Psychiatric Evaluation of Children and Adolescents: It Takes Time

By Jeanne Bereiter, MD | May 1, 2007
Dr Bereiter is assistant professor in the department of psychiatry, child and adolescent division, at the University of New Mexico in Albuquerque. He reports no conflicts regarding the subject of this article.
The author wishes to acknowledge Tracy Anthony, George Davis, Carol Larroque, Scott Holt, Josip Gazic, Cynthia King, David Mullen, and Elizabeth Tully for their ideas.

Psychiatrists know that it takes longer to interview children and adolescents than adults. Child and adolescent psychiatrists are universally struck by how comparatively easy it is to interview an adult patient, whereas general psychiatrists face the evaluation of a child or adolescent with apprehension. We all know that evaluating a child or adolescent is more difficult, but our thinking on the topic stops there. Child psychiatrists and others who evaluate and work with children need to be aware of what they do if they are to justify to health insurers, departments of psychiatry, and themselves why patient evaluations take so long.1

When evaluating a child or adolescent, we have not just 1 patient but 2 or more, and the complexity seems to increase exponentially when more people are involved. For example, the child and his or her mother and father can be included in the evaluation. But there can also be the child and his foster parent, social worker, and birth mother who is in prison but still has parental rights. Frequently, all involved parties are not actually present for the evaluation so they must be contacted by phone or seen at a later date. Family members of children with psychiatric problems often have psychiatric problems themselves for which they may or may not be receiving treatment. When we're lucky, all parties agree on the problem, its time course, its significance, and the treatment. However, more commonly there is disagreement on at least some of this.2,3 Emotionally charged issues such as the mental health of a child seem to increase the chance that natural differences of opinion will flare into conflict.

Faced with 2 or more patients, clinicians must establish rapport with all parties. This can be tricky. Imagine, for example, a clinician faced with a sullen adolescent and her equally angry mother, who are both still upset about their experiences with previous psychiatrists and are waiting to see if the new clinician will side with the mother or with the girl. Neither one can conceive of a treatment relationship in which the psychiatrist is neutral.

Or, consider a 7-year-old who is failing in school, getting picked on in the playground, and who still wets the bed at night. The clinician doesn't know why he's come in until his mother begins talking and his face crumples and his fists clench. Should the clinician send him out of the room, change the subject, reassure him that he hears about problems like this all the time, or hurriedly ask to speak with the patient alone?
To get the full clinical picture we need to interview the child alone, the parent or parents alone, and then talk with everyone together. This can be difficult when there is no one to watch a young child while we talk with his parent. Parents often bring siblings to the appointment. Although this provides wonderful information about how the child interacts with his siblings, the pace of our evaluation slows when a baby needs his diaper changed or a toddler tries to probe an electrical outlet.

**Interviewing the child**

Most children will not and cannot say what brings them to see us, what symptoms have been concerning them, and for how long. Therefore, we need to get at the information indirectly. Our approach must differ depending on the child's developmental level. Often, we need to play with a child in order to get him to open up. Children neither know nor care that we have other patients waiting.

It is rarely the child's idea to visit the psychiatrist. At times it is not even the parent's idea. Sometimes the child does not even know about the evaluation beforehand, perhaps thinking that he is going to the ice cream parlor or to visit his aunt. Feeling angry, betrayed, or just confused, the child may not be the best historian.

We all remember things differently and present differently depending on our degree of hunger or fatigue. This factor is magnified in children, whose state of mind and manifestation of symptoms can vary widely depending on when they had lunch. In addition, children have difficulty putting their feelings and thoughts into words, and they don't think the way adults do about time frame and cause and effect. Multiple appointments may be necessary in order to figure out what symptoms the child actually has.

Mental illness is often more ambiguous in children than it is in adults. As we all know, bipolar disorder does not usually cycle neatly. Its symptoms overlap with attention-deficit/hyperactivity disorder (ADHD) and can even occur along with ADHD. Consider a 9-year-old who "hears voices." In an adult, this would clearly be abnormal but in a child it could be caused by regression, a good imagination, misunderstanding the question, a lie to get out of trouble, or psychosis.

Children are good at reporting internalizing symptoms but often deny or do not recognize externalizing symptoms. Their parents see them arguing and fighting but may not know about the depression or hallucinations. This can cause confusion, hurt feelings between parent and child, and disagreement about treatment recommendations.

**Obtaining a thorough history**

It is always good practice to obtain collateral history of a patient, but with children and adolescents it is essential. Multiple agencies and providers may be working with the child (eg, pediatrician, therapist, teacher, special education teacher, soccer coach, previous psychiatrist, social worker, guidance counselor, babysitter, and so forth). Everyone has valuable information, but obtaining it takes time. Releases of information need to be signed, although the legal guardian may not be present to sign them. Teachers can be difficult to reach and results of psychoeducational testing are hard to obtain. Often, a clear diagnosis and decisions about treatment need to be deferred until the essential people are spoken to and necessary records are received.

Once the information is gathered, we need to integrate it. Information may be conflicting and it is almost always incomplete. When we have come to a diagnosis and are ready to make treatment recommendations, we need to present this to the child or adolescent, the guardian or guardians, and any
other involved parties. All parties then need to agree to the plan and consent needs to be obtained for any medications that are prescribed.5

**Deciding on a treatment**

Prescribing psychotropic medication for children is trickier than prescribing for adults, and we tend to be more conservative, especially in young children. There are more black box warnings that need to be considered and explained in detail to families. Many medications are used off-label, so dosage and possible side effects may be uncertain. Ethical dilemmas may be present; for example, the diagnosis may not be clear, or we may think that if environmental factors were controlled, the child would not need medication.

Discussing treatment recommendations is invariably more complex when treating children and adolescents, especially when medications are involved. Parents are more ambivalent about medications for their children than they are about medications for themselves. This is especially true for psychotropic medications.

Take the case of a 10-year-old who has ADHD that the clinician wishes to treat with methylphenidate. The mother may agree, but the father may think that all the boy needs is more discipline; or both parents may agree but the grandparents tell the parents that the problem is their parenting; or their friends say "I'd never put my child on drugs"; or the parents agree but the child refuses; or they're worried about the addictive potential because the mother used to abuse methamphetamine; or because of reports they saw on television.

Parents feel guilty about "putting their child" on medication. They may blame themselves for bad genetics or for not being good enough parents. Children and adolescents may refuse medication because they do not understand the reasons for taking it, because they do not want to be different from their peers, or because the medication is difficult to swallow.8,9

**Conclusion**

A final issue when interviewing children and adolescents has an indirect relationship to time. The work can be emotionally wrenching: interviewing a child who has been sexually abused by her father, seeing a family devastated by a teenager's schizophrenia, or watching an angry mother berating her child for some minor infraction. Our emotions are stirred. When making a report to social services, the time involved is not just the time to make the report. It is also the time spent talking to the parent, empathizing with him or her, explaining what will happen to the child, and sitting alone for a moment when it is all done.

Interviewing children and adolescents is a complex undertaking. If, in our hurry, we skip a step or two, we are at risk for making an incorrect diagnosis or for developing a plan that, no matter how brilliant, will fail because of lack of follow-through by the family. There are no real shortcuts. Child and adolescent psychiatry takes time.
References