Section I
The Fundamentals of Child and Adolescent Psychiatric Practice

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The Initial Psychiatric Evaluation

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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.

The issue of confidentiality warrants special consideration. Child and adolescent psychiatrists must use their clinical skill to moderate two conflicting demands: the child's right to confidentiality as a patient versus the right of parents and, in some instances, agencies or institutions to be aware of the child's needs and requirements. In my experience, most parents want to know what their child is experiencing; concurrently, most children want their parents to understand them, although they may prefer to conceal some specific details. Younger children may be told they have a right to hold secrets, but that their parents also have a right to know what in general is going on in their lives. Adolescents and their parents may be told that in general they have a right to confidentiality, but that some information involving a serious risk to themselves or others could be shared. Conflicts over confidentiality often overlie larger family issues that, if addressed, make the confidentiality issues moot or irrelevant.

Child and adolescent psychiatrists have traditionally been encouraged to pursue children's fantasies in the course of an assessment. The various approaches to this tend to be highly personalized by each clinician and may include asking a child for three wishes, positive or negative animal identifications (what animal would you like or not like to be), story completion, response to fables, or other techniques. Few if any of these approaches, as used idiosyncratically in an unstructured interview, have ever been validated. They should not be treated as sources of empirical data in and of themselves. They can, however, be important probes to seek other information that can be validated and, more important, that relates to specific emotional concerns of an individual child or adolescent.

Frequently nonmedical professionals refer to the psychiatric evaluation as the "mental status exam," but in fact this examination is not always used in evaluating children and adolescents – certainly a formal mental status examination must be pursued when there is evidence of a thought disorder. In these instances, the type of examination used with adults generally suffices for adolescents as well. In younger children, the mental status examination is often a list of observations that is retrospectively organized from the content of the interview thus far described. (The outline of this examination is summarized in the article by Lewis and King [7], and in Table 1.1.) In most child and adolescent psychiatric assessments, these parameters are not all specifically cited but are mentioned as part of the narrative or may be drawn from inference by the reader. When the patient in question possibly has a major thought or affective disorder, however, specific adherence to this outline may be useful.

Table 1.1 Mental status examination outline.

1.	Physical appearance
2.	Separation from parent
3.	Manner of relating
4.	Orientation to time, place, and person
5.	Central nervous system functioning
6.	Reading and writing
7.	Speech and language
8.	Intelligence
9.	Memory
10.	Thought content
11.	Quality of thinking and perception
12.	Fantasies and inferred conflicts
13.	Affects
14.	Object relations
15.	Drive behavior
16.	Defense organization
17.	Judgment and insight
18.	Self-esteem
19.	Adaptive qualities
20.	Positive attributes
21.	Future orientation

Adapted from Lewis ME, King RA (2002), p. 531 [7].

Other Aspects of Psychiatric Evaluation

Standardized Assessment Instruments

Structured interviews, rating scales, and questionnaires have become increasingly used in child and adolescent psychiatry in recent years, although their primary venue remains in research settings. Angold and Costello, in their masterful review of the current state of nosology and measurement [15], state that a comprehensive and authoritative evaluation should include their use. Many clinicians believe that, in many cases, a useful evaluation can be conducted and reported without resort to these instruments; and some instruments may require a degree of time and expense unavailable outside a research setting. However, as diagnostic categorization under the DSM system has become more standardized and reproducible, clinicians are more frequently using validated instruments, at the very least to clarify or affirm impressions that come from their personal evaluations. Thienemann has produced a thoughtful commentary on the process of combining these elements in a fashion that is both dynamically sensitive and empirically valid:

> Ideally, using intuition and experience, the psychiatrist bloodhound will use clinical senses to sniff out clues to diagnosis at first encounter. On picking up a diagnostic scent, he or she will doggedly follow it into a specific diagnostic room to gather

details, thereby determining a diagnosis' presence and clarifying its severity. Integrating this reliable diagnostic information with clinical observations, the clinician will be better positioned to engage patients and their families with effective treatments [16].

Many clinicians use initial screening or parental report instruments such as the Achenbach Child Behavior Checklist (CBCL) [17] to aid in the early collection of data. Other instruments such as the Conners questionnaires used by parents or teachers [18, 19] may be useful in the ongoing assessment for management of specific disorders such as attention-deficit hyperactivity disorder (ADHD). The Vanderbilt ADHD Rating Scale (VARS) is frequently used in the early assessment of children with these disorders, and has been shown to be useful in ruling out the presence of comorbid reading or spelling learning disabilities [20].

The Children's Interview for Psychiatric Symptoms (ChiPS) [21] is a screening tool that addresses some 20 Axis I entities. Respondent-based instruments rely upon responders to identify the presence or absence of symptoms. Besides the Conners scales, these include the Diagnostic Interview Schedule for Children (DISC) [22], the computer-assisted (but not the live version) Diagnostic Interview for Children and Adolescents (DICA) [23], and the pictorial DOMINIC-R [24], which is used with children under age 11.The specific utility of these instruments is discussed in the references [25] and in Chapters 2 and 8.

Perhaps the most studied diagnostic interviews for children are the K-SADS array (Schedule for Affective Disorders and Schizophrenia for School-Age children, or "Kiddie-SADS"). These interviews are designed to be administered by clinicians to children and parents, and the clinician is given latitude in reconciling the separate accounts, according to clinical judgment. The original K-SADS was developed from the adult SADS, but was designed for use with children and adolescents. The K-SADS presently in use include a number of variants (K-SADS-P-IVR, -E, -PL, and others) [26, 27]. The K-SADS array is designed to correlate with DSM-IV. The instruments can provide useful diagnostic information for conditions beyond schizophrenia and depression, including ADHD [28].

