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THE DIAGNOSTIC PROCESS IN CHILD PSYCHIATRY

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Group for the Advancement of Psychiatry

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THE DIAGNOSTIC PROCESS IN CHILD PSYCHIATRY

I. INTRODUCTION

This report defines the nature and scope of the diagnostic study in child psychiatry and underscores its strategic importance in the care of emotionally disturbed children. Based on current clinical knowledge and on dynamic-genetic principles concerning normal and pathological child development, the report presents the diagnostic study as a comprehensive dynamic medical process. As in general medicine and in other medical specialties, diagnosis in child psychiatry takes into account the multiplicity of etiological factors which may be involved in the emotional disabilities of any one child.

The report describes the diagnostic procedures in clinical child psychiatry, outlines the collaborative work of the psychiatrist and other medical and non-medical specialists and defines their specific and unique contributions to the study and diagnostic formulation. It stresses the ultimate medical responsibility of the psychiatrist for the integration of the various clinical data into a working diagnostic evaluation and for the planning of comprehensive treatment in the light of realistic goals and a reasonably valid prognostic appraisal.

The Committee addresses this report to professional people who are considering the general problem of structuring psychiatric services for children. It is not intended as a manual of procedures for the training of personnel but rather represents the thinking and experience of this group* of child psychiatrists regarding the im-

The membership of the Committee on Child Psychiatry during the period of the major work on this report consisted of the following:

Othilda Krug, Cincinnati, Chairman	*Eveoleen Rexford, Boston*
Frederick H. Allen, Philadelphia	*J. Franklin Robinson, Wilkes-Barre*
Anne R. Benjamin, Chicago	*John A. Rose, Philadelphia*
George E. Gardner, Boston	*Mabel Ross, New York*
J. Cotter Hirschberg, Topeka	*Robert L. Stubblefield, Denver*
William S. Langford, New York	*Exie E. Welsch, New York*

The Committee wishes to express its deep appreciation to Mrs. Ethel Ginsburg for her continuous active participation in the preparation of this report, especially for her contributions to the section on "History and Current Setting of the Presenting Problem" and for her valuable editorial assistance throughout the report.

The Committee is also grateful to Dr. Phyllis Blanchard for her help on "The Psychological Examination".

portance of the diagnostic process. The Committee hopes however that this report will be of value in psychiatric education.

While child psychiatry may be practiced in a variety of settings — private practice, inpatient and outpatient psychiatric facilities for children, or in clinical units in host agencies, such as courts, schools and foster care agencies or institutions — the nature and scope of the diagnostic process remain the same in all settings because they are determined by the nature of childhood itself. In this report the psychiatric clinic for children will be used as the setting to illustrate the areas and methods of investigation.

Comparison of adult and child psychiatry — The similiarities and differences between adult and child psychiatry are nowhere clearer than in the diagnostic process. The ultimate goals are the same: an understanding of the nature of the presenting problem and its etiology, and the development of a plan of treatment designed to eliminate, control or ameliorate the negative forces, while making the fullest possible use of the positive forces in the patient and his situation.

The areas of investigation are the same: the history of the presenting complaint including medical, social and psychological data which might throw light on the development of this problem, followed or accompanied by the study of the patient to learn as much as possible about the nature and severity of his illness and about biological, emotional and environmental factors which must be taken into consideration in planning for his treatment.

The broad outlines of the diagnostic process are the same: the collection, integration and evaluation of pertinent data; the identification of etiological factors, specific or multiple; and the formulation of a working diagnosis, prognosis and treatment plan.

There are other similarities: dynamic theories of personality development apply equally to child and adult; the selective use of psychological tests and other devices aid in differential diagnosis; the psychiatrist carries the medical responsibility for the consideration of organic disease and the final diagnostic and treatment responsibility based on his clinical judgment which is the end product of his training and experience.

However, there are some specific differences between child and adult psychiatry. The adult patient usually presents himself for consultation because of symptoms from which he seeks relief. With

the exception of the psychotic patient or the individual who is referred by an authoritative governmental agency such as the court, the adult turns to the physician voluntarily, albeit often reluctantly. The young child, on the other hand, seldom if ever seeks help actively. He is always brought to the psychiatrist by an adult who is responsible for his care, either because this adult is concerned about the child's health or adjustment or because such action has been recommended, urged or even ordered by persons or agencies in a position to do so.

The first approach to the child psychiatrist is usually made by the parents or by a referring source on behalf of the parents. The child patient may or may not accompany the parents on the first visit depending on the individual situation or the procedures established by the psychiatrist in private practice or by the clinic to which application is made. In an earlier Report, "Basic Concepts in Child Psychiatry" (GAP Report #12), this Committee discussed clinic intake policies and procedures as well as the impact on the parents of the need to seek psychiatric help.

Particularly in child psychiatry it is not enough to seek information about the parent-child relationship from direct observation of the patient alone. Diagnosis in child psychiatry is directed at an understanding of past and present interactions and at the strengths and weaknesses of the major persons in the child's constellation — the child, the parents or parent substitutes, siblings, other key relatives, and the personnel of schools and other social institutions who may influence his maturing personality.

The development of the psychiatric clinic for children as we know it today parallels the growing recognition of the interdependence of child and parents and the need to include the parents in the diagnostic study and treatment of the child. During the past quarter century these clinics have developed special staffing patterns and procedures to facilitate their work with the child and his family. The "clinic team" concept in child psychiatric clinics is a direct outgrowth of this experience. The child psychiatrist in private practice endeavors to include and involve the parents of his patients. In some instances psychiatrists in private practice are now duplicating the clinic team by making use of the services of clinical psychologists and psychiatric social workers.

Clinical classification is different for the child than for the adult;

the adult has lived longer; he presents more cumulative evidence of behavior patterns and structured defenses. Furthermore, clinical syndromes have been described more definitively for adults than for children. As a matter of fact, clearly delineated and universally accepted diagnostic classifications for children have not been established. In the words of one child psychiatrist, "We have yet to find a label that means what it says and says what it is."

The impact of organic disorder is potentially greater on the young child than on the adult. The disorder itself may be no more severe, but in the case of a young child it may produce sufficient anxiety either in him, his parents or both to affect adversely his subsequent physical and emotional development. The presence of organic defect is often less easily discernible in the young child, especially in infancy; in the adult's longer life span there will have been many more opportunities for the development and detection of chronic organic defect. The young child's attempts to compensate for defective vision, hearing or motor control may be viewed as willful misbehavior, while the basic organic defect goes unrecognized.

The adult psychiatrist sees the chronologically mature individual who, in contrast to the young child, can be said to be more nearly an end product of the major portion of the growth process. For the adult patient the diagnostic study and treatment goals are concerned with a personality structure already developed, although some modification continues throughout life. The child psychiatrist sees the chronologically immature individual who is in a fluid state of incomplete personality development, characterized normally by rapid physical and psychological changes. For the child patient the diagnostic study and treatment methods are directed toward helping him achieve sufficient freedom from obstacles to his growth so that he can move with reasonable security through succeeding developmental stages.

These are some of the differences between adult and child psychiatry; these and others will be discussed in more detail in the body of the report, first in the section concerned with basic assumptions and later in the section having to do with methodology — how diagnostic data are gathered, integrated and evaluated.

II. BASIC ASSUMPTIONS

In preparing this report the Committee agreed that certain basic assumptions are essential to the consideration of the diagnostic process in child psychiatry. These basic assumptions relate to current knowledge concerning the development of human personality.

The concept that a child's behavior reflects his attempts to adapt to a series of tension-producing situations is fundamental to the diagnostic study of children. The well-adjusted child's methods of adaptation are personally gratifying and socially appropriate. The emotionally disabled child's adaptive attempts are ineffectual and only partially satisfying, and they may be experienced internally as distressing symptoms. As outer signs of the disability they may be manifested in behavior which is socially unacceptable and often disturbing to others.

Diagnosis involves primarily an investigation of the child's relative successes and failures in mastering in orderly sequence certain universal anxieties which confront all children as they move through the several stages of personality development. In general, the major tasks in this growth are directed toward the achievement of a biologically satisfying utilization of life energies (the libidinal or psychosexual and the aggressive drives) through constructive patterns which are socially and ethically satisfactory.

The delineation of those specific areas which have been seriously impeded at a particular chronological age must be based on the body of knowledge concerning normal personality growth. It is a distinctive feature of child psychiatry that all findings are weighed against the developmental norms for the successive, changing stages of growth. Basic to this concept is the belief that normal personality patterns evolve out of interpersonal relationships. As a unique and distinct biological organism, the child is always interacting in varying degrees with external social forces, especially within the family in early years. In infancy he depends totally on his parents for the primary satisfactions of loving care and for the protection necessary to sustain life. These lay the foundation for

his further biological and psychological maturation which in turn progressively stimulates the inherent and newly emerging energies that increasingly strive for satisfying expression. To meet these successive changing needs the child again depends on adults, first on his parents and later on others in his broadening society. As the unique aspect of childhood, the dependency relationships provide the framework through which the child is helped to develop an awareness of himself as an organized separate individual whose behavior patterns are consistent with both individual and group living.

