

Clinical Practice Guideline for the Psychiatric Assessment of Children and Adolescents

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INTRODUCTION

Child and adolescent psychiatrists evaluate and treat children and adolescents who have psychiatric disorders that impair emotional, cognitive, physical, and/or behavioral functioning. The child or adolescent is evaluated in the context of the family, school, community, and culture. Most of the identified signs and symptoms with their associated impairments in developmental functioning respond to established treatments. The physician must prioritize symptoms and diagnoses so that a reasonable treatment plan will address multiple problems. Many children and adolescents have comorbid disorders which do not fit into a single categorical diagnosis. The physician in an individual situation should consider but not be limited to the treatment guidelines for a single diagnosis.

In this guideline, the term “child” refers to both adolescents and younger children unless explicitly noted; unless otherwise noted, “parents” refers to the child’s primary caretakers, regardless of whether they are the biological or adoptive parents or legal guardians. These guidelines are applicable to the evaluation of child and adolescent patients 18 years of age and younger. This document presumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment in India.¹

PURPOSE AND AIMS OF THE CLINICAL DIAGNOSTIC ASSESSMENT

The purposes of the diagnostic assessment of the child are (1) to determine whether psychopathology is present and, if so, to establish a differential diagnosis; (2) to determine whether treatment is indicated; and, (3) if so, to develop treatment recommendations and plans and to facilitate the family and child’s cooperative engagement in treatment. (For specialized consultative purposes or under emergency circumstances, the focus of inquiry may be narrowed accordingly. Examples of such focal evaluations may include medication consultations, emergency evaluations, or the determination of dangerousness to self or others for the purpose of hospitalization. In these and other circumstances, therapeutic interventions may need to be implemented promptly, with fuller assessment later, during the course of treatment.)

The specific aims of the diagnostic assessment of the child are (1) to identify the stated reasons and factors leading to referral; (2) to obtain an accurate picture of the child’s developmental functioning and of the nature and extent of the child’s behavioral difficulties, functional impairment, and/or subjective distress; and (3) to identify potential individual, family, or environmental factors that may account for, influence, or ameliorate these difficulties.

SOURCES OF INFORMATION

The full diagnostic assessment of the child usually requires gathering data from the patient, the family, and the school, as well as from the primary physician and any past and current mental health providers. For children involved with the child welfare or juvenile justice system or for children living in institutions, information from agency records, caseworkers, probation officers, and/or institutional caretakers is essential. For children who

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are inpatients in either a psychiatric or pediatric setting, the assessment must draw upon the observations and assessments of the many disciplines involved with the child--nursing, milieu therapy, social work, education, physical and occupational therapy, expressive therapy, psychology, pediatrics, etc.

At a minimum, assessment usually entails direct interviews with the child and parents. In order that both the child and parents may speak frankly, it is desirable that the assessment include opportunities to meet separately with each. It is also important to see the child and parents together to observe their interaction and to assess how they formulate and discuss the problem together. Sometimes it may be helpful to see the entire family together.

The practical arrangements of how these interviews are ordered or combined vary with the case and clinical setting. For young children, one or more initial parent interviews without the child may be appropriate, before the child is seen either alone or with the parents. In contrast, it is usually helpful to include adolescents in the initial interviews, either with or without the parents. Excluding the adolescent, risks casting the physician as an agent of the parents in the patient's eyes, thereby potentially undermining the treatment alliance.

The primary clinician may collaborate with other clinicians in gathering such data, but it remains his or her task to assess and integrate the information obtained.

