Autism: A Deep Dive

Elizabeth Harari, MD

Speaker

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Autism: A Deep Dive

- At the end of this session, learners will be able to...
  - Describe the core characteristics of autism spectrum disorder (ASD), including its heterogeneity and common comorbid conditions.
  - Identify commonly used screening tools and diagnostic tests for ASD.
  - Formulate appropriate treatment goals tailored to individual presentations of autism.
  - Evaluate the roles of various therapeutic interventions, including behavioral therapies and pharmacological treatments.
  - Discuss medication options for managing common challenges in ASD, with a focus on insomnia and aggression.

Overview of ASD

- Pervasive, lifelong, and highly heritable neurodevelopmental disability
- Essential diagnostic features
  - Persistent challenges with social communication and social interaction across various contexts
  - Restricted, repetitive patterns of behavior, interests, and/or activities
- Current prevalence rate of 1 in 36 being diagnosed
- Male to female diagnostic ratio is 4:1
- Heterogenous presentation
- Phenotypically identified

Summary of DSM-5-TR Diagnostic Criteria

- Persistent **deficits in social communication** and social interaction across multiple contexts
- **Restricted, repetitive patterns of behavior**, interests, or activities as manifested by at least 2 of 4 symptoms currently or by history
- Symptoms must be present in the **early developmental periods**
- Symptoms cause **clinically significant impairment** in social, occupational, or other important areas of current functioning.
- These disturbances are **not better explained** by intellectual disability (intellectual development disorder) or global developmental delay.

DSM-5-TR Diagnostic Specifiers

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor

Associated with another neurodevelopmental, mental, or behavioral disorder

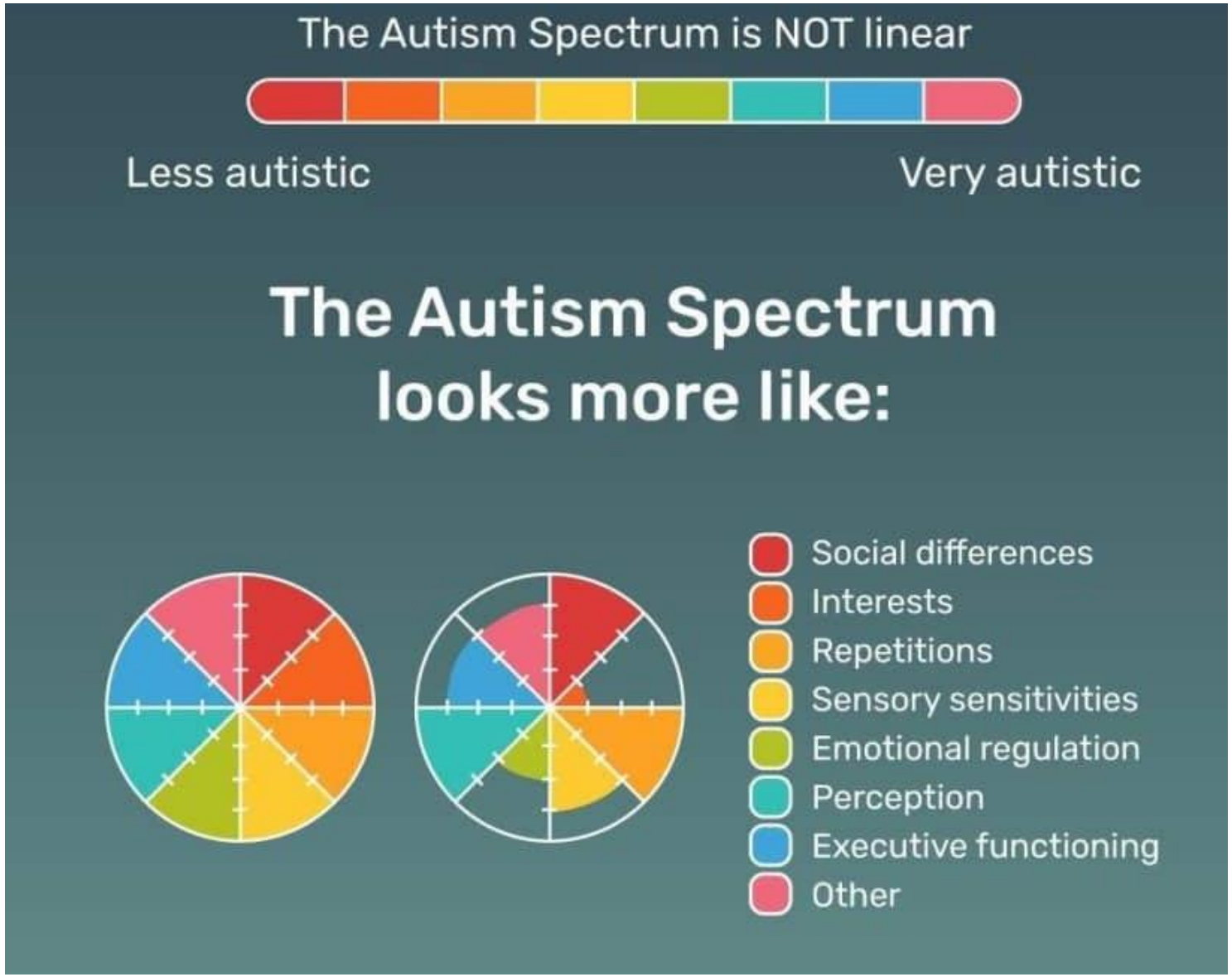
With catatonia

DSM-5-TR Levels of Support

Severity	Social Communication/ Interaction	Restricted and Repetitive Behaviors
Level 1 – "Requiring Support"	• Engages in interactions awkwardly • Decreased interest in social interplay • Able to speak in full sentences	• Moderate inflexibility of behaviors causing interference in 1-2 contexts • Difficulty switching between activities
Level 2 – "Requiring Substantial Support"	• Reduced or abnormal response to social overtures • Able to speak but in simple sentences	• Difficulty coping with change • Restricted behaviors occur more frequently
Level 3 – "Requiring Very Substantial Support"	• Severe deficits in verbal communication • Few words of intelligible speech • Rarely engages in social interplay	• Extreme difficulty coping with change • Restricted and repetitive behaviors interfere with functioning across all domains