The growth of the child's sense of his own identity as a unique and distinct individual is accomplished within the successive developmental phases through certain observable processes of differentiation. In the earliest months the infant is in a relatively undifferentiated state of oneness with his mother. But gradually as the child experiences minimal and hence tolerable frustrations of his basic needs and is satisfied repetitively by his mother, he more actively turns toward her with increasing confidence and patience. He learns that he is separate and different from his mother yet dependent on her and his environment. In the normal, mutually gratifying, symbiotic relationship with his mother the infant's and mother's needs are complementary, for in anticipating and meeting her child's needs the mothering-person is also fulfilling her own mothering function.

Intimately associated and concurrent with this process, the child's neuro-muscular, intellectual and emotional growth leads to an awareness of his bodily parts and their functional differentiation. He also becomes aware of his increasing needs and greater energies for pleasurable and rewarding muscular activities such as reaching, walking, talking and controlling elimination. He strives to master some of his bodily functions so that voluntarily and purposefully he can direct his own actions to satisfy some of his needs. This self-sufficiency is attained through certain appropriate prohibitions and prescriptions. From the parents the child needs some actual protective limitations along with their support and guidance in becoming aware of socially approved standards and in learning the skills and techniques required for gratifying and acceptable behavior. In a sense the outcome of infant development is the increasing ability to bear tension.

Continued physiological maturation and expanding social experiences within the family contribute additional qualities to the child's sense of his own identity. When he begins to recognize the relationships between his parents and siblings, his egocentricity and possessiveness yield to a more precise ego differentiation. He also modifies his previous self-image of narcissistic omnipotence when he is confronted by the unique and exclusive relationship between his mother and father, as he naturally at this stage directs toward them his first diffuse and early genital tensions and his curiosity about the differences between the sexes and between children and adults. To resolve the resultant conflicting feelings of love, anger, rivalry, guilt and fear inevitably created by these universal triangular life experiences, he again needs the guidance of others. He needs adult understanding; a kindly, firm, appropriate balance of limits and permissiveness; and sound parental standards for identification in order to attain a valid acceptance of himself, — of his own biological sex, of his actual native aptitudes, and of his realistic position with his parents, siblings, peers and teachers. The adaptive capacities of the parents help the child achieve this type of identity enabling him to take some initiative and responsibility for his own behavior. The child needs parents who, first individually and somewhat differently as man and woman, and then together as husband and wife, and later as father and mother, have attained the maturity of enjoying and sharing their mutual creative responsibilities in fostering his continued growth.

The diagnostic process, therefore, must include two essential areas of investigation, each with its special characteristics but each understood more fully in its reciprocal relationship with the other. These are (1) the child himself, his basic physical and intellectual endowment and the inner biological and psychological forces and behavior patterns or ego mechanisms which emerge in the development of his own individual identity, and (2) the environment and its social forces which influence the child as he matures. In the exploration of dynamic and genetic factors, any unilateral approach precludes acurate diagnosis. Both the child and his society must be understood separately and in their interactions. The recognition of this necessity for including the family in the diagnostic process has differentiated child psychiatry from *traditional* adult psychiatry. In contrast to the adult with a more structured ego, the child is

still developing as an individual and is not only more flexible but also more vulnerable to the environmental forces around him.

The diagnosis of child pathology requires first of all the accurate delineation of those aspects of development which are primarily disturbed together with some reasonable hypotheses concerning the multiple factors that might have operated to cause the deviation. To construct a psychodynamic formulation requires a frame of reference which is based on the assumptions derived from accumulated clinical data. One basic assumption is that behavioral disabilities arise in an interpersonal milieu in connection with experiences that evoke or reactivate within the child a feeling of helplessness or vulnerability felt as an anxiety. This anxiety may be provoked by either realistic or fantasied threatening situations or by the child's actual or contemplated counter-measures directed against those situations. Its intensity, which reflects the child's valid or distorted estimate of the potential destructiveness of the threatening experience, will depend partly on the nature and intensity of the external challenge or precipitating factor and partly on the child's adaptive capacity as determined by his particular personality structure. Certain common challenges are inevitably experienced during the course of the child's growth. The degree to which they become severe threats varies with the age of the child and with the level of psycho-socio-sexual maturity that he has reeached at any given chronological age. The usual challenges of life may be experienced as severe threats by the immature child with limited ability to tolerate stress, while exposure to extraordinary environmental stress may threaten even the relatively stable child.

The universal primary anxiety connected with loss of love and protection is intensified initially or reactivated later by actual or expected abandonment or deprivation. This might occur with any separation from the parents, such as hospitalization, or with punitive threats of desertion. The common anxiety associated with mutilation and disability may become overwhelmingly great if the child is physically assaulted or threatened with any bodily harm, such as accident, disease, or even the physical injury inherent in a simple tonsillectomy or other surgical procedures. He may also be more vulnerable to this anxiety if, burdened with illogical guilt, he anticipates retaliation for his own destructive impulses. The

anxiety associated with his sense of defeat about his performance and his feeling of inferiority and disgrace about his adequacy as a person compared to his own and others' standards may also disrupt the child's adjustment. This is often true for the child who actually has some disability but it occurs also when a child imagines he is defective.

When the child fails to deal adequately with these external conflicts or environmentally-stimulated anxieties, the process of symptom formation is set in motion. He may resort to earlier behavior patterns which had once been successful in coping with previous developmental tasks. But at best this attempt is only temporarily effective. This process of symptom formation might be illustrated by excerpts from the case history of Jimmy, a greatly over-indulged child of 8, whose basic insecurity was intensified by the arrival of a new sibling. He reverted to the earlier pleasure of persistent thumb-sucking which had previously been relinquished at age 3. This method of coping with his reactivated infantile needs was incompatible with society's expectations of the older child as well as with his own internalized standards and wishes as a growing boy. Moreover, he developed anxiety and guilt over the forbidden hostility he felt in response to the environment which frustrated his infantile impulses. Jimmy first attempted to solve his various internal and external conflicts by compulsively and aggressively repeating the former self-satisfying activity, namely the thumb-sucking. But this method failed as an adequate compromise; it afforded only partial satisfaction for which his guilt, nevertheless, demanded the penalty of personal suffering, energy diffusion and social disharmony. His various tensions were reflected in marked irritability, distractibility, feelings of shame and inferiority, and social withdrawal. In Jimmy's case his continued internal conflicts as well as further parental disapproval led to another equally unsuccessful solution when, along with a diminution of the thumb-sucking, he developed a new combination of patterns manifested as a severe animal phobia. In the face of similar conflicts some children might develop anorexia or vomiting, or over-eating and biting, or demanding, possessive attitudes. In each case, the child has resorted to some compulsive repetitive pattern or to a composite unitary action derived from earlier mechanisms. Although these methods result in some dependency satisfaction through the parental inter-

est and care elicited by the disabilities, the child is distressed and maladjusted. The degree to which his energies are bound and depleted by these conflicts determines the extent to which he is blocked in his further growth.

The type of emotional or behavioral disability which results is determined by the specific configuration of ego mechanisms utilized by the particular child. It is manifested in physiological, psychological or conduct disturbances which are the clinical signs and symptoms of anxiety itself or of the child's attempts to allay the anxiety. In any case the symptom consciously or unconsciously selected is often related to specific areas of parental emotional disturbance. Although the behavioral pattern may be dissatisfying to the child and unsatisfactory to society, it does serve the child in reducing or avoiding some of his anxieties.

The child's pathological response to anxiety may represent varying degrees of ego-disintegration. He experiences the threats as a destruction of his internalized body images — either of the existence of the body as a whole, or of its internal or external organs, or of its continued functioning in an effective and acceptable manner. This breakdown of ego integration is a psychological regression and may be called a "de-differentiation", analogous to the more primitive physiological dysfunctioning in organic pathology. On both the physical and psychological levels, the organism reacts to stress with a defensive attack against the dangerous stimuli by reverting to some previously effective pattern as a starting-point for re-establishing its structure and healthy functioning. In physical healing the cellular response is helpful in attacking noxious agents and restoring the physical integrity. An analogy might be found in the response to psychological stress; earlier successful behavior patterns are reactivated as defense mechanisms for mastering anxiety and for re-integrating the appropriate functional capacity of the ego.

