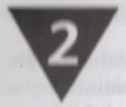

The Psychiatric Evaluation

Essential Concepts

- Providing a comprehensive initial psychiatric evaluation is the cornerstone for all effective treatment planning.
- The psychiatric evaluation is typically initiated by adults, and engaging the child, as well, is essential.
- A comprehensive evaluation includes gathering information from multiple sources (parents/guardians, school, primary care provider, child, and others).
- Inventory strengths as well as deficits/areas of need.
- The assessment of parent and family functioning is integral to the evaluation.

> The work of psychological healing begins in a safe place . . . The psychological safe place permits the individual to make spontaneous, forceful gestures and, at the same time, represents a community that both allows the gestures and is valued for its own sake."
>
> —Lester Havens, M.D.
> *A Safe Place*

The psychiatric evaluation of a child or adolescent is not just a diagnostic interview and checklist of DSM-IV symptoms. It is much more—forming a rapport with the patient and family, learning about the child's functioning in multiple domains and from multiple sources, and assessing the child's family functioning (or environmental match if the child or adolescent is not living in the home). 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.

BASIC PRINCIPLES

Special Considerations in Evaluating Children

The psychiatric evaluation of a child or adolescent has a number of important differences from that of an adult:

- The referral is typically requested by someone other than the patient. The child (or adolescent) may feel ashamed, angry, or convinced that the evaluation is a punishment for being "bad." Try to set the stage to be as nonjudgmental and collaborative as possible, giving the child as much control as is appropriate and safe.
- Children are not just little adults. Remember the developmental stages (Chapter 1) and what to expect of a child of each age.
- Different methods of collecting data and interviewing the child apply at different ages. The goal is to understand the child's inner world and perspective. Techniques may range from observing an infant–parent dyad, or using play to understand the preschool and young elementary school child, to talking directly about symptoms with the adolescent. Remember to alter the approach to fit the developmental needs of the child. Drawing may be a helpful adjunctive tool at any age.
- The assessment of parental and family functioning is crucial. It is not possible to conduct an adequate assessment without an understanding of important environmental characteristics and family relationships, as well as the child's response to them.
- Use multiple informants. It is important to know if the child is having difficulties in all contexts, or only specific ones (for example, doing well at home, but having behavioral difficulties at school). This may help clarify the nature of the difficulty and point to specific areas for remediation.
- Diagnoses are more complicated in children. Although children may technically be diagnosed with almost any DSM-IV diagnosis, the varying presentation of symptoms at different ages, the evolution of disorders, and the lack of diagnostic and etiological specificity for many symptoms (impulsivity and aggression, for example) make diagnoses more fluid and unclear. It should be clarified that the diagnosis may change over time. However, this should not delay intervention and treatment of disabling symptoms.

Defining the Purpose of the Evaluation

Although many components to a psychiatric evaluation are similar to that of adults, how it is conducted, what information you need to glean, and how the information is used may be very different. Before you start, consider the purpose of the evaluation and use this information to structure the evaluation to fit the reason. Possible referral sources include:

- Parents (recommended by school, friends, relatives, themselves)
- Legal guardian (or state custody)
- Schools—they are paying for an evaluation of a student about whom they have concerns
- Courts—the child has legal issues, custody issues

The dynamics of the evaluation and how and where you conduct it depend on *why* you are doing the evaluation.

TIP

Most families and children are intimidated by the prospect of seeing a psychiatrist. Depending upon the reason for and source of referral, you may have more or less buy-in for the evaluation. Clarify the reason up front and be attuned to the reactions of the entire family to your meeting. If another agency has recommended the evaluation, the parents may be suspicious about the process. Never ignore these subtle (or not so subtle) cues.

CLINICAL VIGNETTE

I was conducting an evaluation for a school system of a child with learning issues and acting-out behavior. The first meeting with the parents sought to clarify the dynamics of the evaluation.

Interviewer: *Hello [shaking hand of each parent and sitting down]. You know that I am a child and adolescent psychiatrist and that I have been asked by the school system to evaluate your son?*

Father: *Right [looking disgruntled].*

Interviewer: *I notice that you look unhappy to be here. Perhaps we can review what I have been asked to do to be sure that this is what you want.*

In this case, the parents had requested a therapeutic school for their son (a school placement which would be expensive for the district and would place him with other special-needs children). The school district disagreed and maintained he would be better served in his home school. The parents felt the psychiatrist was a "hired gun" to prove the school's view that the child could be programmed for within-the-home school. The parents felt coerced and helpless. Bringing that out early in the interview helped to identify a needed aspect of the consultation—addressing the school–parent tensions.