Common Characteristics in ASD

- "Splinter skills"
  - Increased ability in one area (ex- memory, math, languages, reading)
- Literal interpretation of language
  - Difficulty understanding humor, teasing, figures of speech
- Concrete thought process
- Tendency to understand pictures or the written word better than the spoken word
- Difficulty attending verbal instructions
- Slower to shift attention
- Overly focused on things or preoccupied
- Poor transitions
- Delay in response


The Autism Spectrum is NOT linear
Less autistic
Very autistic
The Autism Spectrum looks more like:
Social differences
Interests
Repetitions
Sensory sensitivities
Emotional regulation
Perception
Executive functioning
Other

Heterogeneity

Measured intelligence

- severely impaired → gifted

Social interaction

- aloof → passive → interested but odd

Communication

- nonverbal → verbal → conversational

Behaviors

- intense → mild

Sensory

- sensory seeking → sensory aversions

Can be due to comorbidities

Co-Occurring Conditions

Seizures (N = 120, subgroup prevalence 77.5%).

Psychiatric disorders (N = 212, prevalence 33.0%).

Gastrointestinal disorders (24.3%) (N = 197)

Auditory disorders and infections (87.8%).

Injuries

Genetic syndromes

Psychiatric disorder

Doshi-Velez et al, *Pediatrics*, 2014.

Medical Evaluations

Hearing Evaluation:
Audiological assessment to detect hearing impairments that may impact communication and development.

Pediatric Gastroenterology Referral:
Evaluation and management for:

- Severe diarrhea
- Constipation
- Bloody stools
- Undigested food in stool
- Frequent vomiting

Neurology Consultation:
Assessment and diagnosis of suspected seizures and other neurological concerns.

Genetic Evaluation:
Referral for genetic testing to investigate underlying genetic/metabolic conditions contributing to developmental or medical findings.

Behavioral Health and Developmental Evaluations

Developmental Specialist Evaluation:
Comprehensive developmental evaluation for individualized intervention planning.

Child Psychiatric Consultation:
Evaluation and management of emotional, behavioral, and psychiatric conditions.

Psychological Evaluation:
Diagnostic assessment for behavioral, cognitive, and emotional functioning.

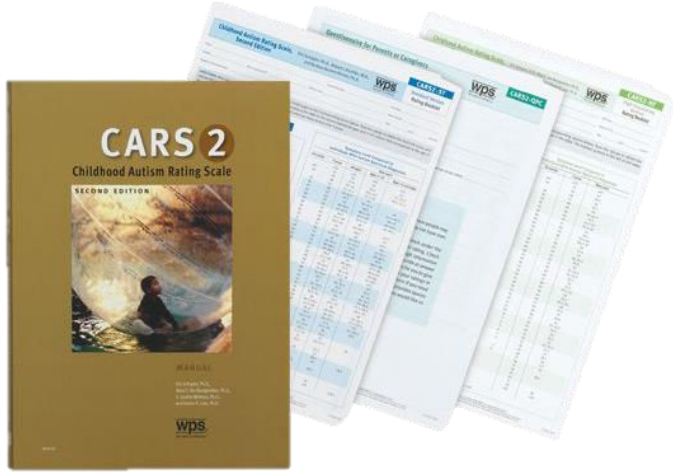
Screening Tools

Screening Tool	Target Age	Purpose	Notes	Validated?	Free to Access?
M-CHAT-R/F	16–30 months	Early detection of autism risk	Parent questionnaire with follow-up interview	**Yes**	**Yes** (with permission for clinical use)
SCQ	4 years and older	Screening for autism traits	Based on ADI-R; parent-report	**Yes**	**No** (requires purchase/license)
SRS-2	2.5 years–adult	Measures social impairments	Tracks social difficulties over time	**Yes**	**No** (requires purchase/license)
STAT	24–36 months	Play-based interactive screening	Requires trained administrator	**Yes**	**No** (training and materials must be purchased)
AQ	Adolescents and adults	Self-assessment of autistic traits	Good for research and screening	**Partially**	**Yes** (free for research/clinical use)
POSI	12–24 months	Early detection of social interaction concerns	Part of broader developmental screening	**Yes**	**Yes** (often integrated into free developmental screeners like PEDS)

Diagnostic Tools

Diagnostic Tool	Target Age	Purpose	Notes	Validated?	Free to Access?
ADOS-2	12 months–adult	Diagnostic observation tool	Structured interaction tasks	**Yes**	**No** (expensive; training and materials required)
ADI-R	2 years and older (developmental level >2 years)	Diagnostic caregiver interview	In-depth developmental history	**Yes**	**No** (requires purchase/license and training)
CARS-2	2 years and older	Diagnostic and severity assessment	Observational rating scale	**Yes**	**No** (requires purchase/license)

CARS 2- ST



Who Can Administer?

