WEAVE SPRINT . PAPER III

Child psychiatry: assessment, treatment, services and protection

The system around the child rather than the disorders within it: how psychotropics are prescribed in childhood, every dose scoped to population and indication and read at current labelling; the assessment apparatus, and what each instrument may and may not do; the interventions, from play therapy and parent management training to family work and early intervention; the Indian service and policy context, with epidemiology stated only as far as it can honestly be grounded; and child protection in law, read from the primary Act, where reporting is a duty and failing it is a criminal offence.

CONTENTS

- Child psychopharmacology
- Child psychiatric assessment and rating tools
- Child and adolescent therapeutic interventions
- Child psychiatry epidemiology, services and national context
- Child protection, abuse and juvenile justice

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PAPER III

Child psychiatry: assessment, treatment, services and protection

Seven bands . one complete notes document

Orientation: the system around the child

1 · Orientation: the system around the child

Why this chapter matters clinically. A child does not arrive as a diagnosis detached from the people, settings and developmental tasks that give symptoms their meaning. The psychiatrist meets a young person whose distress is expressed through behaviour, feeling, body, learning, relationships and participation. The clinical task is therefore to understand the child as a **whole child**, then to make care workable for the family, school and wider systems around that child.

This is an **advance organizer** for a chapter about that surrounding system. It is not a catalogue of childhood disorders. The disorders themselves, including the **internalising and externalising axis** that organises them, are taught in *the Child behavioural, emotional and other disorders notes*. Intellectual disability and autism spectrum disorder are addressed in *the Intellectual disability and autism spectrum disorder notes*; normal temperament, developmental norms and milestones are addressed in *the Normal child development and milestones notes*. Here, the emphasis is on what the clinician does once a child needs psychiatric help: understand, plan, intervene, connect and protect.

WHOLE	CLINICAL	SHARED	SAFE
CHILD	PLAN	SUPPORT	CARE

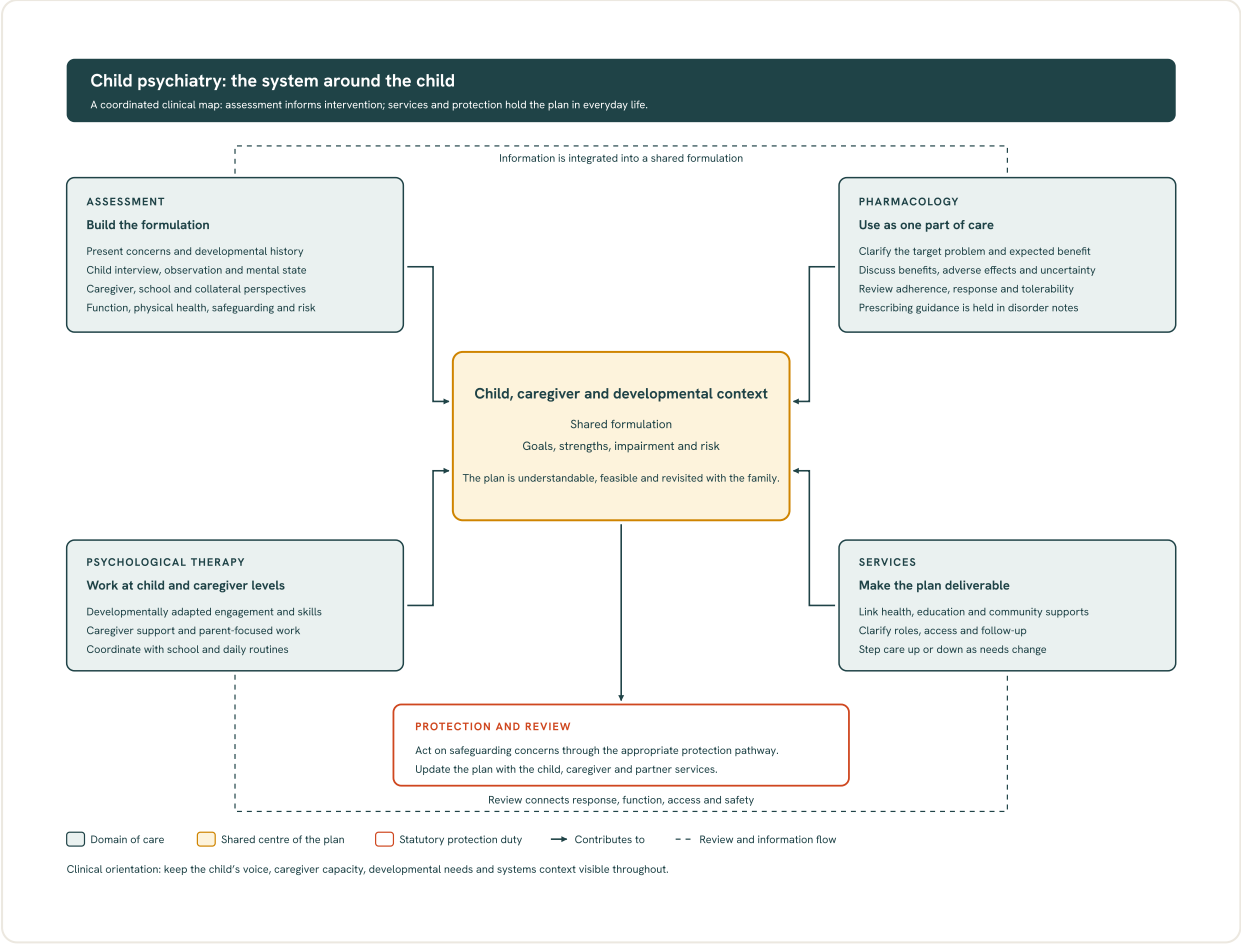


Fig 24.1. The system around the child: how assessment, prescribing, psychological and educational treatment, the Indian service platforms and the statutory protection framework connect for one child. Read it as the chapter's route map rather than as a sequence, since a real case moves between these domains repeatedly.

1.1 The clinical frame: child, context and consequence

Child psychiatry starts with a developmental question: what is happening to this child, in this context, and with what consequences for everyday life? A symptom can alter school participation, peer belonging, family routines and confidence; each of those consequences can in turn maintain distress or restrict recovery. The chapter therefore treats clinical work as a **system around the child**, rather than as a sequence of isolated consultations.

This frame protects against a familiar reductionism. A diagnostic label may guide treatment, but it cannot by itself tell the clinician what a child understands, what a caregiver can implement, what the school observes, or whether the child is safe. Nor should a child be reduced to a family problem, a school problem or a medicine problem. The useful question is always practical as well as descriptive: what would change the child's ability to develop, participate and feel secure?

RULE **Think of the child and the care environment together.** Symptoms are assessed in the child, but intervention succeeds or fails in the relationships and settings in which daily life takes place.

The accompanying figure can be used as a visual reminder of this clinical map. It should not be read as a rigid pathway. A family may enter through a school concern, a behavioural crisis, a developmental worry, a medical referral or a disclosure of harm. The psychiatrist's work is to

organise the response without losing the child's voice or the actual conditions in which care must happen.

1.2 Assessment: turning concern into an intelligible formulation

Assessment is the chapter's starting movement because treatment without a clear understanding is merely activity. The assessment sections show how history, examination, developmental perspective, observation, play, structured measures and cognitive or neuropsychological methods can contribute to an account of the child's needs. They also show why evidence from the child, caregivers, school and other relevant adults may differ without any one informant being simply wrong.

The point is not to collect every possible datum. It is to build a **working formulation** that explains the presenting concern in developmental and relational context, identifies functional impact, and clarifies what must be addressed first. Assessment should generate decisions: whether a further evaluation is needed, who needs to be involved, which supports are realistic, and whether there is a safety concern that changes the pace or setting of care.

- Listen for the child's experience and language, not only the adult account of behaviour.
- Place the concern within development, relationships, education and health.
- Use each assessment method for the question it can answer, rather than treating an instrument as a diagnosis.
- Translate findings into a plan that family and school can understand.

> **GOOD TO REMEMBER**
>
> A careful assessment is already an intervention when it helps adults replace blame with curiosity and gives the child an experience of being heard accurately.

TRAP **Do not confuse a list of findings with a formulation.** Candidates often describe history, tests and ratings well but fail to state how those findings explain the child's current difficulty or alter the management plan.

1.3 Prescribing: medication as one part of accountable care

When medication is considered, the question is not simply whether a drug can reduce a symptom. The psychiatrist must decide whether pharmacological treatment has a clear target within the child's overall plan, whether its likely benefits matter to the child's daily functioning, and how effects will be understood alongside changes at home and school. The prescribing sections address developmental pharmacology, medication classes, cautious use, monitoring, consent and review.

The chapter asks the reader to retain a **prescribing rationale** rather than a prescription habit. A rationale makes explicit what is being treated, how benefit will be recognised, what unwanted effects require attention, and how the family will participate in observation and decision-making. It also keeps medication from displacing educational, psychological, family or safeguarding work when those are the interventions that matter most.

For disorder-specific pharmacological treatment, cross-refer to *the ADHD and specific learning/communication disorders notes*, *the Child behavioural, emotional and other disorders notes*, and *the Intellectual disability and autism spectrum disorder notes*. The present chapter supplies the clinical discipline around prescribing, not a disorder-based regimen.

PITFALL

Improvement in a narrow symptom is not automatically improvement in the child's life. Review must return to function, participation, relationships and the family's capacity to sustain the plan.

1.4 Psychological, family and educational treatment

Psychological treatment in child psychiatry is not an optional conversation added after diagnosis. It is a set of developmentally adapted ways of changing patterns of emotion, behaviour, relationship and learning. The treatment sections cover play-based work, behavioural approaches, parent work, family interventions, cognitive behavioural approaches, special education, remedial measures and early developmental support. Their common thread is that the intervention must fit the child's developmental capacities and the adults who carry much of the treatment between sessions.

The key unit of care is often the **shared plan**: a plan that gives the child a comprehensible role, gives caregivers achievable tasks, and makes space for school or other supports when relevant. This is not a dilution of clinical responsibility. It is how a treatment becomes visible in ordinary life. The psychiatrist remains responsible for coherent formulation, appropriate referral, review and revision when the plan does not fit.

CLINICAL MOVEMENT	QUESTION FOR THE PSYCHIATRIST	PURPOSE WITHIN CARE
Assessment	What is happening, for whom, and in which context?	Make the problem intelligible.
Prescribing	Is medication justified within a broader plan?	Use pharmacology accountably.
Psychological and educational treatment	What change can the child and adults practise in daily life?	Build skills and support participation.
Services	Which setting can sustain the work?	Connect care beyond the clinic.
Protection	Is there harm, risk or a legal duty that changes the response?	Place safety before routine.

1.5 Services in India: making care reachable and continuous

A treatment recommendation has little value if it cannot be reached, understood or sustained. Child mental health care therefore includes the practical work of locating the child within a **continuum of care**: family, school, health services, developmental and educational supports, and community resources. The services sections describe Indian child-health and school-facing platforms, their purposes and how they can complement specialist psychiatric care.

For the psychiatrist, services are not background administration. They determine whether a child is identified early, whether caregivers receive help outside the consultation room, whether educational needs are addressed, and whether follow-up survives distance, cost and competing family demands. Referral is most useful when it is specific about the problem to be addressed and when responsibility for clinical review remains clear.

IN INDIA

The service discussion is deliberately grounded in Indian pathways. Learn to recognise what a school, child-development platform, health service and specialist team can each contribute, then connect them around the child rather than treating referral as a hand-off.

- Ask what support already exists in the child's ordinary environment.
- Specify the purpose of every referral, the information that should travel with it, and barriers that can interrupt follow-up or implementation.

1.6 Protection: safety is a clinical responsibility

Protection enters every child psychiatric assessment because distress may occur alongside abuse, neglect, exploitation, bullying, family violence or other threats to safety. The protection sections distinguish forms of harm, clinical indicators, assessment after sexual abuse, statutory duties, management, juvenile justice and related psychiatric concerns. Their purpose is to help the clinician recognise when ordinary therapeutic pacing is no longer adequate.

Safeguarding requires a **protective response**: attention to the child's immediate safety, accurate documentation, appropriate communication, lawful reporting and connection with the relevant protection system. It is neither an accusation nor a private clinical matter that can be indefinitely deferred while certainty is sought. At the same time, it requires restraint, careful language and respect for the child's dignity. The legal and procedural details belong to the dedicated protection sections and to *the Mental health legislation and forensic psychiatry notes* for general criminal responsibility, mental-health legislation and adult forensic assessment.

MNEMONIC

MAPS: Meet, Assess, Plan, Support, Safeguard

Use this master mnemonic to retain the chapter's clinical route. Meet the child as a person in context; assess before acting; plan medication and psychological care deliberately; support the family and service network; safeguard whenever safety or legal duty enters the case.

The child is never only the diagnosis: assessment, treatment, services and protection must be organised around the child's lived developmental world.

Child psychopharmacology

2 · Principles of prescribing psychotropics in children

Why it matters clinically. Prescribing for a child is not a smaller version of prescribing for an adult. The prescription enters a developing person, a family system, a school context and a network of carers. Its quality is therefore judged not merely by the medicine selected, but by whether the clinician has defined the problem, made the treatment purpose intelligible, anticipated practical obstacles and retained responsibility for review.

Psychotropic medication can reduce suffering and improve a child's capacity to participate in home, school, relationships and psychological treatment. It can also obscure an unclear formulation, displace environmental work, or become a source of conflict if introduced without shared understanding. The central task is disciplined clinical reasoning: prescribe when a medicine has a plausible, proportionate role in a broader plan, and make that role visible to the child and family.

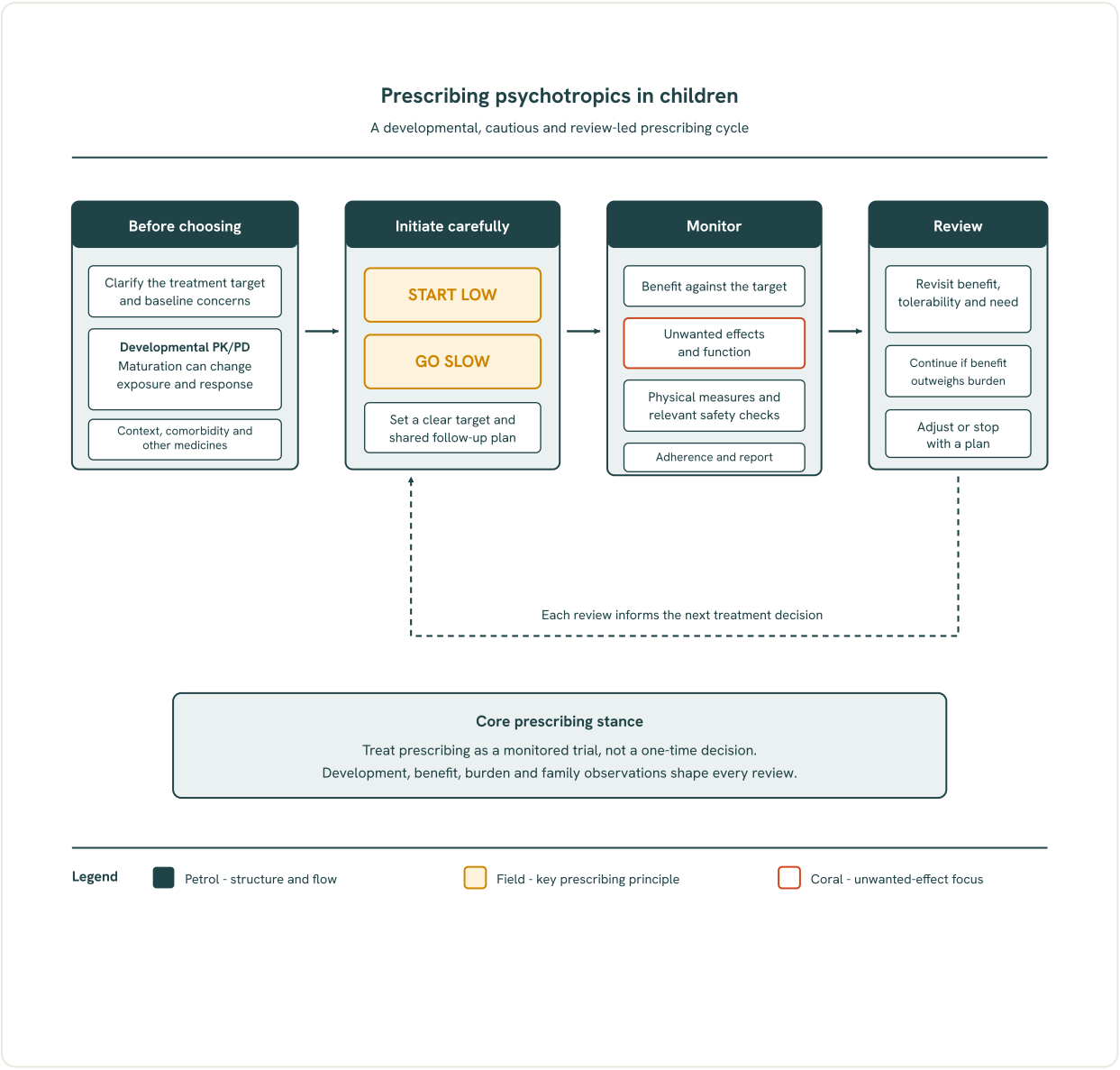


Fig 24.2. A child psychotropic prescription is a developmental, cautious and monitored trial: start low, go slow, assess benefit and burden, and use planned review to guide the next decision.

2.1 The prescribing question

A sound prescription begins with a **treatment target**. This is the concrete difficulty that the medicine is intended to change, described in observable clinical language and linked to impairment. “Behaviour problems” is not a treatment target. Nor is a diagnostic label, by itself, a sufficient instruction to prescribe. The clinician should be able to state what is happening, where it happens, what maintains it, how it affects the child, and what change would count as benefit.

That discipline protects against diagnostic momentum. A child may present with distress, disruptive conduct, sleep disruption, poor concentration, somatic complaints or emotional withdrawal. These phenomena can arise from psychiatric illness, developmental differences, trauma, family stress, learning difficulty, physical illness, substance exposure, medication effects or an interaction among these. Medication may be appropriate, but only after the presenting problem has been placed in a developmental and psychosocial formulation. The prescription should answer a clinical question rather than substitute for one.

RULE **Prescribe for a defined problem within a formulation, not for a label or for pressure to act.** A medication decision should follow a clear account of symptoms, impairment, context and the intended place of pharmacotherapy in the care plan.

Severity matters in a functional sense. The same symptom can carry very different implications depending on its persistence, setting, consequences and the child's available supports. A clinician should ask whether the intervention is intended to relieve acute suffering, reduce risk, enable engagement with other treatment, restore daily functioning, or prevent a pattern from becoming entrenched. Stating the purpose also makes later review possible: benefit is judged against the original target rather than against a vague impression that the child is "better".

- Describe the target problem in language the family can recognise.
- Identify the impairment or risk that gives the target clinical importance.
- Specify what non-medication interventions are active, planned or unavailable.
- Decide what observable change would justify continuing treatment.

2.2 Developmental formulation before pharmacotherapy

Developmental formulation means interpreting symptoms in relation to the child's developmental level, communication capacity, temperament, family relationships, educational demands and medical context. It is not a decorative paragraph added after diagnosis. It determines whether the reported difficulty is best understood as illness, an unmet developmental need, a mismatch between demands and capacity, a response to adversity, or a mixture of these.

The child's own account deserves deliberate effort, even when language, cognition, fear or loyalty to adults limits direct disclosure. Behaviour is often communication. Irritability may express distress, sensory overload, grief, pain, humiliation, anxiety or a coercive family pattern. Apparent non-adherence may reflect swallowing difficulty, unpleasant effects, stigma, a child's wish to retain control, or a caregiver's uncertainty. These meanings do not rule out medication; they determine whether medication is likely to help and how it should be offered.

Collateral information is essential, but it must be interpreted rather than collected mechanically. Different observers see different settings and bring different expectations. Disagreement between home and school accounts may identify environmental triggers, differences in structure, divergent relationships or a problem that is context-bound. It should not automatically be treated as evidence that one informant is unreliable. General child psychiatric assessment is addressed in the assessment section of this chapter; prescribing should use that formulation rather than recreate an abbreviated assessment in the prescription note.

CLINICAL QUESTION	WHY IT CHANGES PRESCRIBING	USEFUL CONSEQUENCE
What is the child experiencing?	Symptoms and their meaning may differ from adult descriptions.	Use developmentally understandable targets and explanations.
Where does the problem occur?	Context can reveal triggers, supports and limits of a medicine-only plan.	Link prescribing to home and educational interventions.
What else could account for it?	Medical, developmental and psychosocial contributors can alter the clinical question.	Address contributors rather than escalating medication reflexively.
What can the child and caregivers realistically do?	A technically sound regimen fails if it cannot be followed or understood.	Choose a plan that fits daily life and review its feasibility.

TRAP **Do not mistake a symptom description for a completed formulation.** A striking symptom can create urgency, but urgency does not remove the need to ask what the behaviour means, what context is sustaining it, and what the medicine can realistically change.

2.3 Proportionality and the place of medication

Proportionality is the fit between the expected benefit of medication and the burden, uncertainty and alternatives in the particular child. It asks more than whether a medicine can work. It asks whether it is the right next intervention, whether the expected gain matters to this child's life, and whether the family understands the trade-off. A medicine is not made benign by familiarity, and a psychosocial intervention is not made adequate merely by being recommended.

Psychological therapy, parent work, educational support, environmental adaptation and treatment of coexisting medical problems are not competitors to pharmacotherapy. Often they provide the conditions in which a medicine can be useful. A severely distressed child may be unable to use therapy until symptoms ease; equally, medication may have little effect on a coercive interaction pattern, an unsafe environment, educational mismatch or lack of routine. The plan should make clear which intervention is addressing which part of the formulation.

Polypharmacy requires particular restraint. When several changes are made at once, the clinician loses the ability to know what produced benefit, what caused harm, and what is no longer necessary. Additional medicines can also conceal inadequate adherence, an incorrect target, a missed contributor or a fragmented service pathway. There are circumstances in which combined treatment is clinically justified, but it should be deliberate, documented and owned by a clinician who can review the whole regimen.

- Ask what the medicine is expected to add to the existing plan.
- Ask what important part of the formulation the medicine cannot address.
- Prefer a plan whose effects can be interpreted clinically.
- Reconsider medication when the original target no longer justifies its burden.

GOOD TO REMEMBER

A clear prescription note links the medicine to a target, the target to impairment, and the medicine to the rest of the care plan. This protects continuity when care moves between clinicians or settings.

2.4 Partnership with the child and caregivers

Shared decision-making is a clinical method, not a formality. It means presenting the treatment purpose, anticipated benefits, important uncertainties, likely burdens and practical demands in a way that the family can use. The child should be included to the extent possible. Inclusion does not mean assigning adult responsibility to a child; it means taking seriously what the child notices, fears, values and can participate in.

Caregivers need a practical account of what the medicine is and is not intended to do. They should know which changes to observe, how to communicate concerns, and why independent changes in administration can make assessment difficult. Questions about dependence, personality change, long-term effects and stigma should be invited rather than dismissed. A family that feels corrected or rushed may agree in the room yet alter the plan outside it. Honest discussion is more likely to produce a usable treatment alliance.

Family disagreement is common and should be explored rather than reduced to "non-compliance". One caregiver may see suffering while another fears labelling; a school may seek rapid behavioural change while the child experiences the medicine differently. The prescriber's role is to restore the clinical question, distinguish values from misinformation, and avoid allowing the prescription to become a proxy battle over blame or control. Formal issues of parental permission, child assent, capacity and documentation belong to the chapter section on monitoring and consent issues in child psychopharmacology.

IN INDIA

Care is often distributed across parents, grandparents, schools and more than one medical service. Ask who actually gives the medicine, who can report change, who pays for follow-up and who may discontinue treatment if adverse effects or stigma are feared. A plan built around the person present in the clinic may fail in the household where it must operate.

2.5 Communicating a plan that can be followed

Adherence is better understood as the degree to which a treatment plan is feasible, acceptable and sustained than as an attribute of a "good" family. It can be undermined by complicated routines, cost, inconsistent supervision, formulation or swallowing difficulties, adverse experiences, poor understanding, stigma and competing household demands. Asking a neutral question such as "What might make this difficult at home?" is usually more informative than asking whether the medicine is being taken.

Written instructions should complement, not replace, conversation. Avoid unexplained abbreviations and make the plan legible to the person who will implement it. Clarify the target, the expected course of review, what observations matter, and what should prompt contact with

the treating team. Medication storage and access require attention wherever there are younger children, family members at risk of self-harm, or a possibility that a medicine may be shared, diverted or used in an unintended way.

Communication with school can be valuable when the educational setting is central to impairment or observation. It should be purposeful and proportionate. The school needs only the information required to support the child and report relevant change; it does not need a full psychiatric narrative. Protecting confidentiality is especially important when medication itself risks becoming a source of labelling or peer attention.

PITFALL

Do not treat a family's difficulty following a regimen as proof that they are careless or oppositional. First examine whether the plan is understandable, affordable, acceptable and compatible with the actual caregiving arrangement.

2.6 Review as a continuing clinical decision

Medication review is the process of returning to the original treatment target and deciding, with fresh information, whether the medicine still has a proportionate role. It is not merely a request for a repeat prescription. The reviewer should ask about meaningful change in the child's life, unwanted effects, the family's experience of administering treatment, changes in context, new symptoms, concurrent medicines and whether the original formulation still explains the problem.

Review is where diagnostic humility becomes visible. Lack of benefit may mean that the target was wrong, the medicine is not useful for that target, the plan was not practicable, a psychosocial driver remains dominant, or the observations are incomplete. The response should not automatically be escalation. Conversely, apparent improvement should not automatically be attributed to medication when school support, family change, maturation, therapy or the natural course may have altered the picture. Attribution is often provisional, which is why a documented baseline and a shared account of the target are so valuable.

Prescribing continuity needs named responsibility. Children may move between outpatient care, emergency services, paediatric specialties, schools or residential settings. At each transition, someone should reconcile the current plan, clarify who is reviewing it, and ensure that old instructions do not persist by inertia. The detailed framework for baseline assessment, safety surveillance, consent and the timing of review belongs to the chapter section on monitoring and consent issues in child psychopharmacology.

Target	Context	Family	Plan
DEFINED	FORMULATED	PARTNERED	REVIEWED

2.7 Boundaries of the general framework

This general framework should not be used to improvise drug-specific practice. Developmental pharmacokinetics and pharmacodynamics are addressed separately. Medication-specific

indications, adverse-effect issues and monitoring requirements belong to the relevant drug sections. Stimulant treatment is cross-referred to *the ADHD and specific learning/communication disorders notes*. Childhood disorders and the paediatric SSRI black-box warning are cross-referred to *the Child behavioural, emotional and other disorders notes*. Intellectual disability and autism spectrum disorder are cross-referred to *the Intellectual disability and autism spectrum disorder notes*.

The realities of off-label prescribing, dose selection and cautious titration belong to the section on off-label prescribing, dosing principles and start-low go-slow in children. This separation matters. A general principle can tell the clinician how to think about a prescription; it cannot safely replace the evidence, indication-specific reasoning or monitoring requirements for a particular medicine.

MNEMONIC

TARGET

Target the problem; **A**ssess its developmental and contextual meaning; **R**elate medication to the wider plan; **G**ive the child and caregivers a real voice; **E**xamine feasibility; **T**rack benefit and burden; retain clear clinical responsibility. It is a thinking aid, not a substitute for drug-specific guidance.

A child psychotropic prescription is justified by a clear target, a developmental formulation, a proportionate place in the plan and an accountable review process.

3 · Developmental pharmacokinetics and pharmacodynamics in children

Why it matters clinically. A child is not a smaller adult with a smaller tablet. Development changes the processes that carry a medicine from administration to the circulation, through the body, and out again. The practical consequence is not simply that a prescriber calculates a smaller amount. It is that the relation between an administered amount, the concentration that results, and the clinical effect must be interpreted through the child's developmental state. This is the pharmacological reasoning that sits beneath safe individualisation of treatment.

Developmental pharmacology has two linked questions. Pharmacokinetics asks what the body does to a medicine: how much reaches the circulation, how it is distributed, transformed, and eliminated. Pharmacodynamics asks what the medicine does at its site of action: how exposure is translated into intended and unintended effects. Neither question supplies a regimen by itself. The general prescribing framework, consent and review processes are addressed elsewhere in this chapter; here the task is to understand why a concentration or a weight-based calculation cannot be read in isolation.

AGE	METABOLISM	BINDING	CLEARANCE
CHANGES DRUG HANDLING	CAN ALTER EXPOSURE	SHAPES LEVEL INTERPRETATION	GUIDES DOSE SCALING

3.1 The developmental frame

Developmental pharmacokinetics is the study of changing drug handling across childhood. Its central clinical value is explanatory. If a medicine produces an unexpected concentration, inadequate benefit, or unwanted effect, the question is not only whether the stated amount was taken. One must also ask whether the child's current physiology changes exposure at an earlier or later part of the pathway. A result that appears anomalous when compared with an adult expectation may be coherent once developmental handling is considered.

This is especially important because childhood is not pharmacologically uniform. Development proceeds along several biological processes that need not move together. A change in one process can alter the meaning of a change in another. Thus, an administered amount is only the beginning of a causal chain. What matters clinically is the exposure eventually available to exert an effect, and the child-specific processes that shape it. This reasoning protects against the easy but unsafe assumption that body size alone completely predicts drug behaviour.

The useful mental model is a pathway rather than a single number:

- the medicine reaches the body and may undergo loss before entering the systemic circulation;
- circulating medicine is present in bound and unbound forms;
- metabolic and renal processes remove parent drug or metabolites; and
- the concentration at the relevant site is interpreted alongside the observed clinical response.

RULE **In children, an administered amount is not a direct measure of exposure.** Developmental physiology lies between the prescription and the concentration that is ultimately available to act.

For the candidate, this is not an invitation to memorise isolated developmental facts. It is a way of explaining clinical variability without collapsing it into adherence, diagnostic error, or presumed treatment resistance. It also clarifies why a prescription should be revisited whenever the child's developmental context or intercurrent illness changes the likely relation between amount and exposure.

3.2 Metabolism, bioavailability and elimination

Drug metabolism is a major source of developmental variation. The capacity to transform a medicine depends on developmental changes in metabolising systems. These changes can alter both **bioavailability** and **elimination**. In other words, metabolism can influence how much medicine enters the circulation as well as how long medicine already in the circulation remains there. This is why metabolism should not be treated as a late, purely eliminative event.

The clinical implication is that the principal metabolic route and the rate at which metabolites form may differ from adult patterns and may also differ among paediatric developmental groups. A medicine can therefore have a different exposure profile in a child even when the arithmetic looks proportional to body weight. The relevant question is not whether a calculation is mathematically tidy, but whether it represents the child's likely route of handling the medicine.

Metabolism also complicates simple interpretations of effect. The parent medicine and its metabolites may not contribute to the clinical picture in the same way. If developmental metabolism changes their relative formation, the observed response may not track an adult expectation based only on the parent compound. At textbook level, the key point is conceptual: an apparent mismatch between amount and response may arise before the medicine reaches its intended site, during its transformation, or during its removal.

GOOD TO REMEMBER

A developmental explanation is most useful when it specifies the link in the chain that may have changed. "Children metabolise medicines differently" is too vague. Ask whether developmental metabolism is plausibly changing entry into the circulation, removal from it, or the relative contribution of metabolites.

This helps separate pharmacokinetic reasoning from a medication "rule." There is no universal developmental direction that can be applied indiscriminately across medicines. The useful inference is conditional: when intestinal or hepatic metabolic processes materially contribute to a medicine's handling, developmental changes in those processes can change exposure. The prescriber must then use drug-specific information and the full clinical context, rather than treating an adult amount as a template that can simply be reduced.

3.3 Protein binding and the meaning of a blood level

A measured concentration is often treated as if it were the clinical answer. It is not. **Protein binding** can change with developmental age and with concomitant illness. This matters because the measured level usually represents circulating drug in a sample, whereas pharmacological action depends on the drug available to leave the circulation and reach its site of action. The interpretation of a reported level therefore requires attention to the binding context, not merely to whether the result lies on one side of a reference interval.

The clinically relevant idea is the **free drug fraction**. When binding differs, the relationship between total measured drug and pharmacologically available drug may also differ. This does not mean that a total level is useless. It means that the level is a piece of evidence whose meaning depends on the child's physiology, illness, sampling circumstances and clinical state. A result should be integrated with the observed response and adverse effects, not made to overrule them automatically.

QUESTION	DEVELOPMENTAL PHARMACOKINETIC INTERPRETATION	CLINICAL REASONING CONSEQUENCE
What does a blood level represent?	A circulating measurement influenced by age and illness-related binding.	Interpret the result in its physiological context.
Why can a familiar value mislead?	The relation between total concentration and available drug may not be constant.	Do not let the number substitute for clinical assessment.
What should a dose adjustment address?	The likely exposure problem, not an isolated laboratory value.	Link the decision to response, tolerability and the child's current context.

Concomitant illness deserves particular attention because it can change binding at the same time as it changes the child's clinical presentation. It is therefore easy to attribute new symptoms either wholly to illness or wholly to medication. Pharmacokinetic thinking holds both possibilities open. It asks whether the illness may change the relation between a measured total level and the active exposure, while clinical assessment determines whether the observed symptoms fit that explanation.

TRAP **A total blood concentration is not automatically a direct measure of active exposure.** Ignoring developmental or illness-related binding turns a useful measurement into a falsely decisive one.

3.4 Clearance as the bridge from physiology to dose

Clearance is the most useful organising parameter for relating age and body weight to paediatric dose. It describes the body's capacity to remove a medicine from the circulation. Because clearance changes the exposure that follows an administered amount, it provides a rational bridge between physiology and dose scaling. Scaling clearance from one paediatric age group to another is a commonly used approach, but it is not a permission slip for uncritical extrapolation from adults.

The distinction matters. Body weight is clinically valuable, but it does not itself describe every developmental process that determines clearance. The same body-size calculation may conceal different contributions from metabolism, filtration, secretion and illness. Clearance-based reasoning asks what removal processes are important for the medicine in question and whether those processes are likely to be developmentally different in the child being treated. The answer can then inform the use of drug-specific dosing information.

Renal clearance is an important example. Glomerular filtration continues to increase until **approximately one to two years of age**, after which it begins to decline toward adult levels. Active tubular secretion follows a similar early trajectory until **two years of age** and then gradually increases into adulthood. For medicines substantially removed through the kidney, this changing physiology makes a fixed assumption about removal particularly unreliable in early childhood.

The point is not to convert a developmental timeline into a universal dose formula. The point is to recognise why renal handling must be part of the explanation when a renally eliminated medicine behaves unexpectedly. Both filtration and secretion belong in the conceptual map. A prescriber who thinks only of filtration may overlook another active component of renal drug removal; a prescriber who thinks only in kilograms may overlook why age-specific drug information remains necessary.

PITFALL

Do not use a general statement about renal maturation as though it determines the regimen for every medicine. Its relevance depends on how much the particular medicine and its metabolites rely on renal removal. The developmental principle guides interpretation; drug-specific information guides the actual prescription.

3.5 Developmental pharmacodynamics

Pharmacodynamics concerns the relation between exposure at the site of action and the resulting therapeutic or adverse effect. Developmental pharmacodynamics asks whether that relation may differ as the child develops. It is conceptually distinct from pharmacokinetics. A pharmacokinetic difference changes the concentration achieved. A pharmacodynamic difference changes the meaning of a given concentration for effect. In practice the two are often hard to disentangle, which is why an observed response should not be used to make a simplistic inference about either process alone.

For psychiatric prescribing, pharmacodynamic reasoning has particular relevance because the desired outcome is an observed change in symptoms, functioning and tolerability rather than a laboratory value alone. A concentration can be compatible with more than one clinical interpretation. It may reflect altered handling of the medicine, altered responsiveness at the site of action, an effect of illness, or a non-pharmacological explanation. The clinician's task is to preserve this differential rather than declare a concentration "effective" or "ineffective" in the abstract.

This distinction is also the reason a laboratory result cannot replace longitudinal observation. Pharmacokinetics helps explain exposure; pharmacodynamics helps explain the exposure-effect relation; clinical assessment establishes what is actually happening to the child. The three sources of information must be read together. This is a framework for thought, not a substitute for the broader monitoring and consent framework.

3.6 A disciplined approach to apparent variability

When response or tolerability appears out of proportion to the expected effect of a prescribed medicine, developmental pharmacology offers a structured sequence of questions. First, identify whether the concern is one of exposure, effect, or both. Second, consider whether developmental metabolism could alter bioavailability or elimination. Third, consider whether binding or intercurrent illness changes the interpretation of any measured concentration. Fourth, consider clearance, including renal processes when relevant. Finally, consider pharmacodynamic variation

and non-pharmacological explanations. This sequence prevents the common error of jumping from an unexpected outcome straight to an arbitrary dose change.

The sequence is deliberately explanatory rather than algorithmic. It does not tell the reader what dose to use, when to alter it, or what monitoring schedule to follow. Those decisions depend on the particular medicine, indication, evidence base, formulation, co-prescribed medicines, medical state and family context. General principles of child prescribing are addressed in the neighbouring prescribing fragment; off-label use and cautious titration are addressed in the fragment on off-label prescribing, dosing principles and start-low go-slow in children.

MNEMONIC

Entry, Binding, Clearance, Effect

Use this sequence to organise an unexpected response: ask what entered the circulation, what was bound, what was removed, and how the available exposure translated into the observed effect. It is a reasoning aid, not a dosing rule.

In child psychopharmacology, developmental physiology changes the path from prescribed amount to clinical effect, so dose, concentration and response must never be treated as interchangeable.

4 · Stimulants in children (recap, safety)

Why this matters clinically. A stimulant prescription is not made safe by a reassuring first review or by a neat entry on a prescription sheet. Safety lies in an organised follow-up relationship: the clinician remains alert to the child's changing body, daily functioning, family observations, and new clinical information. In a child, this matters especially because change can be gradual, expressed indirectly, or first noticed in a setting the prescriber does not see.

Stimulants are commonly discussed as if the important task were selecting a preparation and writing directions. That is not the focus here. The treatment decision and stimulant dosing in ADHD belong in *the ADHD and specific learning/communication disorders notes*. This section is a safety recap: it explains how to think during follow-up, what a useful record is trying to detect, and how to distinguish a measurement from a clinical conclusion.

4.1 Safety as a continuing clinical task

Therapeutic monitoring means using each contact to decide whether the current treatment plan still fits the child in front of the clinician. It is not an administrative ritual and it is not merely a search for adverse effects. The question is broader: what has changed since the last review, how reliable is the account of that change, and does the observed pattern call for attention, clarification, or a different plan?

This approach prevents contrasting errors. Therapeutic inertia occurs when a medicine continues simply because it was once started. Overreaction occurs when a difficult week is treated as proof that medication is responsible for every new problem. These errors arise when follow-up is

reduced to a simplified question about whether the medicine is "working." Children's lives do not present themselves in a simplified form. School demands, sleep, meals, family strain, developmental change, illness, and coexisting symptoms may all alter the picture without yielding a simple explanation.

RULE **At a stimulant review, measure change and interpret it in context before assigning a cause.** A safe review joins physical observations with the child's actual functioning and with a careful search for new medical or psychiatric concerns.

The established teaching account in a historical AACAP practice parameter is that follow-up should include review of behavioural and academic functioning, surveillance for emerging comorbidity or medical conditions, and **periodic assessment** of physical parameters. The wording is useful because it makes monitoring a clinical synthesis rather than a checklist detached from the child's life. It should be read as established teaching, not presented as a substitute for current local guidance or for individual clinical judgement.

A good review therefore begins with a narrative. Ask what the family, child, and relevant carers have actually observed, what has become easier or harder, and whether the report is consistent across settings. Then bring that narrative beside the recorded observations. The record is not there to overrule the family's account; it is there to make a trend visible and to reduce the chance that a meaningful change is missed because each visit is considered in isolation.

4.2 What should be kept in view at follow-up

The core physical safety recap is deliberately simple. At follow-up visits, **height**, weight, blood pressure, and pulse should be assessed periodically. The value of this set is not that any isolated entry automatically answers a clinical question. Its value is that it preserves a shared observational frame across visits. A record that is complete enough to compare is more useful than a collection of unconnected impressions.

Height	Weight	Blood pressure	Pulse
RECORDED OVER TIME	RECORDED OVER TIME	PHYSICAL REVIEW	PHYSICAL REVIEW

The clinical point is **trend recognition**. A value acquires meaning through method, context, and comparison with prior observations. Before deciding that a change is treatment-related, confirm that the measurement is credible and ask whether ordinary circumstances may explain it. Before deciding that a measurement is unimportant, ask whether it departs from the child's earlier pattern or occurs alongside a change in wellbeing or function. This disciplined middle position protects against both complacency and alarmism.

Physical review belongs beside functional review. The same historical AACAP account asks the clinician to review behavioural and academic functioning and to assess for emerging comorbid disorders and medical conditions. This is not an invitation to re-diagnose the child at every visit. It is a reminder that the presenting problem may evolve, that a coexisting difficulty may become more visible as one domain improves, and that treatment should not narrow the clinician's field of vision.

REVIEW DOMAIN	CLINICAL QUESTION	PURPOSE OF THE RECORD
Physical observations	Has there been a change that deserves verification or interpretation?	To make a pattern visible across contacts.
Behaviour and learning	What has changed in everyday participation and demands?	To connect treatment with the child's real-world function.
New symptoms or conditions	Is a fresh concern emerging that needs its own assessment?	To avoid attributing every development to medication.
Family and child account	Whose observations explain the change, and in which setting?	To test whether the clinical picture is coherent.

Growth surveillance is best understood as longitudinal observation, not as an isolated pass or fail event. A child may look well at an appointment while a gradual shift becomes apparent only when earlier records are available. Conversely, a concerning-looking entry may need repetition or contextual explanation before it is allowed to dominate a treatment decision. The same logic applies to **cardiovascular observation**: measure carefully, document clearly, and interpret a pattern rather than attempting to infer risk from an isolated decontextualised reading.

GOOD TO REMEMBER

Bring the physical record into the conversation. Showing a family the sequence of observations turns monitoring into shared clinical work and often clarifies whether the concern is a persistent pattern, an uncertain measurement, or a change in the child's wider circumstances.