IDENTIFYING DATA

The biographic information is intended to familiarize the psychiatrist with the child, his immediate family and his social milieu. This is made possible through the details that are recorded: the ages of the parents, educational status and occupation

PROBLEMS AND HISTORY OF PRESENT ILLNESS

The psychiatrist at this point obtains information on the patient's present problems. It would be useful to obtain a spontaneous account of the patient's problems. Their initial report of the child's symptoms and behaviour will usually suggest other points to be examined and lead to more questions. This is followed by a phase of systematic enquiry. Each complaint is explored further in terms of chronology, associated disturbances, antecedent factors and consequences. In the investigation of each problem that is presented, it is important to ascertain its duration, the circumstances, which seem to have initiated or contributed to its development, whether or not it is recurrent, and the relative intensity of the present manifestations. The history of the present illness should be roughly divided into three parts. The first part is the parent's verbatim account of their child's problems. The second part consists of enquiries on specific aspects which are relevant to the conditions being considered. Finally, it is necessary to enquire whether the patient had received any treatment prior to the present consultation. Reports on previous psychiatric examination or psychological tests, if any, should be obtained wherever possible.

PAST HISTORY

This should include both physical illnesses and psychiatric problems that have afflicted the child in the past. To begin with one should inquire routinely about operations and childhood illnesses and delineate a year-by-year pattern of a patient's health or illness. The description of physical illnesses and how they were treated not only provide information about a child's physical health but may reveal parental attitudes of either under protection or over protection, or sensible handling of their child.

BIRTH AND EARLY DEVELOPMENT

The parent's age and the length of the marriage at the time of child's birth may contribute to an understanding of the atmosphere into which he/she was born. Was the child born out of wedlock or after the parents had been childless for many years, are important factors to note. (1) Circumstances of conception, pregnancy, and adoption: was the pregnancy planned and/or wanted? What was going on in the family at that time, including severe maternal stresses? Prior pregnancies, miscarriages, abortions; complications of pregnancy, including maternal alcohol or drug use; labour and delivery; Circumstances of adoption should be noted. (2) Early development history: Fine and gross motor development and coordination (age of neck holding, tooth eruption, sitting, standing, and walking. Speech and language development (Milestones: first words, first sentences; receptive and expressive languages abnormalities; speech or articulation abnormalities). Bowel and bladder control. Developmental problems (if any) of speech, language or motor function should be noted.

Even when parents are not able to give a precise chronology of the child's early history, they may be able to provide a meaningful account of the child's development relative to other siblings or important family events. Particular attention should be paid to apparent changes or discontinuities in the child's developmental progress or level of functioning.

SOCIAL AND PERSONAL HISTORY

This section of the case history includes the patient's (1) Habits (sleep, feeding, personal care). (2) Neurotic traits (nail biting, thumb sucking, morbid fears of persons, animals, darkness, night mares, night terrors, obstinacy temper tantrums and enuresis or encopresis beyond 3 years). (3) Behaviour problems (stealing, lying, truancy, disobedience and others). (4) Sexual development: pubertal status, noting precocious or lagging development; masturbation, other sexual activity. Relevant parts may have already been covered earlier. Any additional information can be documented here.

EDUCATIONAL HISTORY AND SCHOOL FUNCTIONING

The child's educational history should address the social, emotional, and intellectual aspects of school participation. These include the ability to separate from parents and to attend school regularly, interpersonal relationships with peers and teachers, motivation to learn, tolerance for frustration and delay of gratification, attitudes toward authority, ability to accept criticism, etc. A sequential history of the schools attended should be taken, as well as the reasons for any changes. Educational problems if any e.g. poor progress, financial difficulties, repeated absences, failures, poor peer relationships, or problem with teachers should be enquired.

When the child's behavior or progress at school is among the problem areas, the school records, including any standardized testing, should be reviewed. Direct information-gathering from the child's teachers, counselors, or other school personnel is highly desirable.

TEMPERAMENT

Having completed the basic clinical history, a systematic inquiry needs to be conducted into the child's temperamental characteristics during infancy. The inquiry which is addressed to the parents can be started with a broad question: in the first few weeks and months of his/her life how was he like? Further information of specific nature, can be obtained by taking up areas of behaviour relevant to each of the temperamental attributes. The questions should be directed at obtaining a descriptive behavioural pattern from which the interviewer can get idea of the child's temperamental characteristics. Here is a list of suggested questions appropriate to each of the temperamental categories.

Activity level: 'How much did your baby move around? Did he move around a lot, was he very quiet, or moderately so? Did you have trouble changing his/her diaper, pulling his shirt over his head or putting on any other of his clothing because he wriggled about?'