- Level C - Trained professionals, such as psychologists, psychiatrists, or specialized educators, administer the CARS-2.

How long does it take?

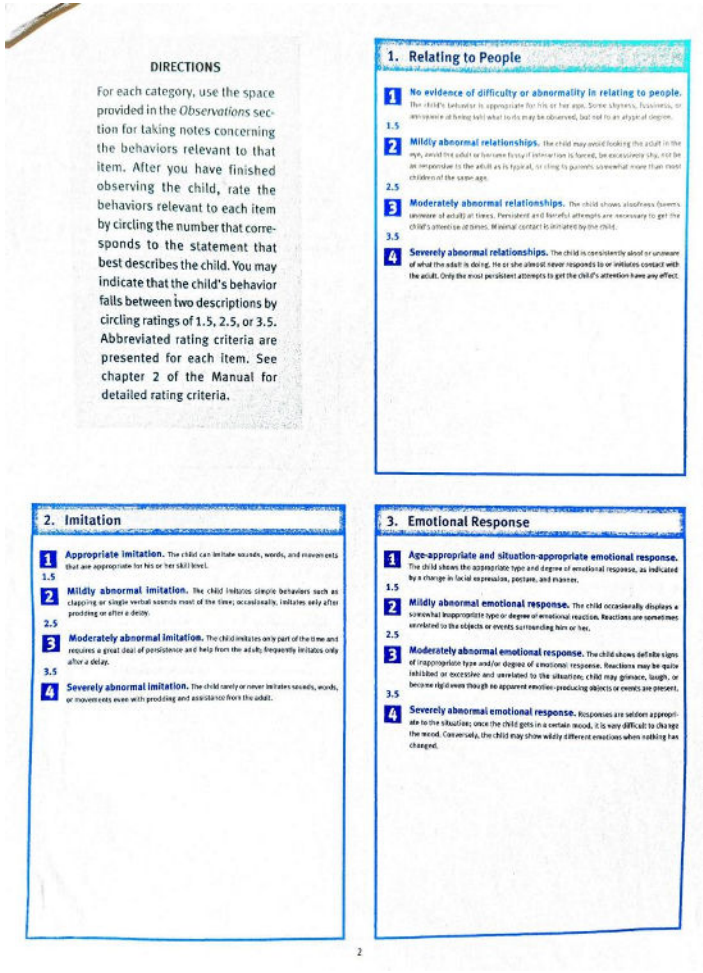
- The process usually takes about 30-60 minutes, depending on the complexity of the case and the amount of additional information available.

What areas are assessed?

- The CARS-2 evaluates 15 functional areas that are crucial for understanding autism spectrum disorder:

1. Relating to People
2. Imitation
3. Emotional Response
4. Body Use
5. Object Use
6. Adaptation to Change
7. Visual Response
8. Listening Response
9. Taste, Smell, and Touch Response and Use
10. Fear or Nervousness
11. Verbal Communication
12. Nonverbal Communication
13. Activity Level
14. Level and Consistency of Intellectual Response
15. General Impressions

It's important to note that these categories are not definitive diagnoses but rather indicators of the likelihood and severity of autism. The interpretation should always be conducted by a qualified professional who considers the CARS-2 results in conjunction with other clinical information and observations.



DIRECTIONS

For each category, use the space provided in the *Observations* section for taking notes concerning the behaviors relevant to that item. After you have finished observing the child, rate the behaviors relevant to each item by circling the number that corresponds to the statement that best describes the child. You may indicate that the child's behavior falls between two descriptions by circling ratings of 1.5, 2.5, or 3.5. Abbreviated rating criteria are presented for each item. See chapter 2 of the Manual for detailed rating criteria.

1. Relating to People

1 **No evidence of difficulty or abnormality in relating to people.** The child's behavior is appropriate for his or her age. Some shyness, fussiness, or annoyance at being told what to do may be observed, but not to an atypical degree.

1.5

2 **Mildly abnormal relationships.** The child may avoid looking the adult in the eye, avoid the adult or become fussy if interaction is forced, be excessively shy, not be as responsive to the adult as is typical, or cling to parents somewhat more than most children of the same age.

2.5

3 **Moderately abnormal relationships.** The child shows aloofness (seems unaware of adult) at times. Persistent and forceful attempts are necessary to get the child's attention at times. Minimal contact is initiated by the child.

3.5

4 **Severely abnormal relationships.** The child is consistently aloof or unaware of what the adult is doing. He or she almost never responds to or initiates contact with the adult. Only the most persistent attempts to get the child's attention have any effect.

2. Imitation

1 **Appropriate imitation.** The child can imitate sounds, words, and movements that are appropriate for his or her skill level.

1.5

2 **Mildly abnormal imitation.** The child imitates simple behaviors such as clapping or single verbal sounds most of the time; occasionally, imitates only after prodding or after a delay.

2.5

3 **Moderately abnormal imitation.** The child imitates only part of the time and requires a great deal of persistence and help from the adult; frequently imitates only after a delay.

3.5

4 **Severely abnormal imitation.** The child rarely or never imitates sounds, words, or movements even with prodding and assistance from the adult.

3. Emotional Response

1 **Age-appropriate and situation-appropriate emotional response.** The child shows the appropriate type and degree of emotional response, as indicated by a change in facial expression, posture, and manner.

1.5

2 **Mildly abnormal emotional response.** The child occasionally displays a somewhat inappropriate type or degree of emotional reaction. Reactions are sometimes unrelated to the objects or events surrounding him or her.