4.3 Attribution: the central reasoning problem

The most important safety skill is **attribution**. An event that follows a prescription is not necessarily caused by it. Temporal proximity can be clinically important, but it is a starting signal for inquiry, not a conclusion. Children have intercurrent illnesses, altered routines, changing educational pressures, family events, developmental transitions, and untreated coexisting difficulties. A prescriber who ignores these alternatives may make an avoidable treatment change. A prescriber who uses them merely to dismiss a concern may miss a genuine problem.

Attribution is strengthened by detail. What exactly changed? When was it first noticed? Does it occur consistently or only in a particular setting? Has someone observed the same pattern independently? Was there a relevant change in routine, health, school, or family life? Have the basic observations been checked? These questions do not demand a formula. They create a defensible clinical account in which action follows evidence rather than anxiety.

It is useful to separate the tasks that are often muddled together:

- recognising that a new observation deserves attention;
- deciding what additional information is needed to understand it; and
- deciding whether the treatment plan should change.

Keeping these tasks separate improves both safety and communication. A parent can be taken seriously when a concern is recognised without the clinician prematurely promising a causal explanation or a medication change. It also leaves room for the child's own account. A child may describe an experience differently from a caregiver, and that discrepancy is information to explore rather than a nuisance to smooth away.

TRAP **Do not equate "reported after treatment" with "caused by treatment."** The equally unsafe opposite is to treat a report as irrelevant because the measurement is not yet conclusive. Record the concern, assess its context, and let the subsequent clinical picture guide the response.

Documentation serves the same reasoning purpose. It should state the concern in clinically neutral language, identify the informant and setting, record relevant observations, and make the plan intelligible to the next clinician. It should not turn a suspicion into an established adverse effect merely by the wording used. Precise notes protect the child from both fragmented care and retrospective certainty that was never actually earned.

4.4 Function is part of safety

Functional review is part of safety because a prescription that looks uncomplicated on a chart may still be poorly fitted to the child's life. The historical monitoring account specifically includes behavioural and academic functioning. The point is not to make academic performance the sole measure of treatment value, nor to reduce behaviour to a report from one adult. It is to ask whether the child's capacity to participate in ordinary expectations is changing and whether that change is experienced as helpful, burdensome, or ambiguous.

Function must be explored across the child's environments. A family may notice a different pattern from school, and neither account should be casually privileged. Apparent disagreement may reflect different demands, different observers, or a real context-dependent effect. The clinical task is to understand the discrepancy. In this respect, monitoring remains child psychiatry rather than a narrow drug review: the medicine is considered within development, relationships, education, and health.

When a child's functioning changes, resist the temptation to collapse the answer into "more" or "less" medication. First establish what is meant by change. Is the concern about attention, activity, distress, participation, conflict, tiredness, learning demands, or something else? What is the child's interpretation? Has the concern emerged alongside a medical or psychosocial change? This does not duplicate the treatment chapter; it explains why follow-up must preserve diagnostic curiosity even after a prescription has begun.

MNEMONIC

RAMP

Record the physical measurements, **A**sk about everyday function, **M**onitor new concerns and context, and **P**lan, summarised so the child and family can understand it. It is a recall scaffold for a review, not a dosing rule or a substitute for clinical judgement.

A clear summary at the end of the consultation is clinically useful. It states what has been heard, which observations were documented, what remains uncertain, and what change should prompt earlier contact. This protects against the family leaving with a vague sense that they have been reassured but no shared understanding of what is being watched. It also gives continuity when care is shared across clinicians or services.

4.5 Scope, currency, and the Indian examination answer

IN INDIA

For an Indian postgraduate answer, keep the stimulant safety paragraph distinct from the ADHD treatment paragraph. State that physical parameters and functional change are followed longitudinally, then direct the reader to *the ADHD and specific learning/communication disorders notes* for stimulant selection and dosing. This prevents an answer from importing a regimen into a question that is actually testing safe follow-up.

Safety advice often becomes unsafe when its scope is lost. A historical practice parameter can provide an enduring clinical principle while no longer functioning as a current, stand-alone protocol. The safe use of such teaching is transparent: identify the principle it contributes, preserve its limits, and check the current local policy or specialist advice when a contemporary operational decision is required. This is especially important when a trainee is tempted to convert a broad instruction to monitor into a rigid schedule, threshold, or universal response.

The practical distinction is between a **monitoring framework** and a management algorithm. A framework tells the clinician what domains deserve recurrent attention. An algorithm tells the clinician precisely what to do under defined circumstances. The supplied historical teaching supports the former. It does not license this section to invent the latter. Keeping that distinction explicit is both good scholarship and good clinical safety.

PITFALL

Do not present an older authoritative document as if it settles a current operational question. Its monitoring principle may remain useful, but current decisions require the applicable policy, the child's clinical context, and appropriate specialist judgement.

The same discipline applies to cross-references. The disorder formulation, diagnostic reconsideration, medication choice, and dosing details must not be smuggled into a safety recap merely because they are clinically adjacent. A focused answer is stronger: it says what the review must observe, why interpretation matters, and where the reader should go for treatment details.

4.6 A usable follow-up note

A concise follow-up note can carry considerable clinical intelligence when it links observation to interpretation. It should identify the child's and caregiver's account of change, note relevant behavioural and academic functioning, record whether fresh medical or psychiatric concerns have emerged, and preserve the physical observations required for longitudinal comparison. It

should then state the clinician's working interpretation and the agreed next step. This makes the reasoning visible rather than leaving a sequence of numbers with no clinical meaning.

The note should also preserve uncertainty honestly. "Concern reported, context under review" is often more accurate than a definitive label. It tells a future clinician that the issue was heard and that the current evidence did not yet justify a stronger conclusion. Honest uncertainty is not indecision. It is a deliberate safeguard against causal overstatement in a developing child whose circumstances may change quickly.

Stimulant safety follow-up is longitudinal: **periodically** record physical parameters, review real-world function, and investigate new concerns before deciding what they mean.

5 · Antipsychotics in children (indications, metabolic monitoring)

Why it matters clinically. An antipsychotic prescription in a child is never simply a choice of molecule. It is a decision to target a clearly described symptom pattern, within a developmental formulation, while accepting the obligation to look actively for physical harm that the child may neither recognise nor report. The useful examination answer is therefore not a list of drugs. It is a disciplined account of indication, scope, baseline metabolic monitoring, review of benefit, and a route back to the wider treatment plan.

In child psychiatry, these medicines are often discussed around highly visible behaviours, but visible behaviour is not itself an indication. The clinician must specify what is being targeted, how it is impairing the child or others, what non-pharmacological work is proceeding, and what observable change would justify continuing treatment. Antipsychotics can have an important place in carefully selected situations; they should not become a substitute for developmental assessment, family work, environmental modification, or treatment of the disorder that gives the symptom its meaning.

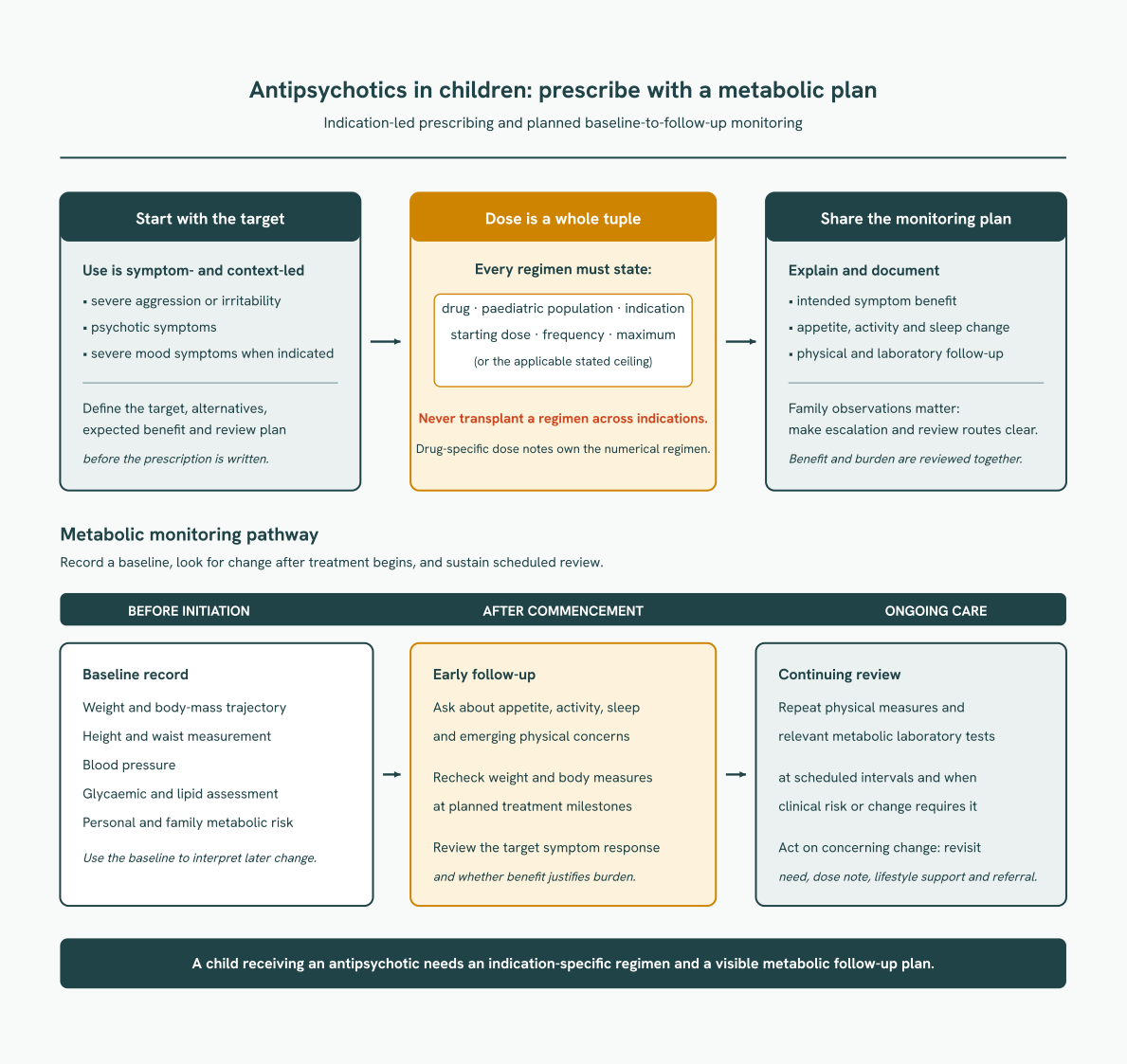


Fig 24.3. Antipsychotic prescribing in children is indication-led: a complete dose tuple belongs to the drug-specific prescribing note, while metabolic monitoring begins before initiation and continues through treatment.

5.1 The indication is a clinical question, not a behavioural label

A **target symptom** is the concrete phenomenon that the prescription is intended to change. It should be described in language that permits subsequent review: its form, setting, precipitants, consequences, and effect on functioning. This prevents the common slide from "difficult behaviour" to medication without a defensible therapeutic question. A severe behavioural presentation may arise from distress, communication difficulty, fear, pain, sleep disruption, conflict, a neurodevelopmental need, an emerging mood or psychotic state, or a safeguarding problem. Medication may be relevant to some formulations, but it cannot settle which formulation is correct.

The prescriber should translate the referral complaint into a working hierarchy. Immediate risk and intolerable suffering take priority, but urgency does not abolish assessment. The practical question is whether an antipsychotic is being considered to relieve a symptom pattern for which it is reasonable, or merely to make a setting easier to manage. The latter may occur when a family,

school, ward, or residential placement is overwhelmed. Their burden deserves attention, yet social strain alone is not an adequate endpoint for a child's long-term medication exposure.

RULE **Prescribe against a stated target and a stated review question.** The target tells the team what benefit to seek; the review question tells the team what would count as insufficient benefit, unacceptable harm, or a reason to change course.

A **functional formulation** protects against treating a symptom in isolation. It links the behaviour or experience to antecedents, developmental abilities, relationships, reinforcement, medical contributors, and the child's environment. The formulation also clarifies what medication cannot accomplish. A medicine may reduce a particular symptom, but it does not teach communication, repair attachment strain, alter a coercive interaction cycle, or create an appropriate educational placement. Those tasks remain active parts of care.

5.2 Scope discipline: named examples are not portable regimens

Regimens in child psychiatry are inseparable from the indication and population for which they were established. A drug name written beside a diagnosis can falsely imply that the same approach applies to every child with that diagnosis, every behavioural difficulty, or every service setting. That inference is especially unsafe with antipsychotics, where the balance between expected benefit and physical burden varies with the clinical problem and the individual child.

For a child with tics, **aripiprazole** may be named as a cross-referenced example; its tic regimen is taught in *the Child behavioural, emotional and other disorders notes*. Likewise, **risperidone** may be named in relation to conduct-disorder aggression, but that regimen belongs to *the Child behavioural, emotional and other disorders notes*. The relevant population and indication must accompany any reading of current labelling. These references are deliberately narrow. They neither authorise a regimen for another presentation nor provide a dose that can be lifted into another clinical context.

Risperidone may also be named as a cross-referenced example for autism-related irritability; its regimen is taught in *the Intellectual disability and autism spectrum disorder notes*. This distinction is more than editorial tidiness. When a child's presentation is linked to autism, the diagnostic formulation, communication profile, sensory context, family goals, and behavioural supports shape the treatment decision. A medication name alone cannot carry that work.

PITFALL

Do not convert a cross-referenced example into a general-purpose prescription. The same antipsychotic may appear in more than one part of child psychiatry, but each use has its own clinical question. A dose or titration recalled from one indication is not evidence for another.

PRESCRIBING QUESTION	WHAT THE RECORD SHOULD MAKE CLEAR	WHY IT MATTERS
What is being treated?	The target symptom and its functional impact.	It prevents medication from becoming a response to an unspecific label.
Why medication now?	The clinical rationale, urgency, and the work already underway around the child.	It keeps pharmacotherapy within a multimodal plan.
What benefit is expected?	A change that the child, carers, and team can recognise.	It makes continuation a clinical decision rather than an automatic renewal.
What harm is being watched for?	Physical measures and the plan for responding to change.	It gives metabolic monitoring the same status as symptom review.
Who will review the plan?	Named clinical responsibility and communication with carers.	It reduces fragmented prescribing across services.

5.3 Metabolic monitoring is part of the prescription

Metabolic monitoring is not an administrative appendix added after the therapeutic decision. It is the means by which the clinician makes the physical cost of treatment visible. Children may have limited language for bodily change, may depend on adults to arrange investigations, and may experience the effects of appetite change, weight change, tiredness, or altered self-image within family and school systems. Monitoring therefore belongs in the initial conversation and documentation, not only in a later laboratory request.

The metabolic monitoring schedule begins before treatment. Before starting an antipsychotic, record **weight or BMI**, **pulse**, **blood pressure**, and a **fasting blood glucose or HbA1c** together with a **blood lipid profile**. These baseline measures create a comparison point. Without them, later change is difficult to interpret and an emerging physical problem can be wrongly attributed to lifestyle, family care, or the child's condition.

Before treatment	**Target**	**Physical change**	**Family**
BASELINE RECORD	CLINICAL BENEFIT	ACTIVE REVIEW	SHARED OBSERVATION

The phrase "metabolic" should not narrow the clinician's attention to a test result. It is a clinical frame for considering bodily change over time and its implications for adherence, confidence, participation, and future health. A child who is gaining weight, distressed about appearance, avoiding activity, or receiving stigmatising comments from peers may not volunteer the connection to treatment. A respectful review asks directly, avoids blame, and includes the carers who organise meals, appointments, and daily routines. It also leaves room for the child's own account of whether the medicine's benefit is worth its burden.

Baseline measurement is not a hurdle designed to delay necessary treatment. Its purpose is to make later judgement more honest. Where clinical circumstances require prompt action, the

prescriber should still document what is known, arrange the outstanding physical work, and make clear who is responsible for seeing the information. The error is not acknowledging uncertainty; the error is allowing an urgent start to become a reason that safety information is never assembled. In the same way, a normal baseline does not predict that the child will remain unaffected. It simply gives the clinician and family a reliable starting point for noticing change.

TRAP **Do not treat baseline tests as permission to stop thinking about physical health.** Baseline information is useful only when it is compared with the child's subsequent clinical course and when concerning change leads to a renewed benefit-harm decision.

5.4 Turning measurement into clinical review

A **benefit-harm review** joins symptom observation to physical monitoring. If the target has not materially changed, the prescriber should not let elapsed time turn an unsuccessful trial into indefinite exposure. If there is benefit but emerging burden, the task is to reconsider the entire plan: the clarity of the target, whether the formulation has changed, the role of psychosocial interventions, the acceptability of the treatment to the child and carers, and whether continued medication remains proportionate.

Review is strongest when it uses information from more than one setting. Carers may observe sleep, appetite, activity, irritability, and family functioning. The child may describe internal experience, embarrassment, sedation, or a change that adults have missed. School observations can help distinguish a home-specific improvement from a more general functional change, while also revealing environmental demands that medication cannot solve. Disagreement between informants is data, not inconvenience. It may show that the target was too broad, that the context differs, or that a desired benefit is being purchased at a cost visible only in one setting.

- Return to the original target symptom rather than asking only whether the child is "better".
- Ask the child about bodily and social effects in language they can use.
- Review the carers' observations without allowing convenience to become the sole outcome.
- Connect physical findings to a documented decision about the treatment plan.

General monitoring and consent issues in child psychopharmacology require their own framework. In particular, the clinician should not mistake parental agreement for a complete account of the child's participation in care, nor allow the technical work of prescribing to crowd out collaborative explanation. The antipsychotic-specific contribution here is that physical monitoring should be explained as a shared safety task from the outset.

5.5 The child, family, and service context

Shared observation is clinically valuable because antipsychotic effects unfold in ordinary life rather than only in the consulting room. Carers need a plain explanation of the symptom being targeted, the changes that should be reported, and the purpose of metabolic monitoring. The child should receive an explanation suited to their developmental and communication level. This is not merely good manners. A child who understands that appointments include attention to

how their body feels is more likely to disclose a problem than one who experiences investigations as unexplained adult activity.

Service design affects safety. The record should make it possible for a clinician meeting the child later to see why the medicine was begun, what has changed, what baseline measures were obtained, and which team member will act on new information. A prescription without that trail can persist through handovers because no individual feels able to revisit the original decision. Conversely, clear documentation supports a proportionate review even when services are busy or the child is seen across settings.

Physical monitoring can also strengthen, rather than weaken, the therapeutic alliance. When its rationale is discussed openly, the child is less likely to experience weighing, blood-pressure measurement, or blood tests as punishment for behaviour. Families can then bring concerns early instead of assuming that appetite, appearance, tiredness, or reluctance to attend school are unrelated problems. The clinician's task is to hold both truths at once: distressing symptoms may need active treatment, and the treatment itself deserves the same careful attention as the symptoms it aims to relieve.

IN INDIA

Children may move between private consultation, hospital care, school-linked support, and family-led follow-up. The prescriber should make the indication and metabolic monitoring plan legible across those settings. A terse drug list is particularly unsafe when the next clinician cannot tell what symptom is being treated or whether physical baseline information exists.

GOOD TO REMEMBER

When a carer reports that a medicine has "settled" a child, ask what has actually changed: distress, aggression, sleep, participation, communication, or simply manageability. The answer determines whether the benefit is meaningful and whether the rest of the formulation still needs attention.

5.6 A disciplined answer in practice and in examinations

A concise but safe answer to an antipsychotic question starts with indication-specific reasoning, not a medication list. It then states that the child's broader formulation and psychological, family, educational, and environmental interventions continue alongside any prescription. Next, it names baseline metabolic monitoring and explains that the measures must inform ongoing review. Finally, it distinguishes a cross-reference from a regimen: named examples point the reader to the chapter that owns the particular condition and dose.

This structure is also useful at the bedside. It makes the clinical team declare what they are trying to change, invites the child and family into observation, and keeps physical health within the same decision loop as behavioural or emotional improvement. It is possible for an antipsychotic to be appropriate and still require active reconsideration. That is not indecision. It is the expected discipline of prescribing a powerful medicine to a developing person.

An antipsychotic prescription for a child is complete only when its target symptom, indication-specific scope, and metabolic monitoring plan can all be read from the clinical record.

6 · Antidepressants in children (SSRIs, black-box warning)

Why this matters clinically. Antidepressant prescribing in a young person is not a miniature version of adult prescribing. The clinical encounter contains a diagnostic formulation, a developmental formulation, the child's and family's account of what treatment is meant to change, and a decision about whether a medicine has a place at all. This section narrows deliberately to the safe reading of one paediatric depression regimen. That narrowness is useful: a dose can look deceptively portable when copied into a note, an examination answer, or a handover, yet it only has meaning when its indication and population travel with it.

Thus, **fluoxetine** is placed first here as the antidepressant whose current paediatric depression label supplies a usable regimen. The chapter does not turn that label into a general account of childhood depressive disorders, an argument for a particular treatment sequence, or a template for every SSRI. Those matters require the disorder formulation and the evidence base that belongs with it. A prescriber's task is to keep the medicine, the clinical problem, the developmental context, and the source of the dose in one sentence rather than allowing any one of them to substitute for the others.

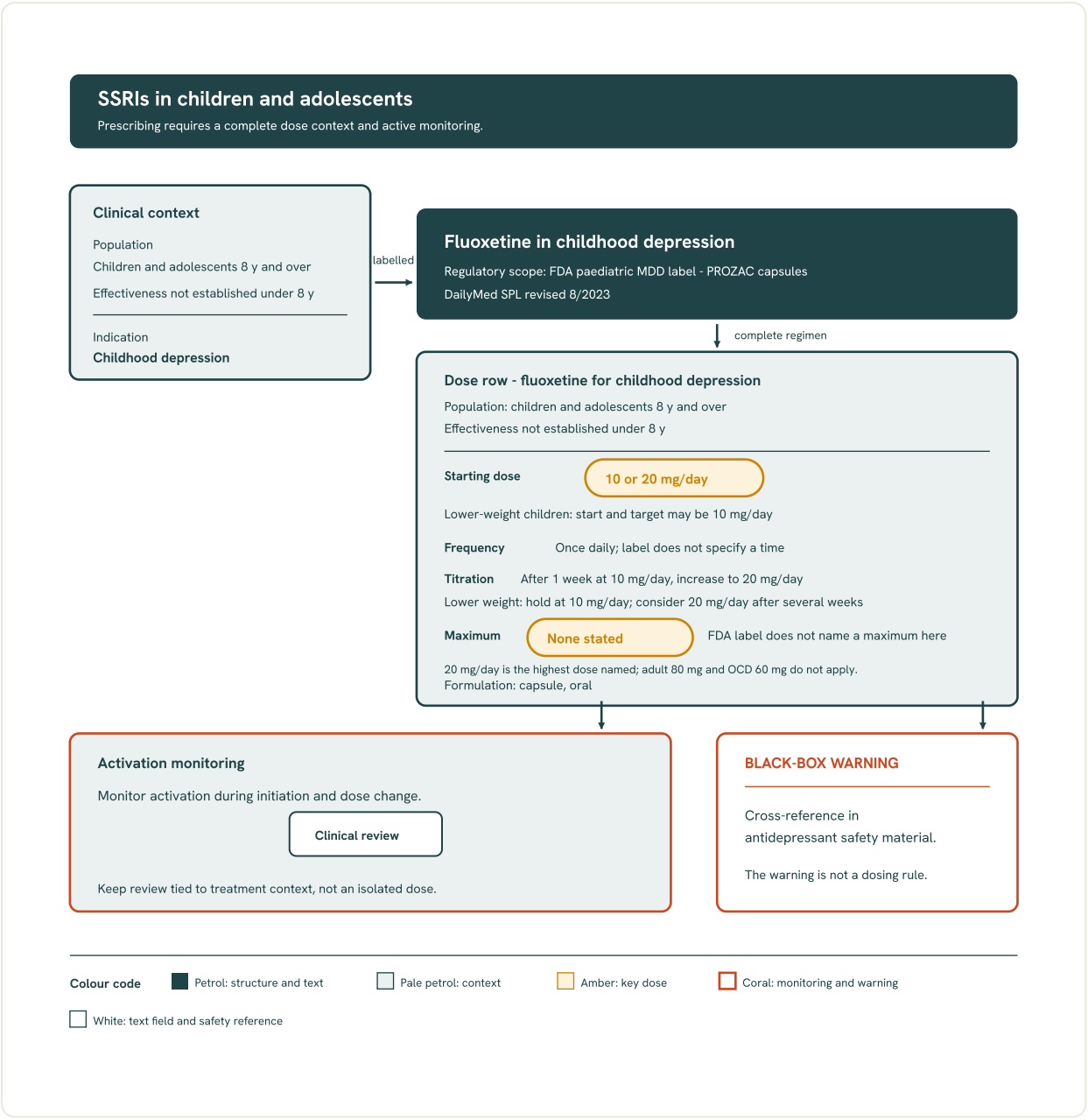


Fig 24.4. Fluoxetine is presented with the complete labelled regimen for childhood depression in the stated paediatric population. Monitor activation at initiation and dose change; handle the black-box warning through the linked safety reference.

6.1 What this section does and does not establish

The term **paediatric indication** is the essential boundary. A regulatory regimen answers a constrained question: for whom, for which named clinical use, and on what schedule has this product information been written? It does not decide that the young person in front of the clinician has that condition, that medication is sufficient treatment, or that the same wording can be exported to another indication. The dose is therefore read at its origin, not treated as a detached property of the molecule.

This distinction matters in both ward and outpatient work. Clinical teams often inherit a medication list without the reasoning that led to it. A copied drug name may survive while the original target symptoms, developmental context, and intended endpoint disappear. Restoring the missing sentence is a safety task. The clinician should be able to say what problem is being

treated, why this medicine is being considered for that problem, and which source governs the proposed regimen. If that cannot be said clearly, a dose entry should not masquerade as a complete treatment decision.

RULE **A paediatric antidepressant dose is a clinical tuple, not a standalone number.** Keep the drug, the indication, the population, the frequency, the route of change, and the ceiling statement together whenever a regimen is written or communicated.

The assessment and diagnostic work that decides whether childhood depression is the relevant formulation belongs with the childhood disorders and their assessment, rather than with a dosing paragraph. Likewise, a discussion of psychotherapy, family intervention, school support, or service referral cannot be replaced by a prescription. Naming these limits is not evasive. It prevents the dose from being used as a shortcut around the clinical work that makes prescribing intelligible.

6.2 The labelled fluoxetine regimen for childhood depression

For children and adolescents **8 years and over** with **childhood depression**, the current FDA product label describes oral fluoxetine at a starting dose of **10 mg/day** or **20 mg/day**, given once daily. The paediatric paragraph states no time of day; the once-daily-in-the-morning instruction appears in the adult depression section of the label and is not carried into the paediatric text. When the lower amount is used, it is increased after **1 week** to a target of **20 mg/day** for childhood depression. In lower-weight children, the label states that the starting and target dose may be the lower amount, and that an increase to the higher target may be considered after several weeks if clinical improvement is insufficient. The maximum statement must be retained separately: in childhood depression the target is **20 mg/day**, and the label does not name a maximum of any kind for this paediatric indication. The ceilings it prints elsewhere belong to adult depression and to paediatric obsessive-compulsive disorder, and neither may be carried across to childhood depression.

The wording above is intentionally complete. A range alone is not a regimen, because it does not tell the reader whether the range describes initiation, a target, or a limit. Nor does a target substitute for a maximum statement. Here, the paediatric paragraph simply does not state a separate weight-based ceiling, and that silence must be reported as silence. It should not be rewritten as an invented weight-based rule, and it should not be silently converted into permission to extrapolate beyond the labelled target.

Scope	Schedule	Change	Ceiling
DRUG + POPULATION + INDICATION	ONCE DAILY, NO STATED TIME	LABELLED STEP TO TARGET	STATE IT EXPLICITLY

PRESCRIBING ELEMENT	WHAT MUST REMAIN ATTACHED TO THE DOSE	WHY IT MATTERS
Drug	The exact medicine named in the label	Prevents a class label from replacing a medicine-specific regimen.
Population	The age and developmental scope stated by the source	Prevents use of a paediatric statement outside the population it addresses.
Indication	Childhood depression, not an implied alternative use	Prevents a regimen from migrating across diagnoses.
Starting plan	Initial amount, timing, and route of increase	Makes the first prescription reproducible and reviewable.
Target and ceiling	A target statement plus the label's ceiling language	Stops a range from being mistaken for either of these distinct ideas.

Write the whole regimen sentence: medicine, child population, indication, start, schedule, titration, target, and ceiling statement.

6.3 Why the lower-weight pathway is clinically meaningful

The phrase **lower-weight children** is not decorative label language. It signals that a young person's developmental and bodily context can alter the labelled starting and target plan even when the diagnostic indication is unchanged. The prescriber should therefore resist a crude age-only reading of a paediatric regimen. The relevant question is not whether the child resembles an adult closely enough to receive an adult-looking dose. It is whether the particular labelled pathway describes this child's population and clinical situation.

That is a reasoning discipline rather than a numerical trick. Weight, maturity, medical comorbidity, concurrent treatments, formulation practicalities, and the family's ability to observe change all shape how a prescription is implemented. The general developmental pharmacology of childhood, the broader principles of cautious titration, and the operational framework for monitoring are discussed elsewhere in this chapter. They should inform the encounter, but they must not be reverse-engineered into an unsourced alternative regimen.

- Identify the clinical indication before opening a dosing source.
- Check that the child fits the population described by that source.
- Preserve the lower-weight branch when it is the relevant labelled pathway.

GOOD TO REMEMBER

A prescription is easier to review when the rationale is written next to it. Record the treatment target in ordinary clinical language and retain the label-based regimen sentence in the medication plan. This allows the next clinician to distinguish a considered paediatric plan from a number that has simply been carried forward.

6.4 Titration is a decision point, not automatic escalation

The instruction to move from the lower start to the higher target is often read as a mechanical sequence. It is better understood as a planned review point. The label supplies the timing and target for its defined population; clinical work supplies the observation and interpretation that surround that plan. A clinician must still know what change is being sought, what the family has observed, whether the medicine is being taken as intended, and whether the formulation remains coherent. These are not reasons to improvise a new dose. They are reasons to decide whether the labelled pathway remains the relevant one.

There is a useful separation of roles. The label governs the regimen stated here. The therapeutic relationship makes observations usable: a young person and caregiver need language for describing benefit, distress, activation, withdrawal from usual activity, and changes that matter to them. The formal framework for monitoring, consent, assent, shared decision-making, and review cadence is owned by the child psychopharmacology section on monitoring and consent. This section names that framework but does not duplicate it.

TRAP **Do not write a target dose as though it were a command to escalate regardless of the child's course.** The target belongs to a defined regimen; the decision to continue along that pathway remains clinical and must be documented in the wider monitoring framework.

Equally, avoiding automatic escalation does not mean replacing the label with unstructured hesitation. Ambiguity can be just as unsafe as overconfidence when it produces unclear instructions for caregivers or a fragmented handover. The safe middle position is explicit: the intended plan is recorded, the source is identifiable, and any departure from the plan has a stated clinical reason rather than an accidental drift.

6.5 The source of a paediatric dose is part of the prescription

The regimen in this section is scoped to the **FDA paediatric MDD label**. This is a source statement, not a claim that regulatory status, product availability, or local practice is identical in every jurisdiction. Current labelling deserves priority over remembered textbook tables because a dose is especially vulnerable to becoming stale when it is detached from its source. A well-written clinical note therefore makes the source visible enough for another clinician to verify it rather than presenting the dose as timeless common knowledge.

Source discipline also improves examination answers. A candidate who writes only a drug and an amount has shown recall but not safe prescribing reasoning. A stronger answer identifies the population and indication, gives the starting plan and once-daily schedule, explains the move toward the target, and records the ceiling statement. It then separates this factual regimen from the broader question of whether the child needs medication, psychological treatment, family work, school intervention, or a different level of care.

PITFALL

Do not infer an Indian paediatric depression approval merely because a United States product label carries a paediatric regimen. The regimen printed here is explicitly sourced to that label. Local regulatory status and available formulations must be checked at the point of prescribing.

6.6 Boundaries with the SSRI suicidality warning

The paediatric SSRI black-box suicidality warning itself is not taught here. It belongs to *the Child behavioural, emotional and other disorders notes*, where it should be read in its disorder-level context. This cross-reference matters because a warning is neither a reason to minimise distress nor a substitute for a full risk formulation. Conversely, a brief mention of a warning must not be allowed to become a generic warning paragraph that is repeated wherever an antidepressant is named.

For the prescribing encounter, the practical implication is architectural. The medicine-specific regimen is documented here; the warning and its clinical interpretation are sought in the named cross-reference; and the general monitoring-and-consent framework is sought in its owning section. Keeping these layers separate prevents a false choice between pharmacological precision and safety. Both are required, but they are not the same construct and should not be taught as though a dose table alone can carry either one.

- Use the disorder chapter for the paediatric SSRI black-box suicidality warning.
- Use the child psychopharmacology monitoring-and-consent section for its general framework.
- Use the current product label for the regimen attached to its indicated population.

6.7 An Indian prescribing stance

IN INDIA

Use the regimen here as a clearly labelled regulatory reference, not as a shortcut to local authorisation. In Indian practice, verify the currently available formulation, the applicable local regulatory information, and the service pathway for the child and family. Documentation should make clear whether the prescribing decision rests on a locally applicable indication or on a separately justified clinical decision.

This stance avoids two opposite errors. One is therapeutic nihilism, in which the clinician treats uncertainty about a label as a reason not to formulate or treat. The other is regulatory overreach, in which an overseas label is cited as if it settles every local clinical and legal question. Neither helps the child. The disciplined approach is to identify the clinical need, use the correct source for the exact regimen being considered, and state openly what that source does and does not establish.

The larger child psychiatry system remains visible in the background. Family engagement, psychological treatment, school coordination, and safeguarding may all determine whether a medication plan can be used safely and meaningfully. They are not adjuncts to be remembered after a dose is chosen. They are parallel components of care, each requiring its own assessment,

intervention, and documentation. This section contributes one precise element: how to read and communicate the fluoxetine label without letting that precision spill into claims the source does not support.

7 · Mood stabilizers in children and adolescents

Why it matters clinically. A mood-stabiliser prescription in a young person is not a class-level decision. It is a tightly bounded clinical instruction: the drug, the indication, the child for whom the regimen was read, the way it is introduced, the safety work that makes continuation defensible, and the point at which the prescriber must reconsider. This matters especially when a familiar adult regimen is being discussed in a family meeting. Familiarity can make a dose look portable when its evidence and label scope are not.

This section is deliberately about the prescription and its safety architecture, not about diagnosing bipolar disorder or choosing a syndrome-level treatment pathway. Those clinical formulations belong with the childhood disorders in *the Child behavioural, emotional and other disorders notes*. General mood-stabiliser pharmacology is considered elsewhere. Here, the candidate should be able to read a regimen as a complete sentence and explain what must accompany it in real practice.

7.1 Reading a paediatric regimen as a whole

The useful unit of learning is the **regimen**, not the isolated milligram figure. A dose becomes clinically meaningful only when attached to a named indication and an explicitly described population. It must also state how the dose changes and where the upper boundary lies. If a label names no milligram ceiling, that silence must be reported as silence rather than as a statement that no ceiling exists; it tells the reader that a serum-guided endpoint, rather than a memorised tablet count, is doing the limiting work. The doses below are read at their regulatory-label origin; the table preserves source-specific scope instead of exporting it across settings.

That distinction protects against opposite errors. Under-reading copies the starting dose without the titration or monitoring plan. Over-reading treats an adult regimen or a foreign label as though it establishes local paediatric approval. Neither error is repaired by adding a vague warning such as “monitor closely.” The prescriber must state what is being monitored, why it is being monitored, and how the result changes the next decision.

RULE **Never quote a paediatric mood-stabiliser dose without its indication, population, titration and ceiling statement.** The dose is only an element of the instruction. Separating it from the rest creates a prescription that sounds precise but is clinically incomplete.

MNEMONIC

SCOPE

Specific indication, **C**hild population, **O**rigin of the regimen, **P**lan for titration and monitoring, and **E**ndpoint or ceiling. Use it before writing the order and again before explaining it to a family.

SCOPE	LITHIUM	VALPROATE	LEVELS
READ THE WHOLE ORDER	LABEL-SCOPED REGIMEN	OFF-LABEL CAVEAT	SAFETY DECISION POINTS

MEDICINE	INDICATION AND POPULATION	STARTING PATH AND CEILING	SAFETY READING
Lithium carbonate	Paediatric bipolar mania in **patients aged 7 years and older who weigh over 30 kg**	**Start at 300 mg three times daily in divided doses, increase by 300 mg every 3 days, and obtain serum lithium at 3 days, drawn 12 hours after the last dose, to guide titration. Maximum: the label names no milligram ceiling for this population; it gives usual dose ranges of 600 mg two to three times daily acutely and 300 to 600 mg two to three times daily for maintenance, and the limiting endpoint is the serum level, with an acute target of 0.8 to 1.2 mEq/L.** Source: US FDA lithium carbonate label, revised October 2022.	Use the baseline and continuing lithium monitoring plan (NICE CG185).
Lithium carbonate	Paediatric bipolar mania in **patients aged 7 years and older who weigh 20 to 30 kg**	**Start at 300 mg twice daily in divided doses and increase by 300 mg weekly, not every 3 days. Maximum: the label does not state a milligram maximum for this weight band. It gives dose ranges, not ceilings: an acute range of 600 to 1500 mg daily in divided doses and a maintenance range of 600 to 1200 mg daily in divided doses. The serum targets are the same as the heavier band, 0.8 to 1.2 mEq/L acute and 0.8 to 1.0 mEq/L maintenance.** Source: US FDA lithium carbonate label, revised October 2022.	Use the baseline and continuing lithium monitoring plan (NICE CG185).

MEDICINE	INDICATION AND POPULATION	STARTING PATH AND CEILING	SAFETY READING
Divalproex sodium	Bipolar mania: use in children is **off-label**.	The label establishes **no paediatric population** for this indication, so it carries no paediatric regimen. The adult mania regimen is deliberately not reproduced here: it is not transferable to a child, and printing it invites exactly that transplant. Dose only against a current label or a specialist protocol written for the child in front of you.	Make teratogenicity and the indication-specific evidence limitation explicit.

At every medication review, the order should make the following questions answerable:

- What exact indication is this medicine treating?
- Which child population does the regimen describe?
- What dose has actually been taken since the last review?
- What monitoring result is needed before the next decision?
- What is the action if benefit, safety, or feasibility changes?

7.2 Lithium carbonate: a scoped paediatric regimen

Lithium carbonate is the regimen in this section with a paediatric label scope for bipolar mania. The population boundary in the table belongs in the verbal handover, in the prescription record, and in the clinician's own reasoning. It prevents a dose learned for one child from becoming an unexamined default for another. The label sets out two paediatric weight bands, and they differ in starting frequency and in titration interval, so the band must be read before the number is used: the lighter band starts twice daily and is increased weekly, not three times daily and **every 3 days**.

The dose path is deliberately written as a sequence rather than a target tablet total. The maximum statement is as important as the start: a serum-guided endpoint is not permission to keep escalating by habit. A candidate should not substitute a remembered serum target from another setting for this label-scoped instruction.

Serum guidance does not make the clinical task mechanical. A concentration can be technically obtained yet be unhelpful if the timing, recent dose changes, adherence, fluid intake, intercurrent illness, or interacting treatment have not been reviewed. The result must be interpreted alongside the child's current clinical state and adverse-effect enquiry. This is why the medication review needs to preserve a clear sequence: what was prescribed, what was actually taken, what was measured, and what action follows. The level is a safety and dosing tool, not a substitute for reviewing the child.

GOOD TO REMEMBER

When handing over lithium care, write the indication and population beside the current dose. A future clinician can then see whether the regimen has remained within the scope in which it was originally selected, rather than mistaking a continuation dose for a universal rule.

7.3 Valproate: make the off-label boundary visible

Divalproex sodium, a valproate preparation, requires a different reading discipline in bipolar mania. No paediatric regimen is supplied here, and that absence is itself the teaching point: paediatric bipolar efficacy is not established, the label carries no paediatric population for this indication, and use in children is therefore off-label. The adult regimen is deliberately not reproduced, because a number printed in a paediatric chapter is a number that gets transplanted. Off-label is not a euphemism for routine. It means the prescriber should be able to articulate why this medicine is being considered for this child, what evidence limitation is being accepted, and what alternative plan exists if benefit does not emerge.

Where a specialist protocol does supply a regimen for a particular child, the same discipline applies to it: increase only to the lowest therapeutic dose, use the trough concentration to guide that judgement, and state the maximum as a distinct safety statement rather than letting it disappear into a dose range or be inferred from the starting instruction.

In an adolescent girl, **teratogenicity** is a hard caveat, not a footnote. The clinical conversation must make reproductive risk visible before treatment is normalised by routine follow-up. The record should show that the risk was discussed in developmentally appropriate language, that family involvement was handled within the applicable consent process, and that a plan exists for any change in pregnancy possibility or treatment circumstances. This is not a reason to withhold thought; it is a reason to make the thought auditable.

TRAP **Reciting a valproate mania dose as though it were "a paediatric bipolar dose".** No paediatric regimen is supplied here, because the label establishes no paediatric population for this indication; any figure recalled from elsewhere is an adult mania number, and the child and adolescent bipolar indication remains off-label. State both facts together, or the answer becomes unsafe.

IN INDIA

Do not infer an Indian paediatric bipolar approval from a regimen read in another regulatory setting. The supplied lithium dose is label-scoped, and no paediatric valproate regimen is supplied here at all, because that use in children is off-label. Check the locally available product information and document the indication-specific rationale rather than allowing a foreign label to stand in for local regulatory status.

7.4 Lithium before treatment: establish a safety baseline

Before lithium is started, **baseline monitoring** should include weight or BMI, urea and electrolytes including calcium, estimated glomerular filtration rate, thyroid function, and a full blood count. An ECG is arranged when cardiovascular disease or its risk factors make that

relevant. The point is not to accumulate investigations. Each element creates an interpretable reference point for later treatment decisions and exposes a reason to pause, clarify, or coordinate care before the medicine is introduced.

Baseline work is also an opportunity to prevent false reassurance. A result should be linked to a plan, not simply marked "normal" in a checklist. If a child already has a medical issue that could complicate interpretation, the prescriber needs a shared plan with the relevant clinician and a clear account of which service will act on an abnormal result. That is especially important during transfer between inpatient, outpatient, and emergency care, where an old result may be mistaken for a current baseline.