Adaptability: 'How did the child respond to changed circumstances? When it was shifted from one room to another, did it take to the change immediately? If its first reaction to a new person was a negative one, how long did it take the child to become familiar with the person? If he did not like a new type of food the first time it was offered, could you count on his getting to like it and most other new food sooner or later? If so, how long would it take to accept the new food if it was offered to him daily or several times a week?

Rhythmicity: 'How did you arrange the baby's feedings? Could you tell by the time the baby was six weeks (two months, three months) old the time of the day during which it would be hungry, sleepy or wake? About what time and how often during the day did the baby have its bowel movements (time and number) and was the routine variable or predictable?'

Approach withdrawal: How did the baby behave with new events, such as when he was given the first tub bath, offered new foods or looked after by an unfamiliar person? Did he fuss, did he do nothing, or did seem to like it?

Threshold level: 'How would you estimate the baby's sensitivity to noise, heat and cold, things he saw and tasted, and texture of clothing?'

Intensity of reaction: 'How did know when the baby was hungry? Did he squeak, did he roar, or were his sounds, somewhere in between? How could you tell that the child didn't like something? Did he just quietly turn his hand away or did he start crying loudly?'

Quality of mood: 'How would you know that the baby liked or disliked something?'

Distractibility: 'If the child was sucking on the bottle or its mother's breast, would he stop if he heard a sound or a person came in or would he continue sucking? If the baby was hungry and crying while the bottle was being warmed, could you divert him easily and stop him from crying by holding him or giving him a toy?'

Persistence and attention span: 'Would you say that the baby usually continued with an activity for a long time or only for a moment? If he reached for something, says a toy in the bath tub, and couldn't get it easily, would he make an effort to get it quickly?'

After completing the inventory of the child's temperamental characteristics during infancy, the next step is to identify attributes which appear extreme in their manifestations, and those which seem clearly related to its current pattern of deviant behaviour. This is followed by an enquiry into the expression of these temperamental attributes at succeeding periods (age and stage of development). Thus, if the history, during the period of infancy suggests a pattern of marked distractibility, it would be useful to gather data on relevant behaviour at succeeding age levels and in varied life situations, such as during play, school activities or homework.

The final step in assessing the child's temperament is the evaluation of its current temperament characteristics. The inquiry into the present behaviour, while attempting to cover all temperamental categories, should concentrate on those, which appear most pertinent to the present symptoms.

FAMILY HISTORY

It would be essential to have a family tree (using standard notations) with age, sex and very brief personality descriptions of each family member. In case there is a family history of mental illness or any significant physical illness that too should be mentioned. Unusual facts about each sib and any other children who may be permanent members of house hold should also be included in family history.

Two other broad areas to be covered are those of family functioning and parent child interactions. Family functioning includes an enquiry into how the family copes with various tasks, pattern of communications etc.

Any discord, lack of communication between members as well as problems that the family faces as a whole e.g. poverty or discriminations, if present, should be highlighted. Interactions between various family members are also important. The areas that we need to focus are the negative interactions such as lack of warmth, hostility towards the child or use of child as scapegoat, sibling rivalry etc.

PARENTALFUNCTIONING

Beginning with the child's conception, what have been the attitudes, involvement, and reactions of family members to the child? To what extent do they agree or disagree regarding the care and management of the child and in their hopes, fears, or expectations concerning the child? Patterns of the parental functioning should be assessed in terms of (permissive/rigidity, consistency/inconsistency, strictness of discipline/liberal, approval of interest/disapproval, protective/ non- protective (any overprotection), toleration/ non-toleration of deviance. How have the parents' own developmental histories with their families of origin and subsequent experiences shaped their responses to the child?

What are the parents' ethnic and religious backgrounds, and are these a source of conflict? What language is spoken by the parents and/or by the child? Is the interviewer familiar with that language or culture and its concepts or with terms relevant to the child's and family's situation?

Who are the other immediate family members and persons living in the home, and what is their relationship to the child? What are the various boundaries and alliances within the family, and how does the child fit into the family system?