KEY POINT

Who is paying for the evaluation is not a minor detail. Being an expert witness for one or the other side of a court case can strongly influence the "spin" of the same information. Be clear with yourself and your referral source who your client is. If the school or other agency is asking for a hired gun, be clear with everyone what you do. I find that the "best interest of the child" model works best. I try to keep my assessments focused on what I believe will ultimately lead to a more healthy developmental outcome for the child.

Setting the Stage

Setting the stage before you even meet the child or family is critical. Different clinics or private practitioners do this in different ways. Parents are often intimidated by the prospect of the evaluation, and few have a good notion of what it will entail. Most clinics use written statements of policies and procedures. As a trainee, you should know what information is given to families about policies and familiarize yourself with these. The following information should be included in communication (either on the phone or in the first session) with the parents or guardians before you begin:

1. Who you are—parents and guardians frequently need clarification about what different mental health professionals do. Explain your training and area of expertise.
2. What the psychiatric evaluation entails—with whom you will meet, in what order, what you do in the sessions, and what other information is needed.

3. How long it will take—how many sessions, how long per session.
4. What it will cost—for the evaluation as well as for ongoing treatment afterwards, if required.
5. What they can expect at the end—recommendations: a written report, ongoing treatment, etc.
6. What your policies are (define for patients and their families)—how and when to contact you, what to do in the event of an emergency, who you have permission to contact about the patient (HIPAA-friendly release of information forms required), and how you deal with missed appointments. Review for whom the evaluation is being done (parents or other agency) and the extent of confidentiality.
7. What to tell the child or adolescent to prepare him or her for the appointment.

If you are in a clinic, much of this work will be done by the intake person. Reiterating the information above is needed to clarify the goals and expectations for the evaluation.

The most uncomfortable part of an entire encounter for the clinician tends to be talking about billing. Although working in a clinic may spare you this difficult task, it is still important to mention it—to reiterate what the billing procedure is. I remember only too vividly my first encounter with a new patient's family after graduation from training. The words "bill" and "payment" seemed to stick in my mouth. Once I finally made this part of my written and verbal policies, I got much better at it—and my patients were less anxious as well.

TIP

I recommend that for an evaluation of a child, you meet first with the parents or guardians. For an adolescent it may be advisable to meet with the parents and adolescent patient in the initial interview to allay concerns of collusion with the parents. It is important to meet with both parents (if they are married or not) whenever possible. This is helpful in terms of getting various perspectives, as well as understanding the nature of the parental interactions, and how they each relate to and understand their child. In the case of divorced parents, you may need to meet with each parent or step-parent group separately. Getting a sense of how the parents work (or don't work) together in raising the child is important.

TIP

Explain to parents what type of professional you are. Many parents may confuse a psychiatric evaluation with psychological testing. The following introduction to the parents may be helpful:

I am a child and adolescent psychiatrist (or fellow)—a medical doctor who specializes in understanding and treating emotional and behavioral problems of children and teenagers. Perhaps we can spend just a few minutes reviewing what I do and what you expect, to make sure we're on the same page.

[Ask at this point what the parents are hoping to achieve from the evaluation. Then give a brief description of the nature of the evaluation.]

I try to get the best understanding I can of your child and his/her strengths as well as areas in which he/she is having real difficulties. To understand and help your child, I need to talk to the people who know him/her best. That is you, as his/her family, of course. But I also find that information from the school, pediatrician, (any others) is helpful. I will also meet and get to know your child. I will talk to him/her about things that he/she likes and is good at, as well as to try to understand the reasons that he/she is having difficulties. For younger children, I also use play with toys or games as a way of getting to know and understand him/her.

It is helpful to mention that you use play as an evaluative (and later, perhaps, therapeutic) tool for younger children. Some parents will be confused and distressed when their child, who has been causing such chaos in the home, comes out of the office and reports, "It was fun! We just played."

Follow up with how many times you will meet and get Release of Information forms signed (be sure to follow Health Insurance Portability and Accountability Act [HIPAA] guidelines).

I will meet with you for (an hour) today. Then I will meet with your child for (50 minutes, how many times and when). With your permission (explain HIPPA and get releases signed) I will also get information from your pediatrician, school, (any prior treaters, protective services, if there is involvement, any others. Ask if there are other sources with whom you should speak).

