

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Practice Parameters for the Psychiatric Assessment of Children and Adolescents

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ABSTRACT

These practice parameters were developed by the American Academy of Child and Adolescent Psychiatry as a guide for clinicians evaluating psychiatric disorders in children and adolescents. The document focuses on the assessment, diagnostic, and treatment planning process, emphasizing a developmental perspective. The assessment process is intended for all children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning to assist the clinician in arriving at accurate diagnoses and in appropriate treatments. Details of the parent and child interviews are presented as well as an outline of specific areas of inquiry necessary for this process. The use of standardized tests and rating scales is addressed. These parameters were previously published in *J. Am. Child Adolesc. Psychiatry*, 1995, 34:1386-1402. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(10 Supplement):4S-20S. **Key words:** psychiatric assessment, psychiatric diagnoses, child and adolescent psychiatry, practice parameters, guidelines.

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Child and adolescent psychiatrists evaluate and treat children and adolescents who have psychiatric disorders that impair emotional, cognitive, physical, and/or behavioral functioning. The child or adolescent is evaluated in the context of the family, school, community, and culture. Most of the identified signs and symptoms with their associated impairments in developmental functioning respond to established treatments. The physician must prioritize symptoms and diagnoses so that a reasonable treatment plan will address multiple problems. Many children and adolescents have comorbid disorders which do not fit into a single DSM category. The physician in an individual situation should consider but not be limited to the treatment guidelines for a single diagnosis.

Practice parameters provide guidelines for patterns of practice, not for the care of a particular individual. This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance. The parameters of practice should not be construed as including all proper methods of care or excluding other acceptable methods of care reasonably directed to obtain the same results. Adherence to these parameters will not ensure a successful outcome in every case. The ultimate judgment regarding any specific clinical procedure or treatment must be made by the physician in light of all the circumstances presented by the patient and family and the resources available.

These parameters of practice were approved as of the date indicated, and they should not be applied to clinical situations occurring before that date.

In this guideline, the term “child” refers to both adolescents and younger children unless explicitly noted; unless otherwise noted, “parents” refers to the child's primary caretakers, regardless of whether they are the biological or adoptive parents or legal guardians. These guidelines are applicable to the evaluation of child and adolescent patients 18 years of age and younger. This document presumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment (see standard textbooks by Kestenbaum and Williams, 1988; King and Noshpitz, 1991; Lewis, 1991a; Rutter and Hersov, 1994; Shaffer et al., 1985; Wiener, 1991).

The purposes of the diagnostic assessment of the child are (1) to determine whether psychopathology is present and, if so, to establish a differential diagnosis; (2) to determine whether treatment is indicated; and, (3) if so, to develop treatment recommendations and plans and to facilitate the family and child's cooperative engagement in treatment. (For specialized consultative purposes or under emergency circumstances, the focus of inquiry may be narrowed accordingly. Examples of such focal evaluations may include medication consultations, emergency evaluations, or the determination of dangerousness to self or others for the purpose of hospitalization. In these and other circumstances, therapeutic interventions may need to be implemented promptly, with fuller assessment later, during the course of treatment.)

The specific aims of the diagnostic assessment of the child are (1) to identify the stated reasons and factors leading to referral; (2) to obtain an accurate picture of the child's developmental functioning and of the nature and extent of the child's behavioral difficulties, functional impairment, and/or subjective distress; and (3) to identify potential individual, family, or environmental factors that may account for, influence, or ameliorate these difficulties.

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Literature Review Process

The literature search included a review of the relevant portions of current child psychiatric textbooks and journal articles, reviews, and monographs on diagnostic assessment published in the past 6 years. In addition, pertinent earlier articles and chapters were reviewed. Finally, the authors drew on their own experience in this area.

Special Considerations in the Evaluation of Children and Adolescents

The psychiatric assessment of the child differs from that of the adult in several important respects.

The clinical phenomenology of certain childhood disorders closely parallels that of the corresponding adult condition. In such cases, the diagnostic criteria described in the official DSM and ICD classification systems may be applied in relatively unmodified terms. In some cases, however, developmental factors may influence the presentation of psychiatric symptoms, such as anxiety or depression.

In many cases, children's abnormalities consist of deficiencies in positive adaptive behaviors and a failure to progress in the expected fashion along one or more dimensions of development, rather than specific symptoms pathognomonic of adult disorders (Achenbach, 1980). For many children, the clinical condition requiring assessment may represent a severe form of symptoms found in milder form in nonreferred children (Cox and Rutter, 1985). For example, transient or isolated problems such as fears, tantrums, or restlessness are common in childhood; in a substantial number of children, however, these difficulties are sufficiently persistent, functionally impairing, and/or distressing enough to warrant clinical attention (Rutter et al., 1970a,b). Certain symptoms, such as poor peer relations, are likely predictors of both current and persisting disorder (Cox and Rutter, 1985).

The focus of both history-taking and the mental status examination of the child is thus developmental, in that it seeks to describe the child's current functioning in various realms and to assess the child's adaptation in these areas relative to that expected for the child's age and phase of development. The child psychiatric diagnostic process is therefore rooted in the clinician's understanding of the vicissitudes of normal and abnormal child development, including the expectable range of behaviors at different ages and the characteristic manifestations of various forms of disturbances in each developmental phase.

The chief complaint and impetus for referral often come from the adults in the child's life, such as parents or teachers, rather than from the child. The child's own understanding of the reason for the assessment and his or her motivation and ability to cooperate in it are variable. One key element of the diagnostic assessment is to clarify the social context and reasons for referral--who is concerned about the child and why?

The child's functioning and psychological well-being are highly dependent on the family and school setting in which he or she lives and studies. The child cannot be assessed in isolation. Obtaining a full and accurate diagnostic picture of the child requires gathering information from diverse sources, including the family, school, and other agencies involved with the child, as well as the child himself or herself.

The child's ability to conceptualize and discuss his or her experiences and feelings differs from that of the adult and is profoundly influenced by maturational and developmental factors, both normal and pathological. The clinician must therefore be able to communicate with and understand the child in a fashion appropriate to the child's developmental level. Information

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gathering from the child may require various modes of communication other than question and answer or verbal discourse.

The child interview and mental status examination must reckon with the characteristic lability of children and their propensity to fall back to more immature ways when tired, sick, apprehensive, or in unfamiliar situations. Hence, although a single initial interview may provide potentially useful information, it may not accurately reveal the child's optimal or characteristic level of functioning. More than one interview with the child is usually desirable to place the child at ease with the interviewer and to obtain a more representative and valid picture of the child.

The clinical assessment of the child thus requires several hours. This should include time for the parent interview, time for the child interview, and time for communicating the diagnostic formulation and recommendations. As clinically indicated, additional collateral contacts, home visits, or observation of the child's functioning at school may be needed.

