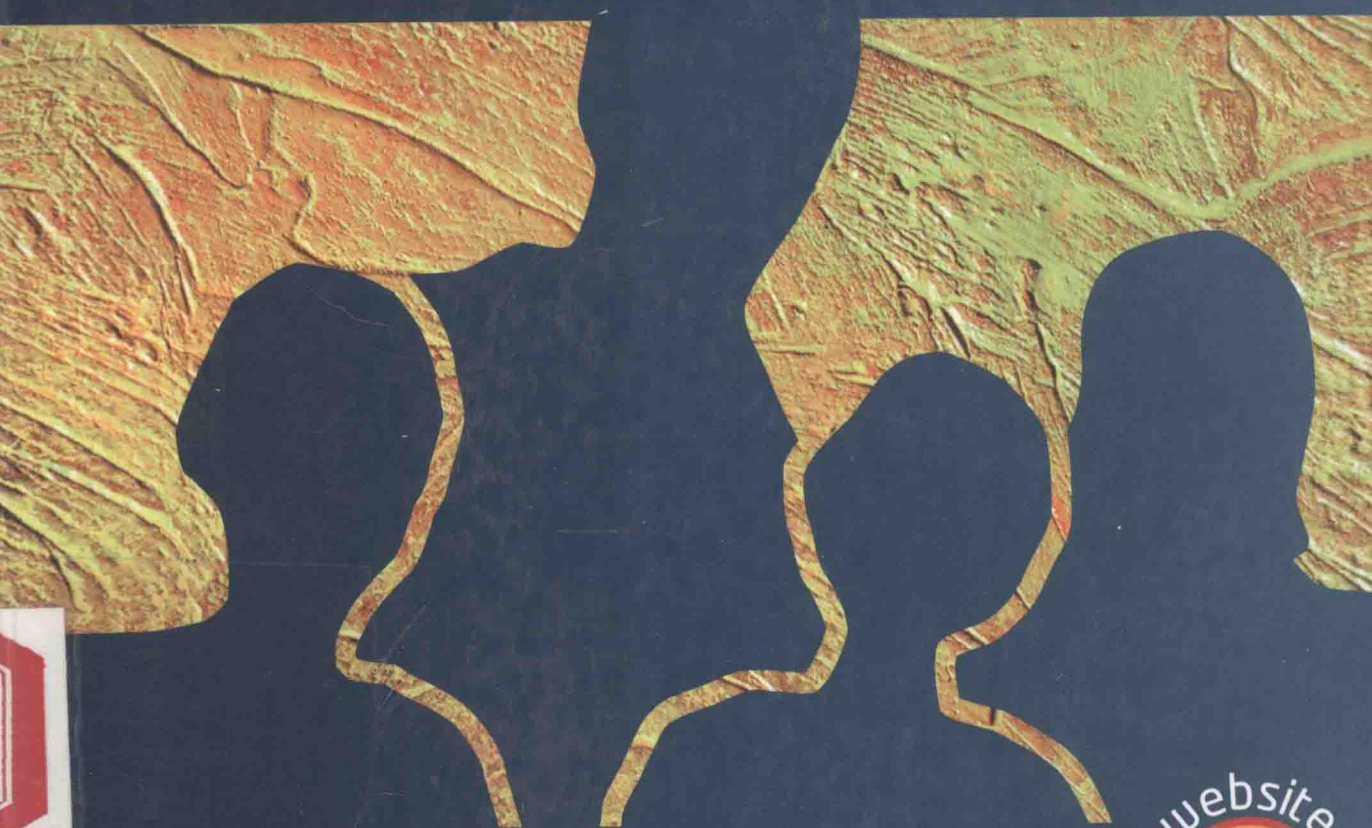
THIRD EDITION

Clinical Child Psychiatry

EDITED BY

William M. Klykylo and Jerald Kay



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Clinical Child Psychiatry, Third Edition

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Clinical Child Psychiatry, Third Edition

DEDICATION

To our teachers, our students, our patients, and our families.