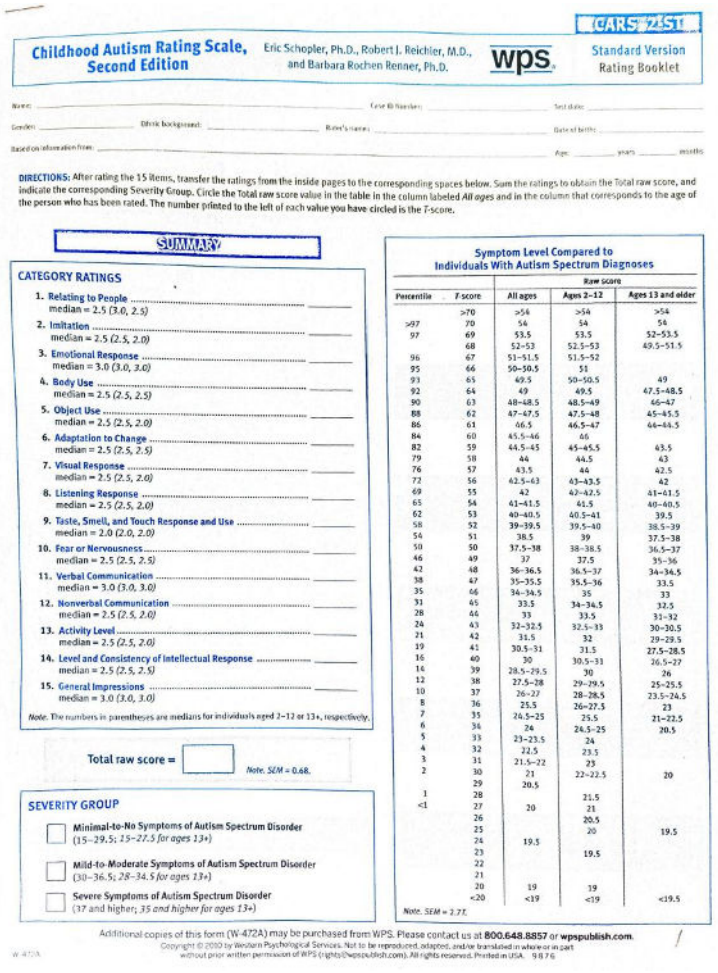
2.5

3 **Moderately abnormal emotional response.** The child shows definite signs of inappropriate type and/or degree of emotional response. Reactions may be quite inhibited or excessive and unrelated to the situation; child may grimace, laugh, or become rigid even though no apparent emotion-producing objects or events are present.

3.5

4 **Severely abnormal emotional response.** Responses are seldom appropriate to the situation; once the child gets in a certain mood, it is very difficult to change the mood. Conversely, the child may show wildly different emotions when nothing has changed.

2



CARS-2 ST

Childhood Autism Rating Scale, Second Edition

Eric Schopler, Ph.D., Robert J. Reichler, M.D., and Barbara Rochen Renner, Ph.D.

wps

Standard Version
Rating Booklet

Name: _____ Case ID Number: _____ Test date: _____

Gender: _____ Ethnic background: _____ Rater's name: _____ Date of birth: _____

Based on information from: _____ Age: _____ years _____ months

DIRECTIONS: After rating the 15 items, transfer the ratings from the inside pages to the corresponding spaces below. Sum the ratings to obtain the Total raw score, and indicate the corresponding Severity Group. Circle the Total raw score value in the table in the column labeled *All ages* and in the column that corresponds to the age of the person who has been rated. The number printed to the left of each value you have circled is the *T*-score.

SUMMARY

CATEGORY RATINGS

1. Relating to People _____
   median = 2.5 (3.0, 2.5)
2. Imitation _____
   median = 2.5 (2.5, 2.0)
3. Emotional Response _____
   median = 3.0 (3.0, 3.0)
4. Body Use _____
   median = 2.5 (2.5, 2.5)
5. Object Use _____
   median = 2.5 (2.5, 2.0)
6. Adaptation to Change _____
   median = 2.5 (2.5, 2.5)
7. Visual Response _____
   median = 2.5 (2.5, 2.0)
8. Listening Response _____
   median = 2.5 (2.5, 2.0)
9. Taste, Smell, and Touch Response and Use _____
   median = 2.0 (2.0, 2.0)
10. Fear or Nervousness _____
    median = 2.5 (2.5, 2.5)
11. Verbal Communication _____
    median = 3.0 (3.0, 3.0)
12. Nonverbal Communication _____
    median = 2.5 (2.5, 2.0)
13. Activity Level _____
    median = 2.5 (2.5, 2.0)
14. Level and Consistency of Intellectual Response _____
    median = 2.5 (2.5, 2.5)
15. General Impressions _____
    median = 3.0 (3.0, 3.0)

Note. The numbers in parentheses are medians for individuals aged 2–12 or 13+, respectively.

Total raw score = _____ *Note. SEM* = 0.68.

