THE CLINICAL EXAMINATION OF CHILDREN, ADOLESCENTS AND THEIR FAMILIES

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Sherlock Holmes statue at Meiringen, Switzerland (Wikipedia commons)

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WAYS OF READING THIS CHAPTER

- You are a *beginner in the field* of pediatric mental health:

  Welcome to this exciting subspecialty! We are inviting you to sit back and read the whole chapter.
- You are already *experienced and trying to improve* your examination skills:

  We suggest that you read the clinical pearls in the right column and try them out in your practice. If you wish, you may collect more of them and share them with clinicians all over the world by sending them to the authors for the next edition of this chapter.
- You are *experiencing difficulties* with a specific patient's diagnostic assessment:

  We suggest that you read the troubleshooting box at the end of this chapter (pages 23-24). If this does not help, check our reading recommendations in the references section (pages 24-25).

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Would you like to share your "clinical pearls"?

If you have comments regarding this chapter, especially more clinical pearls from your own work you are cordially invited to send us your suggestions to lempp@em.uni-frankfurt.de

The Sherlock Holmes illustrations are from Sidney Paget (1860-1908), who illustrated Conan Doyle's stories in The Strand magazine.

Why should I read this chapter?

In many respects it seems worthwhile giving special attention to the clinical examination process in child psychiatry (except when otherwise specified, "child" refers to "child" and "adolescent"):

- It is obvious that there has to be a thorough and comprehensive *diagnostic evaluation before treatment* can be considered. If the diagnosis is wrong, incomplete, not understood or accepted by all parties involved, the chances of treatment failing are fairly high. The planning and initiation of a treatment regime in child and adolescent psychiatry is usually time-consuming and costly. Therefore, the time spent in the diagnostic process to create a valid and solid foundation for effective treatment planning is wisely invested.
- There are *distinctive developmental aspects* in the mental health examination of children and adolescents, which deserve special attention. Children and adolescents are not little adults. They cannot be assessed in isolation, speak a "different language" to the clinician and rarely seek help by themselves.
- Especially for beginners in the field, it is easy to get confused by the amount of information and by inconsistent reports. To minimize this, it is helpful to be *clear about the aims* of the evaluation process. The art in daily practice is in finding the balance between standardization and individualization when using different methods to reach these aims.

"I like to think of myself as Sherlock Holmes during this time. I use the more obvious clues (usually the presenting complaint) to begin the investigation, as well as "digging deeper" to understand the nature of the symptoms and behavior, and the biological, psychological and social factors, which are precipitating and maintaining the impairing symptoms." (Stubbe, 2007).

"Whatever the age of the child, and whatever the clinical issue, it is important that the interview combines an appropriate degree of structure and standardization (which are essential for comparability across children) and sensitivity to the unexpected and to the individual issue." (Rutter & Taylor, 2008).

Be clear about the aims and flexible in the methods.

Distinctive aspects of the mental health examination in children and adolescents

- Children rarely initiate psychiatric assessment and the *referral is typically requested by someone other* than the patient (e.g., parents, teachers, pediatricians, courts). This can be of paramount importance in the interpretation of the case. Perhaps the adult's expectations for the child exceed the child's abilities, or the parenting style may result in a poor fit between parents and this particular child, and parents seek to

change the child in order to remedy this poor fit. In other cases, parents or teachers have mental health problems of their own, which alter their perception of the presenting child in a negative way. In summary:

- It is necessary to consider both the child's and adults' contribution to the distressing behavior for which examination is being sought
- We need to pay explicit attention to the child's perception of the problems and what the child desires to change.

No child can be assessed in isolation!

- Children need to be *evaluated in the context* of the family, the school, the community and the culture, which means that no child can be assessed in isolation. Moreover, most children function differently in different settings and it is helpful to know which surroundings improve or worsen the distressing behavior – also to identify the child's areas of strength. Thus, the simultaneous examination of parental and family functioning is crucial, as is the need for multiple informants. Building rapport with all the parties relevant to the case who may have information or who could play a helpful role in furthering the child's progress is essential. Parental permission should also be obtained. For example:
  - Parents living apart from the child (it is often helpful to involve both parents to the greatest extent as early as possible)
  - Teachers (by phone or email, examination of school records and obtaining teacher rating scales). A teacher will have seen hundreds of children of a given age or grade level to serve as a basis of comparison, in contrast to the parent of an only child.
  - General practitioners and pediatricians
  - Any past and current mental health provider
  - When appropriate: siblings, grandparents, child caretakers, stepparents
  - For inpatient children: nursing staff, social workers, teachers, physical- and occupational therapists.

"There should be no combination of events for which the wit of man cannot conceive an explanation." (Sherlock Holmes, "The Valley of Fear")

- The presenting problems must be considered in a *developmental context*. Developmental factors often influence the presentation of psychiatric symptoms (e.g., depression presents differently at different ages). While some disorders look quite similar in children and adults (e.g., obsessive compulsive disorder), other disorders are notably different in younger children as compared to adolescents or adults (e.g., PTSD). Behavioral problems in children can be due to a delay in skill development (e.g., enuresis or bedwetting), the loss of previously attained skills (e.g., consequence of a serious disorder, loss or trauma), or inability to select appropriate skills from an existing repertoire (e.g., conduct disorder). In summary, one needs to be aware of normal and abnormal child development, including the range of behaviors that can be observed at different ages, contexts and the various forms of disturbance in each developmental stage (see Chapter A.2).
- Children's ability to reflect and discuss their feelings or experiences is influenced by maturational factors. This means that *child and clinician are at different developmental levels* and speak "different languages". Moreover, stage-specific developmental features can impede communication. For instance, younger children may not trust

unfamiliar adults, adolescents often perceive clinicians as simply another adult imposing expectations or judging them. Therefore, information-gathering from the child often requires modes of communication other than question and answer or verbal discourse. Children of different ages need different methods of collecting data and interviewing (e.g., observing a baby, playing with preschool children, talking directly about symptoms to articulate children or adolescents, drawing with anxious or uncommunicative children)

- The clinical assessment of children typically *requires more time than adults* (about 2 to 5 hours), thus using time efficiently is an important consideration. Rating scales and questionnaires is a way of increasing efficiency (see below), but can never replace a thorough face-to-face evaluation.