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Preface To Clinical Child Psychiatry, Third Edition

In the preface to the first edition of this work, we stated that the changes in child psychiatry occurring then would have been barely imaginable 15 years earlier. In the preface to the second edition, we remarked that we could not have predicted then how much the whole world would change thereafter. The subsequent world crises have only intensified the demands placed upon child and adolescent psychiatry. We have ever growing demands for service to our patients, whose stressors and pathology become more severe and pervasive. We are fortunate that our understanding of disease and our armamentarium of treatments also continue to increase. Regrettably, the resources allocated for those treatments have not always grown apace; so we must continue to do more with less and do so ever more quickly and efficiently.

The welcome growth of knowledge in our field continues to change clinical practice, creating a need for an update of this book. Like its predecessors, *Clinical Child Psychiatry, Third Edition* is presented neither as a comprehensive textbook covering the entire field, nor as a brief introduction. It still attempts to serve as a focused study of major problems, challenges, and practices commonly encountered in clinical work. It remains directed toward experienced clinicians encountering new areas of practice, as well as to students and residents entering the field. We especially hope that pediatricians and family physicians, who throughout the world provide the preponderance of child psychiatric services, will find this volume useful. We also wish it to be informative to professionals outside of medicine as an overview of what child psychiatry can – and should – do today. As always, but in these times especially, we must work together as best we can.

Whatever its merits, *Clinical Child Psychiatry, Third Edition* is the product of the individuals' efforts. We have been well served by our publisher John Wiley & Sons, Ltd, and especially by our Project Editor Fiona Seymour, our Associate Editor Robyn Lyons, and our Publisher Joan Marsh. They bring to their work an enviable combination of knowledge, experience, patience, and good humor that has encouraged and sustained us. We could not have assembled this book without the support of our staff at Wright State University Boonshoft School of Medicine, most notably Laura Johnson and Megan McKenzie. Our contributors are the ultimate source of this volume's content and value, and we are in their debt. Finally, our families continue to support us with their affection and patience.

William M. Klykylo
Jerald Kay

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Companion website

The book is accompanied by a companion resources site:

clinicalchildpsychiatry.com

With interactive multiple-choice questions for each chapter.

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Section I
The Fundamentals of Child and Adolescent Psychiatric Practice

1

The Initial Psychiatric Evaluation

William M. Klykylo

This chapter is an introduction both to this textbook and to the approach of patients and families in child and adolescent psychiatric practice. Child and adolescent psychiatrists should be broadly trained clinicians able to address a variety of somatic, psychologic, and social needs of the patient and family. Their approach should combine the caution and competence required of a physician treating an individual patient with a broad concern for that patient's development in the context of family, school, and society. This textbook provides an overview of child and adolescent psychiatric practice while focusing on the more common areas of clinical practice. As such, it should serve the established practitioner as a rapid and accessible introduction to unfamiliar areas by taking into account the ever-expanding breadth of clinical practice. For general readers or students in professions other than medicine, this book will serve as an introduction to both the assessment and management of some commonly encountered clinical entities and to the range and standards of practice expected of a contemporary child and adolescent psychiatrist. There are currently about 6000 child psychiatrists in some sort of clinical practice in the United States, whereas there are between 7 and 12 million children with psychiatric illnesses, as identified by *Diagnostic and Statistical Manual,* Fourth Edition, Text Revision (DSM-IV-TR) criteria [1, 2]. The median prevalence estimate of functionally impairing child and adolescent psychiatric disorders is 12%, although the range of estimates is wide. Disorders that often appear first in childhood or adolescence are among those ranked highest in the World Health Organization's estimates of the global burden of disease [3]. Most of these children will not see a child and adolescent psychiatrist and, in many instances, the parents, teachers, and other professionals attempting to serve them may be unaware of the contribution that child and adolescent psychiatry can make to the child's care.

The traditional roles of child and adolescent psychiatrists are those of diagnostician, therapist, and consultant. First, child and adolescent psychiatrists should offer a child and family a comprehensive diagnostic assessment that addresses the medical condition of the child; delineates the child's emotional, cognitive, social, and linguistic development; and identifies the nature of the child's relationship with his or her family, school, and social milieu.

Second, child and adolescent psychiatrists as physicians treat illnesses, using an armamentarium of somatic treatments and the more traditional skills of individual, family, and group psychotherapists. Because of the breadth of training they receive, child and adolescent psychiatrists should have special skill in appreciating the interaction among these therapies and their effects on one another and on the child and family.

