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Psychiatric symptoms in children and adolescents with higher functioning autism spectrum disorders on the Development and Well-Being Assessment



Outi Reinvall^{a,b,*}, Anu-Liisa Moisio^c, Pekka Lahti-Nuutila^a, Arja Voutilainen^d,
Marja Laasonen^{a,e}, Teija Kujala^{f,g}

^a Institute of Behavioural Sciences, P.O. Box 9, FIN-00014 University of Helsinki, Finland

^b Pediatric Neurology, University of Helsinki and Helsinki University Hospital, P.O. Box 280, FIN-00029 HUS, Finland

^c Department of Child Psychiatry, University of Helsinki and Helsinki University Hospital, P.O. Box 355, FIN-00029 HUS, Finland

^d Pediatric Neurology, University of Helsinki and Helsinki University Hospital, P.O. Box 355, FIN-00029 HUS, Finland

^e Department of Phoniatrics, University of Helsinki and Helsinki University Hospital, P.O. Box 220, FIN-00029 HUS, Finland

^f Cognitive Brain Research Unit (CBRU), Institute of Behavioural Sciences, P.O. Box 9, FIN-00014 University of Helsinki, Finland

^g Cicero Learning, P.O. Box 9, FIN-00014 University of Helsinki, Finland

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ABSTRACT

The Development and Well-Being Assessment (DAWBA) parent interview was used to assess psychiatric symptoms in children and adolescents with higher functioning autism spectrum disorders (ASD) ($n = 60$; age range 6.5–16.7) and in typically developing (TD) children and adolescents ($n = 60$; age range 6.9–16.2). Psychiatric symptoms were reported in the ASD group (68%) significantly more compared to the TD group (12%). Specifically, emotional disorders, attention deficit hyperactivity disorder/hyperkinesia, and tic disorders were significantly more frequent in the ASD group compared to the TD group. Routine screening and early identification of these symptoms could have important implications for planning interventions and thus outcome in individuals with higher functioning ASD. The DAWBA would be a useful interview for this purpose, since it can also be easily and quickly administered in clinics not specialized in psychiatry.

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1. Introduction

Autism spectrum disorders (ASD) are pervasive neurodevelopmental disorders characterized by impaired social interaction, communication, and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities (Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (DSM-5); American Psychiatric Association (APA), 2013; International Classification of Diseases—Tenth Revision (ICD-10); World Health Organization (WHO), 1993). Low-functioning autism (LFA) is used to describe individuals with autism and an intelligence quotient (IQ) less than 70, while higher functioning individuals ($IQ > 70$) with ASD have been referred to as having Asperger syndrome (AS) or high-functioning autism (HFA). In AS, language or cognitive development is generally not delayed, whereas in individuals with HFA, delay of these skills may have been evident in early childhood (Frith, 2004). In DSM-5 (APA, 2013) the diagnostic criteria of ASDs have

* Corresponding author at: Institute of Behavioural Sciences, P.O. Box 9, FIN-00014 University of Helsinki, Finland.

E-mail addresses: outi.reinval@helsinki.fi (O. Reinval), anu-liisa.moisio@hus.fi (A.-L. Moisio), pekka.lahti-nuutila@helsinki.fi (P. Lahti-Nuutila), arja.voutilainen@hus.fi (A. Voutilainen), marja.laasonen@helsinki.fi (M. Laasonen), teija.m.kujala@helsinki.fi (T. Kujala).

changed compared to DSM-IV (Fourth Edition; APA, 1994). The categorical diagnoses of the pervasive developmental disorders, including Asperger syndrome (AS), have been removed, and a single diagnosis of ASD has been substituted (APA, 2013). In the current article, we use the term “higher functioning ASD” to refer to individuals with AS or/and HFA.

The majority of individuals with ASD have one or multiple co-occurring psychiatric disorders (Ghaziuddin, Weidmer-Mikhail, & Ghaziuddin, 1998; Gjevik, Eldevik, Fjæran-Granum, & Sponheim, 2011; Mattila et al., 2010; Simonoff et al., 2008; Tonge, Brereton, Gray, & Einfeld, 1999). Neurobiological, environmental, and ASD-related factors have been suggested as predisposing these individuals to psychiatric symptoms (Mannion, Brahm, & Leader, 2014; Tantam, 2000; see White, Oswald, Ollendick, & Scahill, 2009 for a review). In children with ASD, psychiatric symptoms may lead to poorer school performance and social functioning. Symptoms of attention deficit hyperactivity disorder inattentive subtype (ADHD-I) were reported to be associated with difficulties in learning, whereas symptoms of ADHD combined subtype (ADHD-C) are associated with behavioral problems including aggression in ASD (Gadow, DeVincent, & Pomeroy, 2006; Gadow, DeVincent, & Schneider, 2008). Symptoms of social anxiety disorder and oppositional defiant disorder (ODD) were reported to be associated with greater social functioning difficulties, even after taking into account the ASD symptom severity (Gadow et al., 2008). Finally, co-occurring psychiatric symptoms in individuals with ASD can elevate the risk of hospitalization as well as increase caregiver and sibling stress (Gadow et al., 2008; Kaat, Gadow, & Lecavalier, 2013; Lecavalier & Wiltz, 2006; Mandell, 2008; Sukhodolsky et al., 2008). Thus, psychiatric symptoms co-occurring with ASD appear to aggravate the challenges. Therefore, recognizing psychiatric disorders and their indicative symptoms in individuals with ASD is important to support the psychosocial well-being of these children.