The family needs a practical explanation of why blood tests are part of treatment rather than evidence that something has gone wrong. A calm explanation improves the chance that sampling, review, and dose decisions happen in the intended sequence. It also makes room for the child's experience of procedures and for barriers such as travel, school timing, or fear of venepuncture. Those are not peripheral details. If they are ignored, a theoretically sound monitoring plan may never become a usable treatment plan.

PITFALL

Do not treat a recent laboratory sheet from another encounter as automatically adequate lithium baseline work. Its clinical meaning depends on timing, completeness, and whether it answers the pre-treatment question now being asked.

7.5 Lithium concentrations and maintenance surveillance

Two authorities meet in this section, and it is worth naming them. The dose pathway in the table is read at the US FDA lithium carbonate label (revised October 2022); the monitoring cadence below is taken from NICE Clinical Guideline CG185. The label instruction, a **serum lithium at 3 days drawn 12 hours after the last dose**, is the label instruction for the days immediately after a dose is set. The guideline cadence, measured **1 week after starting and 1 week after every dose change**, expressly covers the same titration period, so the two sources genuinely differ on when the post-change sample is taken. This is a real divergence and not a division of labour: name the source you are following, follow it consistently, and do not blend the two into a single invented schedule. Once titration is settled, early lithium monitoring has a defined rhythm. **Measure plasma lithium 1 week after starting and 1 week after every dose change, then weekly until stable; during the first year, measure it every 3 months.** This is best understood as a series of clinical decision points. After initiation and each adjustment, the team is checking whether exposure has become stable enough to move from active titration into maintenance. The later interval guards against the quiet drift that can occur after a seemingly settled prescription.

Maintenance monitoring is broader than the plasma concentration. **Maintenance monitoring** includes weight or BMI, urea and electrolytes including calcium, estimated glomerular filtration rate, and thyroid function **every 6 months**. Monitoring should be more frequent when there is evidence of impaired renal or thyroid function, raised calcium levels, or an increase in mood

symptoms that might be related to impaired thyroid function. That last trigger is the one a psychiatrist is most likely to meet first, because the presenting change is psychiatric rather than biochemical. The distinction between the level schedule and the organ-function schedule is worth preserving in notes and handovers: they answer different questions and neither replaces the other.

A useful review asks whether the agreed monitoring has actually occurred, whether the sample and the dose history can be interpreted together, and whether the child or family has noticed a change that should alter the plan. This is careful longitudinal prescribing, not a ritual laboratory task. If monitoring cannot be completed reliably, the clinician must address that limitation directly rather than letting refills conceal an unfulfilled safety plan.

> For paediatric mood stabilisers, the safe answer is the whole regimen: indication, population, dose pathway, ceiling, and monitoring - never the milligram figure alone.

8 · Monitoring and consent issues in child psychopharmacology

Why it matters clinically. A prescription for a child is not complete when the medicine is written. It becomes clinically defensible only when the prescriber has made a plan to observe benefit, detect burden, hear the child's experience, and revise the plan with the family. Monitoring is therefore not clerical follow-up. It is the method by which an initial prescribing hypothesis is tested in ordinary life: at home, in school, and in the child's own account of how treatment feels.

Consent is inseparable from that process. A parent or legally appropriate decision-maker may provide permission, but treatment is more likely to be understood and sustained when the child is included in a developmentally meaningful conversation. The psychiatrist must distinguish explanation, agreement, assent, consent, and legal authority without turning the consultation into either a signature exercise or a negotiation in which safety is abandoned. This section addresses the monitoring-and-consent framework around child psychopharmacology. Drug-specific adverse-effect schedules and dosing belong with the relevant medicine classes.

Review	Monitor	Discuss	Record
EFFECT	BURDEN	CHOICE	DECISION

8.1 Monitoring is a clinical loop, not a checklist

The purpose of a **monitoring plan** is to make the next clinical decision easier and safer. Before treatment begins, identify what change would count as useful, which unwanted changes would alter the balance of benefit and harm, who can observe each domain, and how observations will reach the prescriber. The target should be recognisable in everyday functioning, rather than a vague promise that the child will be "better". Carers, teachers, and the child may notice different things and may disagree.

Monitoring also tells the family that medication is revisable, not a verdict about the child. At each review, ask whether the treatment remains proportionate to the child's present needs and costs, not simply whether it has been taken.

RULE **Prescribe with a review question, not merely a review date.** The question links the original target, the observations that answer it, and the decision that will follow. A date without this structure easily becomes a refill encounter; a defined question makes it a clinical reassessment.

A useful record separates observation from interpretation. Document the account of participation, distress, behaviour, or functioning with its informant and setting, then state whether the pattern suggests benefit, intolerance, a contextual change, or inadequate information. This prevents the loudest informant from becoming the sole source of truth and makes the reasoning behind a treatment change transparent.

8.2 Build the monitoring plan before treatment begins

Pre-prescription assessment should produce a baseline that can be compared with later observations. The baseline is not an attempt to measure every possible outcome. It is a disciplined description of the presenting difficulty, the child's current functioning, relevant physical context, concurrent treatments, practical capacity to follow the plan, and the family's principal concerns. When baseline information is thin, later claims of improvement or deterioration are easily distorted by expectation, crisis resolution, school changes, or ordinary developmental variation.

The plan should state who will contact whom if the family is worried, what information should be brought to review, and what changes warrant earlier assessment. Families often interpret a prescription label as a complete treatment plan. Explain that medicines are part of care and that psychological, educational, and family interventions may remain essential. Their coordination is part of safe prescribing.

- Define the treatment target in language the family and child can recognise.
- Identify the settings and informants most likely to observe change.
- Record the child's starting physical and psychological state in clinically useful terms.
- Agree how benefit, burden, adherence, and uncertainty will be discussed at review.
- Document the contingency plan if concerns arise before the planned contact.

GOOD TO REMEMBER

The child's account is data, not a courtesy. Even when the child cannot describe an adverse effect in clinical language, descriptions such as feeling unlike oneself, unable to join in, frightened, dull, or embarrassed can identify an important treatment burden. Ask in private where appropriate, then bring the child back into the shared discussion rather than treating the consultation as an adult conversation conducted over the child.

8.3 Review efficacy, burden, and physical change together

Follow-up should revisit the original target and ask what has changed in the settings where the difficulty mattered. Symptom change alone is insufficient. A treatment can alter a visible behaviour yet leave the child less able to learn, relate, play, sleep, or participate. Conversely, a family may initially report little symptom change while describing a meaningful improvement in

distress or functioning. The prescriber's task is to weigh the full pattern, rather than reward only the most easily counted outcome.

An established practice-parameter teaching account expects medication follow-up **at least several times per year** for pharmacological treatment, with adjustment directed to continuing effectiveness, dose optimisation, and clinically important adverse effects. This is a review-point principle, not a substitute for earlier contact when the clinical situation calls for it. Its source is historical guidance, so it should be understood as established teaching rather than represented as a current live standard.

At these contacts, **height, weight, blood pressure, and pulse** are assessed periodically. That cadence is stimulant-specific; other drug classes carry their own schedules. The wider review asks what has happened since the previous contact, what changed in the child's environment, whether the medicine is being taken as intended, and whether the family's understanding has shifted. Continuation is itself a decision requiring reasons.

Monitoring intensity should respond to uncertainty and vulnerability. It may need closer contact when the clinical picture is changing, the child or family reports a concerning change, a treatment is being altered, information from settings is conflicting, or reliable observation is difficult. That judgement is not a licence for indiscriminate testing. It is a requirement to match the review process to the question being answered and to explain the rationale to the family.

REVIEW DOMAIN	QUESTION FOR THE CLINICIAN	DECISION RELEVANCE
Target difficulty	Has the problem that justified treatment changed in the settings that matter?	Tests whether there is benefit worth retaining.
Function	Is the child more able to participate in ordinary roles and relationships?	Prevents a narrow focus on a visible symptom.
Burden	What unwanted experiences do the child and carers describe?	Clarifies tolerability and acceptability.
Physical observation	Are the relevant physical findings being reviewed over time?	Links safety monitoring to the prescribed treatment.
Understanding	Can the family explain the purpose and current plan in their own words?	Detects misunderstanding before it becomes non-adherence or conflict.

TRAP **Do not call a tolerated prescription an effective one.** Absence of an obvious adverse effect does not establish benefit, and a report of benefit does not remove the need to ask what has been lost or made harder. The examination answer should show that efficacy, function, physical observations, and the child's experience are reviewed together.

8.4 Drug-specific monitoring must remain drug-specific

The general framework should not blur medicine-specific risks into a generic promise that "monitoring was done". The clinician must know which concerns follow from the selected

medicine, why they matter for that child, and how a result will change management. The detailed metabolic monitoring schedule for antipsychotics in children is addressed under antipsychotics in children; it should not be reproduced as a general rule for every child receiving psychotropics.

Treatment choices for attention-related difficulties should be read with the ADHD and specific learning/communication disorders notes, while the childhood disorders themselves and the paediatric SSRI black-box warning are covered in the Child behavioural, emotional and other disorders notes. Cross-reference prevents a general monitoring section from becoming a substitute for indication-specific prescribing knowledge.

PITFALL

Copying a monitoring schedule between medicine classes can create false reassurance. A neatly completed form is not evidence that the relevant risk has been assessed. Record the medicine, the clinical question, the observation sought, and the action that would follow from a concerning finding.

8.5 Assent makes the child a participant in care

Child assent is the child's affirmative, developmentally meaningful participation in a proposed course of care. It is not identical to legal consent and should not be presented as if a child's agreement can settle every question of authority. Its clinical value is substantial: it reveals what the child understands, corrects adult assumptions, permits discussion of fears and practical barriers, and makes it more likely that the child will report benefit or harm honestly.

Adapt the explanation to the child's language, maturity, emotional state, and ability to ask questions. The child should hear the treatment's purpose, what experience should be reported, what choices are open, and what will happen next. Do not ask "Do you agree?" before the child has been enabled to understand. Refusal deserves exploration: it may reflect fear, misinformation, an adverse experience, family conflict, or a concern adults have missed. Listening does not mean that every refusal determines the outcome, but dismissing it damages safety and alliance.

Assent must be revisited. A child who initially accepted a plan may understand it differently after experiencing treatment. Conversely, a child who was fearful at the outset may develop trust after a careful explanation and review. Revisiting assent is particularly important when the treatment purpose, burden, or family circumstances change. The record should show what was explained, how the child responded, questions raised, and how those questions influenced the plan.

8.6 Indian ethics guidance: a useful analogy, not the clinical statute

IN INDIA

The **Indian Council of Medical Research framework** cited here governs biomedical research involving children. It is useful by analogy when teaching how assent differs from parental permission, but it is not a clinical-consent statute. Do not convert a research-ethics age framework into a rule about clinical legal capacity. Statutory capacity, minor-treatment provisions, and forensic questions belong to the Mental health legislation and forensic psychiatry notes.

Within that research-ethics framework, the method of assent changes with the child's age. The table gives the framework once, because its value in clinical teaching is conceptual: the form of the conversation should develop, while parent or legally authorised representative involvement remains central. It should never be quoted as though it supplies the law of treatment consent.

CHILD'S AGE IN THE RESEARCH-ETHICS FRAMEWORK	ASSENT OR PERMISSION DESCRIBED	CLINICAL TEACHING USE
Under 7 years	Parental consent alone is described as sufficient.	Explain care in a manner the child can receive; do not mistake this research rule for clinical law.
7 (84 months) to 11 years	**Oral assent** is obtained with the parent or legally authorised representative present.	Use an understandable conversation and preserve the child's opportunity to respond.
12-18 years	**Written assent** is required.	Invite fuller participation while retaining the distinction between assent and legal authority.

The clinical conversation should remain respectful even where the legal analysis lies elsewhere. There is no therapeutic advantage in treating a child as a passive object of adult permission. The psychiatrist can be clear about the limits of decision-making while still giving the child privacy for questions, acknowledging ambivalence, and making the plan intelligible enough for the child to recognise when something is wrong.

8.7 Parental involvement should match the decision and its risk

The same research-ethics guidance frames **parent or legally authorised representative consent** in relation to the degree of risk. It says that consent from **one parent or legally authorised representative** may generally be sufficient for research involving minimal or low risk, while consent from **both parents** may be needed where research involves more than minimal or high risk. This is a risk-sensitive ethics framework, not a clinical rule that substitutes for applicable law or local institutional policy.

Its useful clinical lesson is that parental involvement should not be reduced to collecting a signature from whichever adult is present. Establish who cares for the child, whether disagreement affects the plan, whether the accompanying adult understands the information, and whether a broader conversation is necessary for safe follow-through. In conflict, do not recruit the child as an ally against a parent. Clarify the rationale, hear concerns, identify immediate risks, and seek the appropriate route when authority is uncertain.

- Separate the child's wishes from the legal question of who may authorise treatment.
- Separate parental disagreement from evidence about benefit and burden.
- Separate an urgent clinical need from the convenience of obtaining agreement.
- Document uncertainty about authority rather than concealing it in a generic consent entry.

MNEMONIC

Hear, Explain, Agree, Review

Hear the child and carers; **Explain** the target and foreseeable burden; seek meaningful **Agree**ment within the appropriate authority structure; and **Review** the decision as treatment unfolds. This is a consultation spine, not a claim that assent replaces consent.

Monitor the medicine, the child's functioning, and the family's understanding; consent is a continuing clinical conversation, not a form completed before treatment begins.

9 · Off-label prescribing, dosing principles and start-low go-slow in children

Why it matters clinically. Prescribing for a child is not a miniature version of prescribing for an adult. The diagnostic formulation may be clear, yet the prescriber still has to decide whether the proposed use is authorised for that age and indication, whether the expected benefit is meaningful to this child, and how to introduce treatment without mistaking an adverse effect, a developmental change, or a change in the home environment for drug response. These decisions are especially visible when a medicine is used **off-label**.

Off-label prescribing is a practical reality in Indian child psychopharmacology. It is neither automatically poor practice nor a substitute for reasoning. It means that the intended use does not match some part of the approved product information, such as the age group, indication, formulation, route, or dose. The clinician's task is therefore to make the mismatch explicit, decide whether it is justified for the individual child, and build a cautious plan around it. This fragment concerns that reasoning and the discipline of *start low, go slow*; disorder-specific regimens belong in the relevant disorder chapters.

9.1 Off-label use: a prescribing status, not a verdict

An off-label prescription is best understood as a description of the relationship between a proposed prescription and its label. It does not establish that the medicine is ineffective, unsafe, experimental, or negligent. Equally, the absence of a matching label must not be treated as a licence to prescribe casually. The label remains important because it records the regulatory indication, formulation, precautions, and population for which approval was granted. Clinical reasoning asks a different but connected question: whether the expected balance of benefit and harm is acceptable for this child, in this context, with this plan for review.

RULE **Off-label prescribing requires a clearer rationale, not a lower standard of care.** State the target problem, explain why the proposed use is reasonable, use the smallest prudent starting exposure, and arrange review that can detect benefit and harm.

For examination answers, the useful distinction is between **regulatory indication** and clinical indication. The former is a statement in authorised product information. The latter is the problem the psychiatrist is trying to treat after assessment. They often overlap, but they are not

interchangeable. A good answer avoids claiming that a label decides all clinical questions; a poor answer implies that a label is irrelevant once a clinician is confident.

QUESTION BEFORE PRESCRIBING	LABEL-ALIGNED USE	OFF-LABEL USE
What must be checked?	That the product and intended use match.	Which part of the proposed use differs from the label.
What must be documented?	The clinical target and review plan.	The clinical target, the rationale for the mismatch, and the review plan.
What must be discussed?	Expected benefit, unwanted effects, and practical use.	The same matters, plus the meaning of off-label use and uncertainty.
What changes the decision?	Benefit, harm, and whether the target remains relevant.	The same factors, with particular attention to whether the rationale remains sound.

OFF-LABEL	LABEL	TARGET
PRESCRIBING STATUS	CHECK BEFORE USE	DEFINE BEFORE TITRATION

9.2 The Indian regulatory context

IN INDIA

The CDSCO registry includes **atomoxetine** capsules for psychiatrist-directed treatment of attention deficit hyperactivity disorders. The same entry directs attention to **growth and weight** during long-term therapy. This is a concrete reminder that a paediatric psychiatric approval can exist, while the prescriber must still verify the current Indian information for the exact medicine, formulation, age group, and intended use. For disorder-specific treatment, see *the ADHD and specific learning/communication disorders notes*.

The available Indian inpatient evidence also cautions against pretending that off-label status is unusual. In a prospective Indian tertiary-care inpatient study, **1152** of **1645** prescribed medicines were classified as off-label, amounting to **70%**. This is general paediatric evidence, not a psychotropic-specific rate, so it should not be quoted as though it measured child psychiatric prescribing. Its teaching value is narrower and useful: off-label status is common enough in paediatric medicine that clinicians need a disciplined method rather than reflexive reassurance or reflexive refusal.

PITFALL

Do not infer an Indian paediatric approval from an overseas label or from a medicine's familiarity in practice. Approval is product- and use-specific. A copied prescription may look routine while its intended age, formulation, or indication has never been checked against the product information being used.

9.3 Making an off-label decision defensible

A defensible decision starts before the prescription. The child needs a formulation that identifies the problem to be changed and separates it from difficulties better addressed by psychological intervention, school support, parent work, environmental modification, or treatment of a physical contributor. Medication becomes difficult to evaluate when it is asked to solve an undefined cluster of behaviour, distress, family conflict, and educational strain. The more uncertain the target, the less interpretable the subsequent response.

The intended outcome should be observable. It may concern a symptom, a functional impairment, a pattern reported by caregivers, or a difficulty seen across settings. The wording should allow the family and clinician to recognise improvement without retrospectively redefining success. It should also name the adverse effects or clinical changes that would make the plan unacceptable. This is not a demand for rigid measurement in every consultation; it is a protection against the common drift in which treatment continues because nobody has decided what would count as benefit.

Next, consider alternatives honestly. The question is not whether medication can possibly be helpful, but whether it is the most proportionate next intervention. An off-label decision is stronger when the assessment has considered non-pharmacological options, when the proposed medicine has a credible role for the target problem, and when delay or non-treatment also carries a recognisable burden. This reasoning should be documented in clinical language, not as a defensive recital. A note that records the target, why the chosen option was selected, and the review plan is more useful to the child and the next clinician than a label alone.

- Specify the target problem and the setting in which change should be noticed.
- Check the current product information and record why the proposed use is appropriate despite any label mismatch.
- Agree on the observations that will count as benefit, harm, or need for change.

Communication with the parent or caregiver should be direct. Explain that the intended use is off-label, what that means in plain language, what is known and uncertain in the individual decision, and what review will look like. The child should be included in the discussion in a developmentally appropriate way. Detailed consent and assent practice, as well as the general monitoring framework, are addressed in the child psychopharmacology section on monitoring and consent; they should not be reduced to a signature obtained after the decision is already made.

TRAP **“Off-label” does not mean “off-evidence,” and “commonly used” does not mean “automatically appropriate.”** Candidates lose the clinical point when they answer only with regulatory language. The examiner is looking for an individualised indication, a transparent discussion, cautious dosing, and review.

9.4 Start low, go slow: what the phrase actually requires

Indian inpatient evidence shows why off-label status should be approached as a familiar paediatric prescribing problem rather than a reason to abandon judgement. Dose titration in children is a planned clinical experiment, not a race to a familiar adult dose. “Start low” means choosing a conservative initial exposure that permits early tolerability to be observed. “Go slow” means making measured adjustments only after there has been enough opportunity to understand the direction of change. The phrase is often repeated as a slogan; its practical value lies in the safeguards it imposes on interpretation.

At the outset, record the child's current symptoms, daily functioning, sleep, appetite, behaviour, physical complaints, concurrent medicines, and relevant medical history. The point is not to create an exhaustive checklist detached from the proposed medicine. It is to establish a baseline against which a new change can be judged. Without a baseline, irritability, fatigue, reduced appetite, activation, sedation, or a shift in behaviour may be attributed to the drug merely because the timing is convenient. The reverse error is equally hazardous: a genuine adverse effect may be dismissed as the child's usual presentation.

Titration should proceed with a single clearly interpretable change whenever feasible. If several interventions, doses, routines, and school responses are altered together, later improvement or deterioration has no clear owner. A paced plan also gives families time to notice changes that do not emerge in the consulting room. Caregiver reports, the child's own account where possible, and information from the relevant setting should be brought together, not used competitively. Disagreement is often clinically informative: it may reveal that benefit is context-bound, that harm occurs at a particular time, or that the treatment target was too broad.

The prescriber must remain willing to pause, reduce, stop, or rethink. A dose increase is not the default response to partial improvement. Before changing the dose, ask whether the target is genuinely improving, whether the adverse-effect burden is acceptable, whether adherence and administration are reliable, and whether the formulation remains correct. If the signal is unclear, greater exposure may magnify confusion rather than improve care. If the signal is unfavourable, a calm reassessment is more competent than persevering until the treatment appears to have been “adequately tried.”

GOOD TO REMEMBER

Slow titration is not therapeutic passivity. It is an information-gathering strategy. Each interval should answer a clinical question: is the target changing, is the child tolerating treatment, and does the next adjustment still make sense?

MNEMONIC

LABEL

Look at the label, define the **A**im, establish a **B**aseline, **E**scalate cautiously, and **L**isten at review. The mnemonic is a sequence for a safe prescribing conversation, not a substitute for a formulation.

9.5 Reviewing response without confusing noise for effect

Review is where the quality of the original prescription becomes visible. Revisit the target in the same words used at baseline. Ask what has changed in the child's experience and functioning, what others have observed, and whether the anticipated burden of treatment has appeared. A broad question such as “better?” often produces a broad answer. More useful questions connect to the agreed target: what is easier, what is unchanged, what has become harder, and when are the changes noticed?

Interpret change in context. A new routine, a school transition, an acute stressor, altered sleep, inconsistent administration, or a concurrent intervention can all affect the apparent response. This does not make medication assessment impossible. It means the clinician should resist premature certainty. Where uncertainty persists, simplifying the plan may be safer than layering new medicines or increasing an unclear dose. The child is not a failed trial because the first plan did not yield a clean answer; the formulation may need revision.

Long-term prescribing needs periodic reconsideration of continuing need. The original target may have changed, development may have altered the risk-benefit balance, or non-pharmacological supports may now carry more of the therapeutic work. Continuation should therefore be an active decision, not a consequence of repeated dispensing. The clinician should preserve a clear account of current benefit, current harm, and the reason to continue, alter, or withdraw treatment. This is especially important when care is transferred between services.

- Compare the current presentation with the original target, baseline, and anticipated unwanted effects.
- Check whether intervening contextual changes explain part of the apparent response.
- Decide explicitly whether to continue, modify, pause, stop, or reformulate the plan.

9.6 How to write and answer the principle

In a short answer, begin by defining off-label use as a mismatch with approved product information rather than calling it illegal or experimental. Then state that it can be clinically justified when the indication is individualised, the rationale is documented, the parent or caregiver is informed, and follow-up can detect benefit and harm. Add the dosing principle: begin conservatively, adjust gradually, and make each change interpretable. Close by stating that a child must be treated as a developing person in a family and service context, not as a smaller adult receiving a scaled-down prescription.

> Off-label prescribing in children is justified by an explicit individual rationale, transparent discussion, conservative initiation, gradual titration, and review against a pre-defined target.

Assessment and rating tools

10 · Principles of child psychiatric history and examination

The central task is to turn an account of a child into an account of functioning. A child psychiatric assessment is not a compressed adult interview and not a catalogue of symptoms reported by an accompanying adult. It asks what the child is able to do, communicate, tolerate and negotiate in ordinary relationships, and how that pattern alters across settings and over time. The examiner must therefore make the child visible without treating the parent, school or wider context as background noise.

The marks in this area reward method. A good answer shows how the clinician obtains a reliable account, observes the child directly, and reconciles apparent disagreement without prematurely converting it into a diagnosis. The core work is **a paired clinical frame**: **two** components, history-taking and the mental status examination, carried out as parts of one assessment rather than as separate rituals.

History	Mental state	Collateral
FUNCTION IN CONTEXT	DIRECT OBSERVATION	FUNCTION ACROSS SETTINGS

10.1 The assessment stance

Begin by deciding what question the referral is asking, while retaining enough breadth to discover that the question may be misplaced. The presenting concern is useful because it identifies distress, urgency and the family's explanatory model. It is not a diagnosis, and it should not dictate the sequence of the interview. The clinician needs a formulation-oriented account: the current difficulty, its context, the child's developmental capacities, relationships, functioning, strengths and risks. This is a clinical map, not an invitation to rehearse the disorder chapters.

History and examination proceed simultaneously. A caregiver's description of avoidance, for example, becomes more meaningful when the child's approach to the room, proximity seeking, speech, play, posture and response to the examiner are observed. Conversely, a striking behaviour in the room should be held as a sample, not promoted immediately to a trait. Children may be tired, frightened, oppositional, ill, overcontrolled, unfamiliar with the language of the interview, or responding to a tense interaction between adults. Good assessment makes room for these possibilities before assigning meaning.

RULE **Assess the child in development, relationship and setting, not as a symptom list detached from context.** The history supplies pattern and meaning; the examination tests how that account appears in the present encounter.

Consent, assent, confidentiality limits, safeguarding responses, formal risk procedures and diagnostic formulation require their own fuller treatment elsewhere in this chapter. Here, the interviewing discipline is simpler and more exacting: explain the purpose of the meeting in language the child can use, preserve respect for privacy without promising secrecy that cannot be

kept, and be clear with caregivers about when separate conversations are helpful. Do not make the child a passive object of adult testimony.

10.2 Building a history that explains development

A chronology alone does not constitute **developmental history**. The clinician elicits what happened in development and asks what those events came to mean to the child and family. The same developmental fact may be experienced as ordinary variation, a source of parental anxiety, a conflict within a family, a marker of loss, or a reason a child has repeatedly been treated as incapable. Those meanings influence expectations, attachment, school communication and help-seeking. They can also alter what caregivers notice and how they describe it.

The history should connect early functioning to the current problem without treating childhood as a deterministic preface. Ask about the child's usual ways of regulating emotion and behaviour, communicating needs, responding to change, relating to familiar and unfamiliar people, learning and managing daily demands. Clarify the sequence: what was present before the concern, what changed around its emergence, and what maintains or relieves it now. Where the history is uncertain, record uncertainty. Retrospective accounts are valuable clinical data, but their confidence, perspective and emotional charge matter.

Family accounts should be heard for both content and process. Who speaks first, who corrects whom, whose worries are minimised, and how the child responds while adults discuss them may illuminate the current relational field. This is not licence to infer hidden motives from a single consultation. It is a reason to seek examples, compare accounts and distinguish observed behaviour from interpretation. A respectful interviewer can ask a parent what a difficult behaviour means to them, then ask the child what the same situation feels like, without making either party the unreliable witness.

- Anchor each concern to a concrete situation rather than accepting a global label such as "difficult" or "lazy".
- Separate onset, course, triggers, consequences and attempted responses, while leaving room for uncertainty.
- Document strengths and effective relationships, because they identify leverage for care as well as resilience.

> **GOOD TO REMEMBER**
> When a caregiver reports a behaviour, ask what happens immediately before it, what the child does next, how others respond and what changes afterwards. This moves the history from a moral description to an observable clinical sequence without importing a diagnosis.

10.3 Collateral information and discrepancy

Multi-informant assessment is necessary because children function in relationships and settings that no single observer can fully represent. For most children, work from at least **three** essential sources: the parent or other primary caregiver, the child and the school. Each source has a different observational position. The child can report subjective experience and meanings that

adults do not see. Caregivers provide longitudinal knowledge and accounts of home life. School information describes demands, peer context and functioning outside the family.

Collateral is not a vote in which the majority account wins. A difference between home and school may reflect variation in structure, expectation, language, relationships, sensory load or opportunities for support. A child may also disclose selectively, or an adult may have limited opportunity to observe a particular domain. The clinical task is to ask what the discrepancy tells us about conditions under which the difficulty appears, improves or becomes invisible. Treating disagreement as error too early discards useful information.

Seek information in a focused, proportionate manner. State what question the school is being asked to help answer and distinguish facts, examples and interpretations in the record. Agency material and reports from other family members may add context, but should not become a substitute for meeting the child or listening to the primary caregivers. In India, school information may be especially uneven: attendance, language of instruction, class size, family mobility and access to trained staff can affect both what is observed and what can be communicated. The response is to interpret the limits of the collateral, not to assume it is useless.

SOURCE	DISTINCT CONTRIBUTION	CLINICAL QUESTION
Child	Experience, meanings and preferred ways of communicating	What is happening from the child's point of view?
Caregiver	Developmental course and daily context	How has the pattern changed and what surrounds it at home?
School	Functioning under educational and peer demands	What changes in another structured setting?

IN INDIA

School collateral may need practical adaptation. A written report is useful when feasible, but a focused conversation with the person who knows the child's day-to-day functioning can be more informative than a generic certificate. Preserve the distinction between a teacher's direct observations and conclusions about the child.

TRAP **Do not call discrepant informants "unreliable" simply because their accounts differ.** The discrepancy may locate the setting, relationship or demand in which the problem is expressed. It requires enquiry, not arithmetic.

10.4 The child mental status examination

The **developmentally adapted mental status examination** begins before formal questions. Observe physical appearance, the manner of relating to the examiner and caregivers, and the ease or difficulty of separation. Note affect and mood, orientation, and motor behaviour, including activity level, coordination, neurological soft signs, dominance and the presence of tics or stereotyped movements. These observations must be described in neutral, behaviourally

anchored language. “Stayed close to caregiver and answered after looking towards her” is more useful than a global claim about attachment or temperament.

The examination then explores thought content and form, speech and language, overall intellectual functioning, attention, memory, neurological functioning, judgment and insight. It also records the child’s **preferred mode of communication**. For some children, play, drawing or direct conversation may make different parts of their experience accessible. The point is not to force every child through an adult verbal template. It is to create enough access to assess what can be observed and communicated, and to state the limits of that access.

Questions should be concrete enough to be understood and open enough to reveal the child’s organisation of experience. Ask for examples and clarify the child’s language before translating it into psychiatric terminology. Evaluate attention in relation to the task, the room and the interaction, rather than treating a brief lapse as a stable conclusion. Similarly, assess apparent insight in the light of the child’s developmental capacity and the information they have been given. Silence, limited language, avoidance or playful deflection can be meaningful, but none is self-interpreting.

- Record behaviour, speech, affect and engagement as observed, then separate the clinical inference from the observation.
- Use the child’s most accessible communication channel while preserving the clinical question.
- State when an item could not be assessed adequately, rather than converting incomplete examination into a negative finding.

PITFALL

A brief, highly structured consultation can make a child appear more settled or more inhibited than in ordinary life. Do not treat the examination as a performance test that overrules the longitudinal history. Integrate it with collateral and revisit uncertain findings.

10.5 Integrating observation without over-reading it

The child’s behaviour in the room is relational data. It is shaped by the examiner’s manner, the caregiver’s presence, the sequence of the visit, the unfamiliar setting and the child’s understanding of why they have come. A calm child may be containing distress; an active child may be engaging, avoiding, testing boundaries or reacting to an overstimulating room. The answer is not to abandon observation, but to make the observation precise and test alternative explanations through gentle changes in approach.

Examination and history should therefore be written so that another clinician can see the bridge between them. Describe the source, the setting, the observation and the inference. If the child’s account and caregiver’s account diverge, say how each was obtained and what further information would help. A formulation may remain provisional while the assessment continues. That is not indecision. It is appropriate calibration when the available data do not yet support a firm conclusion.

For developmental expectations and milestones, use the Normal child development and milestones notes. For the childhood disorders themselves, use the Child behavioural, emotional and other disorders notes. For intellectual disability and autism-related assessment, use the Intellectual disability and autism spectrum disorder notes. Standardised developmental, cognitive, adaptive, behavioural and neuropsychological instruments are addressed in their respective assessment sections; they complement, rather than replace, the child developmental history and mental-state examination.

MNEMONIC

Child, Caregiver, Classroom

Use this as a retrieval cue for the core sources of an assessment: hear the child's account, establish the caregiver's longitudinal account, and obtain the school view of functioning in another setting. The cue is a reminder to compare perspectives, not a licence to collect generic reports.

10.6 Documentation and the examination answer

A defensible record makes the reasoning inspectable. It identifies who provided information, distinguishes reported material from direct observation, preserves relevant examples and records limitations. It should show the relationship between developmental history, present functioning and the mental state examination without manufacturing certainty. The record is strongest when it explains why a particular question was asked and how the answer altered the next clinical step.

In a written answer, begin with the need for developmental, contextual and multi-informant assessment. Then set out the history in an organised sequence, describe the directly observed mental state in developmentally appropriate terms, and finish by showing how discrepancies will be reconciled. Avoid listing adult mental-state headings without adaptation. Avoid writing an instrument catalogue where a clinical examination has been asked for. The candidate who demonstrates method, rather than reciting labels, shows that assessment can guide treatment and referral.

A child psychiatric assessment is credible when developmental history, direct mental-state observation and collateral accounts are integrated without allowing any single source to stand for the child.

11 · Play assessment and interviewing children

Play is clinical material, not a diversion. In an interview with a child, direct questioning can produce compliance, silence, borrowed adult language, or a rapid shift away from what feels unsafe. Play creates a shared activity in which the clinician can listen to what is said, watch how it is said, and notice what happens when the child has some control over the pace and distance of contact. Used well, it enlarges the interview. Used carelessly, it turns an ordinary toy interaction into a premature story about the child.

The marks lie in understanding this distinction. Play assessment is neither a disguised intelligence test nor a treatment session. It is a developmentally adjusted way of obtaining history and mental-state material while preserving curiosity about alternative explanations. The general child psychiatric history, examination, collateral information and multi-informant formulation belong with the general assessment framework. This section concerns the interview encounter itself: how to make room for play, observe it, and translate observations into hypotheses that require corroboration.

11.1 The purpose of a play-based interview

Children often communicate experience through action before they can organise it into an account for an adult. The clinician therefore treats play as a medium that can carry themes of threat, comfort, power, separation, rivalry, loss, bodily concern or mastery, without assuming that any single theme is a literal report. **Imaginative play** using puppets, small figures, or the clinician as a participant can offer inferential material about the child's concerns, perceptions and ways of regulating affect and impulse.

This is especially useful when a question is emotionally loaded. Rather than pressing for an explanation, the clinician may offer an ordinary shared activity and allow the child to decide whether a story, scene, game or silence develops. The gain is not access to a hidden truth on demand. It is the chance to observe the child's manner of approaching a difficult area: whether the child can initiate, sustain, modify, share or abandon an imagined situation; whether feelings are named, enacted, avoided or rapidly displaced; and whether the adult is invited into the child's world or kept at a fixed distance.

Play has a relational function as well as an observational one. A child who has little trust in adults may first need to discover whether the interviewer can be interested without taking over, can tolerate pauses without filling them, and can set a limit without becoming punitive. The clinician's task is to offer structure sufficient for safety while leaving the child enough agency to show how contact is managed. This is interview technique, not play therapy. The purpose remains assessment and formulation, with the child's welfare taking precedence over the production of material.

RULE **Adapt the interview method to the child, rather than forcing the child into the clinician's preferred method.** Technique should be tailored to **developmental level**, **cognitive level**, **linguistic level**, the emotional difficulty of the topic, and the available **rapport**. A playful invitation may be useful in one encounter and intrusive in another.

11.2 Preparing the encounter

A useful play interview begins before any toy is touched. The room should be calm enough for conversation and permissive enough for the child to explore without the clinician repeatedly issuing prohibitions. Materials should be ordinary, durable and open to more than one use. The aim is not an impressive collection but a setting in which the child does not need special skill, prior knowledge or adult permission to begin. Materials that are too elaborate can turn the

encounter into a performance; materials that demand a correct answer can recreate the pressure of school.

The opening should be plain and honest. Explain who you are and what will happen in language the child can follow. State that the child may talk, draw, play, ask questions or say that something is difficult. Do not promise secrecy that cannot be maintained, and do not announce that play will reveal what the child is unable to say. Such statements burden the child and distort the clinical relationship. A brief period of shared orientation lets the clinician observe spontaneous choice without making the child feel watched for a right response.

The caregiver's place requires deliberate management. A caregiver may help a child settle, provide essential context, or inadvertently answer every question. The clinician should neither exclude the caregiver reflexively nor allow the child's account to be overwritten. A separate space for each voice is often necessary. When the child is seen alone, the transition should be explained in a way that does not imply that either child or caregiver is under suspicion. Questions about safety, confidentiality and separate interviewing are part of the general assessment framework and must be handled within local clinical and safeguarding practice.

- Begin with a low-demand invitation rather than a request for a problem narrative.
- Follow the child's level of engagement, but retain a clear clinical purpose.
- Close predictably, giving the child time to shift back from the activity.

IN INDIA

Language choice is often the first clinical adaptation. A child may understand the language used by adults in the family yet express play, emotion and peer experience more naturally in another language. Clarify the child's preferred language for ordinary conversation and avoid treating a quiet response in an unfamiliar language as evidence of limited feeling or limited thought. When interpretation is needed, keep questions short, allow the child time to respond, and record the limits this places on inference.

11.3 Observing play without overreading it

The useful unit of observation is a pattern, not an isolated symbol. Notice the child's entry into play, selection and use of materials, capacity to generate ideas, response to novelty, flexibility when the scene changes, tolerance of frustration, and manner of involving the interviewer. Observe the emotional tone of the activity and its transitions. A child may appear cheerful while repeatedly arranging a controlling scenario; another may use a frightening story with evident enjoyment and imaginative flexibility. Neither observation explains itself.

Content matters, but form often provides the safer starting point. Is the play exploratory or restricted? Is it reciprocal, solitary, controlling, repetitive, hurried, frozen or readily abandoned? Does the child use pretend transformation, or insist that each object retain only its literal function? Does the child's narrative have continuity, or is it made of disconnected actions? The clinician should describe first and infer second. A note that records what happened can be reconsidered against history and collateral; a note that records only a conclusion cannot.

OBSERVATION	CLINICAL QUESTION IT RAISES	APPROPRIATE NEXT STEP
Choice of a familiar activity	What does the child use to establish safety and control?	Join briefly, then see whether the child can extend or vary the activity.
Repeated theme in a story	Is the theme meaningful, rehearsed, situational or prompted by the setting?	Ask open questions and compare with the child's account and collateral.
Difficulty sharing the activity	How does the child manage reciprocal attention and adult participation?	Offer a modest invitation rather than forcing cooperation.
Rapid escalation when frustrated	How are affect and impulse managed in the moment?	Set a calm limit and observe recovery, repair and need for support.
Very limited, concrete and noninteractive imaginative play	Does the form of play raise a developmental hypothesis?	Document the observation and integrate it with the broader developmental assessment; this pattern may suggest **autism spectrum disorder**, but is not diagnostic by itself.

Description protects against projection. Children's play readily activates the clinician's own associations. A dramatic scene may tempt the clinician to infer trauma, aggression or family conflict. Those are hypotheses, not findings. The more emotionally striking the scene, the more important it is to ask whether the theme arose spontaneously, whether it recurs across contexts, whether the child can reflect on it, and whether independent history supports the concern. Silence, avoidance and change of subject may themselves be meaningful, but they are also ordinary responses to an unfamiliar adult, fatigue, shame or uncertainty about what is expected.

PITFALL

Do not translate a toy, drawing or narrative role into a one-to-one diagnostic or forensic meaning. A child may choose a frightening character because it is familiar, powerful, amusing, recently seen, or simply available. The clinical value lies in the whole interaction, its form and affect, and its fit with other evidence.

11.4 The clinician's use of self

The interviewer is part of the play field. Children may invite the clinician to be a character, assign a role, test a rule, or ignore the invitation entirely. Participation can be useful if it follows the child's lead and remains light enough for the child to alter it. Taking over the plot, improving the child's story, teaching a moral, or repeatedly interpreting the scene shifts the task from observation to adult direction. The child then reveals how they respond to the clinician's demands, not necessarily how they play.

Comments should be simple, concrete and tentative. Reflecting an observable action, naming an evident affect, or asking what happens next keeps ownership with the child. Questions that demand explanation too early can collapse imaginative material into a test of verbal skill.

Likewise, excessive praise can make play performance-oriented. The clinician should be capable of waiting, of accepting a child's refusal to include them, and of returning to ordinary conversation when play does not become a useful medium.

Limits are clinically informative when delivered without humiliation. If materials are used unsafely or the child attempts to damage the setting, stop the act clearly and offer a permitted alternative. What follows may illuminate the child's response to frustration, but it must never be engineered as a provocation. The aim is not to expose a deficit. It is to maintain a setting in which the child can continue to engage and the clinician can observe regulation and repair.

GOOD TO REMEMBER

When a child does not play, do not make play the test. Sit alongside, use conversation or a neutral activity, and return to the invitation only if it fits the child's pace. Refusal may communicate discomfort with the setting, unfamiliarity with the materials, tiredness, fear of being judged, or a wish to preserve control. Record the context as carefully as the refusal.

11.5 From observation to clinical inference

Play observations become clinically useful only when they change the next question. A child who repeatedly separates figures may be asked, in an open manner, what happens when people are apart and whom the child misses. A child who makes every adult character controlling may invite questions about rules, conflict and safety. A child who cannot tolerate a change in the game may need a broader enquiry into flexibility across home and school. The inquiry remains open because the same play pattern can arise from many pathways.

Formulation should preserve levels of certainty. A descriptive level records the activity, speech, affect, reciprocity and regulation observed. A hypothesis level states what the pattern may mean. A verification level identifies what information is required before the hypothesis influences diagnosis, risk assessment or intervention. This discipline prevents play from becoming a privileged source that outranks the child's words, caregiver account, teacher information, developmental history or direct mental-state examination.

- Write observations in behavioural language before writing interpretations.
- Link an inference to the question it raises, rather than to a diagnosis it proves.
- Seek convergence across interview, collateral history and longitudinal observation.

TRAP **Do not treat play content as a projective key with a fixed meaning.** The classic error is to move from a striking scene to a categorical conclusion. Good assessment asks what else could account for the observation, then looks for convergence. Play can generate an important clinical question; it cannot settle one in isolation.

11.6 Interviewing across developmental capacities

There is no universally correct child interview format. The same child may need a different approach when discussing a pleasant activity, a school difficulty, a conflict at home or a frightening experience. The choice of method should be guided by the child's capacity to

understand the task, use language, sustain shared attention and tolerate the topic, as well as by the relationship established in the room. The relevant principle is flexible adaptation to the **emotional difficulty** of the topic, not a rule that younger children always play and older children always talk.

