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*Chapter 1*

PREPARING THE CHILD AND INITIATING THE INTERVIEW

MUTUALITY OF ANXIETY

At the first clinical visit, there is often deep anxiety in the child, his parents, and the examiner. Children and parents naturally may feel anxiety at their first meeting with a psy­chiatrist Each of us also felt apprehensive when he first began seeing children as a psychiatrist No matter how sophisticated in adult psychiatry and medicine the examiner might be, the knowledge that very young children, even one's own, can handle adults in ways which lessen the adults control of the interchange is disconcerting, to say the least

Although outwardly calm, the psychiatrist who is new to the child psychiatric clinic must cope with a number of ques­tions running through his mind. Will the staff laugh if the child does not go readily with him? What will the supervisors say if the child will not talk to him or does not like him? What is he supposed to look for? What if the child is completely incomprehensible? How do you tell the difference between sick and well behavior? What is a normal 5- or 10-year-old like? How can a relationship be established if the child is too destructive? What special knowledge and talent allows the rest of the staff to appear so calm?

These and a multitude of other questions cross the mind of every child psychiatrist and pediatrician in the early part of his professional training. To be forewarned is to be fore­armed. It is hoped that the following suggestions about the family's anxiety will also allay some of the initial anxiety the physician.

The child's and parents' anxiety on their first visit may be a reflection of underlying family problems. Nevertheless, much of the manifest anxiety initially seen should be understood and handled as fear of an unknown situation. Knowledge about procedure can attenuate these fears and make them less painful. Therefore, one should not fail to offer the parents simple instructions on how to prepare themselves and their child for the first visit. The exact words used by the parent will depend upon the age of the child and the parent’s esti­mate of the child's ability to comprehend.

Parents are asked *not* to tell the child that he is being taken to a school to see a teacher, to have tests, or to see a nice man who will play with him. If the child is failing in school, this is common knowledge, as is the parents' concern about it, Therefore the child may be told, “We are going to see a doctor to talk about your trouble with schoolwork " If the presenting symptoms are nightmares, fears, or general unhappiness, the parents should have a similar frank discus­sion of the symptoms to prepare the child for going to the physician. In general, it is hoped that, through open discussion with the child, the parents can avoid stimulating feelings of shame or excessive fear in him.

A mother's questions about preparing her child may re­veal her own feelings in a symbolic manner, but it is not necessary to confront her with an interpretation of her be­havior. It seems best during the intake process to deal with the reality factors of the resistance in an educational manner, leaving the less conspicuous and presumably more neurotic resistances to a later time of diagnosis or therapy.

SIMPLE REASSURANCE FOR LESSENING OF INITIAL FEAR

Harry W.’s mother was slow in returning her clinic appli­cation. She telephoned to explain that she was a school teacher and asked whether she could return her application without signing the "permission to obtain a school report" section. She

 was not certain that Harry's need for help was enough ! to justify die stigma he might suffer at school. usefulness : of school reports was explained to her. We added that at times Harry would need to be excused from school and that usually children discuss their clinic visits with their playmates. These factors negate the possibility of keeping the secret. Prejudice about psychiatry and psychiatric patients still exists. This is something with which we will help the family cope and should not delay or cancel the need to have the study done.

If Mrs. W. had persisted, we would have scheduled an appointment without the release forms being signed. The com­pleted application was promptly returned, however. Later, when given the date of their appointment, Mrs. W. asked whether her husband could be excused because of pressing business matters. She was told that the participation of the father is essential and that we would try to arrange another date to suit his schedule. She thought that perhaps he could adjust his schedule, but, if not, she would call and change the appoint­ment. The family arrived at die originally scheduled time.

The experienced reader will understand that such brief telephone conversations tempt one to make some psychologic interpretations about Mrs. W. Perhaps she was reluctant to expose her maternal behavior to criticism from herself, her fellow teachers, or the clinic staff. Perhaps she had an inordi­nate need to control and dominate her environment. She may have been afraid that some severe psychosis or retardation would be found in the child or that he could not be helped. These and many other possible explanations for Mrs. W.'s behavior can be explored later at the appropriate time during the history taking.