Psychological and Educational Evaluation

Psychological and educational evaluation are both discussed in subsequent chapters. Along with psychiatric evaluation, they stand as distinct and useful procedures that cannot be substituted for each other. Today, many patients who come to a child and adolescent psychiatrist have already been given psychological testing; the results, as noted, can be useful information. Far fewer of these children have received an educational evaluation or prescription, which may be an extremely useful part of the child's assessment and rehabilitation, especially as psychiatric treatment progresses. In both cases, psychiatrists should present these assessments as opportunities to better understand a patient's assets and liabilities. Parents should not be led to believe that either the psychological or educational assessment will produce some sort of miraculous answer to chronic problems or that seeking them implies some failure or inadequacy on the part of them or the physician. Rather, these assessments are specialized procedures that hold unique value in understanding a child's cognitive structure, learning style, and educational needs. Projective testing can be useful in obtaining a deeper understanding of the patient's emotional substrate, especially early in the treatment of withdrawn or verbally inhibited children.

Laboratory Assessment

Laboratory assessment has become a much more frequent part of psychiatric evaluation in recent years (see also Chapter 3). Many patients of child and adolescent psychiatrists will have already undergone a comprehensive laboratory assessment, even including neuroimaging, by their referring physicians; the burden of further assessment of these patients is thus not borne by the psychiatrist.

Conversely, some patients will have had little if any laboratory workup, and such assessments may be indicated in an orderly, stepwise fashion. For example, patients might receive standard hematological and chemical screenings prior to more exotic endocrinological and nutritional assessments. Similarly, it is seldom appropriate to seek an expensive and complicated neuroimaging procedure in a patient who has not yet received a neurological examination.

Given both the immense progress in neuroimaging and the intense media coverage devoted to this progress in recent years, some patients and families will assume that procedures such as computed tomography (CT) or magnetic resonance imaging (MRI) scanning are an essential part of the psychiatric examination. This, of course, is frequently not the case. Clinicians may be best advised to deal with these demands by recognizing the underlying motivations of concern, anxiety, or entitlement that evoke these requests. At the same time, as physicians, child and adolescent psychiatrists must be aware of the infrequent but poignant circumstances in which gross central nervous system pathology, such as vascular malformations and space-occupying lesions, may manifest themselves.

Outcome of the Evaluation

Presentation of Findings and Recommendations to Parents and Referring Sources

In the past, some psychiatrists, perhaps out of a specialized conception of confidentiality, have been reluctant or even reclusive in sharing their findings with others. In some instances, this practice has even been directed to parents, who may have been told merely to continue bringing their child for treatment. Such positions were, thankfully, relatively unusual, and current demands for consumer orientation and accountability have since made them utterly untenable. Parents or guardians and referring professionals or agencies are entitled to a concise and comprehensible statement of findings and recommendations. The manner in which this information is delivered depends on the needs of the child and the relationship of the child to these individuals or agencies.

As noted earlier, parents approach psychiatric evaluation with a rich mixture of concerns, hopes, and fears, which often come to a head at the time of the counseling or informing interview. I have met parents who could give me a verbatim account of their contact years earlier with a professional regarding their child's status; the affective intensity of this moment sears it into memory. The fashion in which this powerful circumstance is addressed can profoundly affect the subsequent conduct of the patient's treatment. It is a truism that at such moments, parents may hear only the first thing told them. Indeed, it often may be enough in one interview to convey a single major piece of information and attempt thereafter to address its affective consequences. If a diagnostic impression or therapeutic recommendations are at all complicated, parents may need a frequent restatement of this content, perhaps accompanied by written or audiovisual supplements and aids. Many parents may require a series of contacts to fully understand and process this information. Given the restrictions in contact imposed by some care-management agencies, it may be helpful to incorporate into this process case managers or other professionals who have a relationship with the family. In my experience, however, the ultimate responsibility as well as the ultimate effectiveness in dealing with these issues for families resides with the diagnosing physician. It is therefore absolutely incumbent on child and adolescent psychiatrists to deal first and foremost with the affective consequences of whatever information is being presented. To fail to do so is not only inhumane but is likely to seriously compromise the subsequent physician-family relationship and the family's compliance with treatment recommendations. It should go without saying that all these considerations must also be addressed, in a developmentally appropriate fashion, in explaining the findings and recommendations to the child or adolescent as well.

Many psychiatric disorders of children have been addressed with varying degrees of accuracy in the public media, for example, conveying both conscious and unconscious expectations to parents. The child and adolescent psychiatrist must thus explore the specific meaning and implication of any diagnosis for a given family. Specific treatment recommendations may carry with them certain implications, any or all of which may amplify or exaggerate a parent's feelings of inadequacy or incompetence. Fears may arise in connection with specific treatment recommendations. The use and misuse of psychopharmacology has been pursued in excruciating detail and with variable accuracy by the media. In addition, certain religious and political groups have publicly pursued an agenda opposing psychopharmacology, often in an ill-advised and misinformed fashion. All this information can be on parents' minds. Concurrently, however, they or their children may see medication as a means of control or as a source of some sort of magical improvement.

Although many parents may see psychotherapy as a more benign intervention than somatic treatment, they may still have concerns or misconceptions about it. The usual recommendation for family involvement or family therapy may be interpreted by some parents as an indictment of their own actions. Psychotherapy, and the fashion in which it helps or cures, may also be a mystery to parents. A careful, thoughtful, and concise explanation of the rationale for psychotherapy should always be given. The explanation should include the indications for psychotherapy, the options of therapeutic methods and approaches applicable to a given situation, the manner in which psychotherapy can be expected to help, the role of the family in this therapy, and an estimate of duration and cost.