"It is a capital mistake to theorize before one has the data. Insensibly, one begins to twist facts to suit theories, instead of theories to suit facts"
(Sherlock Holmes, "A Scandal in Bohemia")

AIMS OF THE EXAMINATION

Before beginning the examination it is essential to be clear about its aims. While the methods to reach this goal might differ in individual patients and families, the aims are quite consistent, namely to:

- Create a *good therapeutic relationship*. The need to develop a good alliance between the multiple parties, especially between the clinician and the child, the clinician and the parents and with other, possibly helpful, family members as well as outside agencies. A rupture in these relationships can dramatically interfere with treatment efforts
- Understand the exact *reason for referral* ("Whose problem is it?" "Why now?")
- Identify the child's and parent's implicit and explicit *expectations and concerns* about the evaluation
- Identify the *main complaint* of the child and the family
- *Evaluate the child in the context* of his or her *current functioning* in the family, the school, and with peers, with sensitivity to cultural or community influences and the extent this has been impaired by the current problem(s)
- Obtain an accurate picture of the *child's developmental functioning from birth to now* and to obtain *a picture of the parents and family functioning*, and family history concerning medical and psychiatric disorders
- Identify individual, family or environmental factors that may be causing, accelerating or ameliorating the presenting difficulties
- Condense all the information obtained into a *clinical formulation*. That is, the clinician's distillation of the data put together in a coherent fashion to understand the multiple factors which are contributing to the presentation. This understanding will inform diagnosis, prognosis, and treatment recommendations
- *Communicate this clinical formulation* and recommendations to the parents and the child in an understandable and constructive way
- Establish target symptom priorities and *clarify the focus of treatment*

In short, the aims of the evaluation are the integration of the complex (and sometimes disparate) information gleaned from the examination process, putting it into a certain context to understand the child's behavior and to clarify the treatment focus and appropriate interventions for this individual case.

The first diagnostic steps are observation and collection of facts.
It is a mistake to move quickly relying on single symptoms.

- Discuss with the patient and the family the relative *benefits and risks of the proposed treatments* and to identify and discuss all relevant environmental factors which may influence adherence to treatment
- Achieve all this in a *time-efficient* manner.

BRINGING BUILDING BLOCKS TOGETHER

There are no specific biological or radiological markers for the diagnosis of psychiatric disorders (yet). In their absence, the *multimodal diagnostic process* is the gold standard for the examination of mental health problems. This means that we cannot trust one specific method to make a valid diagnosis (e.g., to give a family a definitive diagnosis after one interview or after filling out a couple of questionnaires). Instead, it is necessary to collect different diagnostic *building blocks* (e.g., separate interviews with parents and child, rating scales from teacher, psychometric assessment). If these blocks fit together (i.e., point in the same direction) we can build a *diagnostic wall* out of them (i.e., the diagnosis). Standing on this more or less solid wall we can see a picture of the whole problem. Only then are clinicians in a position to make appropriate recommendations. The final diagnosis, treatment recommendations and prognosis must only be made in light of all these circumstances.

"We balance probabilities and choose the most likely. It is the scientific use of the imagination."
(Sherlock Holmes, "The Hound of the Baskervilles")

Before you start to build the diagnostic wall (see below: Setting the stage), we suggest collecting at least four basic building blocks:

1. Parents and child interview
2. The mental status examination
3. The medical history and the physical examination
4. Rating scales and psychometric assessment.

Combining these blocks usually helps to find the suitable diagnosis according to one of the two major classification systems: the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 2000), and the International Classification of Diseases (ICD-10; World Health Organization, 1996).

Comorbid problems

Parents and teachers usually describe the most prominent symptoms in their children or those that cause them the most concern, with the result that some problems can be easily overlooked. *Internalizing* symptoms, such as anxiety or depression, can be difficult for children to describe and tend to be less troublesome or apparent to adults than *disruptive* or *externalizing* symptoms (e.g., those seen in ADHD or conduct disorder). Comorbidity (the presence of more than one concurrent disorder) is extremely common in child mental health; the co-occurrence of several disorders has implications for treatment and prognosis.

Differential diagnosis

Differential diagnosis is the method used to systematically identify the presence of a disorder when several alternatives are possible. Psychological symptoms are often equivocal diagnostically in that they often occur in various disorders (e.g., irritability can be found in depression, bipolar disorder, ADHD,

Be as transparent as possible with the patient and the family, especially at the beginning of the examination.

anxiety etc.) thus, disorders that share similar symptoms should be considered and some excluded.

Setting the stage

The aim of this part of the examination is to build a good therapeutic relationship with the child as well as the parents – right from the beginning – and to clarify all relevant *administrative aspects*, the *reason for referral* and *expectations* of all relevant parties.

The right place

To reduce possible fears of the patients it is helpful to evaluate them in a room with enough space, pleasant lighting, colored pictures on the walls and to have at hand toys, pencils and paper.

A good therapeutic relationship from the beginning

Building of a good therapeutic alliance is a key consideration right from the start. Most families and children are intimidated by the prospect of seeing a clinician in a mental-health setting. Increasing the degree of transparency usually helps lessen this difficulty. Often, it is effective to explain in advance every step of the process, especially at the beginning – what you will do, why and how long it will take.

Example of how to explain your profession:

"I am a child and adolescent psychiatrist – a medical doctor who is specialized in understanding and treating emotional and behavioral problems in children and teenagers. My first job is to try to understand the problems you have…"

Young children may need to be reassured about where they are going and which kind of doctor they will meet (e.g., "a feelings doctor", "a talking doctor", "a hospital for emotional problems") and that there will not be needles or painful physical procedures. Children usually have no idea, or a false idea, of what occurs in a mental health examination and may be afraid of being hospitalized, taken away from the family or otherwise punished, especially if their difficulties have been a source of recrimination within the family. Parents and relatives are often misinformed and may share some of these beliefs; it is also helpful to explain to them what type of professional you are.

Administrative aspects

Make clear what the psychiatric examination entails, how long it will take and what the family can expect at the end (e.g., a verbal recommendation, a written report). The cost (if fees are involved) needs to be clarified at the onset. It is important to ascertain also if there are financial or insurance limitations, which may influence the diagnostic process or treatment options. Scheduling, confidentiality, and permission to contact other people to obtain information should also be discussed right at the start. Parents should be asked to bring copies of as many school reports as possible.

School reports should be routinely checked for:

- Sudden or gradual decline in output or performance
- Large differences in marks in different school subjects
- Comments about social and behavioral problems.

Clarifying the reason for referral

Before you start, consider the purpose of the evaluation so that you structure the examination to fit the reasons for referral. For example, assessment will differ if the purpose is to prepare a court report in a custody dispute, if the evaluation is requested by social services, or the consultation is sought by parents concerned that their child may be suicidal. This minimizes the chances of frustrating and disappointing your patient, the family or other people.

Children often do not understand why they are going to see a mental health practitioner because they do not feel ill – they may be attending because

of promises of ice cream or other treats after the appointment. School teachers may want the child to show more self-control and push parents to manage the child differently or consider medication. The mother may want the examination to validate her parenting efforts; the father may want a diagnosis that would allow access to additional school resources to improve the child's school performance, while the grandmother may wish for a totally different ("old-style") parenting approach.

"Whose idea was it that your child might need this evaluation?"

Important questions in this part of the examination are:

- Who initiated the referral and why? (e.g., parents, pediatrician, school, court, the patient, emergency department)
- Who else is concerned about the child and for what reason?
- Why now?
- What are the key concerns or questions for which people want a response?

Two crucial questions one needs to ascertain at the beginning of the examination:

- Whose problem is it?
- Why now?

If there are conflicting reasons for the referral and you become confused, remind yourself that, when in doubt, you are the child's clinician. Try to keep your examination focused on what you believe will ultimately lead to the best possible outcome for the child.

