Domains to be Covered in a Developmental Symptom History Interview for ASD

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General Points to Remember When Conducting a Diagnostic ASD Interview

1) Use good general clinical interviewing skills. To that end, complete a full clinical interview and not just ASD specific questions. Open ended questions that allow the parent/caregiver to teach you about the child are much more fruitful than pointed yes or no questions. Additionally, open ended questions help to protect against reporting bias.

2) Remember typical development! This is always the best benchmark in understanding what is abnormal.

3) ASD involves symptoms from both the social affective domain and restricted repertoire domain; need to have deficits / symptoms in both areas to make an ASD diagnosis.

4) ASD symptoms should be present in early childhood (before age 3), though impairment may not be evident until school years for high functioning kids. ASD is a neurodevelopmental disorder, if symptom onset is in childhood or adolescence, it is not ASD. However, remember that impairment is different than symptoms.

5) ASD is not a disorder that varies significantly by environment: you cannot turn it off and turn it on. If symptoms are only present in one environment, it is not ASD. However, there may be fewer demands placed on kids in one setting (home/with family, school) so symptoms may be more apparent or severe in more demanding situations.

The symptoms below are not to be viewed as appropriate for all kids of all ages—chose the items that best reflect the child’s current functioning, and if you ask about symptoms from an earlier developmental stage, make sure the parent or caregiver is responding from that vantage point. For example, you could say, “Think back to your child’s second birthday...”
Social Affective/Communication Skills

*Remember the focus is on the social use of communication skills given the child’s language level*

- **Verbal communication skills**
  - Level of language skills (single words, phrase speech, fluent sentences)
  - Directed language use (for requesting, social chatting)
  - Conversational skills
  - Topical perseveration
  - Lack of reciprocity
  - Literal interpretation of language/poor sense of humor
  - Weak language pragmatics

- **Nonverbal communication skills**
  - Eye contact
  - Pointing (age of emergence of protoimperative and protodeclarative pointing)
  - Gesture use (instrumental, emotional, descriptive)
  - Joint attention skills (initiation and response)
  - Awareness of nonverbal communication of others
  - Facial expressions utilized for communicative purposes (can you tell how child feels by looking at his/her face, does child use facial expressions to communicate a range of affective experiences)

- **Social interest / motivation**
  - Engagement with peers
  - Interest in making friends
  - Prefers to be alone vs. with others

- **Social awareness**
  - Awareness / understanding of emotions of others (response to distress)
  - Orienting toward others
  - Social referencing

- **Social responsiveness (quality, consistency by environment, frequency)**
  - Response to name
  - Social games (peek-a-boo, duck-duck-goose)
  - Highly motivating situations (preferred activities)
• Less motivating situations (less preferred activities)
  • Social initiation (quality, frequency, related only to strong interests)
    o Requesting*
    o Play based
    o Surrounding specific topics
    o Sharing
    o Showing
    o Starting conversation
  • Poor theory of mind / perspective taking / social prediction skills
  • Odd / unusual social behaviors

*Remember that requesting behaviors for the purpose of assistance with no social intention are not deemed highly social

Restricted Repertoire/Stereotyped Behaviors

• Strong interests
  o Odd or unusual interests
  o Consuming by intensity even if developmentally normal interest
  o Topical perseveration
  o Fixation on parts of objects
  o Odd object attachment
  o Level of distress when access to interest area is blocked or removed
• Inflexibility / Repetitive behaviors
  o Difficulty with transitions
  o Rituals
  o Intolerance of change in routines
• Unusual fears / no fear
• Stereotyped language use
  o Delayed echolalia (context congruent and incongruent)
  o Repetitive language
  o Odd intonation
• Hand / body mannerisms (flapping, finger waving, rocking, spinning)
• Aberrant sensory behaviors (hypo- or hyper-sensory response / interest)
• Self-injurious behaviors / severe aggression
Play Behaviors

- Functional play skills
- Nonfunctional play (lining up objects, hoarding)
- Creative/ imaginative play skills
- Parallel play
- Reciprocal play
- Range and flexibility in play

Review of Systems/Associated Symptoms

- Prenatal & birth history (in utero exposure to prescription medication or substances, prematurity, etc.)
- Developmental milestones / uneven development
  - Gross motor / Fine motor
  - Receptive language / Expressive language
- Sleep patterns (difficulty initiating or maintaining sleep)
- Eating habits (picky, restricted, repetitive, pica)
- Behavior & mood (compliance, aggression, mood, anxiety)
- Executive skills (attention, impulsivity, activity level, flexibility)
- Toileting skills
- Medical conditions
  - Seizure disorders
  - Allergies / Immune dysfunction
  - Gastrointestinal disorders
  - Motor problems (fine motor, apraxia)
  - Fragile X Syndrome (most common single gene identifiable genetic cause of ASD)
  - Other genetic syndromes associated with ASD characteristics: Rett’s, Cohen, Timothy, DiGeorge (22q11.2 deletion), 16p11.2 deletion, 22q11 duplication, Smith-Magenis (17p11.2 del), Tuberous sclerosis (TS1, TS2), Neurofibromatosis, NeurGoldenhar, Moebius, LKS, Lujan-Fryns, WilliamsBeuren (7q11.23 del), Dup 15q, Angelman’s (15q11-q13 del paternal allele), Prader Willi (15q11q13 del maternal allele), Phelan-McDermid (23q13.3 del), Coffin-Lowry, Cornelia de Lange, Smith-Lemli-Opitz, Laurence Moon-Beidl and many more...
*Less than 1 out of 10 kids will have an identifiable genetic cause, but still refer to neurology and genetics

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**High Frequency Rule-Outs**

- Early childhood deprivation (sometimes seen in kids adopted from Eastern Europe orphanages and with severe neglect during infancy)
- Trauma / Abuse / Attachment issues
- Sensory impairment (deafness, blindness) *always suggest vision / hearing test if not completed*
- Language disorder especially when with comorbid anxiety / ADHD
- Severe to profound intellectual disability
- Selective mutism
- Severe social anxiety / OCD
- ADHD (especially with oppositional features)
- Psychosis/prodromal psychosis (negative symptoms, unusual thought patterns, delusional thinking)
- Major depression
- Severe lead poisoning

*Always remember that children with ASD frequently present with comorbidities

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