SOURCES OF INFORMATION

The full diagnostic assessment of the child usually requires gathering data from the patient, the family, and the school, as well as from the primary physician and any past and current mental health providers. For children involved with the child welfare or juvenile justice system or for children living in institutions, information from agency records, caseworkers, probation officers, and/or institutional caretakers is essential. For children who are inpatients in either a psychiatric or pediatric setting, the assessment must draw upon the observations and assessments of the many disciplines involved with the child--nursing, milieu therapy, social work, education, physical and occupational therapy, expressive therapy, psychology, pediatrics, etc.

At a minimum, assessment usually entails direct interviews with the child and parents. In order that both the child and parents may speak frankly, it is desirable that the assessment include opportunities to meet separately with each. It is also important to see the child and parents together to observe their interaction and to assess how they formulate and discuss the problem together. Sometimes it may be helpful to see the entire family together.

The practical arrangements of how these interviews are ordered or combined varies with the case and clinical setting. For young children, one or more initial parent interviews without the child may be appropriate, before the child is seen either alone or with the parents. In contrast, it is usually helpful to include adolescents in the initial interviews, either with or without the parents. Excluding the adolescent risks casting the physician as an agent of the parents in the patient's eyes, thereby potentially undermining the treatment alliance (Schowalter and King, 1991).

The primary clinician may collaborate with other clinicians in gathering such data, but it remains his or her task to assess and integrate the information obtained.

ALL INTERVIEWS

A complete decision tree for all items in the diagnostic interview would be inappropriate. If screening questions do not reveal significant data, the clinician can use judgment to move to another, more salient area. Where screening suggests that an area of inquiry is salient or where significant difficulties or vulnerabilities are noted, the applicable questions in this guideline (as well as other questions based on the clinician's experience and clinical judgment) should be

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asked. The trained clinician will use his or her judgment to elicit the most relevant data in a time-efficient manner.

PARENT INTERVIEW

The parents' or guardians' consent and cooperation are crucial for the assessment of the child. When a custodial parent or legal guardian requests the evaluation, consent is not an issue. When the referral comes from another source, it is usually clinically and legally necessary to obtain a custodial parent's consent for the psychiatric evaluation of the child. In emergency or extraordinary circumstances, such as those provided for by states permitting adolescents to seek mental health treatment without their parents' consent, evaluation may legally begin without the parents' involvement, but even in such cases it is usually clinically desirable to involve the parents as soon as possible.

The parent interview has several goals. The first goal is to obtain the parents' account of the reasons for referral, the child's current difficulties, and the impact of the child and his or her symptoms on the individual parents, the parental couple, and the family as a whole. The second goal is to obtain a careful history of the child's past and current development in the context of his or her family. The third goal is to obtain a picture of the parents' and family's functioning, including their community and cultural setting. The fourth goal is to gather family history concerning medical or psychiatric disorders that may be of genetic or environmental significance for the etiology or treatment of the child's difficulties. Each of these will be considered in turn below.

Technical Issues in Parent Interview

As noted earlier, parents' concerns usually provide the immediate impetus for referral. Mother's and father's accounts, however, may not always agree completely with each other or with those of the child, teachers, or contemporaneous records of past events (Chess et al., 1966; Edelbrock et al., 1986; Ivens and Rehm, 1988; Mednick and Shaffer, 1963; Robins, 1963; Weissman et al., 1980). These discrepancies emphasize the necessity of multiple informants.

These discrepancies may arise for a variety of reasons. First, informants may differ in their access to information concerning the child's feelings and behavior. This is particularly the case when the child's symptoms are situation specific (e.g., occurring only at school or only at home). Second, informants differ in how they perceive or evaluate the events they do observe. Third, informants may differ in their propensity or ability to report their perceptions to the interviewer. For example, parents may be quick to report a behavior of the child which they find disturbing or annoying. The child, in contrast, even if aware of and able to describe the problematic behavior verbally, may refrain from doing so out of feelings of shame or fear of reproach.

Both clinical experience and methodological studies suggest that parents are more likely than the child to report disruptive or externalizing behaviors, such as restlessness, inattention, impulsiveness, oppositionality, or aggression. Conversely, children may be more likely to report anxious or depressive feelings and symptoms, including suicidal thoughts and acts, of which the parents may be unaware (Kashani et al., 1985). Empirical studies suggest that parents are usually more accurate than children in reporting factual time-related information, whereas information from the child is essential to assess his or her feelings and attitudes (Orvaschel et al., 1981). The child may be the only source of information regarding some events, such as sexual abuse. In general, the reliability of children's reports of specific symptoms increases with age, with children under the age of 10 years tending to be less reliable reporters of symptoms than their

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parents (Edelbrock et al., 1985). (Specific issues concerning the evaluation of sexual abuse and child custody evaluations are the subject of separate Practice Parameters under development.)

Parents differ in the type and amount of time spent in interaction with their child. The differences in perspective and context of observation that may exist between mothers and fathers highlight the importance of directly involving both parents in the assessment to the greatest extent possible. Other household informants, such as siblings, grandparents, stepparents, or child caretakers, may also contribute useful information to supplement the parents' perspective. Differences between parents' and teachers' perceptions of a child may stem from the different contexts in which the child is observed, as well as the standard of judgment employed. When observed to be present both at home and at school, symptoms such as hyperactivity and inattention may carry a different clinical significance and prognosis than those noted in only one, but not both, settings (Schachar et al., 1981).

The parent interviewer must use a variety of interview techniques to elicit information. Interview techniques influence the type and quality of information elicited (Rutter and Cox, 1981). (Methodological studies comparing the effectiveness of different interview approaches have been reviewed by Cox and Rutter, 1985.) Specific questions are most useful for obtaining factual and chronological data, whereas information about feelings and relationships may be better elicited by more open-ended, indirect questions (Cox et al., 1981; Graham and Rutter, 1968; Rutter and Graham, 1968). To establish rapport and avoid premature narrowing of focus, it is important to give parents an opportunity to tell their story in their own fashion. This may be supplemented by flexible follow-up questions to clarify details.

The parent interview has the dual goal of gathering information and establishing rapport. These goals are complementary in that parents are most likely to be nondefensive and forthcoming with a clinician whom they perceive as understanding and nonjudgmental. This requires that the interviewer maintain an empathetic stance that is neither aloof nor overly familiar. The clinician must be able to discuss the child's and family's situation and concerns in terms comprehensible to the parents. It is important that the tenor of the diagnostic inquiry (including an interest in the child's strengths and talents) should convey an appreciation that the child is not merely a patient or bearer of symptoms. The clinician must also be aware of the impact on the interview process of perceived differences or similarities between the clinician and the child (or parents) in terms of gender, age, and ethnic or social background.

Parental Account of Reasons for Referral and Child's Current Symptoms, Strengths, and Weaknesses

As most clinical referrals originate with the parent(s), rather than child, the parents' account of the child's presenting difficulties is of paramount importance. Beyond providing factual information about the child's current symptoms and functioning, the parent interview aims to elucidate the meaning and impact of the child's difficulties on the family, as well as the parents' attitude toward the referral and diagnostic process. This interview thus provides the opportunity to develop an alliance with the parents with the shared goals of identifying and helping the child's difficulties (Leventhal and Conroy, 1991). As part of this task, it is especially important to identify the parents' implicit and explicit expectations and concerns about the evaluation.

