

PART 1

Assessment, Classification and Epidemiology

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CHAPTER 1

Assessment

Performing a thorough psychiatric assessment of a child or adolescent can all too easily become a long and dreary list of topics to be covered and observations to be made – turning the occasion into an aversive experience for all concerned. It is far better to start with a clear idea of the goals and then pursue them flexibly. Ends and means are different: this first part of the chapter deals with ends; the second half of the chapter deals with means, providing some ‘how to’ tips with suggestions about the order in which to ask things.

Five key questions

During an assessment you need to engage the family and lay the foundations for treatment while focusing on five key questions, given in the following list, and remembered by the mnemonic SIRSE. There is a lot to be said for carrying out a comprehensive assessment on the first visit, provided this does not result in such a pressured interview that it puts the family off coming again. As long as you are able to engage the family, it is not a disaster if the assessment is incomplete after the first session provided you recognise the gaps and fill them in during subsequent sessions. Indeed, all assessments should be seen as provisional, generating working hypotheses that have to be updated and corrected over the entire course of your contact with the family. Just as it is a mistake to launch into treatment without an adequate assessment, it is also a mistake to forget that your assessment may need to be revised during the course of treatment. Consider the need for a reassessment if treatment does not work.

Symptoms	What sort of problem is it?
Impact	How much distress or impairment does it cause?
Risks	What factors have initiated and maintained the problem?
Strengths	What assets are there to work with?
Explanatory model	What beliefs and expectations do the family bring with them?

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Though child and adolescent psychiatrists and their colleagues may be involved in many types of assessment, these five key questions will be relevant in nearly all cases, albeit with variations in emphasis and approach. Most of the rest of this chapter focuses on an approach that seeks, where possible, to explain the presenting complaint in terms of the child or adolescent having one or more disorders – leading on to a fuller formulation involving aetiology, prognosis and treatment. For some referrals, however, it may be more appropriate to focus on parenting difficulties or problems of the family system as a whole rather than on the problems of the presenting individual.

Symptoms

Most of the psychiatric syndromes that affect children and adolescents involve combinations of symptoms (and signs) from four main areas: emotions, behaviour, development and relationships. As with any rule of thumb, there are exceptions, most notably schizophrenia and anorexia nervosa. The four domains of symptoms are:

- 1 emotional symptoms
- 2 behavioural problems
- 3 developmental delays
- 4 relationship difficulties.

The *emotional symptoms* of interest to child and adolescent psychiatrists will be very familiar to most mental health trainees. As with adults, it is appropriate to enquire about anxieties and fears (and also about any resultant avoidance). Ask, too, about misery and, if relevant, about associated depressive features including worthlessness, hopelessness, self-harm, inability to take pleasure in activities that are usually enjoyable (anhedonia), poor appetite, sleep disturbance and lack of energy. Classical symptoms of obsessive-compulsive disorder can be present in young children, even preschoolers. One difference in emphasis from adult psychiatry is the need to enquire rather more carefully about ‘somatic equivalents’ of emotional symptoms, for example, Monday morning tummy aches may be far more evident than the underlying anxiety about school or separation.

Parental reports are the primary source of information on the emotional symptoms of young children, with self-reports becoming increasingly important for older children and adolescents. Somewhat surprisingly, parents and their children often disagree with one another about the presence or absence of emotional symptoms. When faced with discrepant reports, it is sometimes straightforward to decide who to believe. Perhaps the parents have described in convincing detail a string of incidents in which their child’s fear of dogs has resulted in panics or aborted outings, while the child’s own claim never to be scared of anything seems to be due to a mixture of bravado and a desire to get the interview over with as soon as possible. Alternatively, an adolescent’s own account may make it clear that she experiences a level of anxiety that interferes with her sleep and concentration even though her parents are unaware of this because she

does not confide in them and spends much of her time in her room. In other instances, it is harder to know who to believe – and perhaps it is more sensible to accept that there are multiple perspectives rather than one single truth.

The *behavioural problems* that dominate much of child and adolescent psychiatric practice are less familiar territory for most mental health trainees since adults with comparable symptoms are more likely to appear in courts than clinics. Enquiry should focus on three main domains of behaviour: defiant behaviour, often associated with irritability and temper outbursts; aggression and destructiveness; and antisocial behaviours such as stealing, fire setting and substance abuse. Reports from parents and teachers are likely to be the main source of information on behavioural problems, though children and adolescents sometimes tell you about misdeeds that their parents or teachers do not know about. There is only limited value in asking children and adolescents about their defiant behaviours since they, like adults, often find it hard to recognise when they are being unreasonable, disruptive or irritable, however good they may be at recognising these traits in others.

Evaluating *developmental delay* can be particularly hard for new trainees who do not have children of their own or a background in child health. Development complicates what, in adults, would be a simple assessment. Consider a physical analogy. An adult height of 1 metre is small, whereas a childhood height of 1 metre may be small, average or large; it obviously depends on the age of the child and, unless you have a growth chart handy, you could easily fail to spot children who were unusually small or tall for their age. The same problem is even more pronounced in the psychological domain. What are you going to make of an attention span of five minutes at different ages? Are you missing children whose speech is immature or excessively grown up for their age? How long should a 5-year-old sit still without fidgeting? In the absence of good published norms, you will mostly have to rely on experienced colleagues until you 'get your eye in'. Remember, too, that experienced parents or teachers are rarely concerned without good reason.