"What do you hope this examination will accomplish?"

Handling expectations

A common source of frustration is wrong or inflated expectations. It is helpful to check the expectations of the family at the beginning of the interview. This helps to build rapport and understanding. Preparing families for what to expect diminishes parent and child anxieties. Managing expectations may require clarifying what the examination process can or cannot fulfill.

PARENT AND CHILD INTERVIEW

Who should I talk to and in which sequence?

It is informative and reasonable to have the child together with the parents at the beginning of the diagnostic process. Later on, it is helpful to interview the patient and parents separately. While there are no hard and fast rules about how to do this, it is mandatory to interview patients by themselves at some stage, particularly to clarify issues that patients may not feel comfortable talking about when parents are present such as suicidal thoughts, abuse or sexuality issues.

The child is usually the best information source for internalizing symptoms whereas parents can give reliable information about externalizing ones.

In most cases, parents will have limited knowledge about their child's inner feelings, experiences outside of home and performance at school. Disagreements between parents, child and teachers are common. Studies have shown that agreement between parents and child are low to moderate (e.g., Achenbach et al, 1987; Salbach-Andrae et al, 2009). School-age children and adolescents are themselves the best informants for anxious or depressive feelings, suicidal ideation, and behaviors the parents may not be aware of – such as sexual activity, sexual identity issues, sexual abuse, drug use, obsessive thoughts, and hallucinations. On the other hand, parents are a good source of information for behaviors such as deceitfulness, overactivity, inattention, impulsivity, non-compliance, and aggression.

How should I formulate my questions?

Using parents' actual words in the interview can help ensure that parents feel heard.

It is adequate in almost all cases to start with one to three *open-ended questions*. This helps to establish rapport and avoids premature narrowing of focus. In addition, it is useful to allow parents to tell their version of the problem for at least several minutes. This helps to clarify what truly concerns them, allows them to feel heard and understood by the clinician. It is helpful and improves communication to later on use parents' actual words (e.g., "You talked about the *special hours* of your *little lion* in the evening. When did they first happen?")

As the interview progresses you can use more and more *follow-up questions* to clarify details, and *screening questions* to check areas not yet mentioned. If these do not reveal significant information, move on to another topic.

Who is truthful?

As already mentioned, disagreements between observers' descriptions of children's behavior are common and have several potential sources:

- Disagreement actually reflects differences in the behavior of the child in different settings or with different observers
- Different standards when judging the child's behavior
- Ignorance about how other children of the same age behave
- Observers' biases.

To manage discrepant reports, it is useful to collect information from as many sources as possible giving more weight to those that appear more reliable in the clinicians' opinion. In most cases disagreements are more the result of looking at the child from different perspectives or in a different contexts than of truthfulness. The more perspectives from which you obtain information, the more complete your understanding will be and the more accurate the assessment.

Important topics to ask about

There are five key areas of interest in the clinical examination; you may use the acronym **SIRSE** to remember them:

- **S**ymptoms
- **I**mpact
- **R**isk factors
- **S**trengths
- **E**xplanations.

Many parents become distressed when describing their child's deterioration. Giving parents the opportunity to narrate this history in their own words, even if it is initially confusing, may help.

Symptoms

The initial focus should be on the symptoms that led to referral and those that cause most distress to the patient and the family (main complaint). Important characteristics about the problematic behavior that need to be elucidated are:

- Frequency (changes over time?)
- Intensity (changes over time?)
- Duration
- Context in which the behavior emerged
- Progression of the problem.

The next step is to obtain a detailed *history of the problem(s).* A good understanding of their evolution is necessary to ascertain the right diagnosis. For this, it is important to clarify whether a problem:

- Has been present since early childhood (e.g., symptoms of autism)
- Is intermittent or recurrent (e.g., depressive or manic symptoms, tics), or
- Represents a deterioration from a previously higher level of functioning (e.g., schizophrenia).

Check the impact of symptoms on the patient, family, school and peers.

In this part of the examination one also gathers information about all previous treatments including medication, counseling, hospitalization, or use of traditional, complementary and alternative medicine (see Chapter J.2).

Impact

Next is to ask about the impact of these symptoms on the daily life of the child and family members: effect on the patient's quality of life, siblings, parents' relationship, extended family, school class, academic performance, contact with peers, and development. This includes finding out in what context(s) the problems occur and in which they do not or occur to a lesser extent (an example of marked symptoms in the absence of impairment is frequently seen in specific phobias). Remember that problem behavior may reflect:

- An underlying disorder in the child
- A mismatch between the child and the environment
- A problem within the child's environment, or
- Usually, a combination of all the above.

Risk factor
A risk factor is something that increases the chances of developing a disease. This may come from what one does (e.g., using cannabis increases the risk of psychotic symptoms). Other times, there is nothing one can do about the risk. It just exists. For example, adolescent females are more likely to suffer from depression than males. So, gender is a risk factor for depression.

Risk factors

The next step entails screening for relevant risk factors, currently, in the past, and in the extended family (family history). Important risk factors are genetic, developmental, familial, and social. Most of the presumed *causes* of mental health disorders in children are better understood in terms of *risk factors*. There are three different kinds of risk factors and it is useful to divide them into "*the 3 P's*":

- ***P**redisposing* factors, which render the child vulnerable to a disorder (e.g., genes, birth weight, gender)
- ***P**recipitating* factors, which are associated with the emergence or worsening of symptoms (e.g., onset of puberty in anorexia nervosa)
- ***P**erpetuating* factors, which maintain the symptoms (e.g., inadequate parenting style, lack of professional intervention, no access to health services).

Before beginning to ask questions about the developmental history it is helpful to explain to the parents why this is necessary. Otherwise they might get confused about these issues.

A matching analogy is the wind, which blows through a hole in a window. Before the hole existed, the glass might have been fragile in one spot (*predisposing*). The glass was then hit by a stone (*precipitating*) and there were no craftsmen to seal the hole *(perpetuating).* So the wind is still blowing (*symptoms of the disorder*) (Goodman & Scott, 2005).

Developmental history. This is a detailed account of the child's development from the beginning of the pregnancy to birth and early development. It is helpful and time efficient to use a structured approach with screening questions about

important milestones (see Table A.5.3) and follow-up questions, if necessary. Parents often vary in their recollection and timing of developmental milestones. Check for problems in:

- Basic functions (sleeping, eating, toilet training)
- Psychomotor milestones: walking, sitting, fine and gross motor skills, handwriting skills
- Cognitive development and school functioning: history of the child's language development, reading, writing and math skills. Progress at school requires some innate cognitive abilities but also reflects the child's motivation, capacity to concentrate, attitude towards authority, capacity for peer relations, tolerance for frustration and delayed gratification, and a degree of parental support for learning
- Interpersonal development: reaction to separation early in life, ability to play with other children, stability of relationships, number of friends, types of activities shared
- Emotional development and temperament
- Trauma history: physical, sexual, emotional, neglect, acute or chronic, intra- or extra-familiar, violence, natural disaster
- Harmful behavior: head banging or self-injurious behavior, thoughts or comments about death, self-mutilation, cutting, and harmful acts toward other people or animals.