For a child who uses little verbal elaboration, the interviewer may alternate short questions with observation in a shared activity. For a verbally fluent child, play can still reveal the interpersonal style that a polished account conceals. For an adolescent, a direct conversation may be preferred, while a collaborative task or informal activity can reduce the intensity of sustained face-to-face questioning. The clinician should offer, rather than impose, a mode of communication. Respecting a child's preference does not mean abandoning difficult topics; it means approaching them in a way that preserves the possibility of honest engagement.

Developmental adaptation also means distinguishing inability from unwillingness. A child who cannot answer an abstract question may understand a concrete example. A child who appears oppositional may be confused by an adult's phrasing. A child who changes the subject may be protecting themselves from affect, but may also be responding to embarrassment or loss of attention. The clinician reduces these ambiguities through clarification, pacing and repeated observation, not by assuming a motive.

11.7 Documentation, boundaries and the limits of the method

Document the setting, who was present, the invitation offered, the child's response, the relevant sequence of play, verbal statements that materially altered interpretation, affective shifts, clinician interventions and the child's response to them. Separate observation from interpretation in the record. It is preferable to note that a child repeatedly placed figures apart and became quiet when asked about reunion than to write a diagnostic conclusion. The latter move prematurely converts an observation into a conclusion.

Play should not be used to obtain a disclosure by suggestion, to test an allegation, or to bypass established safeguarding procedures. When the interview raises concern about harm, the clinician must move from exploratory technique to a careful, non-leading and safety-focused response within the relevant protection pathway. The child's immediate safety and the integrity of any necessary assessment take precedence over completing a play narrative. Detailed abuse assessment and its psychiatric sequelae are addressed in the child-protection sections of this chapter.

Nor should the clinician infer that a child who plays freely has no distress, or that a child who does not play has a severe disorder. Play is one channel among several. Its greatest value is often modest but decisive: it shows the child's style of communication and regulation in real time, suggests questions that ordinary history-taking might miss, and helps the interviewer build enough trust for a fuller account. Its limitations are the same as its strengths: it is relational, contextual and therefore demands disciplined interpretation.

PLAY	FORM	PATTERN	CONVERGENCE
A MEDIUM FOR COMMUNICATION	MENTAL-STATE INFORMATION	BASIS FOR HYPOTHESIS	BASIS FOR CONFIDENCE

Use play to open and observe the child's world; use corroboration to decide what the observation means.

12 · Developmental and IQ tests (Binet, WISC, Malin, Bhatia, Seguin form board)

Why it matters clinically. A developmental or intelligence assessment is not a hunt for a single score. It is a disciplined way of describing how a child approached cognitive demands, where performance was relatively easier or harder, and how confidently the clinician can use that information in a formulation. In child psychiatry, the test result often changes the question being asked: whether a difficulty is best understood as globally low performance, an uneven cognitive profile, a language-mediated barrier, a problem of access to learning, a state effect, or a finding that needs further assessment. The useful report therefore connects the referral question to the conditions under which the child worked and to the limits of what the result can bear.

This child developmental and IQ battery comprises child intelligence measures and performance-based tasks. These are not interchangeable labels for the same activity. They differ in the demands they place on language, motor output, visual organization and cooperation. Test choice is consequently a clinical decision, not a ritual. Developmental screening, adaptive assessment, broad-band scales, projective methods and formal neuropsychological assessment have separate roles elsewhere in this chapter.

Question	Mode	Context	Use
WHAT DECISION NEEDS HELP	VERBAL OR PERFORMANCE DEMAND	CONDITIONS OF TESTING	NEXT CLINICAL STEP

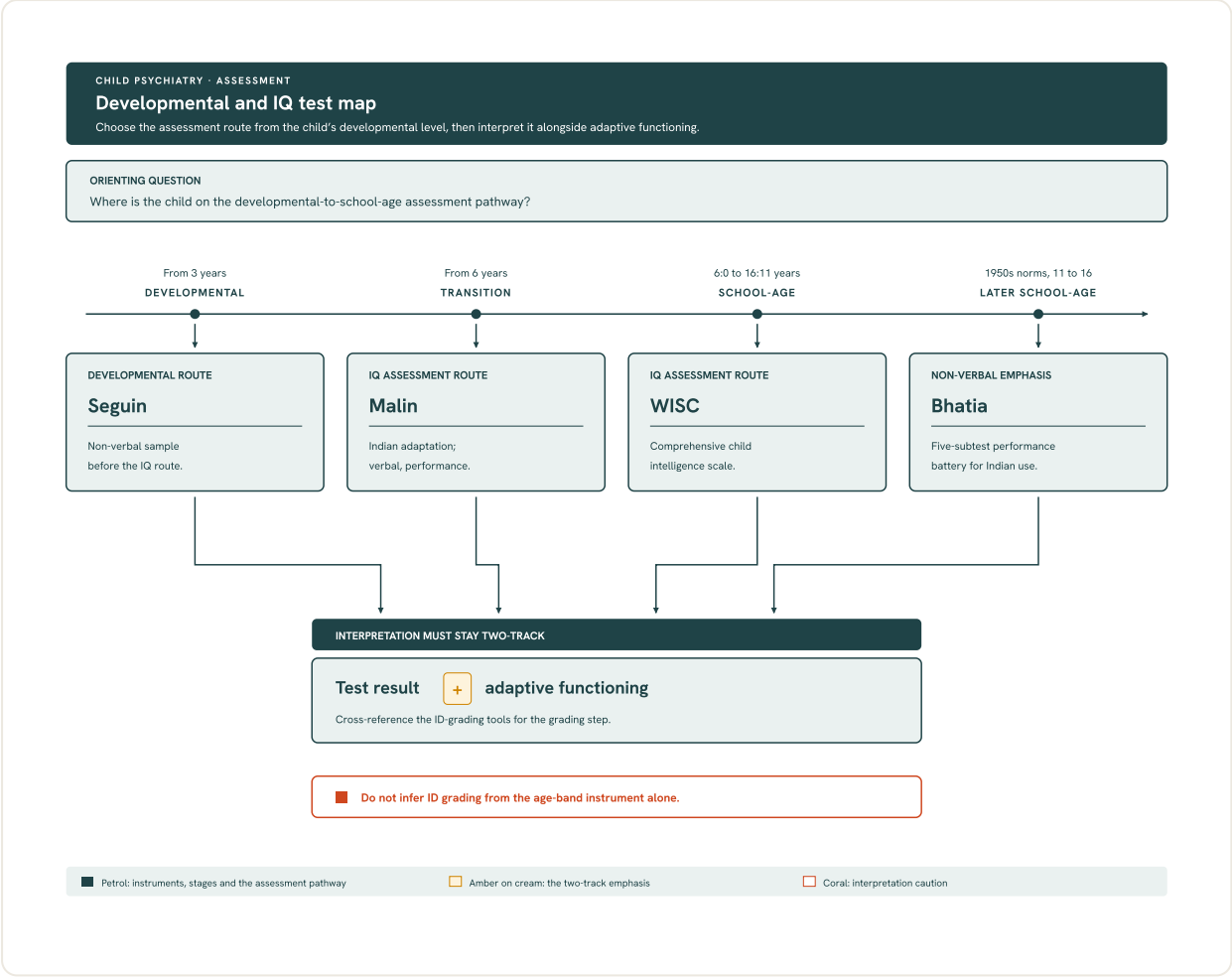


Fig 24.5. The child developmental and intelligence testing map, laid out by age band and by what each instrument is for. Choose the test by the question being asked; the intellectual-disability grading application of these instruments belongs to the intellectual disability and autism spectrum disorder notes and is cross-referred, not taught here.

12.1 What an intelligence test contributes

An intelligence test samples performance under structured conditions. Its value is not simply that it yields a summary estimate. The encounter makes visible the child's comprehension of instructions, pace of engagement, response to novelty, tolerance of correction, persistence, impulsive responding and use of help. These observations can qualify the interpretation more than a polished numerical statement ever can. A child who gives up after a first difficulty and a child who works slowly but methodically may arrive at superficially similar outcomes for very different reasons.

The report should distinguish an obtained test performance from an explanation for that performance. Low output can arise when the child did not understand the task, could not sustain engagement, was anxious, was affected by language mismatch, or had sensory, motor or educational barriers. Equally, an apparently adequate overall performance may conceal a clinically important discrepancy in how different kinds of demand were handled. The psychiatrist should ask what the test has actually sampled in this child, on this occasion, before deciding what it means.

That distinction protects the child from a common category error. Cognitive testing informs clinical judgement; it does not replace it. The result must sit beside the developmental account,

physical and neurological findings when relevant, schooling history, family context, and functional account from the adults who know the child. These surrounding data do not dilute the test. They give it a valid clinical home.

RULE **Interpret the child's way of working before interpreting the score.** A score becomes clinically meaningful only when the referral question, testing conditions, language demands and behavioural observations are made explicit.

12.2 Selecting a measure from the referral question

Begin by naming the decision that the assessment is meant to inform. A vague request for an "IQ test" invites an equally vague answer. A referral may instead concern a child whose spoken language makes verbally mediated work difficult, a child with limited opportunity to show classroom learning, a child with suspected uneven abilities, or a child whose engagement with formal tasks is uncertain. The clinician and psychologist should agree what information would move care forward and what the chosen procedure cannot answer.

The next task is to match the mode of assessment to the child rather than forcing the child to fit the instrument. Verbal demands, familiarity with the language of testing, manual dexterity, visual and motor coordination, fatigue, hearing or vision concerns, and the child's capacity to settle into a structured interaction all matter. This does not mean abandoning standardisation whenever a child is difficult to test. It means recording the circumstances faithfully and using any necessary caution in the conclusion.

- Specify the referral decision that the result is meant to inform.
- Tell the assessor about barriers that may prevent the child from showing usual abilities.

Performance-based tasks can be particularly informative where spoken responses give an incomplete picture. They are not, however, language-free truth machines. Understanding the demonstration, handling unfamiliar materials, tolerating timed or observed work, and organising action all remain part of the demand. The correct clinical question is therefore not whether one test is intrinsically fair, but whether its demands are sufficiently understood for the result to answer this referral question.

GOOD TO REMEMBER

Before requesting testing, state the clinical question in one sentence and tell the assessor about communication, sensory, motor, behavioural and school-access concerns. A better referral produces a more interpretable report and avoids treating the assessment as an administrative certificate.

12.3 A comprehensive child assessment

The **WISC-V, the Wechsler Intelligence Scale for Children, Fifth Edition**, is a comprehensive child intelligence assessment. The publisher's normative age range is **6:0-16:11 years**. Its clinical importance lies in the opportunity to examine performance across differently organised demands rather than reducing the encounter to one global label. That does not license the psychiatrist to

infer detailed cognitive strengths from a summary alone, nor to reproduce proprietary material in a case note or teaching answer.

When a report based on this assessment is available, read the narrative before the conclusion. Look for whether the child understood the task language, required repetition, rushed, sought reassurance, became frustrated, or showed marked variability in effort. Ask whether the child's educational and language background was compatible with the testing situation. A report that describes meaningful variation may guide the next clinical question, whereas a bare score without conditions of testing should be treated with restraint.

For the psychiatrist, the contribution is often relational as well as psychometric. The child's behaviour in an individual, structured encounter may illuminate a familiar difficulty that parents or teachers have described, but it should never be read as proof of a diagnosis by itself. Conversely, a cooperative testing session should not be used to dismiss difficulties reported in less structured settings. The clinical synthesis is stronger when test behaviour is treated as one sample of functioning rather than as a personality verdict.

TRAP **A comprehensive intelligence measure is not a diagnosis machine.** Candidates lose clinical precision when they convert an obtained result into a disorder label without considering language, learning opportunity, adaptive functioning, behaviour during testing and the reason for referral.

12.4 An Indian adapted child measure

Malin's Intelligence Scale for Indian Children is an Indian adaptation that assesses verbal and performance abilities. It is administered by a trained psychologist and is used from **6 years onward**. Its relevance is practical: an Indian adaptation is often encountered in clinical records and referral pathways, and the psychiatrist should be able to read its report without assuming that the name alone settles validity for every child.

An Indian adaptation does not remove the need for clinical attention to the child's actual linguistic, educational and sociocultural context. India contains wide variation in home language, medium of instruction, familiarity with formal testing and experience of school. The clinician should identify a mismatch rather than silently treating it as a child deficit. The report should make clear which language was used, whether translation or explanation was needed, and whether the observed performance reasonably reflects the child's capacity in the setting being assessed.

Verbal and performance information should be read as complementary descriptions of task performance. A difference between them is a prompt to enquire, not a self-contained explanation. Consider communication history, literacy exposure, schooling continuity, behaviour, motor competence and the family's account of everyday problem-solving. A single difference should not be converted into a sweeping statement about ability, motivation or family environment.

IN INDIA

Use the availability of an Indian adaptation as a reason to improve the assessment conversation, not to stop it. Record the language of testing, the child's medium of instruction and barriers to school participation. These details help the team decide whether the result is a sound estimate, a limited sample, or a signal that another approach is needed.

12.5 A performance battery: use and historical caution

Bhatia's Battery of Performance Tests of Intelligence is an Indian non-verbal, performance-oriented battery. Its named components are **five** subtests: **Kohs' Block Design, Alexander's Pass-along, Pattern Drawing, Picture Construction and Immediate Memory**. This makes the battery useful to recognise in Indian practice, especially when the child's performance on material-based tasks is clinically more accessible than a long verbally mediated exchange.

The attraction of a performance battery is understandable. It can offer a route into assessment when expressive language is limited or when a child is reluctant to engage in conversation. Yet performance tasks draw on more than abstract reasoning. The child must understand what is expected, coordinate perception and action, regulate pace and persistence, and work in the presence of an assessor. The psychiatrist should therefore use the result to sharpen the formulation, not to erase communication, motor or contextual difficulties from it.

The original standardisation was on Indian boys aged **11-16 years**. This historical fact has direct interpretive consequences. The clinician should not speak as if the original reference group automatically represents every contemporary child. If a report relies on the battery, ask which reference material and interpretive conventions were used, whether they fit the child before you, and what uncertainties the assessor has documented.

INSTRUMENT	CLINICAL CONTRIBUTION	INTERPRETIVE DISCIPLINE
Comprehensive child measure	Structured cognitive assessment	Read observed task behaviour and testing conditions with the report.
Indian adapted measure	Verbal and performance abilities	Attend to language and educational context.
Performance battery	Material-based, non-verbal approach	Do not mistake motor, organisational or comprehension demands for pure reasoning.
Form-board task	Rapid non-verbal performance sample	Use it as a focused sample, not as a complete account of intellect.

12.6 A focused early performance sample

The **Seguin Form Board Test** is a rapid non-verbal performance test that can be used from **3 years**. It samples motor dexterity, visuomotor coordination, spatial organisation, and the speed and accuracy of performance. This makes it clinically useful when the assessment needs a brief, concrete observation of how a young child approaches a structured material task.

The **form-board apparatus** uses differently shaped wooden blocks fitted into matching slots. The apparent simplicity is one reason it is easy to overinterpret. A child may struggle because of fine-motor difficulty, visual-perceptual difficulty, poor comprehension of the demonstration, reluctance to separate from a caregiver, impulsive placement, or difficulty sustaining the task. The observation of strategy matters: whether the child scans the board, uses trial and error, persists after an error, or abandons the task can be more clinically informative than a decontextualised label.

Its non-verbal form is a relative advantage, not an exemption from careful administration. Demonstration and rapport still matter; so do the child's visual and motor capacities. It is best understood as a focused performance sample within an assessment plan. It cannot independently settle broader questions about developmental level, educational need or intellectual functioning.

PITFALL

Do not reproduce test items, scoring rules or cut-offs in a clinical teaching note. Proprietary instruments require standardised administration and trained interpretation. The useful psychiatric record states the referral question, relevant conditions of testing, observed approach, report conclusion and its limits.

12.7 Observing the assessment, not merely receiving it

Psychiatrists often receive a report after the formal session rather than administering the measure themselves. That does not make the report a black box. A good discussion with the psychologist asks how the child entered the task, what forms of instruction were effective, whether the child was distractible or overcontrolled, and whether performance was consistent across the session. Such questions improve the clinical interpretation without asking the psychologist to disclose protected test content.

Behavioural observations should be described precisely and modestly. "Needed frequent encouragement" is an observation; "unmotivated" is an inference that may be unfair. "Asked repeatedly for the instruction to be restated" is useful; "poor intelligence" is neither an observation nor a formulation. This discipline matters especially when the assessment may influence educational planning, family expectations or access to supports.

Where there is a major discrepancy between the clinical picture and the test report, do not choose the more convenient version. Re-examine whether the referral question was correct, whether the child was able to show their abilities in the testing context, and whether another assessment modality is needed. A discrepancy is often the important finding. It directs curiosity towards the conditions under which the child does and does not function well.

12.8 Writing a defensible psychiatric formulation

A concise formulation after cognitive testing has several jobs. It identifies the source and purpose of the assessment, describes the adequacy of engagement, states whether language, sensory, motor, behavioural or contextual factors limited interpretation, and reports the assessor's conclusion in its proper scope. It then explains how that conclusion affects the immediate clinical

plan. The final step is essential. A report should change an action, a question, a referral or the level of certainty, rather than become an isolated attachment in the case file.

Avoid false precision. If the result is limited, say what limited it and what remains possible to conclude. If it supports a concern, distinguish this from establishing the whole condition or explaining every difficulty. If it is reassuring in the narrow domain sampled, state that narrowness. This language is not defensive hedging. It is professional accuracy, and it helps families understand that assessment is intended to open useful support rather than to impose a fixed identity on the child.

Feedback should be conducted in language that preserves dignity. Lead with what the child was able to do and how the assessment informs practical support. Explain uncertainty without making it sound like failure. Where family members request only a label, bring the conversation back to the child's current needs, opportunities for participation and the next question that needs answering. This stance reduces the risk that a test outcome becomes either stigmatising or falsely reassuring.

MNEMONIC

QUESTION

Question asked, testing **U**nderstanding, **E**ngagement, relevant **S**ensory or motor factors, observed **T**ask strategy, **I**nterpretive limits, **O**utcome for care, and **N**ext assessment step. Use this as a reporting spine, not as a substitute for clinical judgement.

12.9 Boundaries of the battery and cross-references

Intelligence measures and focused performance tasks are only one part of a child assessment. They do not substitute for developmental screening, an adaptive account, symptom ratings, play-based engagement, or a tailored neuropsychological evaluation when those are the actual clinical questions. Requests for a battery should therefore be revisited when the original question changes. Adding tests without a question can make a report longer without making it clearer.

For Binet-Kamat and **MISIC** as intellectual-disability grading tools, and for the wider clinical approach to intellectual disability and autism spectrum disorder, see *the Intellectual disability and autism spectrum disorder notes*. This section deliberately does not convert an IQ result into a severity grade. The grading decision depends on a broader clinical account and belongs with that discussion.

Similarly, normal development, developmental expectations and milestones are considered in *the Normal child development and milestones notes*. If the immediate question is a developmental screen or an adaptive-developmental tool, use the dedicated discussion of screening within this chapter rather than treating an intelligence instrument as a substitute. Clear boundaries between instruments make referrals more efficient and conclusions less misleading.

Choose the test by the question, interpret the child's performance in context, and never let a score do more clinical work than the assessment can support.

13 · Adaptive and developmental screening (VSMS, DST, DDST)

Screening is a decision aid, not a developmental verdict. In child psychiatry, a brief developmental or adaptive screen helps the clinician decide whether a reported concern deserves fuller assessment, what function is affected in everyday life, and which informant or service should be brought into the next step. Its marks lie in choosing the right tool for the question, administering it with discipline, and interpreting its result within the child's lived context.

The useful distinction is between a developmental screen, which samples observable attainments against an expected sequence, and an adaptive measure, which asks how the child manages ordinary demands in the environments in which the child actually lives. Neither replaces a careful history, examination, observation, or collateral account. The general assessment frame belongs with the principles of child psychiatric history and examination; this section concentrates on the narrow but clinically important work of using the VSMS, DST and DDST without turning a score into a diagnosis.

13.1 What screening contributes to assessment

Developmental screening is best understood as a structured way of making uncertainty visible. A parent may say that a child is "slow", "not listening", "unable to manage", or "different from the other children". These descriptions are clinically valuable but broad. A screen organizes the concern into functions that can be discussed, observed, and followed over time. It can also prevent the opposite error: dismissing a concern because the child appears comfortable or cooperative in a brief clinic encounter.

The screen is therefore an entry point to clinical reasoning. A finding that warrants concern should prompt the clinician to ask whether the observation is consistent across settings, whether the opportunity to learn the skill has been present, whether communication or sensory factors alter performance, and whether the caregiver's account describes capacity, opportunity, or a contribution from each. An apparently reassuring result should likewise be tested against the referral question. A child can perform a sampled task in a calm room yet struggle substantially with transitions, self-care, peer demands, or the pace of school.

CLINICAL TASK	WHAT THE TOOL CONTRIBUTES	WHAT REMAINS CLINICAL WORK
Clarify a vague concern	A shared functional language for the caregiver and clinician	History of onset, context, strengths and burden
Identify a possible delay	A structured prompt to consider further evaluation	Decide whether the concern is persistent, meaningful and corroborated
Describe everyday ability	Information on what the child does in ordinary settings	Distinguish ability from opportunity, support and expectation
Plan the next contact	A baseline language for reviewing change	Set goals with the child, family and relevant services

RULE **Use a screen to formulate the next question, never to close the case.** The result gains meaning only when it is integrated with developmental history, direct observation, caregiver account, school information where relevant, and the reason the child was brought for care.

This stance matters especially when a family arrives seeking a certificate, a label, or reassurance. The psychiatrist should neither promise certainty from a brief measure nor treat the family's concern as less real because a screen is not diagnostic. Instead, explain what the tool can contribute: it can map the concern, show which areas need closer attention, and provide a disciplined basis for deciding what assessment or support should follow.

13.2 Developmental attainment and adaptive functioning

Adaptive functioning concerns the practical translation of a child's capacities into daily participation. It is not identical to a test-room performance. A child may know how an activity is done yet not carry it out independently because the environment is confusing, routines are inconsistent, assistance is excessive, communication is limited, or anxiety disrupts performance. Conversely, a child can have a narrow skill repertoire but use familiar routines very effectively with stable support.

For this reason, adaptive enquiry works best when anchored to concrete examples. Ask the caregiver to describe what happens before, during and after a routine rather than accepting global labels such as "independent" or "dependent". Clarify who initiates the activity, how much prompting is needed, whether the child completes it safely, and whether the performance is habitual or exceptional. The aim is not to interrogate parenting. It is to establish the child's ordinary level of functioning in the family's actual circumstances.

Developmental screening samples attainments across functional areas, whereas adaptive assessment foregrounds real-world management. The distinction is clinically useful but should not be made artificially rigid. Each depends on the quality of the informant's report, the child's opportunity to practise, cultural expectations, language used in the interview, and the clinician's precision in recording an answer. A developmental concern can be recognized through everyday function; an adaptive difficulty may point back to a developmental, communication, emotional, physical, or environmental explanation.

GOOD TO REMEMBER

When caregiver and clinic observation do not agree, preserve each account rather than choosing a winner. The discrepancy is often the useful clinical datum: it may reveal a difference between structured and unstructured settings, between a familiar caregiver and an unfamiliar examiner, or between what the child can do and what the child routinely does.

13.3 Vineland Social Maturity Scale in Indian practice

The **Vineland Social Maturity Scale**, or VSMS, is particularly useful when the clinical question is about social maturity and everyday adaptive abilities. It was originally developed by **Doll** and adapted for India by **Malin**. That Indian adaptation makes the measure familiar in local clinical and teaching settings, but familiarity must not become ritual. Its value comes from a careful semi-

structured caregiver interview, not from treating its result as a self-explanatory property of the child.

The Indian adaptation covers **eight social domains and 89 items**, and is usable **from birth to 15 years**. This breadth supports an account of how the child manages across everyday activities rather than a narrow snapshot of one skill. The interviewer should know the manual and retain the wording and sequence needed for standardized administration. In teaching material and routine clinical discussion, it is safer to describe what the scale assesses than to reproduce protected content or substitute improvised items.

Its derived index is the **Social Quotient**, obtained by converting social age into that named index. The index can be useful as a compact summary and as a way to communicate a baseline, but the profile behind it matters more for intervention planning. A single composite cannot tell the team which routines are already established, which require cueing, which are limited by communication, or which depend on family accommodation. Those details should be carried forward into the formulation and practical plan.

IN INDIA

The VSMS has a recognisable place in Indian child assessment because of the Malin adaptation. Use it as an informed caregiver interview about the child's daily social maturity, while keeping the interview sensitive to the household's routines, available supports, language and expectations. A result is most useful when the narrative examples that produced it are retained in the clinical record.

TRAP **Do not convert an adaptive score directly into a diagnosis or a fixed prognosis.** The measure describes functioning through the information obtained at that assessment. It does not settle the causes of difficulty, replace a broader assessment, or tell the clinician which support will be effective without considering the child and environment.

13.4 DST: using a local developmental screen responsibly

The DST belongs with developmental screening rather than with formal intelligence testing. In an examination answer, its role should be stated modestly: it provides a structured sampling of developmental attainments and helps determine whether a fuller developmental evaluation is indicated. The clinician should use the authorised manual, local training and the version available in the service. Item content, scoring rules, thresholds, psychometric indices and normative claims should not be reconstructed from memory or inferred from another instrument.

A defensible DST encounter begins before the child is asked to do anything. Establish the referral question, the language used at home, the child's current health and comfort, the opportunity to practise relevant skills, and the person who can give the most reliable developmental account. During administration, create enough rapport for the child to engage, but do not coach the performance into a pass. If a caregiver supplies an answer, record it as caregiver report rather than converting it silently into observed performance.

- Record the reason for screening in functional language.

- Separate direct observation from caregiver report.
- Document conditions that may have altered engagement or performance.
- State the next assessment or referral question generated by the result.

The result is most helpful when it changes a decision. That decision may be to obtain collateral information, arrange a more comprehensive developmental assessment, explore a communication or sensory barrier, review the child after support has been instituted, or explain why no immediate escalation is needed despite a caregiver's understandable worry. It is not enough to write "screened" in the notes. The clinical record should show what was screened for, what was learned, what remains uncertain, and what will happen next.

PITFALL

Do not mix observation, reported ability and examiner assistance into one undifferentiated result. A child who succeeds only after repeated prompting has supplied different information from a child who completes the task spontaneously. The distinction changes formulation and the usefulness of later comparison.

13.5 DDST-II: scope and domains

The **Denver Developmental Screening Test, second edition**, or DDST-II, is a formal developmental screening tool for children **from birth to 6 years**. It samples development across **four domains**: **personal-social**, **fine motor-adaptive**, **language**, and **gross motor**. These headings help the psychiatrist describe where the concern lies without assuming that difficulty in one area explains all other areas.

Its administration should remain faithful to the authorised instrument. This concerns validity and professional boundaries. A screening tool is a standardized clinical aid, not a collection of memorable tasks to be copied into notes, teaching slides or a waiting-room checklist. The psychiatrist may explain the domains and the purpose to a family, while retaining the manual's protected procedures for trained use.

When considering a DDST-II result, look first for coherence. Does the screened pattern fit the developmental history? Does the family describe similar performance at home? Is a language-related difficulty being mistaken for a more global limitation? Is pain, fatigue, fear, unfamiliarity, or poor cooperation making the session a poor sample of the child's usual abilities? A screen can flag a question, but it cannot resolve these competing explanations on its own.

Screen	Profile	Context	Plan
SAMPLES FUNCTIONING	SHOWS THE PATTERN	EXPLAINS PERFORMANCE	SETS THE NEXT STEP

13.6 Interpretation, communication and follow-through

Interpretation is an ordered clinical task. Describe the observed or reported pattern without premature labels, test the pattern against context and collateral information, then decide whether it calls for fuller assessment, support, monitoring, or explanation. This sequence protects against

false reassurance and unnecessary alarm. It also keeps the result connected to the reason for consultation rather than allowing the scale to become the whole encounter.

Communicate the finding in language that respects the caregiver's observation and avoids fatalism. Explain that the screen estimates how the child is managing in selected areas at that point, and that the next step depends on the whole assessment. Families often hear any score-like output as a permanent ranking. The clinician's task is to redirect attention toward the child's current strengths, the functions needing support, and the practical information still required.

Where there is a clinically significant concern, the referral plan should identify the question for the next professional rather than simply dispatching the family. Where follow-up is chosen, record the same functional targets so that change can be discussed meaningfully. Educational observations, family routines and communication needs can be reviewed alongside the screen, but a screening result should not be used to dictate an educational placement or a formal diagnosis.

For intellectual disability, its IQ-grading instruments and ASD, see the Intellectual disability and autism spectrum disorder notes. For normal temperament, developmental norms and milestones, see the Normal child development and milestones notes. These cross-references are important because developmental screening is frequently used near those questions, but it does not replace the assessment standards set out there.

MNEMONIC

Question, Context, Profile, Plan

Question: why screen now? **Context**: what may shape the performance? **Profile**: what pattern is actually present? **Plan**: what is the justified next step? This sequence keeps the clinician from mistaking a completed form for a completed assessment.

A developmental or adaptive screen is useful only when its pattern is interpreted in context and used to decide the next clinical step.

14 · Broad-band rating scales (CBCL, SDQ, DBC)

Broad-band rating scales turn concern into a structured description. They ask someone who knows the child to rate a defined set of behaviours, emotions and strengths, so that the clinician can see the pattern rather than rely on an undifferentiated report that the child is "difficult" or "not coping". Their value lies in disciplined screening, in comparing settings, and in making subsequent change visible. They do not replace a history, direct observation, developmental examination, physical assessment, or clinical formulation.

A score is therefore an aid to judgment, not a diagnosis in miniature. A parent may be describing a child at home under stress; a teacher may be describing the same child in a highly structured setting; the young person may be reporting internal experience that neither adult sees. The useful clinical question is not simply whether the ratings agree. It is what each rating adds, what the

disagreement means, and whether the pattern alters the next assessment step. This instrument-specific use of an **informant** is central to multi-informant broad-band screening with the **Child Behavior Checklist (CBCL) / ASEBA**, the **Strengths and Difficulties Questionnaire**, and the **Developmental Behavior Checklist 2**.

2-17	25	5	5
SDQ AGE RANGE	SDQ ATTRIBUTES	SDQ DOMAINS	DBC2 SUBSCALE SCORES

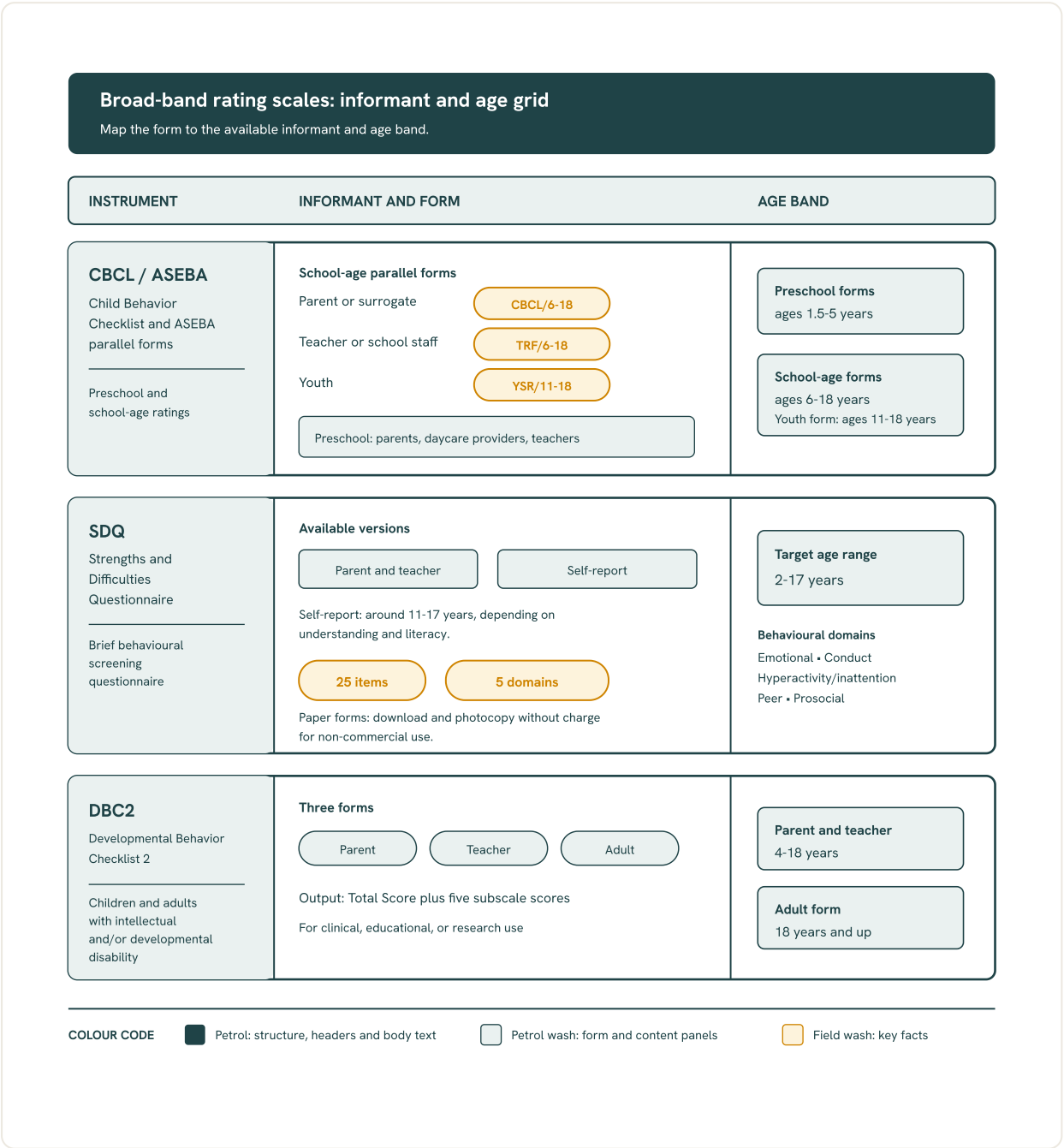


Fig 24.6. Broad-band rating-scale options differ in their available informants and age bands. The SDQ row additionally identifies its item count, behavioural domains, and non-commercial paper-use status.

14.1 What broad-band scales contribute

A **broad-band rating scale** samples difficulties from more than one clinical territory rather than beginning with a single suspected diagnosis. It is particularly useful when the referral question is broad, when the presenting complaint has changed across settings, or when the clinician needs a

common language for parents, school staff and the child. It can make hidden internalising distress easier to ask about, prevent a disruptive presentation from eclipsing strengths, and provide a baseline before an intervention is started.

The scale is not an interview performed on paper. It cannot establish onset, sequence, precipitants, meaning, developmental appropriateness, exposure to adversity, medical contribution, risk, or impairment in the manner required for clinical decision-making. A high score identifies a signal that merits explanation; a low score does not overrule a coherent history of distress or danger. The same item endorsement can have different significance depending on language ability, sensory profile, family expectations, classroom demands, and the situation in which the rater has observed the child.

RULE **Use a broad-band score to sharpen the clinical question, never to close it.** The response pattern should direct further history, observation and collateral enquiry. It should not be used as a substitute for deciding whether the reported behaviour is persistent, impairing, context-bound, developmentally expected, or better explained by another difficulty.

For this reason, broad-band screening is most defensible when the referral question is written before the form is chosen. “What is happening at home and school?” is a different question from “Has the child’s emotional burden changed since the last review?” A scale can serve either purpose, but the interpretation must match the purpose. It is poor practice to administer a familiar questionnaire merely because it is available and then let its score dictate the assessment agenda.

14.2 The informant is part of the measurement

In child work, the rater is not a neutral delivery system. Each informant samples a different relationship, setting and threshold for concern. Parents may be best placed to describe routines, transitions, sleep-related strain, sibling interactions and the child’s recovery after distress. Teachers may contribute sustained comparison with classroom expectations, peer participation, task persistence and response to structure. A young person may disclose worry, shame, loneliness or thoughts that are not outwardly visible. The record should identify who completed the form, what relationship they have to the child, and the period and context that guided their answers.

Informant discrepancy is clinical data, not a defect to be averaged away. Concordant concern across settings can support the impression of a pervasive problem, but disagreement should lead to hypotheses rather than a search for the “correct” rater. Home-only difficulty may point towards demands, routines, relationships or unstructured time that require exploration. School-only difficulty may reflect academic load, peer dynamics, sensory demands, discipline practices or a mismatch between the child and the environment. Self-report that is more severe than adult report deserves a careful, private discussion; it is not disproved by an outwardly composed presentation.

At the same time, discrepancy is not automatically meaningful. A rater may have had too little recent contact, may misunderstand an item, or may answer from a moment of acute conflict. Clarification is often more valuable than immediately repeating the questionnaire. Ask for

examples, antecedents, consequences and exceptions. Then decide whether a second informant, direct school contact, a focused interview, or another component of the assessment is needed. The broader framework for child psychiatric history and examination belongs with the assessment principles section of this chapter; the point here is that the form itself gives a structured way to organise collateral evidence.

GOOD TO REMEMBER

When scores diverge, place the forms side by side before the next interview. Ask about the items on which the accounts differ, not only the overall result. This often converts an apparent disagreement into a useful account of setting, demand and relationship.

14.3 CBCL and the ASEBA approach

The CBCL is used within the ASEBA family of parallel forms. Its practical strength is that comparable information can be sought from the adult caring for the child, school personnel and the young person, instead of treating one account as the whole case. At school age, the relevant forms are **CBCL/6-18, TRF/6-18 and YSR/11-18**. They are completed respectively by a parent or surrogate, a teacher or other school staff member, and the young person. This structure makes it possible to compare a home account, a school account and the child's own account without pretending that they are interchangeable.

The preschool family is also explicitly multi-informant: it covers **ages 1.5 to 5 years** and can draw on accounts from parents, daycare providers and teachers. That matters because early-childhood behaviour is highly dependent on routine, caregiving style, language development and the demands of the setting. A report of a behaviour in one environment should prompt inquiry into its context rather than a premature inference of stable psychopathology.

In clinical use, start with the reason for selecting the form. If the consultation concerns a mismatch between home and school, obtain the relevant adult accounts close enough in time that they represent the same clinical period. If the young person's experience is central, create conditions in which completing a self-report is private and comprehensible, then discuss it rather than leaving it unexplained in the file. The scale profile is best read as a map of areas needing clinical clarification. It does not decide what the child "has", and it should not be used to make a categorical diagnosis without the requisite assessment.

INSTRUMENT FAMILY	WHAT ITS STRUCTURE CONTRIBUTES	CLINICAL USE OF THE COMPARISON
CBCL / ASEBA	Parallel home, school and youth accounts where the relevant forms are used	Locates whether concerns are shared across settings or concentrated in one context
SDQ	A brief screen covering difficulties as well as a strength domain	Provides a concise initial overview and a language for focused follow-up
DBC2	Parallel adult perspectives and an overall score with subscale information	Frames behavioural and emotional concerns where developmental disability shapes presentation

TRAP **Do not turn cross-setting disagreement into a contest between parent and teacher.** Both may be reporting accurately from different environments. Treat the discrepancy as a question about context, exposure and demand, then test that question in the history.

14.4 SDQ as a concise broad-band screen

The SDQ is a brief behavioural screening questionnaire for children and adolescents. It asks about psychological attributes, including positive as well as negative attributes. This is clinically useful because a brief screen that records prosocial capacity alongside difficulties can prevent the assessment from being framed solely in deficit language. It is still a screen: a score pattern should lead to enquiry about severity, duration, impairment and context, rather than being read as a diagnosis.

The attributes are organised into behavioural domains covering emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. The domains are a way of structuring attention, not a replacement for formulation. For example, a peer-related concern may require enquiry into anxiety, social communication, bullying, exclusion, language, classroom climate or a developmental difference. Similarly, a score suggesting difficulty with attention needs a full account of sleep, mood, learning demands, stress and context before it has diagnostic significance.

A **self-report version** is suitable for young people **around 11 to 17 years**, depending on understanding and literacy. The clinician should therefore check comprehension rather than assume that chronological age alone guarantees meaningful self-report. If the young person needs help with wording, preserve privacy and avoid coaching a preferred answer. The aim is to understand their perspective, not to manufacture agreement with the adult forms.

The SDQ can be especially practical when a brief, repeatable screen is needed and when a school or family can complete it without a lengthy assessment session. Its paper forms can be obtained and copied without charge for **non-commercial use**. That access should not be confused with permission to alter the instrument or to treat an informal translation as equivalent to an authorised form. Use the available version as intended, record which version was used, and retain the original response sheet or a faithful clinical record.

PITFALL

A brief score is often copied into a referral letter without the rater, setting or reason for administration. This makes the number clinically thin. Record the informant and context beside the result, and document the question the screen was intended to answer.

14.5 DBC2 when developmental disability is central to presentation

DBC2 is designed for behavioural and emotional assessment in children and adults with intellectual and/or developmental disability. It is useful when communication differences, adaptive dependence, physical health burden, sensory needs or environmental support may alter how distress and challenging behaviour are expressed. The clinical task is not to reduce a behaviour to the developmental condition. Rather, ask what the behaviour communicates, what has changed, which demands precede it, and whether pain, fear, loss, trauma, mood, communication frustration or a change in support could be contributing.

Its parent and teacher forms apply from **4 to 18 years**, while its adult form applies from **18 years and up**. The **Parent, Teacher and Adult forms** provide parallel perspectives, and the measure yields an overall score together with subscale scores. This allows behaviour to be described across familiar environments, but it does not determine cause. A change in score should trigger review of health, communication, routine, support and safeguarding, alongside psychiatric assessment where indicated.

In a child with developmental disability, the most useful preparation for a DBC2 discussion is concrete collateral: a description of the behaviour, the setting in which it happens, changes from the child's usual pattern, what reliably precedes it, and what follows. This protects against diagnostic overshadowing, in which distress is attributed to disability and a treatable contributor is missed. For intellectual disability and autism-spectrum assessment itself, consult the Intellectual disability and autism spectrum disorder notes; the present role of DBC2 is broad behavioural screening and structured follow-up.