Treatment Planning

Treatment planning is considered in greater detail in Chapter 6. It is informed by a variety of considerations, including the specific disorders of the patient or family; the preferences, hopes, fears, and fantasies of the patient or family; and systemic availability and limitation of resources. A treatment plan must be developed that is both appropriate for the disorder under treatment and realistic in the context of patient and family wishes and resource limitations. In today's environment of care management for fiscal ends and with limited resources, clinicians may frequently be tempted to offer treatment

plans that are suboptimal or even inadequate for the patient's needs. It is the professional and ethical responsibility of any physician, certainly including child and adolescent psychiatrists, to provide patients and families with a clear indication of the most clinically effective treatment recommendations – even if they are not economically feasible. McConville (see Chapter 6) offers a model of treatment planning that places interventions on separate continua of directivity and restrictiveness and allows for a sequential arrangement of multiple interventions.

Sharing Information with Other Physicians, Schools, and Agencies

Since many patients seek child and adolescent psychiatrists as a result of a referral from physicians, schools, or other agencies, information must frequently be shared regarding the patient's condition, prognosis, and treatment. It is axiomatic that information on any patient cannot be released without the expressed (and usually written) permission of the patient or, in the case of a minor, the patient's parents or legal guardian. Both the content of shared information and the manner in which it is communicated are matters of clinical judgment and practical wisdom, and should be discussed in advance with patients, families, or guardians. Information should be distributed only as requested, and psychiatrists should avoid automatic release of entire reports or clinical notes. These issues of confidentiality are especially complicated by third-party reimbursement. Many patients and families routinely authorize unlimited release of clinical information for the purpose of reimbursement, and in fact may be forced to do so. Unfortunately, this information can then become accessible to an almost unlimited number of individuals and organizations.

In general, referring sources should not be given detailed information about members of the family other than the patient. This is especially critical in educational settings, since many school records are virtually public documents. Much of the time, these dilemmas can be claimed or resolved before any records or reports are released by conversing with the professional or agency requesting information. The type of information shared with a referring physician may be very different from that shared with the school, however, in both content area and detail.

Referral sources sometimes pursue psychiatric evaluation of a child or adolescent in a conscious or unconscious attempt to gain information about the parents or other family members. Such requests, even when made with good intentions, are usually ethically indefensible. They are also logically suspect, since they seek information that arises from hearsay and surmises. An extreme example of this situation is when the child and adolescent psychiatrist is asked to comment on the fitness for child custody of a parent whom the psychiatrist has never met. Complying with such a request can embroil the psychiatrist in conflicts that make further engagement with the family impossible, while the child has been done no substantive good: The psychiatrist should be ready to discuss the specific needs of a child, however, irrespective of the particulars of physical setting.

Consultation, Collaboration, and Advocacy

Children's needs are addressed in our culture by a wide variety of people: parents, professionals, and educators, among others. Even in the case of the child with a major mental illness whose psychiatric needs may be paramount, it is usually impossible for a child and adolescent psychiatrist to function alone. The psychiatrist will therefore be asked to consult with other professionals and educators. (The manner of these consultations is discussed in Chapters 4, 5, 29 and 30.) Such consultation may be an intermittent advisory relationship, or it may involve ongoing collaboration wherein child and adolescent psychiatrists and other professionals interact in discipline-specific roles.

In today's environment of competition for social and educational resources, and of active intervention in the lives of children and families who are in danger, the child and adolescent psychiatrist has a special role of advocacy. This role may develop as a result of a request by a patient and family or the psychiatrist's perception that some special intervention or communication is required. Despite the changing and challenged role of physicians in our society, the child and adolescent psychiatrist can still be an important and potent agent in the workings of educational, social, and legal systems.

Conclusion

The child and adolescent psychiatrist has a unique role within medicine, providing diagnostic assessment, therapeutic services, consultation, and advocacy for children and their families. In a broad biopsychosocial context, child and adolescent psychiatrists attempt to best meet the needs of children and families by providing these services in a fashion informed by scientific rigor, personal sensitivity, and social responsibility. An encounter with the child and adolescent psychiatrist should provide clinical clarification, personal reassurance, and practical direction.

Appendix 1.1

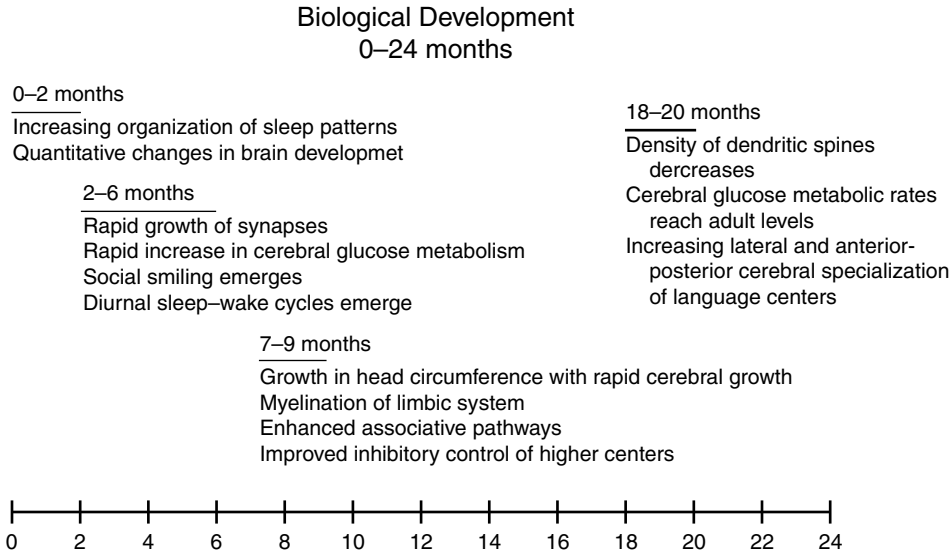

Figure 1.1 Biological development during the first two years of life.