SEVERITY GROUP

☐ Minimal-to-No Symptoms of Autism Spectrum Disorder (15–29.5; *15–27.5 for ages 13+*)

☐ Mild-to-Moderate Symptoms of Autism Spectrum Disorder (30–36.5; *28–34.5 for ages 13+*)

☐ Severe Symptoms of Autism Spectrum Disorder (37 and higher; *35 and higher for ages 13+*)

Symptom Level Compared to Individuals With Autism Spectrum Diagnoses

Percentile	*T* score	Raw score: All ages	Ages 2–12	Ages 13 and older
	>70	>54	>54	>54
>97	70	54	54	54
97	69	53.5	53.5	52–53.5
	68	52–53	52.5–53	49.5–51.5
96	67	51–51.5	51.5–52	
95	66	50–50.5	51	
93	65	49.5	50–50.5	49
92	64	49	49.5	47.5–48.5
90	63	48–48.5	48.5–49	46–47
88	62	47–47.5	47.5–48	45–45.5
86	61	46.5	46.5–47	44–44.5
84	60	45.5–46	46	
82	59	44.5–45	45–45.5	43.5
79	58	44	44.5	43
76	57	43.5	44	42.5
72	56	42.5–43	43–43.5	42
69	55	42	42–42.5	41–41.5
65	54	41–41.5	41.5	40–40.5
62	53	40–40.5	40.5–41	39.5
58	52	39–39.5	39.5–40	38.5–39
54	51	38.5	39	37.5–38
50	50	37.5–38	38–38.5	36.5–37
46	49	37	37.5	35–36
42	48	36–36.5	36.5–37	34–34.5
38	47	35–35.5	35.5–36	33.5
35	46	34–34.5	35	33
31	45	33.5	34–34.5	32.5
28	44	33	33.5	31–32
24	43	32–32.5	32.5–33	30–30.5
21	42	31.5	32	29–29.5
19	41	30.5–31	31.5	27.5–28.5
16	40	30	30.5–31	26.5–27
14	39	28.5–29.5	30	26
12	38	27.5–28	29–29.5	25–25.5
10	37	26–27	28–28.5	23.5–24.5
8	36	25.5	26–27.5	23
7	35	24.5–25	25.5	21–22.5
6	34	24	24.5–25	20.5
5	33	23–23.5	24	
4	32	22.5	23.5	
3	31	21.5–22	23	
2	30	21	22–22.5	20
	29	20.5		
1	28		21.5	
<1	27	20	21	
	26		20.5	
	25		20	19.5
	24	19.5		
	23		19.5	
	22			
	21			
	20	19	19	
	<20	<19	<19	<19.5

Note. SEM = 2.77.

W-472A

CARS 2- ST : Evaluation report

Demographic information and background details about the individual being assessed. This section may include:

- Name, age, and date of birth
- Reason for referral
- Brief developmental and medical history
- Current educational or therapeutic interventions

Individual item scores and descriptions for each of the 15 functional areas assessed by the CARS-2. For each area, the report typically provides:

- The numerical score (1-4, with half-point increments)
- A brief description of the observed behaviors or characteristics that led to this score
- Examples of specific behaviors or responses noted during the assessment

Recommendations and next steps section. This may include:

- Suggestions for further assessments or evaluations
- Recommendations for interventions or therapies
- Strategies for supporting the individual at home and in educational settings
- Resources for parents and caregivers

Environmental Supports

Medications

Therapeutic Interventions

Treatment

Treatment Goals

Improve

- Improve quality of life
  - Improve adaptive skills
  - Decrease maladaptive behaviors

Maximize

- Maximize functioning
  - Social functioning
  - Play skills
  - Promote academic functioning and cognition

Move

- Move the child towards independence
  - Improve communication skills

Environmental Supports

Medications

Therapeutic Interventions

Treatment

Therapeutic Interventions

- **Speech and Language Therapy:**
  Treatment targeting expressive and receptive communication skills.
- **Physical Therapy:**
  Focus on enhancing gross motor skills, balance, strength, and mobility.
- **Occupational Therapy:**
  Intervention aimed at improving fine motor skills, sensory integration, and daily living activities.
- **Feeding Therapy:**
  Specialized therapy to address oral motor difficulties, swallowing issues, and feeding aversions.
- **Applied Behavior Analysis (ABA) Therapy:**
  Behavior-focused intervention promoting functional communication, adaptive behaviors, and skill acquisition.

- **Naturalistic Developmental Behavioral Interventions (NDBI):**
- Implemented in natural settings, involve shared control between child and therapist, utilize natural contingencies, and use a variety of behavioral strategies to teach developmentally appropriate and prerequisite skills.
- **Social Skills Group:**
  Group therapy designed to enhance social interaction, communication, and peer relationships.

School Services

Feature	Child Find Screening	504 Plan	IEP Plan
Purpose	Identify students who may need help	Provide equal access through accommodations	Provide specialized education and services
Law	IDEA (Individuals with Disabilities Education Act)	Section 504 of the Rehabilitation Act	IDEA (Individuals with Disabilities Education Act)
Who it Helps	Any child suspected of having a disability	Students with disabilities needing accommodations	Students with disabilities needing specialized instruction
Services/Support	Referral for evaluation if needed	Accommodations only (no curriculum changes)	Special education services, accommodations, and curriculum modifications
Eligibility	Based on observed concerns	Disability substantially limits major life activity	Disability under IDEA's 13 categories
Type of Plan	Screening/Referral process	Accommodation Plan	Individualized Education Program

Other Interventions

PECS

- Low verbal/non verbal people can communicate with pictures
- A picture of a desired item is given in exchange for that item
- Paired with verbal word
- Will expand communication ability and will improve ability to speak

Environmental Supports

Medications

Therapeutic Interventions

Treatment

Environmental Supports

Sensory-Friendly Environments:

Lighting:

- Using soft, indirect lighting or natural light instead of harsh fluorescent lights can reduce sensory overload.

Sound:

- Noise-canceling headphones, quiet spaces, and controlling background noise can help individuals who are sensitive to sounds.

Tactile Input:

- Fidget toys, weighted blankets, and textured objects can provide calming tactile stimulation.