The areas of development that are of particular relevance to child and adolescent psychiatry are: attention and activity regulation; speech and language; play; motor skills; bladder and bowel control; and scholastic attainments, particularly in reading, spelling and mathematics. When judging current levels of functioning, you will be able to draw on direct observations of the child or adolescent as well as reports from parents and teachers. Asking parents about developmental milestones can tell you about their child's previous developmental trajectory.

Assessing children's and adolescents' *difficulties in social relatedness* is another taxing task, partly because relationships change with development. In addition, it is not always clear whether children's problems getting on with other people reflect primarily on them or on the other people. For example, if a child with cerebral palsy is unable to make or keep friends, how far might this reflect the child's lack of social skills, and how far might it reflect the prejudice of other children?

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The most striking impairments in relatedness are seen in the autistic disorders, generally taking one of three forms: (1) an aloof indifference to other people as people; (2) a passive acceptance of interactions when others take the initiative and tell them what to do; and (3) an awkward and rather unempathic social interest that tends to put others off because of its gaucheness. Disinhibition and lack of reserve with strangers are prominent in some autistic, hyperactivity and attachment disorders, and may also be seen in mania and after severe bilateral head injury. The disinhibition may be accompanied by a pestering, importuning style. In small doses, some of these traits can seem quite charming. For example, after a few minutes acquaintance, you may judge a boy to be delightfully frank or open or eccentric. However, this sort of charm generally palls with longer acquaintance and the history usually makes it clear that his manner soon becomes very wearing for all those in regular contact with him.

Some children and adolescents have difficulty relating to most social partners, whether young or old, strangers or friends. Other children and adolescents have problems with specific types of social relationship, for example, with attachment or friendship relationships. The problems may even be specific to one important social partner. Thus, most children and adolescents are specifically attached to a relatively small number of key people, and the quality of their attachment (secure, resistant, aloof, disorganised) may vary, depending on which of these key people they are relating to. For example, the attachment may be insecure with the main caregiver but secure with the other caregivers (see Chapter 32). Similar specificity can be seen in sibling relationships.

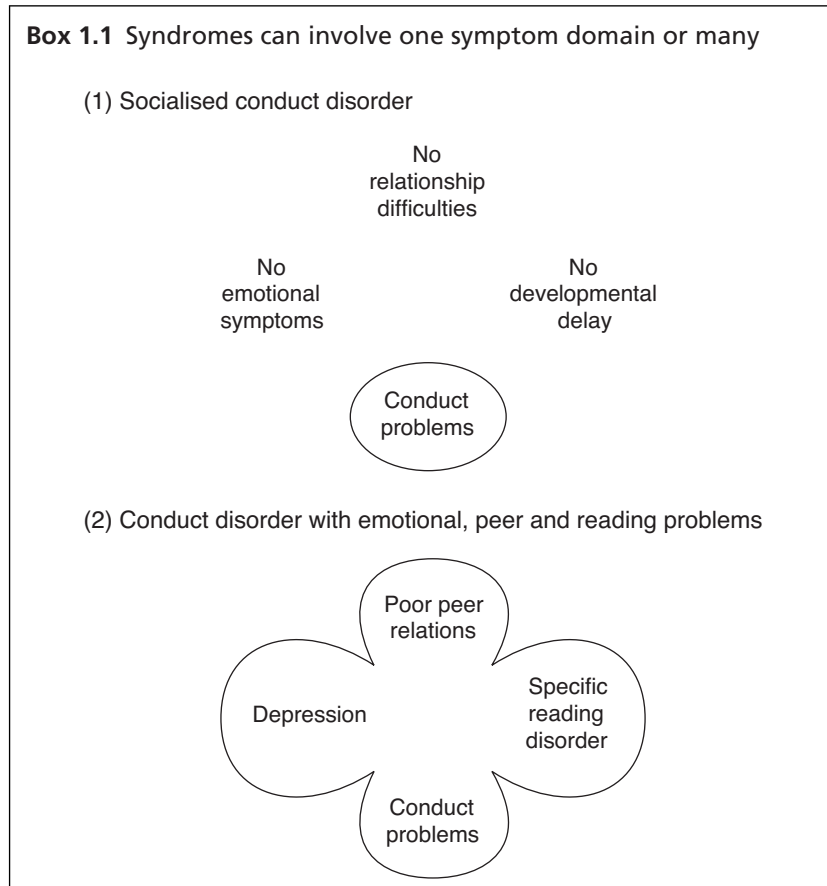
You can gather information on a child or adolescent's social relationships from several sources. Observing the family interactions in the waiting room or consulting room can be very helpful. See how the child or adolescent relates to you during the physical and mental state examinations. If your assessment follows a fairly standardised pattern, it is all the more striking that one child is shy and monosyllabic throughout while another child of the same age greets you as a best friend and wants to climb onto your lap. Also note what might in other circumstances be called the counter-transference, for example, did you find them irritating? Does the interview leave you feeling exhausted? These are often valuable clues to the feelings that this individual evokes in many other people. Direct observation is supplemented by the history. Parents can often tell you a lot about their child's relationships from the early years onwards. It can also be helpful to get a teacher's report on peer relationships at school, but remember that teachers are not always aware of peer problems, even when these are fairly substantial, particularly if teachers do not usually supervise the playground.