And now, for the difficult part—billing, cancellation policy, confidentiality, feedback, and procedure for contacting you. As a trainee, the financial aspects of billing and cancellation may seem irrelevant, but there are important clinical benefits to being clear about expectations (fewer cancellations and

no-shows and more treatment compliance) and important training benefits to practicing this skill.

As you know, *[review the clinic billing and cancellation procedure]*. When my evaluation is complete, I will meet with you *[review the recommendation feedback procedure. If there will be a report generated, or not, clarify that. Also clarify with whom you will share the information. If the entire evaluation is court-ordered or requested by another agency with which a report will be shared, be clear about that. Clarify the extent of confidentiality, or lack thereof, with the parents, as well as the child or adolescent. If the report is being done for the Court, there is no confidentiality. Even in a regular practice, confidentiality is limited if you feel the child or others are in danger—state that up front. Clarify the clinic procedure for contacting you—both regular communication and after hours or for emergencies.]*

Before you end the session, review with the parents what they will tell their child about the evaluation. Help them practice explaining this to their child in a manner that is supportive and nonblaming. I have had parents tell their child that they were going out for ice cream, only to end up in my office. Although I learned a great deal about how the parents deal with their willful child (grist for the mill), needless to say, it did not set an inviting stage for the child to engage with me.

TIP

Define the boundaries of the clinical practice by stating up front how, when, and for what the patients (or their families) can and should contact you.

- Don't give out your home number.
- Use voicemail for all nonemergency matters, and state how often you check it.
- For more urgent matters, specify how to contact you (if you use the pager system, be clear about when they may use this). An answering service contacting you is often preferable, when possible. Specify if you are available after hours or if there is a physician on call who takes care of all emergency matters.
- When you are going on vacation, sign out your patients to a trusted colleague. Having a backup person who knows the basics of your cases will assist in effective coverage.

KEY POINT

Set the stage for negotiation. For example, with teenagers it is sometimes helpful to meet with him or her first, before the parents, or meet with him or her with the parents, in order to give the adolescent some control. Be explicit that each child and family is unique. Be clear about which areas are flexible (with whom and in what order you meet, for example), and which are not (procedures for safety, for example).

TIP

When you first meet with the child or adolescent, have the parents join the initial minutes of the meeting to review the reason for the evaluation and what to expect. I usually ask patients for their understanding of why they are here to see me first, and try to come to some shared agreement.

CLINICAL VIGNETTE

Children and adolescents may be unclear and anxious about the nature of the evaluation and if they are in trouble or being manipulated. In this example, the concerns and conflicts of the 12-year-old girl and her parents are addressed directly:

Interviewer:	*What is your understanding about why you are here to see me today?*
Child:	*I don't know. Didn't my parents already tell you?*
Parent to child:	*Yes, you do! Don't you remember that we talked about it?*
Interviewer to child:	*You're right, I have met with your parents and we have talked. But it helps me to hear what your understanding is.*
Child:	*To make me be a sweet little girl [sarcastically].*
Interviewer:	*I see. So your parents made you come, and you really don't want to be here.*
Child:	*Duh!*

Interviewer to parent:	*Did you tell her that we are here to make her a sweet little girl?*
Parent:	*Of course not! We told her we want to help our family communicate more effectively.*
Child:	*Yeah—meaning that you should talk and I should listen.*
Interviewer:	*So, you both agree that communicating and getting along could use some work?*
Child:	*And it's not just me!*
Interviewer:	*I see. So maybe the whole family needs to work at learning to talk out disagreements?*
Child:	*Yeah!*

With the child's feeling of being coerced brought out into the open, she was more forthcoming and less defensive throughout the rest of the interview.

COMPONENTS OF THE PSYCHIATRIC EVALUATION

The child and adolescent psychiatric evaluation consists of at least three elements: 1) interview, information gathering, and basic assessment of the family or primary caretakers/legal guardians; 2) interview/assessment of the child or adolescent; 3) information from other sources (primary care physician, school, or others, as needed). The logistics of how these three elements are obtained may vary. In my ideal initial evaluation of a new patient whom I may take on in treatment, I first meet with the parents or guardians (together, if possible, even if they are divorced), then with the entire family unit (family that lives in the home with the identified patient), then with the child or adolescent one or two times. I will call the other informants (school, primary care physician, etc.) and then plan a feedback meeting with the parents to discuss findings and recommendations. In real life, it may be impractical to obtain an evaluation in this manner. However, I find that meeting the entire family can be very instructive in terms of understanding dynamics and formulating appropriate and effective therapeutic interventions. It also sets the stage for the difficulties not being the "fault" of the identified patient in isolation (Table 2.1 lists components of a through psychiatric evaluation and Table 2.2

