 2</th>
<th>‘Requiring substantial support’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Communication</strong></td>
<td>Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.</td>
</tr>
<tr>
<td><strong>Restricted interests &amp; repetitive behaviors</strong></td>
<td>Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.</td>
</tr>
</tbody>
</table>
Levels of Severity:

<table>
<thead>
<tr>
<th>LEVEL 3</th>
<th>‘Requiring very substantial support’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Communication</strong></td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.</td>
</tr>
<tr>
<td><strong>Restricted interests &amp; repetitive behaviors</strong></td>
<td>Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.</td>
</tr>
</tbody>
</table>
Imagine that you are a new parent who knew something was not quite right with your child. It seemed that, perhaps, he was just really shy. You consider, maybe even hesitantly, that therapy is what the provider will recommend.
Initial emotional reactions to disclosure of diagnosis:

- sadness (64.2%)
- shock (36.5%)
- anxiety (35.8%)
- sorrow (32.4%)
- self-blame (26.4%)
- denial (11.5%)
- and despair (11.5%)
Ideal mode of information delivery:

• face-to-face communication between physicians and parents (74.3%)
• at the clinic (53.4%) or interview room (45.2%)
• with the parent being accompanied by the spouse (88.2%).
• only after the diagnosis had been confirmed (60.8%)

Expected:

• more information on treatment options (78.8%)
• education and parenting (68.5%)
• educational and welfare resources (63.0%)
• rehabilitation (58.2%).
Experiences of autism diagnosis: A survey of over 1000 parents in the United Kingdom

Crane, et al.

Table 4. Satisfaction scores (%) relating to different aspects of the diagnostic process (n = 1014).

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Very dissatisfied</th>
<th>Quite dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Quite satisfied</th>
<th>Very satisfied</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall diagnostic process</td>
<td>32</td>
<td>20</td>
<td>13</td>
<td>25</td>
<td>10</td>
<td>2.62 (1.41)</td>
</tr>
<tr>
<td>The information given at diagnosis</td>
<td>14</td>
<td>19</td>
<td>19</td>
<td>31</td>
<td>17</td>
<td>3.16 (1.31)</td>
</tr>
<tr>
<td>The manner of the professional disclosing the diagnosis</td>
<td>9</td>
<td>11</td>
<td>13</td>
<td>32</td>
<td>34</td>
<td>3.70 (1.29)</td>
</tr>
<tr>
<td>The support offered post-diagnosis</td>
<td>36</td>
<td>25</td>
<td>15</td>
<td>18</td>
<td>5</td>
<td>2.31 (1.27)</td>
</tr>
</tbody>
</table>

SD: standard deviation.
Comorbid Psychiatric Disorders in Children with Autism: Interview Development and rates of disorders

Leyfer, et al.

- Children from 5 to 17 yrs of age, with a mean of 9 yo.
- n=109 children (only 41 completed the generalized anxiety section of the study)
Prevalence of Comorbid Disorders in individuals with ASD:

- Specific phobia (44%)
- Obsessive compulsive disorder (37%)
- ADHD (31%)
- Other Anxiety disorders
  - Separation anxiety 12% (n=101)
  - Social phobia 7% (n=94)
  - Generalized anxiety 2.24% (n=41)
- None had panic disorder
- 10% had at least one episode of major depressive disorder.
- 2% met criteria for bipolar disorder.
- None met criteria for schizophrenia.
Psychiatric Disorders in Children With Autism Spectrum Disorders: Prevalence, Comorbidity, and Associated Factors in a Population-Derived Sample

112 children

98 were male (7:1 male:female ratio)

Mean age of 11.5 years (range 10-13.9).

Fifty children (39 male) – diagnosis of other pervasive developmental disorders

62 children (59 male) of childhood autism

106 (95%) were white British.
Prevalence of Comorbid Disorders in individuals with ASD:

- 70.8% - at least one current psychiatric disorder (any disorder)
- 62.8% - ADHD, an emotional or behavioral (oppositional defiant or conduct) disorder (referred to as any main disorder)
- 24.7% another disorder of Tourette syndrome, chronic tics, trichotillomania, enuresis, or encopresis (any neuropsychiatric disorder).
Assessing for Comorbid Disorders:

Many psychiatric disorders have some degree of heritability. Screening for disorders, including substance abuse, legal issues, domestic violence and more in first degree relatives can provide valuable information when assessing any child.

Teens and preteens may be self-medicating, masking or even exacerbating symptoms of other disorders with substances or alcohol.