Diagnosis in child psychiatry must be seen as a dynamic process through which are evaluated all the growth-promoting and growth-retarding forces in the child's life as they interact to produce various conflicts and the particular modes of solving them. It is more than the classification of a child in a nosological system based on the clinical observation and description of the presenting signs and symptoms of deviant behavior. In a sense then, it consists of an

evaluation of the functioning of the child's ego, of his integrative capacity, strength and flexibility. It involves an assessment of the nature and intensity of specific anxieties including the time and setting of their onset. Child psychiatric diagnosis delineates the areas and degree of regression as well as those pathological defense mechanisms used in the regression .It identifies also the healthy ego mechanisms utilized in the past and present in adapting to the normal developmental tasks of ordinary experiences and to any unusual or critical life situations. It takes into account any unevenness in the different spheres of personality development. It encompasses the concept that the disability itself represents a strategic withdrawal to a partially regressed level for re-grouping or rallying the child's strengths and that this constructive aspect of the child's disability can be supported for his recovery. In this appraisal it is also important to weigh the ego functions against the nature and strength of the internal drives arising in the biological processes and to recognize that the effectiveness of the ego's defenses against anxiety and the efficiency of its executive mechanisms are largely determined by the intactness and healthy functioning of the total organism, especially the neuro-muscular system.

The comprehensive evaluation of the child's ego functioning takes into account the two-way nature of his relationship with society. The child himself plays an active part in the interaction with his parents and others. Certain constitutional factors may lower his inherent capacity for the effective utilization of positive life experiences. Even in infancy certain characteristics of the child, such as his motility pattern and degree of sensitivity may influence the maternal attitude. A young child's repetitive unrewarding responses to mothering efforts may foster tensions and lead to the vicious cycle of an uncomforted child and a frustrated mother trying desperately to be a good mother. On the other hand, this process may be set in motion by the mother who, in a distorted identification with her child, responds to him as a symbol of an unsettled past. Unhealthy parental attitudes arising from previous or current significant relationships or from social or cultural factors may be displaced to the child so that the parent does not realistically perceive him or his needs. The child thus threatened and deprived may react aggressively in his frustration; he may be forced to turn back to earlier self-satisfying activities. His behavioral responses

then reinforce the distorted identifications of the mother so that tensions increase, and neither mother nor child gains from their relationship the gratifications necessary for each. As an example, severe emotional disturbance in the mother may so distort her perception of early infantile needs that adequate normal symbiosis is never attained. Such children, when they do not die of intercurrent disease, are likely to show primary atypical development or mental retardation. Their behavior may represent fragmented aspects of developmental stages which have never have been fully mastered or integrated into the personality.

Basic to the understanding of parent-child interactions is the recognition that the parental capacity to meet a child's needs may vary greatly in his different phases of growth. The child's normal behavior at one stage may elicit healthy parental responses whereas at another it may reactivate the parents' immaturities around old conflicts pertinent to that level of development. In defining parental attitudes such terms as "rejecting mother" or "competitive father" are as stultifying as is the diagnostic label of "conduct disorder". Dynamic diagnosis is dependent on an accurate determination of those specific developmental areas in which a parent may be "rejecting" or "competitive". For example, a mother may satisfy completely her child's needs for oral dependency only to fail seriously, because of her own anxieties, to meet his increasing need for greater self-expression. Similarly significant is the evaluation of whether a "competitive father" is rivalrous with the dependency of his young son or with the masculine strivings of his growing son. Inadequate parental responses to the child at any level may vary from over-indulgence and the excessive permissiveness of prolonged earlier satisfactions to the overly ambitious and premature stimulation of more grown-up behavior in anticipation of a later stage in development. For normal growth the child needs to exact the appropriate satisfactions to be derived from each stage of development in order to proceed to the next. At the same time the mature gratification of the parents in helping the child at each step serves as a foundation for a continuing mutually beneficial relationship. A major aim of the diagnostic process is the understanding of the breakdown or lack of development of this healthy interaction as it gives rise to behavioral disabilities.

The diagnostic study is a dynamic process which offers new

relationships and potentially meaningful experiences to the child and his parents as they are helped to face their problems together and to reveal the various biological, psychological and social factors involved. It is based on a sound knowledge of both normal and pathological development and function and on an awareness of the continuous interaction of all the psychobiological and psychosocial forces. This understanding demands a multi-facetted approach; no unilateral study can effectively reveal the cross currents and significant forces in a total family situation. Sufficient historical data about physical, psychological and social factors; an adequate evalution of the child's current levels of physical and psychological functionings; and valid appraisals of his native physical equipment and intellectual endowment are all necessary. Therefore, the psychiatric clinics for children are staffed and structured on the basic assumption that the diagnostic process is a collaborative process utilizing the specialized methods of several professional disciplines to investigate the various diagnostic areas. In addition, the psychiatric clinics and other child diagnostic facilities take into account that a special sensitivity to the meaning of the different diagnostic areas is essential in planning comprehensive studies and in insuring their final integration. The diagnostic process for children is therefore developed through the leadership and direction of the child psychiatrist whose specialized training provides the skill and experience for carrying the ultimate responsibility of synthesizing the various diagnostic data into a comprehensive diagnosis of the child in his environment.

The separate diagnostic areas, their particular investigative procedures and their specific contributions to the total diagnostic formulation are considered in further detail in the next section of this report.

III. THE DIAGNOSTIC PROCESS

A. History and Current Setting of the Presenting Problem

1. *Referral and Application* — The term "presenting complaint" as it is known and used in general medicine and in adult psychiatry is not pertinent to child psychiatry, since the "complaint" is not made by the patient but is usually registered by an adult to whom the child's behavior presents a "problem". It is, therefore, a "presenting problem" which is brought to the psychiatric clinic by an adult, usually a parent who may be sufficiently troubled to come on his own initiative or whose application is stimulated by another person or agency.

The most significant complaints of parents are those given initially and spontaneously, even though they may not always concur precisely with those suggested by the community resource which stimulated the application. In a school referral the chief concern is apt to be around the child's academic achievement or social adjustment; in a court referral the emphasis will be on symptomatic delinquent behavior; while in a referral from a medical resource the emphasis may be on more specific neurotic or psychotic symptomatology, psychosomatic disorders or developmental deviations. This may also be true if application is made directly by the referring source, which will naturally be concerned with its own area of specialization or jurisdiction — the social agency, the school, the court, the pediatrician or family physician.

Implicit in the intake process of a child psychiatric clinic is the development and maintenance of a good working relationship with referring sources. An understanding of the way in which the clinic referral is presented to the family and of the relationship of the referring source to the family facilitates the diagnostic study.

Regardless of the source or manner of the referral, the first area of investigation is the parental attitudes toward psychiatric help. The diagnostic process actually begins with the parents' decision, voluntary or forced, to seek psychiatric help for the child. A beginning understanding of parental attitudes can be achieved by learning whether parents are actually motivated primarily by their own concern about the child or by pressures from others in the community. This includes consideration of the parents' awareness of their own involvement in the problem: whether they feel excessive guilt and self-blame or project the total responsibility on the child, on some illogical physical cause, on the school or on other physicians.

Further insights are gained concerning the parents' feelings about the child and their own capacity to participate in the diagnostic study as one begins to understand their conscious and unconscious desires and expectations from psychiatric help. Apparent readiness may hide great resistance, which may be reflected in the child's degree of accessibility in the psychiatric examination. But whether the parents reveal feelings of anxiety, self-criticism and guilt, or complete irresponsibility or hostility either to the child, the referring source or the clinic, the goal of the psychiatric clinic is to provide understanding support to enable them to express the negative reactions which might otherwise block their participation in the diagnostic process.

Time and skill devoted to this initial exploration of the presenting problem enable the parents to take the steps which will involve them and their child in the diagnostic process. All expressions of feeling and observed attitudes are grist to the diagnostic mill. This is true for the parents' reaction to clinic procedures, as well as for the way in which they tell the child about the clinic or express concern about the impact of the clinic experience on the child. The possible variations on the theme are all facets of the parents' anxieties, of their sense of failure, their hidden or manifest hostility, and their fear of being revealed through the child, as well as their concern lest the child find in his relationship with another adult the satisfactions which they presumably were unable to provide. By helping the parents interpret the clinic experience to the child and by dealing with the parents' own anxieties and misconceptions, the clinic lays the groundwork for the kind of relationship on which comprehensive diagnosis depends.

2. *Developmental History* — The specific symptoms and presenting problems which the parents describe at intake serve as a point of departure for an inquiry into the child's longitudinal development. Some organization of historical data must be kept in mind, but formal history schedules, rigidly used, may actually limit the

scope and meaningfulness of the data. In a broad sense it can be said that everything that has happened to the child is of importance in understanding the nature and significance of the present problem. Certainly his feeling about what has happened to him and the feelings and attitudes of significant adults in his life are of major importance.