It is necessary to inquire about frequency, intensity, duration, and circumstances in which problematic behaviors occur, and the attitudes of the parents, child, and others toward the problem. This should include asking for a systematic account of specific instances of the

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problematic behavior (Cox and Rutter, 1985). To assess the degree of functional impairment caused by the child's difficulties, it is necessary to inquire about the degree of the child's distress, interference with social and academic activities, impact on the child's ongoing development, and impact of the child's behavior on others (Cox and Rutter, 1985).

The course of the history taking regarding the chief complaint will vary with the nature of the presenting symptoms and details of the individual case. The goal is not only to obtain a description of the problematic behavior, but to understand the meaning and function of the symptoms in relation to the factors in the child and environment which influence them (Cox and Rutter, 1985). A given symptom, e.g., temper tantrums, theft, or hallucinations, may have quite different meanings, functions, and clinical implications in different children and in different environmental settings (Freud, 1966). To make these distinctions, the interview must assess the preceding circumstances, immediate precipitants, behavioral concomitants, and consequences of the problematic behavior, as well as the broader developmental and family context in which the symptoms occur. Thus, from the very onset of the interview process, history taking and diagnostic formulation are not separate processes; rather, the experienced clinician is continually formulating and testing tentative hypotheses which guide the questions and diagnostic possibilities to be explored in the interview.

History taking should focus not only on the child's difficulties and symptoms, but on the child's strengths, talents, and areas of superior adjustment as well. Such an approach helps to support the child's and parents' self-esteem and provides valuable information about factors that may help to ameliorate or compensate for the child's areas of vulnerability.

An additional aspect of the initial phase of the parent interview is to clarify the practical and administrative aspects of the diagnostic assessment. These include issues of fee, scheduling, confidentiality, and permission for gathering information from school personnel and other clinicians. If the child has not been included in the initial interview(s), appropriate preparation of the child for meeting with the clinician should be discussed with the parents.

Developmental History

One or more interviews with the parents are necessary to provide a detailed history of the child's physical, cognitive, linguistic, social, and emotional development (Canino, 1985). Beginning with conception and pregnancy, this history taking should elicit both the objective facts of the child's development up to the present and the emotional significance of the various facets of the child's development in terms of the parents' own hopes, fears, expectations, and life circumstances. Even when parents are not able to give a precise chronology of the child's early history, they may be able to provide a meaningful account of the child's development relative to other siblings or important family events. Particular attention should be paid to apparent changes or discontinuities in the child's developmental progress or level of functioning.

In assessing the child's past and current development, several realms are of particular importance:

Cognitive and School Functioning. Beginning with early childhood, the child's pattern of cognitive strengths and weaknesses should be surveyed, including verbal, attentional, and organizational skills. The child's educational history should address the social, emotional, and intellectual aspects of school participation. These include the ability to separate from parents and to attend school regularly, interpersonal relationships with peers and teachers, motivation to learn, tolerance for frustration and delay of gratification, attitudes toward authority, ability to

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accept criticism, etc. A sequential history of the schools attended should be taken, as well as the reasons for any changes.

When the child's behavior or progress at school are among the problem areas, the school records, including any standardized testing, should be reviewed. Direct information-gathering from the child's teachers, counsellors, or other school personnel is highly desirable.

Peer Relations. An assessment must address the extent and quality of the child's friendships (including preferences regarding age and gender of friends and any major changes in peer group), social skills and deficits, and participation in, as well as enjoyment of, informal and organized peer activities. For adolescents, this social history includes the capacity for intimate relationships, romantic interests, sexual activity, and any concerns over sexual orientation.

Family Relationships. This part of the assessment covers how the child relates to individual family members and how the child fits into the overall family system. It is also important to inquire about the impact of changes in family composition or relationships, such as deaths, birth of siblings, older siblings leaving the family, marital separation, parental divorce or remarriage, and changes in caretaking arrangements, custody, or visitation. The degree of the child's compliance with family rules and standards should be assessed. The quality and style of parental discipline or limit setting should be assessed, as well as the child's response to such interventions.

Physical Development and Medical History. The medical history begins with the child's conception, gestation, and delivery. Specific inquiry should be made concerning prenatal and perinatal complications (including medication and substance use), length of gestation, birth weight, and neonatal status.

The physical development history includes fine and gross motor development, toilet training and any lapses, eating behavior and attitudes, and sleep patterns. Stage of pubertal maturation and physical growth (including lags or precocious development), as well as the child's feelings concerning them, should be noted. Systematic inquiry is important regarding medication, illnesses, hospitalizations, serious injuries (especially those involving the head), or operations, as well as the child's reactions to these events and their impact on his or her health and activities.

As relevant, specific inquiry should also be made concerning the child's most recent medical examination, the occurrence of tics, difficulties with hearing or vision, and abnormal states or loss of consciousness. Medical reports should be obtained and reviewed as indicated.

Emotional Development, Temperament, and Mental State. This includes an account of the child's personality; present and past mood and affect regulation; style of attachment and reaction to separations; anxieties; and adaptability to new, challenging, or frustrating situations. The assessment of mood explores the child's prevailing mood, as well as the presence or absence of periods of depression (as manifested by the developmentally relevant signs and symptoms of depression). There should be specific inquiry into any occurrence of suicidal ideation, gestures, or attempts. The occurrence of distressing or impairing anxiety should be explored, including its generalized or specific nature, initial precipitants and current evokers, and its impact on the child. Specific inquiry should be made concerning the occurrence of unusual fears, excessive shyness or withdrawal, obsessive or compulsive symptoms, and hallucinations, delusions, or difficulties in reality testing.

The child's capacity for self-reflection should be assessed. How much insight does the child have concerning his or her feelings and those of others? What is the nature of his or her sense of humor?

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The child's regulation of aggression also requires specific inquiry. Under what circumstances does the child become angry or aggressive, and what form does it take? Does the child have homicidal or suicidal ideation or impulses to harm himself or others? Is the child too aggressive or overly fearful of anger?

Development of Conscience and Values. Is the child's conscience excessively harsh, lax, or preoccupied with specific issues, given his age? Does the child have particular religious, ethical, or cultural concerns and how do they relate to the values of his family?

What, if any, are the child's important goals and aspirations for the future? How realistic are they and how do they relate to his family's values and expectations?

Interests, Hobbies, Talents, and Avocations. What are the child's interests and what does he or she like to do for fun? Does the child have areas of special interest or talent?

Unusual Circumstances. Has the child been exposed to traumatic circumstances, such as sexual or physical abuse, family substance abuse, family or community violence, or natural disaster? If so, what was the nature of the child's exposure; the immediate and subsequent response of the child, caretakers, and other adults; and any long-range effects? Is there risk of the child's continued exposure?