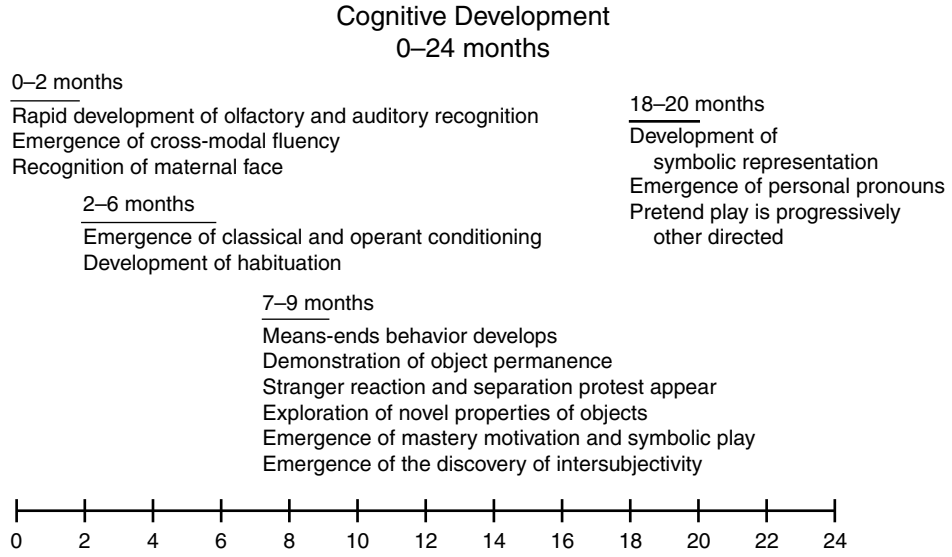

Figure 1.2 Cognitive development during the first two years of life.

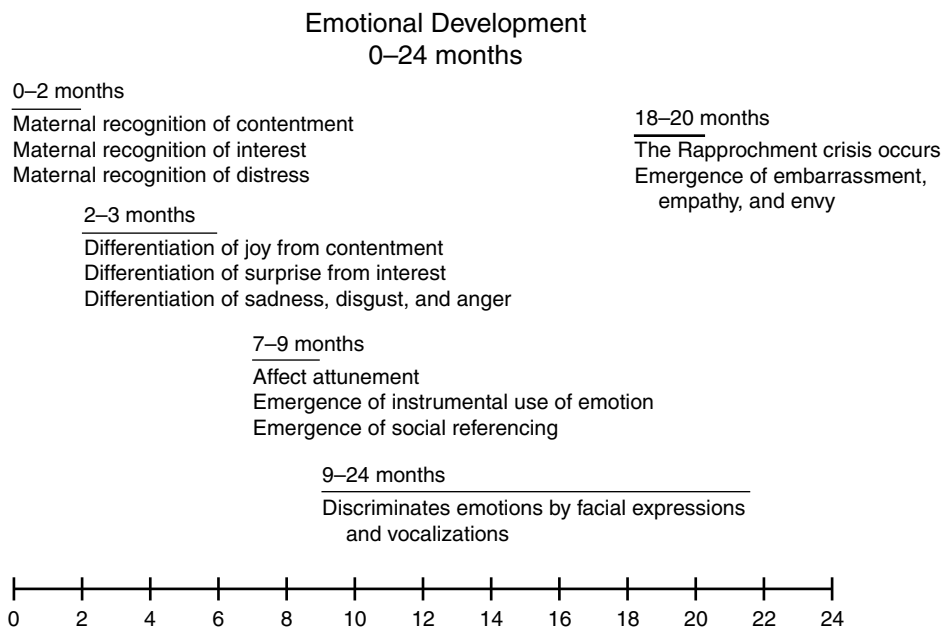

Figure 1.3 Emotional development during the first two years of life.

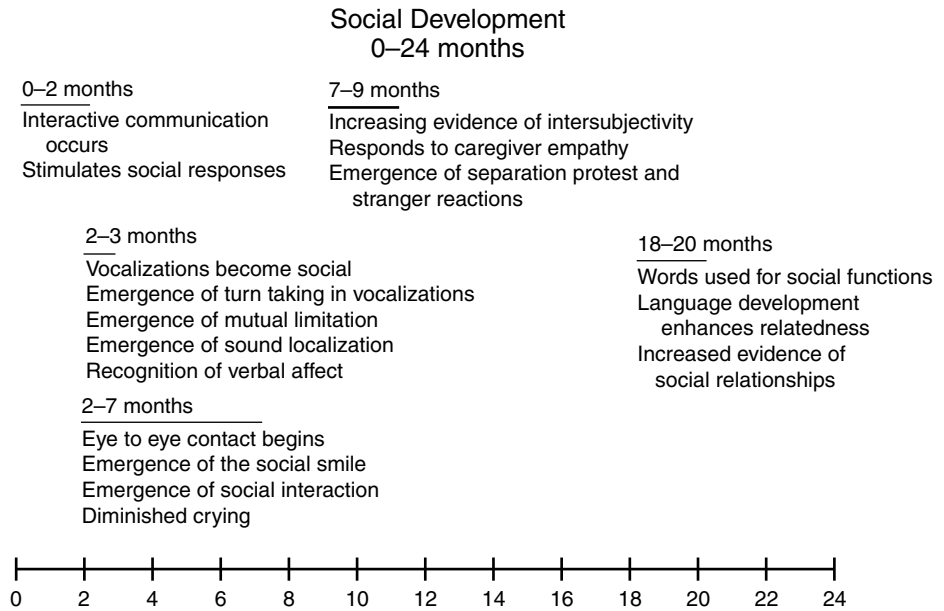

Figure 1.4 Social development during the first two years of life.