Most patients have symptoms from more than one domain

Only a minority of the children and adolescents attending child mental health services have symptoms restricted to just one domain, but such

individuals do exist. Thus you may see pure emotional symptoms in generalised anxiety disorder, pure behavioural symptoms in socialised conduct disorder, and pure relationship difficulties in disinhibited attachment disorder. Pure developmental delays, such as primary enuresis, receptive language disorder or specific reading disorder are not usually seen by child and adolescent psychiatrists in the absence of other symptoms. However, children presenting with ADHD may seem to have fairly pure delays in the development of attention and activity control.

Most of the children and adolescents seen by psychiatrists have symptoms from two or more domains. For example, individuals with conduct disorder also commonly have emotional symptoms, peer problems, and developmental delays, such as specific reading disorder or hyperactivity (see Box 1.1).



Autism provides another illustration of symptoms in multiple domains. The core symptoms of autism span two domains, with characteristic patterns of relationship problems and developmental delays (as well as developmental deviance and rigidity). In addition, autistic individuals

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commonly display some behavioural problems, such as marked temper tantrums, and some emotional problems, such as unusual phobias.

Impact

Nearly all children and adolescents have fears, worries, periods of sadness and times when they misbehave, fidget or fail to concentrate. When do these sorts of symptoms represent a disorder rather than a normal variant? In general, you should only diagnose a disorder if the symptoms are having a substantial impact. DSM-III criteria for psychiatric disorders did not include the need for impact, and the result of that omission is illustrated by a study that found that half of a large representative sample of Puerto Rican children had a psychiatric disorder. This is a ridiculously high rate, and most of these children were not considered 'cases' on clinical grounds. This has since been rectified: DSM-IV and the research diagnostic criteria of ICD-10 generally include impact criteria. Impact is judged from:

- 1 Social impairment
 - (a) family life
 - (b) classroom learning
 - (c) friendships
 - (d) leisure activities.
- 2 Distress for the child or adolescent.
- 3 Perhaps by disruption for others.

The main measure of impact should be whether the symptoms result in significant social impairment, substantially compromising the child or adolescent's ability to fulfil normal role expectations in everyday life. The main areas of everyday life to consider are family life, class work, friendships and leisure activities, though interference with paid work or physical health is sometimes relevant. Two subsidiary measures of impact are also important: distress for the child or adolescent; and disruption for others. Like their adult counterparts, children and adolescents who are anxious or depressed can sometimes fulfil normal role expectations while experiencing considerable inner anguish. Equally, behavioural problems can sometimes lead to substantial disruption for others without resulting in much apparent distress or social impairment for the child or adolescent. For example, the parents of children with severe physical or intellectual problems are sometimes remarkably stoical in the face of marked defiance, tantrums, and destructiveness – suffering themselves, but making sure that the child does not 'pay for it'. In these instances, it may be clinically sensible to diagnose a disorder as present, and treat it, even though the individual is not really socially impaired by the symptoms. Is this a slippery slope to labelling all 'deviants' as psychiatrically ill? We hope not.

Risk factors

Why does the individual you are assessing have his or her particular constellation of psychiatric problems? Though the world is full of people who think they do know the cause of particular psychiatric disorders (dietary allergy, lack of discipline, bad genes, poor teaching, hypothalamic

damage, unresolved infantile conflicts, etc.), the identification of a single cause for a psychiatric disorder is rarely scientifically justifiable. There are exceptions. Thus, it seems reasonable to say that the compulsive self-biting behaviour in Lesch-Nyhan Syndrome (which can lead to affected children severing their own fingers and extensively damaging their lips and tongue) is caused by a specific genetic deficit resulting in complete deficiency of one of the enzymes involved in purine metabolism. The presence of this inborn error of metabolism seems to guarantee the characteristic behaviour, irrespective of other genetic or environmental factors.

By comparison, most of the 'causes' in child and adolescent psychiatry are best thought of as risk factors that increase the likelihood of a particular disorder without guaranteeing that it will occur. Thus, although exposure to a high level of parental conflict is a risk factor for conduct disorder, many of the children and adolescents who are exposed to marital conflict do not develop conduct disorder. Perhaps we need to explain psychiatric disorders in terms of particular combinations or sequences of risk factors. One such scheme invokes three types of risk factors: predisposing, precipitating and perpetuating factors. The window has a hole in it because the glass was particularly thin and brittle (the predisposing factors), it was hit by a piece of gravel (the precipitating factor), and no one has subsequently replaced the broken pane (the perpetuating factor). A child who has always been rather clingy and has never had many friends (the predisposing factors) refuses to return to school after a row with a friend and a few days off sick with a cold (the precipitating factors). His parents are so worried about his level of distress that they feel it would be harmful to force him to return to school, but every day off makes it harder for him to go back since he falls further behind with his schoolwork and his former playmates find new people to play with (the perpetuating factors). The presence of a disorder can be explained in terms of:

- predisposing factors
 - precipitating factors
 - perpetuating factors
- and the absence of
- protective factors.

Even if you do train yourself to think in terms of multiple interacting causes, you will still need to remember how incomplete our present knowledge is. Our current understanding of aetiology will probably look ridiculously simplistic or misguided in a hundred years time (or much sooner). It often helps to admit this to parents: dogmatic insistence that you know the whole truth about causation may be less well received than the more defensible claim that you probably know enough about causation to provide some useful pointers to treatment.