The sequence in which historical data emerge and in which associations to them arise provides valuable clues to the meaning of these events to parent and child. Factual data about the mother's pregnancy and delivery can lead naturally to some discussion and understanding of the mother's concept of herself as a woman and of her attitudes about her children. Age at weaning, dentition, walking, talking, development of motor skills, toilet training and similar specific facts may be ascertained easily since many parents have such data readily available. If they are not readily available, that fact is equally important. Certainly a consideration of habit patterns — eating, sleeping, elimination, masturbation, etc. — offer not only facts but often highly charged emotional material. The investigation of how various habit patterns were acquired and dealt with often reveals parental attitudes which were significant in the child's early emotional development. The original interactions with parents and siblings should be carefully explored, including any family disruptions such as severe marital discord, separations, the birth of siblings and illness or death of relatives. Information as to the age of the child when such events took place and how they were handled both by the child and those closest to him will aid in evaluating their influence on the child's psychosocial growth.

The child's level of development is another major area of concern. His physiological maturation, sexual development and social adjustment in relation to what is expected at a given age represent the framework within which a multi-dimensional picture of the child begins to take shape. However, his present level of development cannot be evaluated without historical data about the rate, sequence and consistency of his growth, such as any unevenness in the developmental history or in the child's adaptive capacity or sudden acceleration or regression and the attendant circumstances.

The child's medical history is of major importance and should be ascertained in every case. A psychodynamic evaluation and a thorough review of the child's past and present physical health

are not mutually exclusive; they are inseparable parts of a full understanding of the child. Of particular significance is the age or developmental phase at which illness occurred and its impact on the parent-child relationship and on the child's subsequent development. As important as the known episodes of childhood illness or accidents and their sequelae is the information which can be obtained from parents or other sources about undiagnosed fevers and marked changes in behavior which may have been associated with episodes of organic illness. In the course of getting a developmental history one may also find clues to defective vision, hearing or motor coordination which can be pursued in subsequent examinations of the child.

3. *Social Setting* — The importance of information regarding a child's school experience is clear. The school history will reflect the ability of the child to separate himself from his family and establish himself as an individual in a group of his peers under an authority other than that of his parents. Information as to his grade progress, subject achievement, scholastic behavior and attitudes will be available from the school. His intelligence and general ability may have been tested formally in the school setting, in which case that information should also be obtained. Knowledge of the child's interrelationships with his peers, his teachers and those in authority is essential to an understanding of his adjustment as an individual. As part of its responsibility to the child it is essential, of course, that the clinic know the school, its auspices, policies and general level of acceptance in the community in order to evaluate the individual child's adjustment to it.

The domestic setting of the child includes not only members of his immediate family but in some instances other relatives, household employees or others living in the home. They are not ordinarily interviewed directly but since each may play a significant role in the life of the child, it is useful to know something of their personality, health, educational level and general social adjustment, as well as their attitudes toward this child and toward the difficulties for which help is being sought.

The general cultural, ethnic and economic standards of the family are valid subjects of inquiry if one is to achieve understanding of the child and the setting in which he finds himself. While the parents' report on cultural, ethnic and economic standards may be

colored by their own status needs and relationships to their environment, this too is useful information which can ultimately be checked against the clinic's knowledge of the community and, in the older child, against the patient's activities in recreational, religious and other groups.

In a child psychiatric clinic, it is usually the psychiatric social worker who implements psychiatric policy at intake and in many of the clinics continuing relationships with referring agencies and other resources in the community. The initial work with parents to interpret the clinic's service, to obtain a developmental and social history, to collect other pertinent data, possibly through home or school visits as indicated, and to schedule the physical, psychiatric and psychological examinations of the child have traditionally been assigned as the psychiatric social worker's function in the diagnostic process. In many clinics today, the psychiatrist interviews the parents at some point during the diagnostic process. He may participate in getting the history, especially developmental and medical data, or in helping the parents learn how to prepare the child for his initial psychiatric visit and other examinations. More often he may be the staff member who interprets to the parents the clinic's findings and recommendations.

As the clinic's representative to referring sources and to parents at a point where they are particularly sensitive and vulnerable, the psychiatric social worker must exercise professional skill and judgment in making available the services of the clinic. The manner in which this is done will influence, either positively or negatively, the community's understanding and use of the clinic, and the parents' readiness to involve themselves and their child in the diagnostic and treatment process.

B. The Physical Examination

As a basic aspect of the diagnostic process, the appraisal of the physical reality of the child includes an evaluation of data both from the medical history and from the general physical examination and special studies. Although usually the physical studies have already been done when the child is referred for psychiatric diagnosis, the child psychiatrist must be concerned with the adequacy, interpretation and integration of these previous studies. He must decide whether further studies would be helpful or in some in-

stances even of crucial importance. This is especially true when physicians who over-emphasize emotional factors refer children without having carefully assessed the child's somatic status. When children are referred from non-medical sources, it is the responsibility of the child psychiatrist to plan for reliable physical examination. In clinics or in private practice child psychiatrists should have good working arrangements for obtaining adequate physical studies by competent physicians. Although it is ordinarily less desirable for the child psychiatrist himself to do the physical examination, he may do so prior to beginning psychotherapy with the child, provided he is competent and is comfortable in doing the examination. Much confusion is avoided for both the psychiatrist and the child if such an examination is done in the usual appropriately-equipped examining room, either within or outside the psychiatric facility, rather than in some makeshift setting. However, regardless of the setting or the examiner, adequate physical evaluations are an integral part of the clinical practice of child psychiatry.

Certain information about the child's past and present medical status, including developmental sequences, is required in order to understand the impact that physical factors have had on his personality and on the presenting problem. It is important to assay the effect upon the child of any previous physical procedures or hospital experiences. Sensitive history taking and adequate medical studies involve much more than the detection or elimination of organic disease; they aid in determining the relative importance of physical disturbance in the genesis of the child's symptoms. The physical examination provides an evaluation of the adequacy of the somatic structures used by the child in coping with daily experiences and some understanding of the influence of disease, injury, congenital defect and developmental difference on this basic equipment. Relatively minor deviations in a child's basic somatic equipment such as mild visual or auditory disturbances are no less significant than gross physical handicaps and neurological disorders in their potential effect on the child's adaptive capacities. Disorders of perception and poor motor coordination may seriously interfere with the child's ability to meet educational and social challenges. Such disorders may occur in a variety of psychiatric disturbances, including brain injury.

The diagnosis of minimal disturbances of central nervous sys-

tem function may be very difficult. Careful observation of the child in his activities, with special emphasis on his neurophysiological patterns, is more significant diagnostically than the more formal and classical neurological examination. Inadequate neurological appraisal is often related to a lack of awareness of neurophysiological maturational patterns and the effect on them of emotional interplay and experience. A careful history with particular attention to events which might result in brain damage is essential. The psychological test battery may also give valuable clues to the presence of diffuse brain injury. Electroencephalography may be helpful but in its present state of development may confuse the issue unless there is other clinical evidence to confirm the suspicion of central nervous system disorder.

Inspection alone may serve to point up certain physical or physiological developmental differences which are important in some children. Youngsters who reach their physiological puberty at an early, though still normal age, may have a physiologically determined pubertal reaction which is crucial in the behavioral decompensation. The late maturing of some children, with their feelings of difference from their group, may also contribute to their problems.

In the neurophysiological evaluation it is also essential to learn if the child has been receiving drugs or any other medications for the treatment of already existing behavioral disability or some organic illness. Certain drugs may alter the basic behavior patterns of the child, leading at times to depression and hypo-activity or to overactivity, irritability, excitement and even hallucinations. At present such drugs include the "tranquillizers", antihistamines, and endocrine preparations as well as the barbiturates.

The physical assessment of the child calls for mature clinical judgment on the part of the child psychiatrist. He should decide not only whether additional studies are necessary, but also whether they will add to the child's and his family's anxieties and only lead to more confusion. Like the thoughtful physician in all specialties he should determine when further diagnostic procedures are actually justified or merely reflect his own illogical concern. When physical studies are indicated, the child psychiatrist should provide adequate psychological preparation for both the child and his parents. On the other hand, he must avoid unwarranted repetitive examinations under pressures from parents who defensively wish to ascribe some organic etiology to psychogenic problems. At such times it may be imperative for the child psychiatrist to indicate confidently and tactfully his disagreement with the family's "diagnosis." The child psychiatrist's help to the parents may include consultations with the referring physician, or if the child was referred by a non-medical agency, it involves referral to and collaboration with a pediatrician or other medical specialist.

For most effective diagnostic work in a psychiatric clinic the other members of the clinic team should be identified with the nature of the physician's medical function. The medical responsibilities of the child psychiatrist include the collection and synthesis of medical information into a sound appraisal of the child's physical reality, the interpretation of the physical findings to professional colleagues and parents, and their integration into the total evaluation of all the accumulated diagnostic data. As a physician the child psychiatrist through his basic medical training and experience brings to the diagnostic process valuable knowledge about the physical aspects of children's psychiatric disabilities such as the sequelae of infectious disease and about many other interactions between physiological and emotional forces.