14.6 From score to formulation and follow-up

Interpret a profile in layers. First, establish whether the form is complete, intelligible and relevant to the current clinical period. Next, identify the broad areas that require interview and observation. Then compare informants and settings, looking for convergence, divergence and missing perspectives. Finally, integrate the rating with functional impact, risks, strengths and the child's account. The report should distinguish clearly between what the instrument records and what the clinician concludes.

Measurement-based follow-up is valuable only when the same construct, informant and context are reasonably comparable over time. A changed score may reflect clinical change, but it can also reflect a new teacher, altered school demands, a family crisis, better understanding of the items, or a different person completing the form. Notes should therefore state the intervention or event occurring between ratings and any change in informant or setting. This prevents false confidence in apparent improvement or deterioration.

- State the referral question before administering the scale.
- Record the instrument version, informant, setting and date in the clinical note.
- Read the profile beside history, observation and impairment, not in isolation.
- Discuss discrepant findings with the relevant informant and, where appropriate, the child.
- Use a repeated measure only when it will answer a defined follow-up question.

IN INDIA

Collateral often has to be assembled across family members, teachers and changing school arrangements. Explain the purpose of the questionnaire in the respondent's preferred language, check that the questions are understood, and avoid treating limited literacy or unfamiliarity with questionnaire formats as evidence of psychopathology. A school form is useful only when the respondent has had enough opportunity to observe the child.

Feedback should be proportionate and non-stigmatising. Explain that the form describes reported difficulties and strengths in a particular context, and that the next step is to understand why they are present. Share only information needed for the agreed clinical purpose, especially when communicating with school. The child and family should not be left with a score whose meaning has not been explained, nor should a school be asked to act on a label that the assessment has not established.

14.7 Choosing and documenting the right scale

Selection starts with fit, not prestige. Choose a broad-band scale when the clinical question calls for a broad description of behaviour and emotion, when multiple settings need comparison, or when a structured baseline will guide later review. Choose the particular family according to the child's developmental context, available informants, respondent comprehension, and the practical setting in which the information will be used. A questionnaire chosen for convenience but mismatched to the child or respondent can create spurious precision.

Document interpretation in ordinary clinical language. A useful note identifies the source of each account, describes the pattern that emerged, names the main uncertainties, and sets out the follow-up questions. It should also record strengths and protective factors reported on the form or in interview. This is more clinically durable than copying a score alone, because another clinician can understand the reasoning and can decide whether a later change represents a real shift or a change in circumstances.

MNEMONIC

SCALE

Source, **C**ontext, **A**greement, **L**imits and **E**xplanation. Before acting on a broad-band result, identify who rated, where they know the child, what agrees or differs, what the form cannot establish, and what clinical explanation must now be tested.

A broad-band rating scale is most useful when its score is interpreted as one informant's structured account within a full clinical formulation.

15 · Projective tests in children (CAT, draw-a-person)

Why it matters clinically. Projective material is often memorable because it seems to offer a route into a child's inner world without demanding a direct verbal account. That apparent immediacy is also its danger. A child's story or drawing is an encounter between the child, the task, the examiner, the setting, and the meaning assigned afterwards. It can enrich an assessment when used as a prompt for curiosity, but it becomes unsafe when it is treated as a shortcut to a diagnosis, a hidden event, or a fixed personality conclusion.

For the psychiatrist, the examinable skill is not to recite supposed symbolic meanings. It is to know what the instrument asks the child to do, what kind of clinical material it can generate, and where its inferences must stop. Projective techniques belong after the general assessment framework, not in place of it. That framework is set out in *Principles of child psychiatric history and examination*.

CAT	DAP	Context	Adjunct
NARRATIVE PROMPT	HUMAN-FIGURE TASK	MAKES MEANING SAFER	NEVER THE WHOLE ASSESSMENT

15.1 What a projective method contributes

A projective method gives the child an ambiguous or relatively open task and attends to the response that follows. The response may be a story, a choice, an elaboration, a refusal, a drawing, a question to the examiner, or a change in affect while doing the task. Its value is therefore qualitative. It can make themes easier to approach when a child has difficulty discussing feelings directly, is unsure what is permissible to say, or is more comfortable communicating through play and imagery than through an interview.

The clinically useful output is a *hypothesis*, not a finding that proves itself. If a child repeatedly centres a theme, the examiner asks whether that theme is also visible in the history, behaviour, relationships, and the child's own later account. If it is not, it remains an observation needing exploration. This protects against the common habit of converting a striking image into a conclusion before the child has been heard.

RULE **Read projective material as a conversation starter, not as a verdict.** Its contribution is strongest when it helps the clinician ask a better next question and weakest when it is used to replace ordinary clinical evidence.

Interpretation must distinguish the product from the process. A bleak story may reflect current worry, imaginative preference, misunderstanding of the task, recent experience, fatigue, or the child's sense of what the adult expects. Likewise, a sparse drawing may be affected by comfort with drawing, visual-motor skill, motivation, time pressure, and the relationship with the

examiner. Recording the child's spontaneous comments and the examiner's invitations is often more clinically informative than preserving an isolated conclusion about the finished product.

- Describe what was actually said, drawn, chosen, or avoided before assigning possible meaning.
- Ask gentle, open follow-up questions that allow the child to confirm, revise, or reject the clinician's initial impression.
- Seek convergence with history, observation, and collateral accounts before a theme influences formulation or management.

15.2 Children's Apperception Test: a narrative task

The **Children's Apperception Test**, commonly abbreviated as CAT, is a projective technique built around pictures. It is associated with **Leopold Bellak, MD, and Sonia Bellak**. The task presents a set of **10 animal pictures** in social situations that include conflict and interpersonal relationships. The child's narrative, the way characters are understood, and the child's manner of engagement give the interviewer material to explore rather than material to decode mechanically.

The stated age range is **3 years to 10 years**. This is an aid to task selection, not a substitute for judgment about whether a particular child can understand and tolerate the task. Before beginning, the examiner should create a calm, non-evaluative atmosphere. The child should not be made to feel that there is a correct story or that the clinician possesses a concealed answer. A brief, natural invitation to tell what seems to be happening is usually more useful than repeated prompting that turns the task into a performance.

During administration, the psychiatrist should attend to the child's approach to the picture as well as the narrative itself. Does the child begin readily, seek reassurance, change the task, repeatedly ask what the examiner wants, become playful, or disengage? Does the narrative permit multiple feelings and outcomes, or does it close rapidly around danger, blame, rescue, exclusion, or triumph? Such features may indicate where a careful interview could go next. They do not establish why the feature occurred.

A practical record gives a near-verbatim account of the story and the child's behaviour. It also records tentative themes in ordinary clinical language, with alternatives rather than certainty, and notes questions to be tested elsewhere in the assessment. This prevents an attractive interpretation from hardening into the record as though the child had stated it directly.

> **GOOD TO REMEMBER**
>
> If a CAT story raises a concern about a relationship or experience, return to the child with an age-appropriate open question and examine the concern against the rest of the assessment. The useful move is clarification, not interpretation by authority.

IN INDIA

Language, family idiom, and the child's familiarity with picture-based tasks shape the narrative. Use the language in which the child can play with ideas most naturally, and document whether an interpreter, caregiver presence, or the clinic setting may have altered the exchange. A translated answer should never be stripped of its context and treated as a literal psychological code.

15.3 Reading CAT responses responsibly

A story should be approached as jointly produced material. The image makes some possibilities more available; the examiner's voice and pace influence what the child risks saying; and the child may be responding to the adult as much as to the picture. The immediate task is therefore descriptive: who is in the story, what happens, what feelings are named, how relationships are arranged, and whether the child comments on the task itself. The next task is collaborative: ask the child to explain uncertain elements rather than filling them in.

Patterns can be clinically useful when they recur across material and fit independently obtained information. For example, a recurrent difficulty in imagining comfort may prompt exploration of support-seeking and caregiving relationships. A repeated focus on control may prompt exploration of the child's recent transitions or family interactions. In each instance, the word *may* matters. The method opens a line of enquiry; it does not identify a cause, establish an event, or rank the severity of a problem.

Negative material should not be confused with pathology. Children use stories to rehearse fear, anger, competition, dependence, and repair. A dramatic narrative can be imaginative, situational, or developmentally understandable. The clinician's task is to consider intensity, persistence within the encounter, the child's own explanation, and convergence with the wider assessment. Equally, a cheerful story does not exclude distress. Children may protect adults, avoid frightening material, or choose a familiar social script.

TRAP **Do not convert a theme into a diagnosis or a factual allegation.** A projective response can justify further sensitive enquiry; it cannot carry a diagnostic or forensic conclusion on its own.

PITFALL

Do not reproduce proprietary pictures in notes, teaching slides, or informal messaging, and do not rely on a second-hand description of a stimulus as if it were the child's actual response. Record the clinically relevant narrative and process in your own words.

15.4 Draw-a-person tasks: method and history

A human-figure drawing task asks the child to make a drawing of a person and provides a different kind of material from a picture-based narrative. The finished drawing is visible, but the encounter also includes how the child begins, whether the child asks for help, the comments made while drawing, corrections, pauses, and the response to a follow-up invitation to talk about the figure. A drawing can be a gentle way to engage a child who is not ready for a sustained verbal

interview, provided the clinician does not mistake familiarity with drawing for a window of equal clarity into mental life.

The **Draw-A-Man Test** was published in **1926** with **standardized instructions for administering and scoring a human figure drawing**. This historical point matters because it corrects a frequent conflation: a drawing task may have a structured scoring purpose, while a clinician may separately use drawings in a projective or conversational way. These are related only by the medium. They are not automatically the same clinical claim.

The earlier work was later restandardized and published as the **Goodenough-Harris Drawing Test** in **1963**. In its scored form, its primary purpose is a measure of **intellectual maturity**. The **projective aspects** of drawings are a distinct use and should not be silently imported into an intellectual-maturity score. For the broader developmental and intellectual assessment battery, see *Developmental and IQ tests*.

CLINICAL QUESTION	CAT RESPONSE	DRAW-A-PERSON RESPONSE	SAFE CLINICAL USE
How does the child make sense of an interpersonal scene?	A story built around pictured social material	Comments about the figure may emerge during or after drawing	Use the material to guide open questions
What happens during engagement with an open task?	Notice narration, pauses, questions, and affect	Notice approach, revisions, requests, and affect	Record the process as well as the product
Can the result stand alone as a clinical conclusion?	No	No	Seek corroboration within the assessment
What should be avoided?	Fixed decoding of a story detail	Fixed decoding of a drawing feature	State uncertainty and test alternatives

15.5 Clinical interpretation of a drawing

The central discipline is to avoid a dictionary approach. An isolated feature of a human figure does not carry a stable meaning independently of the child, the task conditions, and the wider assessment. A clinician who says that a particular feature proves a specific feeling has moved from observation to certainty without showing the necessary reasoning. The more defensible note describes the feature, records the child's account of it, and states how it did or did not fit the rest of the clinical picture.

Ask questions that preserve ownership of meaning with the child: "Tell me about this person"; "What is happening here?"; "What is this person thinking or feeling?"; "Is there anything you would like to add?" The exact wording should be adapted to the child's language and comfort. These questions often reveal whether the drawing was simply a task, a playful character, a self-referential account, or a story about someone else. They also make the assessment less intrusive than an adult narration imposed upon the child.

When drawing behaviour suggests difficulty, consider ordinary alternatives before assigning psychological significance. The child may have limited confidence with drawing, may be

preoccupied by the clinic, may be tired, or may be avoiding an unfamiliar adult. When the drawing seems highly elaborated, consider interest, practice, and the wish to please as well as emotional themes. This is not timidity. It is the ordinary clinical requirement to separate an observation from its possible explanations.

MNEMONIC

Describe, Ask, Corroborate, Explain uncertainty

Use this sequence for any projective response. **Describe** the response and process; **Ask** the child what it means; **Corroborate** against the wider assessment; and **Explain uncertainty** in the formulation rather than overclaiming.

15.6 Documentation, communication, and scope

The clinical note should make clear which parts are observation, which parts are the child's explanation, and which parts are the clinician's tentative formulation. It should also record the context of administration: privacy, interruptions, language used, the child's willingness, and any relevant influence of adults present. This is especially important when later readers did not witness the task. A concise, transparent note is more useful than a long interpretative paragraph that obscures what actually occurred.

In feedback to caregivers, describe the task modestly. It may be appropriate to say that the activity helped the child communicate themes worth exploring, then discuss those themes alongside the child's observed functioning and the family's account. It is not appropriate to present the drawing or story as an objective detector of a private fact. Such framing can alarm families, damage trust with the child, and distract from more reliable avenues of assessment and care.

Where there is a safety concern, the response is not to intensify symbolic interpretation. Clarify the concern using an appropriate child-centred assessment, preserve the child's words carefully, and follow the relevant safeguarding pathway. The safeguarding-specific evaluation is addressed in *Child sexual abuse assessment and psychiatric sequelae*, and the clinical response in *Management and intervention in child abuse cases*. Projective material should never be used to bypass either process.

Projective tests can deepen a child assessment only when their observations are kept tentative, explored with the child, and corroborated elsewhere.

16 · Multiaxial and multi-informant assessment in child psychiatry

Why it matters clinically. A child psychiatric formulation becomes thin when it is reduced to a diagnostic label. The clinician may have recognised a symptom pattern correctly yet still fail to record the developmental picture, physical health, psychosocial context, or the effect of difficulties on everyday life. The **WHO ICD-10 multiaxial classification** is useful as a

disciplined way of holding these domains together. It asks the clinician to write a structured account rather than allow the most conspicuous complaint to stand in for the whole child.

The purpose is not to multiply diagnoses or to turn assessment into a coding exercise. It is to make clinical reasoning visible. A multiaxial record separates questions that are often blurred in hurried notes: what syndrome is present, what developmental factors matter, what physical conditions may alter presentation or treatment, what circumstances burden the child, and how much disability is being experienced. This separation makes omissions easier to see and makes the formulation more useful to families, schools, and colleagues.

WHO	BODY	CONTEXT	FUNCTION
STRUCTURED FRAME	MEDICAL CONTEXT	PSYCHOSOCIAL FIELD	DISABILITY RECORDED

16.1 What multiaxial assessment adds

Multiaxial assessment is a formulation scaffold. It does not replace a careful history, examination, developmental understanding, or collateral account. Instead, it gives each of these strands a defined place in the final record. That matters because the same outward difficulty can be shaped by developmental capacity, a medical condition, adversity, or functional impairment. A single-label summary can conceal these distinctions; a multiaxial summary obliges the clinician to state them.

The framework contains **six** axes. Read them as parallel descriptive fields, not as a ladder of importance. Clinical psychiatric syndromes and specific disorders of psychological development occupy different fields; intellectual level is recorded separately; physical conditions, psychosocial situations, and psychosocial disability are also given their own places. The practical gain is a record that can carry comorbidity and context without implying that one automatically explains the other.

RULE **Use axes to separate dimensions of a formulation, not to manufacture extra diagnoses.** A field is completed because it changes understanding, communication, or planning, not because a blank must be filled with speculation.

In a clinical note, this distinction protects against premature closure. A syndrome field may describe the current psychiatric presentation, while another field records developmental information that affects how symptoms are understood and how communication is adapted. A separate medical field prevents the physical examination and relevant health conditions from being treated as an afterthought. Context and disability fields then stop social circumstances and real-world impact from being appended as vague background prose.

16.2 Reading the axes as a biopsychosocial record

RECORD FIELD	QUESTION IT KEEPS OPEN	USE IN FORMULATION
Clinical psychiatric syndromes	What is the current psychiatric presentation?	States the clinical problem without claiming it is the whole explanation.
Specific disorders of psychological development	What developmental profile alters interpretation or communication?	Prevents developmental needs from being lost inside symptom language.
Intellectual level	What level of cognitive functioning is relevant to assessment and support?	Prompts accessible interviewing and realistic expectations.
Medical conditions	What physical health information belongs in the psychiatric formulation?	Keeps relevant bodily illness and its clinical implications visible.
Associated abnormal psychosocial situations	Which circumstances are linked to the child's difficulties?	Turns a generic social history into a clinically usable context.
Global assessment of psychosocial disability	How are difficulties affecting participation and everyday roles?	Brings functional consequence into the centre of the record.

The table is not a sequence to be completed mechanically. It is a set of safeguards against category error. A psychosocial situation may be relevant without being presented as the sole cause of a psychiatric syndrome. A medical condition may need active attention without becoming an explanation for every behavioural change. Similarly, a developmental difference may shape the interview and treatment plan without making distress less real. The axes help the clinician preserve these distinctions in language that another professional can follow.

The medical field is especially valuable when a referral arrives with an apparently psychiatric question but the child's health history has been summarised poorly. Its task is to record relevant physical conditions in the same formulation rather than leave them in a separate clinic note. This is not an invitation to diagnose beyond one's evidence. It is a prompt to decide whether medical information changes the differential understanding, risk appraisal, communication, or co-ordination of care.

GOOD TO REMEMBER

A useful axis entry is brief but consequential. Record the information that changes how the team understands the child or what the team must do next. Copying an undifferentiated social history into a context field creates length without formulation.

16.3 Context is neither cause nor excuse

Psychosocial circumstances deserve their own field because they are often clinically decisive, yet they should not be used as a shortcut to causal certainty. Context can maintain distress, limit attendance, alter what a caregiver can implement, or change the meaning of behaviour in a particular setting. It may also reveal strengths, available supports, and routes to practical help. A

formulation is stronger when it states the relationship it can justify and leaves causation open when the evidence does not justify more.

This approach also prevents moralising. Describing a difficult home, educational, peer, or care environment should not become a judgement about the child or family. The psychiatrist's task is to identify the clinical relevance of circumstances and translate it into a plan that can be shared. Neutral, observable language is more useful than labels that assign blame. It helps the receiving team see both burden and possibility.

IN INDIA

In Indian clinical records, the multiaxial frame can make fragmented information usable across home, school, health, and social settings. Write the context clearly enough that a colleague receiving the note understands what requires co-ordination, while avoiding assumptions about family motives, resources, or capacity.

TRAP **Do not write adversity as though it automatically proves causation.** The context field records clinically relevant circumstances. It does not license a causal story that has not been established, nor does it remove the need to describe the psychiatric presentation independently.

There is a second, quieter trap. When psychosocial information is scattered across the narrative, it can be mistaken for colour rather than clinical data. A distinct field asks the clinician to decide what is associated with the presentation and why it matters. That decision supports communication with other services without turning the psychiatric note into a catalogue of family details. Relevance, proportionality, and respectful wording matter as much as completeness.

16.4 Disability as a clinical outcome

The historical addition of **Axis Six** after the classification's introduction in **1993** made an important corrective: symptom description is not a sufficient description of a child's clinical situation. The axis directs attention to psychosocial disability, so that the formulation addresses what difficulties are doing to participation and everyday functioning rather than merely naming symptoms.

Its logic remains clinically useful even when contemporary documentation uses different formats. A child may appear less unwell in a brief consultation than in the environments where demands, relationships, transitions, and communication needs become visible. Conversely, conspicuous symptoms do not by themselves tell the clinician what the child can or cannot do with support. Recording **social disability** therefore anchors the formulation in consequence. It asks what has changed in the child's capacity to take part in ordinary life, and what support is needed to restore or protect that participation.

Disability should not be treated as a moral score or as a proxy for diagnostic severity. It is a separate clinical dimension. The interviewer should translate observations into functional language, identify setting-specific barriers, and distinguish a skill from the opportunity to use

that skill. This makes a formulation more useful for planning because it connects the clinician's account to supports that can be arranged and reviewed.

The stated purpose of this axis was a first move towards a systematic approach to assessing disability in young people with psychiatric disorder. That historical intention is worth retaining: function is not an optional closing sentence after diagnosis. It is part of what the clinician is trying to understand.

16.5 Multi-informant material: integrate, do not average

A child's assessment requires information from multiple perspectives, but the general multi-informant assessment framework, including how to obtain and weigh history, belongs with the child psychiatric history and examination. See the assessment framework in the chapter section on principles of child psychiatric history and examination. This fragment does not set out methods for collecting, prioritising, or reconciling informant accounts.

The boundary is important. *Multi-informant* describes the sources from which the clinical picture is built; *multiaxial* describes the dimensions in which that picture is recorded. They are complementary but not identical. In the final record, an informant account should support a clinical formulation field, not be mistaken for an axis in its own right. Where material remains uncertain, the formulation should say so rather than create agreement that the assessment has not established.

> **PITFALL**
>
> Do not turn a disagreement between accounts into an axial conclusion. An axis records the clinician's formulation of a domain; it is not a place to conceal uncertainty by presenting a disputed account as settled fact.

16.6 Turning the framework into a usable formulation

A concise final formulation can move from the current psychiatric presentation to developmental and cognitive context, then note relevant physical conditions, psychosocial situations, and functional disability. Each clause should earn its place by changing interpretation, communication, risk management, or the plan. This order is not a rigid script. Its value is that it forces the writer to show the relationship between dimensions while preserving the difference between them.

- Keep the current presentation distinct from developmental context.
- Record relevant physical conditions rather than burying them in general history.
- Describe psychosocial circumstances without converting them into causal certainty.
- State functional disability separately from symptoms.

MNEMONIC

FRAME

Formulate the presenting syndrome, **R**ecord developmental and cognitive context, **A**dd the relevant physical conditions, **M**ap psychosocial circumstances without asserting cause, and **E**stablish functional disability separately. Use it as a prompt for a coherent formulation, not as a substitute for clinical judgement.

When the record is shared, avoid unexplained technical shorthand. A formulation should be legible to the team and should make clear which statements are observed, reported, inferred, or still uncertain. It should also remain revisable. As further information becomes available, an axis can be clarified without rewriting the entire clinical story or pretending that earlier uncertainty was certainty. This feature makes the framework useful in longitudinal care.

Multiaxial formulation preserves the distinction between symptoms, context, physical health, development, and disability so that clinical planning addresses the whole child.

17 · Neuropsychological assessment of children (NIMHANS battery, executive function tests)

Why it matters clinically. Child neuropsychological assessment asks a different question from symptom counting: how is this child taking in information, holding it in mind, directing behaviour, learning from feedback and using skills in everyday demands? Its value is not a label produced by a test. Its value is a defensible account of a pattern of strengths and vulnerabilities that can explain why a child struggles in a particular context, despite apparently adequate ability or effort in another.

A useful assessment is hypothesis-driven. The referral question may arise from uneven school performance, apparently inconsistent attention, difficulty shifting away from a preferred response, slowed written work, or a mismatch between what the child can explain verbally and what the child can demonstrate independently. The clinician first decides whether a cognitive profile can add something to the clinical formulation, then specifies what observations or measures would materially change management. This keeps testing from becoming a collection of scores without a clinical argument.

Profile	Question	Evidence	Output
COGNITIVE PATTERN	FUNCTIONAL HYPOTHESIS	OBSERVED PERFORMANCE	PRACTICAL SUPPORTS

17.1 What neuropsychological assessment contributes

Executive functions are the control processes that help a child organise behaviour towards a goal. In the clinic, the question is rarely whether a child possesses an executive function in the abstract. It is whether the child can recruit control reliably when demands rise, distractions compete, rules change, feedback is disappointing, or an immediate response must be withheld.

The distinction matters because a child may perform well in a quiet, highly structured interaction and still fail when the same skill must be self-directed in daily life.

Neuropsychological work therefore converts a broad concern into more precise alternatives. A child who does not complete work may be struggling to sustain effort, to keep instructions active, to plan an approach, to shift after an error, or to regulate speed. Similar outward behaviour can arise through different routes. A profile does not remove the need for clinical judgement; it makes the judgement more explicit and tests whether the proposed explanation fits the child's performance across tasks.

RULE **Interpret a cognitive score as evidence about a process, never as a diagnosis by itself.** A score becomes clinically meaningful only when it is considered alongside the referral question, observed approach to tasks, developmental context and real-world functioning.

This is particularly useful when reports from home and school appear contradictory. A difference between settings may reflect different task demands, different levels of cueing, emotional load, fatigue, language demands or opportunities for distraction. It should not be converted automatically into an assertion that a child is choosing when to perform. The assessment helps identify what support allows a skill to appear and what conditions make it collapse.

17.2 The NIMHANS battery in Indian practice

The **NIMHANS Neuropsychological Battery for Children** is a structured option for child neuropsychological assessment. Its original citation credits **Kar, Rao, Chandramouli and Thennarasu**, with the **NIMHANS Publication Division** named as publisher in **2004**. What makes an age-referenced instrument useful is not merely that it produces a result. It allows the child's performance to be considered against **norms for each test at each age level**, rather than against an adult expectation or an informal impression of what children should manage.

IN INDIA

The reported growth-pattern work included **400 Indian school children between 5 and 15 years of age**. This makes the battery especially important as an Indian reference point. It does not, however, permit a clinician to treat every child from every linguistic, educational or social context as interchangeable with the reference group. Local relevance strengthens interpretation; it does not abolish the need to ask whether the comparison is fair for this child.

Norm-referenced assessment is a safeguard against an easy error: reading a performance as poor merely because it looks immature to the examiner. The reverse error is also possible. A child may appear socially fluent, compliant and bright in conversation but show a meaningful difficulty when a task requires self-monitoring or a novel rule. The examiner should describe the conditions of success and failure, not simply attach a global adjective such as “normal” or “impaired”.

17.3 Reading a profile across cognitive sections

The battery is organised into **five** section headings. These cover **motor speed**, **attention**, executive functions, **visuospatial functions**, and **comprehension, learning, and memory**. The

purpose of this organisation is clinical coherence. It encourages the examiner to look for convergence across related performances rather than to overvalue an isolated low result.

OBSERVED PATTERN	CLINICAL QUESTION	INTERPRETIVE DISCIPLINE
Slow or effortful output	Is the difficulty primarily in pace, control of response, understanding of the task, or persistence?	Describe the child's method and errors before drawing a conclusion.
Variable performance across tasks	Which demand changed: novelty, rule maintenance, interference, speed or cueing?	Seek a process explanation, not a character explanation.
Weak learning on a task	Was information encoded, retained, retrieved or used strategically?	Relate the pattern to the demands that trigger the referral.
Difficulty after a rule change	Can the child notice feedback and alter the response plan?	Do not confuse a single error with a stable inability.

For executive function, the informative observation often lies in the route to the answer. Does the child start before hearing the full instruction? Persist with a rule after it has changed? Need repeated external structure? Recognise an error but fail to repair it? Give up when the first strategy fails? Such observations are not decorative additions to a score sheet. They are the bridge from task performance to a clinical formulation of self-regulation.

- Record the child's understanding of the task and the kind of cueing required.
- Note whether errors are impulsive, perseverative, disorganised, slow or inconsistent.
- Ask what changed when the task became longer, less familiar or less structured.
- Connect the pattern only to the functional difficulty that prompted referral.

TRAP **Do not call every low executive-function result an attention disorder.** Executive control is influenced by comprehension, pace, motivation, emotional state, sensory or motor demands and the testing relationship. The task result narrows hypotheses; it does not settle them.

17.4 Administration as clinical observation

Standardised procedures matter because the meaning of comparison depends on administering a task as intended. Yet standardisation should not make the examiner passive. Behaviour during testing can qualify the result: delayed engagement, repeated checking, avoidance of uncertainty, overrapid responding, perfectionistic slowing, loss of the rule, or a response to praise and correction may each help explain a pattern. Record these observations clearly enough that another clinician can see how the conclusion was reached.

The testing relationship requires care. Children may interpret an unfamiliar task as an examination they can fail, or may protect themselves by refusing, joking, rushing or insisting that the activity is boring. The clinician should present the work in developmentally understandable language, preserve dignity when a task is difficult, and avoid turning a struggle into a contest.

This is not merely kindness. A threatened or disengaged child may be showing the examiner the consequences of the assessment context rather than the cognitive process that prompted referral.

GOOD TO REMEMBER

A useful report separates what was measured from what was observed and from what is inferred. "Performance was slow," "the child required repeated restatement of the rule," and "this may contribute to difficulty with multi-step work" are different kinds of statement. Keeping them separate makes the report more honest and more useful to the treating team.

17.5 From test pattern to treatment planning

The report should answer the referral question in practical language. A cognitive profile may guide the choice of environmental supports, the form in which instructions are given, the level of task structure, the need to reduce competing demands, or the way feedback is delivered. It can also clarify what should be monitored after an intervention begins. The report is strongest when its recommendations follow from the observed mechanism, rather than from a generic list of school accommodations.

Recommendations should be framed as testable supports. If difficulty appears when a child must hold several steps in mind, a support might make the sequence visible and check each step before the next begins. If performance deteriorates when a familiar rule changes, the support might make transitions explicit and allow guided practice with the new rule. The clinical team can then ask whether the proposed change improves participation and functioning. That feedback is more valuable than merely repeating a test score in later notes.

Assessment must remain integrated with the broader child psychiatric history and examination. A neuropsychological profile neither replaces the account of symptoms and relationships nor determines treatment in isolation. It provides a structured account of how the child approached cognitive demands, which can sharpen communication between psychiatrist, psychologist, family and school.

PITFALL

A polished numerical report can create false certainty when it is detached from the referral question. Avoid reproducing proprietary items, importing cut-offs from another setting, or presenting a score as if it explains behaviour without corroboration. The clinical task is interpretation, not score display.

17.6 Limits and communication of findings

Neuropsychological assessment samples performance under particular conditions. It cannot directly observe every demand in a classroom, home or peer setting, and it cannot decide whether a difficulty is fixed, situational or remediable without clinical follow-up. A finding may be limited by language fit, educational opportunity, fatigue, physical discomfort, anxiety, engagement or a child's understanding of why the assessment is occurring. These are not reasons to abandon assessment. They are reasons to state limits openly.

When explaining findings to caregivers, avoid converting cognitive language into a verdict on intelligence, character or future potential. Describe a pattern, the situations in which it matters, the strengths on which intervention can build, and the supports that will be tried. Families should leave with a clearer working model of the child's needs, not with a new stigmatising identity. The same discipline protects schools from treating a report as a reason to lower expectations indiscriminately.

- State the clinical question that made assessment necessary.
- Describe relevant observations during the work, including factors that limit confidence.
- Present the pattern before offering an inference about its functional significance.
- Make recommendations concrete enough to be tried and reviewed.

Neuropsychological assessment is most useful when it explains a functional difficulty through a coherent cognitive profile and turns that explanation into supports that can be tested in the child's real environment.

Therapeutic interventions

18 · Play therapy (principles, techniques, indications)

Play therapy is purposeful clinical work, not supervised recreation. It gives the child a mode of participation that does not depend on an adult-style verbal account. The clinician uses play to build a therapeutic relationship, understand the child's experience as it is communicated in action and imagination, and make psychological work possible without forcing premature explanation. The point is neither to entertain the child nor to extract a hidden meaning from every toy. It is to create a reliable interpersonal setting in which experience can be expressed, held, and worked with.

In the definition adopted by the Association for Play Therapy, **play therapy** is a systematic use of a **theoretical model** within an interpersonal process. Its distinctive resource is the **therapeutic powers of play**: play is used deliberately to help with psychosocial difficulties and to support development. This gives the method its clinical discipline. Materials, language, boundaries, interpretation and the therapist's participation all derive their meaning from the formulation and therapeutic approach, not from the presence of a toy box alone.

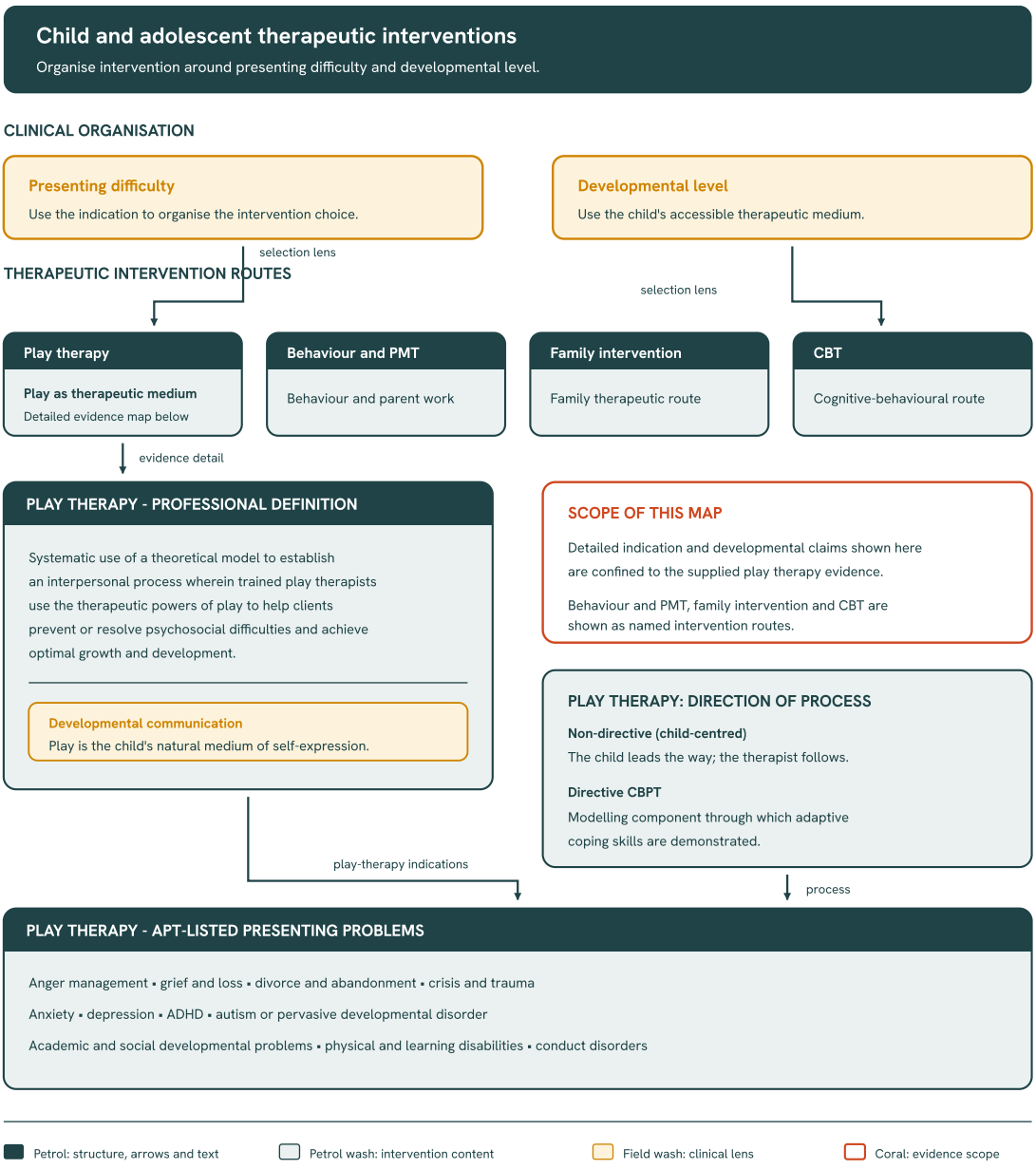


Fig 24.7. Therapeutic-intervention map for child and adolescent practice, organised around presenting difficulty and developmental level. The detailed route shows play therapy as a communicative medium, its directive and non-directive processes, and APT-listed presenting problems; behaviour and PMT, family intervention, and CBT remain named intervention routes.

18.1 Why play can become a therapeutic medium

In child work, experience can be known before it can be narrated. Worry may appear in a rescue scene, anger in a struggle over rules, or loss through disappearance and reunion. These are not codes to translate mechanically. Play creates enough distance for painful material to be approached while its emotional meaning remains alive in the room.

Axline's foundational proposition is that play is the **child's natural medium of self-expression**. The word "natural" should not be romanticised. It does not mean that every child will play freely, that every play theme is psychologically revealing, or that speech has no place in treatment. It

means that imaginative action, choice of role, repetition, construction, destruction, story and rule-making can give a child access to communication that may be less available in a direct adult interview. The therapist attends to the child's use of the medium, not merely to the objects selected.

Play also changes the balance of power in the clinical encounter. The adult remains responsible for safety, frame and professional purpose, but the child can initiate an action, alter a story, refuse a role, test a boundary or invite the therapist into a scene. This makes agency visible. Therapeutic work can then address not only the content of distress but also the child's manner of seeking closeness, managing frustration, using control, tolerating uncertainty and accepting help. What matters is the interaction that develops, not a performance judged as good or bad play.

RULE **Use play as a therapeutic language, never as a decorative substitute for therapy.** A play activity becomes treatment only when it is held in a purposeful relationship, guided by a coherent approach, and connected to the child's therapeutic needs.

18.2 The therapeutic frame

A therapeutic frame protects both spontaneity and safety. The child needs to know that the room is a place where choices can be made, feelings can be shown and difficult themes can be approached without ridicule. Equally, the child needs to discover that the therapist will not become chaotic, intrusive, frightened, punitive or collusive. The frame is therefore communicated as much through the therapist's steadiness as through spoken explanation.

Materials should permit expressive and relational uses rather than demand a correct outcome. They are offered as possibilities, not tests. The clinical question is not whether the child uses them as expected, but how choice, avoidance, repetition, pleasure, aggression, repair and participation appear in the shared space. The child must not be made to feel assessed for creativity, neatness or disclosure.

Boundaries are part of treatment rather than an interruption of it. A clear limit can show that powerful feeling is permissible while harmful action is not. The therapist names the limit calmly, offers a permitted alternative where possible, and remains available to the child's reaction. This can be therapeutically important for a child who expects either unrestricted escalation or punitive rejection. The limit must be real, however. A therapist who permits unsafe conduct in order to preserve rapport teaches that the clinical relationship cannot contain affect.

- Keep the purpose of the meeting clear without demanding a problem narrative at the outset.
- Offer choice, while retaining responsibility for the physical and emotional safety of the setting.
- Respond to feeling and relationship, not only to the visible product of play.

IN INDIA

An Indian play setting should not assume that a particular household, language, family role or cultural story is universal. Invite materials and examples that allow the child's own social world to enter the work. Ask caregivers about the child's ordinary play and preferred language, but avoid turning the family into interpreters of every symbol. Culturally responsive practice means staying curious about meaning while preserving the child's own voice.

18.3 Non-directive or child-centred practice

Child-centred play therapy places special weight on the child's initiative. The therapist aims to be accepting, emotionally available and closely attentive, while resisting the impulse to improve the story, educate the child, solve the conflict or make play conform to adult expectations. This stance is demanding because it requires the therapist to be active in attention and containment while not taking possession of the child's experience.

Axline's **sixth** principle, within her **eight** foundational principles, captures the working position: the child leads and the therapist follows. Following is not passivity. The therapist tracks what is happening, reflects feeling and action in language the child can use, notices shifts in relationship, and maintains boundaries. What the therapist does not do is turn every moment into a question, lesson, interpretation or correction. The child is allowed to discover that an adult can be present without taking over.

Reflection is often more useful than explanation in this approach. A brief response can acknowledge experience, make a sequence more thinkable, and leave ownership with the child. The therapist may reflect determination, disappointment, fear, pleasure or uncertainty without asserting why it exists. Interpretation is used with restraint because premature certainty can replace the child's unfolding meaning with the therapist's story.

Non-directive work should not be confused with lack of clinical responsibility. The therapist still decides whether this approach fits the child's needs, attends to risk and impairment, coordinates with the wider treatment plan, and recognises when the child requires a more structured intervention. It is a way of organising the relationship, not a refusal to formulate. The goal is to make room for the child's agency while providing enough security for emotional work to proceed.

MNEMONIC

PLAY

Provide a safe frame, **L**et the child lead, **A**ttend to affect and action, and **Y**ield neither safety nor therapeutic purpose. The mnemonic describes a stance, not a script to impose on every child.

18.4 Directive play and cognitive-behavioural play therapy

Directive approaches use play to introduce, practise or rehearse a therapeutic task. The therapist may select an activity, invite role-play around a difficult interaction, or guide attention toward coping. The child remains active, but the therapist contributes more structure than in child-centred work.

Cognitive-behavioural play therapy is an example of a directive approach. Its use of **modelling** allows adaptive coping skills to be demonstrated within play. A figure, puppet, story or therapist enactment can make a coping response concrete before the child is asked to attempt it. The strength of this method is that it converts an abstract instruction into an observable sequence. The limitation is that the therapist can too easily become the author of the child's play, thereby losing the child's own language and priorities.

Directive does not mean coercive. The therapist explains the invitation in developmentally understandable language, watches whether the activity is becoming too exposing or performance-based, and changes course if the child cannot engage. The activity should serve the formulation, not prove that a manual has been followed. A child who resists a structured task may be communicating avoidance, confusion, fear of failure, a mismatch of pace, or a need for a different mode of contact. The clinical response is to understand the obstacle, not simply to increase pressure.

CLINICAL QUESTION	CHILD-CENTRED EMPHASIS	DIRECTIVE EMPHASIS
Who initiates the activity?	The child's choice and unfolding play organise the encounter.	The therapist may introduce an activity linked to a therapeutic task.
Therapist's main contribution	Presence, reflection, containment and careful following.	Guidance, rehearsal and focused use of an activity.
How is change approached?	Through expression, relationship and the child's experience of agency.	Through structured experience, practice and demonstrable coping.
Principal risk if poorly used	Confusing permissiveness with a secure therapeutic frame.	Turning the activity into adult-led instruction rather than therapeutic play.

The two positions are best understood as different therapeutic emphases, not as a contest between free play and technique. A clinician chooses and adjusts the degree of structure in relation to the child, the therapeutic task and the developing alliance. The broader principles and disorder-specific applications of cognitive behaviour therapy are addressed in the cognitive behaviour therapy and adaptations for children and adolescents section of this chapter.

TRAP **Do not call every play-based encounter "non-directive".** If the therapist selects the task, teaches a response, arranges rehearsal or steers toward a stated therapeutic target, the work is directive. The distinction matters because it clarifies what the therapist is doing and why.

18.5 Core techniques in the room

Techniques are ways of using relationship and medium, not separate treatments to apply without formulation. Tracking puts into simple language what the child is doing, offering attention without intrusion. Reflecting feeling makes emotional tone available for thought without demanding explanation. Restating a plot can help a child recognise continuity in an

overwhelming story. Silence can communicate that the child need not fill the space to keep the therapist engaged.

Role-play permits a difficult situation to be approached from more than one position. The child may assign the therapist a role, reverse roles, make a powerful character vulnerable, or try out a different ending. The therapist should accept the invitation but avoid making the scene a vehicle for adult advice. Questions can expand possibilities; a moral lecture collapses the play into compliance.

Story-making, drawing and construction can assist communication when direct speech feels too exposed. The process reveals how a child begins, persists, abandons, repairs, seeks help, tolerates mistakes and responds to attention. The clinician can use this to guide therapeutic contact, but should not claim a fixed symbolic meaning for a colour, animal, weapon, house or family arrangement. Symbolic material remains contextual and open to more than one reading.