In gearing your assessment to look for, or ask about, known risk factors, you will have to cover many areas. The traditional focus on family factors is partly justified since our family provides us with our genes and an important part of our environment. Thus, a family history of Tourette

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syndrome could be of genetic relevance, while a history of parental friction could be of environmental relevance, and a history of parental mental illness could have genetic or environmental consequences. Most children and adolescents inhabit three rather different social worlds: family, school and peer culture. Do not confine your interest in environmental factors to the social world of the family – school factors, such as scapegoating by a teacher and peer factors, such as bullying, may be at least as important. Also ask about adverse life events and more chronic social adversities. Physical and psychological examinations may also unearth previously unrecognised risk factors for psychiatric problems. For example, an adequate history and physical examination may suggest a dementing disorder, mild cerebral palsy, complex seizures or fetal alcohol syndrome – warranting referral to a specialist for a more definitive view. Psychometric assessment can detect low IQ and specific learning problems – risk factors for various psychiatric problems that may, sadly, have gone undetected in school.

Strengths

If you asked only about symptoms, impact and risk factors, your focus would be almost exclusively negative, dwelling on what is wrong with this individual and this family. It is also important to establish what is right about this individual and family. Identifying protective factors may make it clearer why this individual has a mild rather than a severe disorder. It may also be possible to identify protective factors that apply to siblings, but not to the referred individual, that help to explain why only one child in this family has developed a disorder. Relevant protective factors include a sense of worth stemming from being good at something, a close supportive relationship with an adult, and an easy temperament.

Your treatment plan needs to build on the strengths of the individual and the family – and also on the strengths of the school and wider social network. Though the aim of treatment is determined by what is wrong, the choice of treatment often depends on what is right. You should design the treatment to harness the strengths in the child or adolescent, such as the ability to make friends or respond to praise, and the strengths in the parents, such as an openness to trying new approaches in the family.

If you dwell exclusively on negatives, the family may leave the assessment feeling emotionally battered – and be correspondingly less willing to return. We live in a society that generally blames parents for their children's problems. If a child has a tantrum in the supermarket, most of the bystanders will look reproachfully rather than sympathetically at the accompanying parent. Parents stand accused, and often feel uncertain in their own minds whether they are to blame or not. On the one hand, they are likely to share society's view that parents cause their children's problems and most parents can identify many ways in which their child rearing has been less than perfect. On the other hand, most of the parents you see in clinic will also feel that they are neither better nor worse than many other parents whose children seem fine.

Many parents are frightened that you will judge them 'guilty as charged' and may be defensive and prickly in anticipation of this. One of your key tasks is to convey that you see them not as fundamentally deficient people but as individuals who, like the rest of us, have strengths as well as weaknesses. An interview presents plenty of opportunities for registering in a non-patronising way the positive things parents and their children do. If parents come to feel that you are not judging them, they are much more likely to accept the treatment plan you recommend, including suggestions for change on their part. If you ally yourself with a child against the parents (which is a common temptation for beginners), you will probably only succeed in redoubling the parents' criticisms of the child and discouraging the family from returning to the clinic.

When you meet parents who seem to have particularly glaring weaknesses, it is vital that you put even more effort into identifying their strengths. This is not to say that you should be blind to their difficulties with parenting (these difficulties may need to be the focus of treatment or even the grounds for initiating care proceedings), but you need to remember (for your own sake as well as theirs) that these parents have their own strengths, often despite harrowing personal backgrounds of their own. Parents have usually put a great deal of effort into parenting. Though successful parents may put in more effort, they also generally get much more back from their children, so failing parents may be putting in more effort per unit reward than successful parents!

It is sometimes helpful to identify the presenting problem as the opposite side of the coin to a valuable strength. For example, a strong-willed child who is seen at the clinic because of defiant and disruptive behaviour at home and at school may also show an impressive determination to succeed in the face of adversity. Similarly, a sensitive child who is prey to all manner of anxieties may show admirable empathy and consideration for others. In each case, identifying a trait as both good and bad rather than as entirely bad may make the trait easier to live with. In addition, the therapeutic task is redefined: it is not to abolish the trait (which is likely to be impossible anyway) but only to reduce the trait's troublesome consequences.

The family's explanatory model

The way we construe a child or adolescent's emotional and behavioural difficulties will depend on our cultural and professional backgrounds. This book draws on a set of explanatory models derived from empirically orientated child and adolescent psychiatry. Other professionals, such as social workers, educational psychologists or psychotherapists, may apply a different set of *explanatory models*, leading to radically different formulations even if they see the same child and family. It is easy to forget that colleagues from other disciplines have different explanatory models – an oversight that can severely hamper communication. The same can be said of communication between professionals and families, since professionals are often unaware that families may have distinctive explanatory

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models of their own, assuming instead that all right-thinking members of the public hold similar, albeit less detailed, views to their own.

Little is yet known about the range of explanatory models that influence the ways in which families from different social and cultural backgrounds think about their children's emotional and behavioural difficulties. Nevertheless, it is clear that members of the public often have complex explanatory models that differ substantially from those of doctors and other professionals – as regards aetiology, phenomenology, pathophysiology, natural history and treatment. In other words, families come to clinics with expectations that may differ radically from your own. You should not guess a family's views on the basis of your stereotypes about their class and culture; the only sensible way to find out what they believe is to ask them open-ended questions and listen carefully to their replies.