The modes and effectiveness of family communication and problem solving should be assessed. How does the family deal with issues of separation or disagreement? What is the prevailing emotional tone of the family, especially as it impinges on the patient? Is there parental substance abuse or psychiatric disorder? Are there episodes of violence or sexual abuse between family members? Have there been significant stresses impinging on the family as a whole or on individual members, such as moves, immigration, illness, accidents, job changes, abandonment, or legal difficulties?

SOCIALANDENVIRONMENTALCONDITIONS

It is useful to obtain an idea of the current living conditions of the patient's family. This would include physical aspects such as type of housing, degree of overcrowding etc. and socio-economic data such as financial status of the family. Any aspect of the living conditions that is found to be stressful for the child should be mentioned.

SPECIALENVIRONMENTALCIRCUMSTANCES

It is important to enquire into significant events or life changes that might have occurred in the child's recent past. The relation between the event and the child's illness should be explored.

MENTALSTATUSEXAMINATION

It is often not possible to formally examine the mental state of young children, although this possible with older children. Thus the child's behaviour should be observed closely and the findings should be noted down systematically and objectively. Global statements about behaviour should be avoided. Observation of infant or preschool children should be best done in the play room situation in the presence of parents.

In case of school age children, the examiner should introduce him, explain the reason for and purpose of interview and its approximate duration. Every effort should be made to reassure the child who is bound to be somewhat anxious during the first visit of the examiner. The extent of confidentiality of the information provided by the child should be clarified by the examiner.

For the mental status examination, the clinician observes and assesses the following areas: physical appearance; manner of relating to examiner and parents, including ease of separation; affect; mood; orientation to time, place, person; motor behavior (including activity level, coordination, neurological soft signs, cerebral dominance, and presence of tics or stereotypes); content and form of thought, including hallucinations, delusions, thought disorder; speech and language; overall intelligence; attention; memory; neurological functioning; judgment and insight; and preferred modes of communication (e.g., play, drawing, direct discourse)

OBSERVATION OF PLAY

Form and content of play, affective reactions during it and accompanying fantasies are all important parameters which help in gaining a better understanding of the child's problems and conflicts. Ideally, toys and other materials should be available in every examining room. When this is not possible, a special room and a therapist are often designated.

REFERRAL FOR PSYCHOLOGICAL OR ADDITIONAL MEDICAL CONSULTATION

As indicated, the child may need to be referred for additional evaluation, including psychological, educational, or speech and language assessment, or pediatric or neurological consultation.

DIAGNOSTIC FORMULATION

The diagnostic formulation represents the clinician's distillation of the data gathered into an account of the potential nature of the child's difficulties, the factors that may have predisposed the child to develop such a problem, the concomitants and consequences of the problem, and the factors that tend to maintain the problem or might ameliorate it. A conclusive answer to these questions may not be apparent by the conclusion of the initial assessment; under such conditions, the appropriate result is a differential diagnosis suggesting the subsequent steps needed to clarify the diagnosis and the appropriate treatment options.

COMMUNICATING FINDINGS AND RECOMMENDATIONS

The clinician's communication of his or her findings and recommendations to the parents and child is an essential part of the assessment, one that may require one or more sessions in its own right. Depending on the nature of the problem and the child's age and level of comprehension, this may entail meeting with the child and parents separately or together.

Several principles are essential to ensure that the clinician's findings and recommendations are heard, understood, and experienced as helpful. First, the clinician must convey his or her sense of the child as a whole person, including strengths and abilities, as well as problems or vulnerabilities. This conveys a sense of the clinician's appreciation and empathic understanding of the child and reduces fears and defensiveness that the news will all be bad.

The clinician's findings must be communicated in terms comprehensible to the parents and, during the child's portion of the interpretive session, to the child as well. Technical terms should be kept to a minimum and jargon avoided. When diagnostic or other technical terms are used, it is important both that they be explained and that the parents' and child's perception of them be clarified. It is important that adequate time and opportunity be permitted for the parents and child to discuss the clinician's impressions and recommendations.