The relationship between IQ and co-occurring psychiatric symptoms in ASD is unclear, with no associations being found in interview-based studies (Gjevik et al., 2011; Simonoff et al., 2008). However, in questionnaire-based studies, significant associations between IQ and anxiety and depression in ASD have been reported (Gadow, Guttman-Steinmetz, Rieffe, & DeVincent, 2012; Sukhodolsky et al., 2008; Vickerstaff, Heriot, Wong, Lopes, & Dossetor, 2007; Weisbrot, Gadow, DeVincent, & Pomeroy, 2005). Specifically, higher IQs have been associated with higher levels of anxiety (Sukhodolsky et al., 2008; Weisbrot et al., 2005) and depressive symptoms in children with ASD (Gadow et al., 2012; Vickerstaff et al., 2007). Possibly higher functioning individuals with ASD are more aware of their social difficulties and of being different from their peers and therefore at greater risk of having co-occurring psychiatric symptoms (Gadow et al., 2012; Rieffe et al., 2011; Vickerstaff et al., 2007).

Anxiety disorders are one of the most common co-occurring psychiatric conditions in children and adolescents with higher functioning ASD (Mattila et al., 2010; Mazefsky et al., 2012; Mukaddes & Fateh, 2010; Mukaddes, Hergüner, & Tanidir, 2010), as well as in LFA (Gjevik et al., 2011; Simonoff et al., 2008). Specific phobias and obsessive compulsive disorder (OCD) are especially frequent in ASD (see van Steensel, Bögels, & Perrin, 2011 for a meta-analysis). To our knowledge, no previous study has assessed symptoms of post-traumatic stress disorder (PTSD) in children and adolescents with higher functioning ASD. In studies including individuals with LFA, the rates of PTSD varied from 0% to 18% (de Bruin, Ferdinand, Meester, de Nijs, & Verheij, 2007; Mehtar & Mukaddes, 2011; Ryan, 1994; see van Steensel et al., 2011 for a meta-analysis). Individuals with ASD can be at higher risk for traumatic events and the probability of developing a PTSD after a traumatic event may be higher in ASD due to emotion regulation and socio-cognitive difficulties (see Kerns, Newschaffer, & Berkowitz, 2015 for a review). Additionally, it should be noted that the experience of being bullied has been shown to be associated with PTSD symptoms in TD children and adolescents (Guzzo, Pace, Cascio, Craparo, & Schimmenti, 2014; Idsoe, Dyregrov, & Idsoe, 2012). Since individuals with ASD often experience frequent and long lasting bullying (Cappadocia, Weiss, & Pepler, 2012), which may be traumatic, evaluating PTSD in these individuals would be beneficial.

Depression is a highly co-occurring condition in adolescents and adults with higher-functioning ASD with the rates in interview-based studies ranging from 37% to 52% (Ghaziuddin et al., 1998; Hofvander et al., 2009; Sterling, Dawson, Estes, & Greenon, 2008). In children and adolescents with higher functioning ASD, the rates of major depression have varied from 6% to 13% in interview-based studies (Mattila et al., 2010; Mukaddes & Fateh, 2010).

Behavioral disorders are a common co-occurring condition in higher functioning ASD as well as in LFA (Green, Gilchrist, Burton, & Cox, 2000; Gjevik et al., 2011; Klin, Pauls, Schultz, & Volkmar, 2005; Mattila et al., 2010; Simonoff et al., 2008). Several studies report high rates of ADHD in these individuals (Ghaziuddin et al., 1998; Green et al., 2000; Klin et al., 2005; Lee & Ousley, 2006; Mattila et al., 2010; Mukaddes et al., 2010). Research on the rates of ODD and conduct disorder (CD) in children and adolescents with higher functioning ASD is scarce, and the findings have been mixed (Green et al., 2000; Mattila et al., 2010; Mukaddes & Fateh, 2010; Mukaddes et al., 2010).

Tic disorders have also been reported in children and adolescents with ASD. However, only a few studies have assessed the rates of specific types of different tic disorders, including Tourette syndrome (TS), chronic tic disorder, or tic disorder not otherwise specified (NOS) in children and adolescents with higher functioning ASD (Ghaziuddin et al., 1998; Mattila et al., 2010).

Finally, regarding eating disorders, in adolescents and adults with anorexia nervosa, co-occurring ASD has been found to range from 5% to 23% (Attwood, 2007; Gillberg & Råstam, 1992; Pooni, Ninteman, Bryant-Waugh, Nicholls, & Mandy, 2012; Råstam, Gillberg, & Wentz, 2003; Zucker et al., 2007). However, not much is known about the prevalence rates of anorexia nervosa and bulimia nervosa in children and adolescents with higher functioning ASD. Other eating disorders, such as pica, and eating-related problems including food refusal and limited food repertoire appear to be common in ASD (Ahearn, Castine, Nault, & Green, 2001; Bandini et al., 2010).

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