***NOTES OF A PSYCHOLOGY WATCHER***

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**Some Guiding Principles for the Assessment of Psychological Disorders in Children and Adolescents**

1. Take a developmental perspective. What is normal at age one year is abnormal at age five years. Remember that a child may be chronologically ten years old, mentally fourteen years old, emotionally seven years old, and physically thirteen years old.
2. Be aware of the pervasiveness of comorbidity in childhood psychological disorders. It is rare for a youngster – or an adult – to have one problem. With physical problems, children can have a broken leg, Crohn’s disease, and need glasses. The same is true for psychological disorders.
3. During your interviews – with parents and youngsters, remain neutral. Your ability to manage transference and countertransference is crucial in forming a treatment alliance and obtaining accurate information. Don’t criticize or blame parents. Pay attention to your tone of voice and nonverbal behaviors. Stay humble – especially if you have not lived personally through the family stage of the child you are evaluating (e.g. if you have never been the parent of an adolescent) - listen and learn. It is difficult to listen your way into trouble.
4. When you have enough information, do not be afraid to “label” a child. A label or diagnosis is helpful for communication, treatment, and prediction. Diagnosis is prognosis. When a child gets an accurate diagnostic label that leads to effective treatment, you may prevent the child and his family from experiencing years of doctor shopping, and intense emotional pain. You may help steer the child and the family into a more normal course of development.
5. Evaluate the following categories:
6. Neurological: Disease/Disorder e.g. autism b. schizophrenia c. attention-deficit/hyperactivity disorder d. pervasive developmental disorder e. learning disabilities
7. Constitutional factors
	1. Temperament: e.g. activity level; patterns of movement; regularity; distractibility; approach versus withdrawal; adaptability; persistence; intensity of reaction – positive or negative affect; sensitivity; quality of mood.
8. Personality traits: e.g. openness, conscientiousness, extrovert, agreeable, neurotic
9. Intellectual and academic resources
10. Attachment behavior: ways of construing and behaving in close relationships
11. Parental expectations: constructive vs. destructive
12. Parenting styles: authoritarian, authoritative, permissive, neglectful
	1. Parental warmth and responsiveness to the child b.
	2. The family’s control of the child and the demands they place on the child.
13. Peer relationships
14. Life events

(10)Influences of school, community and culture

NOTE: Development is a two-way street. Parents and children mold each other. Children are not blank slates, but share half of their parents’ genes. Be cautious drawing conclusions of what parents’ behaviors may “cause” a child’s behavior --- research traces correlation, not causality.

*Babies control and bring up their families as much as they are controlled by them; in fact the family brings up the baby by being brought up by him.*