Prior Psychiatric Treatment History. Inquiry should be made regarding prior psychiatric, psychological, or educational evaluations or interventions which may have been sought for any of the areas of difficulty noted. It is important to assess the outcome of any such interventions, as well as the child's and parents' attitude toward such earlier attempts to obtain help. When relevant, permission should be sought to obtain the reports of prior clinicians.

Assessment of Family and Community Background

An essential part of a complete diagnostic assessment of the child is a picture of his or her family and community background.

Parents or Caretakers. Where the child resides with his or her biological or adoptive parents, this involves an assessment of who the parents are as individuals and as a marital and parental couple, including their individual and joint strengths, weaknesses, and areas of conflict or difficulty. If the child is adopted, in foster care, or residing with relatives other than the biological parents, the history and circumstances of this living arrangement must also be reviewed.

Beginning with the child's conception, what have been the attitudes, involvement, and reactions of family members to the child? To what extent do they agree or disagree regarding the care and management of the child and in their hopes, fears, or expectations concerning the child? How have the parents' own developmental histories with their families of origin and subsequent experiences shaped their responses to the child?

What are the parents' ethnic and religious backgrounds, and are these a source of conflict? What language is spoken by the parents and/or by the child? Is the interviewer familiar with that language or culture and its concepts or with terms relevant to the child's and family's situation?

What are the parents' education, occupation, and financial resources? Are there financial or insurance limitations which are likely to influence the treatment options available to the family?

Who are the other immediate family members and persons living in the home, and what is their relationship to the child? What are the various boundaries and alliances within the family, and how does the child fit into the family system?

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The modes and effectiveness of family communication and problem solving should be assessed. How does the family deal with issues of separation or disagreement? What is the prevailing emotional tone of the family, especially as it impinges on the patient? Is there parental substance abuse or psychiatric disorder? Are there episodes of violence or sexual abuse between family members? Have there been significant stresses impinging on the family as a whole or on individual members, such as moves, immigration, illness, accidents, job changes, abandonment, or legal difficulties?

Community. A full appreciation of the child and family's cultural context is essential in assessing the child and his or her presenting difficulties. For example, what is the community or neighborhood in which the family lives and how do they relate to it? What are the family's religious and ethnic identifications? What is the family's involvement with civic, community, and religious activities (and to what extent does the child participate)? What are the neighborhood's resources (e.g., recreational and academic) and what are its adverse circumstances (e.g., poverty, poor housing, high rates of crime or urban violence)?

Family Medical and Psychiatric History

It is essential to inquire about family members' past and current history of medical and psychiatric disorders which have potential environmental or genetic consequences for the child. Examples of such disorders include, but are not limited to, psychotic and affective disorders, suicidal behaviors, anxiety disorders, tic and obsessive-compulsive spectrum disorders, alcohol and substance use, attention-deficit hyperactivity disorder, learning and developmental disabilities and delays, antisocial personality disorder, and metabolic and neurological disorders. Where any such disorders have been present in family members, inquiry should be made about their severity, treatment, outcome, and impact on the child.

CHILD INTERVIEW

The clinical interview of the child provides the setting for the direct exploration of the child's own perceptions of the presenting problem and the assessment of the child's overall developmental and mental status. As noted earlier, the direct interview with the child provides information that may not be available from other sources, for example, the degree of the child's personal suffering, information concerning affects and mental phenomena which may not be observable (e.g., anxiety, suicidal thoughts, obsessional thoughts, hallucinations), and secrets such as antisocial activities or sexual abuse.

The goals and techniques of the child interview have been reviewed by Goodman and Sours (1967), Simmons (1987), Greenspan and Greenspan (1991), Hill (1985), Bird and Kestenbaum (1988), Lewis (1991b), King and Noshpitz (1991), and Kestenbaum (1991). There is no fixed order or manner of conducting the child interview; these vary with the nature of the chief complaint and presenting pathology, the child's age and development status, the interviewer's personal style, and the clinical setting and context (e.g., emergency room, hospital ward, school-based consultation, private office, outpatient mental health clinic). Whatever the variations in format, the interview is organized and guided by the clinician's attention to the various key areas and phenomena and the interviewer's strategic sense of how best to elicit the relevant data in the case at hand. Some data emerge spontaneously, while others require questioning or other deliberate means of eliciting information (Lewis, 1991b).

The assessment of infants and preverbal toddlers requires specialized techniques, including careful developmental assessment and direct observation of mother-child interaction

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(see Greenspan, 1991, for review). (The assessment of infants is covered under a separate guideline, which is being developed.)

The broad goals of the child interview are often conceptualized under two headings: history taking and the mental status examination. History taking consists of an inquiry into the significant areas of the child's life and functioning, past and present, including the presenting problem. The mental status examination consists of an assessment and description of the child's appearance and functioning as manifested in the interview situation. In the actual practice of the child interview, however, history taking and mental status assessment are not always clearly separable processes and often proceed simultaneously. For example, the interviewer may ask a specific question, such as who lives at home with the child, or how he or she gets along with a sibling or a teacher. From a history-taking point of view, the child's response provides some information about these facts, as well as how the child feels about them. While noting the child's explicit response, the interviewer is also gathering data relevant to the mental status examination, e.g., does the child respond to or rebuff the inquiry; how skillfully does the child conceptualize and articulate his or her response; how confiding or suspicious does the child seem toward the interviewer; how eager to please, defy, or avoid blame? Similarly, while observing a young child at play with human figures, the interviewer may have the opportunity to gather information for the mental status examination simultaneously with inferential data regarding the child's feelings, fantasies, and conflicts regarding his or her own internal and interpersonal situation.

Mental Status Examination

For the mental status examination, the clinician observes and assesses the following areas: physical appearance; manner of relating to examiner and parents, including ease of separation; affect; mood; orientation to time, place, person; motor behavior (including activity level, coordination, neurological soft signs, cerebral dominance, and presence of tics or stereotypes); content and form of thought, including hallucinations, delusions, thought disorder; speech and language; overall intelligence; attention; memory; neurological functioning; judgment and insight; and preferred modes of communication (e.g., play, drawing, direct discourse) (Goodman and Sours, 1967; Hill, 1985; Kestenbaum, 1991; Lewis, 1991b; Simmons, 1987).

Specific Child Interview Techniques

The interview of the child or adolescent requires a blend of techniques flexibly and tactfully tailored to the child's developmental, cognitive, and linguistic level; the emotional difficulty of the topic under discussion; and the degree of rapport.

Interactive Play Techniques. Children may be limited in their ability to give an explicit verbal account of their feelings or social interactions (Glasbourg and Aboud, 1982; Selman et al., 1977). For school-age and younger children, imaginative play with puppets, small figures, or the interviewer himself or herself can provide useful inferential material about the child's concerns, perceptions, and characteristic modes of regulating affects and impulses (Slade and Wolf, 1994; Solnit et al., 1993). The trained interviewer is able to facilitate such play for diagnostic and rapport-building purpose, without unwittingly distorting the material by unwarranted speculations or intrusive reactions.