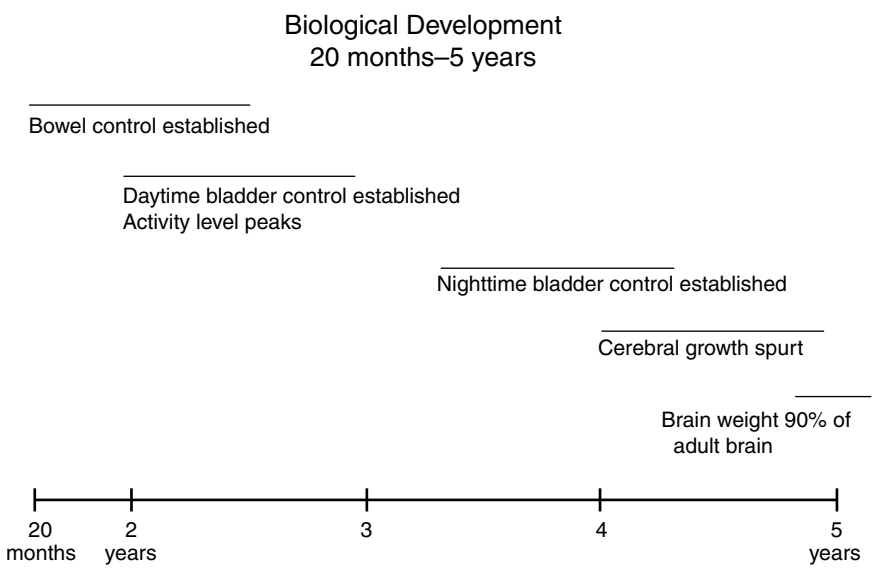

Figure 1.5 Biological development during the preschool years (20 months–5 years).

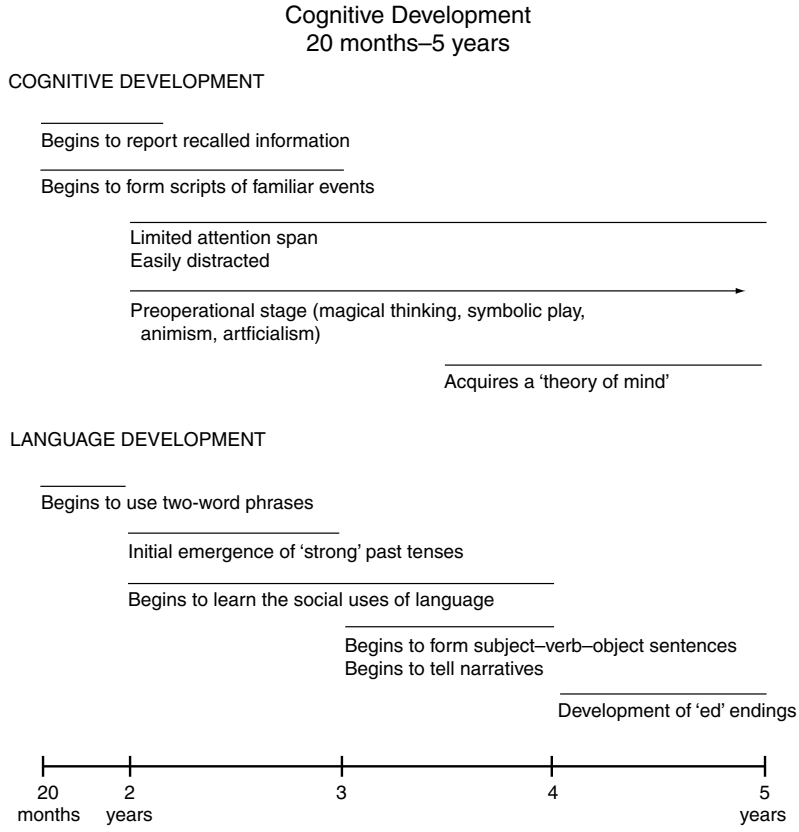

Figure 1.6 Cognitive development during the preschool years (20 months–5 years).

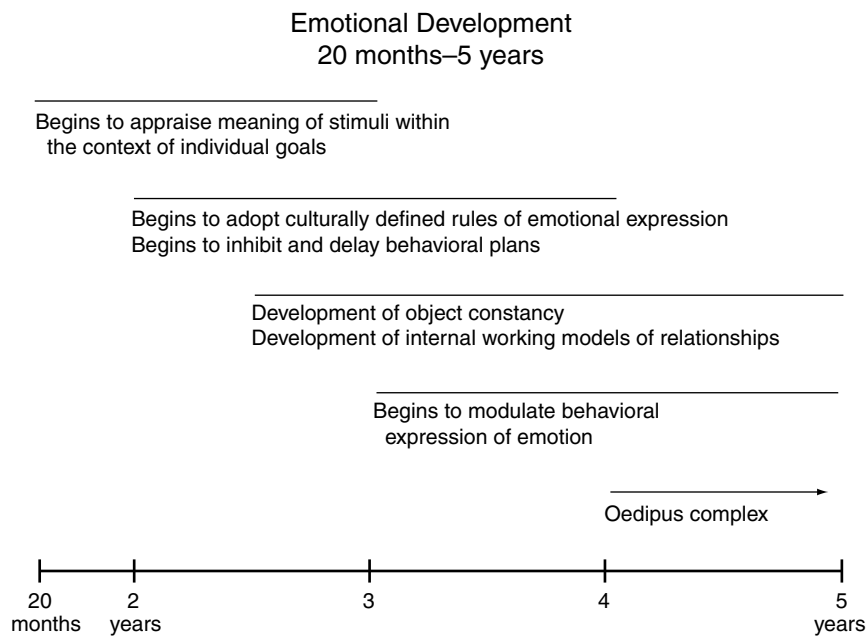

Figure 1.7 Emotional development during the preschool years (20 months–5 years).