After you have asked the family about the presenting complaint, it flows naturally to enquire what they make of the problem; what they think it is due to; and how they think it might be investigated or treated. Some families will look puzzled and say that they don't know, that's for you to tell them. Many others will tell you things you could not easily have guessed. You may learn, for example, that the parents of a child with poor concentration fear he has a brain tumour, or think he needs a brain scan, or believe that you will be able to cure the symptoms with hypnosis. If you had not asked them, they might never have told you and they might have gone away disappointed, never to return again. It is also worth asking the parents whether other important people, including grandparents, friends, neighbours, teachers, have expressed strong opinions about causation, investigation or treatment. A child's mother may tell you, for instance, that her mother-in-law has been very insistent that the child's problems have arisen because the mother has always worked and has not spent enough time with her child.

Knowing about people's explanatory models gives you a chance at the end of the assessment to present your views in the way that will be most relevant to them. You can explain that the symptoms are not at all like those of a brain tumour; that a scan would not alter management; and that although you are not a trained hypnotist, even a professional hypnotist would be unlikely to be of much help in this instance. You can also mention that the quality of the day care that they have arranged for their child gives no reason for concern, and that there is no scientific basis for blaming ADHD on working mothers when the quality of alternative care is good. You can say, too, that you would be very happy to discuss this further with the child's grandmother if the family want you to. Some families hold to their explanatory models with great tenacity, but most families are willing to update their explanatory models if you take the time to present the facts. At the end of a careful assessment in which the family may have invested considerable hope, it would be a great shame if failure to explore the family's explanatory models left you and them at cross-purposes and mutually dissatisfied.

Some 'how to' tips

What means will you employ to answer the five key questions and engage the family? There are no hard and fast rules to suit all clinics, all clinicians, all families and all presenting complaints. This is where good clinical supervision is particularly helpful. Sitting in on assessments carried out by a range of senior colleagues can be very instructive. The rest of the chapter is taken up with a variety of 'how to' suggestions that are guides rather than fixed recipes.

How to: take the history from parents

As a trained clinical interviewer, you should not simply be a speaking questionnaire. If you only want the parents' answers to a fixed series of predetermined questions, a questionnaire would be quicker and easier for them to complete, unless they are poor readers. One style of interviewing, which is known as 'fully structured' or 'respondent-based' interviewing, amounts to little more than a verbally administered questionnaire. The wording of questions is predetermined, and the style of questioning is 'closed', calling for a limited range of possible responses: often a yes/no answer, or a rating of frequency, duration or severity. Questionnaires and fully structured interviews are widely used as research and clinical tools, since they are quick, cheap and easy to administer in a standardised fashion. Their main limitation is that the parents' answers sometimes tell you more about the parents' beliefs (or misunderstandings of the terms used) than about the child or adolescent being described.

A different style of interviewing, known as 'semi-structured' or 'interviewer-based', can help you get beyond the parents' views to the observations on which they are basing their views. The interviewer is expected to ask whatever questions are required to elicit from parents the information needed for the interviewer to decide whether a particular symptom (or impairment or risk factor) is present or not. In order to do this, the interviewer will often need to use 'open' questions that offer the parents the chance to make a wide range of possible responses. Obtaining detailed descriptions of recent instances of the behaviour in question is usually very helpful.

An example may make this clearer. One of the questions in a questionnaire or fully structured interview might be 'Does your child have concentration problems?' If the parents answered 'Yes', you would still not know whether the child's concentration was objectively poor or whether the parents were setting unrealistically high standards (or had misunderstood the question). A semi-structured approach would use a mixture of open and closed prompts to get the parents to describe, using recent examples, how long the child has been able to persist with specific activities without switching from one thing to another: playing alone, playing with friends, watching television, looking at a book, and so on. You could then make up your own mind from this evidence whether the child's concentration at home was age-appropriate or not.

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Similar methods can be used to explore irritability, fearfulness or any other reported area of problems. It is also sometimes relevant to explore why parents are not concerned. For instance, if teachers report major problems with concentration but parents do not, it is important to explore whether the child really does concentrate adequately when out of school, or whether the parents simply have unusually low expectations.

Semi-structured interviewing is a valuable technique but you do have to be careful not to overdo it or the interview will go on for hours! One option is to use questionnaires or fully structured interviews to get an overall view and then use semi-structured interviewing to obtain more details about the most relevant aspects of the case. Finding the time to get parents to describe their child's typical day, perhaps yesterday, can often be a particularly illuminating window, not only on symptoms and any resultant impairment but also on family life, child-rearing tactics and expressed emotion.

Here is one possible scheme for taking a history from parents:

1 *Presenting complaint*

- When did it begin? When was he last completely well or not doing it? How does it show itself? How often? When? Always get specific examples rather than accept general statements. What is going on just before it happens? After? How do you respond? What's the result? What effect is it having on the rest of the family? Why are you coming about it now?
- Review of other symptoms: emotions, behaviour, attention and activity, somatic:
 - sleeping, eating, bladder and bowels, pains, tics.