COPING WITH NEARLY INSURMOUNTABLE INITIAL RESISTANCE

An extreme example is the case of Allen T., age 15. Allen's parents made an urgent call stating that Allen had become violently angry and refused to keep his second appointment with the doctor. He swore at his parents and had begun smashing furniture. They had fled from the house and were calling from the comer drugstore. Mr. T. wondered whether it would not be best for just him and his wife to come to die appointment

without Allen. They were asked whether they believed that Allen was homicidal or would do physical harm to them. They were certain that he would not harm anyone, but when he got upset like this they just could not handle him. They were instructed to return home and insist that Allen come for his appointment. If they could not obtain his cooperation, they should call the Juvenile Aid *Division of* the Police Department It would be necessary for them to file a complaint in order that the boy might be placed in the Juvenile Detention Home. Once this placement was effected, arrangements could be made with the authorities to complete our examination of Allen. In about 30 minutes the parents appeared at the office with an angry but compliant Allen. The police had not been called. It took several visits to complete the study, but it was even­tually possible to establish a working relationship with Allen.

Such strong-arm tactics should be the exception and used only as a last resort. Coercion or other forms of force are not favored, but they may be necessary if the child may possibly do some irreparable harm to himself or others. One might argue that an emergency psychiatric hospital should be used for such cases. Patients, however, cannot wait for adequate or "ideal" facilities to be built. It is possible to do a complete psychiatric evaluation on a youngster who is under legal detention, provided the psychiatrist has good working relation­ships with the local authorities and is willing to put up with some inconvenience to himself.

DIRECT INSTRUCTION OF THE CHILD

Whether preliminary interviews with the parents, tele­phone advice, or coercive measures have been used, most children come for their first visit without understanding the purpose of the examination. The child may have been too anxious, antagonistic, or distrustful to believe or even hear the parents' explanation. On the other hand, the parents may have been *so anxious* about the visit that they could not even approach the subject and have just brought him in, saying nothing or having given him only half-truths and evasions. Therefore some preparation of the child on the first visit by the psychiatrist is essential. (For details of how author instructs the child, see page 8.)

SEPARATING THE CHILD AND HIS PARENTS

ON THE FIRST VISIT

In our clinic we usually meet the child for the first time with his parents in the family group intake session.70 The staff and the family engage in open discussion of the family’s con­cerns and of the clinic's procedures. During this group meeting the child is told that he will have some sessions alone with specific examiners.

The ease with which the child separates from his parents has some diagnostic value. Difficult separation may be owing to a pathologic tie between parents and child or to the child’s anxiety in response to new situations and new people. It should be noted, however, that difficulties in separating the child from his parents can also be inversely proportional to the experience and comfort of the examiner. If the examiner is afraid or expects that he will have trouble, he frequently does.

Since it is not possible to know immediately the signifi­cance of the clinging behavior, it is best not to make this separation forcefully. There is certainly no harm in permitting one parent to accompany you to the playroom, with the in­struction that he or she may return to the waiting room as soon as the child is reassured. On rare occasions, for either the mothers or the child’s comfort, or both, it is necessary for a parent to remain throughout the interview session. By action and by words, however, the examiner should indicate that on subsequent interviews he will try to make this separation. In a few cases, this separation has actually been part of the treatment for both mother and child. Usually, by the second visit, separation should not be a problem.

INTERROGATION VERSUS NONDIRECTION

Planned use of the physician’s time is extremely impor­tant, It is necessary for him to be friendly, relaxed, and un­hurried. If he assumes the role of an authoritarian interrogator, such as may be seen in some law enforcement agencies, he produces uncooperativeness, negativism, and relatively few data. On the other hand, the examiner cannot afford aimless, rambling, nondirective chitchat which usually reveals little about the child.