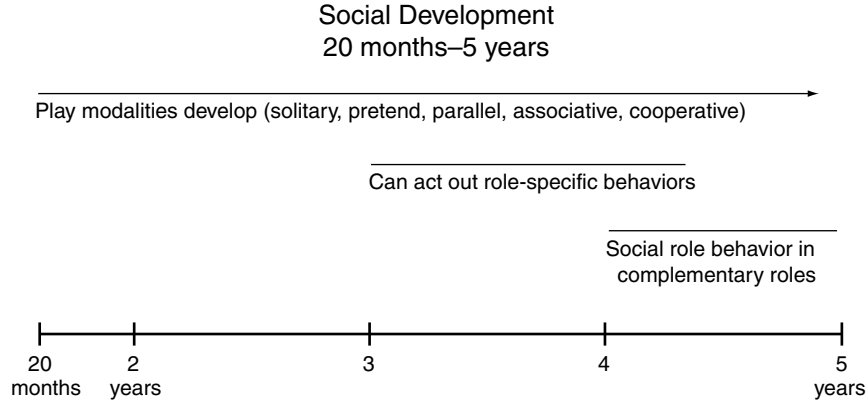

Figure 1.8 Social development during the preschool years (20 months–5 years).

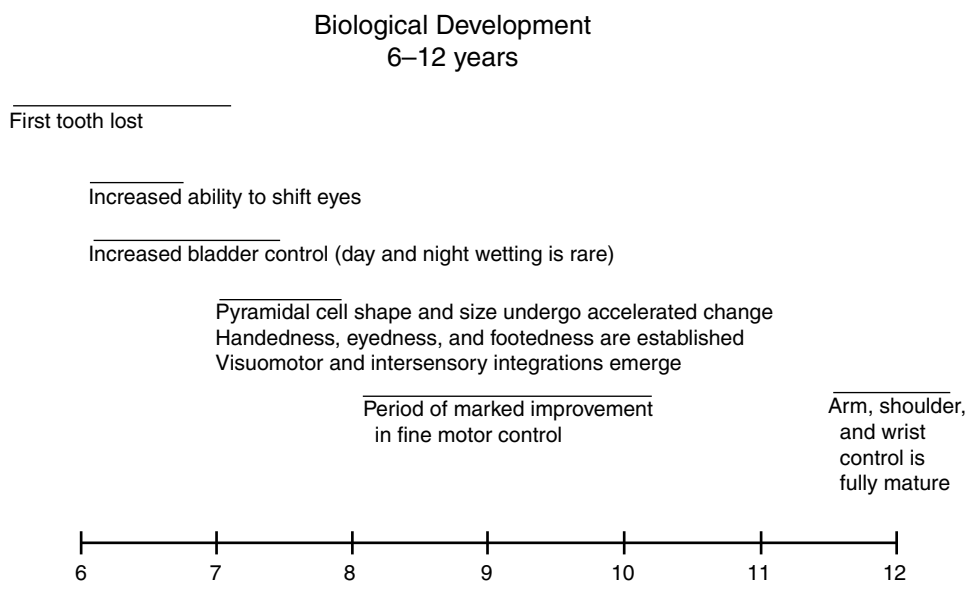

Figure 1.9 Biological development in the school-age child (6–12 years).

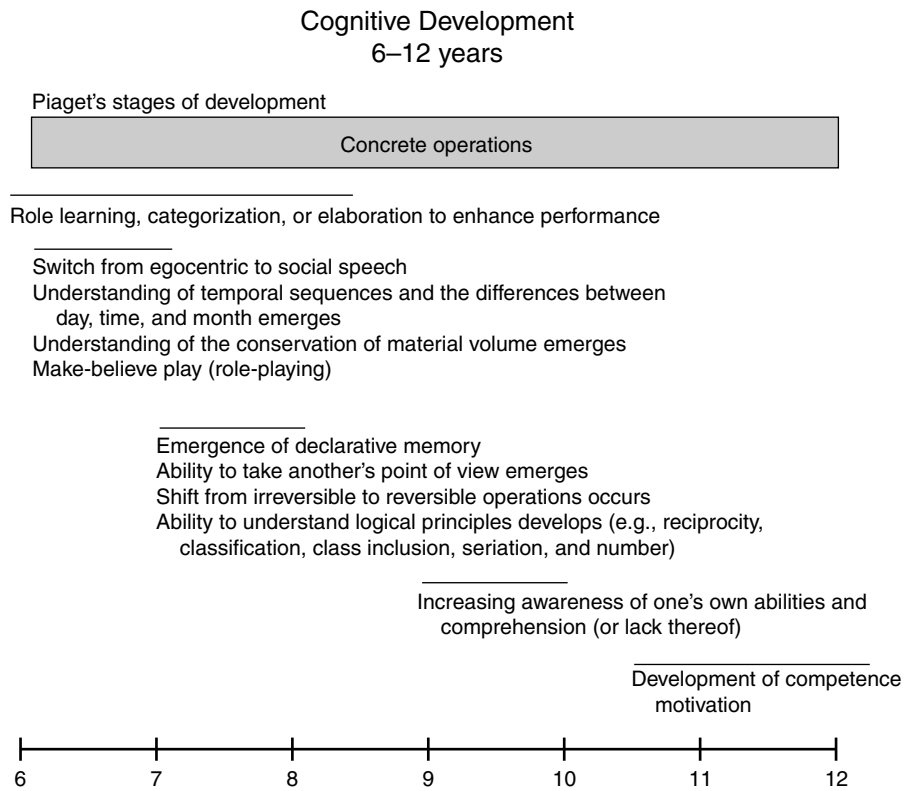

Figure 1.10 Cognitive development during the school-age child (6–12 years).