TABLE 2.1. Components of a Thorough Psychiatric Evaluation

- Referral source—clarify who is requesting the assessment and for what purpose
- Chief complaint(s) and goals of the assessment
- Context—find out in what context(s) problems occur
- Multiple informants—incorporate information from the primary care physician, school or child care, both parents or guardians, mental health providers, and any other involved agencies, e.g., juvenile justice, child welfare. Get Release of Information forms signed to speak to each.
- Patient interview/Mental status examination—interview the child or adolescent alone. Use open-ended questions and try to ascertain the child or adolescent's perspective of the issues. With young children, observing and describing play is more helpful. The Mental Status Exam may be more observational and interactive than with adults.
- Family Evaluation—see the entire family together whenever possible. If not the whole family, seeing the child or adolescent and parents together is helpful to clarify family dynamics.
- Medical Evaluation—obtain the medical history and talk to the primary care physician. Clarify if any further medical workup is required, e.g., EEG to rule out seizures, neuroimaging, screening labs to rule out potential medical causes, ECG or other appropriate labs prior to a medication trial. Table 2.2 summarizes medical factors that may have a psychiatric presentation to be considered.
- Psychoeducational testing, if needed, to rule out learning disability and intellectual impairment (at times, neuropsychological testing to assess executive functioning and more subtle or complex deficits), projective testing, speech and language assessments, or other evaluations may be indicated to clarify the nature of the presenting symptoms.
- Rating scales (such as Conners for ADHD, Beck Depression Inventory for depression, etc.) to assess the number and severity of symptoms. Baseline and follow-up rating scales are helpful in monitoring.
- School functioning—talking to teachers and school personnel may be very helpful in understanding the difficulties (as well as strengths) of the child. Be sure to ask about peer and teacher interactions, how he or she deals with transitions or changes, learning style and motivation, as well as overall academic level. A classroom observation may be helpful.

TABLE 2.2. Medical Factors That May Have a Psychiatric Presentation

Medications/toxic/drug-induced	Corticosteroids, benzodiazepines, amphetamines, anticholinergics, hallucinogens, antihypertensives, asthma medications, narcotics, lead exposure
Genetic	Fragile X syndrome, Wilson disease, Prader-Willi syndrome, Klinefelter syndrome
Infectious/Immunologic	Lyme disease, infectious mononucleosis, HIV/AIDS, tuberculosis, neoplasm, lupus erythematosis and other autoimmune disorders, chronic fatigue syndrome, PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection)
Neurologic	Epilepsy, migraines, central nervous system tumor, traumatic brain injury, anoxia, demyelinating processes
Endocrinologic	Hypo- and hyperthyroidism, diabetes, hypopituitarism, androgenization, Cushing disease, adrenal insufficiency
Other	Hypoglycemia, electrolyte abnormalities, uremia

details medical factors that should be considered in a workup of the etiology of psychiatric symptoms).

Appendix 1a gives an outline of the components of a child and adolescent psychiatric evaluation report.

Family Assessment

Accurate psychiatric assessment and effective treatment of an individual child must involve an examination of family process. Family process refers to the repetitive patterns of interaction between members. The definition of "family" may be broad, but understanding the bonds and processes within a family context will help you more fully understand the child. No child lives in isolation, and the context and dynamics

of the child's nurturing environment may serve a role as a primary protective or primary risk factor (or both). Failure to recognize the importance of family process may prevent the initiation of appropriate treatment interventions and may place a psychiatric clinician in the role of unwitting participant in an unhealthy family system.

Family theorists vary on the type of approach used to assess family functioning. I find the following most useful.

Family genogram. In the initial meeting with the parents I ask about a basic family history. This may be most efficiently done in a genogram. The genogram, as presented by McGoldrick, is a practical and useful framework for understanding family patterns and mapping out how family members are biologically and legally related to one another over a series of several generations. I include any psychiatric, learning, medical or substance use issues, history of abuse or neglect, and legal issues next to each circle (female) or square (male) person in the genogram. Usually grandparents and subsequent generations are sufficient. Ask about cultural and religious background, as well.