Possible trauma screening question to parents: "Has your child ever witnessed anything really bad or frightening?"
Possible trauma screening question to the child: "Has anyone ever tried to hurt you?"

Particular attention should be paid to changes or discontinuities in the developmental progress.

Family history. This includes (screening) questions about current and past family functioning and about neuro-psychiatric disorders in other members of the family (e.g., alcohol dependency, substance abuse, suicide, and unusual or odd behavior in relatives). Knowing about mental health disorders in the family can help in finding the right diagnosis (e.g., a mother with alcohol dependency could lead to the consideration of a fetal alcohol syndrome).

It should be routine to ask about the neuro-psychiatric disorders on both sides of the family.

The possible parental genetic contribution to the disorder of the child should be assessed (e.g., the existence of bipolar disorder in the father would cast his son's depressive symptoms in a different light), but almost no psychiatric disorder appears through genetic transmission alone, although increased vulnerability to various disorders is likely (Luthar & Prince, 2008). Though unspoken during the psychiatric evaluation, many parents fear that their other children may be destined to be affected when one sibling has a disorder, so clarification of the genetic contribution to the expression of disorders can often be helpful in reducing fear, guilt, and distress among parents and siblings.

The clinician should be attentive throughout the interview to parents' psychopathology (e.g., a depressed mother will often give more negative reports about a child's behavior than a parent who is not depressed.)

Strengths

It is a capital mistake to focus only on the patient's and family's deficits and to neglect the almost always existing strengths, which can give important hints for treatment. Such an approach supports the self-esteem of both the child and the parents and provides information about factors that may help to ameliorate or compensate areas of vulnerability.

"It is important that the tenor of diagnostic inquiry should convey an appreciation that the child is not merely a patient or bearer of symptoms" (King, 1997)

Explanations

It is very informative to ask about the ideas parents have about the nature and causes of their child's behavior in order to know what psychoeducation

interventions may be necessary. To understand how parents and the child understand the evolution of their symptoms can also give important references to the cultural background of this specific family (Sholevar, 2007).

Concluding the interview

Allowing the interview to end in a collaborative fashion increases the likelihood that child and family will feel positive about it and any subsequent clinical encounters. Suitable questions at this stage are:

- *"What else have I not asked about that is important?"*
- *"I have asked you a lot of questions. Do you have any questions for me?"*

"When I meet the parents of a child who suffers from a mental disorder, the first thing I ask them is to tell me what is the most special thing about their child, which abilities, resources, feelings, and talents they recognize in him/her." (Giovanni Bollea, Italian child psychiatrist)

INTERVIEW WITH PARENTS

Aims of the interview with parents

The parental interview seeks to clarify:

- Which aspects of their child's behavior is of greatest concern to them
- What they have tried in order to deal with the problem
- The impact of the child's disturbance on the rest of the family
- If the problem behavior is situation-specific or pervasive (e.g., restlessness and inattention at school but not anywhere else could cast doubt on the presumptive diagnosis of ADHD)
- If there are neuropsychiatric disorders in the family.

Parents sometimes fear that they are the only ones who have a problem with their child. It can be a relief to hear from the clinician that such problem is not uncommon and that he or she has seen and helped many families with this type of problem.

Standardized interviews

Standardized interviews (diagnostic tools with specific questions in a given sequence) are often used in research but can also be an effective help in daily practice. On the one hand, especially for beginners, standardized interviews (especially for developmental and family history) can help cover the key domains of psychopathology. They ensure that clinicians inquire systematically about a broad range of symptoms, particularly those that may be clinically significant but are not the presenting complaint. Using these instruments makes it less likely that comorbid disorders will be missed. On the other hand, these tools can never take the place of an individualized psychiatric interview; they cannot be relied upon as the sole basis for establishing diagnosis or planning treatment. Further, many are only symptom inventories and do not ask for important symptom-related information like situational context, ways of coping, feelings etc (Le Couteur & Gardner, 2008).

"It is of the highest importance in the art of detection to be able to recognize, from a number of facts, which are incidental and which vital. Otherwise, your energy and attention must be dissipated instead of being concentrated." (Sherlock Holmes, "The Reigate Puzzle")

THE CHILD INTERVIEW

The aims of the child interview are to:

- Gain the child's trust. In general, the younger the child, the more time is needed to achieve this
- Obtain the child's perception of the problem
- Get a good understanding of the child's current developmental stage
- Obtain information about emotional symptoms, traumatic events, delinquent acts, drug use, sexual problems
- Collect data for the mental status examination (see below).

Children can often indicate an acceptable point for the parents to leave the room, usually within a matter of minutes, and transitional objects (blankets, teddies) may ease this transition, although this may be impossible in cases of separation anxiety. The older the child the sooner you should be able to finish the conjoint session. Children often find it embarrassing to listen to their problems being discussed in front of them.

"The clinician must be aware of the impact on the interview process of perceived differences or similarities between the clinician and the child (or parents) in terms of gender, age, and ethnic or social background." (King, 1997)

How to start?

Once parents have left the room, it is wise to begin the interview with neutral topics that may interest the child such as talking about favorite hobbies, animals, holidays, Christmas or birthday presents. The next step is to inquire about what the child has been told or understands about the purpose of the interview; this often provides information about the relationship and openness of communication between child and parents as well as on the cognitive development of the child. Some children need encouragement to express their *own* concerns, instead of the worries of parents or teachers. Be aware of how you word your questions: younger children are particularly open to influence of suggestion.

Without trust and rapport, valid information is less likely to be obtained.

Developmentally appropriate interview techniques

Preschool children should not be expected to sit still during the interview and the interviewer needs to decide what play material will be made available for the child. Developmentally appropriate techniques include drawing, playing and direct questioning. The appropriate method for each case will depend on the age of the child (the developmental age more than the chronological age) and the presenting problems (e.g., selective mutism). Inviting the child to draw a picture is almost always a good start. Direct questions should be short, in simple, precise vocabulary and deal with one concrete issue at a time (Jones, 2003). For example, not "Do you get into trouble at school, get along with other students and like sports?" but "Are you getting into trouble at school?"

The child's description of feelings, mood, levels of distress, and significant events contribute to a better understanding of the child's predicament.

Getting involved in the child's play can help to:

- Empathize with them
- Assess their affective state
- Ascertain their coordination and motor skills
- Evaluate speech and language development
- Test attention span
- Understand their capacity for complex thinking
- Assess their capacity for interactive play and "as if" games (especially important when a pervasive developmental disorder is suspected)
- Collect information for the mental status examination (see below).

Generic toys are preferable since they are more likely to evoke the child's specific concerns rather than the prefabricated scripts associated with toys based on TV shows or movies. (Bostic & King, 2007)

Questions to explore children's inner feelings include:

- "What animal would you most/ least like to be?"
- "Who would you take with you to a desert island?"
- "What would you ask for if you were granted three magic wishes?"