C. The Psychological Examination

The psychological examination serves as an aid to the evaluation of the limitations and assets of children who are referred for psychiatric study. Testing is particularly indicated when there are questions involving learning difficulties, mental retardation, the possibility of brain injury, or the existence of psychosis. It has the additional function of helping to obtain a general picture of the child's problem areas and intra-psychic dynamics and occasionally that of evaluating the effects of treatment. Some of the controversy concerning the use of tests in this latter role hinges on the fact that they may be given a large share of the diagnostic and prognostic load without the clinical checks and validation of their findings that a more comprehensive evaluation of diagnosis and treatment can offer. However, whether the psychological examination is used selectively or routinely, it is important to bear in mind certain basic questions, such as: What does the experience of being tested mean to the child? When should children not be

tested? How is the child prepared for psychological examination? What do these tests generally measure? What is the role of the psychologist as tester and interpreter? How meaningful are the results? How can the results of testing be put to the best use in helping the child? What is their relation to the psychiatric examination of the child?

The Tests — In most clinics, three types of tests are generally used: intelligence tests, achievement tests and projective tests; and occasionally, measures of aptitude and interest. The Stanford-Binet and the Wechsler Intelligence Scale for Children, and the Wechsler Adult Scale (for adolescents) are most frequently given. All have a high degree of validity when used with children of school age and older. The Binet Test is available for pre-school children down to the age of two, and other tests, such as the Psyche Cattell Infant Tests, the Gesell Scale of Development and the Merrill-Palmer Scales have been devised for infants and pre-school children. The reliability of infants' and young children's tests is comparatively poor in and of themselves exclusive of other studies of the child. In general, it can be said that a high score has more significance and validity than a low score. These tests are often helpful, however, in making gross distinctions between very bright and very dull intelligences. The reliability for prediction of any intelligence test score for a child under the age of 4 or 5 is open to question.

Although performance on an intelligence test is certainly vulnerable to anxiety and emotional upset, the intelligence test gives a better picture than projective tests of the child's assets and of what he can do best. This is true because the intelligence test is structured and because, by the time a child is of school age, the procedure of tapping his knowledge and intellectual functioning is somewhat familiar to him. Unless he is undergoing acute anxiety about the testing situation, in which case he should not be tested, the intelligence test performance yields the more valid insights into the child's capabilities and potentialities, be they meager or abundant.

Achievement tests measure the benefits the child has derived from his educational endeavors. Often the lack of correlation between educational achievement and mental ability uncovers the nature of general learning problems or specific ones such as in reading or arithmetic.

Projective tests have in common the presentation of relatively unstructured material to the child so that his responses to the test material are more of a function of his subjective reactions and his internal dynamics than of the test material. Nonetheless, projective tests differ in the degree of the structuring they present, and this difference is important in evaluating test results. Children differ in their ability to tolerate lack of structure, but in general, lack of structure and familiarity tend to arouse anxiety and hostility. Many responses to projective tests are a reflection of the child's conflicts or his defenses against them. Moreover, projective tests permit responses which are of a more primitive and impulse-ridden nature than responses to more structured tasks. Thus, projective tests are prone to stress the conflicts within the child but do not always indicate the clinical significance of the apparent psychopathology. This does not mean that such assets as creativity and ego-strength are not tapped by these tests, but care must be used to avoid overestimating the degree of psychopathology.

Among the projective tests, the Rorschach Ink-Blot Test is the most unstructured and the one most likely to reveal the nuclear conflicts, basic anxieties, and the level of emotional maturation. However, the Rorschach scoring categories do provide some insight into personality functioning inasmuch as the sharpness of reality testing, the nature of the defenses, the degree of anxiety and capacity for emotional control and inner life are among the many aspects of personality structure which can be evaluated. Tests, like the Thematic Apperception Test, the Children's Apperception Test, and the Michigan Picture Test, where the child is asked to tell stories in response to pictures, are more structured, apparently reveal less of the child's instinctual conflicts than the Rorschach Test, and often give a better balanced picture of the child's ego weaknesses and strengths. These picture-story methods focus on the child's defenses or ways of handling interpersonal and social situations; they reveal what he perceives as being the major internal and external forces acting on him and his methods of meeting these needs and forces. The Draw-A-Person Test which is considered a reflection of the child's body-image gives some insight into the child's self-image.

The very nature of the projective tests is in accord with their relative lack of reliability for the pre-school child as compared to

the school-age child whose personality is more structured. The different facets of personality which these projective measures tap and the different degrees of pathology they measure point to the need for a battery of tests in order to obtain a well-rounded personality picture. Thus, an intelligence test and a variety of projective tests are necessary to arrive at a useful personality description.

The test battery becomes important, too, in attempting to evaluate brain injury in children. There is no single typical pattern of responses in brain damaged children — usually the psychologist has to make inferences from his test data as to whether brain injury might be present. He is best equipped to make these inferences if he has a backlog of experience and if he has a variety of samples of the child's test behavior. The Binet Test may provide some of this information if there are specific impairments in visual-motor coordination, memory, or certain kinds of abstract tasks. The Bender-Gestalt, a test involving the copying of geometric figures, provides clues when the organization of these figures and their forms are destroyed when the child copies them. Organic brain impairment is often reflected on the Rorschach Test in poorly integrated responses of poor form quality, in an inability to handle color, or in the repetition of certain responses. None of these test signs by itself is a positive indicator, and, in fact, diagnosis of brain injury cannot be made on the basis of the tests alone. Nevertheless, a skilled psychologist if provided with sufficient data, can often pick up enough indications from a battery of psychological tests to suggests the possibility of brain damage.

The validity and meaningfulness of projective test results are very dependent on the skill, the experience and the personality of the psychologist. This, of course, is true to some degree of all tests, but takes on more importance both in the administration and interpretation of projective tests. Often, much of what the patient does on projective tests is a function of the personality of the psychologist and the kind of relationship that has been set up between the child and the tester. This does not invalidate the test results if the tester is sensitive to these effects. Test interpretation is enhanced by this sensitivity on the part of the examiner, but when the sensitivity is lacking, test reports may be distorted.

Contra-Indications for Testing — The decision as to whether

a child should or should not be tested depends essentially on two factors: the degree of emotional trauma involved for him and the amount of meaningful information one can glean from his test performance. The first, of course, is the more important. A test is never so important that a child should have to undergo severe anxiety or panic because of it. Sometimes this can be ascertained beforehand with the information one has concerning the child's typical reaction to tests, new situations and new people. The psychologist must be sensitive to signs that might indicate that too much strain is being placed on the child and frequently testing may have to be postponed until treatment is well under way. A child should not be subjected to an over-fatiguing experience, and testing may have to be stopped to meet the child's needs. Young children, especially, cannot be kept for overly-long periods. Negativistic children, acting-out children, the very distractible and very disturbed are not good subjects for valid testing. Sometimes the skill of the tester can overcome some of these drawbacks, or testing can often be accomplished at a later date. Frequently a good psychologist can obtain bits of information concerning the child's intellectual functioning and typical defensive patterns from the fragmentary testing he can accomplish with a disturbed or resistive child.

If psychological examinations are to fulfill their purpose, they should be of some assistance to the child in helping him to meet his problems. Psychological examinations are not ends in themselves, but are aids to the child, his parents, and the clinic team in their endeavors to find ways and means of resolving difficulties. Most frequently test results are used by the psychiatrist and social worker as another source of information to be used as a guide in dealing with parents and child. The information may corroborate what is already known or add new information. In any event, its purpose remains that of helping to answer the question of "how can we best help the child?"

D. The Psychiatric Examination

The child psychiatrist brings to the diagnostic process his medical and psychiatric knowledge of the whole spectrum of human behavior whereby he sees personality development as a continuum from infancy through childhood, adolescence and adulthood. He

uses his appreciation of what is expected of and appropriate for boys and girls of varying ages and social settings. He is aware that the mere collection of biographic and psychodynamic detail does not yield an understanding of a particular symptomatology or of specific psychopathology.

Before he sees the child, the psychiatrist has interviewed the parents or familiarized himself with the information (nature and history of the problem, the child's developmental history, the emotional climate of the home, etc.) already obtained by other professional colleagues. This briefing provides him with working hypotheses about the child's difficulties and some expectation of what he will find in his diagnostic interviews. It is his task to create an emotional setting within which he and the child may interact so that the youngster can express his needs and concerns and the psychiatrist, in his turn, perceives how the child relates to an adult in a new and stressful situation. At the same time, he maintains a certain distance, seeking to give the child a sense of "having room to move around in". Through his disciplined awareness of the child's anxiety as well as the emotional level at which he functions, the psychiatrist provides understanding and an appropriate realistic responsiveness. Within the framework of this relationship he can observe and appraise the child's behavior patterns which reflect both his feelings and his adaptive capacities. These can then be evaluated in terms of the child's expected emotional, intellectual and physical maturity and in light of the pertinent data from the personal history.