Let’s now discuss selected disorders and some confounding issues when evaluating children with ASD.
Anxiety disorders:

Can include;

- Social Phobia
- Specific Phobia
- Obsessive Compulsive disorder
- Panic disorder (not thought to be common in ASD)
- Unspecified Anxiety disorder
- PTSD (under Trauma Related Disorders in the DSM-V)
Anxiety disorders:

• Frequent complaints of headaches, stomachaches, insomnia or other somatic complaints without etiology
• School avoidance
• Irritability
• Difficulty concentrating
• Reactive anger
• Symptoms can look like ADHD – i.e. perceived inattention due to hypervigilance, or restless legs and
Depression:

- Irritability or anger
- Continuous feelings of sadness and hopelessness
- Social withdrawal
- Increased sensitivity to rejection
- Changes in appetite -- either increased or decreased
- Changes in sleep -- sleeplessness or excessive sleep
- Vocal outbursts or crying
- Difficulty concentrating
- Fatigue and low energy
- Physical complaints (such as stomachaches, headaches) that don’t respond to treatment
- Reduced ability to function during events and activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests
- Feelings of worthlessness or guilt
- Impaired thinking or concentration
- Thoughts of death or suicide

WedMD.com
Bipolar disorder:

- Lack of need for sleep - these children/teens may sleep for a few hours or none and be alert without fatigue or sedation after such few hours. These individuals may be up and playing in the middle of the night while the rest of the household sleeps.

- Racing thoughts - Sometimes one can even visibly see the individual "thinking" from subject to subject as their mind wanders, and their eyes dart around the room.

- Rapid speech - changing topics so frequently that the listener cannot follow their train of thought. This is not only when the individual is excited about something, but at any time and about any sort of topic.
Examples of how ADHD manifests in adults

- Requires 6 of either inattention or hyperactivity/impulsivity for those under 17
- Requires 5 of either inattention or hyperactivity/impulsivity for those 17 and older.
- Age to exhibit symptoms has been changed from before 7 to before 12 yo.

Neurodevelopmental disorders

- Allows for comorbid diagnoses of separation anxiety, generalized anxiety, social phobia, and ADHD.
1. Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
- Often has trouble holding attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
- Often has trouble organizing tasks and activities.
- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
- Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily distracted
- Is often forgetful in daily activities.
2. Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level:

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting his/her turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)
In addition, the following conditions must be met:

• Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
• Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
• There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
• The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).
Based on the types of symptoms, three kinds (presentations) of ADHD can occur:

*Combined Presentation*: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months.

*Predominantly Inattentive Presentation*: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months.

*Predominantly Hyperactive-Impulsive Presentation*: if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months.

Because symptoms can change over time, the presentation may change over time as well.
Confounding Factors when Diagnosing Comorbid disorders in ASD:

- Family member compensation and family dynamics
- History of trauma, abuse, neglect
- Speech and communication issues
- Social skills issues
Parent/Family Compensation and Dynamics

• Adrian B. Kelly, et al

• Family cohesion significantly and negatively predicted anxiety/depression, ($p < 0.01$, 95%)

• Anxiety/depression significantly predicted ASD symptomatology ($p < 0.001$)
Boys Town National Research Hospital
Study by P. Sullivan, et al on children with disabilities

History of Trauma and Abuse, including Bullying

Neglect - 1.8 times more likely

Physical abuse - 1.6 times more likely

Sexual abuse - 2.2 times more likely
Abuse in Children with Autism
Mandell, et al.

18.5% of children with autism had been physically abused.

16.6% had been sexually abused.
Bullying and Children with ASD

Zeedyk, et al,

- Victim and parent perspectives
- 75% of ASD youth reported being bullied
- 80% of their mothers reported their child as being bullied.
- High association of internalizing disorders, such as depression and anxiety.
Eliciting Pertinent Information

When there are difficulties with *speech*, inquire about:

- difficulty with sleep (including waking up to go to parents’ room,) with attention to recurring nightmares or intrusive thoughts (trauma/anxiety)
- lack of need for sleep (ADHD, Bipolar disorder)
- rapid speech, racing thoughts, tangential thought processes (bipolar disorder, ADHD, psychosis)
- decreased appetite or interests (depression, anxiety)
- school refusal (anxiety/trauma, depression, ADHD, separation anxiety)
- peer relationships/being bullied (anxiety, poor social skills/ASD, ADHD)
- physical/somatic complaints (anxiety)
Screen for Child Anxiety Related Disorders (SCARED)  
Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: ____________________________  
Date: ____________________________  

Directions: Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not True or Hardly Ever True</td>
<td>Somewhat True or Sometimes True</td>
<td>Very True or Often True</td>
</tr>
</tbody>
</table>

1. When my child feels frightened, it is hard for him/her to breathe.  
2. My child gets headaches when he/she is at school.  
3. My child doesn’t like to be with people he/she doesn’t know well.  
4. My child gets scared if he/she sleeps away from home.  
5. My child worries about other people liking him/her.  
6. When my child gets frightened, he/she feels like passing out.  
7. My child is nervous.  
8. My child follows me wherever I go.  
9. People tell me that my child looks nervous.  
10. My child feels nervous with people he/she doesn’t know well.  
11. My child gets stomachaches at school.  
12. When my child gets frightened, he/she feels like he/she is going crazy.  
14. My child worries about being as good as other kids.  
15. When he/she gets frightened, he/she feels like things are not real.  
16. My child has nightmares about something bad happening to his/her parents.  
17. My child worries about going to school.  
18. When my child gets frightened, his/her heart beats fast.  
19. He/she gets shaky.  
20. My child has nightmares about something bad happening to him/her.