2 *Current functioning*

- Typical day's activities: dressing and eating, play and leisure, going to bed, sleeping. Does this vary much at the weekend? How involved are the parents involved with this child?
- Social relationships:
 - Friends: Got any? What exactly do they do together? Do they go to one another's homes? How often? Shy? Able to take turns? Leader or follower? Sexuality?
- Adults: How does the child get on with each parent? With other carers? How do they feel about the child? Any good times? When?
 - Siblings: Who does he or she spend time with? Like? Dislike? Jealous?

3 *Family history*

- Composition: draw a family tree (a 'genogram'). Ask a few details about each relative, including medical and psychiatric problems. For members of the immediate family, record age, occupation, what they are like.
- Relationships: how do the parents get on together? Do they support each other? What are their expectations of this child? What were their own childhoods like? Do they agree on rules and how discipline should be applied? Arguments? How do the children get on together?

Who is close to whom? Who gets into most trouble? Who least? How are they treated differently?

- Circumstances: housing, debt. Have circumstances changed recently? Has there been contact with social services?

4 *Personal history*

- Birth and infancy: planned and wanted? What sort of baby was he or she? Milestones – were these earlier or later than siblings or friend's baby?
- Schools: names and dates. Difficulties in classroom, playground or small groups? Academic functioning: their position in class, whether they are under-achieving, whether they are receiving, or ought to be receiving, special help. Social functioning: friends, type of play.
- Physical health: fits and faints, illnesses, hospital or psychiatric contact.

How to: see the child or adolescent alone

Do not rush into difficult topics – it is obviously best to engage with the individual first by focusing initially on pleasant and neutral topics or activities. Equally, do not become so focused on making the interview fun that you avoid difficult topics entirely (though you may want to postpone some difficult topics for a second interview).

- Children under 5: observe play, play too, chat, use fewer directed questions.
- Over-5s: you should both sit down. It is often helpful to ask the child to do a drawing. Chat and use directed questioning.

What to cover

1 This is a useful opportunity to observe:

- (a) *Activity and attention.* Is there a lot of squirming and fidgeting? Does he or she keep getting out of the chair and wandering about? Is it hard to get him or her to persist in a task? Is he or she easily distracted by extraneous stimuli?
- (b) *Quality of social interaction.* Does he or she show too much or too little anxiety about coming with you initially? Is he or she interested in social interaction? Does he or she make good eye contact? Does he or she talk *with* you or *at* you? Is he or she inappropriately friendly, over-familiar or cheeky? What feelings does the interaction evoke in you?
- (c) *Developmental level.* Consider the complexity of language, ideas, drawing and play.

2 Ask what he or she likes doing and discuss this, be it watching or playing sport, talking with friends, playing video games, cooking or whatever. This will help promote engagement and demonstrate that you are a human being!

3 You can enquire about emotional symptoms. It is not unusual for older children and adolescents to be experiencing considerable anxiety or misery without their parents being aware of this. You generally

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need to ask directly about obsessions and compulsions – children and adolescents are often ashamed to admit to such ‘mad’ symptoms. Much the same applies to symptoms of post-traumatic stress disorder.

- 4 Ask about friends, teasing and bullying; the individual’s account may differ significantly from the parents’ and teachers’ accounts.
- 5 It is often worth asking a general question about undisclosed abuse or traumas. ‘Sometimes nasty or frightening things happen to people, and they find it difficult to tell anyone about it. Has anything like that ever happened to you?’ Sometimes it is also necessary to ask about abuse more directly.
- 6 Find out what the child or adolescent makes of his or her biography and current life situation. What account can he or she give of the problems that led to referral? In a first interview you will only be able to explore a few themes, but this will often be useful. It is sometimes helpful to ask for a blow-by-blow description of a typical day, or for a detailed account of the last episode of ‘problem behaviour’. ‘What happens when you are naughty?’, ‘How does mummy react when you do that?’ It is often revealing to get a child’s view of potentially significant life events such as the death of an uncle or grandparent (even if the parents have previously told you that the child was unaffected).
- 7 The assessment may lead on to direct work, so it is also your first opportunity to engage the child or adolescent. At the very least, the interview should allay any fears that seeing a professional is bound to be unpleasant. Some parents have used referral to the clinic as a threat. As a result, children may fear that they will be told off, taken into care, admitted to the ward, or have painful things done to them. Remember to explain what will happen and allay fears whenever possible.

How to: observe the family as a whole

Are the parents supervising the children and setting limits if necessary? How sensitive and supportive are the parents if their child shows signs of anxiety or distress? How much warmth and criticism do the parents express about this child? (NB: warmth and criticism are independent, not the opposite sides of the same coin.)

Is there overt friction between parents? Do they countermand or back one another up? Who does the talking? Do they notice if they disagree? If so, do they reach a consensus?

How do siblings relate to one another? Do the parents treat the children differently from one another? Are there particular alignments within the family? For example, a mother’s child, or a father’s child, or father and son ‘ganging up against’ mother?

What is the relationship between children and parents? Possibilities include exploring from a secure base, interrupting their conversation, ignoring or challenging their requests, and watching them at a distance.

If toys are present in the room, are they used? What can you note about the form of play? Is it imaginative? What developmental level does it suggest? Are there any notable themes in the content of the play (for

example, sexualised doll play)? Beware of overhasty interpretation of brief episodes of play.

