KSADS-COMP LLC

Differential Diagnoses Worksheets

Diagnoses matter. As indicated in the table on the following page, most common child psychiatric diagnoses have numerous overlapping symptoms. As the treatment implications of the different diagnoses vary significantly, careful differential diagnosis is essential. For example, the symptom of inattention is associated with the diagnoses Attention Deficit Hyperactivity Disorder (ADHD), Major Depression (MDD), Bipolar Disorder, and Posttraumatic Stress Disorder (PTSD). However, as indicated in the table below, each of these diagnoses are associated with different recommended clinical interventions. The last page of this document includes probes to elicit information which will help to facilitate differential diagnoses, including information about: 1) the episodic or chronic nature of symptoms; 2) patterning of symptoms with other symptoms; and 3) context (e.g., home vs. school) where the symptoms are most problematic. The screen interview of the KSADS-COMP and probes which are built into the instrument are designed to facilitate differential diagnoses. For example, if a child has longstanding inattention problems associated with ADHD, and a new onset of depression symptoms, a question will automatically be included in the KSADS-COMP interview depression supplement to determine if concentration problems got worse with the onset of mood problems. If there was no worsening of longstanding concentration problems with the onset of mood difficulties, the symptom is not counted toward the diagnosis of MDD.

Diagnosis	Recommended Treatments
ADHD	Stimulant treatment, parent training, teacher consultation, social skills training
MDD	Antidepressants, Cognitive Behavior Therapy, Interpersonal Psychotherapy, Behavioral Activation
Bipolar	Mood stabilizer, Multifamily Psychoeducation Group
PTSD	Trauma-focused therapy, safety planning

Mania	Major Depression	Attention Deficit Disorder	Oppositional Defiant Disorder	PTSD
Distinct period of Abnormally Elevated, Expansive or **Irritable Mood** and increased goal directed activity Plus 3 symptoms (four if mood is only irritable) Grandiosity **Sleep Disturbance/** **Decreased Need for Sleep** **Pressured Speech** Racing Thoughts **Distractibility** **Psychomotor Agitation** or Increased Goal Directed Activity **Excessive Involvement in High-Risk Activities** Duration: At least one week (or any duration if hospitalized).	Meets criteria for: Depressed Mood **Irritable Mood**, or **Anhedonia** Plus 4 symptoms **Worthlessness/Guilt** **Sleep Disturbances/ Insomnia** **Fatigue** **Concentration Disturbance** Appetite/ Weight Changes **Psychomotor Agitation** or Psychomotor Retardation Recurrent Thoughts of Death/Suicidality Duration: Minimum of 2 weeks	Meets criteria for at least 6 Inattention symptoms: Makes Careless Mistakes **Difficulty Sustaining Attention** Doesn't Listen Difficulty Following Instructions Difficulty Organizing Tasks Avoids Tasks Requiring Attention Loses Things **Easily Distracted** Forgetful in Daily Activities OR Meets Criteria for at least 6 of the hyperactivity/ impulsivity symptoms: **Psychomotor agitation/ Fidget** **Driven by a Motor** Difficulty Remaining Seated Runs or Climbs Excessively Difficulty Playing Quietly **Talks Excessively** **Blurts Out Answers** Difficulty Waiting Turn Often interrupts or intrudes Duration: Minimum of 6 months	Meets criteria for 4 symptoms **Irritable/ Loses temper** **Argues a lot with adults** **Disobeys rules** **Easily annoyed or angered** **Angry** or resentful Spiteful or vindictive Annoys people on purpose Blames others for own mistakes Duration: Minimum of 6 months	Criterion A trauma plus: One Re-Experiencing item: One Avoidance items: Two of the following: Inability to recall aspects of the traumatic event(s); **Persistent and exaggerated negative beliefs and expectations (e.g., I am bad, the world is unsafe);** **Distorted cognitions about causes or consequences of the traumatic event (e.g. blame self);** Persistent negative emotional states (e.g., anger, fear, guilt, shame) **Anhedonia** Feelings of detachment; Persistent inability to experience positive emotions (e.love,) Two Increased Arousal items: **Irritability** **Reckless or Self-Destructive Behavior** Hypervigilance Exaggerated Startle **Difficulty Concentrating** **Sleep disturbance/Insomnia** Duration: Minimum of 1 month

Mania	Major Depression	Attention Deficit Disorder	Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Manic children often present with severe irritability or mixed states. Presence of some symptoms uniquely associated with mania: Abnormally Elevated or Expansive Mood Grandiosity Decreased Need for Sleep While manic symptoms may appear prior to the age of 7/12, they most frequently emerge later in development. The new onset of ADHD-like symptoms in adolescence should raise concerns of bipolar or another disorder. The development of psychotic symptoms in response to stimulant treatment or mania with antidepressant treatment is considered by some a red flag for mania. Manic symptoms are most often more severe in the home setting. For diagnosis, some evidence of symptoms should be present across settings. Manic symptoms must occur within the context of distinct episodes not as part of a chronic course of illness. They should represent a change from baseline.	Presence of some symptoms uniquely associated with depression: Depressed Mood Appetite/Weight Changes Psychomotor Retardation Recurrent Thoughts of Death/Suicidality If child had pre-existing ADHD with history of concentration disturbances and psychomotor agitation, there should have been a worsening of these long-standing difficulties if these symptoms are to also be counted toward a diagnosis of MDD. MDD cannot be diagnosed without a direct assessment of the child. Parents are often poor informants of depressive symptoms. Self-report questionnaires are an important adjunct to the clinical interview when assessing depressive symptoms in general, and suicidality in particular.	For the diagnosis of ADD and ADHD, the symptoms must have had an onset prior to age 12. If the ADHD-like symptoms were not present in grade school to some extent, they likely represent manifestations of another disorder. ADD/ADHD symptoms are relatively chronic through early childhood. If the symptoms wax and wane significantly, alternate diagnoses (e.g. mania, depression) should be considered. ADD and ADHD symptoms appear worse in school and unstructured settings than at home. They may be completely absent in highly structured one-on-one testing situations. Teachers are critical informants in finalizing an ADD/ADHD diagnosis and in monitoring treatment response.	Presence of some symptoms uniquely associated with ODD: Resentful Spiteful or Vindictive Annoys People on Purpose Blames others for own mistakes Exhibits a disregard for rules. Relatively chronic presence of symptoms. The waxing and waning of symptoms should raise red flags about other possible diagnoses. Symptoms must be present across settings. Typically symptoms are worse in the home environment. If the symptoms are severe at home and completely absent at school, rule-out parent-child relationship problem(s).	Avoidance is a core feature of PTSD. Children do not like to talk about past traumas. It is therefore imperative that multiple sources be tapped to obtain a complete trauma history of children prior to surveying PTSD symptoms (e.g. parents, workers). Many of the symptoms of PTSD overlap with MDD (e.g., irritability, guilt, anhedonia, concentration disturbance, insomnia), ADHD (e.g., concentration disturbances), mania (e.g., concentration disturbance, recklessness, irritability), and ODD (e.g., irritability). The presence of a complete trauma history is essential for making the differential diagnosis. The diagnosis of PTSD requires the presence of re-experiencing symptoms. Nightmares need not be trauma specific to count toward the diagnosis of PTSD in children. The presence of trauma-related hallucinations can further complicate this diagnosis. Trauma-related hallucinations are associated with dissociative symptoms (e.g. trance-like states) and are frequently nocturnal. Children with PTSD and trauma related hallucinations usually have good social relatedness and no formal thought disorder.