REFERENCE:

1. Child Psychiatry in India: An approach to assessment and Management of Childhood Psychiatric Disorders. Savita Malhotra, Macmillan India. 2002.

APPENDIX-I
CHILD AND ADOLESCENT PSYCHIATRY
BRIEF CASE HISTORY & EXAMINATION

Name.....Age.....Sex M/F.....Date.....
Source of referral: Relatives/Friends, School, Others (specify)
Duration of illness: Less than a week, 1-4 weeks, 4-12 weeks, 3-6 months, 6-12 months, 1-4 years, 5 years, since birth, not known.
Onset: Acute (1 week), Sub-acute (1-4 weeks), Gradual (more than 4 weeks).
Course: Worsening, steady, fluctuating, improving, periodic, not known
Associated physical illness: No/ Yes (specify)

COMPLAINTS AND HISTORY OF PRESENT ILLNESS

Emotion: anxiety, sadness, irritability, agitated, fearful, anger, excessive clinging, shyness,
Idea/ delusion: persecution, reference, grandiose, hypochondriacal, depressive, phobias, obsessions, passivity, possession, suicide, bizarre
Conduct & Behaviour: obstinacy, disobedience, aggressiveness, defiant, destructiveness, stealing, lying, delinquent behaviour, attention problems, poor impulse control, hyperactivity, odd, repetitive behaviour, un-understandable, disinhibited Behaviour, suspiciousness, talking/smiling to self, irrelevant talking, apathetic, social withdrawal
Perception: hallucination (auditory, visual, tactile, / olfactory), depersonalization, derealization, illusion
Somatic: aches and pains, numbness, breathing difficulty, weakness, paralysis, tremors, palpitation
Habits: sleep problems, bowel (encopresis), bladder (enuresis), feeding problems, inadequate self care, thumb sucking, nail biting, tics, stereotypy
Fits: Epileptic/ non-epileptic/ mixed
Learning, memory & Scholastic skills: poor memory, low intelligence, scholastic backwardness,
Developmental problems: speech, language, motor function
Impairment: interpersonal relations, household work, studies, leisure activities
Past history:
Family history:
Examination
Significant physical findings.....
Physical development: Average, less than average
MSE: Appearance:Separation anxiety..... Activity level.....
Affect: anxious, sad, elated, irritable, and fearful..... Thought/ideas: delusions, depressive, suicidal, obsession, worries, phobias, preoccupation
Perception: Hallucinations, modality..... Attention span.....
Intellectual capacity..... Other significant findings.....

DIAGNOSIS (ICD-10)

- AXIS I (Clinical Syndrome including Pervasive Developmental Disorders)
- AXIS II (Disorders of Psychological development)
- AXIS III (Intellectual level)
- AXIS IV (Medical/Physical conditions)
- AXIS V (rate 0/1/2) (Associated abnormal psychosocial situations)
- AXIS VI (Global assessment of psychosocial disability)

MANAGEMENT PLANNED

| STRATEGY | OBJECTIVE |
|--|-----------|
| 1. Drug | |
| 2. Further Exploration | |
| 3. Psychotherapy | |
| 4. Behaviour Therapy | |
| 5. Parental counseling | |
| 6. Environmental manipulation | |
| 7. Hospitalization | |
| 8. Investigations-Psychological | |
| PHYSICAL | |
| 9. Consultation with other disciplines of medicine | |
| 10. Referred to other departments for further management | |
| 11. Other (Specify) | |
| 12. Special education | |

ADVICE

**APPENDIX-II
CHILD AND ADOLESCENT PSYCHIATRY
DETAILED CASE HISTORY & EXAMINATION**

Name:

Age:

Date of Birth:

Education:

Sex:

Residence:

REFERRED FROM:

INFORMATION

Relationship with Patient:

Name:

Age:

Sex

Education:

Occupation:

CHIEF COMPLAINTS (IN CHRONOLOGICAL ORDER)

HISTORY OF PRESENT ILLNESS

(If the symptoms are present since birth, start history from conception through early and later development. Give chronological account of symptoms. Mention details of treatment).