Comfortable Seating:

- Providing comfortable furniture and cozy spaces can help create a calming environment

Environmental Supports

Structuring the Environment:

Visual Schedules:

- Creating visual schedules for daily routines can help individuals understand what to expect and reduce anxiety.

Clear Transitions:

- Providing visual cues and warnings for transitions can help individuals prepare for changes.

Consistent Routines:

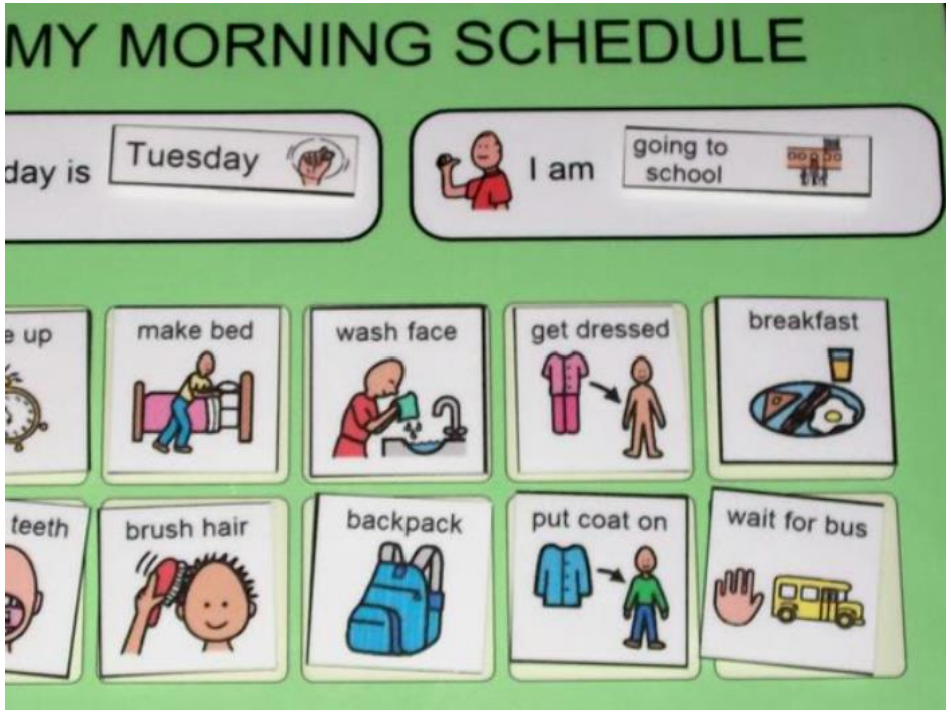
- Establishing consistent routines and predictability can provide a sense of security and control.

Boundary Markers:

- Using visual boundary markers, like colored tape, can help individuals understand safe and unsafe areas.

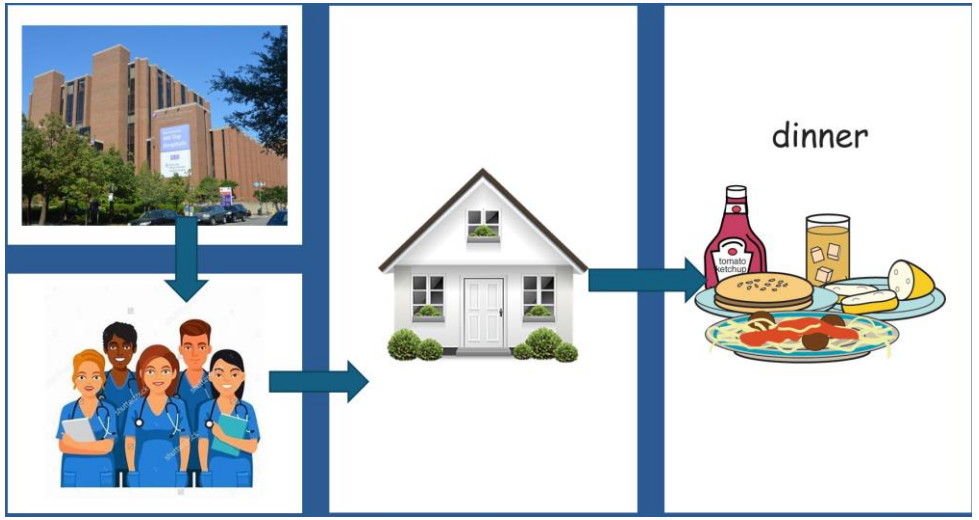
Quiet Zones:

- Creating designated quiet spaces where individuals can retreat when feeling overwhelmed is beneficial