--- Erik Erikson

1. The more psychologically disturbed the parents, the more unreliable their history of their family and child.
2. A common error in assessing children and adolescents is not to get teachers’ observations and information about peer relationships. It is useful to review a sample of the child’s report cards from early on to the present grade level, especially the teachers’ comments. A well-liked child with close chums is less vulnerable to future behavioral and emotional troubles.
3. While observing and participating in play with children is important in uncovering preoccupations and possible symbolic meanings, using play techniques alone do not allow you to assess specific symptoms and to make a diagnosis. To make a diagnostic judgment based on symptoms, you need to develop specific questions geared to the child’s developmental stage. Tools such as the K-SADS are helpful semistructured interviews that promote differential diagnoses.
4. Psychological testing, especially assessing intellectual and academic resources, are important parts of an evaluation. For example, emotional disorders such as depression and anxiety can be secondary to psychological demoralization caused by Specific Learning Disorders, and/or neurological disorders such as Attention-Deficit/Hyperactivity Disorder, and/or family stress. If a child achieves at grade level, it does not mean that the child is performing near his intellectual abilities. Psychological testing allows you to uncover unknown intellectual resources of a youngster than can boost his morale and offer opportunities to enhance skills. A frequent outcome of intellectual assessment is to uncover a child’s significant strengths in nonverbal reasoning abilities.
5. It is crucial to take a comprehensive family history to make a diagnosis of children’s problems. You can always improve the accuracy of your diagnosis if you know the details of the family history. To boost your diagnostic acumen ask the youngsters’ parents questions in at least the following areas of the family history:
6. Who does your child take after? Don’t accept “She’s her own unique person”.
7. Ask about a family history of Learning Disabilities Does anybody in the family have trouble with reading, spelling, math or writing, or was in special classes? Be alert to family members who change jobs a lot, or have a history of underachievement at work. You will be surprised how many people have trouble with spelling.
8. Ask about a family history of hyperactivity, distractibility, and impulsivity. For hyperactivity, ask about family members who have trouble doing nothing, or are live wires, or frequently exercise. For distractibility, ask about people who have trouble filtering out external distractions, and have trouble with reading comprehension. For impulsivity, ask about people with firecracker tempers as opposed to people with slow-burn tempers, or brooding.
9. Ask about a family history of trouble with the law: gamblers, con-artists, crooks, barroom brawlers.
10. Ask about a history of excess use of alcohol and or drugs, including prescription drugs. Ask about family members who have been arrested for drunk driving or substance use.
11. Ask about a history of depression and bipolar disorder. For depression, use such terms as down in the dumps, sad, crying, miserable, and unhappy. Ask about feeling cranky, irritable or easily upset. Ask about whether there are times the adolescent’s energy level is very high or very low; whether during the high periods the adolescent spends a lot of money, takes on too many activities; is more sexual, seems strange or annoying to others; in the low periods if the adolescent needs to stay in bed more and feels hopeless and suicidal.
12. Ask about whether there are things the child feels compelled to do over and over again like touching, counting or checking even though she knows her behavior not make sense. Ask about bothersome thoughts that won’t go away.
13. Ask about going on a diet and whether friends or family get worried. Ask about whether the youngster is afraid of gaining weight. Ask if the adolescent has times when they eat a large amount of food in a short time. Ask about the youngster’s exercise routine, or making themselves throw up.
14. Ask if the child feels that somebody is out to hurt or harm them.

Ask if the youngster ever felt people are talking about you behind your back.

Ask if the adolescent thinks somebody is spying on them.

Ask if the youngster’s eyes ever play tricks on them. Do you see people or visions that other people don’t see? Ask if their ears play tricks on them --- hearing voices that others don’t hear. Do these voices tell you what to do, or interfere with you daily life.

(10)Ask about worries such as being away from parents and worries about your parents getting hurt. Ask whether the youngster thinks he worries more than other kids.

(11)Ask the youngster about getting into fights, using a weapon, stealing things, lying about his actions, starting fires, and threatening people. Ask whether the adolescent feels he can get emotionally close to people.

1. You should recommend to the child and her parents what they need, not just what you have to offer.

For example, with experience, it will occur to you when to refer a youngster to consider pharmacotherapy.

*As far as I’m concerned I have had great help from medical colleagues used to the administering of the modern drugs…In all of these cases the therapeutic use of drugs did not in any way interfere with the progress of the analysis, quite the contrary it helped the analysis to maintain itself during phases when otherwise the patient might have had to be hospitalized.*

--- Anna Freud

1. Every youngster must have a medical evaluation before you diagnose psychological disorders.
2. The more diagnoses the child has the more complicated the management of the problems.

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1. Don’t be afraid to get help from colleagues. We do not understand the etiology of any psychological disorder. Our diagnostic manual is akin to a birdwatcher’s field guide --- we can describe clusters of symptoms but do not understand why these symptoms go together.

As psychologists, we are about at the level of chemistry before Mendeleev began to fill in the periodic table of elements.

Much of our therapeutic efforts are based on rules of thumb that are difficult to prove, and these notions are vulnerable to crank ideas such as false memories of child sexual abuse, and fights between theoretical factions within the field.

Not all psychological problems fit neatly into our diagnostic categories. These categories continue to evolve. Diagnosis deferred, or I don’t know is acceptable. Not all problems have ready solutions. When in doubt, tell the truth.