Interview sessions should be limited from 30 to 60 minutes for the convenience of die examiners’ own schedule, as well as to avoid fatiguing the child. At our center, students are expected to see a child at least twice and preferably three or four times for a psychiatric examination, with a time interval between visits. No matter how experienced the examiner is, an advantage of at least *a second* interview is that anxiety due solely to the newness of die situation will be less. More im­portant is the fact that it takes time to know a person, and it is rarely possible to do a complete mental status evaluation in less than two or three interviews.

PHYSICAL EXAMINATIONS BY THE PSYCHIATRIST

The doing or requesting of a "routine” physical examina­tion merely to rule out organic disease is useless, because ruling tilings in or out is a never-ending responsibility. Never­theless, before visiting the psychiatric clinic, all children should be seen by their family physician or pediatrician, be­cause it is essential for every child to have a physician who is fully responsible for his organic well-being and for the com­monly accepted prophylactic measures against illness.

A physician's report outlining organic illnesses should be part of the child’s psychiatric case record. Beyond that, med­ical judgment should determine the need for requests for physical or neurologic consultations. From die history or dur­ing the course of observation, the psychiatrist may raise ques- , tions about specific aspects of the child’s physical health. Appropriate questions are then resolved by the psychiatrist’s own further investigations, with die aid of consultants. A consultant can always give an expert opinion on a specific

Question but *is as* impotent as anyone else in ruling but organic factors.

In a medically isolated location it may be necessary for the psychiatrist to serve as his own neurologic consultant and do whatever procedures are necessary to answer questions raised about the child’s physical status. Ekstein23 takes the opposite position, feeling that physical examinations should never be done by one who is or intends to become the child's psychotherapist. In our opinion, the child psychiatrist need not abdicate the responsibility inherent in his medical back­ground. He must raise questions about possible organicity and work with his medical colleagues to find answers to these questions. This kind of responsibility begins when the patient enters the clinic or hospital and ends only when he is com­pletely discharged.

VERBAL AND NONVERBAL (PLAY) ACTIVITIES

In our clinic we prefer to use a combined office-playroom setting for interviews. Tins provides a greater flexibility and permits the child to accept either the conversational or play type of interview, or a combination of both. Its secondary ad­vantage is that each person may keep his work space as neat or messy as he chooses, and the administration does not have to deal with the constant query, “Who left the playroom in a shambles?”

The psychiatrists activities are designed to make the child as naturally spontaneous and cooperative as possible. The author usually *tries* the conversational method of interview even with very young children. Nondirective free play should not be relied upon exclusively. Lack of interview structure can make some children more anxious, because they think that the examiner is avoiding the real purpose of the visit. Other children may quickly learn to use play as a means of indefinitely avoiding talking to the physician.

In either fantasy play or in direct discussion, the examiner should encourage the child to take the initiative. Do not be so

**8 ... PREPARING THE CHILD**

passive as to create a new anxiety in the child but, so far as possible, allow him to initiate and direct the play. A suitable balance between play activity and direct conversation comes with experience. The activity-passivity ratio varies consider­ably among equally competent psychiatrists and will also vary according to the examiner's estimate of what approach will be productive with a given child.

Many novice examiners, without realizing it, enter a playroom with a child and immediately go to the doll house (if they are with a girl) or pick up the guns (if with a boy). By this action the examiner initiates play, and the child will then reflect the examiners fantasies rather than produce his own. Adults seem to have an uncontrollable need to engage in some activity when they are with children. The obvious toys in the room are usually invitation enough, though you might add, ‘‘This is my room. You may use any of the things here." (If you use a combined office-playroom, you cannot have per­sonal tilings on display which you would not permit the child to use.) The stated question, "What would you like to do?" is out of place. The psychiatric interview is not a den meeting or a summer camp where children must constantly be doing something to satisfy their leaders.

