# Clinical Evaluation of Children

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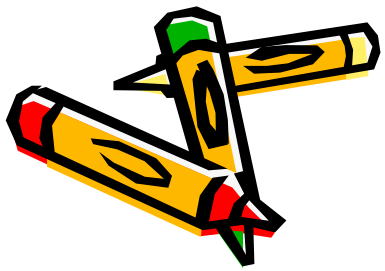
Board of General Psychiatry
Board of Child & Adolescent Psychiatry

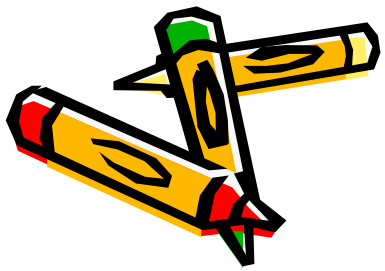
- The clinician should be familiar with:
- The language of the family
- The culture of the family
- How to communicate with the child appropriate to his developmental level



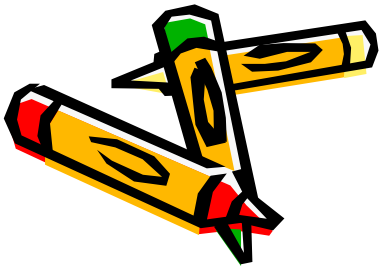
- How to use:
- Direct discourse
- Play
- Stories
- Drawing
- & other alternative modes of interaction

  (in addition to direct discourse)

- There is no best way to interview children.
- Evaluation process may take many weeks.
- No single symptom or test is sufficient to make the diagnosis.



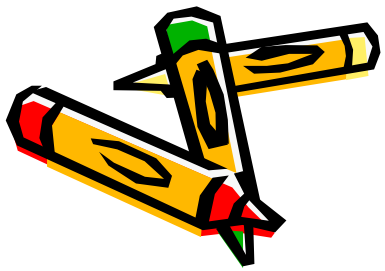
- In most instances:
- Children are simply brought by the parents
- The clinician interviews one or both parents before meeting with the child



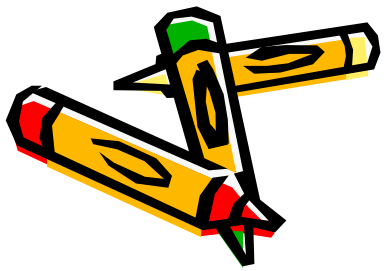
- **Evaluate:**

- The parent's individual views on the causes of the child's difficulties.

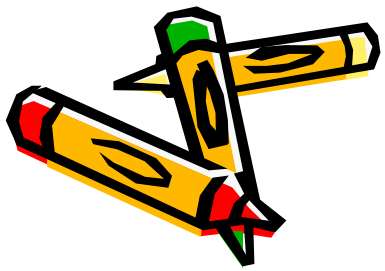
- & the impact of the child's difficulties on the well-being & function of the:
- Parents individually
- Parents as a couple
- Family as a whole



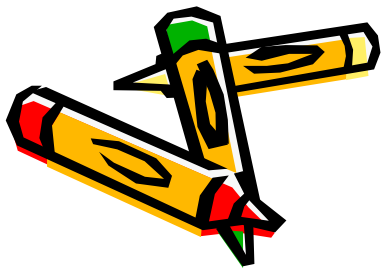
- **Developmental history across:**
- Physical domains
- Cognitive domains
- Linguistic domains
- Social domains
- Emotional domains



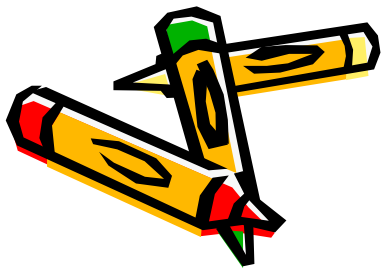
- Family functioning
- Significant people of the child's life
- Home environment
- Important current & past events (sibling birth, new home, traumatic events, parental divorce, Parental death,…)
- Assessment of school

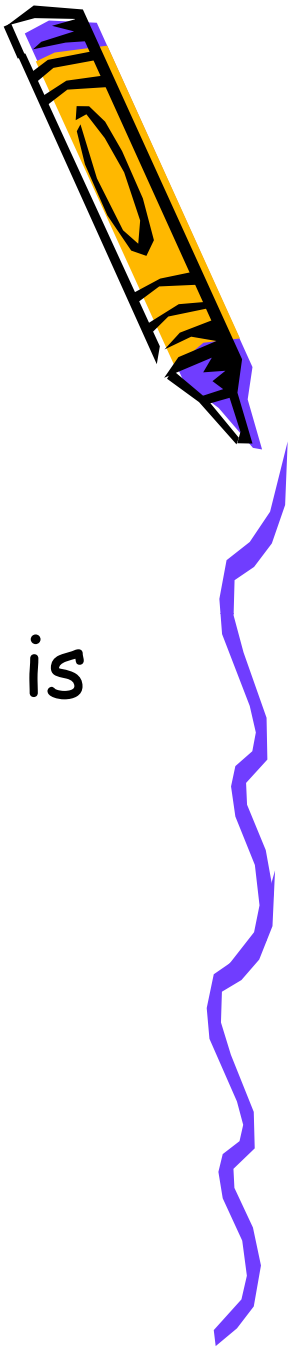


- Genetic background
- Psychological evaluation
- Personality organization
- Fantasy life
- Pediatric records
- Neurological exam