The form of play also provides important information for the mental status examination. For example, when imaginative play is completely absent or very limited, concrete, and noninteractive, it may suggest pervasive developmental disorder.

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Projective Techniques. A variety of formal and informal projective techniques complement the use of unstructured imaginative play as a means of surmounting limitations in children's ability or willingness to introspect or report private concerns (Rabin and Haworth, 1960). Such techniques may also facilitate the interview process by introducing an element of fun, by helping to place the child at ease, or by opening up areas for further exploration.

One of the most common techniques is to invite the child to draw a picture; the content may be left entirely open or a specific request made (e.g., a person, the child's family, or a house, tree, and person) (Thomas and Silk, 1990). Various systems have also been developed for assessing the cognitive and emotional aspects of such drawings (DiLeo, 1970; Harris, 1963; Koppitz, 1968; Naglieri, 1988; Naglieri et al., 1991).

Common projective questions are to ask the child what animal he or she would most like or least like to be, whom he or she would take along to a desert island, or what he or she would wish for if given three magic wishes (Winkley, 1982).

Interactive imaginative techniques can also be usefully employed. These include Winnicott's (1971) "squiggle" drawing game and Gardner's (1985) Mutual Story-Telling Technique. The Despert (1937) fables are a series of incomplete stories, evocative of various affective themes, which the child is asked to complete.

Asking the child to describe a dream or a book, movie, or television show which he or she recalls may also provide information regarding the child's interests, preoccupations, and distortions. Asking about a child's future ambitions provides information about the child's concerns, self-esteem, aspirations, and values.

Direct Questioning. Inquiry about the presenting problem or other aspects of the child's life requires tact, timing, attention to the child's cognitive and linguistic level of development, and respect for the child's self-esteem.

Questions must be phrased in words and concepts comprehensible to the child (Lewis, 1974). Overly abstract or wordy questions may lose the child, while leading, closed, or overly concrete questions may yield unproductive or inaccurate responses (Hill, 1985). Young children may be overly acquiescent or prone to producing what they perceive to be socially desirable responses; older children may be uncomfortable in acknowledging sad or vulnerable feelings.

Structure of the Child Interview

Preparation and Orientation of the Child. Before meeting with the clinician, the parents should discuss with the child the nature and purpose of the assessment and interview. It is best if the purpose can be stated in supportive terms that are not pejorative or accusatory, to avoid putting the child unnecessarily on the defensive or casting the assessment in a punitive light. Young children may need some explanation of who the physician is in terms appropriate to the referral (e.g., "a feelings [or talking] doctor" or "a doctor who helps children with problems and worries") and reassurance (if true) that there will not be any needles or other painful physical procedures. It is also important that the parents give their permission and encouragement to the child to let the doctor know about whatever concerns he or she has, even those that might otherwise be private family matters.

Beginning the Interview. Especially for young children, it may not be desirable to begin with the presenting problem. The initial priority may be to place the child at ease. This may be done by letting the child explore the available play materials or inquiring about neutral or pleasurable topics, such as what the child likes to do for fun. These initial modes of engagement

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also provide useful information, such as the child's style of handling situational anxiety, recreational interests and skills, capacity for enjoyment, verbal fluency, and social relatedness.

Presenting Problem and Referral Process. Early in the interview itself, it is useful to review and clarify what the child believes and has been told about the purpose of the assignment. With an adolescent, this may be a suitable way to begin the interview. With a younger child, it may be advisable, as noted above, to wait until the child is somewhat at ease. The topic should not be deferred indefinitely as excessive delay may convey to the child that the subject is somehow off limits or that the interviewer is uncomfortable or engaging in some sort of subterfuge.

Asking what the child knows about why he or she is coming to see the interviewer provides an opportunity to address misapprehensions or to summarize and frame the examiner's own understanding of the reasons for referral. The duration of the assessment, confidentiality, and the role of the clinician should also be discussed in developmentally appropriate terms.

Assessment of the Major Realms of Functioning. It is necessary to inquire about the child's interests, strengths, weaknesses, and feelings in the major realms of his or her life. These include the external world of family, peers, and school (or work), as well as the child's inner sense of self (including body image and concerns) and inner world of fantasy. Even when aspects of these have been covered in relationship to the presenting problem, it is important to inquire systematically about these realms.

Inquiring about Psychopathological Symptoms. It is important to inquire specifically about various symptoms, especially those diagnostic of various disorders, unless information about them has already emerged in the course of the interview. The presence of the following symptoms should be probed for in developmentally appropriate terms: depression, low self-esteem, or suicidal ideation or behavior; excessive anxiety or unusual fears; hallucinations and delusions; abnormal eating or dieting attitudes and behaviors; obsessions and compulsions; antisocial or delinquent behaviors; and alcohol or substance use. It is also important to inquire in developmentally appropriate terms about exposure to potentially traumatic experiences, such as physical or sexual abuse or family or community violence.

ROLE OF STANDARDIZED INSTRUMENTS

The past two decades have seen the development of numerous standardized interviews and rating scales which seek to systematize the assessment of childhood psychiatric disorders and symptoms. (For recent reviews of such instruments, see Barkley, 1988; Costello, 1991; Edelbrock and Costello, 1988; Hodges, 1993; Rosen et al., 1988; Schwab-Stone, 1992.) Although these instruments have revolutionized child psychiatric clinical and epidemiological research, their usefulness and suitability for routine clinical practice remain to be defined.

Standardized instruments exist for systematically recording and assessing the development of children with respect to various realms of adaptive functioning (e.g., John et al., 1987; Sparrow et al., 1984).

Various structured and semistructured formats for performing or recording portions of the mental status examination of the child have been developed. Some provide specific standardized items for screening cognitive functions including orientation, attention, memory, language, and constructional ability (e.g., Ouvrier et al., 1993), while others provide a format for organizing mental status data derived from a semistructured clinical interview (Chambers et al., 1985; Kestenbaum and Bird, 1978).

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Several structured and semistructured diagnostic interview schedules have been developed to assess the presence of the major categorical psychiatric disorders in children; these instruments provide a standardized format for the parent and child interviews to elicit the presence, duration, and severity of symptoms for diagnoses listed in various versions of the DSM, as well as, in some cases, algorithms for deriving these diagnoses from the responses elicited (Angold et al., in press; Chambers et al., 1985; Fisher et al., 1993; Herjanic and Reich, 1982; Hodges et al., 1990; Kestenbaum and Bird, 1978; Kovacs, 1985; Puig-Antich and Chambers, 1978; Welner et al., 1987). These various instruments differ in many ways, namely, the flexibility permitted the interviewer, the order and phrasing of questions, the degree of clinical training required of interviewers, the time frame and range of disorders assessed, and the instruments' intended purpose and subject population (e.g., clinical patients versus nonreferred community subjects).