The examination of the child really begins in the waiting room, where the psychiatrist meets and briefly welcomes the child and his parents, utilizing this opportunity to note the interaction between parents and child and their anticipatory attitudes about the coming session. He can then observe the child's physical appearance and note any striking resemblances or lack of them to the parents. The ease or difficulty with which the child can separate from his parents to go with the physician to the office is often extremely revealing of both the parent-child relationship and the child's degree of differentiation from his mother and father. The child or the parents may suffer from marked separation anxiety, and it may be well in that case to allow all of them to go to the interviewing room for at least a few minutes. If the child and

parents are helped to tolerate their anxiety, this obvious respect for their separation fears will prove an important step in their being able to overcome them.

It is desirable that the interviewing room be set up to provide the child with a reasonable balance of freedom and protection and to offer simple play materials appropriate to his age, affording both creative and aggressive expression. Physical examining rooms or luxurious adult offices rarely afford an appropriate setting for a psychiatric session with a young child. He should not be expected to sit quietly in a chair the entire time, and he may be quite reassured to have the bathroom pointed out to him on the way to the office. As the child goes along with the psychiatrist some spontaneous comments about reality matters such as the trip to the clinic or office, the child's school or an incident in the waiting room may help to allay his anxiety about the separation from his parents and facilitate his perception of the psychiatrist as a responsive human being.

As the two settle down in the office the psychiatrist often finds it helpful in establishing a mutual understanding to inquire about the child's ideas of the reasons for his visit. Even more important will be the child's feelings about the visit, even though he may not be able to express them freely at this time. Almost all children who come to a clinic require some clarification of the kind of place it is, the troubles children may have that bring them there and the roles of the different persons he and his parents see. Many children fear that the "doctor will give them needles or medicine", and it is worthwhile for the psychiatrist to spend a few minutes talking of the kind of doctor he is, and of the ways in which he can help the child. The precise technique of the initial as well as the later stages of the psychiatric evaluation of the child will naturally vary with the individual, his age, and the nature of his difficulties, as well as with the personality and skill of the psychiatrist, and cannot be particularized in this brief report.

Fairly early in the first interview a child should receive some orientation about the likely duration of the session and the number of such sessions and about other procedures as the psychological testing or neurological examination. One cannot assume that any child will automatically trust an adult who is strange to him, and some children who come to a clinic feel that they have many rea-

sons for mistrusting adults in general. The child patient may expect and fear that all he does and says will be reported to his parents and the psychiatrist should make it clear that if he does talk with them, he will tell the child about the purpose and nature of their conversation.

Except with the very young or severely disturbed child, early discussion of his home, the members of his family, his friends or interests will often facilitate a productive relationship between the child and the psychiatrist and will give the latter some insight into the areas of the child's life which are gratifying as well as those in which he is experiencing difficulty. The way in which he talks of himself and his life may reveal his anxieties, fears and conflicts as well as his modes of dealing with them. Strong resistances against facing his feelings and problems and against change may be clearly reflected in such an interchange.

Play activities suitable for his age and interest can be suggested to foster the interchange and to elucidate further those areas of conflict which are unconscious to him and his methods of protecting himself against becoming aware of them. His capacity to utilize modes of symbolic communication, his expression of fantasy preoccupation and the ways in which he involves the psychiatrist in his play are important clues in evaluating his conflicts, defenses and capacity to change. Whether he asks to play or begins to play spontaneously, as well as his selection of play materials, whether drawing, painting, writing stories, modeling clay or play with toy soldiers, should be noted. Play activities provide an opportunity for participation of the psychiatrist if the child wishes it.

While the nature of the participation of the psychiatrist in the diagnostic sessions with the child is admittedly difficult to define, the phrase, "receptive participant", expresses as well as any the appropriate attitude in which the psychiatrist lets the child take the lead while he interacts responsively with his young patient. The diagnostician who leaves all initiative to an uncertain, uneasy child may increase his patient's anxiety to an undesirable degree. On the other hand, one who presents his young patient with set play situations and stereotyped questions may fail to elicit nuances of reaction and spontaneous behavior which contain important clues to the child's anxieties or to his defensive operations. The fact that a psychiatrist is carrying out a diagnostic study and may see

the child but a few times makes it important that he follow certain technical limitations. The number of diagnostic sessions may vary from one to five or six. One interview may give an initial impression but usually three or four at weekly intervals provide the most favorable opportunity for observation of the child and are less likely to provoke an intense relationship difficult for the child to give up, than the maximum of five or six. It is usually possible to achieve a working appraisal during the diagnostic study which is at the same time a constructive and gratifying experience for the young patient. Above all the psychiatrist seeks to avoid mobilizing excessive anxiety or guilt feelings with which the child may have no help in the immediate future.

In these interviews the psychiatrist's attitude should facilitate the child's perception of him as an interested, responsible adult whose greater size and strength will be used willingly in the child's best interests, if necessary, by actively controlling the situation when the child's impulses and anxieties get out of bounds. Precisely because the child's visits may be limited in number, his defenses should be respected and any suggestion of seduction into forbidden activity avoided. It may be particularly important to limit the child's destructive or regressive behavior during the sessions and it is rarely necessary for information purposes, nor advantageous to the patient to permit acting out behavior to go unchecked. How the child responds to such limitation is in itself a diagnostic clue. The psychiatrist may also need to protect the child by guarding him from activities which will bring punishment and disapproval from the parents.

Usually it is well for the psychiatrist to bring up in due time the parents' reasons for the visits if the child has not discussed them. If it is obvious that the topic is highly charged, that the child is too ashamed or frightened to talk of his bed-wetting or fire-setting for example, it may be preferable not to press him for details since the relationship may be a brief one. However, total silence from the psychiatrist concerning the child's problem is rarely reassuring to him and may only serve to reinforce the denials which the child and perhaps his family use to cope with his behavior.

The child may change considerably in his behavior, mood and relationship to the psychiatrist during the diagnostic study.

However, unless the psychiatrist has forced his own impress upon the sessions, the three or four interviews with the child will display a certain continuity, with consistent themes and elaborations, characteristic expressions of anxiety and ways of handling it. A sense of the child's style should emerge, a sketch of the main outlines of his personality, the nature of his problems and his habitual modes of dealing with them.

E. The Diagnostic Formulation

From the diagnostic examinations described above an initial understanding of the child's problem gradually emerges. Each individual examiner arrives at some tentative hypothesis based on the data obtained from his specialized observations and studies which he evaluates within the framework of the knowledge of his own discipline. From his own point of view he collects and objectively describes his findings, summarizes them into generalizations and sifts out any inconsistencies. Within the structure of his theoretical concepts, he searches for correlations between the child's problems and his clinical findings, and he makes some speculations concerning dynamic and causal factors. Within each investigative area this synthesis of the diagnostic material becomes an important though incomplete aspect of the diagnostic thinking.

The comprehensive diagnosis of the total child-in-his-environment involves the integration of the various syntheses achieved by the separate examiners. It consists of accumulating all the clinical evidence and weighing the multiple factors against each other. Valid findings complement and corroborate each other and fit together like the parts of a puzzle into the outlines of a meaningful whole picture. However, any discrepancies and conflicting evidence point to a need for delineating more precisely the areas in which they occur and for enlarging the dynamic understanding either through further studies or in an on-going diagnostic-treatment process.

The initial diagnostic formulation is derived from this total diagnostic process. It serves a valuable purpose although it yields only incomplete insights rather than final answers. Its aim is to provide a sound working diagnosis leading to a valid prognosis and a practical course of action in dealing with the presenting problem.

The diagnostic formulation is achieved in the psychiatric clinic through the collaborative efforts of the child psychiatrist and other medical and non-medical professional personnel. In other settings the psychiatrist may work with fewer colleagues, or in private practice may work alone in gathering and evaluating data. Whatever the setting, the nature, scope and purpose of the diagnostic study remain the same. In traditional clinic practice, the formulation of the diagnosis is facilitated by the procedure of having a diagnostic conference following the completion of the several examinations. Each professional worker summarizes the strengths and weaknesses of the child and his environment as they have been discovered and substantiated in the course of his investigation. On the basis of his knowledge and experience each also presents for further exploration his own impressions for which the evidence is still inconclusive as well as any areas about which no information is available. Thus, each examiner contributes to the understanding of the multiple physical, psychological and social aspects of the problem. This understanding is then summarized into a comprehensive clinical-dynamic-genetic diagnosis, which is much more than the mere descriptive labelling of clinical signs and symptoms.