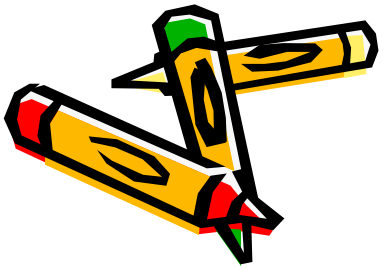
- The child's functioning & psychological well-being are highly dependent on:
- The family setting
- The school setting

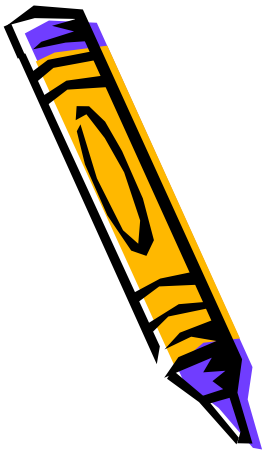




- The behavior of infants & young children is highly state dependent

  ⟹ Seeing them on more occasion is needed!



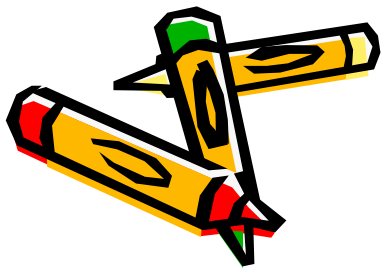


- Different informants:
- Interact with the child in different settings
- Have different perspectives, standards, & expectations.

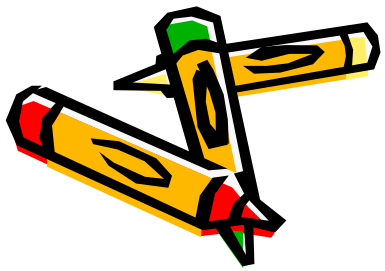
  ⇒ Provide different accounts of the child's problems.

- **Begin the interview with neutral questions:**

- The child's home
- Family members
- Pets
- Favourite activities
- Friends
- Playmates
- Toys & favourite games
- Favourite TV programs

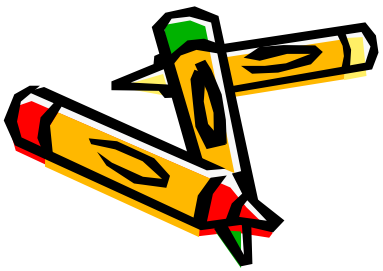


- Don't limit the interview to areas of difficulties!
- You must learn about the child's:
- Strengths
- Interests
- Talents
- Areas of adequate or superior adjustment



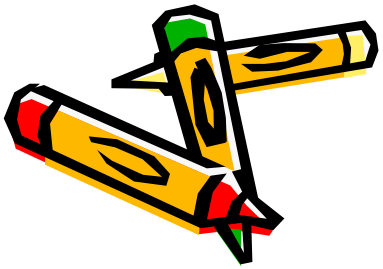
- Therapist-patient interactions are confidential.

- The exception is when the therapist believes the patient or someone else is in danger.



- Patients sometimes want the clinician to tell something to others.

- Spokesperson role occasionally may be indicated but should be done in the patient's presence!

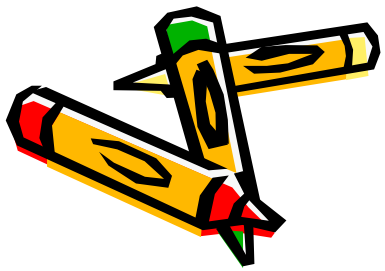


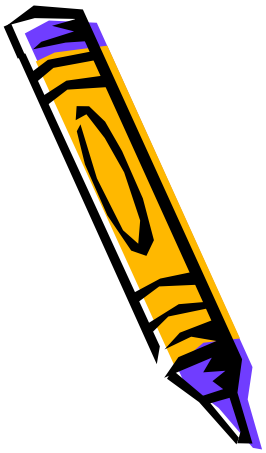
- Parent's early experiences influence the meaning they place on their child's behavior.

→ Important to assess:

Parent's perceptual distortions, attitudes, & expectations of their child

To reflect their perceptual biases

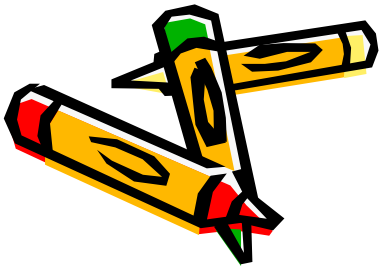


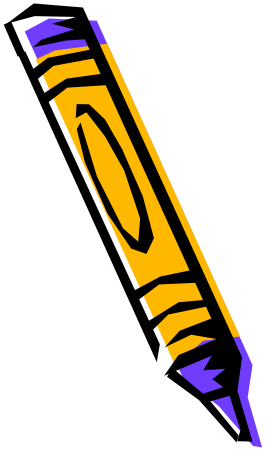


- Prevent the session from deteriorating into:

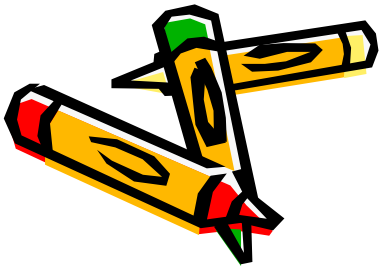
  **"You hold him while I hit him!"**

  In which the parents tell the therapist what is wrong with their child!



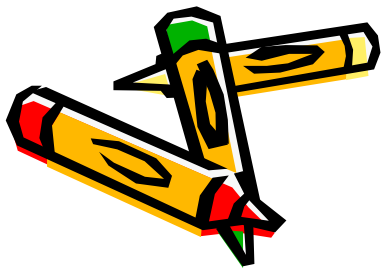


- Young children are suggestible
- May repeat information fed to them
- Children < 10 years are less reliable than their parents.
- The reliability of children's reports of symptoms increases with age.



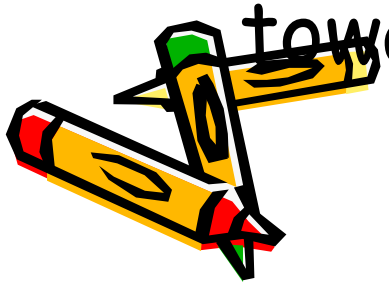
- Frequently will children deny having any problem.

- The child may be the only source of information on:
- Sexual abuse
- Exposure to violence
- Behavior occurred in peer context



- Inquire about the problematic behavior's:
- Frequency
- Intensity
- Duration
- Circumstances of occurrence, improvement, or worsening

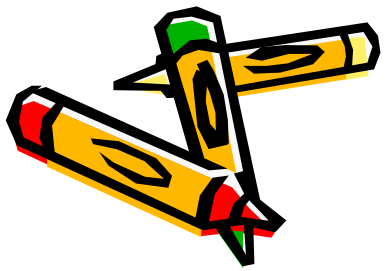
- & the attitude parents & others have toward them.



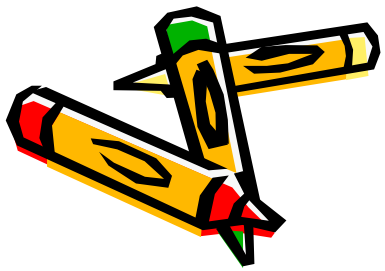
- Symptom changes are usually gradual

  → Family & teacher may lose sight of the original symptom's severity & obvious progress.

- In many cases children's behavior is a greater source of distress to others than to the children themselves.



- Parents often feel anxious or guilty because they believe problems in their young child imply that their parenting skills are inadequate.



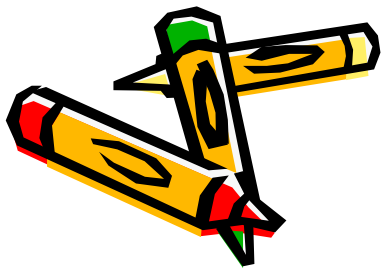
- The parents' early experiences influence the meaning they place on a child's behavior.

- It is important to assess

  the parents'

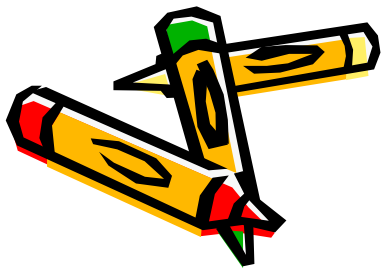
  perceptions, distortions, attitudes, & expectations about the child

  to reflect perceptual bias.

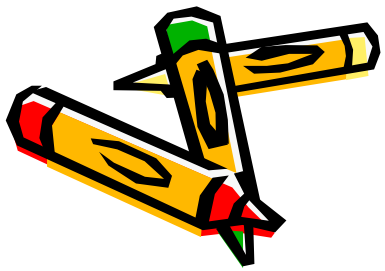


- A given symptom may have different meanings, functions, & clinical implications in different children.

- The clinical condition may represent a severe form of symptoms found in milder forms in nonreferred children.



- In every assessment the clinician should ask about the cardinal symptoms of:
- Mood disorders
- Anxiety disorders
- DBD (ADHD,CD, ODD)
- LLD



- Rate of diagnosable psychiatric disorder in general child population is 20%.
- 1/2 of those who meet criteria for one disorder also meet criteria for at least another disorder.
- Comorbidity is not the exception but the rule in childhood disorders.