Used in a clinical setting, these interviews may be useful in prompting the clinician to inquire systematically about a broad array of symptoms and disorders, including those that may be clinically significant but are not part of the initial chief complaint. Similarly, comprehensive symptom checklists that can be completed by parent and/or older child outside the interview situation provide a useful screen for the presence or absence of a broad range of symptoms (Achenbach, 1993; Barkley, 1988). (Some parents or children, especially adolescents, may initially be more willing to report an area of difficulty in the seemingly more anonymous context of a questionnaire than they are in a face-to-face interview.)

More narrowly focused symptom rating scales have been developed to permit the valid and reliable quantitative assessment of specific symptom realms. Such symptom scales may be useful in quantifying the presenting severity of a symptom; this serves to establish a baseline against which response to a therapeutic intervention, such as medication, can then be compared. Among the rating scales useful in clinical practice are a variety of scales for assessing the severity of depressive symptoms (Costello and Angold, 1988; Kazdin, 1990); symptoms of hyperactivity, inattention, and impulsivity (Barkley, 1990; Conners, 1989); anxiety symptoms (Gittelman-Klein and Last, 1992); tic severity (Leckman et al., 1989); disordered eating attitudes and behaviors (Garner et al., 1983); and obsessive-compulsive symptoms (Berg et al., 1988; Goodman et al., 1989 a,b). The global assessment scale provides a means for the clinician to make a quantitative rating of overall impairment (Shaffer et al., 1983).

Whatever the potential adjunctive utility of such interviews and instruments, however, they cannot take the place of an individualized child psychiatric interview, nor can they be relied upon as the sole basis for establishing diagnoses or planning treatment. Eliciting data for clinical child assessment purposes requires a comprehensive, detailed, and flexible inquiry within a context of empathic rapport with parent and child; these elements cannot be provided by means of a standardized interview format alone. Furthermore, most standardized interview schedules are designed as symptom inventories and do not aim to provide the comprehensive assessment of feelings, personality style, coping mechanisms, situational context, and adaptive strengths that the clinical interview provides (Kestenbaum, 1991; Lewis, 1991b). Such factors may be as crucial to the clinical assessment and treatment planning as is the presence or absence of a given pathognomonic symptom or categorical diagnosis.

REFERRAL FOR ADDITIONAL CONSULTATION

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As indicated, the child may need to be referred for additional evaluation, including psychological, educational, or speech and language assessment, or pediatric or neurological consultation.

DIAGNOSTIC FORMULATION

The diagnostic formulation represents the clinician's distillation of the data gathered into an account of the potential nature of the child's difficulties, the factors that may have predisposed the child to develop such a problem, the concomitants and consequences of the problem, and the factors that tend to maintain the problem or might ameliorate it. A conclusive answer to these questions may not be apparent by the conclusion of the initial assessment; under such conditions, the appropriate result is a differential diagnosis suggesting the subsequent steps needed to clarify the diagnosis and the appropriate treatment options.

One outcome of the assessment may be the diagnosis of one or more categorical psychiatric disorders as defined by DSM-IV (American Psychiatric Association, 1994) or ICD-10 (World Health Organization, 1994). The assessment process must go beyond the assignment of a categorical psychiatric diagnosis, however; it is on the basis of the extent and nature of a child's symptoms, distress, and/or impairment that the clinician must decide whether to consider the child psychiatrically impaired and whether or not to recommend treatment. The clinician's diagnostic formulation must also take into account perspectives excluded from the DSM-IV nosology, which, as currently conceptualized, lacks a developmental context and is primarily descriptive and atheoretical, in that it does not explicitly specify presumed causes or treatments for the various diagnostic categories. Furthermore, children who share a given categorical diagnosis may differ in crucial respects which influence current severity, natural history, and treatment response. Such factors include intelligence, family resources and supports, and the presence of compensatory skills or such exacerbating vulnerabilities as comorbid personality traits or neurological impairments. When the DSM system is used, it is important that the full multiaxial diagnostic system be applied.

The clinician's diagnostic formulation thus seeks to supplement the assignment of any formal categorical diagnoses by identifying, to the fullest extent possible, the potential causes, predisposing factors, and current determinants of the child's difficulties. On the basis of this information and the clinician's expertise regarding the treatment of various forms of child psychopathology, the clinician formulates an appropriate series of treatment recommendations to ameliorate the child's difficulties.

COMMUNICATING FINDINGS AND RECOMMENDATIONS

The clinician's communication of his or her findings and recommendations to the parents and child is an essential part of the assessment, one that may require one or more sessions in its own right. Depending on the nature of the problem and the child's age and level of comprehension, this may entail meeting with the child and parents separately or together.

Several principles are essential to ensure that the clinician's findings and recommendations are heard, understood, and experienced as helpful. First, the clinician must convey his or her sense of the child as a whole person, including strengths and abilities, as well as problems or vulnerabilities. This conveys a sense of the clinician's appreciation and empathic understanding of the child and reduces fears and defensiveness that the news will all be bad.

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The clinician's findings must be communicated in terms comprehensible to the parents and, during the child's portion of the interpretive session, to the child as well. Technical terms should be kept to a minimum and jargon avoided. When diagnostic or other technical terms are used, it is important both that they be explained and that the parents' and child's perception of them be clarified. It is important that adequate time and opportunity be permitted for the parents and child to discuss the clinician's impressions and recommendations.

When the assessment is initiated by a request for consultation by another clinician or an agency or school, the results of the assessment and recommendations should also be communicated to the referring party after being shared with the parents and child and their consent has been obtained.

SCIENTIFIC AND CLINICAL RATINGS

Decisions regarding the appropriateness of either diagnostic or treatment recommendations were made by considering both the available scientific literature as well as the general clinical consensus of child psychiatry practitioners. The validity assigned to any particular scientific finding was judged using the routine criteria by which research is assessed, that is the appropriateness of design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies. The limitations in the available research literature as well as the relative indications for specific interventions are noted in both the literature review and the specific parameters.

The recommendations regarding specific diagnostic evaluations and treatment interventions reflect those methods of practice that are either supported by methodologically sound empirical studies and/or are considered a standard of care by competent clinicians. However, the general paucity of sound scientific data regarding childhood psychiatric disorders and their treatment necessitated that most of the recommendations set forth in these parameters be based on clinical consensus. Those practices that are described as having limited or no research data to support them and that also lack clinical consensus regarding their efficacy may still be used in some selected cases, but the clinician should be aware of the limitations and document the rationale for their use.

Clinical consensus was initially derived by the members of the Work Group on Quality Issues in preparation of these parameters. A preliminary draft was sent to experts for review and their comments were incorporated. A draft was distributed to the entire membership of the American Academy of Child and Adolescent Psychiatry for review. In addition, the proposed recommendations were discussed at an open forum held at the Academy's 1994 annual meeting. The Work Group incorporated suggested revisions into the final version of the parameters, which then was sent to the Academy's Council for review and approval.