Family diagnostic interview. Different clinicians do this in different ways. I use the following format:

Greeting: This is the time to set the stage that you are interested in the entire family and how they get along, not just the "identified patient" (who may not turn out to be the primary difficulty). Example: "Hello. It is so nice to get to meet your whole family." [*Have each sibling say his or her name and age*]. You may ask what their understanding of the meeting is. A statement such as the following may be helpful: "I understand that we are meeting here today to help me get to know your family and how you get along together."

Typical day: Ask the family to describe a typical weekday. Who gets up first? How do they organize to get ready for school, work, etc.? Who goes where? How do they like school, job, etc.? When do they get home? Do they eat dinner together? What is a usual evening like? Where does each person sleep?

What they like to do together: Ask the family in general to say what they like to do together. I try to be sure that each member (if old enough) contributes.

What they like best about their family: Again, be sure to hear from all members.

What they would like to change or be different in their family: Let each family member answer.

TIP

If there are young ones (preschool or kindergarten age), set up some simple toys in the circle (crayons and paper can be quite sufficient) and allow them to play as you talk; they usually are listening intently and know what is going on. Be sure to include the little ones, if they can talk. It may be the youngest member who has the most insight (the 4-year-old is often the one that "spills the beans" about dysfunctional family secrets) and gives a good overall sense of the family's strengths, vulnerabilities, and areas of need.

Family Functioning Rating Scales

A variety of rating scales are available to help clinicians assess family functioning. These may already be used in your clinic. If not, examples of family rating scales include:

Family Environment Scale (FES) by Moos and Moos—measures family cohesion, expressiveness, conflict, independence, and achievement

Family Assessment Devise (FAD) by Miller—based on a problem-centered model and examines the structure of families regarding problem-solving abilities, communication, roles, and general functioning

Family Adaptability Cohesion Evaluation Scale (FACES III) by Olson et al. —a self-report instrument that describes family processes such as negotiations, family roles, boundaries, coalitions, decision making, assertiveness, and discipline

Family Formulation

This need not be formal but will integrate into your overall formulation of the child's biopsychosocial functioning at the completion of the assessment. Consider overall family functioning, problem-solving abilities, intrafamily communications and boundaries, behavioral control, affective processes, and family cohesion and adaptability as areas that impact each family member.

Patient Interview: The Mental Status Examination

For children and adolescents, the mental status examination components may be gathered through direct questioning, play activities, or observations during the session.

- Appearance and behavior: grooming, size, type of dress, dysmorphic features, bruises, scars or injuries, eye contact
- Ability to cooperate and engage with assessment
- Social relatedness
- Speech and language: fluency, volume, rate, and language skills (appropriateness for developmental level, articulation issues, social speech)
- Motor function: activity level, coordination, attention, frustration tolerance, impulsivity, tics and mannerisms
- Mood and affect: neurovegetative symptoms, manic symptoms, range and appropriateness of affects
- Thought process and content: psychotic symptoms (hallucinations, delusions, thought disorder)
- Anxiety: fears and phobias, obsessions or compulsions, post-traumatic anxiety, separation difficulties
- Conduct symptoms: oppositionality, conduct symptoms, aggression (verbal or physical)
- Trauma history: physical or sexual abuse, neglect
- Assessment of risk: suicidal thoughts or behavior, self-abusive behavior, thoughts or plans to harm others, risk-taking behaviors, sexual behaviors, internet usage, legal issues, cigarette, substance or alcohol experimentation/use
- Cognitive functioning: overall assessment of developmentally appropriate vocabulary, fund of knowledge, drawings
- Insight and judgment: acknowledgment of having a problem, judgment for hypothetical situations

Rating Scales/Assessment Instruments

Rating scales range from systematized questionnaires that assess psychiatric symptoms in general to those that probe specific areas of difficulty in depth. Advantages of using rating scales include their assisting the clinician in the systematic evaluation of the child, including detecting problems that are clinically significant but not part of the presenting problem. Some adolescents may reveal concerns in writing that they do not verbalize. Disadvantages of using rating scales include the time needed to complete them, the feeling of being "check-listed," and clinicians' tendency to over-rely on rating scales for diagnosis. Rating scales are adjunctive tools used to complement a diagnostic evaluation, not replace it.