Finally, in many cases, child and adolescent psychiatrists will serve as consultants. This role is more developed in our specialty than in most other areas of medicine because of the constant disproportion between the number of patients and the number of clinicians. Inevitably, we consult and collaborate with parents, educators, and other professionals who may see the child and family more frequently and intensively than we do; because of the breadth of our training, we should offer a special competence in coordinating these efforts. Concurrent with this role, we often must serve as advocates for children and their families in today's environment of great clinical needs and comparatively limited resources.

Referral Sources

Because of the broad responsibility shared by child and adolescent psychiatrists, our evaluations must address not only a narrow consideration of clinical diagnosis but also a larger set of issues that are truly biopsychosocial

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and require a more than casual competence in each of these areas. We must therefore address the specific needs and questions posed by each referral source. Children are today served by a variety of individuals and agencies, each possessing their own particular agendas and separately approaching physicians and other consultants. These agendas must be recognized and served, given today's consumer-oriented society. At the same time, we have a responsibility to those individuals seeking our professional services to educate them with the wider range of concerns that may be affecting a given child's or family's life.

In today's environment, we frequently receive referrals from, or may be employed in contractual relationships with, various social and legal agencies such as courts and departments of human services. Each of these agencies has a particular agenda, generally mandated by legislation or charter, to determine the eligibility of children for various services or proceedings. The agencies frequently approach their duties with an intense dedication to children but an incomplete familiarity with the knowledge and assumptions that inform our practice. Referrals may also come from teachers or schools. These referrals may be a result of the child's behavioral disruptions or eccentricities, his or her academic difficulties, or simply the distinct if sometimes uncertain perception of a dedicated teacher that something is wrong. Referrals may come to us from other physicians. In today's atmosphere of comprehensive primary practice, these physicians may have already begun the diagnosis and treatment of mental illness in a child, and established an ongoing relationship with this child and his or her family. Such referrals require a balanced response of both expertise and respect. Finally, many referrals come directly from parents, who are generally very concerned about their child's impaired functioning and suffering. They may bring to the process a mixed heritage of concern, guilt, and shame, frequently fearing that they will be judged as they seek help. Concurrent with this are often ambivalent feelings of love and frustration toward a difficult child. The task of child and adolescent psychiatrists is to recognize all these needs and address them in a fashion that is not only authoritative but also tactful and empathetic.

Elements of the Evaluation

This section provides an overview of the elements of a comprehensive child and adolescent psychiatric evaluation in the context of contemporary knowledge and patient needs. More detailed considerations of the process of the clinical interview are also available [4–8]. The assessment of particular disorders as well as laboratory, psychologic, and educational assessments is covered in other chapters of this book.

Collateral and Preliminary Information

Today, most children who are seen by child and adolescent psychiatrists have already received a great deal of attention from other professionals. To fail to gather information from these people prior to a formal evaluation is a serious mistake, leading to wasted time and frustrated relationships. If at all possible, it is usually most efficient to speak directly with a referring professional. This is especially true in the case of primary care physicians, who may have a long-standing relationship with the child and family. Other mental health professionals referring a child usually have conducted their own evaluation. Children's school records can be a rich source of information about their cognitive and emotional development. Examination of all these data can enrich an evaluation; similarly, failure to do so can lead to embarrassing lapses.

Clinicians in the past may have at times assessed a child while deliberately ignoring collateral information, presumably to evolve an unbiased assessment. There may be certain unusual situations in which this tactic is indicated. More often than not, however, this approach ignores the reality of the lives of children, who live in asymmetrical relationships with adults and agencies, all of whom have considerable knowledge and power over them. This approach is almost always a departure from best practice.

Encounters with Referring Professionals

Often a child and adolescent psychiatrist's first personal encounter in assessing a patient is with another professional – a clinician, educator, or case worker who has sought the evaluation. The enormous value of their information has already been addressed. The clinician must also recognize the sensitivities of these people: they may be grateful for the opportunity to meet with the psychiatrist and eager in their anticipation of the evaluation, perhaps even to an unrealistic degree. At the same time, the act of seeking a consultation may, at least unconsciously, signify to them a failure on their part. They may be concerned that their relationship with the child or family will in some way be disrupted or supplanted, or that they will be criticized by the psychiatrist.