Those practices that are not recommended represent areas in which there is neither sound empirical data nor high clinical consensus that such practices are effective, or where their potential risks are not justified. If such practices are to be used, the clinician should clearly document justification for that decision.

CONFLICT OF INTEREST

In keeping with the requirement that practice parameters be developed by experienced clinicians and researchers, some of the contributors to these practice parameters are in active clinical practice. Through their practices, it is likely that most of these child and adolescent

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psychiatrists have received income related to treatments discussed in these parameters. Some contributors are primarily involved in research or other academic endeavors; it is possible that through such activities, many of them have also received income related to treatments discussed in these parameters. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest: First, the development process calls for extensive review of the document before it is finalized. All members of the Academy have the opportunity to comment on the parameters before they are approved. Comments have been solicited and received from a broad group of reviewers from child and adolescent psychiatry. Second, the contributors and reviewers have all been asked to base their recommendations on an objective evaluation of the available evidence. Third, we ask that any contributor or reviewer who believes that he or she has a conflict of interest that may bias or appear to bias his or her work should notify the Academy.

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PRACTICE PARAMETERS FOR THE PSYCHIATRIC ASSESSMENT OF CHILDREN AND ADOLESCENTS

I. Purpose and aims of the clinical diagnostic assessment

A. Purposes of the assessment:

1. To determine whether psychopathology is present and, if so, to establish a differential diagnosis and tentative diagnostic formulation;
2. To develop a treatment recommendation and plan;
3. To communicate the above findings in an appropriate fashion to the parents and child;
4. To facilitate the child's and family's cooperation and engagement in treatment.

B. Aims of the assessment process:

1. To identify the stated reasons and factors leading to the referral;
2. To assess the nature and severity of the child's:
 - a Behavioral difficulties;
 - b Functional impairments;
 - c Subjective distress.
3. To identify individual, family, or environmental factors that may potentially account for, influence, or ameliorate these difficulties.

II. Sources of information

A. Accurate assessment of the child requires gathering information from a variety of informants to obtain a picture of the child's functioning over time and in a variety of settings.

B. For most children, the essential informants include:

1. The parents (or other primary caretakers);
2. The child;
3. The school.

C. Other family members may provide useful information.

D. For children involved with the child welfare or juvenile justice system, or in institutional care, it is important to obtain records and current information from the agencies, caseworkers, and caretakers working with the child.

E Records of relevant prior pediatric, psychiatric, psychological, or special educational evaluations should be reviewed.

III. Parent interview

A. The parent interview should include both parents, if possible. The clinician should have an opportunity to meet with the parents without the child present; in addition, it is important to interview the parents and child together. Family interviews, including siblings and other family members, may also be informative.

B. Parental account of reason for referral and present illness.

1 Reason for referral:

- a Clarify who is concerned, why, and why help is being sought now;
- b Parents' attitude toward and expectations of referral.

2 Details of current problem, including nature of difficulties, and for each facet of current problem:

- a Duration;

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- b Frequency and intensity;
 - c Precipitants, if any;
 - d Circumstances in which problem occurs;
 - e Consequences, including:
 - (1) Degree of associated distress;
 - (2) Interference with social, family, cognitive, emotional, and/or academic functioning;
 - (3) Adverse impact on development.
 - f Attitudes of parent, child, peers, and others toward problem behavior;
 - g Details of prior attempts to obtain help for problem.
- C Discussion of practical and administrative matters.
- 1. Duration, format, and scheduling of assessment;
 - 2. Cost;
 - 3. Confidentiality;
 - 4. Permission to obtain relevant records from school, social service agencies, and other clinicians;
 - 5. Preparation of the child for interview;
 - 6. Consent as to who is to receive reports of the evaluation.
- D. Parents' reaction to interviewer's age, sex, ethnic characteristics, institutional setting, and other aspects of the interviewer or setting of the assessment.
- E. Developmental history in context of family.
- 1. The developmental history elicits both the objective facts of the child's development up to the present and the emotional significance of these facts for the family and child.
 - 2. The relevant chronology may be in terms of important events in the child's or family's life or relative to the development of other siblings.
 - 3. Circumstances of conception, pregnancy, adoption, infancy:
 - a Was the pregnancy planned and/or wanted?
What was going on in the family at that time, including severe maternal stresses?
 - b Prior pregnancies, miscarriages, abortions;
 - c Complications of pregnancy, including maternal alcohol or drug use;
 - d Labor and delivery;
 - e Circumstances of adoption;
 - f Early infancy, including temperament and patterns of regulation and attachment.
 - 4 Physical development and medical history:
 - a Physical growth: height, weight;
 - b Fine and gross motor development and coordination, including tics, hyperactivity;
 - c Eating behavior and attitudes;
 - d Toilet training and lapses;
 - e Sleep patterns;
 - f. Medical history: hospitalizations, operations, serious injuries (especially head trauma); physical disabilities; chronic and acute illnesses;

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seizure-like episodes; allergies; vision or hearing impairments; exposure to lead or other toxins; medications;

g. Sexual development: pubertal status, noting precocious or lagging development; masturbation, other sexual activity.

5 School functioning:

a Speech and language:

(1) Milestones: first words, first sentences;

(2) Receptive and expressive languages abnormalities;

(3) Speech or articulation abnormalities.

b Cognitive and academic strengths and weaknesses;

c Attention span, concentration;

d School history, including problems with separation or attendance; changes in schools; disciplinary problems;

e Motivation to learn;

f Tolerance for frustration or criticism;

g Attitude toward authority;

h Organizational skills;

i Special educational or advanced placements.

6 Emotional development and temperament:

a Mood and affect regulation:

(1) Developmentally relevant signs of depression, dysphoria;

(2) Mood lability;

(3) Hypomania or mania;

(4) Suicidal ideation or behavior;

(5) Irritability.

b Unusual or excessive anxiety:

(1) Initial precipitants;

(2) Psychophysiological concomitants;

(3) Distress, avoidance, impairment;

(4) Excessive timidity, behavioral inhibition, or withdrawal;

(5) Obsessions or compulsions.

c Adaptability to new, challenging, or frustrating situations;

d Degree of psychological mindedness, capacity for empathy or humor;

e Sexual interests, concerns, and activities; gender identity and orientation; parental reactions;

f Regulation of aggression, including:

(1) Excessive aggression and/or aggressive thoughts (including homicidal ones) and circumstances thereof:

(a) (2) Excessive inhibition of aggression.

g Interest in fireplay or firesetting;

h Running away, destructiveness, or stealing;

i Lying, blaming others;

j Negativism or oppositionality;

k Substance use and/or abuse.

7 Peer relations:

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- a Number and quality of friendships, including preferences regarding age and gender;
- b Social skills and deficits;
- c Participation in informal and organized peer activities;
- d For adolescents:
 - (1) Capacity for intimate relationships and romantic interests;
 - (2) Sexual activity;
 - (3) Concerns over sexual orientation.