www.wpic.pitt.edu/research (under “tools and assessments,”)  
or at www.pediatricbipolar.pitt.edu (under “instruments.”)
## SNAP-IV

A revision of the Swanson, Nolan and Pelham (SNAP) Questionnaire (Swanson et al, 1983)

<table>
<thead>
<tr>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>Tourette’s Disorder</td>
</tr>
<tr>
<td>Stereotypic Movement Disorder</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>Narcolepsy</td>
</tr>
<tr>
<td>Histrionic Personality Disorder</td>
</tr>
<tr>
<td>Narcissistic Personality Disorder</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
</tr>
<tr>
<td>Manic Episode</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
</tr>
<tr>
<td>Item</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks</td>
</tr>
<tr>
<td>2. Often has difficulty sustaining attention in tasks or play activities</td>
</tr>
<tr>
<td>3. Often does not seem to listen when spoken to directly</td>
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<td>4. Often does not follow through on instructions or fails to finish schoolwork, chores, or other tasks</td>
</tr>
<tr>
<td>5. Often has difficulty organizing tasks and activities</td>
</tr>
<tr>
<td>6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort</td>
</tr>
<tr>
<td>7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)</td>
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<tr>
<td>8. Often is distracted by extraneous stimuli</td>
</tr>
<tr>
<td>9. Often is forgetful in daily activities</td>
</tr>
<tr>
<td>10. Often has difficulty maintaining alertness, orienting to requests, or executing directions</td>
</tr>
<tr>
<td>11. Often fidgets with hands or feet or squirms in seat</td>
</tr>
<tr>
<td>12. Often leaves seat in classroom or in other situations in which remaining seated is expected</td>
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<td>13. Often runs about or climbs excessively in situations in which it is inappropriate</td>
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<td>14. Often has difficulty playing or engaging in leisure activities quietly</td>
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<td>15. Often is “on the go” or often acts as if “driven by a motor”</td>
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<td>16. Often talks excessively</td>
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<td>17. Often blurts out answers before questions have been completed</td>
</tr>
<tr>
<td>18. Often has difficulty awaiting turn</td>
</tr>
<tr>
<td>19. Often interrupts or intrudes on others (e.g., butts into conversations/games)</td>
</tr>
<tr>
<td>20. Often has difficulty sitting still, being quiet, or inhibiting impulsive behavior in the classroom or at home</td>
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<tr>
<td>21. Often loses temper</td>
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<tr>
<td>22. Often argues with adults</td>
</tr>
<tr>
<td>23. Often actively defies or refuses adult requests or rules</td>
</tr>
<tr>
<td>24. Often deliberately does things that annoy other people</td>
</tr>
<tr>
<td>25. Often blames others for his or her mistakes or misbehavior</td>
</tr>
<tr>
<td>26. Often touchy or easily annoyed by others</td>
</tr>
<tr>
<td>27. Often is angry or resentful</td>
</tr>
<tr>
<td>28. Often is spiteful or vindictive</td>
</tr>
<tr>
<td>29. Often is quarrelsome</td>
</tr>
<tr>
<td>30. Often is negative, defiant, disobedient, or hostile toward authority figures</td>
</tr>
<tr>
<td>31. Often makes noises (e.g., humming or odd sounds)</td>
</tr>
<tr>
<td>32. Often is excitable, impulsive</td>
</tr>
<tr>
<td>33. Often is seekers</td>
</tr>
<tr>
<td>34. Often is uncooperative</td>
</tr>
<tr>
<td>35. Often acts “smart”</td>
</tr>
<tr>
<td>36. Often is restless or overactive</td>
</tr>
<tr>
<td>37. Often disturbs other children</td>
</tr>
<tr>
<td>38. Often changes mood quickly and drastically</td>
</tr>
<tr>
<td>39. Often easily frustrated if demand are not met immediately</td>
</tr>
<tr>
<td>40. Often teases other children and interferes with their activities</td>
</tr>
</tbody>
</table>

www.wpic.pitt.edu/research (under “tools and assessments,”) or at www.pediatric bipolar.pitt.edu (under “instruments,”)
Social Skills Deficits

Difficulty interpreting your questions and purpose of questions
Rephrasing
Parents can help rephrase or interpret answers
In conclusion…

- thorough history
- observation of
  - the child
  - the child’s reactions to the environment, including to the parent’s cues
  - the parent’s reaction to the child’s cues
- screening or rating scales

…can help guide treatment options
Thank you.

Josette Weibrecht, MD
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cfpptucson.com