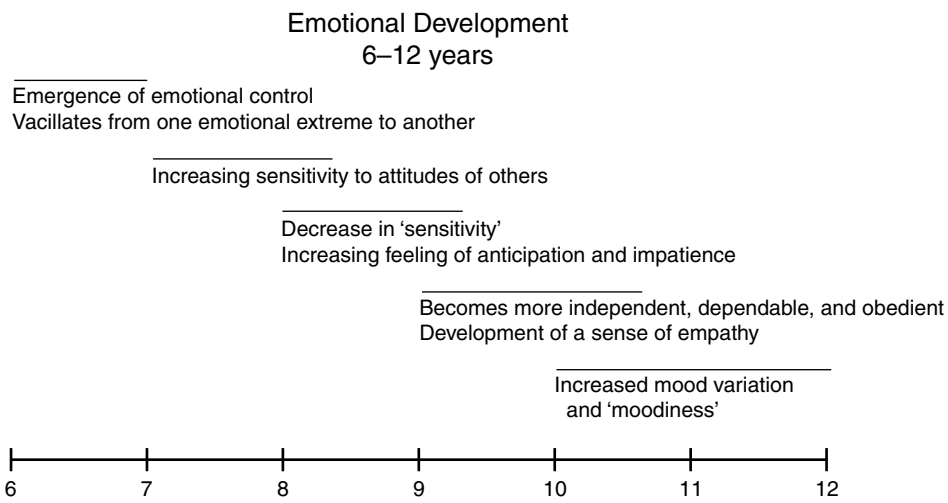

Figure 1.11 Emotional development during the school-age child (6–12 years).

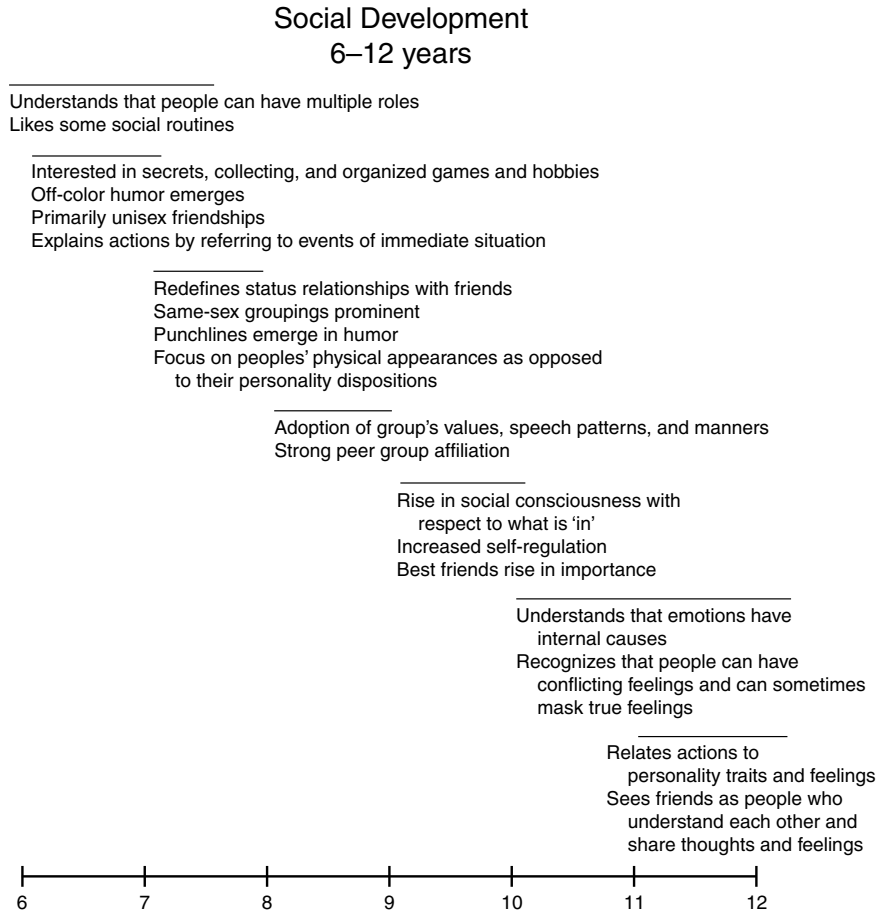

Figure 1.12 Social development during the school-age child (6–12 years).