Interviewing adolescence patients

The overall sequence is similar to when interviewing other children. However, one would spend considerably more time with the adolescent alone. It is crucial to avoid the perception that parents and clinician are allied against him.

The purpose, duration, confidentiality issues, and the role of the clinician should be discussed early in the child interview in developmentally appropriate terms. Sample questions:

- "What did your parents tell you about coming here today?"
- "How do you feel about being here?"

A suitable way to begin the interview with adolescents is to review and clarify what the adolescent believes and has been told about the purpose of the interview. Adolescents are very sensitive to beliefs that they are perceived as weak, weird or different, about being included or excluded, and about fairness and justice. In this line, useful questions for adolescents include:

- "What do you see as fair or not fair in your life?"
- "What would you most like to change in your school/ family/ the world?"
- "What are your plans for the next 10 years?"

Contrary to popular beliefs, asking about suicide will not induce or trigger it. A caring clinician may be the only adult able to talk about these thoughts with the adolescent.

Confidentiality: "*will you tell my parents?*"

One of the key concerns among adolescents in relation to seeking medical help is confidentiality. Adolescents should always be informed of the confidential nature of the doctor-patient relationship and its limits at the outset: that confidentiality would be broken without the patient's consent only if the patient's safety or the safety of others is at risk. Many countries impose statutory obligations on mental health practitioners to report instances of abuse. Laws in this regard vary and clinicians need to be up to date with the local requirements. The best way to discuss confidentiality is at the beginning of the interview, when the parents and adolescent are present, thus educating parents that what their child discloses is kept confidential.

"Never trust general impressions, my boy, but concentrate yourself upon details."
(Sherlock Holmes, "A Case of Identity")

Special areas of interest for the interview with adolescence patients

- Antisocial or delinquent behavior (e.g., *"Have you done anything that you now look back on and think that was pretty dangerous?")*
- Sexual identity and activity (e.g., *"Have you ever had romantic feelings toward anyone?"* Try to avoid asking questions to a male/female teenager like *"Is there a girl/boy whom you like?"* that may be interpreted by them that you assume heterosexuality when adolescents may be struggling with homosexual feelings
- Alcohol and substance abuse (start with previous exposure, context use – parents, friends, effects of substances – whether they believe that substances alleviate their symptoms, e.g., self-medicate).
- Suicidal ideation or behavior, including non-suicidal self-injury (e.g., *"Do you sometimes feel an urge to hurt yourself?", "Have you ever thout that your life was not worth to live?")*

"The day may come when there are drugs that are specific to particular diagnoses but that day is a long way off at the moment. Both psychological and pharmacological treatments need to focus on particular patterns of symptomatology rather than the diagnosis as such" (Rutter & Taylor, 2008)

MENTAL STATUS EXAMINATION

The aim of the mental status examination (MSE) is to be an objective description, not interpretation, of the child's appearance, symptoms, behavior and functioning as manifested *during the examination*. A well-written MSE enables another clinician or the same clinician weeks, months or years later to have a clear picture of the patient's mental state at the time of assessment. The MSE is an essential part of any psychiatric examination (see Table A.5.1). Strictly speaking, the MSE is purely descriptive, includes no judgment of whether the appearance and behavior is normal or abnormal, clinically significant or non-significant.

Most disorders do not show abnormal feelings or behaviors that cannot be found in normal children or adolescents in some circumstances. The severity

Table A.5.1 Mental status examination

MSE component	Take notice of:	Example
Physical appearance	• Age (actual and apparent) • Age-appropriate clothes, • Grooming and cleanliness • Dysmorphic features, bruises, scars	"Stephanie is a pleasant looking, well groomed and appropriately dressed 9-year-old girl who looks older than her age (like a 12 year old)"
Manner of relating to examiner and parents, including ease of separation	• Eye contact • Ability to cooperate and engage with examination • Behavior towards parents and siblings	"She avoids eye contact but cooperates with the examination process."
Mood and affect	• Type, range and appropriateness of affect (e.g., depressed, elated, irritable)	"Stephanie looks depressed (e.g., cries often, does not enjoy activities and pastimes, feels hopeless), her affect shows limited variation (i.e., within a narrow range) and she describes a depressed mood"
Anxiety	• Fears • Phobias • Obsessions • Compulsions or rituals • Separation difficulties	"She shows no evidence of unwarranted fears or anxiety symptoms"
Psychomotor behavior (including activity level and unusual motor patterns)	• Tics, mannerisms • Activity level • Coordination	"Activity level seems reduced"
Form and content of thinking	• Hallucinations • Delusions • Thought disorder	"Thinking is slowed down but coherent. There is no suggestion of hallucinations or delusions."
Speech and language	• Fluency • Volume • Rate • Language skills,	"Her speech is age-appropriate. There is no pressure of speech."
Overall cognitive functioning	• Developmentally appropriate vocabulary • Fund of knowledge • Appropriate drawings	"Her cognitive ability seems impaired and her vocabulary is below average for her age."
Attention and concentration	• Attention • Concentration	"Becomes easily tired and appears to have difficulty following conversations over a long period."
Memory	• Short-term • Long-term	"Shows no deficits in recalling events."
Orientation	• Orientation in time, place, person	"Is oriented in time and place."
Judgment and insight	• Acknowledgement of problems • Capacity to judge hypothetical situations • Attitude towards receiving help • Compliance with treatment	" patient is aware of the fact that she has a problem, wants to be helped and cooperate with treatment"
Examination of risk	• Suicidal thoughts or behavior • Self-harming behavior • Thoughts or plans of harming others • Risk-taking behavior	"There is no evidence suggesting suicidality or threats to others."

Source: King (2007) modified.

(amount), pervasiveness and nature (quality) of the symptoms determines their clinical significance.

Although presented as a separate component that is distinct from the history-taking, in reality much of the MSE takes place implicitly as the clinician interacts and observes the child during the individual and family interviews. While some components of the examination may require specific inquiry or examination (e.g., orientation, memory, specific symptoms such as hallucinations or obsessions) most will be noted as the interview progresses.

Clinicians should use every opportunity to observe the patient and his interaction with others, particularly with the family. For example behavior:

- In the waiting room (e.g., how did they choose to sit? Are they talking to each other? Arguments?)
- During the initial greeting and introduction
- In the office
- Upon separation (e.g., when parents leave the room)

Describe before interpreting

Since any given symptom may have different meanings, functions and clinical implications in different children it is important not to jump from symptom to diagnosis.