Functioning/Impairment: (A global assessment of the child's functioning in the areas of interpersonal relations with parents, other adults, peers; household work; leisure activities. If impaired- mention moderately or severely.)

PAST HISTORY

- a. Physical illness
- b. Psychiatric problems

PERSONAL AND DEVELOPMENTAL HISTORY

History or early Development

1. Parental attitude towards pregnancy: wanted/Unwanted _____
2. Mother's health during pregnancy _____
 - i) Generally good
 - ii) Exanthematous fever in first trimester
 - iii) Serious illness _____
 - iv) X-Ray exposure
 - vi) Prolonged drug administration
 - vi) Attempted abortion
 - vii) Any other _____
3. Nature of birth:
 - i) F.T.N.D.
 - ii) Premature birth
 - iii) Instrumental or operation
 - iv) Complicated delivery
 - v) Head injury
 - vi) Jaundice, cyanosis, delayed cry after birth
4. Feeding habits (till age)
 - i) Breast _____
 - ii) Bottle _____
 - iii) Breast and bottle mixed _____
 - iv) Weaning age _____
5. Age of:
 - i) Neck holding _____
 - ii) Tooth eruption _____
 - iii) Sitting _____
 - iv) Standing (Unsupported) _____
 - v) Walking _____
 - iv) First word _____
 - vii) Three word sentence _____
 - viii) Bowel Control _____
 - ix) Bladder control _____

Development problems (if any) of speech, language, motor function.

II SOCIAL AND PERSONAL HISTORY

1. Habits
 - a) Sleep: i) Normal ii) Fearful iii) Bruxism iv) Any other _____
 - b) Feeding: i) Normal ii) Fussy _____ iii) Over-eating _____
 - iv) Others _____
 - c) Personal care: i) Adequate ii) Unkempt
2. Neurotic traits
 - i) Nail biting
 - ii) Thumb sucking
 - iii) Morbid fears of persons, animals, and darkness

Approval of interests/disapproval

Protectiveness/Non-protectiveness (any overprotection)

Toleration of deviance/non-toleration

Expectations from the child (any pressures, deprivation)

Reactions towards the illness

SOCIAL-ENVIRONMENTAL CONDITIONS (mention any aspect of living conditions which you might consider stressful for the child)

Types of Dwelling

Degree of crowding

Type of amount of help in the care of child

Affluence of the family/degree of financial stress

SPECIAL ENVIRONMENTAL CIRCUMSTANCES

(Like birth, death, illness, accident, divorce, hospitalization etc. in the family, if present mention the effect of the life event on the child e.g. on self esteem)

PHYSICAL EXAMINATION

MENTAL EXAMINATION

General appearance and behaviour: Describe

Relationship capacity: (response to separation from parents, reaction to interview situation)

Spontaneous motility and speech:

Affective Behaviour (any evidence of anxiety, fear, depression, shyness including the child attitude towards the examiner)

Attitude towards family, school and play-mates:

Stated interest & content of thought:

Attention span and distractibility:

Intellectual capacity

Motivation: (Child's knowledge of the reasons for his attendance, his desire for help, his sense of own capacity to change)

PROVISIONAL DIAGNOSIS

(Try, as far as possible, to make multiaxial diagnosis according to ICD-10, See under final diagnosis)

Final Diagnosis: (ICD 10)

AXIS I (Clinical Syndrome including Pervasive Developmental Disorders)

AXIS II (Disorders of Psychological development)

AXIS III (Intellectual level)

AXIS IV (Medical/Physical conditions)

AXIS V (rate 0/1/2) (Associated abnormal psychosocial situations)

AXIS VI (Global assessment of psychosocial disability)

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| 7. Environmental manipulation | |
| 8. Hospitalization | |
| 9. Investigations-Psychological | |
| PHYSICAL | |
| 10. Consultation with other disciplines of medicine | |
| 11. Referred to other departments for further management | |
| 12. Other (Specify) | |
| 13. Special education | |
| ADVICE | |