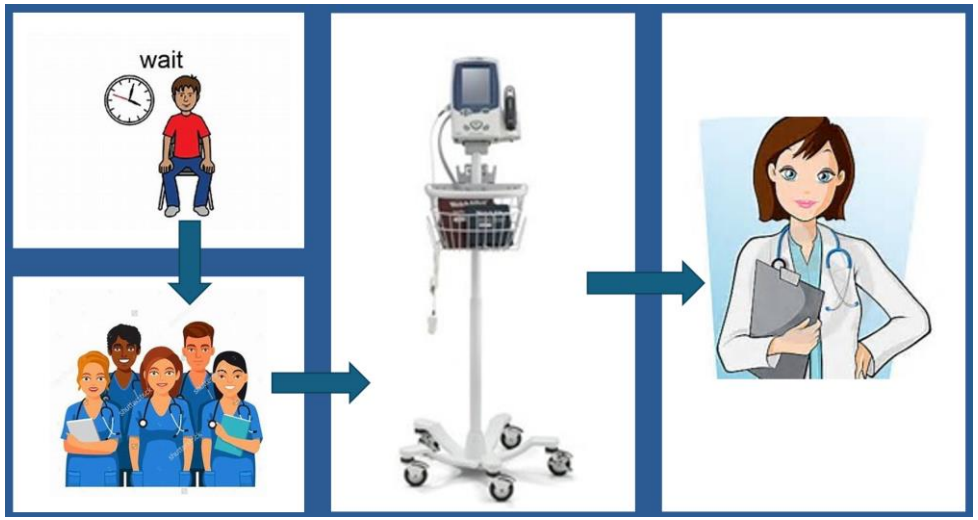
Schedules

1. Visual support
2. Written word
3. Pictures
4. Helps patient predict what will happen
5. Can help decrease anxiety



Social Stories

1. Tells the story of what is happening
2. Visual support
3. Written word
4. Helps patient predict what will happen
5. Can help decrease anxiety



Environmental Supports In Office

Reduce sensory overload	Eg – dim lights, beepers, minimize number of people in room, approach slowly, only touch when necessary
Reduce wait time when possible	Eg – first appointment of the day
Provide alternative waiting areas if possible	Eg – quieter room if patient is overwhelmed, for very prolonged waiting periods allow to check in and go offsite or to the car if possible/ desired
Calm tone of voice and body language	Move slowly get on their eye level
Praise and reward	
Allow repetitive behaviors	These may be warning signs that patients are overwhelmed and/or a way to help themselves calm down
Provide appropriate activities	

Communication Strategies

- Ask about preferred form of communication
  - Some may use pictures or an app
- Communicate with patient directly when possible
- Use simple concrete language
- Give one step at a time
- Explain what is coming next
- Allow time for processing and response
- Use visual supports when possible

Environmental Supports

Medications

Therapeutic Interventions

Treatment

Medications

Response may be atypical

- Sensitivity
- Side effects

Hyper responsive

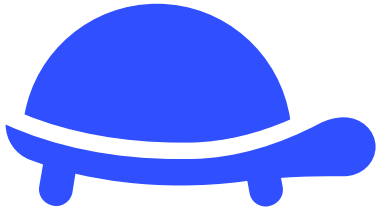
Under responsive

Co-occurring conditions

- Drug-Drug interactions
- Multiple target symptoms

Medications

Treat the symptoms



Start low and go slow !!!

Aggression

Identify where the aggression is stemming from

Physical Symptoms

- Pain
  - High threshold for pain
  - Difficulty communicating pain
  - Ex – tooth pain, menstrual cramps, headaches
- GI disorder
- Seizure
- Other medical illness

Psychiatric Disorder

- ADHD
  - Impulsivity
- Anxiety / Mood disorder
- Psychosis
- OCD like symptoms / Rigidity
- Sleep difficulties
  - Irritability

Other

- Side effects from medication
- Core ASD Characteristics
  - Poor communication

Aggression

Antipsychotics

- Risperidone (Risperdal) – FDA approved for aggression/ irritability in ASD
- Aripiprazole (Abilify) – FDA approved for aggression/ irritability in ASD

Alpha agonist

- Clonidine (Kapvay) or Clonidine ER
- Guanfacine or Guanfacine ER (Intuniv)

SSRI

Mood stabilizers

ADHD

30-80% diagnosed with ASD have comorbid ADHD

- Hyperactivity
- Poor attention span
- Impulsivity

Follow the standard algorithm, but remember: start low and go slow

Can be sensitive especially to stimulants, if aggression is observed discontinue the stimulant

Sleep Difficulties

40-80% complained of sleep difficulties

Possible contributing factors:

Sensory Sensitivities

- Excessive noise, light, or other sensory stimuli can disrupt sleep patterns in individuals with ASD.

Biological and Behavioral Rhythm Problems:

- Disruptions in melatonin regulation, circadian rhythms, and other sleep-wake cycles can contribute to insomnia.

Co-occurring Conditions:

- Conditions like ADHD, anxiety, depression, and other medical issues can exacerbate sleep problems.

Core ASD Symptoms:

- Challenges with communication, social interaction, and repetitive behaviors can also impact sleep

Sleep Difficulties

- **Sleep Hygiene**
  - Establishing consistent sleep routines, creating a calming bedtime environment, and limiting exposure to screens before bed are important.
- **Behavioral Interventions:**
  - Cognitive Behavioral Therapy for Insomnia (CBT-I) and other behavioral therapies can help individuals learn strategies to improve sleep.
- **Medications:**
  - Melatonin/ Melatonin ER
  - Alpha Agonist
  - Clonidine ER
  - Trazodone
  - SSRI
  - Antipsychotics
- **Addressing Co-occurring Conditions:**
  - Treating co-occurring conditions like ADHD can also improve sleep

CASE PRESENTATION

CC: Behavioral Issues

Legal Guardian/Relationship to Patient: mother and father - separated ; father sees patient about 1-2x/ month

HISTORY OBTAINED FROM: mother and patient

HISTORY OF PRESENT ILLNESS:

MM is a 6yo female with PPH of ASD, speech delay and developmental delay who presents for psychiatric intake.

Her mother states that she gets "really aggressive and hits others." Her mother states that she will grab things that are "dangerous for her such as grabbing the knife, turning on knobs on stove." She will also try to run away when they are on the street and will frequently imitate her cat. Patient will also hit self. She will hit self sometimes out of nowhere or when she doesnt get something she wants. She also gets aggressive when she leaves the home and she wants to go home.