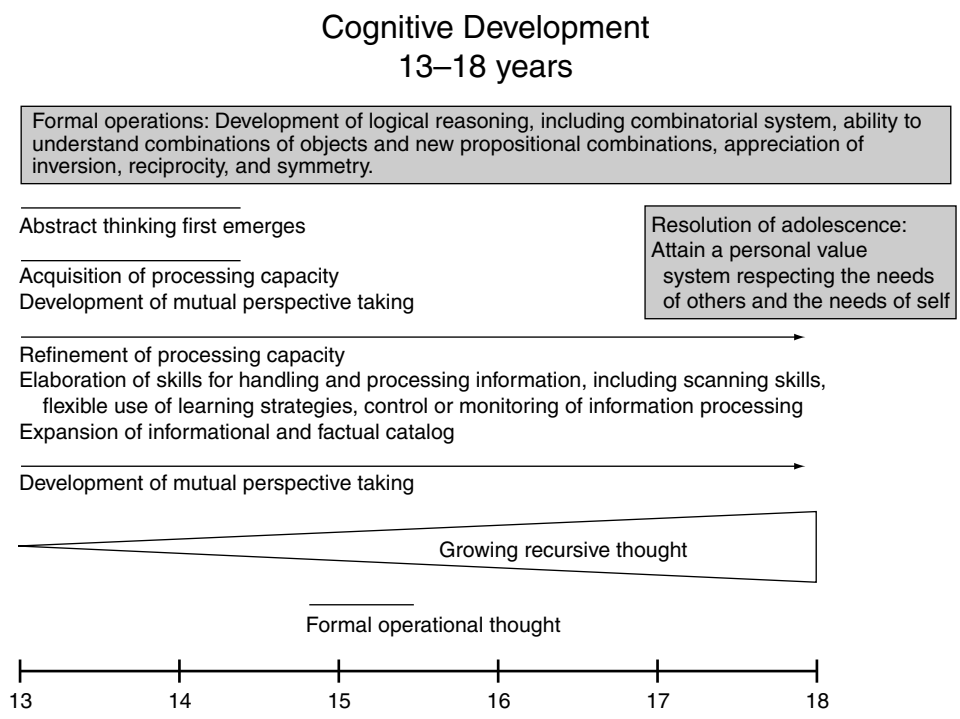

Figure 1.13 Cognitive development during the adolescent period (age 13–18 years).

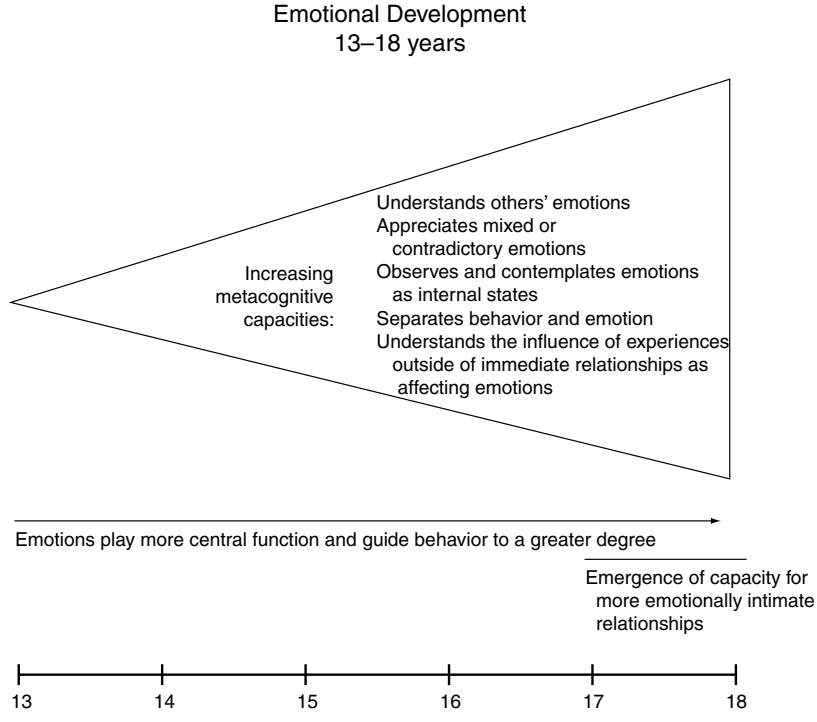

Figure 1.14 Emotional development during the adolescent period (age 13–18 years).

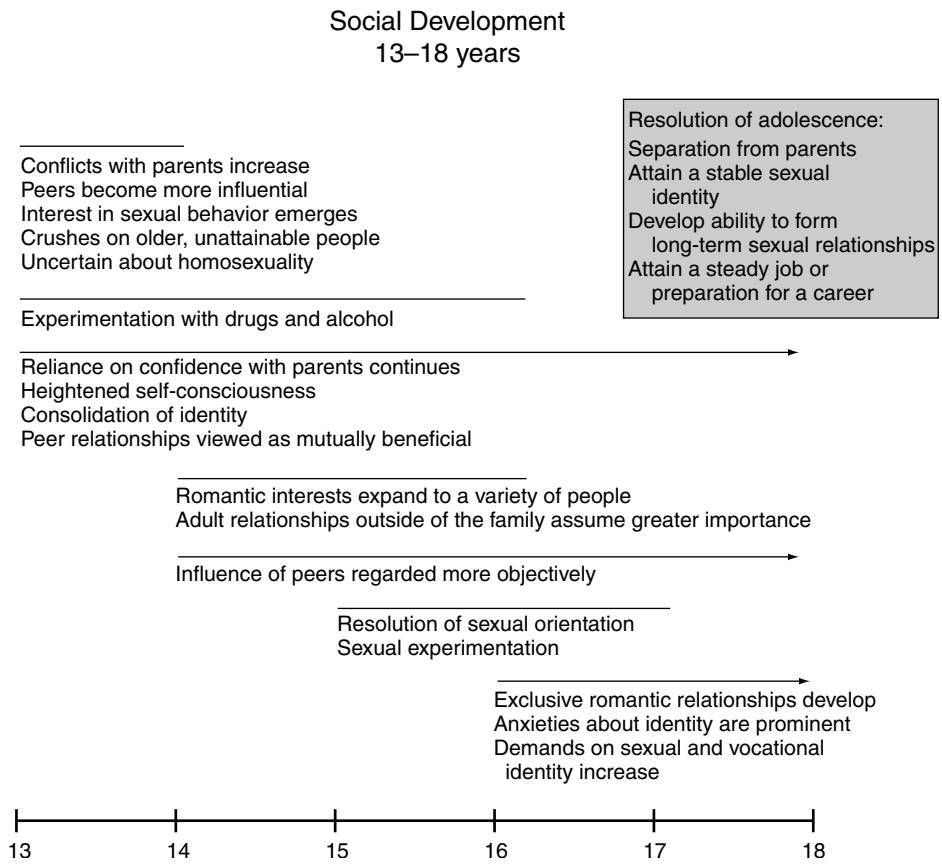

Figure 1.15 Social development during the adolescent period (age 13–18 years).

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