- Use reflection to make action and affect more available for the child to notice.
- Use role-play and narrative to explore possibilities without forcing disclosure or a preferred ending.
- Use limits and repair to show that strong affect can be contained within a continuing relationship.

Work with caregivers is often necessary around the edges of play therapy. Caregivers need a plain explanation of the therapeutic purpose, a way to share relevant changes in the child's life, and guidance about how the clinical relationship will be protected. They should not be asked to interrogate the child after each meeting or demand a report of play content. At the same time, the therapist should not create secrecy that excludes caregivers from essential treatment planning. The balance is to share what is clinically necessary while respecting the child's emerging sense that the therapeutic space can be trustworthy.

GOOD TO REMEMBER

When a child offers a dramatic play scene, begin by joining the child's level of meaning: notice what happens, acknowledge the feeling if it is evident, and ask whether the child wishes to say more. An interpretation can wait. Once the therapist has imposed a story, it is difficult to know whether later material belongs to the child or to the suggestion.

18.6 Formulation, selection and indications

Play therapy is selected because play is likely to be a useful route into therapeutic work, not because the child is young or because verbal treatment feels difficult for the clinician. The formulation should ask what difficulty is being addressed, how the child currently communicates distress, what kind of therapeutic relationship is possible, and whether an expressive, relational or structured play approach fits the task. It should also identify when another intervention needs to carry the main burden of treatment, with play therapy contributing a supportive role.

The Association for Play Therapy describes use across a broad range of **indications**. These include anger management, grief and loss, divorce and abandonment, and crisis or trauma. It also includes anxiety and depression, ADHD and autism or pervasive developmental disorder, academic and social developmental problems, physical and learning disabilities, and conduct disorders. These are indications for considering play therapy as a primary or supportive intervention, not diagnostic labels made by observing play.

The list is not an automatic referral rule. A child with loss may need a relationship in which remembering and reunion can be approached symbolically. A child with anxiety may externalise a feared situation or try coping. A child with disruptive behaviour may need intervention directed at daily contingencies and caregiver responses, even if play work also helps communication. Formulation, family context and engagement determine the treatment choice.

When the concern is ADHD, its treatment is addressed in the ADHD and specific learning/communication disorders notes. When the concern is a childhood behavioural or emotional disorder, its diagnostic and disorder-specific treatment is addressed in the Child behavioural, emotional and other disorders notes. Intellectual disability and autism spectrum disorder require the broader developmental formulation set out in the Intellectual disability and autism spectrum disorder notes. These cross-references protect against using play therapy as a substitute for comprehensive assessment or disorder-specific care.

PITFALL

Do not send a child to play therapy because “the child will not talk,” without first asking what makes talking difficult and what treatment task is being proposed. Silence can reflect fear, language mismatch, developmental differences, family pressure, a distressed therapeutic alliance or simple unfamiliarity with the setting. A referral without formulation burdens both child and therapist with an unclear goal.

18.7 Limits, coordination and review

Play therapy should be reviewed as therapy, not protected from evaluation because it feels child-friendly. The clinician and therapist need a shared account of the difficulty, intended direction of change, engagement and relation to other care. Lack of progress is information: it may signal a mismatch of approach, an unaddressed contextual problem, insufficient coordination or a need to revise the formulation.

Coordination must preserve role clarity. Behaviour therapy and parent management training focus on daily contingencies; family interventions address relationship patterns; and educational, remedial, early-intervention and stimulation work address other defined needs. Play therapy may coexist with each, but its unique contribution is a therapeutic use of play within an individual relationship. Describing all child interventions as “play therapy” blurs treatment goals and makes review impossible.

There are circumstances in which the clinician must move beyond ordinary therapeutic exploration. If play raises concern about immediate harm, coercion or abuse, safety takes

precedence over completing a narrative or interpreting symbolism. The clinician should use the relevant protection pathway and avoid suggestive questioning. Detailed child-protection assessment, reporting duties and management are dealt with elsewhere in this chapter. Play therapy can support recovery, but it should not be misused as a forensic method or as a means of testing an allegation.

PLAY	RELATIONSHIP	STRUCTURE	FORMULATION
A MEDIUM FOR EXPRESSION	THE THERAPEUTIC VEHICLE	VARIES BY APPROACH	GUIDES SELECTION AND REVIEW

Play therapy is a formulated therapeutic relationship in which play helps the child express, explore and work through difficulty; the therapist follows or directs the medium only as the clinical task requires.

19 · Behaviour therapy and parent management training in children

Why it matters clinically. Behaviour therapy and parent management training translate a formulation into small, observable changes in the child's daily environment. They are not shorthand for blaming a caregiver, asking a parent to be stricter, or rewarding compliance indiscriminately. Their clinical purpose is to alter the interactional conditions that keep a problem going, while preserving the child's dignity and the caregiver's capacity to remain connected.

The marks in this area usually come from showing that the psychiatrist can move from a complaint to a workable behavioural formulation. The candidate should be able to identify the target behaviour, locate its antecedents and consequences, explain the learning principle in ordinary clinical language, and describe how caregivers will practise a consistent response. The disorders themselves, including their diagnostic thresholds and disorder-specific treatment plans, belong in the Child behavioural, emotional and other disorders notes and the ADHD and specific learning/communication disorders notes.

19.1 Scope and therapeutic stance

Behaviour therapy is a structured psychological approach that uses an agreed description of behaviour and its context to guide change. In child work, the environment is usually shared with caregivers, siblings, teachers and peers. This makes the intervention relational without turning it into family therapy: the immediate task is to change the contingencies surrounding a carefully chosen behaviour, rather than to interpret the whole family system. Family therapy and broader family interventions are considered separately in this chapter.

Parent management training places caregivers at the centre of intervention because they are the people most able to make daily routines predictable and to notice small improvements. The clinician is neither a distant expert issuing instructions nor an adjudicator deciding who is at fault. The stance is collaborative: hear what the family has already tried, acknowledge exhaustion and practical constraints, then build a plan that can be carried out in the actual home rather than in an idealised household.

A good formulation distinguishes a child's intention from the function of behaviour. A behaviour can communicate distress, obtain access to something desired, avoid an aversive demand, or recruit adult attention. These possibilities are hypotheses to test with observation, not moral labels. The same outward act may have a different function in a different setting. That is why a generic instruction such as "be consistent" is weaker than a shared, concrete plan for a particular routine.

RULE **Change the interaction around a behaviour before judging the child's character.** The useful clinical question is what happens immediately before and after the target behaviour, and what each person learns from that sequence. This directs intervention toward modifiable events and protects the alliance.

19.2 Building a behavioural formulation

The starting point is an operational description. "Does not listen" is too broad to guide treatment; it blends a caregiver's understandable frustration with several possible behaviours. The team instead agrees on what an observer would see or hear, the situations in which it occurs, and the response that will count as improvement. This language makes it possible for caregivers to notice progress and for the clinician to revise an ineffective plan without personal criticism.

Antecedents are the immediate contexts in which the behaviour is more likely to occur: transitions, demands, delay, fatigue, competition for attention, ambiguity, or an escalating adult tone. They are not excuses for harmful behaviour. They are leverage points. A plan may simplify a routine, prepare a child for a transition, offer a limited choice, or ensure that an instruction is clear enough to be followed. Such changes reduce unnecessary conflict before discipline is needed.

Consequences are what follows the behaviour and therefore shape the likelihood that the sequence will recur. The relevant consequence may be attention, access, escape, relief from a demand, or the ending of an unpleasant exchange. Caregivers often discover that an apparently sensible response is accidentally maintaining the very pattern they want to reduce. This is not a parental failure. It is the clinical finding that makes a more effective response possible.

FORMULATION ELEMENT	QUESTION FOR THE CLINICAL INTERVIEW	HOW IT INFORMS THE PLAN
Target behaviour	What would an observer describe?	Creates a shared and measurable treatment target.
Setting event	What makes the routine harder on some occasions?	Identifies preventable pressures and reasonable adjustments.
Antecedent	What happens immediately before the behaviour?	Guides preparation, clarity and environmental change.
Behaviour	What does the child actually do?	Keeps the plan observable rather than judgmental.
Consequence	What changes immediately afterwards for child and adult?	Shows what needs reinforcement, withholding or replacement.
Alternative	What safer or more workable response can be taught?	Prevents treatment becoming punishment alone.

Observation may be informal but should be purposeful. Invite caregivers to recount a recent episode in sequence, including their own words, tone and actions. Ask what happened when the child complied, not only when conflict occurred. Where a setting outside the home is important, the clinician can seek a parallel account from the adults there, while avoiding a hunt for a single "correct" informant. The formulation becomes useful when it identifies a pattern that the family themselves recognises and can modify.

Target	Context	Response	Practice
OBSERVABLE BEHAVIOUR	WHAT COMES BEFORE	WHAT FOLLOWS	NEW SHARED ROUTINE

19.3 The coercive interactional cycle

Parent-child coercive cycle is a useful description of escalating exchanges in which both people seek short-term relief. A caregiver makes a demand or attempts a limit. The child protests or escalates. The adult, faced with mounting distress, may withdraw the demand or change course. The episode ends, but the sequence has taught both participants something about how conflict can be ended. This pattern can compromise the caregiver's sense of efficacy and make the next limit harder to hold.

The central learning mechanism is not that either party wishes to create conflict. It is that disengagement in the face of escalation can be **negatively reinforcing** for the child's misbehaviour: the aversive demand disappears, so escalation becomes more likely to be used again. The adult may also experience relief when the immediate conflict stops. That reciprocal relief explains why insight alone rarely changes the pattern. A different response has to be rehearsed before the next pressured moment.

The treatment aim is not stubborn endurance. It is planned, calm and proportionate follow-through, coupled with frequent attention to the behaviour the caregiver wants to see more often. When the proposed demand is unrealistic, the correct intervention may be to alter the demand.

When the boundary is necessary, the caregiver needs a brief response that does not accidentally turn escalation into negotiation. The psychiatrist helps the family discriminate these situations, because rigid application of a technique can intensify distress or rupture trust.

GOOD TO REMEMBER

When a caregiver says, "Nothing works," first ask what happens immediately after the child escalates. That question often reveals both the family's strain and the point at which a new response can be practised.

TRAP **Do not equate behaviour therapy with a harsher punishment plan.** A plan that focuses only on stopping undesirable behaviour often misses antecedents, fails to teach an alternative, and gives too little attention to cooperation. The clinical skill is contingency management with warmth, clarity and repair.

19.4 Core components of parent management training

Parent management training converts the formulation into skills that can be used under ordinary domestic pressure. The clinician selects a small set of targets, demonstrates the skill, invites rehearsal, anticipates obstacles and reviews what happened. The sequence matters. Information without rehearsal is easily understood in the consulting room and lost in a difficult bedtime or school-morning routine.

- Specify the behaviour to increase or decrease in plain, observable terms.
- Arrange the setting so that cooperation is possible before giving a demand.
- Use brief, calm and unambiguous instructions, with a realistic opportunity to comply.
- Notice and respond promptly to desired behaviour, including small approximations to the target.
- Choose a predictable response to the target problem behaviour that does not inadvertently reward it.
- Review the outcome without shaming the child or caregiver, then adjust the plan.

Reinforcement is often misunderstood as bribery. Clinically, it means arranging consequences so that adaptive behaviour becomes more likely to recur. It works best when the behaviour is clearly identified, the response is linked closely to it, and the caregiver's attention is credible rather than mechanical. Genuine descriptive praise can be especially useful because it tells the child what was done well and strengthens the relationship at the same time.

Responses to problem behaviour must be selected from the formulation, not applied as ritual. A response that reduces attention may be appropriate only when attention is maintaining the behaviour and when safety is secure. Removal of a privilege may be meaningful only if it is realistic, proportionate and not silently reversed during conflict. The child also needs an alternative route to attention, choice, help or escape from an overwhelming demand. Otherwise the plan removes a behaviour without creating a workable replacement.

MNEMONIC

Notice - Name - Nurture - Navigate

Notice the sequence, **name** the target behaviour, **nurture** the behaviour worth repeating, and **navigate** predictable conflict without abandoning the plan or the relationship.

19.5 Delivery, participation and review

For conduct-related presentations, NICE recommends offering a group parent-training programme to the parents of children aged between **3 and 11 years** when there is identified risk or established oppositional, conduct or antisocial difficulty. This is an indication for a structured parent intervention, not a substitute for a full clinical formulation. Comorbidity, developmental profile, safety concerns, caregiver mental health, substance use, domestic stress and the child's wider supports all affect whether a group format can be used as planned.

The programme model specified by NICE is a **social learning model**, using modelling, rehearsal and feedback. A typical programme has **10 to 16 meetings**, each lasting **90 to 120 minutes**. These features are worth remembering because they distinguish a genuine skills programme from general advice. They also explain why participation needs active support: caregivers have to observe a skill, try it, report the outcome and receive constructive feedback.

Group work offers normalisation and opportunities to learn from other caregivers, but it should not make a family invisible. The facilitator must be alert to caregivers who feel exposed, who cannot safely practise a recommended response, or whose literacy, language, work pattern or travel make participation difficult. A flexible clinical service may use individual contact, a different delivery format, or coordination with other supports, while retaining the same behavioural logic. Practical adaptation is not dilution when it preserves the treatment mechanism.

IN INDIA

Parent work is most useful when the plan is fitted to the household that exists: who actually cares for the child, which language carries authority and affection, how school expectations enter the routine, and what material pressures limit follow-through. Avoid importing a scripted programme unchanged. Adapt examples and homework collaboratively, while keeping the target behaviour and response plan clear.

Review is a clinical intervention, not merely an attendance check. Ask what was attempted, what the child did, what the adult did next, and what made success easier or harder. Look for improvement in the interaction before expecting every target behaviour to vanish. If a plan has not worked, return to the formulation: the target may be too broad, the antecedent may have been missed, the chosen consequence may not matter to the child, or caregivers may need more rehearsal and support.

PITFALL

Do not interpret non-completion as lack of motivation. A caregiver may be unable to attend or practise because of shift work, transport, crowded living conditions, competing care responsibilities or fear of criticism. Explore the barrier directly, then decide whether the intervention needs adaptation or additional support.

19.6 Boundaries, integration and referral thinking

Behavioural work is strongest when it is embedded in a broader child psychiatric plan rather than presented as a universal answer. The clinician should consider whether pain, sleep disruption, communication difficulty, learning problems, trauma, mood symptoms, neurodevelopmental differences, medication effects or environmental adversity are changing the child's capacity to respond. Naming these possibilities does not mean re-teaching their assessment or treatment here; it means refusing a simplistic formulation when the behavioural pattern is a signal of something else.

Behaviour therapy may be coordinated with school support, individual psychological work or other family interventions, but each contributor should know the target and avoid giving contradictory advice. Where the child's safety is at risk, where there is abuse or coercion within the caregiving environment, or where a caregiver cannot safely implement a plan, the priority changes from routine behaviour management to protection and appropriate multidisciplinary action. The clinical safeguarding response is addressed elsewhere in this chapter.

For children with intellectual disability or autism spectrum disorder, behavioural principles may still inform daily supports, but diagnostic formulation and the wider developmental intervention belong to the Intellectual disability and autism spectrum disorder notes. For attention-related presentations, disorder-specific assessment and medication decisions belong to the ADHD and specific learning/communication disorders notes. The value of parent management training here is its disciplined focus on observable interaction, not an attempt to make one method cover every need.

Formulate the sequence, strengthen the behaviour you want repeated, and help caregivers respond predictably enough that escalation no longer becomes the easiest route out of conflict.

20 · Family therapy and family interventions in child psychiatry

Why it matters clinically. A child's difficulty is lived in relationships long before it is described in a consultation. Family work therefore asks not only what is troubling the child, but what happens around the difficulty: who notices it, who responds, who is drawn into an argument, who withdraws, and what relief follows. This is not a search for a culpable relative. It is a way of understanding how a family's ordinary attempts to cope may inadvertently keep a problem active, and how the same family can become the chief resource for change.

For the psychiatrist, **family intervention** is both a treatment and a clinical stance. It makes room for the child's developmental dependence, the authority and burden carried by caregivers, and the practical realities that shape whether any plan can be carried home. It is especially useful when a child's difficulty has become organised around conflict, avoidance, inconsistent responses, divided caregiving, or a narrowing of the child's role within the household. The task is to restore useful relationships and workable caregiving, while preserving the child as a person rather than reducing the child to the family's symptom.

SYSTEM	PATTERN	CHANGE
RELATIONSHIPS MATTER	MAP WHAT REPEATS	PRACTISE IT IN SESSION

20.1 Scope and therapeutic stance

Family therapy is not a single technique applied whenever relatives are present. It is a way of working in which the unit of attention shifts between the child, the caregiver, the relationship, and the wider household context. The psychiatrist needs a clear reason for making that shift. A consultation may require brief work to align caregivers around a plan, sustained work on interactional patterns, or careful liaison when a child cannot safely be asked to carry a family conflict. The intensity and format should follow the formulation, not the therapist's preferred school.

A useful **family formulation** links the presenting difficulty to reciprocal responses. It asks what tends to precede an episode, how each person understands it, what each person does next, and what consequence makes that response likely to recur. Such a formulation remains provisional. It must accommodate developmental level, communication ability, physical illness, learning needs, stress, separation, and the child's own account. A relational account that ignores the child's individual experience is as incomplete as an individual account that ignores the household in which care is delivered.

Neutrality is often misunderstood as emotional distance or as pretending that every action has the same effect. In practice it means respectful curiosity toward each participant's position. The clinician can acknowledge a caregiver's exhaustion, a child's fear, and another family member's wish to help without endorsing harmful conduct or making the child responsible for adult distress. This stance reduces defensiveness and permits difficult material to be discussed. It also protects against the familiar error of treating the most articulate adult as the sole narrator of family life.

RULE **Formulate a pattern, not a culprit.** The clinical question is how responses connect and persist, while keeping the child's safety, experience, and developmental needs in view.

20.2 Mapping the family pattern

The opening phase is active clinical enquiry, not a social history recited for formality. Ask who is involved in daily care, who makes decisions, where authority sits, how transitions are managed, and how conflict is repaired. Notice alliances, exclusions, abrupt changes of topic, and whether the child is expected to speak only through an adult. Ask each person for a concrete account of a

recent difficult interaction. General descriptions such as “he never listens” or “she is always stubborn” often conceal an interactional sequence that becomes visible only when reconstructed in detail.

A **transactional sequence** is clinically more useful than a global label. The clinician follows the exchange from the first cue through each response to the eventual outcome. Attention to sequence reveals points where a different response could interrupt escalation. It also shows the function of behaviour in context without declaring that the child is deliberately manipulating the family. The purpose is explanatory precision, not moral judgement.

The interview should include the child in a manner that is comprehensible and emotionally safe. Direct questions can be paired with observation of how adults respond when the child speaks. The clinician may ask caregivers to describe what they believe the child is trying to communicate, then invite the child to correct or add to that account. This both gathers information and begins to alter an entrenched pattern in which the child is spoken about but not heard. Equally, a child should not be recruited to reveal private adult material or to decide between caregivers.

- Identify the concern in the family’s own language before translating it into clinical terms.
- Trace a recent interaction from trigger to consequence, rather than relying only on trait descriptions.
- Attend to participation: who speaks, who answers for whom, and whose view is absent.
- Clarify strengths, routines, and moments when the difficulty is less dominant.

> **GOOD TO REMEMBER**
>
> When a caregiver asks for the clinician to “fix the child,” hear the request for relief but widen the task gently. A useful response is to make the child’s distress important while inviting the adults to examine what they can change around it.

20.3 Structural thinking: subsystems and boundaries

Family subsystems allow a family system to differentiate and carry out its functions. In clinical work, this directs attention to the organisation of participation and responsibility rather than to personalities alone. A caregiver relationship may need room to coordinate care; children may need space for age-appropriate relationships; and the child should not be placed in an adult role simply because the family is under strain. The psychiatrist assesses these arrangements by observing interactions and by asking how decisions are actually made, not merely how the family says they ought to be made.

Boundaries are the rules within a subsystem that determine who takes part in a situation, when participation occurs, and how it occurs. They are best understood as functional patterns, not as fixed virtues. A boundary may be too permeable for a particular task, leaving a child exposed to adult conflict, or too rigid, preventing support from reaching someone who needs it. The clinical aim is not to impose an ideal household design. It is to help the family create enough clarity, protection, and flexibility for caregiving and development.

Structural observations are hypotheses to test collaboratively. If a caregiver repeatedly answers a child's questions, the clinician should not immediately infer domination. The behaviour may reflect anxiety, habit, language difficulty, fear of being misunderstood, or a response to earlier crises. The therapeutic conversation tests meaning and effect: what happens when the child is given room to answer; what makes that difficult; and what support would make a small change possible. This protects structural work from becoming a set of labels applied to families.

TRAP **Do not turn structural language into a verdict on a family.** Terms such as boundaries and subsystems organise observation; they do not excuse a clinician from hearing context, checking hypotheses, and treating each family member with respect.

20.4 Conduct of the therapeutic meeting

The meeting is both an assessment setting and a place where change can be rehearsed. The therapist establishes a clear frame: the purpose of the conversation, how each person will be invited to contribute, and what will happen if discussion becomes overwhelming. The clinician's authority is used to slow accusation, protect the child from being made a messenger, and make room for quieter participants. This is not passive chairing. It is deliberate management of the interaction so that the family can experience an alternative to its usual sequence.

Enactment means inviting family members to address a relevant issue with each other in the session rather than only reporting it to the clinician. It provides direct information about pace, tone, interruption, authority, and repair. It also lets the therapist coach a small, observable change while the interaction is live. The invitation must be graded to tolerance. Pushing a family into emotionally charged material without preparation can produce compliance in the room and collapse outside it. A modest exchange that can be repeated safely is more therapeutic than a dramatic confrontation.

Reframing changes the meaning attached to behaviour without denying its impact. A caregiver's repeated checking might be recast as an attempt to protect that has become constricting; a child's withdrawal might be understood as a signal of overload rather than simple defiance. A good reframe reduces blame and opens alternatives. It is not a clever explanation imposed by the therapist. If the family does not recognise itself in the reframe, the clinician should revise it rather than defend it.

Tasks between meetings should be concrete, proportionate, and linked to the observed pattern. They are experiments, not tests of obedience. The next meeting examines what happened, what made change easier or harder, and what the result teaches the family about its pattern. When a task has not been attempted, the response should be curiosity rather than rebuke. Non-completion may reveal that the task was unrealistic, that the family's formulation differs from the therapist's, or that an unspoken barrier requires attention.

MNEMONIC

MAP the meeting

Make room for each voice, **A**ttend to the live interaction, and **P**ractise a manageable alternative. It is a practical spine for keeping the session relational rather than turning it into parallel individual interviews.

20.5 Strategic and problem-focused work

A strategic family approach is **present problem-focused**, **directive**, and **practical**. Its clinical appeal in child psychiatry is that it keeps attention on the current interactional pattern that accompanies the referral concern and asks for observable changes. Direction is not synonymous with coercion. The therapist remains accountable for explaining the purpose of an intervention, inviting concerns, and adapting the plan to the family's capacity and safety.

Problem-focused work is most useful when the family can identify a specific interaction they want to change. The clinician clarifies the shared aim, identifies the sequence that blocks it, and collaborates on an alternative response. Progress is judged by whether the family can use a more helpful pattern in ordinary circumstances, not by whether they can reproduce the therapist's language. The approach should not flatten complex grief, trauma, coercion, or severe adversity into a simple communication problem. Where these are present, pace, protection, and appropriate parallel care take priority.

The psychiatrist should distinguish a directive that changes an interaction from advice that merely sounds firm. Vague instruction can leave caregivers feeling blamed for failing to implement an undefined plan. Conversely, overly prescriptive advice may disregard the realities of work, housing, illness, and extended-family influence. Good direction is specific enough to try, flexible enough to revise, and anchored in the family's own stated goal.

20.6 Integrating family intervention with child care

Family work should sit within a coherent treatment plan, not compete with it. The psychiatrist makes explicit what family sessions are intended to change and what they are not intended to replace. Individual psychological work, behavioural intervention, educational support, medication decisions, and safeguarding processes each have their own indications and limits. They can be coordinated around a shared formulation without being collapsed into a single intervention. The childhood disorders themselves are addressed in the Child behavioural, emotional and other disorders notes; intellectual disability and autism spectrum disorder are addressed in the Intellectual disability and autism spectrum disorder notes.

Coordination requires careful communication. Caregivers need to know why more than one professional may be involved and how information will be shared. The child needs an account that is truthful, developmentally understandable, and respectful of privacy. When parents or caregivers disagree, the clinician should not privately recruit one side into a therapeutic alliance. Instead, name the disagreement, clarify which decisions need a shared plan, and preserve a space

for the child's interests. A family meeting is not automatically appropriate merely because family conflict exists.

CLINICAL QUESTION	FAMILY-THERAPY RESPONSE	WHAT THE PSYCHIATRIST MONITORS
What has become stuck?	Map the recurring interaction.	Whether the account includes every relevant voice.
What role is the child carrying?	Examine participation and responsibility.	Whether adult conflict is being placed on the child.
What can change at home?	Rehearse a manageable alternative.	Whether the task is safe and feasible.
What requires another response?	Coordinate rather than overextend family work.	Whether protection, individual care, or practical support is needed.

Confidentiality needs thought before the first emotionally charged disclosure. The clinician should explain the practical limits of private conversations and avoid making promises that cannot be honoured. Separate conversations may sometimes be clinically necessary, but hidden coalitions can make relational work unsafe or ineffective. Where there are concerns about violence, coercion, abuse, or serious intimidation, the priority is protection and an appropriate safeguarding response, not joint exploration of the relationship.

20.7 Indian clinical practice and service realities

IN INDIA

Family participation is often central to how a child reaches care and whether a plan can be implemented. Use that strength without assuming that every relative should be in the room or that the loudest family member represents the child's interests. Ask explicitly who the child trusts, who provides daily care, and who can support a realistic change between appointments.

In an Indian setting, the family meeting may include people whose authority is practical, emotional, or financial rather than formally parental. This can be valuable when it broadens support, but it may also silence the child or overwhelm a caregiver. The clinician should decide attendance by therapeutic purpose. A meeting to support a caregiver may need a different membership from a meeting intended to reduce a child's exposure to conflict. Cultural humility does not mean accepting hierarchy as an explanation for avoidable distress; nor does it mean importing an individualistic model that ignores interdependence and care.

Language is a clinical tool. Family therapy concepts should be expressed in words that participants can use outside the clinic. Translating a formulation into everyday language helps a family notice the pattern without turning clinical terminology into another source of shame. It is also worth checking that agreement is genuine. Polite assent in a consultation may conceal confusion, fear of contradicting an elder, or an impractical burden placed on one caregiver.

PITFALL

Do not mistake family involvement for family consent to disclose everything. Bringing relatives into care does not remove the need to protect the child's privacy, to ask about safety, or to consider whether a joint meeting could increase pressure on the child.

20.8 Limits, safety, and the examination answer

Family therapy has limits. It is not a neutral container for situations in which a child or caregiver may be harmed by speaking openly. It should not be used to mediate abuse, to obtain a child's disclosure in front of a potentially unsafe person, or to distribute responsibility for adult violence onto the child. In such circumstances, the clinician must shift from relational exploration to protection, follow the relevant service pathway, and use a child-centred clinical response. The statutory and safeguarding framework is addressed in the child-protection sections of this chapter.

A strong written answer begins with the systemic rationale, then shows how the therapist assesses patterns, participation, and boundaries. It explains how an interaction is brought into the room, how a small alternative is practised, and how the work is integrated with the wider plan. It should state plainly that family work is collaborative, non-blaming, and contingent on safety. The answer gains depth when it distinguishes observation from interpretation: seeing a child interrupted is an observation; deciding why it occurs requires enquiry and hypothesis testing.

Family intervention changes the conditions around a child's difficulty by helping the family see, test, and sustain a safer and more workable pattern of care.

21 · Cognitive behaviour therapy and adaptations for children and adolescents

Cognitive behaviour therapy is a way of making change visible, testable and usable. In child psychiatry, it is not a smaller version of adult psychotherapy delivered with simpler words. It is a collaborative, structured intervention in which the clinician helps a young person notice links between situations, meanings, feelings, bodily states and actions, then practise alternatives in ordinary life. Its value lies in converting an overwhelming, global problem into a formulation that can be shared, revised and acted upon.

The examination answer should therefore show more than a list of techniques. It should explain how developmental capacity, language, play, family context and school demands alter the delivery of CBT. The therapist remains active, but does not become a lecturer or an external disciplinarian. The work is designed so that the child or adolescent can increasingly recognise a pattern, generate a manageable alternative and learn from the result. Disorder-specific indications and protocols belong in the relevant disorder chapters; this section concerns the therapeutic method and its developmental adaptation.

21.1 The therapeutic stance and cognitive formulation

Cognitive behaviour therapy begins with the proposition that distress is shaped not only by events but also by the meaning assigned to them and by the response that follows. This is not an

invitation to tell a child that their problem is imaginary or that they ought to think positively. A formulation asks what happened, what the young person noticed, what they made of it, what they felt in mind and body, what they did next, and how that response altered the situation. It preserves the reality of adversity while identifying points at which agency may be restored.

A useful **cognitive formulation** is a working map, not a diagnostic label and not a verdict on the child. It should be expressed in language the child can recognise, checked against concrete examples, and modified when it fails to fit. The therapist listens for recurring predictions, self-statements, rules and interpretations, but also for avoidance, reassurance seeking, withdrawal, impulsive responding and other behaviours that may bring immediate relief while preserving the difficulty. The formulation makes these patterns discussable without making the child feel blamed for them.

Children often communicate the relevant meanings indirectly. A drawing, game, recent disagreement, bodily complaint, or account of a difficult school moment may offer a better route into the formulation than an abstract question about beliefs. Adolescents may tolerate more direct reflection, but apparent verbal sophistication should not be mistaken for emotional readiness. The clinician tests understanding rather than assuming it, and deliberately separates a thought from a fact, a feeling from an instruction, and a feared possibility from a certainty.

RULE **Formulate with the young person rather than explaining the young person to themselves.** A shared map gives techniques a purpose and lets the child correct the therapist's assumptions.

Collaboration also changes the handling of disagreement. If the child rejects the therapist's account, the task is to find the missing context, not to persuade them into compliance. A parent may describe a behaviour as defiance while the child describes it as panic, humiliation or unfairness. Both accounts can be explored, provided the session does not turn into a tribunal. CBT is strongest when it makes competing accounts testable and when its language remains respectful of the child's experience.

A formulation ready for treatment should make clear:

- the situations in which the difficulty is most likely to occur;
- the meanings and responses that appear to keep it going; and
- a change target that the young person can recognise as relevant.

21.2 From formulation to behavioural learning

CBT is maintained by doing, observing and reviewing. Discussion can open a door, but change usually requires action outside the consulting room. The therapist and young person select a task that is understandable, relevant and within reach. The task should test a prediction, practise a coping response, or interrupt a maintaining pattern. Its result is then reviewed with curiosity. A task that did not go as hoped is information for revising the formulation, not evidence that the child has failed treatment.

Behavioural experiments are especially useful because they replace argument with learning. Rather than assure a young person that a feared outcome will not occur, the clinician helps them state the prediction, identify what would count as evidence, and observe the outcome. The exercise must be proportionate and safe. It is not an ordeal arranged to prove bravery, nor is it an adult's test of obedience. The child needs to know why the task was chosen, what support is available, and how the experience will be discussed afterward.

Graded practice is the developmental answer to the common error of asking for too much too soon. Difficult tasks are broken into meaningful steps, with the pace set by learning rather than by adult impatience. Repetition matters because a new response becomes credible when the young person has experienced it in varied contexts. Where avoidance is prominent, the therapeutic target is willingness to approach a valued or necessary activity while using skills, not the elimination of every uncomfortable feeling before action begins.

THERAPEUTIC ELEMENT	QUESTION FOR THE THERAPIST	DEVELOPMENTALLY ADAPTED DELIVERY
Situation	What was happening just before the difficulty?	Use a recent scene, picture, role play or game rather than a remote summary.
Meaning	What did the child think the situation meant?	Invite speech, drawing, choice cards or enacted alternatives.
Emotion and body	How was distress recognised?	Link words to faces, body cues, movement and familiar experiences.
Response	What happened next?	Rehearse a different response in session before asking for practice elsewhere.
Review	What was learned from trying it?	Use a brief, concrete review that credits effort and notices obstacles.

Behavioural activation is another way of restoring contact with activity, mastery, pleasure or connection when the young person has become narrowed by distress. The therapist explores what has fallen away and what might be reintroduced in a realistic form. The point is not to prescribe busyness. It is to create experiences that can challenge hopeless conclusions and provide opportunities for reinforcement. Family routines and school demands may either support this work or quietly defeat it, so they need to be considered in the plan.

TRAP **Do not mistake a worksheet for CBT.** A completed form has no therapeutic value unless it is understood, linked to an individual formulation, followed by practice, and reviewed for learning.

21.3 Developmental adaptation as a clinical skill

Developmental adaptation concerns the entire therapy, not merely the vocabulary of the handout. The child must be able to grasp the task, hold it in mind, relate it to a real situation and use it when the therapist is absent. The clinician therefore adjusts the level of abstraction, pace,

method of expression, amount of scaffolding and expected independence. This is a matter of access and therapeutic fidelity, not dilution of treatment.

With younger children, the work often needs to be anchored in the here and now. Thoughts may be introduced as speech bubbles, characters, detective clues, or alternative endings to a story. Feelings can be represented through faces, colours, body outlines or a simple scale without demanding a polished verbal narrative. Role play permits rehearsal of a response before the child has to use it in a consequential setting. Play is used purposefully: it creates psychological distance, reveals a pattern and enables practice. The principles and techniques of play therapy itself are addressed separately in the play therapy section.

Attention, memory, literacy, communication style and sensory needs all affect whether a task is usable. Instructions may need to be brief, concrete and repeated in the child's own words. Visual prompts can be co-created rather than handed down as schoolwork. A young person who cannot record a thought in writing may still notice it through speech, drawing or a cue agreed with the therapist. The therapeutic question is always: what format lets this child demonstrate understanding and practise the intended skill?

Before setting practice, the therapist checks whether the task:

- has a purpose the child can state;
- can be carried out in the setting where it matters; and
- has a review plan that treats obstacles as information.

Parents or carers often serve as **therapeutic coaches**. They can help notice opportunities for practice, reduce unhelpful accommodation, reinforce effort and bring observations back to the session. Their participation should be transparent to the child and bounded by the treatment rationale. If the adult takes over the monitoring, answers every question, or turns homework into surveillance, the work loses the child's ownership. Parent management training has its own methods and indications; CBT uses caregiver involvement to support the young person's formulation and skill use.

MNEMONIC

MAP

Make it concrete, **A**ctively rehearse it, **P**lace practice in the child's everyday world. This is a delivery check, not a substitute for formulation.

Guidance for children aged **5-11** with mild depression that continues after **2 weeks of watchful waiting**, and without significant comorbid problems or active suicidal ideas or plans, asks clinicians to consider psychological options, including CBT, **adapted to developmental level as needed**. The practical implication is important: developmental adaptation is not an optional embellishment added after a standard protocol has failed. It belongs in treatment selection, explanation, materials, tasks and review from the outset.

GOOD TO REMEMBER

If a child repeatedly cannot complete a task, first reconsider the task's developmental fit, clarity and environmental support. Escalating pressure may teach shame rather than skill.

21.4 Working with adolescents without becoming didactic

Adolescence permits greater use of reflection, self-monitoring and discussion of long-term consequences, but these capacities are uneven and context-sensitive. The therapist should not confuse an adolescent's ability to debate an idea with readiness to test it in a difficult social setting. Privacy, autonomy and the wish not to be managed by adults are clinically relevant. A collaborative agenda, clear explanation of what will be shared with carers, and genuine choice about between-session practice help preserve engagement.

Guided discovery is preferable to cross-examination. The clinician asks questions that help the adolescent examine an interpretation, identify an exception, compare alternatives and decide what experiment would be fair. This approach respects intellect while avoiding a contest about who is right. It also makes room for structural problems such as conflict, exclusion, academic pressure or unsafe environments. CBT can clarify what is modifiable without implying that the young person is responsible for adversity around them.

Digital communication can be incorporated as content where it is central to the young person's experience, but it should not automatically become the medium of therapy. The clinician considers privacy, misunderstanding, family access and whether a digital task will increase monitoring rather than learning. The durable therapeutic aim remains the same: to help the adolescent carry a flexible formulation and tested coping responses into ordinary relationships, education and daily routines.

21.5 Family, school and the treatment environment

CBT takes place in an ecology. A child may leave a useful session and return to routines that reward avoidance, amplify threat, make practice impossible or communicate that distress is a moral failure. The clinician asks which adults and settings need a shared understanding of the treatment goal. This does not mean recruiting every adult into therapy. It means choosing supports that protect practice while preserving the child's dignity and confidentiality.

Communication with school is most useful when it is specific to function: what helps the student begin a task, use a coping plan, return after distress, or avoid being singled out. It should not become a broad disclosure of private therapy content. Educational and remedial interventions are addressed separately in the special education and educational interventions section. Likewise, where family patterns themselves require therapeutic work, the reader should refer to the family therapy and family interventions section rather than relabel family therapy as CBT.

IN INDIA

Developmentally adapted CBT may need to move flexibly between the language of the child, caregiver and school. Materials that fit the family's daily routines and preferred language are often more usable than imported worksheets. Explain the formulation in plain, non-stigmatising terms, and agree in advance what information may be shared with teachers or extended family.

PITFALL

Translating a worksheet word for word is not the same as adapting therapy. If its examples, literacy demands or assumptions about privacy do not fit the child's setting, the form can make the young person appear uncooperative when the intervention is actually inaccessible.

21.6 Reviewing progress, obstacles and scope

Review is part of the intervention, not an administrative ending. The therapist asks whether the formulation still fits, whether the child understands the skill, whether practice occurred in the intended context, and what blocked it. A lack of progress may reflect an inaccurate formulation, insufficient developmental adaptation, competing stressors, an unhelpful family response, poor fit between task and setting, or a need for a different therapeutic emphasis. It should not automatically be attributed to lack of motivation.

Outcome monitoring is most helpful when it is tied to the goals the child and family can recognise: greater participation, more flexible responding, recovery after distress, improved use of coping plans, or a meaningful activity regained. The young person's own account should remain central even when adult observations are also useful. General principles of child psychiatric assessment and multi-informant work are covered in the child psychiatric history and examination section and the multiaxial and multi-informant assessment section.

CBT also has limits of scope. It cannot make an unsafe environment safe, substitute for protection when there is abuse, or resolve every social and educational barrier through individual effort. When safety concerns arise, the clinical safeguarding response belongs to the child abuse management section, with the statutory reporting framework addressed in the POCSO Act section. When the principal difficulty is a childhood disorder, the relevant formulation and disorder-specific treatment should be taken from the Child behavioural, emotional and other disorders notes, the ADHD and specific learning/communication disorders notes, or the Intellectual disability and autism spectrum disorder notes as appropriate.

Developmentally adapted CBT keeps the formulation and therapeutic aim intact while changing the route by which the child can understand, practise and own the work.

MAP	TEST	SHARE	REVIEW
MAKE THE TASK CONCRETE	LEARN FROM PRACTICE	USE SUPPORTS WITH CONSENT	REVISE THE FORMULATION

22 · Special education and remedial and educational interventions

Education is a clinical outcome. A child may improve in clinic yet remain excluded from learning if school cannot use those gains. Special education, remedial teaching and educational interventions translate a clinical formulation into opportunities to participate, learn, belong and progress. The psychiatrist is not the child's teacher and a diagnosis is not an educational prescription. The task is to identify school barriers, help family and school agree on a response, and review whether it helps.

Marks are usually earned by making distinctions. **Special education** concerns planned teaching and support for a learner whose needs cannot be met adequately by ordinary classroom provision alone. **Remedial teaching** targets a defined gap in an academic skill through explicit, graduated teaching. **Educational intervention** is the wider bridge between the child, curriculum, classroom, family and service system. These overlap but are not interchangeable. A sensible plan protects access without confusing poor attainment with laziness, low expectations, a psychiatric diagnosis, or a permanent verdict on ability.

22.1 Educational formulation: from complaint to participation

The presenting complaint is often deceptively brief: the child is “not coping”, “slow”, disruptive in class, avoiding schoolwork, or repeatedly sent out of the room. Such phrases identify a problem but not its mechanism. The educational formulation asks what the child is being asked to do, at what point performance breaks down, what the child does next, and how adults respond. It examines the fit between the learner and the demands of the setting rather than locating the whole problem within the learner.

This formulation is functional and prospective. It should specify strengths that can be used in teaching, the task that currently defeats the child, conditions that improve performance, and obstacles that recur across lessons or settings. Relevant observations may include the child’s response to spoken instruction, written work, transitions, peer demands, sensory load, pace, correction and evaluation. The educational report should convert these observations into practical requests. “Needs support” is too vague to guide a teacher; a description of the condition under which the child can start, sustain and complete a task is useful.

- Define the educational concern in observable terms, including what the child can already do independently.
- Identify the demand, trigger or environmental feature that exposes the difficulty.
- State the support to be tried, who will provide it, and what change would count as improvement.

RULE **Prescribe an educational response to a functional barrier, not to a diagnostic label alone.** A diagnosis may clarify likely needs, but it does not tell a teacher which task to alter, what support to provide, or how to know that the alteration has worked.

The psychiatric assessment provides essential context, but the general framework for child psychiatric assessment belongs in the chapter on assessment. Here, the crucial move is

translation. Symptoms, developmental profile, communication style, family stress and school observations must become an educational hypothesis that the people around the child can test. This protects against both extremes: making the school responsible for everything, and assuming that medication or clinic-based therapy alone will restore participation.

22.2 Special education and the continuum of support

Special school is one possible setting, not a synonym for educational care. The central question is the adequacy of support, participation and learning for this particular child. A child may need changes in instruction, classroom organisation, communication, materials, assessment or adult support. Some children also need a setting with specialised teaching. Placement should arise from an individual educational plan, not from the convenience of the institution, the discomfort of peers, or a belief that one setting is inherently superior.