Parents

Parents bringing their child to a child and adolescent psychiatrist come with a rich and often contradictory mix of feelings. Frequently they reach the psychiatrist at

the end of a long, complicated process of evaluations and treatment attempts. They are almost invariably concerned and anxious over their child's condition and prospects. In a way that, for those who are not parents, may be difficult to understand fully, they may have many fears about the consequences of a psychiatric referral, as do referring professionals. They may feel that they will be judged or, in extreme cases, that their children will be removed from their care. In a more subtle way, they may also worry that their relationship with their child will be supplanted or superseded. They may be concerned about the moral and philosophic basis of the psychiatrist's approach, fearing that parental ethical standards and religious beliefs will in some way be contradicted. Sometimes, simultaneously, they may have unrealistically optimistic or hopeful fantasies of "absolution" of unconscious guilt, or of quick cures. More often than not, in my experience, parents have no idea of the specifics of psychiatric assessment or treatment. Their opinions may have been formed by mass media or public prejudice. Before any specific information can be gathered or plans made, the above issues must be addressed, in the interest of time and efficiency as well as of engagement. Simply put, the child and adolescent psychiatrist needs to understand how the parents feel about the referral and what they expect to gain from it.

A great deal of information should be collected from parents, since they know the child best. The details of this data collection, including various outlines for its organization, are described elsewhere in this book. Most child and adolescent psychiatrists today use a traditional medical format to organize their data, with headings such as Chief Complaint, History of Present Illness, Past Medical History, Family History, and Review of Systems. More often than not, the specifically medical aspects of these data are already available. Not infrequently, however, child and adolescent psychiatrists encounter families that have not received regular primary pediatric care. In these cases, it is incumbent on the psychiatrist as physician to take a comprehensive medical history in addition to acquiring other information. In all these areas of questioning, psychiatrists collect data as do all other physicians, usually attempting to delineate and organize the information in a chronological fashion. What is unique about a psychiatric evaluation is that physicians pursue not only the specific data but also their affective implications. In other words, they seek to find out not only what specifically happened but also how it made the child or family members feel and what consequences it had on their lives.

Another area of inquiry of particular importance to physicians treating children, and certainly to child and adolescent psychiatrists, is the developmental history. Child and adolescent psychiatrists must be absolutely familiar with normal developmental patterns, milestones, and expectations. Psychiatrists often approach these phenomena informed by traditional theories of psychosexual, social, and cognitive development. Although these theories frequently hold great importance for their heuristic value, the clinician must remember that they are, at best, models or theories and not immutable facts. Thus, the clinician must also be aware of contemporary empirical data about normal development and its variations. The developmental history secured by a child and adolescent psychiatrist should in many ways be similar in depth and breadth to that obtained by a developmental pediatrician. At the same time, as psychiatrists we should focus special emphasis on the social and affective consequences of developmental phenomena. In other words, we should be concerned about not only at what age a child reached a given milestone but also how the attainment of that milestone affected that child and his or her family. We must recognize that some developmental processes or stages may inherently be more or less comfortable for some parents, and that there is a wide range of variation in the degree of comfort and discomfort that development engenders. Finally, we must recognize the great variations in developmental patterns and expectations found among different cultures. Summaries of typical developmental sequences are found in Appendix 1.1.

A detailed consideration of family dynamics and therapeutics is beyond the scope of this textbook. We know from the contributions of clinicians with approaches as diverse as those of Satir [9], Whitaker [10], Minuchin [11], Haley [12], and cognitive therapists [13] that the family has an immense and profound influence on the development of each of its members and may be viewed as a distinct entity [14]. It is therefore invaluable, as part of a comprehensive psychiatric observation, to spend some time in the company of the entire family. Frequently, families referred to us have already been assessed in this fashion by competent family therapists, and the child and adolescent psychiatrist may not need or have the opportunity to pursue extensive family treatment. Nonetheless, the opportunity to observe firsthand how the members of a family act with each other can be enriching for a clinician attempting to understand the consequences of each family member's behavior on the others. In addition, if this observation is done early, it may serve as a more comfortable entrance to the evaluation process for a shy or otherwise recalcitrant child or other uncooperative family member.