How to: obtain information from teachers

Behaviour in school is often markedly different from behaviour at home. Although parents can often tell you if teachers have relayed any complaints or concerns about their child, it is best to get the information first hand from the school if at all possible, provided parents are willing to agree to you contacting the school. Having identified someone to contact, you can write and ask for their comments and a copy of a recent school report. It is often helpful for the teacher to complete a brief behavioural screening questionnaire such as the Strengths and Difficulties Questionnaire (www.sdqinfo.org). Since teachers have considerable experience of what to expect of children of any given age, their views are generally accurate. Whereas parents' answers to questionnaires often need to be explored through semi-structured interviewing, it is usually appropriate to take teachers' answers at face value. It is sometimes helpful, though, to get back to the teacher by phone to explore one or two particular issues in greater depth. Though teachers are generally excellent observers, they may miss or misconstrue some symptoms. In a busy classroom, disruptive behaviours are generally a lot more obvious than emotional symptoms. Consequently, teachers may miss anxiety or depression unless these have resulted in a dramatic decrease in the quality or quantity of the child's work. Subdued children may even seem better behaved than before. Thus, in one study, the rate of problems reported by teachers on a standardised questionnaire went down in the aftermath of a disaster.

Recognising the symptoms of ADHD in the classroom can also pose problems when a pupil has learning difficulties or dislikes academic work. Imagine how any child would behave if placed in a class taught in a language they did not understand – they, too, might well appear distracted or wander round the room at any excuse! What you really want to know to make a diagnosis of ADHD is whether the individual is restless and inattentive when engaged in tasks that are within their capabilities and that interest them. Sadly, some children and adolescents are never engaged in any such tasks at school. Finally, as noted earlier, teachers are sometimes unaware of problems in peer relationships because a pupil who seems to be getting on with classmates in class may be isolated or victimised in the playground without teachers necessarily spotting this.

When a pupil is reported to have marked problems in school, it is often very useful to go to the school and observe that individual both in the classroom and playground. Much may be learned, say, from observing a high level of restless, inattentive and impulsive behaviour in the classroom and playground, even though he or she had been fairly well controlled with you and other adults in the clinic; or from discovering that the child is constantly being told off by a highly critical teacher with limited classroom-management skills.

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How to: do a physical examination

Systematic observation of a child or adolescent's physical features and skills is an essential part of a complete psychiatric assessment. You are primarily looking for:

- 1 Evidence of a physical disorder that definitely or probably affects the brain. Recognising that there is a 'hardware fault' is important – characterising the type of disorder is less important, provided the child is referred to an expert. Relevant evidence includes abnormal neurological signs, dysmorphic features, and cutaneous stigmata of a neurocutaneous syndrome.
- 2 Signs of neglect or abuse. Observing, weighing and measuring the child, and plotting the values on an appropriate growth chart, can provide evidence of injury and growth failure.

Medical trainees should not discard their hard-won medical skills; if the child or adolescent is present at the assessment, you should always set aside some time for observing them with a 'medical hat' on. Even if you never lay hands (or tendon hammer or stethoscope) on them, there is much that you can learn just by looking at their face, hands, gait and play. So, during the time you see them (in the waiting room, in the family interview, or in the individual interview), take some time off from thinking about family relationships or psychiatric symptoms and consciously concentrate on physical features. Are there dysmorphic features? If you do not spot these fairly rapidly, you will be so used to the way they look that you will probably never notice. Do they have a neurological syndrome? Are they peering at things or straining after sounds? Are there any visible bruises, burns, bites or other possible signs of abuse?

Which children and adolescents need neurological examinations?

Ideally you should examine everyone, if only to practise your technique and learn the range of normal variation. If time constraints prevent this, you should at least examine anyone who has one or more of the following features:

- 1 history of seizures or regression;
- 2 developmental delay or intellectual disability;
- 3 abnormal gait;
- 4 not using both hands well, for example, when playing;
- 5 dysmorphic features;
- 6 skin signs of a neurocutaneous disorder;
- 7 other suspicious features, for example, speech difficulties.

A basic neurological examination

Though some items will be impossible with very young children, aim to include the following in your neurological examination:

- 1 Measure head circumference and plot it on a chart.
- 2 Get them to walk, run, hop and walk along a line on the floor as if it was a tightrope.

- 3 Observe them standing with feet together, arms outstretched, eyes closed.
- 4 Check eye, face, and tongue movements.
- 5 Move and shake all four limbs (as part of a game) to assess tone.
- 6 Test strength: pyramidal weakness is most evident from testing abduction at shoulder, extension at wrist, abduction of fingers, and dorsiflexion of ankle and big toe.
- 7 Test reflexes.
- 8 Test coordination: getting them to touch your finger, touch their own nose, touch your finger, and so on; touch their thumb to each finger in turn; tap their finger rapidly, pretend they are playing a piano; put the cap on a pen; or thread a bead.

If you find an abnormality (and asymmetries are often easier to detect than bilateral changes), this probably needs further evaluation by a paediatrician or paediatric neurologist. Similarly, if you suspect visual or hearing problems, it is essential to refer to an appropriate clinic.