THE PSYCHIATRIST'S INITIATIVE

If the child does not take the initiative, it often helps to discuss quickly with him the reason for his clinic visit. This is the examiners obligation and his opportunity to prepare the child for interviews. The child should be asked what he was told about coming and then asked for *bis* fantasies, thoughts, and guesses about coming. If he can give any in­formation, he is asked how the actual experience compares with what he was told or what he imagined about the event.

If he does not know or was not told, he may be asked to guess why others might come to the clinic. If the child re­sponds with any statements at all, it is then possible to cor­rect any erroneous ideas he may have and allay his anxiety. If

**PSYCHIATRIC EXAMINATION OF CHILDREN ... 9** he comes up with nothing, he may be told that the examiner is a doctor who helps people with their troubles or worries and problems. Children come to see him because of worries or problems about their friends, their family, their school, or themselves. If the child does not pick up these suggestions, he can be told that his parents were worried because he does not sleep well, because he is unhappy at home, or because tilings are not going well for him at school, whichever is the case for him. With delinquent children who are highly suspicious, it is frequently useful to say that we understand they are in deten­tion or have been in some trouble and would like to hear their side of the story.

If the patient cannot or will not use such openings to talk about the presenting complaints or other topics, it is useless to push questions or conversation in the initial interview. More important, the child should understand you are not an object to be feared. You are definitely interested in him as a person, and you at least know of the existence of his prob­lems. Mentioning problems early may be useful only to try to dispel the suspense about what the examiner knows.

Often the entire first interview is spent trying to put the child at ease and clarifying the purpose of the visits. With some children, anxiety and confusion about the examination are not problems, and one can proceed to obtain as much of the data outlined in the next sections as time permits. The psy­chiatrist should remember that the amount of data he obtains will often be inversely proportional to the amount of pushing or authoritarianism used.

The reader may feel that this admonition against pushing a child too authoritatively is contradicted by the previous illustration of Allen T. Allen's case was unusual, however, and was used to illustrate extreme action which is only *rarely* necessary in order to do a thorough examination. Allen was a very angry and uncooperative boy, and our threat to use police action to control his behavior did not endear us to him. On the other hand, he did not become violent or mute, but

excused die examiner for his (the examiners) behavior on the grounds that we did not understand what he had "to put up with” around the house. He spontaneously reassured us that he would not actually harm “them,” even though hee felt like it at times. He caustically suggested that we had forced him to come in order to be certain that we collected our fee for die time. Even though he doubted our abilities and our intentions, die situation at home was so bad that he thought he would keep subsequent appointments to see what we could do.

DIFFICULTY IN ELICITING SPONTANEITY

Marilyn, age 8.5, was brought to the clinic because of a severe school phobia. She separated from her mother without difficulty but in the playroom sat with a “frozen” body posture. Tears were in her eyes, but she did not cry. Her pupils were dilated, her hands trembled; and her speech was a barely audible whisper. Attempts to discuss the scary feelings of her first visit did not produce any relief, nor did invitations to play with toys. After 15 minutes she did accept an invitation to go down die hall for a Goke. She drank it slowly and looked at the pictures on the wall around the building. Her body posture relaxed, but she remained too tense to talk or play. On the way home she told her mother that she was “really scared, but the doctor bought me a Coke and it made me feel better.”

Sometimes it is impossible to relieve a child’s fear of die examination except through gradual lessening of the anxiety with each succeeding visit.

SELECTING CLUES FROM INITIAL PLAY ACTIVITY

Permitting the child to take the initiative in die inter­view produces valuable material. Often the child may begin by telling you in words or action some symbolic illustration of his presenting problem, his feeling about die examination, or both.

John, age 7.5, was referred for aggressive behavior at home and at school. He rushed to the playroom the instant, he was invited. He quickly took the guns and shot wildly around the room with vivid sound effects and descriptive phrases such as

( ‘I got ’em! He's dead! You dirty Jap!” He tried to shoot the examiner but was easily persuaded to direct his fire at the targets and the doll figures. As the intensity of his play sub­sided, he began to talk about his father and of the fun they had fishing, boat riding, and playing ball together last summer.