Nosological classifications, which in themselves are incomplete, are only the beginning of the diagnostic formulation. Nevertheless, as convenient clinical shorthand they cannot be ignored since they have some place in the development of theoretical concepts and in the establishment of psychiatric treatment services. The diagnosis of a clinical entity such as conversion hysteria, schizophrenia or a post-encephalitic syndrome is not only helpful in determining the immediate practical management of the patient but is essential for statistical purposes. When it is based on a thorough knowledge of general and childhood psychopathology, it may also afford significant leads for investigating pertinent dynamic-genetic factors. However, care must be exercised in using these clinical classifications of children's disabilities because sometimes parents, physicians and community agencies misunderstand and misuse such labels to the detriment of the child. Nosological classifications actually label only the pathology and do not include the child's and his family's assets. Whenever possible a clinical diagnosis should be made, but with children in a developmental state, such classification is often difficult since the clinical entities are not clearly defined.

This Committee believes that further work on the delineation of clinical classifications related to developmental stages in childhood and to the interaction of the child and his environment is an essential step in the growing field of child psychiatry.

Diagnosis is first a clinical-dynamic evaluation or a current cross-sectional formulation of the presenting problem in its total context. Such understanding includes an assessment of the area and degree of the disability, of the environmental stresses, of the strengths of the child and his family, and of the specific ego patterns used in current relationships with others, including the clinic staff. It takes into account the readiness of both the child and his parents for help. The interplay of the child and his parents with the clinic staff includes not only certain realistic aspects of the situation but also some illogical displacements from current and past significant relationships. These transference attitudes are reviewed in the light of and correlated with historical data concerning emotional responses to former key people and events, including reactive patterns to developmental experiences. This leads to a second important aspect of total diagnosis, the reconstruction of a longitudinal or dynamic-genetic diagnosis. It is a formulation of the interplay of the multiple sources of conflict and anxiety as they have arisen in the past throughout the entire course of development. The dynamic diagnosis is a clarification of what the patient does and how he interacts with his environment; the genetic diagnosis is an interpretation of why he responds as he does and where and how his problems originated. Without such dynamic-genetic understanding sound treatment plans cannot be established, and the staff of a psychiatric treatment facility cannot function as a cohesive unit in its service to the child and his parents.

Implicit in the clinic's approach to diagnosis is the conviction of the importance of the involvement of the parents from the very beginning of the dynamic diagnostic process. For future help to the child and parents it is desirable that the family and the clinical staff arrive at the diagnostic summary period with sufficient mutual understanding to make it likely that the family is ready and able to continue a relationship with the clinic, if treatment is recommended.

In this early stage, such comprehensive diagnostic formulation is only an initial, partial dynamic evaluation, which is, nevertheless, necessary for planning treatment. It may later be revised or reinforced and elaborated since diagnostic thinking continues throughout the whole course of treatment. The diagnostic process provides experiences for the child and his parents which often constitute a sound beginning for treatment. In itself it has therapeutic value for many families, and this potential is more apt to be realized when the diagnostic procedures are carried out in a treatment setting.

IV. TREATMENT GOALS, PLANS AND PROGNOSIS

Comprehensive treatment evolves directly from the diagnostic formulation which gives purpose and direction to therapeutic goals, prognostic speculations, and appropriate plans to ameliorate or correct the child's emotional disability. The plan will vary depending on the child's needs, the family relationships and potentialities as well as on the resources within the community and clinic. The choice of professional personnel to carry out the treatment plan requires consideration of the training, experience, skills and personality of the available staff members.

Treatment goals and methods are planned individually for each child and his family according to the specific dynamic-genetic diagnosis. Since the nature of the symptoms alone does not reflect the severity of the underlying disturbances or the degree to which the child's development is blocked, this procedure is followed whether the symptoms are minimal or marked and regardless of the frequency of similar presenting problems in other children. For example, the need for an individual approach is clearly understood when the child psychiatrist is confronted with planning treatment for children who present the rather common symptom of enuresis. The treatment plan for the child whose lifetime enuresis is primarily associated with severe mental deficiency or neurological disease will be very different from that which is recommended for the persistently enuretic child who manifests no significant internal disorder but lives in a large sub-standard family of several bed-wetters where little if any stimulation or assistance is given the child for learning appropriate habits of cleanliness. Treatment will differ too for the child who was previously toilet-trained, perhaps by complying prematurely to rigid demands, and who later regressed to bed-wetting when his basic anxieties were reactivated by insurmountable life situations.

In each instance the attempt is made to devise specific treat-

ment measures. However, only too frequently the treatment plan of choice cannot be put into effect because of limited community and clinic resources. In this event an alternative plan with a more limited goal may have to be followed. This Committee believes that an ideal plan of treatment should be constructed and recorded whenever possible along with the reasons which necessitate the adoption of a less-desirable plan of action. This procedure would foster the development of diagnostic skills, sound judgment and flexibility in planning treatment. In addition it would provide valuable documentary data for evaluating existing services and for demonstrating the need for improved child care and therapeutic facilities.

The individual treatment plan may include a variety of direct and indirect methods. Occasionally only one type is indicated, centering primarily on physical, social or psychological factors. For example, the treatment for one child with a learning problem is the direct medical treatment of his visual defect; for another it is direct work with the child in remedial reading; while for a third it consists of an indirect environmental approach by effecting an appropriate grade placement in school. More often the plan of action involves both indirect and direct procedures and deals with multiple inter-related facets of the child's personality and his environment. For a mentally defective child, the plan may encompass direct medical treatment, specialized education with vocational training while living at home or in institutional placement, and perhaps psychotherapy to help the child resolve some of his inevitable internal conflicts. It includes work with the parents, often social casework services, to help them face both the negative and positive factors in the situation and to prepare them to take the next steps constructively.

Indirect treatment of the child solely through casework or psychiatric treatment for the parents is frequently the preferred plan when the child's anxiety has not yet been internalized and when his problem occurs transitionally in response to the parents' inappropriate attitudes and child care methods. Such a reactive disability may represent prolonged or exaggerated conflicts specific to a particular developmental stage which the child has difficulty in resolving because of the parents' illogical expectations. For these children, treatment is geared to helping the significant parent or

both parents to understand the developmental problem and to handle it more constructively. This method is often effective in dealing with the problems of the very young child, but a hopeful prognosis is predicated on an accurate evaluation of the parents' capacity to modify their interactions with the child.

When a child has developed marked intra-psychic conflicts and emotional disabilities which cannot be alleviated by parental treatment alone or by some other environmental modification, the treatment plan includes direct psychotherapy for the child. Within a therapeutic relationship with an interested, understanding, relatively mature adult, a corrective emotional experience is provided. Depending on the nature and degree of the child's psychopathology and strengths, varying intensities of therapeutic work in particular areas of conflict might be indicated. The specific psychotherapeutic methods may range from supportive relationship therapy alone to several kinds and levels of dynamic insight therapy, including psychoanalytic child psychotherapy and child psychoanalysis. They may be planned to emphasize one or more aspects of the treatment process: the abreaction of feeling while the child is revealing directly or symbolically his conflicts and defenses; the working through of inner conflicts within the relationship by the development of some insight through the clarification of dynamic patterns and the interpretation of genetic factors; and the strengthening of ego functions through re-education and through the ultimate resolution of illogical attitudes in the therapeutic relationship.

Regardless of its level or intensity, effective psychotherapy for the child requires the participation of the parent or parents. For example, the ultimate prognosis for achieving continued masculine development in a passive inhibited boy depends largely upon the concomitant help to the parents in overcoming their restrictive infantalizing attitudes and faulty identifications as the child himself is helped to become more active. This collaborative parent-child treatment, which is frequently the plan of choice, constitutes a unique contribution of the American child psychiatric clinic. In many clinics, work with parents has traditionally been the function of the psychiatric social worker. The prognosis in collaborative treatment is largely determined by the flexibility and strength of the several family members who are involved in the therapeutic plan.

It also depends on the skills of the psychiatrists, psychiatric social workers, and clinical psychologists and on available time and opportunity for them to work together closely in integrating their cumulative insights and in developing further their methods and goals in the continuous diagnostic-treatment process.

Occasionally the parents' active participation in a collaborative treatment process is contra-indicated because of their lack of motivation and capacity to change or because their modification might be detrimental to the child's improvement or the family's welfare. This occurs when parental patterns protect them from psychoses by maintaining some equilibrium, albeit pathological, within the family. In these instances, direct psychotherapy with the child alone has a very poor prognosis; and even with attempts to foster healthier identifications and improved adaptations outside the family, direct psychotherapy still demands an unreasonable degree of self-sufficiency on the part of the child. Moreover, significant improvement by the child might seriously disrupt the tenuous family balance. Although older adolescents can occasionally be helped without the continued active participation of the parents this is rarely if ever true for the younger child, whose further development still depends largely on his parents. Even with adolescents in the less seriously disturbed families, parental interest and support and at least their cooperation and agreement to the treatment plan for the child are required.