Congenital syndromes

There are hundreds of these, only some of which have known chromosomal, genetic or environmental causes. When should you suspect one? The best clues are dysmorphic features, such as unusual-looking facial features or fingers, and extreme values for height, weight and head circumference (below the 3rd or above the 97th centile). Look carefully for unusual features whenever an intellectual disability is present. Three examples are:

- 1 *Fragile X syndrome*. Probably the most common cause of inherited intellectual disability. Although once said to affect about 1 in 1,000 births, more recent estimates based on DNA analysis suggest that the rate may be closer to 1 in 5,000. It affects both males and females, though the degree of intellectual impairment tends to be greater in males. Physical characteristics are highly variable, but may include a long face, prominent ears, wide jaw, hyper-extensible joints and large testes after puberty. Equally, physical appearance may be normal. Fragile X is associated with gaze avoidance, social anxiety and hyperactivity, but the link with autism remains controversial. It is due to an excess of trinucleotide repeats at a specific site on the long arm of the X chromosome and may be detected by direct DNA analysis.
- 2 *Fetal alcohol syndrome*. Affects up to 1 in 300 births. May cause up to 10% of mild intellectual disability. Height, weight and head circumference are low from birth onwards. Short palpebral fissures, hypoplastic philtrum. Associated with hyperactivity.
- 3 *Sotos syndrome* ('Cerebral gigantism'). Sporadic. Excessive height, head circumference and bone age, particularly when young. High forehead with frontal bossing, prominent jaw, widely spaced eyes with a downwards slant. Clumsy. Most have mild or borderline intellectual disability. Associated with hyperactivity and autistic problems.

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The neurocutaneous disorders

These disorders involve characteristic combinations of brain and skin abnormalities (reflecting their shared ectodermal origins). Recognising the skin signs allows you to infer a 'hardware' defect. The commonest three neurocutaneous syndromes are:

- 1 *Tuberous sclerosis* is an autosomal dominant disorder with variable penetrance and expression. It is often a new mutation. Skin lesions include: hypo-pigmented leaf-shaped patches from birth, best seen with UV light (Woods light); the adenoma sebaceum butterfly rash on face, rarely evident before two years, but present in half by five years; a rough irregular 'shagreen' patch over lumbar area; and lumps (periungual fibromata) in and around finger and toe nails. There is a high rate of severe intellectual disability, infantile spasms, and other seizures. Autistic and ADHD features are common in affected individuals, particularly if they have had infantile spasms.
- 2 *Neurofibromatosis-1* is transmitted as an autosomal dominant with variable expression. Skin lesions include *café au lait* patches that increase in size and number with age (so that by adulthood the presence of over five patches of over 1.5 cm diameter is highly suggestive); axillary freckling; and cutaneous and subcutaneous nodules in the distribution of cutaneous nerves appearing in later childhood. Various neuropsychiatric manifestations are reported but unconfirmed.
- 3 *Sturge-Weber syndrome* is usually sporadic. There is a port-wine naevus from birth, involving the forehead and variable amounts of the lower face. It is usually unilateral but can be bilateral. The ipsilateral hemisphere is affected, resulting in seizures, hemiplegia, and generalised intellectual disability, plus variable neuropsychiatric features.

Putting it all together: the formulation

Having carried out your full assessment, you are in a position (with advice from other team members as appropriate) to generate a formulation that will crystallise your views on the situation, inform your feedback to the family and referrer, and guide your subsequent management. The elements of a formulation include:

- 1 *A socio-demographic summary*, for example, Amy is a 7-year-old girl who lives with her mother, stepfather and younger half-brother in a one-bedroom rented flat in Newtown.
- 2 *The clinical presentation*, for example, John has always been overactive, inattentive and impulsive, and these symptoms have become more apparent and have made more of a difference to his life since starting school.
- 3 *Diagnosis*. Sometimes this is simple, for example, John meets the full diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD), or for both ADHD and oppositional defiant disorder. On other occasions, matters are more complicated. Perhaps John's symptoms could

be explained by several alternative diagnoses, and you then need to review the evidence for and against each possibility before reaching a conclusion on the likely diagnosis (or diagnoses), or suggesting further assessments or investigations that will clarify the picture. Or perhaps John has elements of several different disorders but does not meet the full criteria for any of them – you may need to recognise that he falls between the cracks of the current diagnostic systems. Or maybe Amy's distress about teasing at school, overcrowding at home and rows between her mother and stepfather warrant recognition and help, but do not warrant a diagnosis.

- 4 *Causation*, for example, Alan developed obsessive compulsive disorder and tics following a streptococcal infection, probably mediated by an auto-immune response; or Jane's post-traumatic stress disorder followed sexual abuse by a babysitter; or Michael's disruptive behaviour may reflect the combination of constitutional vulnerability linked to his fetal alcohol syndrome, and suboptimal parenting linked to his mother's continuing alcohol problems and depression.
- 5 *Management plan*, including specific psychological or pharmacological treatments, as well as psycho-educational work with the individual, family and school. The plan should build on the individual's and family's strengths, and boost these still further.
- 6 *Predicted outcome*, for example, Sarah's specific phobia of dentists is likely to resolve with a brief course of behavioural therapy, and will probably not recur; Roger's conduct disorder is likely to persist, carrying a high long-term price for him and society, unless he receives appropriate intensive treatment such as multi-systemic therapy.

It is not easy to produce a formulation that is accurate, brief and useful – the best way to learn is by practising the skill and getting constructive feedback from more experienced colleagues.

Subject review

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Further reading

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