In tins instance it was not necessary for the psychiatrist to become active or take the initiative; indeed, such was prob­ably contraindicated. John appeared acutely anxious and dem­onstrated that he handles anxiety by overactivity. He further showed that his behavior can be controlled by mild prohibi­tions when he acquiesced to the request to shoot inanimate targets rather than the examiner. He also evidenced inner control by gradually stopping the aggressive play. This is in contrast to some children, whose aggressive actions tend to snowball in intensity and will cease only with strong external prohibitions.

The diagnostician needs to learn to identify die feelings revealed by play and the sources of these feelings. Violent shooting can be a direct expression of angry feelings and pos­sibly a defensive cover-up for strong fear. In Johns case it seemed highly probable that both fear and anger were stimu­lated by die examiner and the clinic visit. Had John been asked directly to describe his feelings about coming to die clinic, he might have confirmed this hypothesis.

The fact that John’s violent play subsided so easily with a willingness and a desire to talk about his father made the examiner feel that factors outside the clinic experience were more related to John’s behavior. Usually die examiner would have some history that would provide additional clues to die meaning of the behavior. In this instance the history was not available until after the initial interview. (Such a procedure should be done occasionally to sharpen interviewing skills.) John’s spontaneous, glowing account of his positive rela­tionship with his father made the examiner suspect some problem with the father. It is usually safe to pursue any topic introduced by the patient. Therefore John was asked to tell

more about his activities with his father. When asked about tilings which caused disagreements and conflicts between him and his father, John revealed that his father had died six months ago. Without a strong emotional display, plans for the summer recreation that never took place were reviewed.

John was a highly active boy whose aggressive feelings spilled out but were brought under control easily. His father had died recently, and John was still struggling with the mourn­ing process. His desire to shoot “dirty Japs" and the physician, followed by a glorification of the father relationship, was a graphic portrayal of ambivalence to the lost father. Child psychiatrists frequently find that strongly emotional and sig­nificant topics determine the initial play activity in the first interview. Equally often, the child may avoid these same topics for several weeks in subsequent interviews.

An 11-year-old delinquent boy opened the interview by bragging about how much he liked to have his immunization shots. He spontaneously told about a doctor friend back home who permitted him to go on house calls and sometimes give the shots. Sensing his fear, the examiner volunteered that he would not be given any shots. The patient responded by saying he had thought that the examiner would give him a blood test. The examiner explained that he wished to talk to the boy about the troubles he had been having. The patient responded that there were some things he would not care to discuss. He then launched into a long discussion of legal procedures followed by a detailed account of the inner workings of automobiles.

This boy was not a car thief. Rather the entire first inter­view was concerned with his fear and distrust of the physi­cian and probably all adults. He also revealed that he had developed some skill in the arts of evasion and prevarication as a means of handling threatening adults.

CONFIDENTIALITY AND LIMIT SETTING

Limit setting and confidentiality are issues which the examiner must keep in mind during the initial interview and in all subsequent interviews during both diagnosis and ther­apy. The limits that will be set or enforced and the degree to

**PSYCHIATRIC EXAMINATION OF CHILDREN ... 13 which the psychiatrist can be trusted are problematic to the relationship.**

On the basis of experience the child does not readily trust adults, especially strangers. If you are trustworthy, the child will come to trust you. With some children, however, this will not occur until treatment is completed. When a child stares at our note-taking or looks for hidden microphones, we should try to get him to discuss his concern for confiden­tiality. One cannot swear to absolute and eternal secrecy about the interviews, but One can promise the youngster that he will be told when we plan to talk with his parents or others and will be told in advance what we will tell them.