When intensely disturbed family relationships prevent the child and parents from engaging constructively in a collaborative treatment process, the child's separation from the family is sometimes recommended as a temporary measure to facilitate treatment opportunities for both the child and his parents. As a necessary adjunct to psychotherapy the child may require a corrective living experience in the therapeutic milieu of an inpatient psychiatric treatment facility. Some parents, relieved of the stress of the everyday care of the disturbed child, have greater energies and motivation to face their own involvements and to modify their responses to the child. Inpatient psychiatric treatment for the child with actively participating parents facilitates the development of sound parent-child collaborative treatment. The goal is the child's return to his own home in a happier, more stable family relationship which will foster his continued emotional growth.

When parents lack the capacity or motivation for participation, whether the child is treated on an inpatient or outpatient basis, the child's placement outside the home might be recommended in order to offer the child a more supportive environment and the opportunity to benefit from such other treatment measures as might be indicated. The placement recommendation should be based on the child's particular needs. It should indicate whether a foster home, boarding home, resident school, a special type of inpatient psychiatric unit or other institution is desirable. Only too frequently a specific plan cannot be carried out because of the dearth of appropriate facilities. Often the parents are unable to accept separation from the child. At all times, collaborative work in preparing the child and parents for placement is the clinic's responsibility in the treatment plan in cooperation with appropriate community agencies. Sometimes when placement is more desirable but cannot be effected, the diagnostic formulation offers some reasonable basis for trying the traditional methods of outpatient collaborative treatment. At other times it is folly to proceed with treatment while the child remains in the home. In extreme situations when the child's welfare demands placement outside the home it may be necessary to bring the child's plight to the attention of the official child welfare agency or court.

Other social modifications are frequently recommended as major or adjunctive aspects of a treatment plan. Diagnostic study may reveal that the child's disability represents a direct reaction to parental anxieties associated with difficult experiences such as financial insecurity or serious family illness. In such cases the treatment plan is geared to the correction of the family problem by referral to appropriate community resources. At other times children themselves are helped through environmental modification with or without direct psychotherapy. Community recreational facilities, organized club activities and day nurseries offer normal group experience and opportunity for developing skills and healthy behavior patterns. Special educational facilities are sometimes indicated. Teachers serve as significant adult figures for the child. Moreover their observations of child behavior can be helpful to the psychiatric facility which in turn can offer them support and understanding of the child's problems.

A vital step in treatment planning is the discussion with the

parents of what they and the clinic have learned during the diagnostic process. It includes an appropriate explanation of the clinical findings and recommendations as well as a review of the understanding which the parents have gained about themselves, especially in relation to their children. Insights acquired by the parents in the initial diagnostic study often have a significant therapeutic potential. However, many parents may require further help in clarifying their motivations or in overcoming their resistances to the recommended treatment plan. Treatment planning also includes the appropriate interpretation of the diagnostic formulation and recommendations to the referring person or agency. This communication is a basic medical responsibility.

In conclusion, while this report has described the diagnostic process in a psychiatric clinic for children, the Committee wishes to re-emphasize that the same careful consideration of the child and his setting is indispensable wherever child psychiatry is practiced. The effectiveness of any treatment plan recommended for an emotionally disabled child evolves from a sound diagnostic appraisal.

SUGGESTED REFERENCES

The following references have been chosen as examples of the excellent body of literature available on topics pertinent to this report. The Committee thinks that these selections should be helpful in illustrating the broad range of material which is relevant to the understanding of the diagnostic process in child psychiatry.

Ackerman, N. W. "Psychiatric Disorders in Children, Diagnosis and Etiology in Our Time". CURRENT PROBLEMS IN PSYCHIATRIC DIAGNOSIS. Paul H. Hoch and Joseph Zubin, eds. Grune and Stratton, 1953.

———— and Behrens, Marjorie H. "Child and Family Psychopathy: Problems of Correlation". PSYCHOPATHOLOGY OF CHILDHOOD. Paul H. Hoch and Joseph Zubin, eds. pp. 177-196. Grune and Stratton, 1955.

———— "Interlocking Pathology in Family Relationships". CHANGING CONCEPTS IN PSYCHOANALYTIC MEDICINE. S. Rado and G. E. Daniels, eds. Grune and Stratton, 1956.

Allen, Frederick H. PSYCHOTHERAPY WITH CHILDREN. Norton, 1942.

Benda, C. E. et al. "The Inadequacy of Present-Day Concepts of Mental Deficiency and Mental Illness in Child Psychiatry". *Am. J. Psychiat.*, 107:721-729, 1951.

Bender, Lauretta. CHILD PSYCHIATRIC TECHNIQUES. C. C. Thomas, 1952.

Benedek, Therese. "The Psychosomatic Implications of the Primary Unit: Mother-Child". *Am. J. Ortho.* XIX, 642, 1949.

Doll, E. A. "The Feeble-Minded Child". Ch. 17, MANUAL OF CHILD PSYCHOLOGY. Leonard Carmichael, ed. John Wiley & Sons, Inc., 1946.

Erikson, Erik H. CHILDHOOD AND SOCIETY. W. W. Norton, 1950.

Freud, Sigmund. THE EGO AND THE ID. Hogarth Press, 1927.

———— "Three Contributions to the Theory of Sex". THE BASIC WRITINGS OF SIGMUND FREUD. pp. 553-629. Modern Library, 1938.

———— INHIBITIONS, SYMPTOMS AND ANXIETY. Hogarth Press, 1936.

Freud, Anna. THE EGO AND MECHANISMS OF DEFENSE. Hogarth Press, 1937.

———— THE PSYCHOANALYTICAL TREATMENT OF CHILDREN. Imago, 1946.

———— et al (ed.). THE PSYCHOANALYTIC STUDY OF THE CHILD. Vols. I-XI. International University Press, 1945-1956.

Gardner, George (ed.). CASE STUDIES IN CHILDHOOD EMOTIONAL DISABILITES. Vol. I., Vol. II. American Ortho. Ass'n, 1953, 1956.

Gerard, Margaret. "Emotional Disorders of Childhood". Ch. VII, DYNAMIC PSYCHIATRY. F. Alexander and H. Ross, eds. University of Chicago Press, 1952.

Goodenough, Florence L. "The Measurement of Mental Growth in Childhood". MANUAL OF CHILD PSYCHOLOGY. Leonard Carmichael, ed. Ch. 9, pp. 450-475. John Wiley & Sons, Inc., 1946.

Group for the Advancement of Psychiatry. BASIC CONCEPTS IN CHILD PSYCHIATRY. Formulated by The Committee on Child Psychiatry. Report 12, April, 1950.

———— INTEGRATION AND CONFLICT IN FAMILY BEHAVIOR. Formulated by the Committee on the Family. Report 27, August, 1954.

Josselyn, Irene. PSYCHOSOCIAL DEVELOPMENT OF CHILDREN. Family Service Ass'n of America, 1948.

Kanner, L., CHILD PSYCHIATRY. C. C. Thomas, 1948.

Levine, Maurice. "Principles of Psychiatric Treatment". DYNAMIC PSYCHIATRY, Ch. XI. F. Alexander and H. Ross, eds. University of Chicago Press, 1952.

Lippman, Hyman. TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT. McGraw-Hill, 1956.

Lowrey, L. G. (ed.). ORTHOPSYCHIATRY 1923-1948: RETROSPECT AND PROSPECT. Amer. Ortho. Ass'n, 1948.

Pearson, Gerard. EMOTIONAL DISORDERS OF CHILDREN. W. W. Norton, 1949.

———— PSYCHOANALYSIS AND THE EDUCATION OF THE CHILD. W. W. Norton, 1954.

Piaget, Jean. THE LANGUAGE AND THOUGHT OF THE CHILD. Harcourt Brace & Co., 1932.

Rambert, Madaleine. CHILDREN IN CONFLICT. Int'l Univ. Press, 1949.

Rank, Beata. "Adaptation of the Psychoanalytic Technique for the Treatment of Young Children With Atypical Development". *Am. J. Ortho.*, 19:130, 1949.

Selye, Hans. THE STRESS OF LIFE. McGraw-Hill, 1956.

Szurek, S. A. "An Attitude Towards (Child) Psychiatry". *Quarterly J. Child Behavior*, 1:22-51, 178-213, 375-399, 401-423, 1949.

Van Amerongen, Suzanne. "Initial Psychiatric Family Studies". *Am. J. Ortho.*, 24:78-83, 1954.

Witmer, H. L. PSYCHIATRIC INTERVIEWS WITH CHILDREN. Commonwealth Fund, 1946.

Young, Leontine. "Diagnosis as a Creative Process". *Social Casework*, Vol. XXXVII, No. 6, p. 275. June, 1956.

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