APPROACH	PRIMARY QUESTION	TYPICAL CLINICAL CONTRIBUTION	COMMON MISUSE TO AVOID
Universal classroom support	Can ordinary teaching be made more accessible?	Describe environmental and communication needs.	Calling ordinary flexibility "special education".
Targeted educational support	Which specific barrier needs additional teaching or scaffolding?	Clarify the functional target and review progress.	Offering generic extra work without a hypothesis.
Special education	What planned, specialised provision is required for meaningful participation?	Support an individualised plan and coordination.	Equating specialised provision with segregation.
Remedial teaching	Which academic skill requires direct, graduated instruction?	Distinguish a skill gap from a broader participation problem.	Using repeated drilling as the only response.

An individual educational plan is most useful when it is brief enough to be used and precise enough to guide action. It should identify priority learning and participation goals, adaptations, responsibility for implementation, communication with family, and a method of review. Goals should describe a valued function, not merely adult compliance. For example, the aim is not simply that a child remains silent or seated; it is that the child can engage safely and productively with the learning activity.

Access does not mean lowered expectation by default. An accommodation changes the route by which a child can show learning or participate. A modification changes what is expected to be learned or demonstrated. Either may sometimes be appropriate, but they should not be used casually. The psychiatrist should ask whether a proposed change removes an irrelevant barrier, or whether it unintentionally removes the educational opportunity itself. This distinction is especially important when families are desperate for relief and schools are under pressure to manage a classroom.

TRAP **Do not treat "inclusive" as a mere place name.** Physical presence in an ordinary classroom without accessible teaching, peer participation or a responsive plan can be exclusion in another form. Conversely, a specialised setting is not automatically a failure if it genuinely meets the child's educational needs and respects family choice.

22.3 Remedial teaching as a clinical partnership

Remedial work begins with a narrow, teachable target. The target may concern understanding instruction, reading, writing, numeracy, organisation, task initiation or persistence, but it should be phrased in terms that permit the teacher and family to observe progress. A broad complaint such as "poor studies" is not a target. It may conceal an instruction-comprehension problem, a gap in prior learning, a mismatch between language of teaching and language of understanding, emotional avoidance, repeated failure, irregular attendance, or an unrecognised need for a different method of communication.

The teaching response should therefore be explicit and graded. The skill is broken into manageable steps, the child is given enough opportunity to practise successfully, feedback is immediate and specific, and the level of support is adjusted as competence grows. Teaching must be humane: repeated exposure to tasks at which the child predictably fails is not remediation. The child needs an experience of mastery, while adults need evidence about which component of the task remains difficult.

- Choose a priority skill that matters to the child's current participation.
- Start from a task the child can enter with support, then make the next step visible and achievable.
- Record the child's response and alter the teaching method when progress does not occur.

GOOD TO REMEMBER

A referral for remedial teaching is more useful when it states the functional question for the educator. "Please assess the child's learning needs and advise teaching strategies" is weaker than describing the task, the observed barrier, the strengths to build on and the outcome the family and school want to see.

Psychiatric symptoms can alter availability for learning. Anxiety, mood symptoms, sleep disturbance, medication effects, family conflict or repeated peer adversity may reduce attendance, concentration, confidence or persistence. The educational plan should acknowledge these influences without turning each academic difficulty into a psychiatric symptom. When the concern suggests a childhood disorder or a specific learning or communication difficulty, the diagnostic teaching belongs in the relevant disorder chapters, including *the ADHD and specific learning/communication disorders notes*, *the Child behavioural, emotional and other disorders notes*, and *the Intellectual disability and autism spectrum disorder notes*.

22.4 Classroom adaptations and educational participation

Many adaptations are low technology and depend more on consistency than on specialist equipment. They may include making instructions concrete, presenting one step at a time,

demonstrating before expecting independent work, using visual supports, allowing a different mode of response, reducing unnecessary copying, arranging predictable transitions, offering a quiet route back into a task, or providing planned breaks. The rationale must be clear. Adaptations should reduce a barrier while preserving the learning purpose wherever possible.

The teacher's observations are clinical data when they are specific. "Does not listen" may mean that the child loses the instruction in a noisy group, cannot hold a long sequence in mind, does not understand the language used, is fearful of public correction, or has learned that disengagement prevents humiliation. A good psychiatrist does not adjudicate this from the consulting room. Instead, the report asks the school to observe the child under defined conditions and makes it safe for the teacher to report what is not working.

PITFALL

Do not write a certificate that lists a diagnosis and simply instructs the school to "give concessions". Such language is easily interpreted as either a demand for lowered standards or a document to be filed without action. Name the functional barrier and the proposed support, while leaving detailed curriculum planning to the education team.

Peer participation also matters. Educational success is diminished if the child receives individual help at the cost of stigma, isolation or loss of agency. A plan should anticipate how support will be offered respectfully, how the child will be included in ordinary routines, and how adults will respond to misunderstanding or ridicule. These are not cosmetic matters. Belonging affects willingness to attempt difficult work, accept help and return to school after failure.

22.5 Working with family, school and the child

Educational intervention is a collaborative treatment. The child should be heard about what feels difficult, helpful, embarrassing or unfair; this prevents adults from designing a technically sound plan that the child cannot tolerate. Parents bring knowledge of strengths, language, routines and prior attempts. Teachers bring knowledge of curricular demands and classroom reality. The special educator or remedial teacher brings expertise in teaching method. The psychiatrist contributes formulation, treatment of coexisting mental-health barriers, communication and advocacy.

Collaboration works best when communication is purposeful. With appropriate consent, a concise school note should state the relevant functional concerns, strengths, suggested adaptations and a request for feedback. It should not disclose more clinical detail than the educational purpose requires. Families need realistic discussion of what the school can implement and what must be reinforced at home. They also need protection from blame. Home practice can consolidate a skill, but it should not convert every evening into a second school day or a conflict around unfinished work.

Agree on one shared priority rather than giving each adult a separate agenda. Use a common language for the target behaviour or skill so that feedback is coherent. Review barriers to implementation before concluding that the child has "not responded".

Where disagreement arises, return to the child's educational participation and dignity. Families may fear stigma; schools may fear that requested changes are unmanageable; the child may refuse support that marks them as different. The psychiatrist can hold these concerns without promising an outcome that no single professional controls. Advocacy is strongest when it is concrete, respectful and grounded in what the child needs to learn and participate now.

22.6 Indian educational rights and the psychiatrist's advocacy role

IN INDIA

The Right of Children to Free and Compulsory Education Act provides the general statutory foundation: children aged **six to fourteen years** have a right to free and compulsory education in a **neighbourhood school**. The Rights of Persons with Disabilities Act adds a disability-specific right: a child with **benchmark disability**, aged **six to eighteen years**, has a right to free education in a neighbourhood or special school of choice.

For the psychiatrist, these provisions change the tone of the consultation. Education is not a discretionary favour to be requested when a child is easy to accommodate. It is a right within a statutory framework. The clinician should explain the practical relevance of this right, document educational needs clearly, and direct the family toward an informed discussion with the school and appropriate educational services. The doctor should not make unsupported promises about admission, resources or the exact form of provision, because these require local implementation and educational decision-making.

The disability statute also requires a periodic **survey of school-going children** to identify children with disabilities, determine their **special needs** and consider whether those needs are being met. This is to occur every **five years**. It matters clinically because identification should lead to a question about support, not merely to the production of a certificate.

Access	Choice	Need
EDUCATIONAL RIGHT	SETTING MATTERS	SUPPORT MUST FOLLOW

The educational prescription is complete only when it names the barrier, the support, the responsible partner and the route for review.

23 · Early intervention and stimulation programmes

Why it matters clinically. Early intervention improves participation and developmental opportunities before difficulties entrench. Stimulation programmes are its practical means: they help caregivers and professionals create meaningful opportunities for communication, movement, play, self-care and social engagement. The psychiatrist coordinates support.

The central question is whether the child can use emerging abilities in relationships, routines and settings that matter to the family. A programme begins with strengths, interests, health, sensory and motor needs, communication style, caregiving environment, opportunities to practise and

barriers to participation. This prevents generic advice when the obstacle is distress, family strain or an unmet physical need.

START	SHARED	REPEATED	REVIEW
WITH DAILY LIFE	FAMILY GOALS	MEANINGFUL PRACTICE	PARTICIPATION

23.1 Scope and therapeutic rationale

Early intervention is a coordinated developmental and family-centred response offered when a child has developmental vulnerability, delay, disability, or a context that threatens opportunities to learn. **Developmental stimulation** refers to intentionally enriching the child's ordinary experiences so that attention, interaction, exploration and practice are more likely to occur. These are related but not identical ideas. The former is a service approach that joins assessment, goal-setting, support and review; the latter is a set of everyday therapeutic opportunities within that approach.

Its rationale is developmental rather than diagnostic. Early experience shapes how a child learns to attend, anticipate, communicate and act on the environment. When an adult notices the child's signals, responds contingently, simplifies a task without stripping it of meaning, and repeats it within an enjoyable routine, the child has a clearer opportunity to connect action with consequence. The aim is not accelerated performance for its own sake. It is growing competence and agency in activities that the child and family actually need.

This distinction has practical consequences. A child may have a label yet need a plan centred on shared attention and communication; another may have no settled label but need help with play, mobility or caregiver interaction. Diagnostic clarification remains important, but intervention need not wait passively when current developmental needs are clear and support is safe.

RULE **Build intervention around participation in daily life, not around a list of isolated developmental tasks.** A skill becomes clinically useful only when the child can access it with real people, in ordinary routines and across relevant settings.

23.2 From concern to an individualised plan

A useful plan converts a broad concern into a shared working formulation. Begin by asking what is hard for the child and family at present, what is already going well, and what change would make the next period easier or more meaningful. Observe the child in interaction when possible. The child's initiative, affect, regulation, response to adult support and preferred activities often tell the clinician more about a workable starting point than a catalogue of deficits.

Functional goals are concrete descriptions of participation rather than abstract targets. They should be recognisable to the caregiver, relevant to the child's routine and capable of being observed without a specialised test. A goal about joining a mealtime exchange, tolerating a transition with support, seeking help during play, or participating in a self-care step is more useful than a vague instruction to improve development. The clinician should ask what the family will notice when the goal is becoming easier and what support will make that change possible.

- Identify a meaningful routine or activity in which participation is currently limited.

- Describe the child's present way of engaging, including strengths and successful conditions.
- Agree on an achievable next step and the adult response that will support it.
- Decide how the family and team will recognise progress, difficulty or an unintended burden.

The plan should specify who will do what, where opportunities will occur and how responsibilities will be coordinated. It also exposes a familiar service problem: a recommendation can sound clinically elegant while requiring time, transport, money, equipment or adult availability that the family does not have. The correct response is adaptation, not blame. A smaller intervention woven into real routines is often more therapeutic than a plan that survives only on paper.

GOOD TO REMEMBER

When a caregiver says, “We cannot do all this,” treat that statement as assessment data. It may reveal exhaustion, competing care demands, poverty, grief, misunderstanding, family conflict or a plan that has not yet become usable. Simplifying the plan may be the intervention that restores continuity.

23.3 The active ingredients of stimulation

Stimulation is not the accumulation of toys, worksheets or appointments. Its active ingredients are attunement, repetition, graded challenge, feedback, enjoyment and transfer into daily life. Adults first follow the child's interests and signals. They then create a small, manageable demand, wait for the child's response, and adjust assistance so that the child has a genuine role in success. This is **scaffolding**: support that makes participation possible without permanently doing the task for the child.

Play is particularly valuable because it permits repetition without making the child feel tested. Shared play can support turn-taking, symbolic communication, motor planning, frustration tolerance and relationship-building, but it should be guided by the child's developmental level and sensory profile. The detailed principles and techniques of play therapy belong in the play therapy section. In a stimulation programme, play is usually a vehicle for practice and connection rather than a separate psychotherapy.

Communication support is embedded in ordinary encounters. Adults can make language and gestures easier to understand, allow time for a response, offer meaningful choices, and respond to attempts to communicate rather than waiting for polished performance. Motor and self-care opportunities work best when the activity has an immediate purpose. Feeding, dressing and moving through the home can become therapeutic contexts when adapted thoughtfully.

THERAPEUTIC ELEMENT	CLINICAL QUESTION	PRACTICAL IMPLICATION
Child interest	What draws the child into interaction?	Use preferred people, objects and activities as the entry point.
Adult response	How does the caregiver recognise and answer the child's signal?	Model waiting, noticing and responding in a way the child can use.
Task demand	What makes participation fail or become distressing?	Reduce unnecessary complexity and increase challenge gradually.
Routine	Where can practice happen naturally?	Attach the activity to a familiar part of the family's day.
Generalisation	Can the child use the emerging skill with other people and places?	Plan transfer deliberately instead of assuming it will occur.

The mechanism is relational. A programme works through adults as well as through the child. Caregivers gain confidence when they can read the child's cues and see that their response changes the interaction. That confidence can reduce helplessness and make ordinary family routines more predictable. Conversely, instructions that imply the caregiver is solely responsible for developmental outcome can intensify guilt and undermine engagement. The clinician should explicitly distinguish responsibility for providing opportunities from responsibility for producing a particular developmental result.

23.4 Caregiver partnership and family work

Caregiver coaching is the process of helping a caregiver observe, try, reflect on and adapt an interaction with the child. It is not simply teaching the caregiver to reproduce professional techniques. The caregiver knows the child's habits, comforts, fears and available routines; the professional contributes developmental reasoning and an outside perspective. The partnership is strongest when these forms of knowledge are treated as complementary.

Use demonstration sparingly and then return the activity to the caregiver. Ask what felt easy, what the child seemed to enjoy, where the interaction broke down, and what change might make the next attempt more feasible. This reflective loop converts advice into learning. It also avoids an unhelpful service pattern in which the child appears to perform with a therapist but the family leaves without a method that can be used between visits.

Family intervention may be needed when parental mental health difficulties, conflict, stigma, bereavement, substance use, violence, unsafe housing or competing caregiving burdens limit the child's opportunities. These circumstances are not “non-compliance.” They are part of the formulation. The family therapy and family intervention section addresses therapeutic approaches to relational difficulties in greater detail. Here, the task is to ensure that the developmental plan does not ignore the conditions that make implementation possible or impossible.

IN INDIA

Early support often requires coordination across home, clinic, educational settings, rehabilitation providers and local child-development services. The psychiatrist should help the family navigate these interfaces without assuming that every locality has the same professional availability. A written, plain-language plan can reduce fragmentation when families move between public, private and voluntary-sector care.

23.5 Interdisciplinary and educational coordination

Early intervention is rarely delivered by psychiatry alone. Depending on the child's formulation, collaboration may be needed with paediatrics, rehabilitation professionals, speech and language support, psychology, nursing, social work and educators. The psychiatrist's role is to hold the clinical formulation together, address co-occurring emotional or behavioural barriers, clarify priorities with the family and prevent parallel services from becoming competing services.

Educational support should be considered early whenever learning or participation is affected. The special education and remedial intervention section addresses educational planning in detail. Within an early intervention plan, the essential question is whether the environment can be adjusted so that the child can participate, communicate needs and experience success. A recommendation for a setting is not enough. The team should communicate the child's helpful supports, likely triggers for disengagement and practical ways to preserve dignity.

Generalisation is the transfer of a developing ability from the place in which it was learned to other people, materials and settings. It is a clinical outcome, not an optional extra. A child who can perform only under highly structured professional prompting may still be unable to participate in family life or education. Plans therefore need planned overlap between home, therapy and school, with shared language and expectations where feasible.

MNEMONIC

START

Share goals with the family, **T**ailor activity to the child, **A**rrange practice in routines, **R**eview participation and burden, and **T**ransfer gains across settings. It is a compact way to remember that stimulation is a coordinated process rather than a collection of activities.

23.6 Monitoring change and revising the plan

Review should ask whether participation is changing, not simply whether the family has completed prescribed exercises. Look for the child's initiative, comfort, capacity to recover from frustration, use of support and ability to engage with familiar people. Ask caregivers what has become easier, what remains hard, what has changed unexpectedly and what the intervention costs them in effort or conflict. A plan that expands a child's skills while exhausting the caregiving system needs revision.

When progress is limited, return to the formulation. The task may exceed the child's current readiness; the goal may lack relevance; the setting may be too distracting or demanding; the adult

prompt may be poorly timed; health, sensory, sleep or emotional difficulties may be interfering; or the family may need a different kind of support. Escalating intensity without understanding the mismatch is rarely good clinical practice. A respectful review protects the family from feeling judged and protects the team from mistaking activity for effectiveness.

TRAP **Do not equate a busy intervention schedule with an effective programme.** Candidates often describe multiple therapies but omit the child-specific goal, caregiver role, setting and review process. In practice, the same omission produces fragmented care and makes it impossible to know what should be continued, changed or stopped.

PITFALL

Do not make a caregiver demonstration into a performance test. Correcting every imperfect response can silence the very adult whose consistency the programme depends on. Preserve curiosity, identify the next useful adjustment and acknowledge what the caregiver already does well.

23.7 Boundaries, referral and ethical stance

Early intervention does not replace diagnostic assessment, medical care, safeguarding, education planning or specialist treatment when these are needed. It brings their developmental implications into the child's everyday world. If a child has acute medical concerns, sensory difficulties, nutritional problems, exposure to violence, severe caregiver distress or a marked change in functioning, address the relevant pathway rather than persisting with stimulation alone. Safeguarding concerns require the protection response described in the child protection sections.

The psychiatrist should avoid deterministic language. Families may hear a developmental formulation as a verdict about the child's future or their parenting. Explain uncertainty honestly, describe the present purpose of intervention, and invite the family to identify what a good outcome would look like in their circumstances. Respect for culture and family priorities does not mean accepting harmful practices or excluding the child from opportunity. It means designing support with the family rather than imposing a professional script.

Early intervention succeeds when a child gains meaningful participation through repeated, enjoyable opportunities that caregivers can realistically sustain.

Epidemiology, services and national context

24 · Epidemiology of child psychiatric disorders in India

Why this matters clinically. Epidemiology in child psychiatry is not a decorative prevalence quotation. It determines how confidently a clinician can describe the size and distribution of need, whether a local service claim is defensible, and whether a research finding can be carried into an individual formulation. In India, the central skill is often not recalling a headline

percentage; it is recognising the population to which that percentage does, and does not, apply. This distinction is especially important when a family, school, administrator, or trainee asks for "the Indian figure" for child mental disorder.

For the present purpose, **epidemiology** means the disciplined description of mental health phenomena in a defined population. It asks who was sampled, how cases were identified, the period to which findings refer, and whether the denominator matches the question being asked. It does not establish the diagnosis of the child in front of the clinician, nor does it replace a developmental and multi-informant assessment. Those clinical tasks are addressed in the assessment sections of this chapter and the childhood disorders themselves are covered in *the Child behavioural, emotional and other disorders notes*.

24.1 What an Indian child-psychiatry prevalence statement must mean

A prevalence statement is only as useful as its case definition and sampling frame. "Mental morbidity" may represent a diagnostic interview threshold, a symptom screen, a clinician's judgement, a service contact, or an administrative record. These are related but non-interchangeable constructs. A symptom measure can be useful for detecting need or planning further assessment; it cannot silently be converted into the prevalence of a psychiatric disorder. Likewise, clinic attendance tells us about treated or help-seeking morbidity, not the frequency of disorder in children who are outside services.

Case definition is therefore a priority interpretive question. It should make clear whether the estimate refers to current mental morbidity, symptoms, impairment, a particular diagnostic grouping, or a mixture of these. In developmental psychiatry, impairment and context matter greatly: behaviour that prompts concern in a classroom may have a different meaning after considering developmental level, language, family stress, neurodevelopmental profile, and the informant's opportunity to observe the child. A defensible epidemiological estimate preserves the method used to decide who counted as a case.

The next question is the **denominator**. A denominator is not merely a total at the foot of a table. It identifies the population from which the estimate was derived. Household samples, school samples, clinic samples, and selected community groups answer different questions because the children available for recruitment, and the pathways by which concerns become visible, differ. A school-based study may be highly valuable for school planning while excluding children whose educational participation is interrupted. A clinic sample may accurately describe service demand while being shaped by access, referral practices, stigma, affordability, and local specialist availability.

- Ask whether the source sampled the population named in the question.
- Identify how a case was defined and whether impairment was part of that definition.
- Check the age group before applying a finding to "children".
- Separate a local estimate from an all-India estimate.

RULE **Never detach a prevalence figure from its population, age group, case definition, and sampling frame.** A number may be accurate within its study yet misleading when presented as a national child estimate. In an answer, state the scope before interpreting the figure; this shows epidemiological judgement rather than rote recall.

24.2 What the NMHS adolescent finding can support

The National Mental Health Survey, commonly called **NMHS**, is the key national survey reference that candidates are likely to encounter. Its adolescent module reported current mental morbidity of **7.3%** among adolescents aged **13-17 years**. The estimate used a structured diagnostic approach. The report does not specify which instrument the adolescent module used, so this note names none. It is reasonable to cite this as an adolescent-stratum finding when the wording remains equally precise about its limits.

Its limits are not footnotes. The adolescent component was a feasibility sub-sample confined to **four** of the survey states, rather than a nationally representative adolescent survey. The wider survey covered **12** states, but that does not make the adolescent module a national child survey. The exact adolescent-stratum denominator is not provided in the cited report, so a clinician should not manufacture precision around the estimate or imply that it describes every Indian region.

7.3%	13-17 years	four	not established
CURRENT ADOLESCENT MENTAL MORBIDITY	AGE STRATUM	STATES IN FEASIBILITY SAMPLE	ALL-INDIA CHILD FIGURE

IN INDIA

Use the NMHS result as a carefully bounded adolescent finding, not as a shortcut for "Indian child prevalence." This is particularly relevant in local planning discussions: a national survey label may create unwarranted confidence if the reader does not notice which participants contributed to the adolescent result.

External validity is the question of how far a study's finding can travel beyond those studied. Here, the result travels to the adolescent feasibility stratum defined by the survey methodology. It does not automatically travel to younger children, every state, all school settings, or every clinical service context. This is not a criticism of the survey. It is the ordinary discipline of applying evidence to the population actually represented.

24.3 The honest national gap for children

No established all-India psychiatric prevalence figure can be quoted for children under **13 years**. That gap is substantive, not a wording problem. The available NMHS adolescent stratum begins later, so it cannot be extended downwards by intuition, by averaging unlike studies, or by treating "child and adolescent" as a single epidemiological population. The correct answer is that the all-India child prevalence is **not established**, while an adolescent feasibility-subsample estimate is available with the limitations already described.

This phrasing protects against a common but consequential error: welding a national-looking range from studies with different ages, settings, instruments, informants, and thresholds. Such a range looks balanced because it appears to acknowledge variation, but it does not acquire national validity by spanning several local results. It can also conceal the distinction between symptom burden, probable disorder, diagnosed disorder, and service use. Where evidence is heterogeneous, a careful narrative description of the evidence base is stronger than an invented composite.

TRAP **Do not quote the adolescent NMHS percentage as the prevalence of child psychiatric disorders in India.** The age band and sampling design limit the claim. A polished-looking number without its denominator is a category error, not a concise answer.

PITFALL

Do not substitute a foreign data platform for Indian prevalence evidence merely because it is easy to search or presents polished charts. A source that is **US-only** cannot supply an India estimate. The practical response is to label the Indian evidence gap, not to import a figure.

24.4 Geographic inference and the Karnataka limitation

National language can obscure geographic limits. In the NMHS state list, **Karnataka** was not included. Therefore, the survey cannot be cited as a Karnataka child or adolescent prevalence source. This matters for clinicians and teachers working in the state because a national report is often assumed to settle a local question. It may offer useful context about survey methods and the broader Indian evidence base, but it does not replace a population estimate from the population of interest.

Local relevance should be reasoned rather than presumed. A finding is more likely to inform local planning when the population, setting, language context, social conditions, pathways to care, and service availability resemble the intended setting. Conversely, a difference in any of these can alter observed prevalence or, more commonly, the probability that distress is noticed and reaches care. The point is not that a study from elsewhere is useless. It is that transportability must be argued, and uncertainty stated, rather than hidden behind a national title.

QUESTION BEFORE QUOTING A FIGURE	WHAT MUST BE CHECKED	CONSEQUENCE IF THE ANSWER IS UNCLEAR
Who was sampled?	Household, school, clinic, or other defined population	Do not relabel the result as community prevalence.
What ages were included?	Whether the child group matches the clinical question	Do not generalise an adolescent estimate to younger children.
How was morbidity identified?	Diagnostic interview, symptom measure, or service record	Name the construct rather than calling all results "disorder".
Where was the study done?	Geographic coverage and whether the locality was sampled	Describe it as contextual evidence, not local proof.
What is the denominator?	Whether the relevant stratum is explicitly reported	Avoid false precision and unsupported comparisons.

Transportability is the clinical version of this judgement: whether evidence collected in one context is likely to be informative in another. It is especially useful when discussing service needs. Epidemiology can guide the scale and direction of planning, but it should not be used to predict a particular child's diagnosis, family trajectory, or treatment response. Individual care remains anchored in direct assessment and formulation.

24.5 Why estimates vary without being mutually contradictory

Variation between studies does not by itself prove that a study is wrong. In child mental health, observed differences may arise from the age composition of the sample, whether parents, teachers, and children contribute information, the threshold selected for a case, the privacy of interviews, local explanatory models, and the route by which participants are recruited. These factors affect ascertainment as well as the underlying distribution of difficulties. The reader's task is to distinguish a real epidemiological difference from a difference created by study design.

Ascertainment refers to the process by which possible cases are noticed, assessed, and counted. It is vulnerable to both under-recognition and over-interpretation. Children with internalising difficulties may not be noticed in the same way as children with disruptive behaviour; conversely, school or family concern may be shaped by expectations that are not themselves diagnostic. Such observations are clinically important, but they are not grounds for supplying a prevalence figure where no appropriately sampled figure exists.

Keep symptom detection separate from diagnostic classification; functional concern separate from the prevalence of a named disorder; service utilisation separate from population burden; and an evidence gap separate from an assertion that no affected children exist. These distinctions make the epidemiological description clinically usable without inflating what the evidence can establish.

For examination writing, this reasoning earns marks because it explains why figures cannot be compared casually. For service work, it prevents a more serious problem: allocating scarce attention solely to the forms of distress that are easiest to count. Epidemiology should widen clinical curiosity, not reduce a child to a survey category.

GOOD TO REMEMBER

When asked for a prevalence figure during a case discussion, state what the available estimate actually measures, then state the limit on applying it to the child population in question. This is more clinically useful than giving an unsupported number with apparent confidence.

24.6 Using epidemiology without misusing it

At bedside level, epidemiology supports anticipation and advocacy. It reminds the psychiatrist that childhood mental health need exists beyond specialist clinics, that detection pathways are selective, and that absence of a local population estimate is not evidence of absence of clinical need. It can help frame a request for school linkage, developmental supports, family intervention, or service strengthening. It should never become a diagnostic shortcut, a reason to dismiss symptoms that fall outside a survey category, or a substitute for listening to the child and caregivers.

At service level, use epidemiological language proportionately. Describe the need as recognised but incompletely quantified when the population evidence is incomplete. Specify whether a proposed programme is responding to clinic demand, observed school concerns, or population surveillance. These categories can inform each other, yet they are not interchangeable. School mental health programmes and life-skills education are addressed separately in this chapter; their justification should not depend on pretending that a single national prevalence statistic answers every planning question.

In India, cite the NMHS adolescent result only with its age and sampling limits; for younger children, state plainly that an all-India psychiatric prevalence figure is not established.

The mature answer is therefore neither nihilistic nor numerically performative. It is evidence-literate: it acknowledges the available adolescent signal, protects the boundary around it, identifies the missing child and local estimates, and explains why those boundaries matter for clinical interpretation. That stance is not evasive. It is the ethical use of epidemiology in child psychiatry.

25 · School mental health programmes and life-skills education

Why this matters clinically. A child's mental health is lived in ordinary settings, not only in the clinic. School is where learning demands, peer relationships, exclusion, bullying, family expectations and emerging autonomy become visible. **School mental health** therefore means more than placing counselling in a school. It is a way of making the school safer, more emotionally literate and more able to notice when a pupil needs support beyond the classroom. For the psychiatrist, it is a service question: what can be strengthened in the child's daily environment, what needs clinical assessment, and how can the two remain connected without turning teachers into diagnosticians?

The examination value of this area lies in making those distinctions clearly. A well-written answer moves from health promotion through life-skills teaching to referral pathways, then locates

Indian programmes without confusing one platform with another. It does not re-teach childhood disorders, behavioural treatment or the formal child assessment. Those require their own clinical formulations and are addressed in the Child behavioural, emotional and other disorders notes; the general assessment framework is addressed elsewhere in this chapter.

25.1 What a school mental health programme is for

A school mental health programme is a planned response to the social and emotional conditions in which pupils learn. Its aim is not to find a psychiatric label for every difficulty. Its practical task is to improve the everyday capacities that help children and adolescents negotiate demands, relationships, conflict, disappointment and help-seeking. It also gives adults in the school a language for responding thoughtfully rather than with humiliation, exclusion or an automatic demand for medical certification.

Good programmes work at the level of the school climate as well as the individual pupil. A child who is quiet, irritable, distracted or repeatedly absent may be signalling distress, but none of those observations is itself a diagnosis. The school can offer predictable routines, respectful communication, opportunities for participation and an adult who takes concerns seriously. Where difficulties are persistent, impairing, risky or beyond the school's competence, the school's role is to share observations with caregivers and facilitate an appropriate referral. Diagnostic assessment remains a clinical responsibility, undertaken with developmental, family and multi-informant context.

RULE **Teach competence and create a route to care; do not convert the classroom into a diagnostic clinic.** A school can reduce barriers to disclosure and support early help-seeking, but it should neither assign diagnoses nor manage serious risk in isolation.

The distinction protects both child and school. If every academic or behavioural difficulty is medicalised, ordinary adversity is treated as pathology and the pupil can acquire a stigmatising identity. If every difficulty is dismissed as indiscipline, a child with real distress may be shamed and left unsupported. The useful middle position is curiosity: describe what has changed, ask what context might explain it, listen to the child and caregiver, and decide whether ordinary school support, a planned conversation or clinical referral is needed.

Why the setting changes the intervention. Therapy often asks a child to practise a new response between sessions. School is one of the places where that practice either becomes possible or is repeatedly undone. A programme that normalises respectful peer interaction, problem solving and asking for help can make clinical gains easier to use in real life. Conversely, a punitive or mocking environment can defeat carefully planned treatment. Liaison is therefore not an optional add-on to child psychiatry; it is part of making an intervention usable in the child's world.

25.2 Life-skills education: the educational core

Life-skills education is skills-based teaching intended to build **psychosocial competence**. It is not a lecture on good behaviour and not a covert diagnostic screen. Its central premise is that

children benefit when they can recognise a situation, consider options, regulate an immediate response, communicate their needs and learn from the result. The emphasis is on rehearsal and reflection, so that an idea becomes a usable action rather than a slogan remembered after an assembly.

The WHO core set is most useful as an organising language for curriculum and teacher preparation. It connects thinking, relating and emotional self-management without implying that each domain is a separate subject or that the child must perform a particular personality. The accompanying table groups the skills for teaching purposes while retaining their practical meaning.

CORE CAPABILITY	WHAT IT LOOKS LIKE IN A SCHOOL ACTIVITY	CLINICAL RELEVANCE
Decision making and problem solving	Pausing to define a difficulty, generate options and consider likely consequences.	Supports a move from impulsive reaction to deliberate choice.
Creative thinking and critical thinking	Considering more than one explanation, questioning assumptions and imagining alternatives.	Helps pupils examine peer pressure, rumours and self-defeating conclusions.
Effective communication and interpersonal relationship skills	Listening, expressing a request, disagreeing without attack and repairing a misunderstanding.	Makes interpersonal stress discussable before it escalates.
Self-awareness and empathy	Noticing one's own feelings and perspective while attempting to understand another person's experience.	Supports reflection, peer inclusion and less hostile attribution.
Coping with emotions and coping with stress	Naming an emotional state, identifying a trigger, using a safe coping response and seeking support when needed.	Creates a common vocabulary for distress without presuming illness.

These skills are learned best through participation. A teacher may use a brief vignette, a role-play, a classroom dilemma, a guided discussion, a drawing task or a reflection on a familiar conflict. The educational sequence matters: introduce a concrete problem, allow pupils to generate responses, practise a response in a safe setting, receive feedback, and return to where that skill may be useful outside the activity. A child should not be compelled to disclose private experiences in front of peers in order to demonstrate learning.

GOOD TO REMEMBER

When a child is already in treatment, ask what skill is being practised and where it fails in the school day. A small, specific environmental adjustment - a predictable check-in, permission to step aside briefly, or a named adult for help-seeking - may make therapy more transferable without asking the school to provide therapy.

Life-skills teaching should remain developmentally intelligible. Abstract language about resilience or emotional intelligence is easily repeated without being understood. Activities should use situations pupils actually recognise, offer alternatives rather than moralising, and permit different ways of participating. The desired outcome is not silent compliance. It is a child who can think, communicate and seek help with increasing agency while respecting the safety and dignity of others.

25.3 From a session to a school culture

A programme fails when it treats a single teaching session as a completed intervention. The content needs a place in ordinary school life: teachers need to model respectful disagreement, classroom rules must not contradict the message of empathy, and pupils need safe opportunities to use the skills. Repetition is valuable when it is practice in varied situations, not when the same message is simply recited again. Follow-up discussion allows children to identify what was difficult, what helped and what support would make the next attempt more realistic.

- Choose situations that are familiar enough for pupils to engage, but do not require public disclosure of personal adversity.
- Use active methods that let pupils try language, choices and coping responses rather than only hear about them.
- Build in a private route for a pupil to seek help after a session, because a group activity may surface an individual concern.
- Review whether the school's disciplinary and peer practices reinforce or undermine the values being taught.

Teachers are central because they are the adults who can make a classroom emotionally predictable, but they must be supported rather than burdened with a vague instruction to "handle mental health". Training should clarify the limits of the teacher role, the route for consultation, how to speak with caregivers, and when a concern needs urgent escalation. It should also address the teacher's own anxiety: staff may avoid a distressed pupil because they fear saying the wrong thing. A calm, non-judgemental first conversation and a known referral route are safer than avoidance.

PITFALL

Do not mistake a school programme for a substitute for clinical care. A school may support attendance, inclusion and help-seeking, but it cannot safely absorb a complex presentation, sustained functional deterioration or a concern about immediate safety merely because a life-skills session exists.

Peer involvement can be constructive when it expands inclusion and reduces isolation, but peers should never be made responsible for surveillance, counselling or secrecy. A child may prefer a trusted friend to accompany them in seeking an adult, yet the adult remains responsible for deciding what support is needed. This protects friendship from becoming an unacknowledged clinical role and keeps the burden of safeguarding with the institution and appropriate services.

25.4 Boundaries, confidentiality and referral

School work frequently raises a tension between privacy and collaboration. The child should know, in language they can understand, who will be told about a concern and why. Information shared with a school should be limited to what is necessary for the agreed support plan. A psychiatrist need not disclose a diagnostic formulation or detailed family history for a teacher to understand the practical accommodations that may help. Equally, a teacher should not promise secrecy when information suggests that the child may be unsafe or needs protection.

Referral communication is strongest when it is descriptive. It records observable changes, relevant school context, duration in ordinary language and the supports already tried, rather than attaching a label. The clinician can then integrate that account with the child's history, caregiver perspective and direct assessment. This approach also reduces the common conflict in which a family feels blamed by the school while staff feel dismissed by the family. Both are usually reporting different parts of the same child's context.

TRAP **Do not equate a teacher's observation with a psychiatric diagnosis.** Teachers provide indispensable ecological information, but an observation gains clinical meaning only when it is integrated with developmental, family and direct assessment. The general assessment framework is addressed elsewhere in this chapter.

Where the concern indicates abuse, serious violence, self-harm, sexual harm, or immediate danger, the matter leaves the ordinary school support pathway. The clinician and institution must follow the relevant protection and emergency processes rather than wait for further classroom observation. The statutory duties and child-protection response are addressed in the chapter sections on POCSO, juvenile justice and management of child abuse; a school programme should have a clear pathway to those systems, not improvise one in a crisis.

25.5 India: DMHP school outreach

IN INDIA

Under the District Mental Health Programme, targeted outreach includes life-skills education and counselling in schools. The programme model specifies **100 teachers** as master trainers from each block, with a block described as having **25-30 schools**. This makes the teacher a capacity-building link, not a replacement for a mental-health professional.

The DMHP formulation is important because it places school work within public mental-health outreach rather than treating it as an isolated educational experiment. Its strength is reach: a trained teacher can carry a consistent set of activities and can identify when a pupil needs a conversation or referral. Its limitation is equally important: the quality of implementation depends on supervision, protected time, turnover of trained staff, links with the district team and the school's willingness to use a non-stigmatising approach.

For a psychiatrist working with a district or medical college service, the useful contribution is not to deliver every session personally. It is to help build a workable system: orient staff to what school support can and cannot do, advise on referral criteria, receive clinical referrals

appropriately, and use feedback from schools to improve the pathway. Consultation should focus on function and safety rather than asking teachers to master psychiatric terminology. A brief, respectful response to a referred child also builds trust in the pathway and makes future help-seeking more likely.

- Clarify who in the school receives a concern and who communicates with caregivers.
- Ensure that referral does not become a disciplinary disposal of a difficult pupil.
- Agree how urgent concerns will reach a responsible adult and appropriate service without delay.
- Feed back practical school recommendations while preserving the child's privacy.

25.6 RKSK and adolescent-facing care

Rashtriya Kishor Swasthya Karyakram was launched on **7 January 2014**. It is framed to reach **253 million adolescents aged 10-19 years, including those in and out of school, across gender, residence and marital status**. This breadth matters when school mental health is discussed: school delivery is valuable, but it cannot be the only route to adolescent support.

RKSK places mental health alongside sexual and reproductive health, nutrition, substance misuse, injuries and violence including gender-based violence, and non-communicable diseases. Its Adolescent Friendly Health Clinics provide a clinical and counselling interface for these concerns. The domains should be understood as connected in the young person's lived experience. A school discussion about coping, relationships or violence may open a question that needs an adolescent-friendly health service rather than a further classroom activity.

The psychiatrist's role is to understand the interface, not to collapse it. School-based promotion can improve recognition and reduce hesitation about seeking help. Adolescent-friendly services can offer an accessible point for counselling and health concerns. Specialist mental-health care is indicated when the presentation requires diagnostic assessment, risk management or treatment beyond that setting. Clear hand-offs protect the young person from being sent repeatedly between systems with no one accepting responsibility.

25.7 The School Health and Wellness Ambassador model

The Ayushman Bharat School Health and Wellness Programme uses a teacher-led health-promotion model. The designated **Health and Wellness Ambassadors** are two teachers per school, preferably one male and one female where possible. The programme describes a health-promotion session of one hour each week. These details are useful as an examination anchor, but the clinical interpretation remains more important: the model creates a named, trained point of contact within the school rather than leaving health promotion to individual enthusiasm.

10	**100**	**253 million**	**2**
WHO CORE LIFE SKILLS	DMHP TEACHER MASTER TRAINERS PER BLOCK	ADOLESCENTS TARGETED BY RKSK	TEACHERS DESIGNATED PER SCHOOL

Named ambassadors can make it easier for pupils and families to know whom to approach, and for a school to sustain health conversations over time. Yet designation alone does not guarantee

safety or quality. The programme needs administrative support, a private and respectful route for individual concerns, a clear escalation pathway, and collaboration with local health services. The teacher is best viewed as a facilitator of health promotion and access, not as a counsellor for every personal problem.

> School mental health succeeds when life-skills teaching, a supportive school climate and a clear route to clinical or protection services work as one system.

26 · Rashtriya Bal Swasthya Karyakram (RBSK) and the 4Ds

Why it matters clinically. A child psychiatrist sees only a fraction of the children whose development, behaviour, communication, hearing, vision, nutrition, chronic illness, or congenital health needs may affect mental health. The service question is therefore not merely whether a child meets criteria for a psychiatric disorder. It is whether the child has been noticed early, whether the family has understood the concern, and whether there is a workable route from a screening finding to assessment, intervention and review. **Rashtriya Bal Swasthya Karyakram (RBSK)** is an Indian child-health platform built around early identification and linkage to care.

For the examination candidate, RBSK is best understood as a service architecture rather than as a list of diagnoses. It supplies a common public-health language for a heterogeneous set of childhood health concerns and creates a route into district-level intervention. Its relevance to psychiatry is especially clear when developmental, sensory, medical and family factors coexist. A referral generated by the platform is a clinical starting point: it should lead to formulation and coordinated care, not to premature diagnostic labelling.

26.1 The 4Ds: a service language for early identification

The organising frame is the **4Ds**. It brings together defects at birth, deficiencies, diseases, and developmental delays including disabilities. This is deliberately broader than psychiatric nosology. A public programme must detect concerns that are visible to families, teachers, frontline workers and health staff before specialist diagnosis is possible. The framework also prevents the false separation of physical and developmental health: a concern that begins in one domain may change a child's learning, participation, sleep, communication, behaviour or family stress in another.

4Ds	birth to 18 years	up to 6 years	30
ORGANISING FRAMEWORK	SCREENING SCOPE	PRIMARY DEIC FOCUS	CONDITIONS, ORIGINAL SCHEME

Do not read the categories as separate clinical silos. They are a prompt to ask what has been found, what may be contributing to it, what the child can currently do, and what service can act next. For example, a child with poor classroom participation may need medical or sensory clarification, developmental assessment, educational support and family guidance in parallel. Psychiatry contributes a formulation of emotional and behavioural consequences, caregiver

burden, adherence barriers and comorbid symptoms. It does not convert a screening category into a diagnosis by itself.

RULE **The 4Ds are a route into care, not a psychiatric diagnostic system.** Use the framework to widen the clinical lens and to organise referral, then complete the assessment needed for the individual child.

MNEMONIC

Birth, Body, Biochemistry, Behaviour and development

Use this bedside prompt to remember that the programme categories include birth defects, diseases, deficiencies, and developmental delay including disability. The added behavioural wording is a clinical reminder, not an additional programme category: it asks the psychiatrist to consider the child's functioning and family response after the health concern has been identified.