8 Family relationships:

- a Child's relationship with parents, siblings, other family members;
- b Child's place in overall family system;
- c Reaction to family life events, including deaths; births; moves; parental separation, divorce, or remarriage; illnesses; changes in visitation or custody arrangements; foster care;
- d Compliance with family rules, chores.

9 Conscience and values:

- a Assess conscience in terms of:
 - (1) Age-appropriate development;
 - (2) Specific areas of excessive harshness, laxness, or conflict;
 - (3) Effectiveness in helping child conform to expected family and community norms;
- b Religious or ethical concerns;
- c Goals and future aspirations:
 - (1) How realistic;
 - (2) How congruent with family's values and expectations.

10 Interests, hobbies, talents, avocations:

- a Recreational interests alone or with peers; include patterns of television viewing, degree of parental supervision;
- b Special talent or interest; if so, how regarded by family, school, or peers;
- c Impact of child's problems on enjoyment and involvement with usual recreational activities.

11 Unusual or traumatic circumstances:

- a Sexual or physical abuse, neglect, overstimulation;
- b Alcohol or drug abuse by parent or family member;
- c Family, community, or political violence;
- d Natural disaster;
- e Nature of exposure, reaction of child and family, risk of continued exposure.

F. Assessment of family and community background.

1 Parents:

- a. Strengths, weaknesses, areas of conflict as:
 - (1) Individuals;
 - (2) Marital couple;
 - (3) Parental couple.
- b. Parental attitudes toward the child, including hopes, fears, expectations, or areas of disagreement regarding child;

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- c. Parental attachment patterns toward the child over the course of development;
- d. Experiences with parents' own families of origin that influence attitudes or behavior toward child;
- e. Quality of temperamental fit between parent and child;
- f. Ethnic, cultural, religious background;
- g. Education, occupation, financial resources.

2 Family and household:

- a. Composition of family, including nearby relatives;
- b. Composition of household, including non-family members;
- c. Boundaries and alliances within family and child's role with respect to them;
- d. Family's style of communication and problem solving;
- e. Prevailing emotional tone of family, especially as it impinges on the patient:
 - (1) Supportive;
 - (2) Critical or hostile;
 - (3) Over- or undercontrol;
- f. Family activities, including activities of daily living, leisure and recreational activities;
- g. Family expectations and discipline;
- h. Family stresses:
 - (1) Moves;
 - (2) Changes in family or household composition;
 - (3) Unemployment, poverty;
 - (4) Illnesses, accidents, or other disability;
 - (5) Legal difficulties.
- i. Housing:
 - (1) Adequacy of heating, cleanliness, safety;
 - (2) Privacy and sleeping arrangements.

3. Family medical and psychiatric history. Inquire concerning the past and current history of physical and psychiatric disorders with potential environmental or genetic consequences for child, including history of hospitalization or symptoms impinging on child, and child's reaction.

4. Community and culture, including adverse circumstances.

IV. Child interview

A. Aims of the child interview:

- 1 History taking to obtain the child's implicit and explicit views of:
 - a Factors leading to the referral;
 - b Presenting problem;
 - c Relevant life circumstances and psychological factors.
- 2. To perform a developmental mental status examination to assess and describe the child's appearance and functioning as manifested in the interview situation.
- 3. To establish rapport with the child to facilitate the child's engagement in and cooperation with the assessment and subsequent treatment recommendations.

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B. Specific child interview techniques. The child interview requires a flexible blend of the following techniques, utilizing words and concepts appropriate to the child's cognitive, linguistic, and emotional level of development:

- 1 Interactive play techniques;
- 2 Projective techniques;
- 3 Direct discussion.

C. Structure of the child interview includes, as developmentally appropriate, in flexible order:

1. Preparation and orientation of the child prior to interview;
2. Clarifying purpose of assessment, including reason for referral and child's view of referral, role of clinician, confidentiality, duration;
3. Discussion of presenting problem;
4. Major realms of functioning (as outlined in developmental history);
5. Inquiry about specific psychopathological symptoms:
 - a. Depression, low self-esteem, suicidal ideation or behavior;
 - b. Excessive anxiety, unusual fears;
 - c. Psychophysiological symptoms, such as headache, abdominal pain;
 - d. Hallucinations, delusions;
 - e. Obsessions and compulsions;
 - f. Antisocial behaviors;
 - g. Alcohol and other substance use.
6. Inquiry about potentially traumatic experiences:
 - a. Physical or sexual abuse;
 - b. Exposure to family or community violence.
7. Structured or informal assessment of mental status examination items.

D. Developmental mental status examination assesses the following areas. Relevant data may emerge spontaneously in the course of the interview or may require explicit evaluation or inquiry.

1. Physical appearance;
2. Manner of relating to examiner and parents, including ease of separation;
3. Child's reaction to interviewer's age, sex, race, or ethnic characteristics; reaction to setting of the assessment;
4. Mood and affect;
5. Orientation to time, place, person;
6. Motor behavior including activity level, coordination, and presence of unusual motor patterns (e.g., tics, stereotypic movements);
7. Form and content of thinking and perception, including presence of hallucinations, delusions, thought disorder;
8. Speech and language, including reading and writing;
9. Overall intelligence;
10. Attention and concentration;
11. Memory;
12. Neurological functioning (such as soft signs, cerebral dominance);
13. Judgment and insight;
14. Preferred modes of communication (e.g., play, drawing, direct discourse).

V. Referral for psychological or additional medical consultation

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As indicated, the child may need to be referred for the following types of additional detailed evaluation:

A. Formal psychological testing, including psychometric and projective evaluation and/or neuropsychological testing;

B. Pediatric or medical consultation, such as:

1. Physical examination;
2. Neurological evaluation (including, as needed, electroencephalographic and imaging studies);
3. Metabolic, endocrinological, or genetic evaluation;
4. Evaluation of vision or hearing.

C. Educational assessment;

D. Speech and language evaluation;

E. Social service or agency evaluation of home environment.

VI. Diagnostic formulation

Provides integrated summary of:

- A. Nature of child's difficulties;
- B. Predisposing and potential etiological factors;
- C. Potential exacerbating or mitigating factors;
- D. Concomitants and consequences of child's difficulties;
- E. Overview of child's and family's strengths and weaknesses;
- F. Multiaxial DSM-IV diagnosis;
- G. Implications for treatment and intervention.

VII. Communication of findings and recommendations

The clinician should:

- A. Communicate his or her findings and recommendations to the child and parents in comprehensible terms;
- B. Place the findings in the context of the child's overall strengths and vulnerabilities;
- C. Indicate remaining areas of uncertainty and nature of the additional assessment(s) needed;
- D. Assess the parents' and child's understanding of the clinician's findings and recommendations;
- E. With the necessary consent, communicate the findings and recommendations in appropriate terms to the referring clinician or agency;
- F. Where treatment or additional assessment are best done by someone other than the assessing clinician, assist parents with finding a suitable referral.

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