Meeting the Child

In practice, most clinicians develop a somewhat personal style of interaction usually formed by psychodynamic and interactional approaches and also more structured, empirical techniques. Clinicians in any setting soon realize that, outside of the specific requirements of a structured interview instrument, they need to be flexible in their approach. The schemes that we use for reporting an interview are generally best conceived as devices for retrospective organization rather than templates for an interview. This is of particular importance with children. Any pediatrician knows that in the course of a physical examination one does what one can when one can. Similarly, in the psychiatric interview with the child, one must be flexible and mobile both verbally and physically.

The most important element of an initial psychiatric interview with the child is the establishment of a productive relationship – in other words, "making friends." The clinician must keep in mind how children feel in the context of an interview. Children may share or reflect the same complicated and ambivalent mixture of fear, shame, hope, and misapprehension that their parents bring to the process, and they often have not been fully prepared by the parents or others for the interview. Such preparation, if it can be done by parents prior to bringing the child in, can be helpful. Many children, in my experience, have been told nothing at all, other than "Come along, we are going to see someone." Or they may have been told that they are going to see a doctor, which can convey fears of injections and manipulations. Some children may have been led to assume that the evaluation is part of a punitive process. Others may feel that by virtue of referral they have been singled out in some way as "weird" or "crazy." Concurrently, the child may expect to see the physician as some sort of remote, distant, punitive, or bizarre figure. All these issues must be promptly investigated and addressed in a developmentally appropriate fashion for a productive interview to ensue.

How one deals with the above issues is affected by one's own personality and training, and by the circumstances of the child and family. Preschool children are seldom able to sustain any type of formal interview, although they may answer some questions during play activities or while "on the run." Their preoperational style of cognition makes the standard interview format, with its attention toward consequence and chronology, irrelevant. One assesses these children through observation and interaction. By contrast, the school-age child will have some comprehension of the psychiatrist's role. It may help to introduce one's self as a "talking doctor" or "problem doctor" who deals with the problems that many children have (generalization may make the child feel less singled out) through conversation as well as traditional somatic treatments, and who does not give injections in the office setting. Older children and adolescents can often be asked directly about how they were brought to evaluation, as well as their opinions about its necessity and desirability. With school-age children, an initial request about what sort of problems they may have encountered in their life may be met with diffidence or avoidance. In this instance, simply playing together at some mutually acceptable activity may be an important first step. Older children and adolescents may at this time be able to tolerate tactful questions or the mention of other material or information. They will still benefit from the opportunity to talk or interact about areas that they like, perhaps later in the interview. A frequent icebreaker employed by child and adolescent psychiatrists is drawing. Children who are seated in the waiting room while their parents are being interviewed can be given the opportunity to draw a picture of their family or some other subject of interest to them. Such a drawing can serve as both a projective device and a conversation starter later in the process. Of course, children can also be encouraged to draw at other times during the interview.

In many instances, children do not respond to a standard, direct, complaint-centered line of questioning, even after several attempts by the clinician. The clinician is then best advised to relent and ask the child to talk about more general aspects of his or her life. The patient can be encouraged to tell the physician about his or her family, including each individual member and relationship, and school, including academic and social behavioral aspects and social life in general. In doing so, the clinician can often assemble a broad picture of the child's life as well as specific medical information about phenomenology. Some areas may need to be more directly pursued, usually later in the interview when a presumably more trusting relationship has been established. These include items that are considered part of the mental status examination, such as the presence of affective symptomatology (including suicidal ideation or plans) and psychotic phenomena (including hallucinations, delusions, or ideas of reference). Not every child needs to be asked about these things since for some children merely inquiring in an initial interview can be disruptive or fearful. Nonetheless, these issues must be pursued if there is any indication of a disorder in the given area. Suicidal ideation in particular must be pursued in the context of any affective disorder. Other important behavioral areas such as sexual behavior, using drugs, and health risk behavior may also need to be pursued.

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