Table A.5.2 Psychiatric symptoms and examples for corresponding somatic differential diagnoses

Symptom	Differential diagnosis
Depression	• Neurological disorders (e.g., tumor, epilepsy, trauma, cerebral atrophy) • Endocrine disorders (e.g., hypo-/ hyperthyreosis, Addison's disease, Cushing's disease) • Kidney diseases (e.g., chronic nephritis) • Metabolic diseases (e.g., hypoglycemia) • Infectious diseases (e.g., AIDS, Lyme borreliosis) • Intoxication (e.g., alcoholism) • Malignant disorders (e.g., chronic leukemia) • Pharmacologic: antihypertensives (e.g., beta blockers), antiepileptic drugs, psychotropic drugs (e.g., neuroleptics, barbiturates), steroids (e.g., glucocorticoids), analgesics • Other: tuberculostatics, antibiotics, cytostatics, antimycotics
Psychosis	• Neurologic disorders (e.g., brain tumor, epilepsy, encephalitis, infections, multiple sclerosis) • Illegal substances (e.g., marijuana, cocaine, LSD) • Intoxication (e.g., alcohol) • Pharmacologic: psychotropic drugs , anticonvulsants, anticholinergics, steroids, antibiotics
Anxiety	• Substance-use disorders: drugs, amphetamine, cocaine, hallucinogens, alcohol, nicotine, caffeine, ecstasy, opioids • Neurologic disorders: organic seizures, migraine, multiple sclerosis, increased intracranial pressure, reduced cerebral perfusion • Other medical disorders: hypoglycemia, hypoxia, hyperthyroidism, carcinoid, dysrhythmia, pheochromocytoma
Anorexia nervosa	• Cancer • Endocrine disorders (e.g., hyperthyroidism, diabetes mellitus) • Gastro-intestinal disorders(e.g. Crohn's disease, ulcerative colitis, gastritis, gastric ulcer) • Malabsorption (e.g. coeliac disease)
Enuresis	• Urological and genital abnormalities (e.g., urethral valve, labial fusion) • Urinary tract infection • Neurologic disorders (e.g., myelomeningocele, spina bifida, tethered cord) • Other medical disorders (e.g., diabetes mellitus)

Source: Herpertz-Dahlmann & Bachmann (2007), modified.

- During psychological testing
- During physical examination

MEDICAL HISTORY AND PHYSICAL EXAMINATION

The aim of the medical history and physical examination is to identify causative, associated or exacerbating medical problems; it has the potential to uncover a treatable somatic condition. Medical conditions can:

- Increase the child's risk for psychopathology
- Be relevant for treatment
- May explain the current psychopathology.

While physical illness mimicking psychiatric disorder is relatively rare in daily practice, knowledge of these possible "diagnostic traps" is important (Table A.5.2.). If there are hints in the medical history that medical conditions or treatments play a role in this patient, further investigations should be done.

Don't forget the somatic part of your diagnostic process, but mental health clinicians also need to know when to accept that a child has been adequately examined and investigated.

We suggest a *stepwise approach* to this part of the examination (time and cost-effective):

- Step 1: brief medical history
- Step 2: basic physical examination.

If steps 1 and step 2 are unremarkable, it seems reasonable to avoid further examination and investigations. If further examination is necessary:

- Step 3 (if indicated by steps 1 or 2): investigations and specialist referral.

Past medical history

A systematic history-taking approach should be used as a guide to the possibility that somatic problems might be relevant with respect to the presenting symptoms. This includes a clinical history of medical disorders in the patient and in the family. Studies have shown that medical history-taking often influences management while physical examination only rarely does (Dooley et al, 2003).

Red flags that would suggest the need for a more detailed physical examination (step 3) include:

- Atypical presentation of symptoms or atypical age of onset (e.g., hallucinations in a 7-year-old girl)
- History of seizures
- History of head trauma or central nervous system infection
- Regression in development
- Over the 97th or under the 3rd percentile in any of the growth curves
- Suggestions of child abuse or factitious illness (e.g., Münchausen by proxy)
- Sudden onset of new and odd behavior (e.g., hand flapping in Rett syndrome)
- Altered level of consciousness, severe fatigue, cognitive changes, and physical symptoms such as sore throat, fever, headache, nausea, and weight changes

Parents will occasionally report a loss of previously acquired skills; this always needs to be taken seriously and should lead to suspicion of neurodegenerative disorder and specialist referral.

- Acute onset of obsessions and compulsions and or motor or vocal tics, particularly following pharyngitis (PANDAS, see Chapters F.4 and H.5).

The following checklist lists all relevant parts of a medical history in child mental health:

"The little things are infinitely the most important." (Sherlock Holmes, "A Case of Identity")

Pre- and perinatal development

- Consanguinity of the parents?
- Use of assisted reproductive technologies?
- Pregnancy (full range of teratogens: alcohol, tobacco, illicit substances, medications; history of rashes and fever during pregnancy – may indicate exposure to congenital viral infection)
- Previous neonatal deaths or acute life-threatening episodes in siblings (could be a pointer towards inborn error of metabolism)
- Previous spontaneous abortions (two or more) – one in 20 of these parents will carry a chromosome translocation or inversion (Gardner & Sutherland 1996)
- Birth and neonatal history: gestational age at birth; weight; APGAR score, if available (difficult birth is a risk factor for developmental problems).

Table A.5.3 Overview of developmental milestones

Age	Motor skills	Language
3 months	Holds head steady	Imitates sounds
6 months	Can roll over	
9 months	Sits without support	Combines syllables into word-like sounds
12 months	Stands alone	Uses 20 single words
15 months	Walks alone Plays with ball	
18 months	Carries items while walking	Can make two-word sentences
2 years	Can run Can kick a ball forward	Child uses own name Asks "Why?" Can name at least six body parts
3 years	Jumps, balances on one foot	Uses four to five words in a sentence Uses singular and plural
4 years	Bounces	Uses past tense, recounts experiences
5 years		
6 years	Bounces cross-step	Language development completed

*Use only as rough reference.

Accidents or illnesses with a potential for central nervous system impact deserve specific inquiry.

- Lead exposure
- Seizures
- Head trauma
- Loss of consciousness.

Postnatal development

Early developmental history (up to 5 years). Encourage bringing parent-held records of vaccinations etc to the first examination if available. A general view of the milestones of development is given in Table A.5.3.

History of past illnesses

Common disorders in childhood (e.g., asthma) should lead to an enquiry into medications that the child takes, both prescribed and over-the-counter. All extended hospital stays after birth; surgical procedures; vaccination; states of loss of consciousness and seizures; hearing or vision difficulties; allergies (particularly to medications); and response or side effects to previous medications should be collected.

The clinician should be especially alert to the mentioning of diseases that can affect the central nervous system including HIV/AIDS, tuberculosis, lupus erythematosus, epilepsy, migraine, traumatic brain injury thyroid disorders, diabetes.

Basic physical examination

Who should do medical examination?

Physicians who keep up their skills to perform a physical examination (for which they usually worked hard in medical school) this can provide an additional opportunity to learn more about the child's concerns (especially about body-related

Table A.5.4 Skin inspection in child psychiatry

Dermatologic symptoms	Possible hints for:
• Needle tracks, abscesses or hyperpigmentation on the arms	• Substance use disorder
• Bruises, hematomas of different age	• Child neglect • Physical abuse
• Signs for non-suicidal self-injury (e.g., scars)	• Borderline personality disorder[a]
• "Café-au-lait" marks after age of 1 year >1.5cm • Freckling in armpits after 3 years	• Neurofibromatosis type 1[b] (rare)
• Ash-leaf depigmented macules • Adenoma sebaceum • Periungual fibromas	• Tuberous sclerosis[c,d] (rare)
• Port wine stain usually in the trigeminal region	• Sturge Weber syndrome[b] (rare)

[a]The most common location for non-suicidal self-injuries is the inner part of the left under arm.
[b]Neurofibromatosis Type 1, tuberous sclerosis, and Sturge Weber syndrome are neurocutaneous syndromes (phakomatoses). These disorders affect the central nervous system, the skin and the eye. All these tissues have a common ectodermal origin.
[c]0.4%-3% of children with autism are found to also have tuberous sclerosis (Smalley et al, 1991).
[d]The best diagnostic test is a cerebral MRI.

Click on the picture to access an 8-minute crash course on neurocutaneous disorders.

issues) and about the mental status. For psychologists and other mental health professional with a non-medical education it is practical to find out if there had been a physical examination of the child in the recent past or to refer the patient to a physician (optimally, a pediatrician).

A screening neuro-developmental examination is sufficient and does not require the child to fully undress.

The following parameters should be assessed:

- Height and weight (centile charts)
- Head circumference (centile charts; the most common cause of large and small heads is simply familial, and thus comparison of mid-parental head centiles should precede interpretation of a single measurement)
- Blood pressure (use an appropriate cuff for the size of the child – e.g., one that covers two-thirds distance from the elbow to shoulder; interpret with age-appropriate values)

The following procedures should be undertaken:

- Skin check (see Table A.5.4)
- Basic neurological examination:
  - Stance and gait
  - Tests for cerebellar function (e.g., check for dysdiadochokinesia)
  - Tone, power, reflexes
  - Abnormal movements (fasciculations, tics, myoclonus, dystonia, athetosis, hemiballismus, tremor).

Of all the aspects of the neurological examination, observing the child's gait is the most valuable. A normal gait depends on intact and delicately balanced motor, sensory, and coordination systems. A normally walking child is unlikely to have a severe neurological impairment (Wolf et al, 2008).

Investigations, tests and specialist referral

The range of investigations, tests and specialist referrals available may vary substantially from country to country. What is described here is the optimal situation but many of these investigations will not produce positive findings in the immense majority of cases:

- Blood tests
- Urine tests (toxicology screen, pregnancy testing)
- Brain imaging (first choice: MRI; second choice: CT)
- Genetic investigation (key pointers in physical examination: noticeable dysmorphy of the face, hands and feet; over the 97th or under the 3rd percentile in any of the growth curves).
- Metabolic investigation (key pointers in history: consanguinity, failure to thrive, episodic decompensations, often during minor illnesses; hepatosplenomegaly, coarse facial features). A general metabolic screening is more useful than a genetic investigation, EEG or cerebral imaging, and may therefore be more worthwhile.
- Electroencephalography (EEG)

If you suspect a rare metabolic or genetic disease and you do not have the option of referral to a specialist, click on the picture to access "orpha.net" and check the "search by signs" function. This portal (for rare diseases and orphan drugs) is available in English, Spanish, German, Italian, French and Portuguese.

Use any chance you have to see children with rare disorders. Knowledge of what phenotypes exist is a precondition for their recognition. Phenomizer is a site with useful information that allows clinicians to enter a patient's clinical features and obtain probabilistic differential diagnoses. For a tutorial on how to use Phenomizer click here.

Rating scales are tools to complement an evaluation, not to replace it.

- Electrocardiogram (EKG)
- Hearing examination
- Eye examination.

RATING SCALES AND PSYCHOMETRIC ASSESSMENT

The aim of this section is to give readers a brief overview of tools that may assist in finding the right diagnosis and in individualizing treatment.

"There is nothing more deceptive than an obvious fact."
(Sherlock Holmes, "The Boscombe Valley Mystery")

Rating scales

Rating scales are instruments (paper and pencil or computer-based) used to collect data about the presence (qualitative measurement) and severity (quantitative) of symptoms. Rating scales can be used as a source of additional diagnostic information, to monitor and measure the effectiveness of treatment (outcome), and as research tools. They can also be used for screening, to ascertain whether a child should be evaluated more thoroughly for mental health disorders (Verhulst & Van der Ende, 2008).

Pros and cons of rating scales

Pros:

- Helping to detect problems that are clinically significant but not part of the presenting problem
- Helping to conduct a comprehensive examination
- Some parents and adolescents may reveal concerns in writing that they do not verbalize
- Rating scales can be completed by parents, teachers, and patients outside the interview and so help to make the interview more effective and efficient
- Scales that rate severity can be useful to quantify a baseline to later assess response to treatment (e.g., ADHD-symptom checklist before and after treatment with methylphenidate).

Cons:

- Require time and literacy
- May be disliked by parents or children

Table A.5.6 The Strengths and Difficulties Questionnaire (SDQ)

Purpose	Languages	Comments
Screening for mental health disorder in children and adolescents (Goodman et al, 2000)	Available in 73 languages	• Free for noncommercial purposes • High SDQ-scores –upper 10% in a community sample – were associated with increased psychiatric risk • Used worldwide • Very brief: 25 items all in one page • High specifity but low sensitivity (use only as a screening instrument) • Can be completed by the patient on-line and get immediate feedback.

Source: Carandang and Martin (2009).

- Require time to rate and analyze
- Clinicians may over-rely on them.

There are rating scales for completion by the patient, the clinician, the parents, teachers and other informants (e.g., youth workers). A combination of these tools is used in everyday practice. An example of a rating scale used worldwide – available free in numerous languages for noncommercial purposes – is the Strengths and Difficulties Questionnaire (SDQ), presented in Table A.5.6. Completed by parents, teachers, the child, or all of them, the 25 SDQ items were designed to include both strengths and difficulties. The SDQ is a generic scale to rate a wide range of problems. In many cases, however, particularly if a specific disorder is suspected (e.g., depression, ADHD) using a more detailed, targeted rating scale in addition to a generic one is useful (see the diagnosis section of the respective chapter in this e-book).

Psychometric assessment

The art of an effective psychometric assessment is the accurate use and valid interpretation of psychometric tests. Test results may help clinicians to:

- Find the diagnosis or comorbidity
- Identify the individual's profile of cognitive strengths and weaknesses
- Plan treatment (e.g., the level of communication in future psychotherapy).

There are a huge number of psychological tests for children and adolescents and the choice depends on the individual patient, the suspected diagnosis and the knowledge and experience of the tester. Assessment of the patient's cognitive functioning is often helpful for diagnosis and treatment planning (see Chapters C.1 and C.3).

Intelligence: "the sum of all higher mental processes"

There is disagreement among experts on what exactly *intelligence* is but there is strong empirical evidence that intelligence tests measure something meaningful about development, cognitive abilities and adaptive behavior (Charman et al, 2008). The *intelligence quotient (IQ)* shows moderate to high stability over time and correlates highly with real-life outcomes, such as academic achievement, employment and income.

Suitable IQ-Tests have age-graded norms and are well standardized (see Chapter C.1). *When* a test was normed is relevant because there has been a modest increase in scores over time in some countries, possibly due to improvements in diet and education. Standardized intelligence tests produce scores with a mean of 100 and standard deviation of 15. Standard scores are then used to define average, below average or superior ability depending on how many standard deviations above or below the general population mean a child's performance lies. An IQ below 70 is a strong indicator for the existence of an *intellectual disability* (see Chapters C.1).

Observation of the child in the test situation is an important part of assessment. The following characteristics should be documented and considered when interpreting the test results:

- Degree of cooperation with the examiner

Testing the theory of mind: the Sally/Anne test

The Sally/Anne test is a psychological test with dolls, used in developmental mental health to measure a person's social-cognitive ability to attribute false beliefs to others (i.e., the theory of mind, for more details see Chapter C.2). The clinician uses two dolls, "Sally" and "Anne". Sally has a basket; Anne has a box. Clinicians show the children a simple sketch, in which Sally puts a marble in her basket and then leaves the scene. While Sally is away and cannot watch, Anne takes the marble out of Sally's basket and puts it into her box. Sally then returns and the children are asked where they think she will look for her marble. Children are said to "pass" the test if they understand that Sally will most likely look inside her basket before realizing that her marble isn't there. Children under the age of four, along with most autistic children (of older ages), will answer "Anne's box," seemingly unaware that Sally does not know her marble has been moved.

Click on the picture to access a video clip explaining the Sally/Anne test.

"There is nothing more stimulating than a case where everything goes against you."
(Sherlock Holmes, "The Hound of the Baskervilles")

- Activity and concentration level
- Social and communication skills
- Specific areas of difficulties

Test results may be influenced by:

- Language problems
- Motor coordination problems
- Medications
- The current psychopathology (e.g., depression)
- Vision and hearing problems.

If there are major discrepancies between the test results and the child's performance described by parents or teachers or with the clinical observations, this will always require further study.

The examination is not complete until findings are communicated to parents, the child and referring agency.

COMMUNICATING FINDINGS AND RECOMMENDATIONS

The aim of this last but essential part of the examination process is to summarize the findings into a clinical formulation, a clinical diagnosis and to communicate them in a clear and helpful way to all relevant parties. This may require one or more sessions where treatment recommendations and options are discussed and decided upon.

In most cases it is useful to spend some time processing all the information collected, scoring rating scales and considering the differential diagnoses and recommendations. Parents may be anxious to hear what is wrong with their child (and family). So, much sensitivity is required. Disappointment, sadness or grief, denial and other emotions are common, especially when the diagnosis destroys expectations about the child's future.

Guiding principles for feedback:

- Plain, non-technical language
- Nonjudgmental
- Strength-orientated
- Sensitive
- Practical.

You need to be aware that *very little* of the information you give *will be retained*, especially if the session is highly emotive. So, in some cases you may

provide a report or a succinct written summary for the parents. If appropriate and feasible, offer further sessions to discuss issues once the family has had the chance of working through the information.

Never let a family go with just the diagnostic information. Always present them with treatment options and hope.

An explicit emphasis on the child's and the family's *strengths and abilities* facilitates the feedback process and gives a more realistic picture of the patient as an individual rather than a mere illness-oriented diagnosis. Avoid technical terms and psychiatric jargon (instead of: "*The theory of mind of your daughter is insufficient*" it seems better to say: *"Sally has some problems understanding that others have beliefs, desires and intentions that are different from her own."*). Just naming the diagnosis is never enough. Explain the rationale for the diagnosis and influencing factors. The formulation is more helpful than a simple clinical diagnosis in understanding and helping the child and the family. Explain if *areas of uncertainty* remain, including whether diagnosis can change over time and what the likely outcome, treated and untreated, might be. If the diagnosis is provisional, be clear that you are not sure.

"To cure sometimes, to relieve often, to comfort always." (Edward Livingston Trudeau, 1848-1915)

With or without the child?

- Depending on the nature of the problem and the developmental stage of the child it may be appropriate for the child to be present. If yes, take a few minutes and explain your findings to the child directly. A good strategy is to start describing the strengths of the patient, then talk about the difficulties and the options to reduce them, and end again talking about the strengths and instilling hope that the current situation will get better
- Provide a clear focus for therapeutic intervention.

Clinicians have to ensure that findings and recommendations are:

- Heard
- Understood and
- Experienced as helpful.

"Nothing clears up a case so much as stating it to another person."
(Sherlock Holmes, "Silver Blaze")

To enhance compliance with future treatment, rather than experts, clinicians should become partners with the patient and family in the decision-making process. In most cases it is possible to outline several treatments, with their risks and side effects, and help parents decide which one they wish to follow. If parents are eager to pursue treatments that are unhealthy, unproven or dangerous, the clinician should highlight the risks of such a decision.

When discussing prognosis, it is necessary to combine instilling hope with a realistic view of the long-term outcome of the disorder. In many cases the long-term therapeutic goal will be finding ways to live with the illness (including the risk of recurrences), than a cure.

There is an imperfect match between the neat diagnostic descriptions given in textbooks and the clinical presentations seen in clinical practice. Clinicians must always be on the alert for unusual patterns that do not fit existing diagnostic conventions.
(Rutter & Taylor, 2008).

TROUBLESHOOTING

The following advice is in case you feel lost in the evaluation process and have no idea about the right diagnosis in a particular child. The sequence should be applied flexibly:

- Ignore the DSM and ICD constructs for a moment and go back to the description of the problems. Just try to describe as well as you can what is unusual in this patient. After that, think again about which diagnosis(es) match this pattern of symptoms

- Talk with a colleague about this case, especially experienced ones
- If possible, videotape an examination (with the permission of patient and parents), show it to colleagues and ask for their opinion
- Maybe there is nothing wrong with the child. For whatever reason the child is presented seeking help when a family member is the one with mental health problems
- It is often not possible to conduct the whole diagnostic process in one appointment
- If you get stuck in the differential diagnosis, remember that common disorders are frequent and rare disorders are rare
- Symptoms can present atypically in cases with multiple comorbidities (e.g., depression in an autistic child)
- If you have a prime suspect diagnosis but you are still unsure, then check the differential diagnosis part of the respective chapter in this or another good-quality textbook (see References)
- Do not ignore possible somatic diagnosis, side effects of medications or effects of illicit drugs
- Think about the possibility of factitious or shared disorders (e.g., a mother with schizophrenia makes her young child believe that both are being pursued by the secret service)
- There will always be cases in which symptoms do not fit in with a specific diagnosis because classification systems are not perfect and presumably will never be. As Leo Kanner, a pioneer child psychiatrist, put it in the title of his paper on differential diagnosis: "The children haven't read those books" (Kanner, 1969).
- There will be cases in which there is no suitable diagnosis, because the illness is not yet described or, more likely, because the patient has no psychiatric or medical illness but a problem of living and is more in need of advice than of complex therapy.

"When you hear hoof beats behind you, don't expect to see a zebra" (Theodore E Woodward MD)

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*Recommended reading.