With children and adolescents, the rating scales may be completed by the patient or by parents or teachers. Additionally, semistructured diagnostic interviews (Diagnostic Interview for Children, or DISC; children's version of Schizophrenia

and Affective Disorders Scale, or K-SADS) are typically used for research purposes, but may be used clinically for diagnostic clarification.

Appendix 2 gives a summary of some commonly used rating scales.

Clinical Formulation and Diagnosis

I consider the clinical formulation and diagnosis the critical skill that characterizes child and adolescent psychiatry. It is the integration of the complex and sometimes disparate information gleaned from the evaluation above, putting it in a context to understand the child's behavior and to clarify the treatment focus and appropriate interventions. There are two primary formulation prototypes: biopsychosocial and the 4 Ps.

Biopsychosocial formulation. This is still the most commonly used formulation type for the Board examinations. It interweaves biological vulnerabilities (prenatal, birth, early temperament, development, genetic predispositions/family history, medical and neurological disorders), psychological factors (personality, psychological issues and attributions, defense mechanisms, developmental stage tasks), and social/environmental contributors (family/interpersonal, socioenvironmental, trauma, and cultural factors) to postulate an understanding of what brings the child or adolescent to this point in life. With this understanding, the most focused and effective treatment recommendations can be formulated.

The 4 Ps. Another useful method of formulation is the 4 Ps, as proposed by Barker.

1. Predisposing—those factors that render the child vulnerable to a disorder
2. Precipitating—stressors or developmental factors that are associated with the emergence or worsening of symptoms
3. Perpetuating—factors that maintain the disabling symptoms
4. Protective—strengths and assets that may be accessed to promote more healthy adjustment and diminish the severity of symptoms

Each of the 4 Ps may be described along the following dimensions: (a) biological/constitutional (including prenatal, birth, early temperament, and genetic vulnerabilities), (b) psychological/personality/temperament, (c) family/interpersonal, and (d) socioenvironmental.

The formulation need not be lengthy, but it is important. The formulation serves to integrate and synthesize the information

obtained into a coherent understanding of the multiple factors which are likely contributing to or diminishing symptom severity. It is this understanding that informs the diagnosis, prognosis, and treatment recommendations.

Diagnosis. Diagnosis is typically given in Axis I-V as recommended in the DSM-IV.

Axis I	*Clinical disorders*
	Other conditions that may be a focus of clinical attention
Axis II	*Personality disorders*
	Mental retardation
Axis III	*General medical conditions*
Axis IV	*Psychosocial and environmental problems*
Axis V	*Global assessment of functioning*

COMMUNICATING FINDINGS AND RECOMMENDATIONS

Feedback to the Family

The evaluation is not complete until findings are communicated to parents, the child, and/or other referring agencies. The purpose of the feedback is to help provide an empathic understanding of the etiology of the difficulties and strengths of the youngster assessed, and to communicate this diagnostic understanding in a manner that will help provide a clear focus for therapeutic interventions. Avoid psychiatric jargon when possible.

Be sure to set aside sufficient time to explain the rationale for the diagnoses given and treatment recommendations. If you give the diagnoses in all five axes, they will need to be explained. For purposes of the family, axis I and II are usually sufficient. If you have provisional diagnoses, be clear that you are not sure. I often tell parents that children frequently don't fit neatly into our diagnostic categories, and each child is unique. The formulation may be more helpful than definitive diagnoses in understanding and helping the child.

Feedback to Other Agencies

Feedback given to schools or other agencies will be focused primarily on the referral questions, although a comprehensive evaluation is typically conducted to answer those questions. If dangerousness is a concern, this should be explored in detail, including precipitating factors, chronic stressors, and previous history of violence. Recommendations should

emphasize the most practical, helpful, and necessary treatment approach that is in the best interest of the child. Crucial information should be elucidated, while maintaining sensitivity to family and personal information which is not relevant to the evaluation. Recommendations should be clear and as specific and concrete as possible.

TIP

Keep feedback in lay language that is nonjudgmental, sensitive, and practical. Parents may be very anxious about hearing what is wrong with their child (and family). Remember that very little of the information you say will be retained, especially if there is an emotional component. Usually feedback is given to the parents first, but, depending on the nature of the problem and the developmental level of the child, it may be appropriate for the child or adolescent to be there. If the child is there, talk to him or her directly about the findings. Be sure to provide a written report or succinct summary for the parents and/or ongoing dialogue, discussion, and psychoeducation regarding your findings and recommendations.