Limit setting is such a personal matter, charged ,with the professional's attitudes and feelings about aggression, that it cannot be dealt with adequately on the printed page. The effect of limits on the productivity of an interview is probably dependent upon both the conscious and unconscious intent of the examiner, his timing, and his intuitive grasp of the child's need for permissiveness or limits, as well as the past experience and nature of the child's illness. If you consistently have un­productive hours, you may be too restrictive. On the other hand, if the playroom is always a shambles and the patient is in an agitated state after your interviews, you may be either failing to set limits or unwittingly stimulating the child to act out In either of these instances, some firsthand observa­tions of your interviewing techniques by a colleague or super­visor would be much more helpful than a printed discourse on limit setting.

INITIATING INTERVIEWS WITH HOSPITALIZED CHILDREN

The psychiatrist's introduction of himself to a child hos­pitalized on a general medical ward requires a different approach from that described for the initial outpatient visit. Hospitalization can be frightening in itself, and being taken to strange places in the hospital can provoke unnecessary anxiety if the child is unprepared. It helps to have the psy­chiatrist visit the child first at his bedside and introduce

himself. Has the attending physician explained the purpose of the consultation? If not, an explanation and the reason for the referral should be given to the child in much the same way as instructions are given to the parents for preparing the child. The term " psychiatrist" is well known to many children, but it is best not to use this term until the child indicates some comprehension of the psychiatrist’s function. One can make a comparison between his own role and that of the attending physician. "We are both doctors. However, while Dr. Jones examines your sore throat, or your tummy, or your chest, I'm a doctor who is particularly interested in children who have problems, worries, or troubles. I do not plan to undress you or listen to your heart, since that has already been done, but Dr. Jones would like me to talk with you about some of your problems"

Usually the children’s ward presents many stimuli about which one could talk for a few minutes. Some inquiry should be made about how long the child has been there and how he feels about it. If there is sufficient privacy from the other children, he may briefly discuss his problems. It is our practice then to inform him of our plan for a playroom or office inter­view. He is told the time and place of the interview and given some instruction about the location of the office in relation to his own ward.

It is not possible to cite all potential variations of the initial interview. The majority of introductory sessions with patients go smoothly, and fortunately, patients are usually charitable about our blunders. Nevertheless the initial inter­view is troublesome to the patient, to the novice examiner, and in some instances it may adversely affect all future attempts to work with the patient. Hence the physician can-well afford introspective evaluation of his initial interviews.

SUMMARY

The initial interview for examination usually provokes anxiety in both the child and his parents. This experience

**PSYCHIATRIC EXAMINATION OF CHILDREN ... 15** also heightens the discomfort of the examiner when he first begins his study and practice of child psychiatry. Advance instruction of the parents for preparing themselves and the child, and simple reassurance, will usually lessen much of the initial fear. It is also important sometime early in the interview for the psychiatrist to offer the child some explanation of clinical procedures and reassure him about his knowledge of the child's problems.

Occasionally, initial resistance and anxiety may be nearly insurmountable. It is important for the physician to recognize that the anxiety accompanying the first visit may unduly in­fluence the child's behavior and that one must be cautious about drawing hasty conclusions from the initial interview. Although a firm stand or even force may occasionally be indi­cated with a particularly rebellious child, a patient, easygoing approach is usually more successful than authoritative ques­tioning.

It is the authors conviction that physical examinations or consultations, when definitely indicated, are the responsibility of the examining physician and will not unduly interfere with the establishment of a relationship if thoughtfully and proper­ly performed.

Eliciting spontaneity in the child can be difficult. There must be an opportunity for both verbal and nonverbal activi­ties during the interview situation. The examiner must avoid being so passive that he frightens the child unduly, but at the same time he must permit the child free rein for fantasies with as little direction and suggestion as possible.

Some illustrations for selecting clues from the child’s play activity are presented. Confidentiality should be assured by both words and deeds of the examiner. The matter of limit setting during the interview situation will vary greatly, de­pending upon the personality and tolerance level of the examiner. Yet if the psychiatrist is too restrictive or if he fails to offer the child any behavioral guidelines, the child’s pro­ductivity in the interview may be seriously distorted.