Her mother states that at school, when patient doesn't get what she wants "she can get very aggressive, she will start hitting her teachers." Her mother states that she will be aggressive at school 1-2x/ week.

In the office patient is poorly cooperative at first. Later is able to engage. Lots of repetition when asked questions. She says that she feels "happy" at home and school. Is unable to tell this writer name of teacher or favorite color or food.

She was on guanfacine prescribed by her pediatrician but this was discontinued about 1 month prior as she ran out of refills. Her mother states that with guanfacine "she would calm down a little bit for a short period of time." She would be calm for 2-3 hours but would then start behaviors over again. The medicine did not make her tired. At school the medicine would sometimes be beneficial.

CASE PRESENTATION

PSYCHIATRIC REVIEW OF SYSTEMS:

Sleep: takes melatonin 1mg PO qHS ; goes to bed around 10pm and wakes up at 7am

Appetite: eats alot; her mother reports that her appetite stabilized with the medicine

Concentration: Her mother states that the teachers need to give patient constant reminders if not she will not pay attention

Energy Level: high

Interest Level: enjoys playing with cat litter, likes putting puzzles, drawing (will draw for about 5 mins then throw everything)

Mood: see above

Anxiety: when her father left patient would often cry, when her father comes to visit she tries to get them to hold hands

Impulsivity: present

Compulsion/Obsession: lines up toys

Body or Vocal Tics: will move her head from side to side and laugh

Psychotic Features: none

Patient needs help getting ready, can put on clothes but needs help bc she will put on clothes backwards

Manic Features: none

Abuse/Neglect: none

Trauma: none

CASE PRESENTATION

PAST PSYCHIATRIC HISTORY:

Past psychiatric outpatient care: Patient has never previously seen a psychiatrist. She has been seeing a therapist at EHC since 7/2024. Patient had neuropsych testing completed in 7/2024 at Rush where she was diagnosed with ASD.

Past psychiatric hospitalizations: none

Past psychiatric medications: guanfacine ER 0.5mg PO qBID - Discontinued one month ago due to running out of refills

Suicide attempts/Self-injurious behavior: When she gets upset will pull her hair and bite self, used to grab cables and wrap them around neck (does not do this anymore)

CURRENT MEDICATIONS: none

PAST MEDICAL HISTORY: none

PAST SURGICAL HISTORY: none

ALLERGIES: none

CASE PRESENTATION

SUBSTANCE USE HISTORY: none

BIRTH AND DEVELOPMENTAL HISTORY:

- Born full term
- Complications During Pregnancy: No
- Complications During Delivery: C-section due to breech
- In Utero Drug Exposure: none

Milestones:

- First Words: 2yo
- Walking: 1y5m
- Potty Training: 4yo , but still needs help

EI: ST, DT, OT

SOCIAL HISTORY:

- Lives with: mother, uncle ; patient has adult sister who lives in Mexico

School/Grade: Daniel J Corkery School and has an IEP. She is in special education and receives ST .

CASE PRESENTATION

Peer relationships: poor

DCFS Involvement: none

Legal Involvement: none

Weapons in home: none

PSYCHIATRIC FAMILY HISTORY: half cousin with down syndrome

Review of Systems

HEENT: normal
Cardiovascular: normal
Respiratory: normal
GI: normal
Musculoskeletal: normal
Neuro: normal

CASE PRESENTATION

Mental Status Exam

- Appearance: well-groomed, clean, normal weight
- Behavior: eye contact, pleasant, active, hyperactive, impulsive, disruptive (running around the room, first ran away from her mother, attempting to elope)
- Speech: normal volume, speech delay (lots of repetition/echolalia)
- Perception: no hallucinations
- Cognition: alert, oriented to situation, oriented to time, oriented to place, oriented to person
- Intelligence: below average
- Mood: ("happy")
- Affect: not congruent to thought content (irritable, then happy)
- Insight: impaired
- Judgment: impaired
- Thought Processes: flight of ideas (concrete)
- Thought Content: unremarkable
- Motor Activity: intact

CASE PRESENTATION

Assessment and Plan
FORMULATION: MM is a 6yo female with PPH of ASD, speech delay and developmental delay who presents for psychiatric intake. She has no known genetic predisposition. Patient has never previously seen a psychiatrist. She has been seeing therapist since 7/2024. Patient had neuropsych testing completed in 7/2024 at Rush where she was diagnosed with ASD. She has no psychiatric hospitalizations. She has been on psychotropic medications as per below, prescribed by her pediatrician. Lives with mother, uncle. Her parents are separated, her father visits 1-2x/ month. Patient attends Daniel J Corkery School and is in special education, receives ST .

Past psychiatric medications: guanfacine ER 0.5mg PO qBID - Discontinued one month ago due to running out of refills

Currently, patient **is impulse, hyperactive, low frustration tolerance which seems to be leading to aggression**. She was previously taking guanfacine ER 0.5mg PO BID, with some benefit for a couple of hours after taking the medicine. This is likely since the ER tablet was being split in half. Given current safety concerns secondary to patients behaviors have recommended restarting guanfancine, will however increase the dosage and have her take a full tablet in the morning in order to get benefits from ER properties. Will provide parent/ teachers Vanderbilt forms to get a better assessment of her behaviors. **She can also benefit from ABA therapy and her mother can benefit from PMT**. Patient and guardian voice understanding and agreement to plan.

PLAN:
- start guanfacine ER 1mg PO qAM
- start ABA therapy
- start PMT - continue therapy
- continue ST at school

FOLLOW UP: 4 weeks

QUESTIONS?