RECOMMENDATIONS FOR TREATMENT

Recommendations should flow naturally from your formulation and diagnoses. Just as the formulation is biopsychosocial, so are treatment recommendations. Begin with any further assessments required (neurological, medical, and/or psychoeducational assessments) for more specificity of treatment and diagnosis.

Selection of appropriate treatment is based on multiple factors, including diagnosis and symptom severity, acute and ongoing risk of harm, capacity of the family to support treatment and provide a safe environment, capacity of the child to engage in and use interactive treatment approaches, and availability of treatment options in the community.

A comprehensive treatment plan should include consideration of the intensity of treatment required for the child in a systems-based manner:

1. Child is at imminent risk and requires acute hospitalization
2. Child needs higher level of care than can be provided safely in the home, but is not at imminent risk—residential treatment, group home, subacute temporary residential stabilization, therapeutic foster home, safe home, etc.

3. Child can be maintained safely in the home only with intensive wraparound services—in-home behavioral services, partial hospitalization or after-school therapeutic program, intensive case management, etc.
4. Child requires regular outpatient therapeutic services
   a. Individual therapy (cognitive behavioral therapy (CBT), insight-oriented, supportive, interpersonal therapy (ITP), dialectic behavioral therapy (DBT), anger management, etc.)
   b. Psychotropic medication for treatment of psychiatric symptoms that are amenable to medication
   c. Group therapy (therapy group, social and coping skills groups, DBT group)
   d. Family therapy (regular family therapy, parent management training, parent psychoeducation, multisystemic treatment (MST), couples therapy, divorce mediation and conflict resolution, or parents accessing needed treatment for themselves)
5. Other adjunctive services
   a. School services (special education or Section 504) for emotional, attentional, and/or learning issues, including in-school counseling, therapeutic interventions and services within mainstream classroom, special education classroom, or out-of-district placement at a school specializing in working with children with emotional, social, and/or behavioral difficulties
   b. Speech therapy for language problems (including social conversation) as appropriate to the child's difficulties
   c. State Protective Service involvement as needed for suspected abuse or neglect or for voluntary services for the family
   d. Legal involvement accessed by the family to help monitor a child with severe out-of-control behavior
   e. Other supports, such as Big Brother or Sister, mentoring programs, respite home, recreational therapy, and pet therapy.

TIP

Many parents ask if their child will "grow out of" the difficulties or express concerns that if they start medications their child will require medications for his or her lifetime. I take the tact that we cannot predict the future, but we do know that developmental scars may remain when a child does not receive the help he or she requires academically, socially, emotionally, or behaviorally. Not all children will require intensive or

long-term treatment for these issues, but it is crucial that they be addressed and taken seriously to allow the child to develop as optimally as possible.

CLINICAL VIGNETTE

Parents brought their 10-year-old fourth-grade son for evaluation because of increasing behavioral problems at home and at school. He had always had difficulties in school—fidgeting, calling out in class, being disorganized and disruptive. He had begun to act out behaviorally in school when called on in class. He spoke to his teacher in a disrespectful manner and did not complete his work. At home he refused to do his homework and became angry and shouted, slammed doors, and stomped off when his parents tried to insist. On evaluation, he seemed easily distracted and very defensive and difficult to engage about any perceived inadequacies. A Conner's Scale of attention deficit hyperactivity disorder symptoms completed by the teacher and parents suggested a high level of symptoms. Further investigation revealed a family history of ADHD and learning disabilities. A recommendation was made for psychoeducational testing, which demonstrated above-average overall cognitive ability with a specific reading disability. In formulation, the *predisposing* factors (family genetics for ADHD and a reading disability) and *precipitating* factors (increasing expectations in school and at home as he got older) were manifested in oppositional and defiant behavior to ward off feelings of inadequacy academically and in his inability to control his impulses. This was *perpetuated* by a family and school stance of punitive consequences for misbehavior and unreasonably high expectations for this otherwise bright boy. *Protective* factors included above-average overall cognitive skills, concerned parents, athletic abilities, and some friends. Recommendations were for a reading tutor and special assistance with reading, including the use of tapes, oral tests, extra time for tests, and modifications of assignments. Special accommodations for the ADHD symptoms, including preferential seating near the teacher, subtle cues to gain and focus attention, and organizational assistance were recommended, along with the recommendation for a stimulant medication trial. Parent counseling and psychoeducation and child anger management training were also suggested. When these interventions were implemented, the child made significant improvements.

II

AXIS I DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE