THE CHILD AND ADOLESCENT PSYCHIATRIC EVALUATION

IDENTIFYING DATA: Age (years, months), sex, grade, school, and any special identifying data we want to know up front (e.g. foster custody, special ed status)

CHIEF COMPLAINT:
- Chief complain from child
- Chief complaint from parent

HISTORY OF PRESENT ILLNESS:
- Elicit symptoms
  - Try to obtain DSM IV criteria to substantiate or rule out diagnoses and generate differential diagnoses.
  - Precipitating circumstances?
  - Exacerbating factors?
  - Course of illness
  - Comorbid conditions - obtain DSM IV criteria for each comorbid condition
  - Pt response to illness
  - Dysfunction associated with illness - school, family, peer

PAST PSYCHIATRIC HISTORY:
- Any previous or ongoing psychiatric treatment
  - Individual therapy, counseling in school or elsewhere
  - Group therapy
  - Family therapy
  - Medication? therapeutic effects (did it help?) side effects?
- Special education certification? If so what type of disability?
- Psychiatric hospitalization?
- Day treatment programs or other special treatment programs?
- Residential treatment programs?
- Substance abuse? What treatment if any?
- Physical or sexual abuse - CPS involvement?
DEVELOPMENTAL HISTORY:

Pregnancy history:
- Did mother have any complications during her pregnancy?
- Any alcohol or drug use? How much? When?
- Tobacco use? How much?
- Any complicating illness (e.g. diabetes, preeclampsia)?
- Any medications?
- Labor complications?
  - any fetal distress?
  - if C-section - why?
- How long in labor?
- Birth weight?
- APGARS if known

Developmental milestones:
Motor milestones: crawling, walking
Speech milestones: 1st words, sentences, any speech impediments
Social milestones: interaction with peers
Toilet trained at what age?

PAST MEDICAL HISTORY:

Illness: any medical problems (asthma, heart murmurs, ear infections)
Hospitalizations:
Surgeries:
Injuries: fractures, injuries requiring sutures; any head trauma with loss of consciousness, any suspicious injuries suggesting physical abuse
Current Medication: name, dosage
Allergies:

FAMILY HISTORY:

Draw a family tree with three generations if possible
Any family history of problems like the identified patient?
Anyone in the family with a history of:
- depression
- alcohol or drug abuse
- problems controlling anger
- problems with the law
- difficulty in school - getting into fights, suspensions, etc.
- reading, writing, i.e. learning disabilities
- anyone seen a psychiatrist or psychologist? for what problem?

SOCIAL HISTORY:

Where does patient live?
Who lives in the household? Where do other parents or siblings live, if parents are separated or divorced?
If parents are divorced, who has physical/legal custody? How old was patient at the time of the divorce? What is the visitation schedule? How is the patient handling the divorce?
How is the patient getting along with parents and siblings?

How does the parent discipline the children? What type of discipline works for patient?
How consistent are the parents in disciplining children?
How structured is the household? Is there a regular mealtime? bedtime?
Are there consistent rules in the household?

How is the patient doing in school?
Do they have friends? girlfriend/boyfriend? sexually active?
What activities involved in?

What are patient's strengths?
What do they enjoy doing in their spare time?
MENTAL STATUS EXAM FOR CHILDREN/adolescents

GENERAL APPEARANCE AND BEHAVIOR:

Appearance:
- body habitus - size for age, obese, thin
- grooming and cleanliness
- dress
- any dysmorphic features or deformities?

Behavior:
- Ability to separate from parent
- Demeanor - is the child outgoing, shy, slow to warm up, angry, oppositional, pleasant, etc.
- Ability to engage the child/adolescent in the interview
- Eye contact
- Ability to cooperate with the interview
- Attention span, ability to stick with a particular activity
- Ability to follow directions
- Hearing, vision - any obvious impairment
- Speech - articulation, fluency, rate, volume? any obvious speech impediments?
- Motor activity - level of activity, overly or underactive, psychomotor retardation or agitation,
  - any unusual movements? tics, nervous habits,

MOOD AND AFFECT:
- describe the general mood of the child
- describe the affect, affective range and lability
- any suicidal ideation, plans, intentions

PERCEPTION:
- hallucinations
- illusions

THOUGHT PROCESSES:
- are thoughts organized, logical, goal oriented?
- is there any distractability or difficulty maintaining focus?
THOUGHT CONTENT:

- delusions, preoccupations, obsessions, phobias
- fantasy material:
  - "what would you want if you had three wishes?"
  - What/Who would you be if you could be anything or anybody?
  - What do you want to be when you grow up?
  - If able to observe the child in play, what themes are evident?
  - Draw a person

COGNITION:

- level of alertness
- orientation to person, place, time
- general estimate of intelligence - based on vocabulary, fund of knowledge, ability to express themselves verbally
- memory: recall, short term, long term
- three step command
- judgement
- ability to abstract (for adolescents)
  - similarities
  - proverbs
- insight into illness
Formulation:

➢ Identification and presenting symptoms

➢ Biological:
  o Genetic
  o Toxic
  o Medical / medication
  o Neurodevelopment
  o Temperament

➢ Psychological:
  o Psychosexual / development (Freud, Erickson, Piaget, Mahler)
  o Gross psychological trauma, abuse, neglect, loss, separation
  o Management of affect (anger, self esteem, functioning in daily life)

➢ Social / Cultural:
  o Ethnic, cultural, socio-economic status (SES)
  o Social context of child’s life (school, empathic parenting, family traditions, religion, culture)

➢ Severity assessment
  o Burden suffering on child and family
  o Number and intensity of risk factors
  o Resiliency
  o Strengths that may be helpful in treatment planning

(Adapted from Jellinek and McDermott. 2004. JAACAP. 43:913-916)
Review of Behavioral Science

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Topic 1: Human Development

Infancy (0-15 months):
- Development: builds on earlier stages; pathology if disruption.
- People recognition -> attachment (4-6 months) If doesn't happen: depression, attachment disorders, failure to thrive (e.g., Mele Smith, Unit 5)
- -> Stranger anxiety at what age?
- Object permanence (12-15 months) -> separation anxiety.
- Social developmental milestones: delayed in what conditions?

Infancy

- Remember your developmental charts.
- Developmental domains: motor (gross, fine), language (receptive, expressive), cognitive, social
- Motor development: cephalocaudal, proximodistal.
- Approximate ages of social smiling, rolling over, sitting, crawling, walking, talking? “Obvious” developmental delay. Remember Mele Smith (Unit 5)?
- Language delay: rule out hearing loss

Premature babies

- The Frazer twins, Ikaika and Kawai (Unit 5)
- Attention to development both in the NICU (Als, 1994) and in follow-up.

Toddler (15months – 2 ½ years)

- Separation anxiety – difficulty with hospitalization
- Remember Kili Kahipa (Unit 1)?
- 2 years = 2 words; 3 years = sentences
- More in pediatrics clerkship

Preschool (3-6 years)

- Improved separation (e.g., preschool)
- “No evidence that daily separation from working parents in a good day care setting has long-term negative consequences…”
- Remember some milestones?
  - Keoni Lee (Unit 5), at age 4 years: clumsy, didn’t know colors, cannot count to 10
Schoolage (7-11 years)

- Good coping with separation: best age for elective surgery.
- Normal milestones? try to remember your own childhood.
  - Kawai Frazer (Unit 5) – drew many of her letters and numbers backwards.

Adolescence (11-20 years)

- Early, mid, late adolescence
- Normal: masturbation, homosexual experiences.
- Education regarding high-risk behavior
- Challenges with compliance (physician like a parent)
- Morals, ethics, self-control, humanitarian/global concerns -> formal operations (what preceded this? Whose developmental schema is this?)

Practical applications...
Death, divorce, medical illness

(these always seem to show up on standardized exams)

Example 1: Death
Developmental concepts

- Irreversibility
- Finality
- Inevitability
- Causality

What are the earliest years of age at which most children can understand that death is permanent?

A. 0 to 2
B. 3 to 4
C. 5 to 10
D. 11 to 14
E. 15 to 18

Consider the perspective of Linda Corbett (age 11 with ALL, Unit 5).

Clinical implications

Pre-understanding of irreversibility:
Difficulty detaching from deceased; difficulty mourning.
Clinical implications

Pre-finality understanding:
Possible preoccupation with physical suffering of deceased.

Clinical implications – risk factors

Loss in a child <5 or in early adolescence.
Loss of a mother in girls <11; loss of a father in adolescent boys.
Pre-morbid psychological difficulties; lack of prior knowledge about death.
Prior conflictual relationship; poor relationship between child and step-parent (remarriage)

Clinical implications

Pre-understanding of inevitability and pre-understanding of causality:
Possible perception of punishment, leading to guilt.

Clinical implications – risk factors

Psychologically vulnerable/dependent surviving parent; environmental instability.
Lack of adequate family/community supports or inability to access.
Unanticipated or result of suicide/homicide.

Example 2: Divorce – statistics

• 38% of all children born in the mid-1980s will experience the divorce of their parents.
• Children in single-parent or stepfamilies have a 2-3x greater likelihood of experiencing emotional/behavioral difficulties.

Divorce – initial reactions

Rare for youngsters to be relieved; some older children who have witnessed conflict may be.
Anger – related to powerlessness, fear of being disregarded.
Guilt – especially in young children, or if children were often fought over.
Divorce – developmental factors

Preschool – regression, separation/abandonment fears, sleep disturbances, yearning, aggression.
The Frazer twins (Unit 5) experienced parental divorce “before they reached school age”
5-8 years – open grieving, fear of replacement, difficulty with permanence, fantasies which may interfere with school

Responses to divorce that include fierce anger at one or both parents, the tendency to see one parent as good and the other as bad, and grief over the loss of an intact world would characteristically be exhibited by children in which of the following age groups?
A. Preschool (3 to 5 years old)
B. Early School (6 to 8 years old)
C. Late School (9 to 12 years old)
D. Adolescent (13 to 17 years old)
E. Young adult (over 18 years old)

Divorce – developmental factors

8 ½ to 12 years – fierce anger, loss of intact world, 1 parent good/the other bad, engrossment in battles, adverse effects on school performance.
Adolescence – depression, suicide, violence, involvement in battles, fear of marital failure.

Divorce – gender factors

Marital turmoil may have a greater impact on boys than on girls.

Custody – factors predicting outcome

Neither custody arrangement itself nor the frequency of access/visitation influenced child’s psychological outcome.
More important: prior psychological functioning of the parents and the degree of post-divorce hostility.

What’s your pick?

“Just tell the people whom you’d rather be with – mommy or daddy. Whomever you pick is okay with me.”
“Sometimes when grownups don’t get along with each other and can’t agree on things, a person called a judge helps us to decide what may be the best to do.”
Divorce – psychological tasks
1. Acknowledging its reality.
2. Disengaging from conflict and resuming routines.
3. Resolution of losses (including presence of one parent)
4. Resolving anger/self-blame
5. Accepting permanence
6. Achieving realistic hope regarding relationships.

Example 3: Illness
Developmental concepts
Doctor: “It will only feel like a pinch.”
Child (mind-read): “I might die if you take out all my blood!”

Illness: developmental concepts
Immanent justice – the belief that a form of natural justice can emanate from inanimate objects.

Possible clinical implications:
• Self-blame for personal illness.
• Fear of reporting symptoms.

Illness: developmental concepts
Contagion versus non-contagion – may be achieved in concrete and formal operations stages.
9-10 years: belief that germs may cause illness, but little understanding of mechanisms
12-13 years: multiple causes, agent/host interactions.
Adolescence: able to associate unrelated symptoms, appreciate temporal progression of illness.
  – Keeni Lee (Unit 5) – 11th grader, history of ALL, developed pneumothorax.

A child or adolescent who must cope with a congenital, physical deformity is most vulnerable to experiencing related emotional disturbances during which of the following periods of development?
A. Late infancy (12 to 18 months of age)
B. Late preschool period (4 to 5 years of age)
C. Middle childhood (7 to 10 years of age)
D. Early adolescence (11 to 13 years of age)
E. Late adolescence (17 to 19 years of age)
Formulation: Putting the Diagnosis Into a Therapeutic Context and Treatment Plan

MICHAEL S. JELLINEK, M.D., AND JOHN F. McDERMOTT, M.D.

What we observe is not nature itself but nature exposed to our method of questioning (p. 58).

—W. Heisenberg

Currently there are two competing methods for evaluating and diagnosing children with psychiatric disorders. There are marked differences between them. One is represented by the DSM-IV-derived structured interview and is symptom based; the other is the traditional open-ended interview, sometimes using play or projective materials. The first is quantitative and seeks accuracy; the second is more qualitative and seeks meaning. Each has its own advantages and disadvantages. Together they represent the science and the art of child and adolescent psychiatry. The science of the structured interview is built on reliability, evidenced based, and tested by well-accepted research methods, although some question the clinical validity and comprehensiveness of a symptom-based system that does not address underlying psychopathology. The traditional open-ended interview is more subjective, hard to quantify, difficult to reproduce reliably, and heavily dependent on clinical judgment. Some argue that its subjectivity is inevitably hit or miss and can never serve as the basis for a scientific medical specialty.

This drift toward bifurcation rather than integration has been noted in the general psychiatry literature by Gabbard and Kay (2001) in their article “Fate of Integrated Treatment: What Happened to the Biopsychosocial Psychiatrist?” They expressed concern that general psychiatry was moving away from comprehensive formulation and integrated treatment. They wondered, for example, whether too narrow a focus would result in limiting the impact of a therapeutic relationship that otherwise might improve the patient's adherence to medication and add to the overall improvement. The child psychiatric literature has often neglected the integrated use of the biopsychosocial model. Our field's research on evaluation is supportive of structured interviews used to assess symptoms and diagnosis. However, much of this work has been defining diagnosis and prevalence rather than focusing on formulation or the integration of biopsychosocial factors.

Over the past decade, multiple pressures on our field have encouraged the use of a more reliable structured approach for diagnostic evaluation, often leading to multiple diagnoses that are then prioritized. Current managed care contracts offer higher rates of payment for time spent on psychopharmacology and scrutinize time for evaluation and therapy. Many child psychiatrists, researchers, and pharmaceutical companies support a symptom-based, structured approach as not just more reliable but more succinct and accurate in its ability to define a treatment plan. Yet, many experienced clinicians and training directors have continued to use the open-ended approach, using a broader range of evaluation and interventions than suggested by the symptom-based approach. The effect of each method on the frequency of medication use is unknown. Some, however, wonder whether the more focused, symptom-based approach results in more use of medications (Jellinek, 2003; Zito et al., 2003). Of course, without external validation, one cannot know the “correct” frequency. In any case, the modern clinician needs to know both methods and find the best way to combine features of both with his or her own personal/professional style.

After gathering data using either or both methods, a formulation is necessary to sift, prioritize, and integrate data for treatment planning. We need to understand how this patient and family came to be as we see them
now. What initial problems, attempted solutions, and further dysfunction necessitated facing a child psychiatric evaluation and treatment?

The biopsychosocial approach to formulation identifies three domains to be considered in every evaluation: the biological, the psychological, and the social. George Engel, the father of the biopsychosocial approach, believed strongly that this broad approach was essential to avoid premature closure of our efforts to understand the patient's needs, tunnel vision, or an overly narrow approach to treatment: "While the bench scientist can with relative impunity single out and isolate for sequential study components of an organized whole, the physician does so at the risk of neglect of, if not injury to, the object of study, the patient" (Engel, 1980, p. 536). Engel conceptualized that a biopsychosocial formulation was an essential link between evaluation and treatment planning.

In this Clinical Perspective, we highlight the critical importance of a comprehensive and balanced formulation and offer an approach to integrate the three influences, biological, psychological, and social, into a clinically meaningful framework for treatment planning.

Limits of the DSM Symptom-Oriented Approach to Diagnosis

Patients come to us with symptoms that are causing personal suffering and dysfunction in daily life and limiting their optimal development. However, these symptoms are much like words in a dictionary whose meanings change with the context. Consider the metaphor in which the meanings of words in our "psychiatric dictionary" (the DSM-IV) parallel words or symptoms found in Webster's (1991, Ottenheimer Pubs, Inc.). For example, Webster's defines the noun "pipe" as "a tube for making musical sounds; a long tube to convey water or gas." However, a pipe, just like a symptom, has a number of possible meanings depending on its context. A pipe can bring us water to wash in the morning or cook our food. It melts into the background of our lives until it breaks. Then the same pipe can cause disaster in our home, indeed in the whole neighborhood.

The word pipe can have very different meanings in different contexts. It can serve as a weapon in someone's hand or be part of a celebration when played as a bagpipe, or, metaphorically, it can be part of a "pipe dream" or a description of intensity, as in "piping hot."

Likewise, the presence of a symptom is only a starting point, not sufficient by itself for us to understand the context, feeling, or behavior behind it. Is a child's "oppositional" behavior in school an attempt to cover up a learning disability? Or to re-engage the interest of a divorced father who is starting a new family? Or a maneuver to gain entry as a junior member of a school-based clique or even local gang? Or might it be related to an older sibling's impending delinquency hearing? Is that child's punching a peer related to bullying, hyperactivity, or physical abuse at home? Is the child fulfilling the family myth of physical dominance, compensating for being viewed as a "sissy," or wrestling with emerging homosexual feelings? Of course these symptoms may reflect a biological vulnerability to frustration or anxiety, prodromal to affective disorders, and thus much less related to psychosocial environmental challenges. All the variables must be considered together to weigh their influence.

There are even more judgments concerning severity or impairment that the clinician must make in designing a treatment plan. How violent was the child's oppositional behavior? Provoked or unprovoked? How frequent? How typical for the particular classroom—is this a problem with the teacher? Or the school—does this reflect a breakdown in the school as a safe place? Or the community—are street gangs common or unheard of?

Many children come to mind when a comprehensive biopsychosocial rather than unidimensional formulation was critical to their treatment. One sixth-grade girl became quite oppositional and withdrawn at home and at school. Her parents, both mid-life university professors, had very high academic expectations. This girl had an undiagnosed learning disability (inability to organize thoughts into paragraphs or produce a coherent essay) whose symptoms included feeling dysphoric, inadequate, and hopelessly trapped. She could not meet the expectations of sixth grade and was described by all her teachers (except her math and music teachers) as lazy, disobedient, distracted, and withdrawn. The school called in the parents and wondered whether she should be admitted to the junior high school. Symptoms quickly resolved with tutoring, helping parents set reasonable expectations, and the school seeing her as a hard worker rising to this challenge rather than delinquent.

Another child was a 14-year-old boy who presented with symptoms of depression, suicidal ideation, poor schoolwork, and avoidance of his friends, whose par-
ents were in the midst of a difficult divorce. The treatment plan included antidepressant medication, supportive therapy, tutoring to catch up in school, and appointing a court-ordered guardian ad litem to mediate the unending parental discord. His depressive symptoms gradually improved, and he began to function better, first with peers and then in school. Which aspect of the treatment plan was most essential? Did the interventions work in synergy? We do not know.

The Diagnostic Process

Current reimbursement and practice demands may well require us to arrive at a diagnosis, formulation, and treatment plan within 2 hours—a challenge for even the most experienced clinicians. Some framework is necessary to gather the biological, psychological, and social data critical to the formulation. The following suggested path (and typical time spent) is a compromise that combines the essential features of the DSM-IV symptom-focused assessment with an understanding of their meaning:

1. Semistructured interview including a description of symptoms, stability of symptoms in different settings of the child's daily life, and brief symptom survey (15 minutes)
2. Biological history with an emphasis on family psychiatric history, substance use (including intraterine exposure), medical illness, head trauma, etc. (15 minutes)
3. Psychological interview with an emphasis on quality of relating, reaction to loss, management of affect including anger, self-esteem, and functioning in major areas of daily life (40 minutes)
4. Social context of child's life including school (ideally the teacher's perspective), empathic parenting, family traditions, culture, and religion (20 minutes)
5. Severity assessment, including the burden of suffering on the child and family, number and intensity of risk factors, resiliency, and strengths that may be helpful in treatment planning (e.g., enhancing a strength in favor of attempts at remediation of what may not be remediable) (10 minutes)

This path is not a rigid outline but one that we have found helpful. The times are average and vary, as does the balance of time spent between child, parents, and family. This schedule leaves about 20 minutes of a 2-hour evaluation to discuss treatment planning with the child and family.

Biopsychosocial Linkages in the Diagnostic Process

How do these five components produce the necessary data for a biopsychosocial formulation, and what are the data to be gathered along these lines? Let us consider this data gathering on the three biopsychosocial levels and then integrate them into a formulation.

The biological component includes family/genetic history, the child's inborn "temperament," development (realities of height, weight, physical abilities, age, and stage of maturity), and intelligence. We know of biological linkages such as the risk of depression in the offspring of parents with depression, the likelihood of response to particular medications that may parallel in parent and child, the connection between a father with alcoholism and a son's history of early adolescent drinking, or the likely comorbidities (e.g., depression and anxiety). The linkages of the biological aspects of symptoms are essential sources of any formulation.

The psychological component includes the child's and family's emotional development, personality styles, primary defenses and weakness, and the child's sense of self-esteem. (Assessing self-esteem is a deceptively "easy" task—what may be a more superficial reaction to the psychiatric disorder presenting for evaluation versus a long-standing, profound sense of low self-worth. For example, profound low self-esteem makes failure an expected outcome and limits a child's motivation to achieve in school, to adhere to medication, and to make or use choices that could enhance personal development.)

The social component is an acknowledgment that the child functions within a social unit (the family) as well as an assessment of a broader context that includes community, race, economic status, and spiritual and cultural traditions. For example, information that symptoms manifest in only one setting, i.e., home, but not at school, may be critical to the formulation. In addition, poverty is a substantial social factor that adds stress to the individual and family as well as limiting options across the spectrum of psychiatric disorders.

The final step before arriving at a formulation is the assessment of severity. The Diagnostic and Statistical Manual for Primary Care, developed by the American Academy of Pediatrics (1996), in collaboration with both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, suggests that assessing severity may assist in the process of formulation. In addition to the usual de-
scription of symptoms in their developmental context, assessing severity includes emphasis on functioning in major areas of daily life (friends, family, school, activities, and sense of well-being or mood), "burden of personal suffering," which allows for a clinician's judgment of distress, and both risk and resiliency factors. For example, poverty, frequent changes in address, chronic disease, and divorce are all risk factors but may be reflected in different dimensions of the biopsychosocial approach; alternatively, higher intelligence and planning skills (biological), financial resources (social), and special talents that support self-esteem (psychological) all enhance resilience.

A Biopsychosocial Formulation for Clinical Practice

We believe that the data from the five lines of questioning outlined above give us the building blocks for a scientific clinical formulation. (The art that underlies the science, of course, is the relationship between clinician and child, which is at the heart of eliciting the pertinent information and affects.) Consider the following case example:

Joan is a very attractive 14-year-old who presents with dysphoric mood, suicidal ideation, abdominal pain, weight loss, failing grades in school, and ongoing arguments concerning "rules and dress" with her somewhat elderly appearing mother. There is a family history of major depression in both maternal grandparents and moderately heavy alcohol use by Joan's father, a salesman. There had been increasing tension in the home as Joan, an only child, went through puberty, with covert marital discord and a strong suggestion that Joan and her father had "abandoned" her mother through a number of shared interests, especially sports.

Although a DSM-IV depressive disorder was part of the differential diagnosis, a biopsychosocial formulation that considered the context and severity of her depressive symptoms suggested that current social and psychological factors were more powerful forces in her disorder than biological ones. As a consequence, initial efforts were directed at social and psychological factors, re-establishing the marriage, creating a reasonable set of house rules, and giving Joan opportunities to spend more time with peers. Over 12 weeks, the depressive symptoms resolved, and there as yet has been no recurrence.

Of course, we do not know whether the depression was already spontaneously ending, whether it would have responded better to medications, or whether all these family issues were true but unrelated to this episode and possibly future depression. Joan's treatment was based on a five-step process (outlined above) and a formulation that the meaning of her depressive symptoms was secondary to marital tensions, her mother's feeling of loss and aging, and Joan's emerging adolescence.

It is easy for even experienced clinicians to overinvest in one aspect of the biopsychosocial model or stay narrowly committed to only one of the three domains. Noting and prioritizing each of the three factors help remind the clinician that, in Joan's case, a biological intervention such as an antidepressant may be indicated if the prioritized approach has not been as effective as hoped. Clinicians may want to develop their own numerical weighting system, such as the Child Global Assessment Scale that reminds us to score each area of a child's daily functioning. If we wanted to score the biological, psychological, and social factors in Joan's presentation on a 10-point scale with 10 being highest priority, her formulation may have been scored 5 (biological), 7 (psychological), and 3 (social) to remind us that if our focus on the psychological (7) was ineffective, the estimated contribution of the biological (5) was worthy of reconsideration.

The biopsychosocial formulation derives from a series of clinical judgments that can serve as a common ground to bring together the open-ended, semistructured, and structured approaches into a third approach, a semistructured model that includes symptom context. The process of formulation integrates the data from the evaluation and uses this information to define a treatment plan. The treatment plan organizes and prioritizes interventions in the major areas of the child's life (i.e., home, peers, school), may add medication to reduce symptoms and facilitate functioning, and tries to unencumber or enhance strengths through therapy or activities to promote the child's development. Formulation must draw not only from evidence-based data but also from theoretical inferences, using biology, developmental psychology, and sociology, and from the clinician's judgment of severity. Research findings, reimbursement systems, and new treatments will continue to evolve and affect the balance in the biopsychosocial approach to formulation. Integrating and operationalizing biopsychosocial dimensions is in the best interest of our patients.

REFERENCES


Jellinek MS (2003), Mirror, mirror on the wall. Arch Pediatr Adolesc Med 3:14-16

### Narcissistic Defenses

**Avoiding the awareness of some painful aspect of reality by negating sensory data.** Although repression defends against affects and drive derivatives, denial abolishes external reality. Denial may be used in both normal and pathological states.

Crossly reshaping external reality to suit inner needs (including unrealistic megalomania beliefs, hallucinations, wish-fulfilling delusions) and using sustained feelings of delusional superiority or entitlement.

**Projection**

Perceiving and reacting to unacceptable inner impulses and their derivatives as though they were outside the self. On a psychic level, this defense mechanism takes the form of frank delusions about external reality (usually persecutory) and includes both perception of one's own feelings in another and subsequent acting on the perception (psychotic paranoid delusions). The impulses may derive from the id or the superego (hallucinated retributions) but may undergo transformation in the process. Thus, according to Freud's analysis of paranoid projections, homosexual libidinal impulses are transformed into hatred and then projected onto the object of the unacceptable homosexual impulse.

### Immature Defenses

**Expressing an unconscious wish or impulse through action to avoid being conscious of an accompanying affect.** The unconscious fantasy is lived out impulsively in behavior, thereby gratifying the impulse, rather than the prohibition against it. Acting out involves chronically giving in to an impulse to avoid the tension that would result from the postponement of expression.

Temporarily or transiently inhibiting thinking. Affects and impulses may also be involved. Blockading temporarily resembles repression but differs in that tension arises when the impulse, affect, or thought is inhibited.

**Exaggerating or overemphasizing an illness for the purpose of evasion and regression.** Reproach arising from bereavement, loneliness, or unacceptable aggressive impulses toward others is transformed into self-reproach and complaints of pain, somatic illness, and neurosis. In hypochondriasis, responsibility can be avoided, guilt may be circumvented, and instinctual impulses are ward ed off. Because hypochondriacal intrusions are ego-alien, the afflicted person experiences dysphoria and a sense of afflication.

**Internalizing the qualities of an object.** Although vital to development, introjection also serves specific defensive functions. When used as a defense, it can obliterate the distinction between the subject and the object. Through the introjection of a loved object, the painful awareness of separateness or the threat of loss may be avoided. Introjection of a feared object serves to avoid anxiety when the aggressive characteristics of the object are internalized, thus placing the aggression under one's own control. A classic example is identification with the aggressor. An identification with the victim may also take place, whereby the self-punitive qualities of the objects are taken over and established within one's self as a symptom or character trait.

**Regression**

Attempting to return to an earlier libidinal phase of functioning to avoid the tension and conflict evoked at the present level of development. It reflects the basic tendency to gain instinctual gratification at a less-developed period. Regression is a normal phenomenon as well, as a certain amount of regression is essential for relaxation, sleep, and orgasm in sexual intercourse. Regression is also considered an essential concomitant of the creative process.

**Expressing aggression toward others indirectly through passivity, masochism, and turning against the self.** Manifestations of passive-aggressive behavior include failure, procrastination, and illnesses that affect others more than oneself.

**Passive-aggressive behavior**

**Schizoid fantasy**

Indulging in autistic retreat to resolve conflict and to obtain gratification. Interpersonal intimacy is avoided, and eccentricity serves to repel others. The person does not fully believe in the fantasies and does not insist on acting them out.

**Somatization**

Converting psychic derivatives into bodily symptoms and tending to react with somatic manifestations, rather than psychic manifestations. In desomatization, infantile somatic responses are replaced by thought and affect; in resomatization, the person regresses to earlier somatic forms in the face of unresolved conflicts.
### Neurotic Defenses

<table>
<thead>
<tr>
<th>Defense</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Controlling</strong></td>
<td>Attempting to manage or regulate events or objects in the environment to minimize anxiety and resolve inner conflicts.</td>
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<tr>
<td><strong>Displacement</strong></td>
<td>Shifting an emotion or drive cathexis from one idea or object to another that resembles the original in some aspect or quality. Displacement permits the symbolic representation of the original idea or object by one that is less highly cathedrized or evokes less distress.</td>
</tr>
<tr>
<td><strong>Externalization</strong></td>
<td>Tending to perceive in the external world and in external objects elements of one's own personality, including instinctual impulses, conflicts, moods, attitudes, and styles of thinking. Externalization is a more general term than projection.</td>
</tr>
<tr>
<td><strong>Inhibition</strong></td>
<td>Consciously limiting or renouncing some ego functions, alone or in combination, to evade anxiety arising out of conflict with instinctual impulses, the superego, or environmental forces or figures.</td>
</tr>
<tr>
<td><strong>Intellectualization</strong></td>
<td>Excessively using intellectual processes to avoid affective expression or experience. Undue emphasis is focused on the inanimate to avoid intimacy with people, attention is paid to external reality to avoid the expression of inner feelings, and stress is excessively placed on irrelevant details to avoid perceiving the whole. Intellectualization is closely allied to rationalization.</td>
</tr>
<tr>
<td><strong>Isolation</strong></td>
<td>Splitting or separating an idea from the affect that accompanies it but is repressed. Social isolation refers to the absence of object relationships.</td>
</tr>
<tr>
<td><strong>Rationalization</strong></td>
<td>Offering rational explanations in an attempt to justify attitudes, beliefs, or behavior that may otherwise be unacceptable. Such underlying motives are usually instinctually determined.</td>
</tr>
<tr>
<td><strong>Dissociation</strong></td>
<td>Temporarily but drastically modifying or modifying a person's character or one's sense of personal identity to avoid emotional distress. Dissociation is a kind of identity disorganization when states and hysterical conversion reactions are common manifestations of dissociation. Dissociation may also be found in phobic behavior, dissociative identity disorder, the use of pharmacological highs, or religious joy.</td>
</tr>
<tr>
<td><strong>Reaction formation</strong></td>
<td>Transforming an unacceptable impulse into an opposite one. Reaction formation is characteristic of obsessive neuroses, in which a mechanism is frequently used at any stage of ego development, it becomes a permanent character trait, as in an obnoxious character.</td>
</tr>
<tr>
<td><strong>Repression</strong></td>
<td>Expelling or withholding from consciousness ideas or feelings. Primary repression bars the curbing of ideas and feelings that they have been attained consciousness: secondary repression excludes from awareness what was once experienced at a conscious level. The repression is not really forgotten. Symbolic behavior may be present. To defense differs from suppression, which has a conscious inhibition of impulses to the loss of normal behavior and not just postponing the appearance. Conscious perception of instinctual feelings is blocked in repression.</td>
</tr>
<tr>
<td><strong>Sexualization</strong></td>
<td>Endowing an object or function with sexual significance that it did not previously possess. When transferred to a smaller degree to another object or objects, it contains the same type of functions and involves the problems of the original object.</td>
</tr>
</tbody>
</table>

### Mature Defenses

<table>
<thead>
<tr>
<th>Defense</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Altruism</strong></td>
<td>Using constructive and instinctually gratifying service to others to undergo a vicarious experience. It includes benign and constructive relocation reaction formation. Altruism is distinguished from altruistic surrender, in which a surrender of direct gratification or of instinctual needs and in which the person is free to take place in favor of fulfilling the needs of others to the detriment of the self, and the satisfaction can only be enjoyed vicariously through introduction.</td>
</tr>
<tr>
<td><strong>Humor</strong></td>
<td>Using comedy to openly express feelings of thoughts without personal discomfort, immobilization, and without producing unpleasant effect on others. It allows the person to tolerate and yet focus on what is too terrible to be borne; is different from wit, a form of displacement that involves a rejection of the affective issue.</td>
</tr>
<tr>
<td><strong>Sublimation</strong></td>
<td>Achieving impulse gratification and the reduction of goals but altering a socially acceptable aim or object to a socially acceptable one. Sublimation allows instincts to be channeled, rather than blocked or diverted. Feelings are acknowledged, modified, and channeled toward a significant object or objects, and modest instinctual satisfaction occurs.</td>
</tr>
<tr>
<td><strong>Asceticism</strong></td>
<td>Eliminating the pleasurable effects of experiences. There is a moral element in assigning values to positive pleasures. Gratification is derived from renunciation, and asceticism is directed against all base pleasures perceived consciously.</td>
</tr>
<tr>
<td><strong>Suppression</strong></td>
<td>Consciously or semi-consciously postponing attention to a conscious impulse or conflict. Issues may be deliberately cut off, but they are not avoided. Discomfort is acknowledged but minimized.</td>
</tr>
</tbody>
</table>

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*The categorization of these defenses as narcissistic is controversial. Many psychodynamic analysts would subsume them under "Immature Defenses."

by the development of shame and disgust in relation to anal impulses and pleasures.

Defenses can be grouped hierarchically according to the relative degree of maturity associated with them. Narcissistic defenses are the most primitive and appear in children and persons who are psychotically disturbed. Immature defenses are seen in adolescents and some nonpsychotic patients. Neurotic defenses are encountered in obsessive-compulsive and hysterical patients as well as in adults under stress. Table 6.1 lists the defense mechanisms according to George Vaillant's classification of the four types.

Theory of Anxiety

Freud initially conceptualized anxiety as "dammed up". In other words, a physiological increase in sexual tension...
Table 6.2-1  Erikson’s Psychosocial Stages

<table>
<thead>
<tr>
<th>Psychosocial Stage</th>
<th>Associated Virtue</th>
<th>Related Forms of Psychopathology</th>
<th>Positive and Negative Forerunners of Identity Formation</th>
<th>Encouraging Aspects of Identity Forma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust vs. mistrust (birth—)</td>
<td>Hope</td>
<td>Psychosis</td>
<td>Mutual recognition vs. autistic isolation</td>
<td>Temporal perspective confusion</td>
</tr>
<tr>
<td>Autonomy vs. shame and doubt (-18 months—)</td>
<td>Will</td>
<td>Addictions, Depression, Paranoia, Obsessions, Compulsions</td>
<td>Will to be oneself vs. self-doubt</td>
<td>Self-certainty vs. self-conception</td>
</tr>
<tr>
<td>Initiative vs. guilt (-3 years—)</td>
<td>Purpose</td>
<td>Conversion disorder, Phobia, Psychosomatic disorder</td>
<td>Anticipation of roles vs. role inhibition</td>
<td>Role experiential role fixation</td>
</tr>
<tr>
<td>Industry vs. inferiority (-5 years—)</td>
<td>Competence</td>
<td>Creative Inhibition, Inertia</td>
<td>Task identification vs. sense of futility</td>
<td>Apprenticeship, paranalysis</td>
</tr>
<tr>
<td>Identity vs. role confusion (-13 years—)</td>
<td>Fidelity</td>
<td>Delinquent behavior, Gender-related identity disorders</td>
<td></td>
<td>Identity vs. identification</td>
</tr>
<tr>
<td>Intimacy vs. isolation (-20s—)</td>
<td>Love</td>
<td>Borderline psychotic episodes, Schizoid personality disorder</td>
<td></td>
<td>Sexual polarizaion, bisexual conflict</td>
</tr>
<tr>
<td>Generativity vs. stagnation (-40s—)</td>
<td>Care</td>
<td>Distintation, Mid-life crisis, Premature invalidism</td>
<td></td>
<td>Leadership and responsibility, ideological conflict vs. confusion</td>
</tr>
<tr>
<td>Integrity vs. despair (-60s—)</td>
<td>Wisdom</td>
<td>Extreme alienation, Despair</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


longer passively receptive to stimuli; it reaches out for sensation and grasps at its surroundings. The social modality shifts to that of taking and holding on to things.

The infant’s development of basic trust in the world stems from its earliest experiences with its mother or primary caretaker. In Childhood and Society Erikson asserts that trust depends not on “absolute quantities of food or demonstrations of love, but rather on the quality of maternal relationship.” A baby whose mother can anticipate and respond to its needs in a consistent and timely manner despite its oral aggression will learn to tolerate the inevitable moments of frustration and deprivation. The defense mechanisms of introjection and projection will provide the infant with the means to internalize pleasure and externalize pain such that “consistency, continuity, and sameness of experience provide a rudimentary sense of ego identity.” Trust will predominate over mistrust, and hope will crystallize. For Erikson, the element of society corresponding to this stage of ego identity is religion, as both are founded upon “trust born of care.”

In keeping with his emphasis on the epigenetic character of psychosocial change, Erikson conceived of many forms of psychopathology as examples of what he termed *aggravated development crisis*, development that, having gone awry at one point, affects subsequent psychosocial change. A person who, as a result of severe disturbances in the earliest dyadic relationships, fails to develop a basic sense of trust or the virtue of hope, is predisposed as an adult to the profound withdrawn regression characteristic of schizophrenia. Erikson emphasized that the depressed patient’s experience of being and of being good is an outgrowth of a developmental derailment that causes oral pessimism to predominate. These may also be traced to the mode of oral incorporation.

Stage 2: Autonomy versus Shame and Doubt (18 Months to about 3 Years). In the developing speech and sphincter and muscular control, the toddler enters the social modalities of *holding on and letting go*. Experiences the first stirrings of the virtue that Erikson called *will*. Much depends on the amount and type of consciousness of adults over the child. Control that is exerted too early or too early deflates the toddler’s attempts to develop internal controls, and regression or false progress in Parental control that fails to protect the toddler from the consequences of his or her own lack of self-control or judgment is equally disastrous to the child’s development of a sense of autonomy. In *Identity: Youth and Crisis*, Erikson asserted: “This stage, therefore, becomes decisive for between loving good will and hateful self-insistence, cooperation and willfulness, and between self-expressive compulsive self-restraint or meek compliance.”
Deprivation Syndromes and Maternal Neglect. 1

...ers, especially Rend Spitz, have long documented the severe mental retardation that accompanies maternal rejection and infants in institutions characterized by low staff-to-infant ratios. In such settings, infants tend to display marked development patterns, even with adequate physical care and freedom from The same infants, placed in adequate foster or adoptive care, show accelerated development.

Anxiety. A fear of strangers is first noted in about 26 weeks of age but is not fully developed until weeks (8 months). At the approach of a stranger, babies cling to their mothers. Babies exposed to, only nurse are more likely to have stranger anxiety than those reared by a variety of caregivers. Stranger anxiety is a result of a baby's growing ability to distinguish from all other persons.

A form of anxiety, which occurs between 10 and 18 months, is related to stranger anxiety but is not identical to it. From the person to whom the infant is attached, separation anxiety arises. Stranger anxiety, however, occurs when the infant is in the mother’s arms. The infant learns as it starts to crawl and move away from the mother, it constantly looks back and frequently returns to the mother for reassurance.

Mahler (1989–1985) proposed a theory to describe how children acquire a sense of identity separate from the notion of self. Her theory of separation-individuation was based on the interactions of children and their caregivers. Her theory is outlined in Table 2.2–6.

<table>
<thead>
<tr>
<th>Table 2.2–6</th>
<th>Stages of Separation-Individuation Proposed by Mahler</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Normal autonomy (birth to 2 months)</td>
<td>Periods of sleep outweigh periods of arousal in a state reminiscent of intrauterine life.</td>
</tr>
<tr>
<td>2. Symbiosis (2 to 5 months)</td>
<td>Developing perceptual abilities gradually enable infants to distinguish the inner from the outer world; mother-infant is perceived as a single fused entity.</td>
</tr>
<tr>
<td>3. Differentiation (5 to 10 months)</td>
<td>Progressive neurological development and increased alertness draw infants' attention away from self to the outer world. Physical and psychological distinctiveness from the mother is gradually appreciated.</td>
</tr>
<tr>
<td>4. Practicing (10 to 18 months)</td>
<td>The ability to move autonomously increases children's exploration of the outer world.</td>
</tr>
<tr>
<td>5. Rapprochement (18 to 24 months)</td>
<td>As children slowly realize their helplessness and dependence, the need for independence alternates with the need for closeness. Children move away from their mothers and come back for reassurance.</td>
</tr>
<tr>
<td>6. Object constancy (2 to 5 years)</td>
<td>Children gradually comprehend and are reassured by the permanence of mother and other important people, even when not in their presence.</td>
</tr>
</tbody>
</table>

and child. Each newborn has innate psychophysiological characteristics, which are known collectively as temperament. Chess and Thomas identified a range of normal temperamental patterns, from the difficult child at one end of the spectrum to the easy child at the other end.

Difficult children, who make up 10 percent of all children, have a hyperalert physiological makeup. They react intensely to stimuli (cry easily at loud noises), sleep poorly, eat at unpredictable times, and are difficult to comfort. Easy children, who make up 40 percent of all children, are regular in eating, eliminating, and sleeping; can adapt and change new stimuli with a minimum of distress; and are easily comforted when they cry. The other 50 percent of children are mixtures of these two types. The difficult child is harder to raise and places greater demands on the parent than the easy child. Chess and Thomas used the term goodness of fit to characterize the harmonious and consonant interaction between a mother and a child in their motivations, capacities, and styles of behavior. Poorness of fit is likely to lead to distorted development and maladaptive functioning. A difficult child must be recognized, because parents of such infants often have feelings of inadequacy and believe that they are doing something wrong to account for the difficulty in sleeping and eating and the problems comfort the child. In addition, most difficult children have emotional disturbances later in life.

Good-Enough Mothering. Winnicott believed that infants begin life in a state of nonintegration, with unconnected and diffuse experiences, and that mothers provide the relationship that enables infants’ incipient selves to emerge. Mothers supply a holding environment in which infants are contained and experienced. During the last trimester of pregnancy and for the first
tendency to orient the initial interview toward diagnostic possibilities, leaving the full data unexplored. Factors impinging on diagnosis such as environmentally harmful events, physical history, and family circumstances may be unelicited. While making rounds on a pediatric unit I was asked to help with an interfering and anxious mother. The child patient had a mild self-limiting kidney disorder, but the mother suspected that a lethal diagnosis was being kept from her. I interviewed the mother with the pediatric residents and interested nurses present. The first routine question of my interview was the names of the child, other siblings, and their ordinal position in the family. The child patient was a second son, age 3, named Jacob. The first child, also named Jacob, had died four years previously of renal failure and the new baby was clearly a replacement. Within seconds, the pediatric staff changed from hostile to supportive. Yet what had been elicited was a routine question unasked previously because of focus on the pursuit of diagnosis and effective treatment.

All science and arts flourish with innovations and challenges to settled theories and practices which themselves had been innovative in their day and are now being questioned and revised. Complacency leads to stagnation. I do worry that I may myself treasure too much the content of my own contributions. I give my appreciation to the staff of the Bellevue Pediatric/Psychiatric Liaison Clinic and the members of the Occasional Conferences on Temperament who continue to innovate and provide me with knowledge of advances. Each new advance brings new questions, each new solution brings new dilemmas.

References

TEMPERAMENTAL CATEGORIES AND THEIR DEFINITIONS

1. Activity Level. The motor component and its diurnal proportion of active and inactive periods.

2. Rhythmicity (Regularity). The predictability and/or unpredictability in time of any function. It can be analyzed in relation to the sleep-wake cycle, hunger, feeding pattern, and elimination schedule.

3. Approach or Withdrawal. The nature of the initial response to a new stimulus (a new food, toy, or person). Approach responses are positive, whether by mood expression (smiling, verbalizations, etc.) or motor activity (swallowing a new food, reaching for a new toy, active play, etc.) Withdrawal reactions are negative, whether displayed by mood expression (crying, fussing, grimacing, verbalizations, etc.) or motor activity (moving away, spitting a new food out, pushing a new toy away, etc.).

4. Adaptability. Responses to new or altered conditions. One is not concerned with the nature of the initial responses, but with the ease with which they are modified in the desired direction.

5. Threshold of Responsiveness. The intensity level of stimulation that is necessary to evoke a discernible response, irrespective of the specific form that the response may take, or the sensory modality affected. The behaviors utilized are those concerning reactions to sensory stimuli, environmental objects, and social contacts.

6. Intensity of Reaction. The energy level of response, irrespective of its quality or direction.

7. Quality of Mood. The amount of pleasant, joyful, and friendly behavior, as contrasted with unpleasant crying and unfriendly behavior.

8. Distractibility. The effectiveness of extraneous environmental stimuli in interfering with or in altering the direction of the ongoing behavior.

9. Attention Span and Persistence. Two categories that are related. Attention span concerns the length of time a particular activity is pursued by the child. Persistence refers to the continuation of an activity in the face of obstacles to the maintenance of the activity direction.

THREE TEMPERAMENTAL CONSTELLATIONS

Easy Temperament—Typically, this comprises the combination of biological regularity, approach tendencies to the new, quick adaptability to change, and predominantly positive mood of mild or moderate intensity.

Difficult Temperament—This is the opposite of easy temperament, namely, biological irregularity, withdrawal tendencies to the new, slow adaptability to change, and frequent negative emotional expressions of high intensity.

Slow-to-Warm-Up Temperament—This comprises withdrawal tendencies to the new, slow adaptability to change, and frequent negative emotional reactions of low intensity. Such individuals are often labeled as “shy.”
on the parents' patterns of childcare. Our initial interview with the
parents was scheduled when the child was 2 or 3 months of age.

The sample comprised middle- and upper-middle-class families liv-
ing in the New York area. A homogeneous sociocultural group mini-
imized the influences that could be introduced by substantial sociocul-
true variability. Our study protocols did include such phenomena as
unusual events, and idiosyncratic parental attitudes. The use of
a healthy homogeneous sample provided a baseline for generalizing
findings to other populations of different economic, cultural, and
class status. We initiated a second longitudinal study of 95 children
in New York of unskilled and semiskilled working-class Puerto
Ricans. This group was also followed longitudinally from early
childhood, using the same approach to data collection as in the NYLS.
The reports in the discussion that follows from our major study, the
NYLS.

Data Collection

The NYLS sample comprised 129 children from 80 families. There
retention rate of 97% over this 25- to 30-year period with 129 sub-
jects and their parents. Our semistructured parent interviews were con-
ducted at 3-month intervals during the first 18 months of life, at 6-month
intervals until 5 years of age, and yearly until 8 or 9 years of age. The sub-
s and their parents were interviewed separately in adolescence, and the
procedures were followed in the 18- and 22-year age period. In the
ups in the mid- and late twenties and again in the thirties, only the
parents were interviewed. Data were also collected yearly through inter-
views and observations from nursery school, kindergarten, and first
Standard psychometric testing was carried out at ages 3 and 6. A
structured interview to elicit information regarding parental prae-
tural attitudes was held in the child's home with the mother and father,
but by turns simultaneously when each child was 3 years old.

THE CLINICAL SAMPLE

The goal of the NYLS was the determination of the functional
measures of temperament for the origins and evolution of behavior.
Psychiatric consultation and advice were provided at any
stage of the child's development.

A clinical evaluation was offered if the child's undesirable path-
ology was not improving or became worse. Neurologic or psycho-
logical studies were arranged as needed. Teachers were interviewed
about problems, and additional observations were done in class. All
data corresponded to the Diagnostic and Statistical Manual, third edi-
tion (DSM-III-R). The child's perspectives were followed in the
first psychometric evaluation. The formulation of the
child's pathologic child-environment interaction, and the osteo-
articular behavior problem were derived from a composite of clinical
information. A decision was made as to direct treatment of
parent guidance, or other patterns of therapeutic intervention, discussed with the parents. A yearly follow-up was discontin-
ued if the child showed a sustained recovery.

Data Analysis

The data analysis was primarily qualitative: parent and teacher
data, narrative description of the child's behavior at school and
at IQ test, and special interviews with the parents when each
child was 3 years old. In other words, our primary data were not
through scores or other methods of quantitative ratings. We
in meaningful subtleties in the developmental course of indivi-
duals. It also permitted the raw data to be reexamined.

Birch then conducted an inductive content analysis of the
interview protocols of each of our first 22 NYLS subjects
first year of life. Blind to our postulated temperament traits, he
nine categories of temperament, established scoring criteria for
categories, and determined a method of rating each item of behavior
in each interview. His unique contribution served to transform our nar-
more categories into categories with precise definitions and criteria for the
scoring of behavioral items that could then be rated quantitatively for
each temperament category.

TEMPERAMENT CATEGORIES

The nine categories and their definitions are as follows:

1. Activity level: The motor component present in a given child's func-
tioning and the temporal proportion of active and inactive periods.

2. Rhythm (regularity): The predictability and/or unpredictability
in time of any function. It can be analyzed in relation to the
sleep-wake cycle, hunger, feeding pattern, or elimination schedule.

3. Approach or withdrawal: The nature of the initial response to a new
stimulus, be it a new food, toy, or person. Approach responses are
positive, whether displayed by mood expression (smiling, verbaliza-
tions, and the like) or by motor activity (swallowing a new food,
reaching for a new toy, active play, and so on). Withdrawal reactions
are negative, whether displayed by mood expression (crying, fussing,
grimacing, verbalizations, or the like) or by motor activity (moving
away, spitting new food out, pushing new toy away, and so forth).

4. Adaptability: Responses to new or altered situations. One is not con-
cerned with the nature of the initial responses but with the ease with
which they are modified.

5. Threshold of responsiveness: The intensity level of stimulation nec-
ecessary to evoke a discernible response, irrespective of the specific
form that the response may take or the sensory modality affected.
The behaviors utilized are those concerning reactions to sensory
stimuli, environmental objects, and social contacts.

6. Intensity of reaction: The energy level of response, irrespective of its
quality or direction.

7. Quality of mood: The amount of pleasant, joyful, and friendly behav-
ior, as contrasted with unpleasant, crying, and unfriendly behavior.

8. Distractibility: The effectiveness of extraneous environmental stimuli
in interfering with or altering the direction of the ongoing behavior.

9. Attention span and persistence: These two categories are related.
Attention span concerns the length of time a particular activity is
pursued by the child. Persistence refers to the continuation of an
activity in the face of obstacles.

Qualitative analysis, supplemented by factor analyses, led us to for-
mulate in addition three constellations of temperament made up of var-
ious combinations of the individual categories, which appeared to have
functional significance. These are:

1. Easy temperament: Typically, this comprises the combination of bio-
logical regularity, approach tendencies to the new, quick adaptability
to changes, and a predominantly positive mood of mild or moderate
intensity (approximately 40% of the study population).

2. Difficult temperament: This is the opposite of easy temperament,
namely, biological irregularity, withdrawal tendencies to the new,
slow adaptability to change, and frequent negative emotional expres-
sions of high intensity (approximately 10% of the study population).

3. Slow-to-warm-up temperament: This category comprises withdrawal
tendencies to the new, slow adaptability to change, and frequent neg-
ative emotional reactions of low intensity. Such individuals are often
labeled "shy" (approximately 15% of the study population).

Temperamentally easy children typically adapt quickly and posi-
tively to new situations and demands. The temperamentally difficult
child, by contrast, although normal, often finds adaptation to the new
distressing and stressful. The slow-to-warm-up child may also present
difficulties in management, but her or his negative reactions to new
foods, places, or people are expressed mildly, rather than with the
violent intensity of the difficult child. Caregivers and teachers can usually
tolerate this slow-to-warm-up behavior and give the child time to make
a gradual adaptation to the new.
USE OF THE AMSIT IN DOCUMENTING THE CHILD AND ADOLESCENT PSYCHIATRIC EXAMINATION

In every diagnostic interview, the examiner must document the patient's mental status examination. The AMSIT is an acronym representing the components of the mental status examination: A (appearance, behavior, and speech); M (mood and affect); S (sensorium); I (intelligence); and T (thought). The AMSIT allows systematic documentation and organization of data collected during the psychiatric examination of adults. It was originated in the early 1970s by David Fuller at the University of Texas at San Antonio (1). The AMSIT has undergone a number of improvements. The latest version was written in 1997 (Table 3-1). Medical students, interns, general psychiatric residents, and fellows in child and adolescent psychiatry are expected to be proficient in the AMSIT.

The psychiatric examination provides data needed to establish a psychiatric diagnosis and to develop a comprehensive treatment plan. A comprehensive psychiatric evaluation of the child includes an inquiry into the child's presenting problems, his or her developmental course, and the nature of the family context or rearing environment. The developmental progression (which refers to the acquisition of abilities or skills at a given age) and the developmental context (which refers to psychosocial factors and the nature of the rearing environment) are fundamental concepts in the field of child and adolescent psychiatry.
APPEARANCE, BEHAVIOR, AND SPEECH

Table 3-2 summarizes the specific areas of the AMSIT that are related to appearance, behavior, and speech. Keen, disciplined, and systematic observations must be made during this section of the AMSIT. Methodical inspection and careful observation account for approximately two-thirds of the work involved in arriving at a diagnosis. A "clinical eye" and expertise give examiners an advantage in this area.

First impressions are significant. The examiner should consider the following questions: What is my first impression of the child (or the family)? Is the child likable? Is there anything odd about the child? Is there any sense of detachment, apprehension, or even danger? The answers to these questions are important in the overall assessment of the child and his or her family. While the examiner is assessing the child and the family, they are assessing the examiner: Is the doctor likable? Does the doctor come across as reassuring, or as critical and severe? Does the doctor appear to be comforting? Does the doctor seem willing to help?

Physical Appearance

The examiner should note whether the child appears to be his or her chronological age or looks younger or older than the stated age.

<table>
<thead>
<tr>
<th>TABLE 3-2. Elements of the appearance, behavior, and speech section of the AMSIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical appearance</td>
</tr>
<tr>
<td>Gait and posture*</td>
</tr>
<tr>
<td>Exploratory behavior*</td>
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<tr>
<td>Playfulness*</td>
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<tr>
<td>Relatedness</td>
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<tr>
<td>Eye contact</td>
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<tr>
<td>Behavioral organization</td>
</tr>
<tr>
<td>Cooperative behavior*</td>
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</tbody>
</table>

*Denotes topics that are considered in the AMSIT for children and adolescents.

The examiner should observe the child's nutritional state, his or her sense of vitality, and the presence or absence of secondary sexual characteristics. Marked slimness, cachexia, heaviness, or obesity will be readily apparent. In children showing such characteristics, issues related to eating disorders need to be explored, no matter what the presenting problem may be.

The examiner should note the presence of dysmorphic features in any of the following areas: facial complexion, shape and configuration of the eyes (e.g., slanted or mongoloid; different-colored irises), breadth or shape of the forehead, setting or configuration of the ears, and texture and docility of the hair (e.g., "electric" hair). The shape and configuration of the head should be noted. The examiner should also note any other unusual facial or cranial features.

The examiner should pay attention to the child's attire and physical presentation. Children with deviant social behavior often wear striking and unconventional attire. The examiner should note the child's footwear, hairstyle, and hair color. With female patients, the examiner also should note the use of nail polish and the quality of any makeup used. Revealing or see-through garments may indicate a defiance of norms and the transgression of social conventions. Children who wear such garments may also demonstrate precociousness, sexualization, or evidence of antisocial behavior. Rings and perforations are in style among some youth. If the examiner observes perforation of the nose, eyebrows, or tongue, he or she might also inquire about perforations elsewhere on the body, including the navel, nipples, or genitals. Children with sexual identity conflicts often present with ambiguous attire or with makeup that is more appropriate to the opposite sex. Masculine females frequently present without makeup; their attire and demeanor betray their intentions of wanting to be male.

The examiner should observe any visible skin for the presence of tattoos; for signs of recent injuries or self-abusive or suicidal behaviors; or for evidence of old injuries such as multiple scarring of the knuckles, wrists, or forearms. These marks may be indicative of chronic self-abusive behavior or impulsive aggressive tenden-
cies. If the patient’s upper limbs show evidence of self-abusive behavior, the examiner should explore whether the patient abuses other parts of the body (e.g., legs, chest, breasts, genitals). The examiner should ask the child about all visible scars: each scar has a history to tell. The possibility of nonvisible scars needs to be kept in mind even if no scars associated with self-abusive behavior are visible.

Alert examiners may detect vein tracks or other signs of drug abuse. An attentive interviewer will detect evidence of hair pulling (trichotillomania) of the scalp or of the eyebrows and will observe signs of nail biting, nose picking, skin picking, and other compulsive traits. If the patient has an obvious disability, the examiner should note it and observe the limitations that it imposes on the patient and how he or she copes with it.

Gait and Posture

As the examiner enters the waiting room and then guides the child to the interviewing room, he or she should note the child’s gait, including the child’s grace, smoothness, and coordination. Does the child waddle, shuffle, or tiptoe? Does he or she move with agility? Does the examiner detect any unusual movements associated with the child’s gait? For these and related observations, see Chapter 7.

Does the child sit or stand erect, or does he or she slouch? Some children are unable to keep an erect posture while sitting or standing. Does the child lean on the chair, the table, or on any other available support? Some children look hypotonic, or sluggish. Children with a background of early deprivation display unusual and ungraceful postures and may seem hypoactive or even apathetic. Children with chronic regressive states are likely to lean on the chair or to lie down on the sofa or on the floor, even though they exhibit no neuromotor impairment. The same is true for children with severe neuromotor retardation, the child’s inactivity may reach a catatonic state.

If the child is catatonic, the examiner should evaluate the degree of akinesia, including lack of blinking, persistence of unusual postures, vacant staring, or flatness of the emotional display. The examiner may also observe echopraxia, echolalia, and other automatic imitative behaviors. The examiner may test the patient for cerea flexibilitas (in which the patient maintains whatever body position he or she is placed in).

Some children come across as weak, anergic, or as temperamentally being hypoactive or hyporeactive. These children lack enthusiasm, and it is difficult to keep them motivated about anything.

Exploratory Behavior

Some children demonstrate no reticence when entering the examiner’s office. Some children appear fearless in new circumstances and do not show any restraint in unfamiliar settings. These children often show a sense of familiarity with the examiner, even though this is the first time they have met him or her. Some children look around first but seem comfortable even though they are in a new environment. Others are apprehensive about coming into the office and need the active encouragement or assistance of a parent or other caregiver to help them in. These children show evidence of behavioral inhibition:1 they hide behind their mothers and stay near them or they hide their faces with their hands to avoid eye contact. Other children fret or show wariness and need reassurance before any diagnostic engagement.

Playfulness

Playfulness is a quintessential characteristic of childhood. It should be present in well-adapted, so-called normal children. If the examiner encounters an overtly serious child, he or she needs to

1Behavioral inhibition is an enduring temperamental trait present in 20% of children, characterized by inhibition in situations of novelty, shyness, fear, and by a high level of psychophysiological arousal (e.g., high stable heart rates, muscle tension, pupillary dilation, high levels of cortisol and catecholamines) (2).
seek explanations for this demeanor. If the child lacks the quality of playfulness, the examiner will probably observe other evidence of developmental deviations, for example, lack of behavioral organization and exploratory behavior (both are discussed later in this chapter). The examiner may also observe inhibition, passivity, and separation problems.

Once the child engages in play, the examiner should attend to the content and process of the child’s play. The examiner should note the nature of the child’s enactments (see Chapter 1), the degree of the child’s affective involvement (i.e., the child’s emotional involvement with the examiner and the child’s overt affective display), and the manner in which the child involves the examiner in the play. Frequently, children enact themes related to the major psychological issues that preoccupy or surround them (e.g., major anxieties or conflicts going on in their families).

Relatedness

Relatedness refers to the child’s manner of relating to the examiner. Normal preschool and preadolescent children are reserved when they meet strangers. After they have gotten a “feeling” for the situation and have been reassured, they relate more warmly. Adolescents may be expectant and hesitant. Once the child feels comfortable, he or she will become more spontaneous and engaging. Anxious children need more time and more reassurance to feel at ease and to develop rapport. Schizoid children will appear distant and uninvolved. These children will not warm up to the interviewer, no matter how much effort is made to engage and comfort them. Psychotic children will show oddness and inappropriateness in relating, or they may display signs of self-absorption, evidence of response to internal stimuli, or inappropriate affect.

Some children show immediate familiarity with the examiner and, for that matter, with any stranger. Such children demonstrate boundary problems and will require ongoing structure to behave adaptively. Children who demonstrate promiscuous relating may also show evidence of seductive or even overt sexual behavior.

Management of these behaviors requires active limit-setting throughout the diagnostic interview (see Chapter 1). Other children behave in a hostile and aggressive manner or even in a paranoid fashion. These children are hyperalert and suspicious.

Eye Contact

Eye contact is a fundamental interactive behavior. It is a universal nonverbal behavior that increases attachment and rapport. Warm eye contact is a basic element of interpersonal engagement, and its absence indicates a significant relational problem. Children who display poor eye contact also display problems in interpersonal social behavior. These children avoid eye contact when they are anxious or when attachment or neuropsychiatric difficulties are present.

The more deviant the nature of the eye contact, the more serious the likelihood of profound developmental psychopathology in the social-relational area. Examples of deviant eye contact include the “see-through” eye contact observed in autistic children and the “staring” eye contact observed in paranoid and psychotic children. Seizure disorders and dissociative states must be considered in the differential diagnosis when staring is observed.

Behavioral Organization

The examiner should note the patient’s degree of adaptability and organizational behavior. Some children, no matter what is happening around them, are able to initiate or create adaptive activities or to immerse themselves in generative activities (e.g., play). Other children, even in the most propitious circumstances, are unable to generate constructive or productive activities and depend on the alter-ego functions of responsible adults for their organized and adaptive behavior. Children who lack behavioral organization will

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1 Behavioral organization refers to the degree to which the patient’s behavior is self-structured. It indicates a capacity for generative activities (e.g., play) independent of the current circumstances. Children who lack this capacity need active structuring throughout the evaluation.
also show other deficits, such as an inability to focus, the absence of an organized approach to problem solving, or a lack of self-soothing functions.

Some children exhibit behavioral disturbance as soon as they enter the psychiatrist's office. They are fidgety, restless, and hyperactive. These children need active structuring throughout the evaluation. The structuring may include verbal redirection, limit setting, or even physical redirection or restraint.

Cooperative Behavior

The examiner should note the child's active and cooperative participation during the psychiatric examination. This quality is associated with the child's understanding of the presenting problems, the dystonicity of the symptoms, and his or her motivation to change.

Problems with compliance or with following directions are common and challenging complaints in the field of child and adolescent psychiatry. When faced with a child's oppositional behavior, the examiner should attempt to determine whether the behavior stems from a need to control, a power struggle motivation, or a sense of personal incompetence. In the latter case, when children are aware of their real or perceived incompetence (or mastery limitations), they will be reluctant to try a given task because they know, or believe, they cannot do it. Many so-called oppositional children have significant unidentified language disorders. These children often have major language receptive problems and cannot understand expectations or given commands. They may also have neuropsychological deficits that interfere with their ability to understand a task or its solution. The examiner should also determine whether these patients have any hearing problems.

Psychomotor Activity

Disturbances of psychomotor activity are probably the most commonly encountered disruptive behaviors in clinical settings. Psychomotor disturbances are caused by a multiplicity of medical, neurological, and psychiatric conditions. Attention-deficit/hyperactivity disorder (ADHD) is one of the most prevalent psychiatric diagnoses, and some of its features are among the most common behavior problems cited by school teachers. The triad of hyperactivity, distractibility (inattentiveness), and impulsivity commonly occurs as a primary disorder, a complicating comorbidity, or a secondary manifestation. When the examiner observes signs of ADHD, he or she should search for evidence of common comorbid disorders associated with this condition (e.g., oppositional defiant disorder, conduct disorder, depressive disorders, anxiety disorders, developmental language and learning disorders).

The examiner should distinguish between a child who exhibits hyperactive behavior (e.g., fidgetiness, aimless behavior) and a child who is driven by goal-directed behavior. The examiner should test the child's response to redirection or structure to determine whether the hyperkinesis is responsive or impervious to structuring or limit setting. The examiner also should attempt to determine whether the child's impairments are secondary to ADHD, one of the commonly associated conditions, or both.

Agitation and sensorium disturbances should alert the examiner to the possibility of delirium. Because delirium is a potentially life-threatening process, it should be considered in the differential diagnosis of hyperactivity, agitation, and restlessness in children.

Mania and akathisia should be considered in the differential diagnosis of agitation and restlessness. Manic patients are quite hyperactive. The examiner should pay attention to other manic manifestations, such as pressured speech, loose associations, and grandiosity. If akathisia is suspected, the examiner should determine whether the patient uses neuroleptics or selective serotonin reuptake inhibitor (SSRI) antidepressants and should look for other extrapyramidal symptoms (EPS) or other signs of neuropsychological dysfunction.

Involuntary Movements

The examiner should observe whether the child displays tics of the face or the limbs, or muscle twitching or jerking. These signs
should immediately raise the examiner’s suspicion that the child may have Tourette’s syndrome. Other involuntary movements (e.g., choreic or dyskinetic movements) may indicate a movement disorder, cerebral palsy, or other neurological conditions (e.g., Sydenham’s chorea, Huntington’s disease, Wilson’s disease). The examiner should also be attentive to the child’s production of vocal tics or guttural noises such as grunting, throat clearing, involuntary noises (including shrill noises), or barking.

With children who are taking neuroleptic medications, the examiner should be alert to the presence of involuntary movements associated with acute dyskinesia and the orolingual and choreiform movements associated with tardive dyskinesia. Any of these findings require full neurological clarification. SSRI antidepressants can also induce EPS reactions (3).

Behavioral Evidence of Emotion

The examiner should observe any affective or emotional manifestations and pay special attention to the flow and vicissitudes of the child’s emotional display. The examiner should note whether the child’s emotional display is enduring or whether it is variable and unstable.

Anxiety disorders and depressive disorders are common afflic tions treated in clinical psychiatric practice. Common signs or features of anxiety include the presence of specific and unspecific fears, thumb sucking, nail biting, hair pulling, frequent scratching, skin flushing, and bowel sounds. Cracking of the knuckles or the back is common in anxious adolescents. Preadolescents may exhibit manifestations of primitive anxiety and fear (e.g., urinating, passing gas, or defecating) during the interview.

Separation anxiety complaints are common. Children with these disorders refuse to separate from their mothers, stay close to their caregivers, and display limited curiosity and exploratory behavior. Equally common in anxious children are inhibitions in social settings, “freezing” in social situations, and elective mutism.

Common features of melancholia include a sad face, a down-
est demeanor, crying, and limited level of activity. Melancholic signs are commonly accompanied by negative cognitions such as helplessness, hopelessness, and worthlessness and by suicidal thoughts or behavior. Tiredness, sleep and appetite disturbances, and anhedonia are other components of melancholia. In contrast, euphoric mood coupled with restlessness, distractibility, a sense of grandiosity, and pressured speech should make the examiner suspect mania or hypomania. In general, mania and melancholia are infectious moods, meaning that the examiner is “contaminated” by the patient’s prevailing mood. Often the examiner evolves a countertransference that is concordant with the child’s prevailing mood (4, pp. 135–137). In addition, the examiner needs to recognize signs of fear, confusion, perplexity, hostility, seductiveness, and many other emotional states.

Repetitious Activities

The examiner should pay attention to the presence of repetitive motoric activities. On the most benign end of the spectrum are continuous hand-rubbing, frequent preening, and other behaviors associated with anxiety and tension. In the middle of the spectrum are behaviors such as thumb sucking, nail biting, and knuckle or spine cracking. At the most pathological end of the spectrum are behaviors such as rocking, arm flapping, and other autistic behaviors. When careful inspection does not reveal the presence of overt repetitious activities, the examiner should proceed with sensitive probing to rule out the presence of less obvious compulsive activities (see Chapter 4).

Disturbance of Attention

Although hyperactivity is commonly associated with inattentiveness and impulsivity, disturbance of the attentional processes sometimes occur without hyperactivity or impulsivity. In general, disturbances of attention reflect distractibility (a lack of a capacity for selective and sustained attention). Distractible children move
from one activity to the next without finishing any of them.

Attention comprises many functions, including selective attention, sustained attention, intensity of attention, inhibitory control, and attentional shifts. The selection and organization of responses to stimuli depend on high-level executive functions (5). Attention is a fundamental function in information processing and cognitive and language functioning. Attention disturbances are implicated in the etiology of schizophrenia.

Speech

The speech area of the mental status examination is rich in findings and rewarding in the overall diagnostic process. The findings in this area range from overt aphasias with associated neurological findings to the less specific developmental language disorders. If a child does not seem to understand what the examiner is attempting to convey or when the child’s responses seem to miss the point (e.g., when non sequitur responses are given), the examiner should suspect a receptive language disorder. The examiner must ascertain whether a hearing loss is present in these cases.

As the child speaks and responds to the examiner’s questions, special attention should be paid to the spontaneity and flow of the child’s speech, the richness of the vocabulary used, the child’s abstraction capacity, the quality of the grammar used, and the child’s ability to communicate emotion and meaning.

Children with receptive language difficulties look lost and confused. The examiner should consider the following questions: Is the patient attempting to communicate at all? Is the patient gesturing or attempting to use other nonverbal behavior? Is the patient capable of developing rapport? Is the patient attempting to connect with the examiner? The answers to these questions will assist the examiner in differentiating autism from other communication disorders.

Limited lexicon, grammatical mistakes, inappropriate use of prepositions, and problems with syntax are common in children with expressive language delays. Their speech and language are usually immature. Expressive language disorders may be associated with psychosocial developmental immaturity.

The examiner should also note the naturalness of the patient’s speech and the quality of the communication process used. Odd speech, affectation in the communication (i.e., pedantic talk), or unusual features of the communication process or of its contents, such as echolalia, neologisms, or bizarre productions, should raise the suspicion of a thought disorder (e.g., schizophrenia).

The examiner must attend to the volume and rate of the speech as well as to the quality of its articulation. The examiner should note whether the patient’s speech is loud, pressured, or slurred and whether evidence of mispronunciations, stuttering, or other unusual speech qualities is present.

The examiner should note the amount of time that elapses before the patient initiates a verbal response. Some patients take a rather long time before beginning any response, whereas others blurt out responses impulsively before the examiner finishes the question or before he or she has completed a thought.

Disturbances of Speech Melody

Disturbances of speech melody (called dysprosody) are prevalent in severe aphasias and developmental language disorders. The examiner should pay attention to these speech qualities because they are revealing. Disturbances of the musicality and rhythm of the speech indicate that an injurious event affected the child’s neuro-linguistic development in early periods of language and speech formation.

Instead of the soft, childlike, sweet, and melodious quality of the typical child’s speech, the examiner may hear a grave, hoarse voice that resembles an adult’s or elderly person’s voice. The child’s voice may have a high-pitched tone, or, in male children, the child’s speech may have an effeminate quality (see Carlos’s case example in Chapter 10). Dysprosody is a striking finding.

Children who have pervasive personality disorders or other severe neurodevelopmental disorders also exhibit problems with
voice melody and voice inflection. For instance, when they attempt to make a statement, they may raise their voice as if asking a question.

**MOOD AND AFFECT**

Cummings’s definitions of mood and affect are clear and succinct: “Mood is an internally experienced pervasive emotion. Affect is the outward emotional display” (6, p. 168). In this section of the mental status examination, the examiner notes the child’s predominant affect and the subjective states that accompany it. He or she may also observe the quality and intensity of affective expression.

Among the most valuable and clinically relevant aspects of the AMSIT is the expectation that the examiner will consider the presence of depression or mania in every psychiatric evaluation. The AMSIT expects the examiner to rate the patient’s depressive or elated affect on a seven-point numerical scale. The scale includes depression at one extreme, euthymia at the center, and mania at the other extreme. Every AMSIT should assess the patient’s degree of affective expression or mood disturbance.

Loved and well-cared-for children are, by nature, bubbly and expansive. The examiner should describe any deviation from this state. Thus a serious child may already be demonstrating emotional disturbance. A serious countenance may be part of a restrained, euthymic state in an adult, but this is not necessarily the case in children.

Reactivity to environmental factors complicates both the identification of affective disturbance and the determination of its severity. Many depressed children react positively to reassurance and may even engage in playful interactions. These observations may mislead the diagnostician.

The examiner should note the child’s spontaneous affective display and any changes of affect that occur during the interview. The examiner should describe the intensity and the range of the affective expression. It is equally important to observe if the affect is appropriate to the thought content or if it is inappropriate either to the thought content or to the interviewing context.

Silliness and inappropriateness of affect are common in immature and regressed children. These affective states may represent early forms of hypomania. Some children are openly silly, whereas others display overt euphoria. Affect disturbance is common in so-called borderline disorder, in Asperger’s syndrome, and in schizophrenia.

Other mood and emotional states may be as prominent and as important as those associated with depression and mania. Anger, anxiety, fear, and other states of emotional arousal are common phenomena observed in clinical practice.

The examiner should differentiate depression related to a psychiatric disorder from depression related to neuropsychiatric dysfunction. Harris warns, “In the assessment of affect, apathy must be distinguished from depression. Moreover, the experience of emotion must be clarified because in some conditions, such as certain right-hemispheric dysfunction presentations or in pseudobulbar palsy, the physical expression of affect (e.g., facial expression, voice tone) may be impaired although inner experience may remain intact. Finally, with some frontal lobe lesions and in some metabolic encephalopathies, severe apathy may be noted in the absence of depression” (7, p. 31).

**SENSORIUM**

Orientation

Children of normal intelligence, even early preadolescents, frequently know the day of the week, the month, and the year of the evaluation. Less precision should be expected with the date, but
even so, alert and bright children will be very close to the correct date. It is telling when the examiner asks the child questions regarding orientation, and the child turns to the mother for guidance or expects her to give the response. The examiner needs to look beyond the overt dependency and explore cognitive problems or generalized difficulties with orientation in time and space. Significant deviations from orientation to time are common in children who have cognitive impairments and in children who have neurodevelopmental disorders such as learning disorders and right-hemispheric dysfunctions. The same can be said of orientation to place.

**Memory**

Disorders of memory result from problems with encoding (i.e., registration secondary to attentional disturbances) or from difficulties with decoding or retrieval (see Chapter 7). "The impairment of new learning, or anterograde amnesia, is a defining attribute of organic amnesia" (8, p. 448). **Retrograde amnesia** refers to impairment for memories acquired before brain damage (8, p. 448). The examiner should notice the accuracy of the child’s recall and the coherence and relevance of details included in the child’s narrative. Memory problems should be suspected when, in response to the questions posed by the examiner, the child looks confused or uncertain or seeks support for his or her answers from significant others.

A child of normal intelligence will be able to talk about important recent events. For example, if the child is a sports enthusiast, the examiner may test the child’s tracking of recent sporting events and the accuracy of the recall.

The task of remembering three different words is a classical and practical short-term memory test. The examiner should select unrelated words. This challenge becomes more demanding if one of the words is abstract (e.g., honesty, fairness).

**Concentration**

Concentration reflects the patient’s ability to focus and sustain attention in cognitive tasks. An adolescent with normal intelligence and without specific learning disabilities in arithmetic should be able to demonstrate proficiency with the serial sevens test (e.g., "take 7 away from 100 and keep taking 7 away from the result"). The response to this challenge is considered satisfactory when the adolescent gives five or six accurate responses. For an early latency child, this may be a formidable challenge, in which case the examiner may choose a less difficult task such as serial threes (e.g., "take 3 away from 20 and keep doing so from each answer you get").

The repetition of digits forward and backward is a traditional test of concentration and immediate memory. Adolescents with good concentration and good immediate recall should be able to repeat five or six numbers forward and up to four or five digits backward. Younger children should be expected to be proficient with fewer digits (see Chapter 7).

**Calculating Ability**

If the examiner is testing the child’s concentration and calculating ability with serial sevens, and the child finds the task too difficult, the examiner could try easier challenges such as serial threes (as described in the preceding section) or could present simple calculation problems such as 6 + 7 = ? or 9 - 4 - 3 = ? Even these simple tests may be very trying for children who have cognitive limitations or for those with specific developmental learning disorders.

**Overall Conclusion**

The AMSIT requires the clinician to make an overall assessment of the patient’s sensorium based on the entire examination or specific findings. A significant impairment of the sensorium should raise the suspicion of delirium, which requires diligent exploration of the central nervous system. Because delirium can be fatal, its elucidation and treatment are medical and neurological emergencies.
INTELLECTUAL FUNCTION

Even experienced clinicians err in their estimation of a patient's intelligence level. Children may appear retarded although they are not, or they may come across as being brighter than they really are. Factors that may mislead clinicians in this assessment include the presence of comorbid conditions and the presence of language or learning disorders.

In ascertaining intellectual functioning, a detailed developmental history is required. A record of the child's achievement of milestones and the time at which the child began to produce speech are of particular importance. The child's history of academic progress or academic retention is also relevant. The fact that the child has a history of grade retention does not mean the child is intellectually impaired. Similarly, the fact that a child is promoted year after year does not mean he or she is devoid of cognitive or learning problems.

Sometimes teachers may perceive bright students as retarded. For example, a child was referred for an evaluation because his teacher believed he was too "slow." The child came across to the examiners as extremely bright, creative, and imaginative; and his IQ score was about 142. Comprehensive psychometric testing, complemented, when indicated; with neuropsychological testing, will assist in the clarification of language or learning disabilities.

THOUGHT

The basic caveat in the identification of thought disorders is that the presence of severe language disorders can confuse the clinical picture. Developmental and academic histories are very helpful in preventing this confusion, as are the child's affective expression and his or her efforts to communicate. Table 3-3 lists the topics covered in the thought section of the AMSIT.

There are no typical symptoms that make the diagnosis of schizophrenia unequivocal. It was formerly thought that first-rank symptoms (the Schneiderian criteria) were associated only with schizophrenia. Akiskal and Puzantian demonstrated the presence of first-rank symptoms in affective disorders with psychotic features (9).

Some clinicians still confuse the concepts of psychosis and thought disorder. Psychosis refers to problems with reality testing and the presence of hallucinations or delusions; thought disorder refers to disorders of the process of thought production, thought concatenation, and thought organization.

Coherence

The examiner should note the threading and convergence of the patient's thinking. The examiner should consider the following relevant questions: Are the child's thoughts threaded together to express the intended idea? Does the narrative make sense? Is the narrative clear? Are the topic or themes connected to one another? When the child speaks, can the child's train of thought be followed?

Logic

In assessing the child's logic, the examiner should consider the following questions: Does the child respect the laws of reasoning? Does the child respect the laws of time and space, of the contradiction of the opposites (i.e., if you state something, you rule out or exclude the opposite) (see Troy's case study, Note 2, in Chapter 4)? Do the child's conclusions derive from established premises? Are

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cause-effect relationships respected in the child’s arguments? According to Caplan, illogical thinking is based on a defective control of cognitive processing and represents a negative sign of childhood-onset schizophrenia (10, p. 610). This defect appears to reflect frontal lobe impairment (10, p. 611; see Chapter 4).

Metaphoric Thinking

Adolescents sometimes use metaphors to describe their conflicts or concerns; it is useful to stay within the metaphor and to make interventions that use the patient’s metaphorical language. This approach parallels the process of interviewing in displacement (see Chapter 1). The following case examples illustrate the use of metaphors:

Tim, a 15-year-old Caucasian adolescent, was evaluated for rebellious, aggressive behavior and anger dyscontrol. He said to the interviewer that he “felt like a bull.” This metaphor was helpful in understanding the patient’s sense of being “untamable” and out of control and it clarified the child’s narcissism and his concerns about losing control. When the interviewer stressed that the patient was behaving like a bull, the adolescent responded with satisfaction. This approach improved the therapeutic alliance and made the patient more receptive to the examiner’s recommendations.

Sharon, a 15-year-old Caucasian adolescent, was referred for an evaluation because of her belligerent behavior, which had continued for more than a year. She was preoccupied with her looks and compared herself unfavorably to her more attractive mother, who had been a beauty pageant queen in her younger years. She was also very preoccupied with boys and sex. She said, “When I was younger I could handle the ‘small hormones’ but now that I’m becoming older, I feel I can’t handle the ‘big hormones.’” Sharon was terrified of the idea of turning 18 and being on her own. Her concerns with the “big hormones” clearly indicated her difficulties with her emerging sexuality and the separation process involved in turning 18.

Goal Directedness

When observing goal directedness, the examiner should observe whether the child’s narrative includes details that are relevant to the idea he or she wants to communicate. Does the child branch off into unimportant details? Does the child deviate from the point that he or she initially wanted to make? The examiner should listen for irrelevant or unnecessary details. While listening to the child’s narrative, the examiner should consider the following questions: Does the child go into the substantive matter of the idea he or she wants to communicate? Does the child get lost in minutia unrelated to the core idea?

The most common disturbances in goal directedness are circumstantiality and tangentiality. In circumstantiality, the child’s train of thought branches off into irrelevant details, but the child eventually gets back the main idea. In tangentiality, the child’s main idea is lost and he or she goes off into extraneous ideas. The following example illustrates a thought disorder involving goal directedness:

Jennifer, an 11-year-old Caucasian girl, underwent a psychiatric evaluation for explosive and assaultive behavior that resulted in her biting and punching a teacher. In less than 6 weeks, she had three episodes of dyscontrol at school, all involving fights with peers. School administrators felt that they no longer could provide a psychoeducational program for Jennifer on school grounds, because she posed a serious risk to other students. Jennifer attended a day hospital program the previous year for similar reasons. She was described as moody and grandiose. She was her mother’s only source of emotional support, and the mother and child were entangled in a dependent, symbiotic relationship.

During the initial status examination, Jennifer showed a mildly expansive mood and a clear thought disorder, exemplified by ever-present circumstantiality, tangential thinking, and loose associations. During the interview, the examiner asked Jennifer, an obese child, “What do you think of your weight?” She responded, “Okay. My belly is good for many things. The
belly floats in the water.... I can bob other kids with my belly, it doesn’t bother me.... I’ve seen 500-pound guys. They are huge.... in Sumo wrestling in Japan.... Yokosama.... It doesn’t matter.... This big guy...."

According to Caplan, “certain aspects of thought disorder, such as illogical thinking, are found in childhood psychiatric disorders other than schizophrenia. Looseness of the associations, however, seems to occur specifically in childhood schizophrenia” (10, p. 608). Caplan clarified that “to date, there have been no studies on thought disorder in representative samples of children with psychotic depression and manic disorder. Additional studies are warranted, therefore, to determine whether formal thought disorder is a nonspecific clinical manifestation of childhood psychosis or whether it occurs specifically in childhood schizophrenia” (10, p. 608). Caplan also asserted that loose associations are secondary to distractibility and represent a positive sign of childhood-onset schizophrenia (10, p. 610). She postulated that this defect is secondary to a disconnection between the prefrontal cortex and the subcortical regions (i.e., basal ganglia and thalamus) (10, p. 612).

Reality Testing

By mid-latency age, a child’s reality testing (ability to differentiate reality from fantasy) should be established solidly; however, reliable reality testing can be demonstrated even earlier. This issue relates to how old the child is before he or she can distinguish fantasy from reality and how old he or she is before hallucinations or delusions can be observed. What follows is an example of reality testing disturbance in a preschooler:

Fabio, a 4½-year-old Hispanic boy, was referred for evaluation of aggressive behavior. He demonstrated murderous behavior toward his baby brother. He spontaneously verbalized that the “jungle,” a monster-like figure, was coming to kill him, and he added that the jungle was going to kill his family, too. To protect himself against the jungle, Fabio would take a knife to bed with him. He saw the jungle and heard it. He said that he heard the jungle telling him that it was coming to hurt him. This is the youngest child with overt psychotic features (i.e., visual and auditory hallucinations) that the examiners had ever encountered.

By early mid-latency age, children can clearly differentiate between thoughts coming from inside their heads and voices coming from outside their heads. Consider the following case example:

Dione, a 9-year-old African American girl who was referred for suicidal behavior, complained of hearing voices. When the examiner asked Dione if she was hearing her own thoughts, she said, “A thought and a voice are different. A thought comes from inside of my head; a voice comes from outside of my head.”

The following case example illustrates confusion of reality with fantasy and gross impairment of reality testing in a late preadolescent child:

Dwayne, an 11-year-old African American boy, was evaluated for explosive and assaultive behaviors. He had hit his female teacher and bitten her nose. The school was no longer willing to put other students at risk because Dwayne had lost control around his peers several times before. Dwayne had been seeing a child psychiatrist for over a year, had been in acute inpatient programs, and had taken various psychotropic medications without any significant effect. He lived with his father at the time of the evaluation. Before that, he lived with his mother in another state. His father took custody of the child when he learned that Dwayne was physically abused at his mother’s house. Dwayne’s stepbrother allegedly would encourage the family dogs to attack Dwayne. Dwayne had extensive scars on his back.

The mental status examination revealed a handsome African American child who was extremely dysphoric; he also displayed an apathetic demeanor. He was not spontaneous and did not respond verbally to any questions. He exhibited a disgruntled
countenance and an ongoing sense of irritation. The omega sign (a persistent frown) was prominent. He appeared to be very depressed. Because his internal world was inaccessible to exploration, his thought processes could not be assessed. The dosage of his antidepressant medication was increased, and he was asked to come the following week for another diagnostic appointment.

When Dwayne came to the second appointment, this time with his father, he brought several pieces of chewing gum. Upon entering the office, he put a piece of gum in his mouth. This time he was talkative. He began narrating a fantasy story, and his father pointed out that the theme of the story was related to a movie he and Dwayne had watched a couple of days earlier. Shortly after this, Dwayne opened his mouth and showed the examiner that the gum was stuck on his lower molars. He didn’t seem to know what to do. The examiner suggested that Dwayne could dislodge the gum with his finger.

At this point, Dwayne said that he had fought with Mike Tyson the night before. His father promptly explained that Dwayne had played a Mike Tyson boxing video game the night before. Dwayne went on, saying that he had “blown out Tyson’s teeth” and so on. Suddenly Dwayne opened his mouth and indicated that the place where the gum had stuck was the place where Tyson had hit him the previous night. This was followed almost immediately by the revelation that he had bad dreams that night. Dwayne reported dreams of monsters eating his hands. He then showed the examiner his fingers and said, “I had some funny feelings where the monsters were eating my fingers.” The nature and extent of this child’s psychotic thinking had not been appreciated earlier. Dwayne was placed on neuroleptics with positive results.

whether the patient returns to the original thought after digressing into other topics. Does the patient jump from one idea to the next without a clear thread linking the two ideas? The examiner should note the affective prosody (i.e., the emotional coherence of the thought content). Ideo-affective dissociation involves a noticeable incongruency between the expressed thoughts and the associated emotions.

The main disturbances of association are blocking, loose associations, and flight of ideas. Blocking refers to the interruption of the train of thought. It is detected when the child stops presenting the main idea and either becomes silent (i.e., making a prolonged pause) or, after a short pause, goes onto another thought that is not connected to the preceding, unfinished thought. When the examiner calls attention to this disturbance, the child has significant difficulty coming back to the interrupted idea. In general, patients are unaware of disturbances in their thought processes.

When a child’s ideas are weakly connected to one another, the disturbance is called loose associations. In flight of ideas, the chain of thoughts is presented as an apposition of ideas that are not connected to one another. In the most extreme case, the ideas are so disconnected that no sense can be made of them. This condition is often described as word salad. In flight of ideas, the child presents his or her thoughts at a fast pace. The speech frequently may be increased in rate if not pressured. Correspondingly, the patient may acknowledge that his or her thinking is rushing or going very fast. In other words, the patient can’t control his or her thinking. This symptom helps explain the impulsivity or lack of judgment exhibited by hypomanic and manic patients.

Associations

Associations refer to the manner in which the child’s thoughts are connected among themselves. As the child speaks, the examiner should follow the sequence of the child’s thinking and the links between each of the child’s thoughts. The examiner should note whether the child’s thoughts flow smoothly. The examiner should also observe the transitions between thoughts and should note

Perceptions

Normal perceptions are those that have consensual validation within a given culture. Consensual validation means that what a person sees, hears, or touches is similar to what another person sees, hears, or touches. Disturbances of perception occur when the objects of the perception do not exist, do not have consensual vali-
dation, or both. This process is called hallucinating and the experience itself, a hallucination. When the object of experience is present but is distorted in its nature or relation to the person, or when it is misidentified, the process is called an illusion.

Hallucinations may occur in any of the sensory modalities—visual, auditory, gustatory, olfactory, or tactual—or they may be visceral (i.e., in other body sensations) or experiential. Complex partial seizures represent a neuropsychiatric condition that must be considered in the differential diagnosis of perceptual disturbances and other psychotic disorders. In the following case example, the examiner ascertained the unsuspected diagnosis of complex partial seizures, through the use of systematic questioning:

Ralph, a 14-year-old mixed-raced adolescent, was admitted to an acute psychiatric care program for unrelenting suicidal ideation and serious conflicts with his mother. He had a background of gang involvement and other conduct disorder problems. Ralph lost his most important source of emotional support when his maternal grandfather died a short time before the admission. Ralph had been quite attached to his grandfather. His parents were divorced but still continued a bitter relationship. He was caught in a painful loyalty conflict because both parents were pressuring him to live with them. Ralph had witnessed his father physically abusing his mother and hated him for that. Ralph’s medical background was positive for an episode of meningitis at age 15 months. He also had complained of “panic dreams” 2 years earlier, but a magnetic resonance imaging scan taken at the time was normal.

Ralph, who weighed 280 pounds, looked older than his stated age and appeared depressed. During the mental status examination, he denied hearing voices and denied visual hallucinations. When he was asked if he smelled any unusual smells, he readily reported olfactory and gustatory hallucinations: “An ugly smell, like a cadaver... a pretty bad taste, like rotten meat.” While experiencing those hallucinations, he heard screeching, yelling, and beeping noises, and all of this was accompanied by a disturbance of consciousness and a sense of confusion for about 2 minutes. When this happened, he didn’t know what was going on. At times he felt like he was going to faint and his legs would get weak. During the previous summer, while playing basketball, Ralph’s legs gave way after he experienced the olfactory hallucinations. He had a feeling of “strangeness” and experienced profuse sweating, even during the winter. Additional exploration revealed that he had experienced déjà vu phenomena, dreams that foretold the future, and an urgency to urinate during these episodes. The diagnosis of complex partial seizures was substantiated, although it had not been suspected initially.

Commanding auditory hallucinations are of particular clinical importance. The examiner should explore how strong the hallucinations are and what the patient does when he or she hears the voices. Is the patient able to fight them and resist their commands? Invariably, parents are skeptical about the reality of preadolescents’ perceptual symptoms and need to be educated about them (see Note 1).

A disturbance of perception may be centered in the sense of self, in the body image, or in aspects of it. Depersonalization denotes a sense of strangeness in the sense of self; that is, the patient feels he or she is not the same as before and feels strange. This experience may be accompanied by a sense of confusion or bewilderment. This phenomenon occurs in affective disorders and dissociative states and is commonly observed in psychotic children.

When a girl with anorexia nervosa looks at the mirror and sees a fat person, she has, among other things, disturbances of perception of body image. Disturbance of body image may be localized, as in the cases of body dysmorphic disorder (when the patient thinks something is wrong with a specific body part). When there is a sense of internal body damage, uncorroborated by medical evidence and impervious to reassurance, the distortion is called hypochondria.

Out-of-body experiences are reported with some frequency. Autoscopic hallucinations are an uncommon complaint in the field
of child and adolescent psychiatry. A sense of the presence of a dead person or even experiences such as talking to or hearing from dead people are common experiences for children in bereavement.

**Delusions**

*Delusional thinking* refers to a belief or system of beliefs without consensual validation in a given culture. Hallucinations are far more common in children than are delusions. *Ideas of reference* refer to the beliefs that everything the patient perceives is related directly to himself or herself. The most common problems in this area relate to the belief that when people are talking or laughing, they are talking about or laughing at the patient. Some patients feel that others are following them. Others harbor persecutory delusions. These patients think that others are plotting to kill them or harm them in some way. Patients may see signs in the environment that somehow convey a secret or special message to them. Delusions of guilt are described in Chapter 4 (see case examples on Salim and Fred).

Children’s concerns can sometimes be quite bizarre, as the following case examples show:

Ted, an 8-year-old Caucasian boy, reported that monsters were coming at night to exchange his blood for a green liquid. He was so terrified that he asked his father to cover the opening under his bed with a board. Ted believed that the monsters lived under the bed and that nailing the board there would keep the monsters from coming out.

Mat, a schizoid 10-year-old Caucasian boy, frequently worried that scorpions would come out from the showerhead or climb into his bed while he slept. This child was ostracized, ridiculed, and rejected by his peers.

Extreme forms of disturbances of body image or its functions occur when the patient complains that his or her body or body parts are damaged or, worse, that the patient’s insides may be “rotting.”

The following case examples illustrate the presence of such somatic delusions:

Donna, a sophisticated and talented 16-year-old Caucasian adolescent, was evaluated for intense and unremitting suicidal ideation. She had a long history of depression, dating back to when she was 7 years old. She had been a patient in a number of psychiatric hospitals. In explaining her sense of hopelessness, she reported that her “insides were rotten” and that parts of her were “dead inside.” She acknowledged that 90% of her suicidal intent stemmed from that belief.

Ming, a 16-year-old Asian American adolescent and the mother of a 13-month-old infant, exhibited a severe major depressive episode with psychotic features. Besides auditory commanding hallucinations ordering her to kill herself, she had a deep-seated belief that she had cancer. No amount of reassurance or medical evidence could persuade her to the contrary.

In clinical practice, after observing the patient’s thought processes, the following *chain inquiry* is useful: 1) systematic questioning regarding the presence of auditory, visual, olfactory, gustatory, tactile, and other atypical perceptions such as depersonalization and out-of-body experiences; 2) systematic questioning of referential and persecutory ideation; and 3) systematic questioning regarding beliefs of thought intrusion or thought withdrawal. This line of inquiry may be completed with a full exploration of obsessive-compulsive symptomatology.

**Other Thought Content**

In addition to the concerns that the patient expresses, the examiner should note the presence of the following: 1) suicidal and homicidal ideation, 2) obsessional thinking, 3) compulsive activities, 4) alcohol and substance abuse, 5) gang involvement, and 6) other significant content not included elsewhere.
Judgment

The AMST demands that the assessment of the patient's judgment be based on observations and on the patient's response to specific situations presented during the psychiatric examination. A child is assumed to have good judgment if he or she gives a satisfactory answer to questions such as "What do you do if you are in a theater and you see smoke?" or "What do you do if you find a stamped envelope?" The determination regarding impairment of judgment needs to take into account the patient's history of chronic impulsivity and the patient's lack of forethought before carrying out impulsive actions. The patient's history tells far more about the patient's judgment than do his or her responses to standard questions. A clever and manipulative child may be able to give the right answers to hypothetical questions posed by the examiner, even though the child displays poor judgment in the real world.

Abstracting Ability

The assessment of the child's abstracting ability (i.e., his or her capacity for categorical thinking) needs to take into account the child's cognitive development. A common but incorrect assumption is that when a person reaches late adolescence or adulthood he or she has reached the cognitive developmental stage of formal operations. As such, this person should be capable of abstract thinking, as tested by similarities and interpretation of proverbs. However, not everyone reaches this state of cognitive development. Children who are in the process of acquiring this cognitive sophistication should not be expected to perform well in this area, although some bright children do. In general, preadolescents and some adolescents tend to be concrete.

This area is often assessed by paying close attention to the patient's language and the sophistication of his or her responses. The examiner should also note the richness of the child's vocabulary and the manner with which the child discusses problems. For example, does the child use rich, complex, and metaphorical language?

Insight

It is difficult to make judgments about a child's insight. Preadolescents begrudgingly acknowledge their problems, and adolescents more often than not only pay lip service to recognition of personal problems and express no willingness to change. Judgments about the presence of insight are based on the degree of the patient's dystonicity over the symptoms and the explicit desire to change.

NOTE

1. Hallucinations may be more prevalent in children than is currently thought. Schreier quotes Garraula (1984), who distinguishes nonpsychotic children who hallucinate from psychotic children: "They are not delusional; they do not exhibit disturbance in the production of language; they do not evidence decreased motor activity or signs of incongruous mood; and they do not present with bizarre behaviors or social withdrawal" (11, p. 623). Long-term follow-up of hallucinations has little prognostic significance. In Schreier's view, "hallucinations of critical voices or of those demanding that the patient do horrific acts to the self or to others do not predict severity or necessitate a poor prognosis" (11, p. 624). The presence of a single voice seems to indicate a good prognosis. The presence of internal versus external voices does not have any predictive value. Hallucinations may persist for several years without a major role in the child's functioning (11, p. 624). Schreier has found an association between nonpsychotic hallucinations and migraine (11, p. 624).

REFERENCES

1. Fuller D: The AMST (student handout). University of Texas Health Science Center at San Antonio, Department of Psychiatry, 1998
In this chapter, I further illustrate the age- and phase-appropriate differences in the categories described in Chapter 2 by means of a schematic chart. We see that, for example, both the fine and the gross motor coordination of a 7- or 8-year-old are quite different from those of a 2- to 3-year-old. In the latter, coordination in gross motor capacities may already be developed, whereas some fine motor capacities will be just emerging (e.g., holding a pencil and drawing lines). In a child age 7 or 8, in contrast, fine motor skills will be quite developed. With respect to style of relatedness, you would expect a 3-year-old to relate in a need-fulfilling manner, whereas you would expect a 7- or 8-year-old to show a more balanced capacity for partnership and sharing. In both instances, however, you would expect the capacity for emotional relatedness to be present.

In terms of mood, you might expect to see variations in younger children depending on their immediate external circumstances. A shift from elation to sadness in the course of an hour would not raise concern. In a child age 8 or 9, you would expect some stabilization of mood. At the same time, the content of the mood—happy, sad, depressed, apprehensive, and so forth—would be independent of age and would be determined by the emerging personality structure of the youngster.

In terms of the organization, depth, variation, and (predominant) types of affect, age will be a determining factor. With a 2- or 3-year-old, we might see affects concerned with egocentric needs, jealousies, and so forth. In 5- or 6-year-olds, we expect a range of affects, with predominant types reflecting some degree of organization and depth around themes of jealousy and competition as well as love and curiosity. In 8- or 9-year-old...
### Table 3.1: A Developmental Approach to Observing Children: Birth through Age 10–1st Year

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Physical milestones, including tongue and nonspecific reactions, develop. The child is Influenced by contact, physical contact, and comfort.</td>
</tr>
<tr>
<td>10–1st Year</td>
<td>Includes characteristic features of the physical and psychological functioning, with a special focus on the level of orientation, perception, and movement.</td>
</tr>
</tbody>
</table>

- **Cell 1**: Physical milestones, including tongue and nonspecific reactions, develop. The child is Influenced by contact, physical contact, and comfort.
- **Cell 2**: Includes characteristic features of the physical and psychological functioning, with a special focus on the level of orientation, perception, and movement.
Table 3.1. A developmental approach to observing children: birth through age 10 first year (continued)

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Affect</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Affect Consideration</td>
<td>a. Range and variety of affect, the number of affects the child manifests during early developmental phases, and their distinctive types (e.g., mild, moderate, intense), and include gestures, mimicry, facial expressions, and voice intonation. Polarity of affect remains highly variable and is easily dominated by context.</td>
</tr>
<tr>
<td>b. Appropriateness of affect, particularly in relation to overall mood and context.</td>
<td></td>
</tr>
<tr>
<td>c. Discriminative capacity of affective states is a function of ability to distinguish affects from other emotional states and to recognize the meaning of emotional experiences.</td>
<td></td>
</tr>
<tr>
<td>5. Anxiety and fear</td>
<td>a. Anxiety is usually of the social or moral type, often related to distress and disorganization. Children may manifest anxiety in various ways, including decreased activity, withdrawal, or increased agitation.</td>
</tr>
<tr>
<td>b. Discriminative capacity of affective states is a function of ability to distinguish affects from other emotional states and to recognize the meaning of emotional experiences.</td>
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</tr>
</tbody>
</table>

Table 3.1. A developmental approach to observing children: birth through age 10 first year (continued)

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Affect</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Thematic expression</td>
<td>a. The capacity to express organized, developmentally appropriate, causal behavioral chains (e.g., mother smiles, baby reaches out with hand to another, either indirectly through play or directly through verbal communication). Clearly, some children develop such a capacity in time, and others never do.</td>
</tr>
<tr>
<td>b. Discriminative capacity of affective states is a function of ability to distinguish affects from other emotional states and to recognize the meaning of emotional experiences.</td>
<td></td>
</tr>
<tr>
<td>c. Discriminative capacity of affective states is a function of ability to distinguish affects from other emotional states and to recognize the meaning of emotional experiences.</td>
<td></td>
</tr>
<tr>
<td>d. Thematic sequence: Can be used in describing children at each age phase.</td>
<td></td>
</tr>
</tbody>
</table>
Table 3-1. A developmental approach to observing children, birth through age 10—second year

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Second year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Physical (sensory, motor, integration) includes characteristic behavior patterns, including running, climbing, and so on. Note: (e.g., running, climbing, and so on) may develop in two directions: emerging and emerging cognitive capacity.

2. Pattern of relationships includes characteristic style of relating, either social or group context. (e.g., social vs. group context.)

3. Overall mood or emotional tone includes characteristic patterns of emotional tone (e.g., social vs. group context.)

4. Affect includes characteristic patterns of emotional tone (e.g., social vs. group context.) (e.g., social vs. group context.)

5. Anxiety and fear include characteristic patterns of emotional tone (e.g., social vs. group context.) (e.g., social vs. group context.)

Age and Phase-appropriate illustrations

Anxiety related to loss of loved caretaker—potentially devastating.
Table 3–1. A developmental approach to observing children: birth through age 10—second year (continued)

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Second year</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Thematic expression</strong> Includes the capacity to express organized, developmentally appropriate, rich themes. How well can child communicate his or her personality to another, either indirectly through play or directly through verbal communication? Clearly, some children develop such a capacity in time because their basic sense of trust in the world, their security about their own inner controls, and the availability of their fantasy life enable them to communicate a rich feeling and content sense of themselves. Other children, by comparison, will be disorganized in their thematic expression (or very constricted, fragmented, impulsive, etc.). To subdivide thematic expression further, consider it from the following perspectives:</td>
<td></td>
</tr>
<tr>
<td><strong>Capacity for organization of behavior into complex causal chains</strong> (e.g., taking mother by hand to refrigerator and showing her desired food); <strong>initiative and originality at behavioral level</strong> as well as increased <strong>initiative behavior</strong>. At behavioral level, child reflects themes of love, curiosity, exploration and protest, anger, negativism, and jealousy—all in organized modes (e.g., running to father and hugging and kissing him as one organized series; or turning away, throwing down toy, and screaming as another). Toward end of second year, emerging capacities to <strong>integrate</strong> themes that reflect <strong>polarities</strong> of love and anger, passivity and activity, emerging (e.g., in one game—&quot;The doll is bad, gets spanked, and then is hugged.&quot;). Also emerging representational or symbolic capacities in relationships and emotional themes.</td>
<td></td>
</tr>
<tr>
<td>a. <strong>Organization of thematic expression</strong>: e.g., similar to organized or fragmented thinking.</td>
<td></td>
</tr>
<tr>
<td>b. <strong>Depth and richness of thematic development</strong>.</td>
<td></td>
</tr>
<tr>
<td>c. <strong>Relevance in age-appropriate context</strong>: How typical is content of themes to age-appropriate concerns?</td>
<td></td>
</tr>
<tr>
<td>d. <strong>Thematic sequence</strong>: This can be used in describing children at each age.</td>
<td></td>
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</tbody>
</table>

Table 3–1. A developmental approach to observing children: birth through age 10—third year

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Third year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Physical functioning: neurological, sensory, motor integrative</strong> Includes characteristic observations pertaining to the physical aspects of the child having to do with mental and psychological functioning, with special focus on the level of integration of the central nervous system (e.g., gross and fine motor coordination, perceptual-motor integration, emerging cognitive capacities).</td>
<td></td>
</tr>
<tr>
<td><strong>Coordinated gross motor activity</strong>: running, walking up and down stairs without holding on, etc. Fine motor coordination more differentiated (e.g., can scribble circles, hold feeding utensils). Can comprehend phrases, simple sentences, and complex gestures. Can name many objects, use personal pronouns and sentences to describe events, and make needs known. Symbolic capacity expanded as evidenced in wider fantasy life (e.g., dreams, fears, make-believe stories and people); capacity for concentration and self-regulation still variable but improving.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Pattern of relationships</strong> Includes characteristic style of relating or nonrelating (e.g., withdrawn, autistic), patterns of nonrelating, dyadic relating, capacity for group relating and sharing, and egocentric styles of relating.</td>
<td></td>
</tr>
<tr>
<td>Relationships, although still dyadic and need-fulfilling, now become organized at a representational or symbolic level (i.e., a sense of self and other in terms of thoughts, memories, etc., is emerging) and permit use of fantasy. Balance between dependency and autonomy may shift for a brief time to the former. Power struggles and negativism may intermittently dominate relationship pattern. Dominant issues continue to be basic dependency, the need for security, and fear of separation. Symbolic interactions in power, control, aggression, and different types of pleasure in relationships emerging. Capacity for more complex interactions because internal imagery can now be used (e.g., language or a doll used to represent needs in a complex game).</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Overall mood or emotional tone</strong> Based on direct observation of specific emotions as well as themes or topics the child discusses. Characteristic patterns of this category may not be as clearly defined for each age group as those of the other categories.</td>
<td></td>
</tr>
<tr>
<td>Initially may become quite variable (e.g., moody, fussy, and clinging behavior together with secure explorativeness) but then gradually stabilizes into even pattern organized around a basic sense of security and optimism, with capacity for excitement, negativism, passivity, tendency to cling, etc., present but not dominant.</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.4: A developmental approach to observing children: birth through age 3 (third year (continued))

<table>
<thead>
<tr>
<th>Observation Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Caregiving</td>
<td>Children who are observed in their early caregiving context can be observed in a variety of settings, such as homes, childcare centers, or classrooms. Observations can be conducted in both structured and unstructured environments. The focus is on the child's interactions with caregivers and peers.</td>
</tr>
<tr>
<td>Social Interaction</td>
<td>Children's ability to engage in social interactions with others is observed. This includes social skills, such as sharing, taking turns, and problem-solving. Observations can take place in group settings or one-on-one interactions.</td>
</tr>
<tr>
<td>Communication</td>
<td>Children's language development is observed through their ability to produce and understand speech and language. Observations can be conducted in various settings, such as during play or in conversation with caregivers.</td>
</tr>
<tr>
<td>Cognitive Development</td>
<td>Children's cognitive development is observed through their ability to think, learn, and problem-solve. Observations can be conducted in both structured and unstructured environments, such as during play or in a classroom setting.</td>
</tr>
<tr>
<td>Physical Development</td>
<td>Children's physical development is observed through their ability to move, explore, and engage in physical play. Observations can be conducted in both indoor and outdoor settings, such as during play or during physical education activities.</td>
</tr>
</tbody>
</table>

Legend:
- **E**: Early Caregiving
- **S**: Social Interaction
- **C**: Communication
- **G**: Cognitive Development
- **P**: Physical Development

Note: Observations can be conducted in both structured and unstructured environments. The focus is on the child's interactions with caregivers and peers.
### Table 3-1. A developmental approach to observing children: birth through age 10—fourth year

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Fourth year</th>
</tr>
</thead>
</table>

1. **Physical functioning: neurological, sensory, motor integrative**
   Includes characteristic observations pertaining to the physical aspects of the child having to do with mental and psychological functioning, with special focus on the level of integration of the central nervous system (e.g., gross and fine motor coordination, perceptual-motor integration, emerging cognitive capacities).

Gross motor coordination continues to improve; child can run, jump, hop, throw a ball accurately, etc. Fine motor coordination improves; child can almost tie shoes, can draw circles, handles utensils very well.

Comprehends two or more connected concepts or ideas. Can talk in full sentences, connecting ideas with words such as “but” and “because,” and make needs known. Symbolic capacity expanded (e.g., complex play with dolls), and ability for reality orientation (distinguishing fantasy from reality) increasing; concentration and self-regulation possible with appropriate context and support.

2. **Pattern of relationships**
   Includes characteristic style of relating or nonrelating (e.g., withdrawn, autistic), patterns of nonrelating, dyadic relating, capacity for group relating and sharing, and egocentric styles of relating.

Relationship patterns becoming more complicated not only in content (language, symbolic modes) but also in form, as dyadic patterns begin to recede and capacities for dealing with triangular and other more complicated patterns emerge (e.g., rivalries, intrigues, secrets, two against one, jealousies, envy). Capacity for peer relationships increasing as well. Greater sense of security; capacity for separation and for carrying sense of the “other” inside relatively well established by end of fourth year. Anger and other strong feelings do not compromise secure capacity for separation. Capacity for intimacy (not simply need-fulfilling) in relationships emerging more fully.

3. **Overall mood or emotional tone**
   Based on direct observation of specific emotions as well as themes or topics the child discusses. Characteristic patterns of this category may not be as clearly defined for each age group as those of the other categories.

Mood stabilizes further and organizes complex feelings; less extreme reactions to frustration (e.g., having to delay). Basic attitude toward self and world conveyed in organized mood, which optimally reflects security in psychological and bodily self and curious expansive interest with excitement in family, peers, and the world. Insecurity and negativism receding in importance.

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<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Fourth year</th>
</tr>
</thead>
</table>

4. **Affects**
   Consideration of
   a. **Range and variety of affect:** the number of affects the child manifests: during early developmental phases, range is limited or narrow; later, range is broader. Also includes characteristic types of affects: rage, jealousy, anger, empathy, love.
   b. **Depth of affect expression:** substantive nature of affects manifested: shallow versus substantive, etc.
   c. **Appropriateness of affect,** particularly in relation to overall mood and content.
   d. **Discriminative capacity of affects:** to what degree can the affects be highly discriminative of specific feeling states?
   e. **Relation of intensity of affect to stimulation or capacity for regulation of affect.**

Pride and joy in psychological and bodily self further emerge. Increased interest in power; affects of shame and humiliation become dominant. Increased feelings of jealousy and envy; more differentiated sadistic and masochistic trends. Emerging capacity for sharing and concern for others. Empathy and tenderness increasing. Affect system well organized, showing many affect states of the emerging sense of self.

5. **Anxieties and fears**
   Best observed either directly in child’s verbalized fears or indirectly through play. Anxiety in particular can be observed by disruptions in thematic development during either play or conversation. Level of anxiety can be indicated by nature of the disruption and themes that follow it (e.g., anxieties around fear of physical injury; or of more global, undifferentiated types such as fear of loss, world destruction, or fragmentation of one’s inner self).

Anxiety over loss of loved person’s approval and bodily injury sometimes disruptive but usually not. Multiple fears of being robbed, kidnapped, or hurt or of parents being taken away or hurt not uncommon, but usually understood as either "only a dream" or "not real."
<table>
<thead>
<tr>
<th>Table 3.1: A developmental approach to observing children: birth through age 10—fourth year (continued)</th>
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<tbody>
<tr>
<td><strong>Fourth year</strong></td>
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<tr>
<td><strong>Observational categories</strong></td>
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<tr>
<td><strong>Physical functioning:</strong></td>
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<tr>
<td><strong>Patterns of relationships:</strong></td>
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<tr>
<td><strong>Sensory-motor:</strong></td>
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<td><strong>Emotional development:</strong></td>
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<td><strong>Cognitive development:</strong></td>
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<tr>
<td><strong>Social development:</strong></td>
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<thead>
<tr>
<th>Table 3.1: A developmental approach to observing children: birth through age 10—fifth and sixth years</th>
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<tr>
<td><strong>Fifth and sixth years</strong></td>
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<tr>
<td><strong>Observational categories</strong></td>
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<tr>
<td><strong>Physical functioning:</strong></td>
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<tr>
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<td><strong>Social development:</strong></td>
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<table>
<thead>
<tr>
<th>Observational categories</th>
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<tbody>
<tr>
<td><strong>Overall mood and emotional tone:</strong></td>
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<thead>
<tr>
<th>Table 3.1: A developmental approach to observing children: birth through age 10—seventh and eighth years</th>
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<tr>
<td><strong>Seventh and eighth years</strong></td>
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<tr>
<td><strong>Observational categories</strong></td>
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<tr>
<td><strong>Physical functioning:</strong></td>
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<tr>
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<tr>
<td><strong>Emotional development:</strong></td>
</tr>
<tr>
<td><strong>Cognitive development:</strong></td>
</tr>
<tr>
<td><strong>Social development:</strong></td>
</tr>
<tr>
<td>Observational categories</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Best observed directly in child's verbalized fears or indirectly through play. Anxiety in particular can be observed by disruptions in thematicity and irregularity in thematic expression. Anxiety may be indicated by nature of the disruption and themes that follow it (e.g., anxiety around fear of physical injury or to the world, destruction, or misperception).</td>
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**Table 3.1: A developmental approach to observing children: age 10-15 and sixth years (continued)**

<table>
<thead>
<tr>
<th>Observational categories</th>
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**Table 3.1: A developmental approach to observing children: age 10-15 and sixth years (continued)**

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**Table 3.1: A developmental approach to observing children: age 10-15 and sixth years (continued)**

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</tr>
</tbody>
</table>
Table 3-1  A developmental approach to observing children: birth through age 7-7th and eighth years

1. **Physical functioning: motor coordination**
   - Gross motor coordination improves overall; fine motor coordination also increases.
   - The child's ability to manipulate objects, such as toys or drawing tools, becomes more refined.

2. **Language and communication**
   - The child's vocabulary grows, allowing for more complex and detailed expression.
   - The child begins to use more complex sentence structures.

3. **Mood and affect**
   - The child's emotional range expands, with more variation in mood and affect.
   - The child learns to identify and express a broader range of emotions.

4. **Observational categories**
<table>
<thead>
<tr>
<th>Sevens and Eights</th>
<th>Sevens and Eights (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observational categories</strong></td>
<td><strong>Observational categories</strong></td>
</tr>
<tr>
<td>Physical functioning: motor coordination</td>
<td>Language and communication</td>
</tr>
<tr>
<td>Gross motor coordination improves overall; fine motor coordination also increases.</td>
<td>The child's ability to manipulate objects, such as toys or drawing tools, becomes more refined.</td>
</tr>
<tr>
<td>The child's vocabulary grows, allowing for more complex and detailed expression.</td>
<td>The child begins to use more complex sentence structures.</td>
</tr>
<tr>
<td>The child's emotional range expands, with more variation in mood and affect.</td>
<td>The child learns to identify and express a broader range of emotions.</td>
</tr>
</tbody>
</table>
Table 3–1. A developmental approach to observing children: birth through age 10—seventh and eighth years (continued)

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Seventh and eighth years</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Thematic expression</strong></td>
<td>Relatively rich, organized thematic development with perhaps slightly less richness or breadth than in 5- to 6-year-old period, but more organized with less fragmentation. Less emphasis now on expanding interest in world, triangles, intrigues, the human body, what goes on behind closed doors, and various aggressive themes (e.g., monsters, attacking); more emphasis on containing these interests (e.g., “I’m not interested in what’s going on behind the door; let me look, and I’ll show you I’m not interested”). In sense of polarities, there is a slight shift from pleasurable pursuits toward themes of control, but balance should still be present. Interest in “roles” (what I am—a football player, etc.) emerging as more dominant. Activity and assertion should be better modulated (e.g., regulates self and follows instructions). Occasional passive compliance may be present. Sense of morality (what is right and wrong) emerging but still unstable. Concern with rules and structure emerging; relatively greater interest in peers and the group and slightly diminished interest in the family and adults.</td>
</tr>
<tr>
<td>a. Organization of thematic expression: e.g., similar to organized or fragmented thinking.</td>
<td></td>
</tr>
<tr>
<td>b. Depth and richness of thematic development.</td>
<td></td>
</tr>
<tr>
<td>c. Relevance in age-appropriate context: How typical is content of themes to age-appropriate concerns?</td>
<td></td>
</tr>
<tr>
<td>d. Thematic sequence: This can be used in describing children at each age.</td>
<td></td>
</tr>
</tbody>
</table>

Table 3–1. A developmental approach to observing children: birth through age 10—ninth and tenth years

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Ninth and tenth years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Physical functioning: neurological, sensory, motor integrative</strong></td>
<td>Greater muscle strength enhances gross motor coordination: gradual further improvement in all areas, with the capacity for complex activities (e.g., basketball, football, tennis). New learning more established. Fine motor coordination also improves, with more fluid writing and the capacity to take things apart (e.g., with screwdriver) skillfully. Language now used to comprehend and express complex ideas with relationships among a few elements (e.g., “I did this because he did that, and he did that because she made him”). Able to use logic to understand gradations in feelings or aspects of physical reality and more complex inverse and reciprocal relationships. Tendency for logical exploration to dominate fantasy; greater sense of morality; increased interest in rules and orderliness; increased capacity for self-regulation; and well-established ability to concentrate.</td>
</tr>
<tr>
<td>Includes characteristic observations pertaining to the physical aspects of the child having to do with mental and psychological functioning, with special focus on the level of integration of the central nervous system (e.g., gross and fine motor coordination, perceptual-motor integration, emerging cognitive capacities).</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Pattern of relationships</strong></td>
<td>Peer relationships continue to grow in importance and complexity. Family relationships and friendships may be organized around role models (e.g., simplified adult stereotypes). Relaxed capacity for integrating and enjoying family, peer, teacher, and other adult relationships. Special relationship with same-sex parent as role model, with only hints of earlier levels (e.g., triangles, power struggles, passive manipulation). Preparation for adolescent styles of relating emerging, with special patterns of relating to same- and opposite-sex peers. Capacity for long-term relationships with family, peers, and friends—including “best friend(s).” Less reactive to day-to-day peer fluctuations toward end of tenth year.</td>
</tr>
<tr>
<td>Includes characteristic style of relating or nonrelating (e.g., withdrawn, autistic), patterns of nonrelating, dyadic relating, capacity for group relating and sharing, and egocentric styles of relating.</td>
<td></td>
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</tbody>
</table>
Table 3-1. A developmental approach to observing children: birth through age 10—ninth and tenth years (continued)

<table>
<thead>
<tr>
<th>Observational categories</th>
<th>Ninth and tenth years</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Overall mood or emotional tone</td>
<td>Stability, depth, and organization of mood further developed, as evidenced by capacity to deal with frustration, complex interpersonal relationships, and so forth, with sense of curiosity and realistic optimism (which is gradually replacing expansiveness). Overwhelming sadness, negativism, passive helplessness, and withdrawn moods should emerge only intermittently (e.g., in appropriate circumstances of stress).</td>
</tr>
<tr>
<td>Based on direct observation of specific emotions as well as themes or topics the child discusses. Characteristic patterns of this category may not be as clearly defined for each age group as those of the other categories.</td>
<td></td>
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<tr>
<td></td>
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</tr>
<tr>
<td>4. Affects</td>
<td>Well-developed capacity for empathy, love, compassion, and sharing and emerging capacity for sadness and loss in context of concrete rules. Internal self-esteem very important. Feelings of guilt and internalized fears present. Expansive lust, hunger, and jealousy in background. New affects around sexual differences beginning to emerge (e.g., excitement and shyness in relation to sexual themes).</td>
</tr>
<tr>
<td>Consideration of</td>
<td></td>
</tr>
<tr>
<td>a. Range and variety of affect: the number of affects the child manifests: during early developmental phases, range is limited or narrow; later, range is broader. Also includes characteristic types of affects: rage, jealousy, anger, empathy, love.</td>
<td></td>
</tr>
<tr>
<td>b. Depth of affect expression: substantive nature of affects manifested: shallow versus substantive, etc.</td>
<td></td>
</tr>
<tr>
<td>c. Appropriateness of affect, particularly in relation to overall mood and content.</td>
<td></td>
</tr>
<tr>
<td>d. Discriminative capacity of affects: to what degree can the affects be highly discriminative of specific feeling states?</td>
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</tr>
<tr>
<td>e. Relation of intensity of affect to stimulation or capacity for regulation of affect.</td>
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<tr>
<td>5. Anxieties and fears</td>
<td>Anxiety related to internalized conflicts generally not disruptive; may be dysphoric and/or serve a signal function and lead to change in behavior, interpretation of events, or more sophisticated changes in meanings and fantasies (e.g., rationalizations). Fears of loss of self-esteem related to loss of respect, humiliation, and shame are still present. Fear of one’s own guilt growing stronger (“I can’t do that. It will make me feel bad”).</td>
</tr>
<tr>
<td>Best observed either directly in child’s verbalized fears or indirectly through play. Anxiety in particular can be observed by disruptions in thematic development during either play or conversation. Level of anxiety can be indicated by nature of the disruption and themes that follow it (e.g., anxieties around fear of physical injury; or of more global, undifferentiated types such as fear of loss, world destruction, or fragmentation of one’s inner self).</td>
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</tbody>
</table>
Table 3.1: A development approach to observing children; birth through age 10–11 and 10–11 years (continued)

<table>
<thead>
<tr>
<th>Observation categories</th>
<th>Ninth and tenth years</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Thematic expression</td>
</tr>
<tr>
<td></td>
<td>Subdivides thematic expression (in most cases, children are too young to follow or do not have the capacity to follow or do not have the capacity to express themselves effectively). Children may still be in the preoperational stage of cognitive development, which makes them rely heavily on concrete experiences and direct interactions. They are also developing their social skills and learning to communicate in a more complex manner.</td>
</tr>
<tr>
<td></td>
<td>Depth and richness of thematic development.</td>
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<tr>
<td></td>
<td>Fragmented thinking.</td>
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<tr>
<td></td>
<td>Organization of themes.</td>
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<td></td>
<td>Age-appropriate content.</td>
</tr>
<tr>
<td></td>
<td>Considering the child's age and level of development.</td>
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<tr>
<td></td>
<td>Communication and interaction.</td>
</tr>
<tr>
<td></td>
<td>Expressions and reactions.</td>
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<tr>
<td></td>
<td>Social and emotional development.</td>
</tr>
<tr>
<td></td>
<td>Language and communication skills.</td>
</tr>
<tr>
<td></td>
<td>Cognitive development.</td>
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</tbody>
</table>
Down to Earth

Choosing a Child and Adolescent Psychiatry Residency

Steven Schlozman, M.D., Robert Althoff, M.D., Ph.D., Jane Caplan, M.D., Jennifer Derenne, M.D., Hope Levin, M.D., Peter Newberry, M.D., David Rubin, M.D., Maya Strange, M.D., William Wood, M.D. and Eugene Beresin, M.D.

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INTRODUCTION

Child and adolescent psychiatry, a rewarding yet surprisingly underserved discipline, is one in which few medical students receive sufficient exposure. One out of five U.S. medical schools does not sponsor child and adolescent psychiatry residency programs. Furthermore, almost one-third of U.S. medical students have little to no clerkship experience in child and adolescent psychiatry (1). As a result, medical students often are

puzzled by some of the most fundamental aspects of child and adolescent psychiatry training. Beyond the obvious questions about what constitutes the job of a child psychiatrist, many of the students at our institution have wondered about how one applies for such training, whether this training necessitates prior experience in other disciplines, and where residency opportunities exist. Given the lack of opportunity for experience during medical school, if you are considering training in this specialty, a mentor can help provide an introduction to this field, help you develop particular interests, and assist you in the important deliberations of whether this is the right specialty for you to pursue. In addition, the American Academy of Child and Adolescent Psychiatry (AACAP) also has a mentoring program that can assist in connecting students with mentors. Finally, interested students should seize some time during their psychiatry clerkship to seek out clinical experiences in child and adolescent psychiatry. Other opportunities for exposure include possible electives during the fourth year of medical school. If your school is unable to arrange a rotation, consider a visiting clerkship at a program to which you consider applying.

Those who are attracted to child and adolescent psychiatry often are drawn to the opportunities that the field engenders. Residents work with children, adolescents, and their families. Trainees and attendings interface with both medical and nonmedical disciplines. It is not unusual to be part of a large team of professionals, all of whom care deeply about the well-being of children and adolescents. In fact, many who choose to train in child psychiatry begin general psychiatry training after initially having an interest in pediatrics. If pediatrics is a strong interest, some students may wish to look further at triple board programs. These 5-year programs provide training in pediatrics, general psychiatry, and child and adolescent psychiatry. After completion, residents will be board eligible for all three specialties. Alternatively, if you know at the time you apply for residency that you would like to train in child and adolescent psychiatry, some residencies offer 5-year programs with separate adult and child psychiatry components, while others offer integrated programs combining adult and child and adolescent psychiatry. The majority of residents will stay in the departments in which they do their general psychiatry residencies; it is important to consider this when looking at general psychiatry programs if you have an early interest in child and adolescent psychiatry training. For many students with such an early interest, it would be wise, when interviewing for general psychiatry, to meet some of the child and adolescent faculty in the local child program. Many general training directors who are eager to recruit interested students can make this opportunity available, even if they do not have a combined or integrated program. Most medical students do not realize how valuable they are and how much the general training directors need to recruit actively. Do not be afraid to ask for this on the interview circuit.

This article will review the basics of choosing to specialize in child and adolescent psychiatry. We will discuss the application process, the resulting interview trail, the nuances of the interview and the post-interview period, and the considerations as one negotiates the intricacies of the match itself. As the article demonstrates, becoming a child psychiatrist is no small task, but the rewards for this line of work are immense and deeply gratifying, and the
Deciding to Apply

Once you have decided to take the plunge and apply to child and adolescent psychiatry programs, you will need to formulate a career timeline. Unlike the other psychiatry fellowship programs, child and adolescent psychiatry training allows applicants to apply for entry after their third year of training, provided that all general psychiatry training requirements have been met. The most cited benefit of "fast tracking" into child psychiatry is that there is less total time in training, which facilitates earlier entry into the workforce. Some trainees feel that the burden of educational debt necessitates earning an attending level salary as soon as possible. Others want to devote time to childbearing and child-rearing. However, some trainees opt to complete 4 years of general psychiatry training prior to matriculating into a child psychiatry program. Many, especially those who completed full medical internships, feel that they could benefit from an additional year to consolidate their general psychiatry skills. In addition, many general training programs leave ample time in the fourth year for research, chief residency, and other electives. In general, fast tracking seems best for applicants who are certain that they want to be child psychiatrists. Those who are undecided or want additional experience in administrative and supervisory capacities may choose to complete a fourth year of general training.

Child and adolescent psychiatry has participated in the National Resident Matching Program (NRMP) since 1995. However, unlike general psychiatry, each program has its own application, rather than using a centralized application service such as the Electronic Residency Application Service (ERAS). Some programs also accept the universal application. In addition, the child and adolescent psychiatry match typically takes place in January rather than in March with the general psychiatry residency programs. Because the process begins earlier in the academic year, decision-making and paperwork need to be completed in a timely fashion. Applications are accepted in July for admission 1 year later, and most interviews are scheduled in the fall. Match lists are generally due by late December. Applicants will need to register with the NRMP, and will need to pay a registration fee, which will permit the applicant to generate a rank order list.

Most child psychiatry applications require a curriculum vitae (CV) and personal statement in addition to the demographic information, proof of training, proof of licensure, and United States Medical Licensing Examination (USMLE) scores requested in the application packet. Be sure to allow sufficient time to retrieve medical school transcripts, USMLE scores, and letters from internship and general psychiatry training directors. Your CV should contain information regarding education, work history, hospital appointments, and extracurricular...
activities. Some programs require that it be specially formatted; guidelines may be downloaded from most medical school websites. While many feel that personal statements in psychiatry can be longer than one page, it is more likely that an interviewer will take the time to read your statement if it is interesting and concise. If possible, keep it to one page, and do not regurgitate your CV. Try to give the reader a sense of your individuality, personality, and strengths. Many people decide to revise the personal statement used for the general psychiatry match, which can save time and energy.

Once your CV and personal statement are complete, you’ll need to decide where to apply. When applying to general psychiatry programs, applicants often have more flexibility in terms of mobility and familial obligations. However, those applying to fellowship programs often have already settled down, which may limit their search to a particular geographic area. Though many child psychiatry programs recruit heavily from their own general psychiatry programs, some also have heavy regional or national competition. A complete listing of accredited programs participating in the match can be found on the NRMP website (www.nrmp.org). Demographics and other statistics regarding each program can be found on the Fellowship and Residency Electronic Interactive Database Access System (FREIDA). Most residents apply to a good number of programs. Doing so will allow the applicant to explore different programs and will increase the likelihood of a successful match.

Once your application is complete and has been screened by the residency selection committee, you will be asked to schedule an interview visit. As the interview itself is your best opportunity to get a sense of different programs, it is an immensely important element of the process. Your experiences during the application will guide you through decisions that will affect the next 2 years of training, and possibly your career and academic trajectory. For these reasons, it is important that this article discuss the nuances of the interview in as much detail as possible.

▶ The Interview Process

The interview day will be among the most important experiences contributing to the choice of a particular residency. Naturally and understandably, the majority of energy will be devoted to one’s own performance; however, try to remember that you are interviewing as well as being interviewed. In other words, you need to scrutinize carefully the culture and the "feel" of the program as you make your way through the interview day. Any program that is making the effort to interview you has already decided that to some extent you are qualified for their program. The point now is to see if you and the program will be a good fit for each other, and this should be as much your objective as it is the program’s.
Prior to the interview, be sure to review the program’s website and any written materials provided. This will help you organize which aspects of the program to learn more about during your interview day. Programs will often publish faculty members' names and interests, active research projects, specialty clinics and current residents' names, and prior training programs. If there are particular faculty members that you would like to be able to work with closely during training, be sure to try to meet them during your interview day and inquire as to what extent such collaboration would be possible. Programs will vary in how accessible senior and prominent faculties are to the residents.

The residency training director, along with the other faculty, set the pace for your training experience. You will want to inquire as to what characteristics in residents have been seen as most compatible with their program. Faculty should offer continued availability to you following the interview and, to the extent possible, be willing to facilitate your meeting any particular staff even after the formal interview is over. Faculty can also give insight into the philosophy and possible theoretical bent of the program. At this stage of training, it is most important to have a didactically and philosophically balanced and diverse curriculum, and faculty will be able to discuss how this is achieved in their program. Faculty members are also in the best position to comment on any recent or anticipated changes in the program.

Make sure to meet with current residents during your interview day. If this is not possible, ask whether any residents would be willing to be contacted directly at another time. Residents can offer the best perspectives on how your daily life will be inside and outside of the program. Topics such as the call schedule, quality of call, coverage for vacations, moonlighting, cost of living, and peer competition are all best discussed with residents. The frequency of call, and whether it is primary or a back-up to other residents or staff, is often a prominent concern for any prospective resident. Beyond these considerations, it is important to get a sense of how rigid or flexible these systems are. Are call shifts easily traded between residents without administrative involvement? Do vacations have to be "locked in" prior to the year you begin, or is it left up to the residents to decide? These systems are ultimately reflective of a departmental culture, and you should seek a program whose culture best matches your ideal academic environment.

Another important topic to discuss with residents is their perception of the quality of supervision and didactics. Is supervision individual or in groups, weekly or in real-time? Are didactics protected time, free of immediate clinical obligations? Questions about issues such as the costs of real estate, day care, recreation, local schools, cultural activities and so on are also often best handled by residents, though faculty will have valuable input for these topics as well. Finally, do your best to get multiple perspectives on each of these topics. Individual impressions will vary among residents, and sometimes even with the same resident! Ideally, residents should offer you contact information for further questions following the interview day.

Other things to note during your interview day include the locations and conditions of the facilities, electronic versus paper records, availability of laboratory and imaging studies,
relationships with other departments and access to libraries. Similarly, you should investigate the availability of any special accommodations that you might need in order to maximize your training experience.

At the end of the day, regardless of what has been said, whom you have met, and what you can remember, take some time to consider your intuitive sense of the program. Evaluate how the prospect of returning in a few months to start work there feels. Did you enjoy the interview day? Would you look forward to seeing any of those people again? Can you imagine yourself living in the area? Trust your gut, as your instincts provide invaluable guidance in this complicated process. Combining empirical observations with your own honed intuition is essential to creating your resulting match list.

Guidelines for the Match

The National Resident Matching Program (NRMP) was established in 1952. It remains the primary means of regulation and organization that helps tens of thousands of applicants into their respective postgraduate positions each year. The NRMP provides timelines, rules and contractual framework to facilitate this process. Child psychiatry utilizes the "Specialty Matching Services" which has managed the "match" for 34 subspecialties in 2006. The ultimate hope of the NRMP is to make the surprises on match day as pleasant as possible.

Do Not Ask and Do Not Tell

The cardinal rule of the NRMP is that neither program nor applicant may solicit a contingent commitment outside of the match. However, even the NRMP concedes that it is important for applicants and programs to have some sense of how highly they value one another. Communicating the level of interest to each other is often seen as something of a special art. In this light, phrases such as "You'd be a perfect fit for this program" or conversely, "I can see myself thriving in this program and I'd welcome the chance to be here" serve their purposes.

The interview season and the post-interview ranking period are a fine time for candid exchanges between applicants and program members. As long as these exchanges do not imply or state a commitment, they are not in the realm of "match violations." It is important to know who might be interested in you; it is of equal importance that you communicate that you find yourself especially drawn to those programs. To this end, e-mails, letters, phone calls, and re-visits are commonly sufficient.

"We will rank you number one if you rank us number one," is evocative of age-old and often frustrating playground arrangements. "I'll be your best friend if you'll be my best friend" did not work on the schoolyard and is equally problematic during the match. The fact that these...
deals are fraught with uncertainty and exclusivity is the basis for which the NRMP forbids such "outside" deals to be made between participants in the match. "Deal making" strips the applicant of the luxury of delineating his or her genuine preferences in private, with minimum outside distraction or pressure.

If You Do Not Want To Go There, Do Not Rank That Program
The actual rank order should be made with the care and knowledge that you are entering into a contractual agreement to go wherever you match. Though you do not have ultimate control of where on your list you will match, you do have the luxury of clearly stating where you do not want to go by not ranking a program. The ultimate rank order should be a reflection of both reality and your wishes. If the two seem far apart, the advice of confidants or mentors may be helpful in closing this gap.

If It Has To Be Sold, It Is Not Worth Buying
If you are being pressured by a particular program to commit to them, or if they have gone out of their way to convince you that you would best be served by their program without any encouragement on your part, proceed with caution. It is one thing to be told you are a great applicant, and it is quite another to be told that your greatness depends on your choosing a specific program. There is no road map to delineate the exact path to take in encouraging applicants to consider a certain program, but there are clear rules that prohibit applicants from being pressured to commit on paper or verbally to a program outside the match. It bears repeating: if it has to be sold, it is not worth buying.

As you would imagine, the goal of the NRMP, though simple, necessitates complex rules and algorithms. These features are described at length on their website: www.nrmp.org.

Choosing a Program

Choosing a child and adolescent psychiatry residency program is an exciting, but at times overwhelming process. You may be considering just a few programs in your local area or you may be applying to a broad range of programs across the country. Either way, you want to train at an excellent program and ensure that the final piece of your long journey of medical education is the best available.

Programs are required to teach a variety of therapeutic modalities—psychopharmacology, dynamic psychotherapy, family therapy, supportive psychotherapy, cognitive behavior psychotherapy, and group psychotherapy. Find out exactly how each is taught, and be wary of programs that stress any single modality.

As in general psychiatric training, supervision is the main method by which the art and science of child psychiatry is taught. Pay attention to the number of supervisory hours in
both the inpatient and outpatient arenas. Ideally, a program will have supervisors with a range of therapeutic orientations, ages, and experience. Supervisors often serve as mentors as well as teachers, so a broad range of faculty will increase the chances that you will find someone with whom you truly connect. A combination of seasoned and wise supervisors with younger ones closer to training is ideal. Also, it is often extremely helpful to have supervisors who work in academic, community, and independent practice settings. Many programs have supervision on group, pair, and individual levels. Group supervisions can be a nice way to learn from your classmates’ cases and increase exposure to a broader number of patients. Ask about how supervisors are assigned—can you choose for your second year? Also find out about the availability of specialty supervision in a more focused area, especially for your second year.

Learning about psychopharmacology in children is obviously a key component of training. Some programs may have outpatient psychopharmacology clinics with an attending on site, while others may have a panel of psychopharmacology cases and review them weekly with a designated psychopharmacology supervisor. Be sure to inquire about the number of psychopharmacology cases a resident typically follows to ensure exposure to an adequate number of patients over time. Also, how available is your psychopharmacology supervisor for urgent questions or emergencies? Is your supervisor able to see a patient with you if you have a diagnostic question or sticky situation?

Formal didactics are another key aspect of a program. Seminars need to cover a range of topics in the biological and psychological realms. Areas specific to child psychiatry include developmental theory, child forensics, infant mental health, psychological testing, and family/systems theory. Some programs have didactics on one designated day, while others spread them across the week. Ask if didactics are protected time from consults, admissions, and other clinical responsibilities.

Child psychiatry involves consultation liaison work with pediatrics, as well as community organizations, courts, and schools. Thorough training is important since often a child psychiatrist is called upon to advocate for a child in a nonmedical or nonpsychiatric arena. Pay attention to exactly what each consult experience will involve because often consultation rotations are off-site from main teaching hospitals. Unfortunately this can lead to variability in quality of education. Consider speaking directly with faculty in these rotations, especially if you already know you are particularly interested in one of the areas.

A basic component of child and adolescent psychiatric training is the treatment of mentally ill children on inpatient and partial hospitalization programs. These rotations often are a core part of the first year, but sometimes occur during the second year. Direct detailed questions about the experiences to current residents and faculty. Are the child and adolescent units combined or split? How many patients will you carry? Will you do the case management and/or psychotherapy with your patients? Is there designated time for supervision? What is the nature of the relationship with the support staff? What are the demographics and backgrounds of the patients? Who covers the patients in the evenings and on weekends?
Have the attendings been working as inpatient physicians for a long time, or is there high turnover? Will you rotate there full-time for several months or part-time for a longer period? What is the average length of stay for a patient?

Arguably, since the bulk of child psychiatry occurs in the outpatient setting, training in outpatient care is the most important factor differentiating the excellent programs from the adequate ones. In most programs you will start treating outpatients in the first year. Your caseload is key. You want to follow some patients for long-term treatment to watch disease processes unfold and change as patients age. Diversity of age, diagnosis, and background are important factors to consider. Learn how patients are assigned for each treatment modality. How many cases will you be expected to carry at a time? How many new patient evaluations will you do each year? Find out as much as possible about the clinic structure. Who is in charge? Are multiple insurers accepted? How much paperwork is involved? Will you have your own office? Are records computerized? Are there therapists or case managers available?

Additionally, many residencies have elective opportunities at some point during the 2 years. Electives can be meaningful chances to gain in-depth experience in areas of interest or to improve upon topics of relative weakness. Find out if electives are offered in specific blocks of time or on a longitudinal basis (e.g., a half-day per week for 1 year). Electives are usually clinically- or research-based, but can also be teaching or community experiences. Explore the range of possible electives—typically, larger hospitals have more opportunities. Often, programs have connections with outside organizations such as college mental health services, community mental health clinics, forensic court clinics, therapeutic schools, etc. Ask current residents if they actually can use the allotted time for electives, noting that sometimes particularly rigorous workloads can interfere with these other important experiences.

The culture of a program can be difficult to discern, but it is a crucial aspect to explore. Do your best to get a sense of how cohesive the residents are with each other and with faculty. Do they seem to like each other and support one another? If you get the feeling that this is a problem at a particular program, be very wary of ranking it. Some programs have difficult residents and groups that do not work quite well together. Explore whether this is a chemistry or personality problem in the group or a systemic problem in the program. Will you have time with your classmates or are you generally separated on different rotations? Do residents tend to spend time with one another outside of work? How available are faculty members, and how much do they seem to value teaching? Ask about how child psychiatry is related to the hospital’s general psychiatry department and pediatric department. A child psychiatry department that is well regarded by the hospital at large usually has financial stability and solid leadership.

Feedback from faculty and program directors is essential to assess your development as a child psychiatrist. The best programs offer ongoing mutual feedback between residents and faculty that is meaningful for training and clinical care. Are you observed and critically apprised of your clinical strengths and weaknesses? Do you get to observe your teachers interviewing and interacting with patients? Feedback and evaluation are crucial, both
formative and summative.

At some point in your child and adolescent psychiatry training, you will begin to plan for the next step. You will want the flexibility in your training program to be able to identify areas of your own interest and flesh out that area during the residency. One way to do this is through an independent study or a research program. If you are strongly interested in an academic career path, or if you know that you plan to go into a particular area of study, make sure that the residency program has the ability to accommodate your special interests and will allow you to explore them through a research program or an elective of independent scholarly work. For example, would the program be flexible enough with scheduling if you want to begin analysis or advanced training in therapy? This ability, as well as the remainder of the training program, should have the support of the administration of the department. It is hoped that there will be support from the top down in the program that will allow you to develop into an independent child and adolescent psychiatrist. This should include support from the chief of the department, the training director, and other faculty members dedicated to making sure that your career develops. The emphasis should not be focused solely on getting the basic work done in the hospital or clinic. Ensure that there are adequate mentors in your area of special interest, if you have identified one. If there is a local faculty member with interests similar to your own, but who is not affiliated with the department, ask questions as to whether it is possible to go out of the department (or even the college) for independent work. Get a feel for whether or not this will be supported or discouraged. Openness to new ideas is difficult to assess, but these kinds of questions will let you know whether the administration is willing to think outside of the norm.

Once you have completed your residency, you will find that you are a desired member of the medical community with a very specialized talent—the ability to communicate with and about children. Ask questions about the opportunities for and support of teaching opportunities. You will want to begin to hone your skills as an educator, since you likely will be educating parents, children, schools, and colleagues when you are finished. Look for chances to engage in a variety of teaching styles—classroom, clinic, and wards. Is there instruction or support for learning how to teach? What form does that take? Some of the process of learning to teach is through watching mentors. Make sure that the system has the ability to accommodate your interests and has the depth in its faculty to have mentoring available. Mentoring takes many forms in psychiatry—individual supervision, research mentor, teacher, etc. Ensure that there is enough variety of interest among the faculty that you will be able to find someone to model multiple types of interactions with patients and colleagues. The identification of positive mentoring relationships can be one of the most important paths in your development. Do not take it lightly. If you see no one on the faculty roster sharing any interests with you, consider looking elsewhere.

Though work, money, call, and eventual career choices are important, it is also important to be able to live well while you are in training. This means taking care of yourself and your family. If you are considering starting a family during your training, be sure to inquire about parental leave. Ask about the policies for making up time lost if leave is extended. A question
to pose to residents in the program is how they spend their spare time. Will your interests
mesh with those of the people already in the program? Is there time for your family and other
interests? Do other people in the program have outside interests, or are "off" nights spent
recuperating from "on" nights? In addition to time for family, money to do things with the
family can also be an important consideration. Talking about compensation or doing
moonlighting outside of the residency can be difficult, but is necessary. Presumably, if you
plan to moonlight or to open an independent practice, you will need to apply for and
maintain a full license in the state where you will practice as well as a federal and sometimes
state DEA number. Figure this into your cost of living. Ask about opportunities for
moonlighting within and outside of the system. Examine the compensation from the
residency and whether it will it cover expenses for the area in which the residency is located.
Talk to the residents about these issues when you meet them. If there are moonlighting
possibilities, how is malpractice covered? Are you able to extend the policy at your home
institution, or do you need to purchase independent insurance? Is there support for opening
an independent practice of adult outpatients? Is it encouraged or discouraged? Is there a
mechanism to help you set this up and get office space? Is there a mechanism to generate
patients for your independent practice?

If "location, location, location" is the mantra of real estate, "call, call, call" is often the
mantra of choosing a residency. Your call schedule is an important part of choosing a
residency and you should certainly ask about it during the interview process. Call is most
significantly dependent on the number of residents in the pool. You want to consider who
takes call—is it all covered by the first-year residents, or is it shared across the two classes?
What is the frequency of call? What about weekends? What time are you off post-call? How
frequently do you have call-free weekends? What are the responsibilities when on call? Will
you be covering an emergency department, a hospital floor or both? Are you covering for all
of the outpatients in the child clinic, or do residents cover their own outpatients even when
not on call? If you are covering an emergency department, are there clinicians or general
residents who see the cases and take care of disposition, or is that entirely your
responsibility? Are there measures in place as stopgaps in case a particular call gets
overwhelming? You’ll want to ask the residents in the program to describe their best and
worst call night. If their best call night sounds like your worst nightmare, consider whether
this program is right for you. On the flip side, if call is described as "a walk in the park" and
there are rarely any children seen, consider whether this is helpful to your education. You
want to look for a program that offers experience on call that is educational, but not
overwhelming. When on call, you want to be supported. You should ask about back-up both
on call and off hours. How easy is it to get in contact with a supervisor if you have questions
about a phone call or a patient you have seen? Ideally, you will have frequent and
educational contact with supervisors early in training that will allow for autonomy and
development of your own style later in training. Is there always someone available to call?
Ask the residents how often they actually call their back-up and what that experience is like.

While the "little things" may not seem important, they tend to be the things that are most
annoying. You will be spending 2 years of your life with this institution, so you’d appreciate

knowing that you’ll be comfortable there. Is the clinic comfortable? Is office space available? Will you have your own office scheduled at particular times, or will you be vying for offices at random? What type of support is there for scheduling, rescheduling, and insurance issues? Are there toys available for community use, or are you asked to purchase your own? Is there monetary support for purchasing toys and supplies? Is the medical notes system manageable? Is it computer-based or paper-based? What about lab and specialty services? Are they easily accessible, or do you have to give your left arm for a lithium level? How are the library services? Do you have access to the important online journals? Is there support to help you learn to search the medical literature? How easy is it to get a "hard to find" article?

You may find that you do not need to ask all of these questions for every program you consider. Find faculty and residents in your current program who have experience with programs you are considering. They may be able to answer many of these questions for you. You may also find on the interview path that residents and faculty at one institution may refer you to someone at a competing institution. Child and adolescent psychiatry tends to attract caring, friendly people. Comments directing you toward someone at a competing institution do not necessarily mean that the program does not like you or want you in their program, but more likely reflect the interviewer’s desire to help you make an informed decision about your career.

All of this leads to the post-interview period. Much happens after the interview itself, and a brief summary of these developments is helpful in delineating the flurry of events that leads up to match day itself.

After the Interview and Before the Match

On the day of your interview, most programs will provide you with a list of their current child residents, as well as contact information. If you are not given this information, be sure to ask for it; staying in touch with potential future colleagues is crucial in helping you make the best decision possible. Inevitably, after the interview day you will find that either you forgot to ask a question or you thought of additional information you need to know about the program. Generally, you can ask questions of the child fellows and receive the accurate information about the program you need to make your decision. Be cordial, friendly, concise, and well-directed with your inquiries. This the best way to obtain the information you need and to ensure that you make the best impression possible at each program.

In fact, every person you meet during the interview process is a future colleague. The world of child psychiatry is quite small. There are only approximately 6,000 child psychiatrists in the United States. Given such a small number, all interactions have far-reaching
repercussions. It is particularly important to keep this in mind as you write your thank you notes and ultimately contact the program director to express your interest in your top choices.

Ideally, every person who interviewed you should receive a thank you note. This gesture demonstrates your thoughtfulness as you prepare to enter this close-knit community. Notes need not be elaborate. Make clear your appreciation for the time the interviewer took to meet individually with you and for the information received about the program. You might also mention your particular interest in the program itself.

All of these preparations lead to the generation of your rank list. It is entirely acceptable to approach your top-ranked programs, keeping in mind the balance between honesty and diplomacy. However, never mislead a program director. (Remember, every person you meet during the interview process is a future colleague.) If you tell a program director that you are going to rank their program first and they subsequently put you in their top three, but you do not match at their program, then they will know that you were possibly not altogether truthful. Program directors often speak with one another about applicants and share information. If you later apply for a faculty position, work on an AACAP committee, or refer a patient to that institution, you may encounter resistance. You do not have to risk your reputation or future working relationship in order to guarantee yourself a spot at one of your top programs.

In order to give yourself the best chance of obtaining a spot at your ideal program, personally call the program director and express your desire to be one of his or her child fellows. Be clear that you have decided to rank this program number one on your NRMP rank list, but do not worry if the program director does not immediately reveal where you stand on his or her list. Just as you are making your decisions, programs themselves are in the midst of intense discussions about how to rank their candidates for training. Directors will be delighted to hear of your interests, and each director has his or her own style for conveying this information.

Finally, multiple variables conspire to land you in a program. You might not end up in your first-ranked program, and it therefore makes sense to have in mind other residencies where you would feel at home. Contact those programs as well and express interest. As always, be sure to show enthusiasm and respect, but you need not let these programs know that they are not among your number one or two choices. What is most important is that you do all that you can to ensure ethically and respectfully that you match at a program that will meet your future needs.

All we have stressed, all of this careful planning, sets the stage for your eventual career path. Things happen quickly in a 2-year training program; it therefore makes sense to approach the various options for long-term professional development soon after you have begun your residency.

Early Career Planning

A helpful exercise is to project yourself into positive future life scenarios, and then to "think backward" to the experiences that will best allow you to achieve your goals. Next, identify the strengths and potential shortcomings of each residency program within the context of your specific professional and life goals. This process can be a useful filter for assessing which programs will best be able to meet your individual needs. It is also an important element in your early career planning.

Early career planning begins long before graduation from residency and will be a critical aspect of your child and adolescent psychiatry residency experience. Guidance in the preparation for post-residency practice is an important responsibility for all residency programs. Usually this is done through a combination of formal and informal means. Many programs have a practice seminar to give an overview of the central issues in transitioning to post-residency employment (2). As mentioned previously, individualized faculty mentoring is also very important. The mentoring process is complex, but one role of good mentors in a training program is to help facilitate decisions about career issues (2, 3).

The intersection between a residency program and your early career planning will affect you in three broad areas: professional development, personal priorities, and finances. Professional development has been broadly addressed throughout this article and includes progressive growth in your unique combination of specific clinical skills, capacity for teaching and supervision, research pursuits, independent practice interests, management and administrative abilities, and job negotiation skills. When evaluating residency programs, keep in mind whether the program will be able to train you and advocate for you in the career areas that you want to pursue. Are there faculty mentors who specialize in your area of interest, whether in clinical work, teaching, or research? What is the program’s track record of facilitating the career development of past residents with similar interests? It can be very helpful to speak with program graduates and ask them if they feel that they were appropriately prepared by their residency program to meet the challenges of their first few years out of training. Another important issue to consider is that one’s professional relationships take time to develop, and the period spent in child and adolescent psychiatry residency is an opportunity to network within the mental health resources of a community. With the relative shortage of child and adolescent psychiatrists, early career child psychiatrists have significant flexibility to relocate into new communities after training. However, those who settle close to where they completed residency often have an easier time integrating into the professional community in the initial period of professional practice.

Your personal life is also important to consider when choosing child and adolescent psychiatry residencies.
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psychiatry residency training. This is true for the 2 years you are in training, and also because it is common for physicians to settle geographically close to where they completed training. In fact, geography can be as important an issue as the content and quality of a training program for some applicants, particularly for those with strong family and community ties. Ask yourself if the location of a given program meets your needs for developing personal relationships, raising a family, addressing the interests of a significant other, engaging in recreational activities, and facilitating your general well-being.

An area that is increasingly an issue for both psychiatry trainees and early career psychiatrists is finances. With many residents needing to manage debt in excess of $100,000 upon entering into child and adolescent psychiatry training, economic factors may be an important consideration for you in selecting a residency, balancing your time during residency, and structuring your career after residency. Again, speaking with recent graduates can give insight into the resources available during residency to help with both career development and management of personal finances, which may affect your early career trajectory. Faculty at both your home institution and the programs you are considering can be a valuable source of guidance. There are also several published resources that are helpful in preparing for one’s early career pathway, taking into consideration those factors important in choosing a residency and during residency training (4–8).

**Conclusion**

Choosing a child and adolescent psychiatry residency is the last step in shaping your formal medical training experience. It is necessary to be organized with respect to paperwork and applications, thoughtful about career planning, and alert to important mentoring opportunities. However, it is also essential to consider the quality of life outside of training. When considering various programs, be sure to talk to enough faculty members and trainees to get a "nuts and bolts" perspective and a true sense of a program’s culture. Be honest and respectful throughout the process. Most of all, do not underestimate the importance of your gut reaction when ranking programs. After all, as a psychiatrist, it is one of your most useful tools.

**REFERENCES**

1. AACAP Workforce Data Sheet. Available at http://www.aacap.org/training/workforce.htm


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K. Edenharter
Practical Knowledge for Academic Psychiatrists
Acad Psychiatry, June 1, 2006; 30(3): 238 - 238.
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