The programme's screening and referral card, as issued under the original scheme, listed **30** core health conditions under this framework, and that remains the figure most examination answers expect. It is no longer the current list. The RBSK 2.0 operational guidelines set out a revised and longer table and publish no total at all, so the count is best taught as the classical figure with that caveat rather than as a settled number. The revision matters here for a second reason: the current table names behavioural and neurodevelopmental conditions explicitly, among them anxiety disorders, sleep disorders, attention-deficit hyperactivity disorder, autism spectrum disorder, specific learning disorders and global developmental delay. The practical lesson is not to memorise a card as though it were a diagnostic manual. Rather, recognise the card as a standardised handover. It records why the child was identified and helps the receiving service decide what must be clarified, what can be acted on locally, and where specialist input is needed. A useful referral note adds the child's functional difficulty, the informant's concern, prior care, family understanding and the immediate question for the next clinician.

26.2 From population contact to a clinically meaningful referral

The programme uses **Mobile Health Teams** for **community screening** in Anganwadis and Government schools. This matters because these are routine child-contact settings rather than specialist clinics. They can surface a concern in a family that has not sought mental-health care, or in a child whose difficulties have been normalised, attributed to temperament, or hidden by school absence. The initial service task is detection and communication, not a definitive mental-state examination.

In service terms, the pathway must preserve information as it moves. A vague referral such as “developmental problem” can leave the caregiver uncertain and the receiver unable to triage. A good handover states what was observed, the context in which it was observed, the functional consequence, any already-known health information, and what the referring worker has told the family. When a psychiatrist receives such a child, the referral concern should be checked against caregiver and child accounts before it is interpreted. This protects against both under-recognition and the equally damaging tendency to treat a screening label as settled fact.

STAGE IN THE PATHWAY	PRIMARY PURPOSE	PSYCHIATRIC CONTRIBUTION	COMMON ERROR TO AVOID
Child-contact setting	Notice a possible health or developmental concern	Recognise that distress or behaviour may signal unmet developmental, medical or family needs	Expecting a screening encounter to establish diagnosis
Referral communication	Transfer the reason for concern and the next step	Clarify what the family understands and what may impede attendance	Using a label without describing functional difficulty
Receiving service	Decide what assessment and intervention are needed	Place symptoms in developmental, family, educational and health context	Reducing the case to a narrow specialty
Care plan	Make responsibilities visible to the family and services	Integrate psychological, family and educational needs with other care	Giving advice without a named follow-up route
Review	Check whether the planned help was actually accessed and useful	Reassess function, burden and emerging mental-health needs	Equating referral completion with clinical benefit

The screening population extends from **birth to 18 years**. That breadth should shape a psychiatrist's service thinking. The referral question, the informant and the setting change across childhood and adolescence, even when the broad programme language remains the same. Avoid assuming that the same presentation, threshold for concern, or pathway will be appropriate across the entire age span. The programme gives a common entry point; clinical assessment remains developmentally anchored.

TRAP **Do not describe RBSK as a child psychiatry service.** It is a child-health screening and linkage platform whose categories may bring children with mental-health relevance to attention. The psychiatrist's role begins with collaborative clinical work after the concern has been identified.

26.3 DEIC as the district intervention and coordination hub

A **District Early Intervention Centre (DEIC)** is intended to provide **comprehensive management** under one roof. This phrase should be read functionally. It signals a hub that can receive children flagged through screening, direct them towards appropriate assessment or intervention, and maintain a referral link when the required service lies elsewhere. The value is coordination: the family should not be left to translate a screening observation into a sequence of disconnected consultations.

IN INDIA

For psychiatric practice, RBSK provides a public-system route for a child whose presenting concern crosses developmental, medical, sensory, educational and emotional boundaries. The useful clinical question is not whether the DEIC replaces specialist care. It is whether the centre can help assemble the next assessment, intervention and follow-up steps around a family who may otherwise move between services without a shared plan.

DEICs primarily serve children **up to 6 years of age**. This distinction is important. The broader RBSK screening platform reaches through adolescence, whereas the DEIC is particularly oriented to the early childhood window. In an answer, state the distinction plainly rather than collapsing all RBSK functions into the DEIC. In clinical work, it prompts an early check of whether a young child with a developmental or disability-related concern has an accessible intervention route, while older children may need linkage through the relevant services available locally.

Coordination is not a passive administrative act. It includes making the referral question intelligible, checking whether caregivers can reach the destination service, identifying whether several disciplines must be involved, and ensuring that a child is not lost because one part of the plan is delayed. Psychiatric input can be particularly useful when caregiver anxiety, stigma, conflict about the meaning of the child's difficulties, or behavioural distress threaten engagement. That work is supportive and collaborative. It should not pathologise an understandable family reaction to uncertainty.

GOOD TO REMEMBER

When a young child is referred after programme screening, ask the caregiver to show what the child can and cannot do in daily routines. This converts an administrative referral into a functional clinical question and makes it easier to coordinate advice across services without prematurely assigning a disorder label.

26.4 Why the early-intervention window is emphasised

The rationale for early action is developmental rather than merely administrative. The programme identifies **early intervention** from **birth to 6 years** as a particularly critical period for child development, especially when developmental delay is present. This does not imply that later intervention is futile. It means that delay in recognition can allow difficulties in communication, participation, learning, caregiver confidence and access to support to compound before a plan is in place.

The guideline also locates peak brain **plasticity** in the **birth-2 year period**. For the psychiatrist, this is a reason to act on a credible developmental concern without waiting for every diagnostic uncertainty to disappear. Action may consist of developmental assessment, parent guidance, a medical or sensory referral, educational planning, or help to stabilise an overwhelmed caregiving environment. The exact package must follow the child's formulation. Early intervention is a principle of timely, proportionate response, not a justification for indiscriminate treatment.

Clinical urgency is often obscured by diagnostic anxiety. Families may be told to “wait and see” because a child is young, while professionals fear overcalling a disorder. The better distinction is between caution about labels and inaction about needs. One can remain cautious about diagnosis while actively documenting function, supporting caregivers, arranging relevant evaluations and reviewing change. This is especially important when the child is not yet able to give a full account of internal experience and when the family's ability to navigate services is limited.

26.5 The psychiatrist's role within a non-psychiatric platform

RBSK does not ask the psychiatrist to duplicate general screening. It creates an opportunity for consultation where a child's health finding has psychological, behavioural, developmental or family consequences. The psychiatrist should frame the referral question before deciding the scope of assessment: Is the immediate need clarification of behaviour, support for caregiver coping, evaluation of emotional symptoms, coordination around developmental function, or advice to another service? This protects the child from a broad but unfocused work-up and protects the family from receiving contradictory explanations.

Several principles keep this consultation clinically sound:

- Begin with function in home, learning and peer contexts, rather than with a label carried on the referral card.
- Seek the child's perspective in a developmentally appropriate manner, alongside caregiver and other relevant accounts.
- Separate the emotional effect of a health or developmental concern from symptoms that require their own psychiatric formulation.
- Return a plan that names who will do what, what the family should watch for, and how uncertainty will be reviewed.

This is also where the limits of the platform should be stated honestly. A screening pathway can identify risk or need for further attention, but it cannot substitute for the comprehensive child psychiatric assessment described elsewhere in this chapter. Nor should it be used to re-teach the childhood disorders themselves. When a disorder-specific question becomes central, use the relevant disorder chapter for diagnostic and treatment detail, while retaining the service pathway as the means of linking the child and family to care.

The multidisciplinary implication is practical. Families often experience services as multiple doors, each with a different language and waiting process. The psychiatrist can reduce this burden by translating findings into everyday goals and by ensuring that psychiatric recommendations fit, rather than compete with, developmental, medical, educational and social interventions. A medication decision, if one is eventually indicated, belongs within the child psychopharmacology framework rather than being inferred from an RBSK category.

PITFALL

Do not let a referral label become the child's identity. A programme finding may explain why a child needs further attention, but it does not establish the cause of behaviour, define family capacity, or predict outcome. Record the observed concern and its functional impact before making psychiatric inferences.

26.6 Writing and answering about RBSK with precision

A strong service answer follows the child's journey. Introduce RBSK and the 4Ds, explain screening through Mobile Health Teams in child-contact settings, identify the DEIC as the district hub for coordinated management, and distinguish the wider screening scope from the

primary early-childhood DEIC focus. Then add the clinical implication: early identification only matters when referral, family understanding and follow-up turn it into usable care. This sequence demonstrates that the candidate understands both policy language and what it changes in practice.

Be equally precise about what the programme does not establish. It does not make a psychiatric diagnosis, replace a developmental formulation, or remove the need for disorder-specific assessment and treatment. It does, however, create a structured opportunity to identify children whose needs may otherwise remain invisible. In a service-based chapter, that is its central contribution: it converts an isolated concern into a route that can be followed, clarified and coordinated.

> RBSK uses the 4Ds to identify childhood health concerns and link them to care; the psychiatrist turns a referral into an individual, developmental and family-centred plan.

27 · Integrated Child Development Services and child mental health policy in India

Why this matters clinically. A young child rarely arrives at a psychiatric service because someone has already named a mental-health problem. The concern is more often expressed as difficult behaviour, poor participation in play or learning, feeding trouble, an unresponsive child, a worried caregiver, or a pattern of missed developmental opportunities. The **Anganwadi Services** platform, formerly described as ICDS, matters because it is a continuing child-development contact rather than a specialist clinic. It can make concern visible early, place it in the child's family and nutritional context, and create a route from concern to an appropriate health or developmental response.

For the psychiatrist, this is not a substitute for child psychiatric assessment, a diagnostic service, or a treatment programme. It is a service platform through which health, nutrition, early learning and caregiver contact can be connected. A good answer therefore does not claim that an anganwadi worker diagnoses a disorder. It explains how a developmental platform can notice difficulty, support the caregiver, reduce practical barriers to care, and help a family reach the service that must take responsibility for assessment or treatment.

27.1 The anganwadi platform as a mental-health opportunity

Child mental health in a public system begins before the consulting room. Emotional regulation, communication, play, attention, attachment and behaviour are lived out in ordinary routines. A platform that sees the child in relation to food, play, caregivers and early learning can therefore detect a mismatch between what the child appears able to do and what daily participation demands. This is a developmental opportunity, not a licence to convert every variation into illness.

The useful policy question is practical: what should happen when an adult who knows the child notices that participation has become difficult or that a caregiver is struggling? The answer is a sequence of listening, documenting the concern in plain language, considering whether health or

developmental factors may be relevant, discussing it respectfully with the caregiver, and linking the family to the appropriate service. The specialist's role is to make that pathway clinically intelligible and humane. A referral letter that only says “behaviour problem” abandons the very context that makes the referral useful.

RULE **Use the anganwadi as a bridge into care, not as a diagnostic endpoint.** Its value lies in sustained contact with the child and caregiver, followed by an accountable link to the service that can assess and respond.

There is also a preventive logic. When caregivers receive understandable support around routine, play, communication and help-seeking, they may be better able to act before strain hardens into conflict, exclusion or repeated non-attendance. This is not a claim that one worker or one service can prevent all psychiatric morbidity. It is an argument for locating mental-health work within the child's actual environment, rather than waiting for distress to become severe enough to cross a specialist threshold.

IN INDIA

The anganwadi is especially important as a shared local point of contact. A psychiatrist should ask whether the child attends, what the caregiver has been told there, and whether the family would accept a coordinated conversation. This preserves continuity between clinic advice and daily life without asking a non-specialist platform to carry a specialist clinical burden.

27.2 The integrated package of services

The programme is built around an **integrated package**, rather than a single intervention. It contains **six** services. For clinical reasoning, the list matters less as an enumeration than as a reminder that behaviour and development should not be detached from nutrition, health access, caregiver knowledge or opportunities for early learning.

SERVICE IN THE PACKAGE	WHY IT MATTERS TO A CHILD-MENTAL-HEALTH FORMULATION
Supplementary nutrition	It keeps nutrition within the clinical context when a child presents with low energy, irritability, feeding difficulty or reduced participation.
Pre-school non-formal education	It provides a natural setting in which play, participation, communication and separation from the caregiver may be discussed.
Nutrition and health education	It creates a caregiver-facing channel for simple, non-stigmatising discussion of routines and help-seeking.
Immunization	It illustrates that some elements of the package depend on connection with the health system rather than stand alone at the centre.
Health check-up	It encourages the clinician to keep physical and developmental contributors in view when a behavioural concern is raised.
Referral services	It is the operational route by which a concern can move beyond observation to a service with the needed competence.

The integration is clinically useful because the same presentation can have multiple meanings. A child who is quiet in a group may be temperamentally reserved, physically unwell, fearful, communication-impaired, poorly nourished, overwhelmed by demands, or distressed by adversity. The platform should not decide among these possibilities by label. It should preserve observations, ask what has changed, involve the caregiver and create a route for further evaluation when the concern persists, impairs participation, or raises safety concerns.

- Describe what is observed before attaching a diagnostic explanation.
- Ask about the child's everyday routine, participation and the caregiver's understanding of the difficulty.
- Record what action was agreed, who will make contact, and what information needs to travel with the referral.

PLATFORM	BRIDGE	TASK
CHILD-DEVELOPMENT CONTACT	CAREGIVER TO SERVICE	NOTICE, LINK, FOLLOW THROUGH

27.3 Age focus and the clinical frame

The core child focus is **0-6 years**. This makes the platform particularly relevant to the early period in which a clinician often has to work from observation, caregiver report and the child's functioning in familiar settings. It also explains why the language of policy should remain child-development language: routine, play, communication, feeding, sleep, interaction and participation can be discussed without prematurely converting the child into a diagnosis.

A psychiatrist should resist two opposite errors. The first is to romanticise early childhood and dismiss meaningful impairment as a phase. The second is to make a categorical psychiatric diagnosis from a brief community observation. The platform is most valuable when it supports **developmentally informed observation**: what the child does across situations, what caregivers notice, what appears to help, what worsens the difficulty, and whether the child can participate in expected daily life.

Caregiver engagement is central here. Advice that ignores food insecurity, caregiving burden, transport difficulty, family conflict, stigma or a caregiver's own distress is unlikely to be carried into the home. The service contact can instead become a place where the caregiver is treated as an informant and partner. That stance is clinically safer than presenting professional opinion as a verdict on parenting.

TRAP **Do not mistake a programme contact for a completed mental-health assessment.** A familiar setting can yield valuable observations, but formulation, diagnosis and treatment decisions require the child psychiatric assessment framework.

27.4 Working with the Anganwadi Worker

The **Anganwadi Worker** is a named provider for supplementary nutrition for children aged **3 to 6 years**. That narrow, verified statement is enough to make an important clinical point: the worker's relationship to the child and caregiver is embedded in ordinary service use. The psychiatrist should build on that relationship without turning the worker into an informal mental-health technician.

Useful collaboration is specific. With caregiver agreement, the clinical team can ask for concrete observations about attendance, participation, interaction with peers and adults, response to routines, and changes from the child's usual pattern. It can then return equally concrete advice: what the family has agreed to try, what signs should prompt renewed contact, and whether the worker's support is limited to encouragement, observation or helping the family navigate a referral. Vague requests to “monitor behaviour” invite judgement and inconsistent reporting.

GOOD TO REMEMBER

When writing to a community contact, state the function rather than the diagnosis: “please note participation in play and response to routine” is more useful and less stigmatising than asking the worker to verify a psychiatric label.

Confidentiality and dignity still apply. Community collaboration is not a reason to circulate a child's clinical history. Share only the information necessary for the agreed task, speak with the caregiver rather than around them, and avoid language that brands the child as difficult, abnormal or dangerous. If there is a safeguarding concern, the clinical response and legal duties belong to the child-protection pathway discussed elsewhere in this chapter, not to informal management at the centre.

27.5 Referral, follow-through and policy translation

The point of referral is continuity. A referral becomes useful only when it carries enough context for the receiving service to understand why the concern arose and when the family can realistically complete the next step. A **functional referral** identifies the observed concern, relevant changes, caregiver concerns, actions already attempted and the reason a further opinion is needed. It does not require the community worker to make a diagnostic claim.

For the psychiatrist, policy translation means turning a broad platform into a usable local pathway. That pathway should identify who speaks to the caregiver, where the child should go next, how feedback returns to the family, and who notices if contact is lost. The details will vary by locality and service availability. What should not vary is ownership: a child should not be passed from one doorway to another because each service assumes that referral alone completes care.

- Make the next contact understandable to the caregiver, including its purpose and practical requirements.
- Use plain descriptions of concerns so that the family can repeat them accurately to the receiving service.
- Seek **closed-loop communication** where feasible: confirmation that contact occurred, clarification of the next responsibility, and renewed outreach when the plan has failed.

MNEMONIC

LINK

Listen to the caregiver, **I**ntegrate the child's daily context, **N**avigate to the appropriate service, and **K**eep responsibility visible until the next link is made.

Existing school mental-health work and the RBSK screening platform may be named as neighbouring parts of the wider child-service environment, but their structures and methods are distinct. Similarly, specialist treatment, early intervention and educational support require their own assessment and service pathways. The exam-worthy point is coordination: a platform is useful when it makes the right next contact more likely, not when it claims to contain every needed intervention.

PITFALL

Do not use the word “referral” as if it ends clinical responsibility. A slip of paper, an instruction to “go to hospital”, or an uncontextualised label can leave a caregiver unable to act. The clinically meaningful unit is a referral that the family understands and a pathway that can recognise non-completion.

27.6 How to write the service answer

A strong service answer begins with the platform's purpose, states the service package, and then explains its mental-health relevance through early recognition, caregiver engagement, contextual observation and referral. It distinguishes the function of a community child-development service

from the function of a specialist mental-health team. It also avoids the false choice between medical and social explanations: both may matter to a child's participation, and the service platform is designed precisely to keep these domains in conversation.

In practice, the psychiatrist's contribution is often to improve the quality of the handover. The medical record should translate complex formulation into a small number of observable goals, while preserving diagnostic nuance within the clinical team. The community contact should receive only what is needed to support the caregiver and the agreed plan. Where a child needs specialist assessment, the relevant assessment, treatment and protection chapters should guide that work; the anganwadi platform remains the local bridge, not the place where those specialised functions are reproduced.

> Anganwadi Services are an integrated child-development platform whose mental-health value lies in contextual observation, caregiver partnership and a reliable bridge to appropriate care.

Child protection, abuse and juvenile justice

28 · Types of child abuse (physical, sexual, emotional, neglect)

Why classification matters clinically. A child-protection formulation begins by naming the kind of harm that is being considered. Vague labels such as “a difficult home” or “poor parenting” can conceal the central question: has a child been harmed, or placed at risk of harm, within a relationship in which an adult or another person holds responsibility, trust, or power? **Child maltreatment** gives the clinician a vocabulary for making that distinction. It is not a diagnosis, an accusation, or a prediction of how a family will be judged. It is a protection concept that keeps the child’s health, survival, development and dignity in view.

The WHO framing applies to children **under 18 years of age**. It places apparently different experiences within a shared clinical frame: harm may be enacted on the body, imposed through sexual violation, communicated through degrading or frightening relationships, or created by a failure to provide necessary care. The categories are useful because they direct attention to the pathway of harm. They are not mutually exclusive boxes. The strip below names the four pathways that carry distinct clinical indicators; commercial and other exploitation is the fifth element of the same definition and is set out in the comparison table rather than the strip. The operational descriptions in this section are explanatory synthesis for teaching, not definitions established by the cited row, and the fragment records that as a declared gap. A child may live with several forms at once, and the most damaging feature may be the cumulative pattern rather than the event that initially brought the family to attention.

PHYSICAL	SEXUAL	EMOTIONAL	NEGLECT
HARM THROUGH ILL-TREATMENT	VIOLATION AND SEXUAL EXPLOITATION	HARM WITHIN RELATIONSHIPS	HARM THROUGH UNMET CARE AND NEGLIGENCE

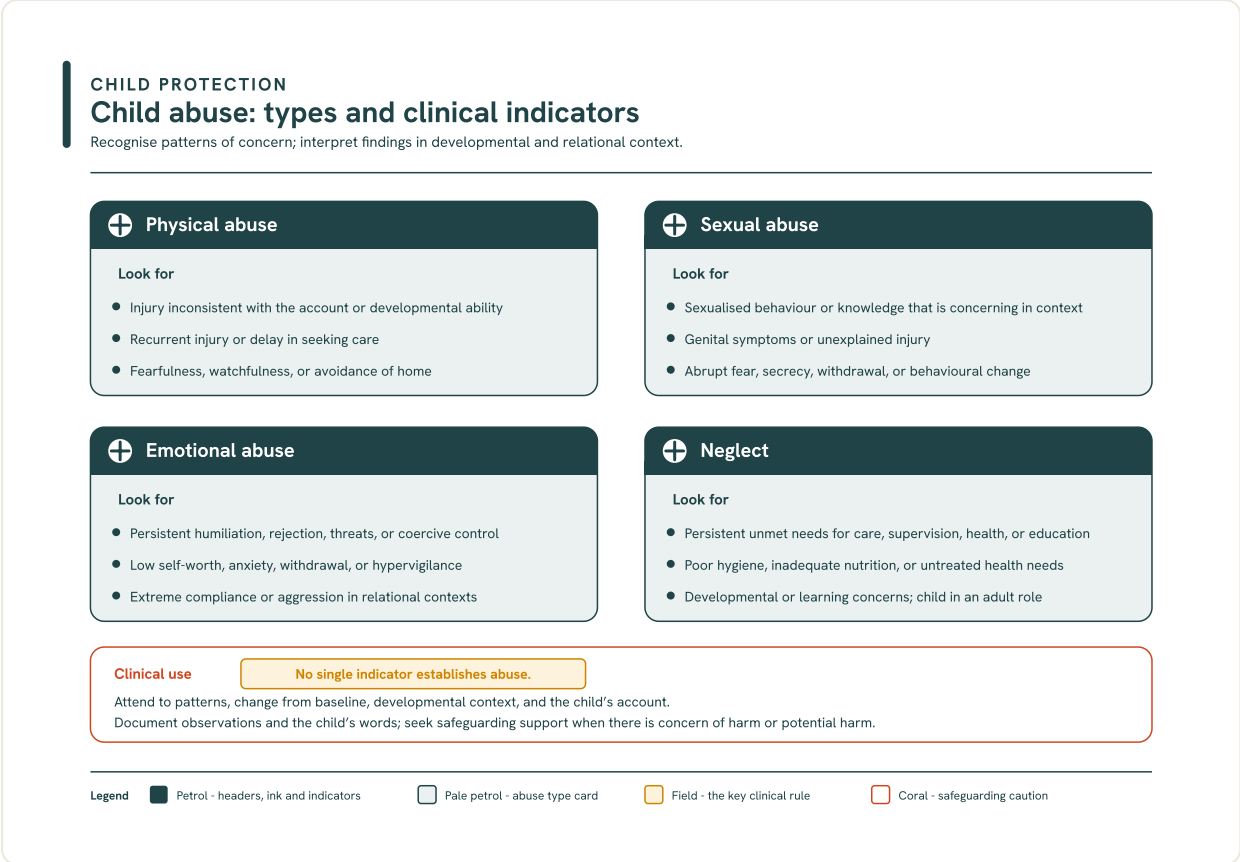


Fig 24.8. The types of child maltreatment set against the clinical indicators that should raise concern. An indicator is a reason to look further and to act on safety, never a finding of fact on its own.

28.1 The organising idea: maltreatment is relational harm

The key to the definition is not simply that a child is distressed or injured. Children can be distressed by illness, bereavement, poverty, conflict, developmental difference and many other adversities. Maltreatment concerns harm that occurs in a **relationship of responsibility, trust or power**. This directs attention to the asymmetry between the child and the person or system on which the child depends. The question is therefore not whether an adult intended to be cruel, but whether the relationship has exposed the child to harm or failed to protect the child from it.

That relational emphasis prevents errors in opposite directions. Narrowing abuse to an obviously violent act can overlook chronic humiliation, coercive sexual conduct, abandonment of care, or exploitation. Treating every imperfect interaction as maltreatment is equally unhelpful. Clinical thinking must hold context without making context an excuse. A parent may be exhausted, frightened, unwell or materially constrained; these circumstances can help explain a pathway, but they do not erase the child's experience of danger, deprivation or degradation. The task of classification is to describe what has happened to the child before attempting to explain why it has happened.

RULE **Classify the pathway of harm before you interpret the family's intention.** Physical, sexual, emotional, neglectful and exploitative experiences may coexist, and each describes a different route by which a child's welfare can be compromised.

For teaching and documentation, it is helpful to distinguish the *act or omission* from its *effect*. The same act may be experienced differently according to the child's developmental understanding, dependence, prior experiences and the surrounding relationship. Conversely, the same emotional outcome may arise from different types of maltreatment. This is why classification is a starting point for formulation, not a substitute for it. It gives a shared language to the multidisciplinary team while preserving the need to understand the individual child.

- Describe the child's experience before assigning a family explanation.
- Identify whether the route of harm is an act, an omission, exploitation, or a combination.
- Ask how responsibility, trust or power has shaped the child's freedom and safety.

28.2 Physical abuse: harm enacted on the body

Physical ill-treatment refers to harmful physical acts directed towards a child. Its clinical meaning is broader than visible injury. The body may be used as the site of punishment, intimidation, control or retaliation; a child can learn that safety depends on anticipating an adult's mood rather than on receiving reliable care. The defining concern is the harmful use of physical force or physical treatment within the unequal relationship, not the explanatory story offered after it.

Physical abuse is often imagined as a discrete incident because incidents are easy to narrate. Yet its psychological significance can also lie in the atmosphere it creates: vigilance, fear of making mistakes, concealment, divided loyalties and an altered sense of what care should feel like. The child may protect the caregiver, minimise the event, or describe it as deserved. Such language should not be read as proof that the experience was benign. Children commonly organise their accounts around preserving attachment and avoiding consequences, especially when the person who hurts them is also a source of food, shelter, affection or authority.

Classification also requires restraint. The psychiatrist does not decide the truth of a family narrative merely from a label such as "discipline," "accident," or "misbehaviour." Those words are interpretations. The clinical category asks a prior question: was physical treatment used in a way that harmed the child or placed the child at risk? This keeps the focus on the child without prematurely converting a clinical discussion into a forensic conclusion. Detailed recognition of indicators and the safeguarding response belong in the dedicated sections on clinical indicators and management.

> **GOOD TO REMEMBER**
>
> When a child describes physical punishment, listen for the relational meaning as well as the event. Fear, secrecy, conditional affection and the child's belief that pain is deserved may be clinically important even when the child does not use the word "abuse."

28.3 Sexual abuse: violation of bodily and relational boundaries

Sexual abuse concerns sexual violation of a child and includes sexual conduct that exploits the child's developmental dependence, lack of freedom, or inability to give meaningful agreement. Its defining clinical feature is not restricted to overt force. Secrecy, grooming, inducement, threats,

emotional manipulation and misuse of authority can all shape the child's experience of entrapment. The category is therefore about an adult or more powerful person using the child for sexual purposes, not about whether the child appeared compliant, curious, affectionate, or unable to resist.

This distinction matters because children may not recognise a sexual experience as abusive while it is occurring. They may have been told it is normal, private, loving, deserved, or dangerous to disclose. They may also be frightened of loss, blame or disruption within the family. A clinician should avoid importing adult assumptions about consent, resistance or disclosure into the child's account. Compliance can reflect dependency, fear, confusion, conditioning or an attempt to preserve a crucial relationship. It does not convert exploitation into a voluntary relationship.

Sexual abuse also needs to be kept conceptually separate from its psychiatric sequelae. A child may present with fear, shame, behavioural change, dissociation, somatic distress, sexualised behaviour, mood symptoms or no obvious psychiatric symptom. These presentations are not themselves the definition of sexual abuse, and the absence of a particular presentation does not settle the question. The safeguarding-specific assessment, including how to take an account without contaminating it, is taught in the section on child sexual abuse assessment and psychiatric sequelae. Legal duties and procedures belong in the dedicated statutory section.

TRAP **Do not equate absence of force or apparent cooperation with absence of sexual abuse.** The clinical concept centres on exploitation within unequal power, not on an adult model of freely negotiated sexual choice.

28.4 Emotional abuse: injury communicated through the relationship

Emotional ill-treatment is harm conveyed through how a child is repeatedly regarded, spoken to, controlled, rejected or frightened. It is sometimes called psychological abuse, but the central point is simpler: the child receives an enduring message that safety, worth, belonging or reality itself cannot be relied on. Unlike a physical act, the injury may not be visible to others. Unlike an isolated harsh remark, the concern is the harmful relational pattern and its impact on the developing child.

Emotional abuse can operate through contempt, humiliation, terrorising, scapegoating, isolation, hostility, coercive control, exposing the child to a persistently threatening interpersonal climate, or making affection contingent on compliance. These descriptions should be used as conceptual pathways rather than as a checklist to be mechanically scored. Their common mechanism is an attack on the child's secure sense of self and relationship. A child may adapt by becoming excessively compliant, volatile, withdrawn, perfectionistic, parentified or chronically alert to others' emotional states. Such adaptations can be mistaken for temperament, defiance or maturity unless their relational context is examined.

It is tempting to treat emotional abuse as less serious because there is no obvious physical injury. That is a category error. Emotional maltreatment can be the principal form of harm in a family, but it also commonly accompanies physical abuse, sexual abuse and neglect. It may be embedded in everyday language, threats, denigration or unpredictable caregiving, making it difficult for

children and professionals to name. The psychiatrist's contribution is often to translate a child's diffuse symptoms and relational expectations into a coherent account of how the environment has become psychologically unsafe.

Care is needed not to medicalise ordinary conflict, cultural difference, an impatient exchange, or the caregiver's understandable distress. The clinical question is whether a pattern of interaction is degrading, frightening, rejecting, controlling or otherwise harmful to the child. That question remains child-centred while allowing a compassionate understanding of family stress. The aim is neither to moralise nor to excuse, but to identify the relationship that the child is having to survive.

PITFALL

Do not dismiss emotionally harmful parenting as merely "a family style" because it lacks a visible injury. Conversely, do not label every family disagreement as emotional abuse. The formulation turns on the child's sustained experience of harm within a dependent relationship.

28.5 Neglect: harm through omission of care and protection

Neglect is the failure to provide or secure care, protection or responsiveness that a child requires. It is often misunderstood as the passive counterpart of abuse. In fact, omission can be an active source of harm: the child is left without reliable attention to basic needs, safety, health, emotional availability, supervision or access to necessary support. Neglect is therefore not defined by a caregiver's emotional distance alone, nor by material hardship alone, but by the child's unmet needs in a relationship where care should be organised.

This category demands especially careful reasoning. Some families face severe constraints and may genuinely lack resources, services, housing security or support. A child can be harmed by deprivation even where no caregiver wishes harm. The clinician should recognise that structural adversity and neglect may coexist without collapsing them into the same moral judgement. What matters for the classification is the lived pattern of unmet need, the available caregiving capacity and whether those responsible for the child are failing to protect or seek help in ways that expose the child to avoidable harm.

Neglect may be physical, emotional, educational, medical or supervisory in its expression, but these are ways of thinking about the area of unmet need rather than separate diagnoses. Emotional neglect deserves particular attention in psychiatric practice. A child may be fed, clothed and attending school while receiving little comfort, attunement, protection or response to distress. Such a child can appear outwardly cared for and yet experience relationships as unavailable or unreliable. Conversely, a caregiver's temporary inability to meet every need during crisis should be understood in context rather than assumed to establish a chronic pattern.

Because neglect often unfolds gradually, it can disappear into the background of a family story. The child may not complain because there is no remembered alternative. Professionals can also become habituated to low expectations for a child who is described as "independent" or "used to managing." A developmentally inappropriate burden of self-care is not evidence of resilience by

itself. It may be an adaptation to the absence of dependable adult care. The precise indicators and intervention pathway should be sought in the subsequent protection sections rather than inferred from this classification alone.

- Ask what the child needs in order to be safe, cared for and emotionally held.
- Ask which of those needs are persistently unmet and how the child compensates.
- Keep structural deprivation in the formulation without allowing it to obscure a child's unmet need for protection.

28.6 Overlap, cumulative burden and exploitation

The categories should be distinguished in order to be recognised, then brought back together in formulation. A child who is physically harmed may also be threatened and humiliated. Sexual abuse may be sustained by emotional manipulation and by the neglect of adults who fail to notice or protect. Neglect may coexist with a climate of rejection that makes it emotionally abusive as well. Recording only the most dramatic type can flatten the child's experience and can lead the team to miss the mechanism that keeps the harm in place.

TYPE	CENTRAL PATHWAY OF HARM	QUESTION THAT SHARPENS FORMULATION	COMMON INTERPRETIVE ERROR
Physical ill-treatment	Harm enacted through physical treatment	How is force, pain or bodily control being used in the relationship?	Reducing the account to an isolated injury
Sexual abuse	Sexual violation or exploitation of dependency	How are power, secrecy, inducement or coercion shaping the child's freedom?	Reading compliance as consent
Emotional ill-treatment	Harm conveyed through the relational environment	What repeated message about safety, worth or belonging does the child receive?	Ignoring harm because it is not visible
Neglect and negligence	Harm through unmet care, protection or responsiveness	Which needs remain unmet, and how does the child manage without dependable care?	Confusing material adversity with the whole formulation
Commercial or other exploitation	Harm through use of the child for another's gain	Who benefits from this child's labour, body, image or dependency?	Treating exploitation as a social problem outside the clinical formulation

The WHO framework also includes **commercial or other exploitation**. This reminder matters because a child can be harmed when another person gains from the child's vulnerability, labour, body, image, access, status or dependency. Exploitation may overlap with physical, sexual, emotional and neglectful maltreatment, but it directs attention to the use of the child for

another's benefit. The clinician need not force every experience into a single label. A better formulation states the principal pathways and explains how they interact.

MNEMONIC

Body, boundaries, belonging, basics, benefit

Use this as a brief bedside prompt: physical ill-treatment concerns the body; sexual abuse violates boundaries; emotional ill-treatment attacks belonging and safety; neglect and negligence leave the basics of care and protection unmet; exploitation turns the child into another person's benefit. It is a memory aid, not a substitute for a child-centred formulation.

28.7 Language, formulation and the limits of classification

Precise language protects the child and the clinical record. "Abuse" is a useful umbrella term in teaching, but a formulation should say what is meant: physical ill-treatment, sexual abuse, emotional ill-treatment, neglect, negligence or exploitation. The WHO description explicitly includes **negligence** alongside abuse and neglect. Naming the pathway avoids euphemism, but it should not turn a child's complex account into a label that speaks over them. Whenever possible, retain the child's own words alongside the clinician's conceptual description.

Classification has limits. It does not determine credibility, identify an alleged perpetrator, establish legal liability, replace a developmental assessment, or dictate the immediate safeguarding response. It also does not tell the clinician the child's psychiatric diagnosis. The WHO scope remains the child **under 18 years of age**, but the category alone does not explain that individual child's developmental needs or psychiatric presentation. The disorders that may be relevant to a child's presentation are addressed in the Child behavioural, emotional and other disorders notes and the Intellectual disability and autism spectrum disorder notes. Normal developmental context belongs in the Normal child development and milestones notes. Here, the aim is narrower and foundational: recognise the form of maltreatment without losing the person inside the category.

IN INDIA

In Indian practice, family, school, neighbourhood and extended-kin settings can all shape how a child describes harm and whom the child believes can be told. Use plain, non-accusatory language when eliciting the child's account, while keeping the clinical formulation explicit. Cultural sensitivity should improve understanding of context; it must not make coercion, degradation, sexual violation or unmet care invisible.

A useful final distinction is between classification and response. The present section helps the clinician identify the type of maltreatment. Recognition of clinical indicators is covered separately; child sexual abuse assessment and psychiatric sequelae have their own section; statutory obligations are addressed in the dedicated statutory section; and the safeguarding response is covered in the management and intervention section. This division is deliberate. In practice these tasks are connected, but clear conceptual boundaries prevent a rushed label from becoming a substitute for careful assessment, protection and treatment.

Child maltreatment is best understood as harm or threatened harm within a relationship of responsibility, trust or power: name the pathway - physical, sexual, emotional, neglectful or exploitative - then formulate the child's whole experience.

29 · Clinical features and indicators of child abuse

Why it matters clinically. Abuse is often first encountered as an ordinary clinical presentation rather than as a declared safeguarding concern. The child may be brought for pain, a change in behaviour, a poorly explained injury, or a difficulty noticed by another adult. The psychiatrist's contribution is not to convert a sign into an accusation. It is to recognise when the presentation cannot safely be treated as routine, to distinguish observation from interpretation, and to preserve the child's account and the clinical evidence with care.

Clinical indicators are signals for concern, not diagnostic labels. Their value lies in the relationship between the observed finding, the account offered for it, the child's developmental capacities, and the wider clinical context. An unexplained or patterned injury, a disclosure, or a behavioural change can each be clinically important. The central question is not whether a clinician can prove abuse in the consulting room. It is whether the available information makes a benign account inadequate and requires the presentation to be held as a possible protection concern.

29.1 The purpose and limits of clinical indicators

An indicator is a feature that should alter clinical attention. It may arise from the body, the history, the child's words, behaviour, or the relation between these sources. It does not identify a perpetrator, establish intent, or settle a legal question. This distinction protects both the child and the quality of clinical reasoning. A clinician who dismisses concern because one feature is non-specific may miss the pattern. A clinician who treats one feature as conclusive may contaminate an assessment, harden an uncertain narrative into a fact, and cause avoidable distress.

The useful mental move is from isolated sign to coherence. Ask what has been observed; what account is being given; whether the account can plausibly explain the observation; and whether the child can meaningfully corroborate, contradict, or qualify it. This is a reasoning task, not an exercise in detecting a particular kind of family. Abuse can be concealed within an apparently coherent story, while an anxious or inconsistent caregiver may still be describing an accidental event. The clinical standard is disciplined curiosity: neither premature reassurance nor premature certainty.

RULE **Read the finding and the explanation together.** A mark on the body is clinically meaningful in relation to its pattern, the account of how it arose, the child's capacities, and the rest of the presentation.

Indicators should also be understood as prompts to slow down. In ordinary practice, time pressure encourages rapid closure: a plausible explanation is accepted, the injury is coded, and

attention shifts to symptom relief. Protection work requires the opposite habit when concern is raised. The practitioner separates what was seen from what was reported, records uncertainty honestly, and avoids allowing the emotional force of a case to replace careful description. This is especially important in psychiatry, where behaviour may be quickly attributed to temperament, stress, or a psychiatric disorder even when the change requires a broader safeguarding lens.

OBSERVE	COMPARE	CONTEXTUALISE
WHAT IS PRESENT	ACCOUNT WITH FINDING	DEVELOPMENT AND PRESENTATION

29.2 Pattern as clinical evidence

Patterned bruising is a particularly important physical indicator because the morphology of the mark can retain information about the force or object involved. Clinical recognition guidance treats bruising in the shape of a **hand or ligature**, **stick, teeth mark, grip or implement** as a reason to suspect maltreatment. The teaching point is not that every such mark determines the history. It is that a recognisable pattern should make an unexamined explanation feel insufficiently safe.

Describe before interpreting. The record should preserve the clinician's own observations in plain language, including what made the mark appear patterned, rather than replacing description with a conclusion. A conclusion can later be tested against examination, photographs where lawfully obtained, medical opinion, and the evolving history. A vague note such as “bruise present” loses the very feature that generated concern. Equally, a categorical note that labels an injury as abuse overstates what the observation alone can establish.

Pattern matters because accidental histories commonly describe an event, whereas a patterned mark invites attention to the means by which force may have been applied. That is a clinical inference to examine, not a shortcut to judgment. The account should be heard without coaching or adversarial questioning. The psychiatrist may need to acknowledge that a caregiver's narrative is emotionally compelling while still recognising that it does not answer the physical question raised by the finding.

GOOD TO REMEMBER

When an injury is concerning, the most useful note separates observation, reported history, and clinical interpretation. This preserves both the uncertainty and the reason concern was raised.

A pattern can be missed when the consultation is framed around an apparently unrelated symptom. A child may be distressed, withdrawn, irritable, or reluctant to be examined. The task is not to search the body indiscriminately, but to allow physical findings that are already apparent or clinically relevant to alter the assessment frame. The psychiatrist should remain alert to the possibility that emotional and physical data belong to the same presentation without assuming that they do.

29.3 The unsuitable explanation test

A clinician should be concerned by **bruising or petechiae** that are not explained by a medical condition when the history offered is unsuitable. This is a combined test. The physical finding must be considered alongside medical possibilities and the account of its occurrence. It is not sound practice to infer maltreatment merely because a bruise has no immediately obvious cause. Nor is it safe to accept a history merely because it is confidently delivered.

An **unsuitable explanation** is one that is **implausible, inadequate or inconsistent**. In practice, the explanation is examined against the presentation, the child's ordinary activities, any relevant medical condition, and developmental stage. An account may be unsuitable because it does not describe a mechanism capable of producing the observed finding, because essential elements change, or because it asks the child to have done something outside their capacities. The point is not to demand a perfect story from frightened adults. It is to notice when the story does not carry the clinical weight placed upon it.

CLINICAL QUESTION	WHAT IS BEING EXAMINED	WHY IT MATTERS
What is observed?	The finding itself, described without conclusion.	It keeps the record anchored to evidence.
What account is offered?	The reported sequence and mechanism.	It identifies what is being tested, rather than what the clinician assumes.
Could the account fit?	Its plausibility in the clinical and developmental context.	It reveals whether reassurance is justified.
What else could explain it?	Medical and contextual alternatives.	It prevents both missed illness and over-attribution.

This formulation is deliberately more rigorous than asking whether the adult “seems believable.” Demeanour is a poor substitute for evidence. Fear, shame, anger, exhaustion, language difference, and prior difficult experiences with institutions can all affect how a history is given. Conversely, a calm account can be rehearsed. The clinical work is therefore to compare content with content: the observed presentation, the mechanism described, and the child's developmental context.

TRAP **Do not equate inconsistency with proof.** An inconsistent account increases concern when it cannot explain the presentation; it does not by itself establish why the inconsistency occurred.

Medical uncertainty should not be used as a refuge from safeguarding thought. If a medical condition is possible, it deserves proper consideration. If the account remains unsuitable after that consideration, the presence of an alternative question does not erase the protection question. These lines of reasoning can proceed together. Psychiatry contributes by resisting simplistic psychological explanations for either the child or the caregiver, and by keeping the formulation open enough for new information to matter.

29.4 Hidden injury and delay in seeking care

Concern is heightened when a child has an **intra-abdominal or intrathoracic injury** in the absence of major confirmed accidental trauma and there is no explanation, an unsuitable explanation, or **delay in presentation**. This is a useful corrective to the visual bias of clinical practice: a serious injury may not declare itself through an external mark. The **absence of external bruising** does not remove concern in this setting.

Delay is not a moral verdict on a caregiver. Families may encounter fear, uncertainty, limited resources, competing demands, or difficulty recognising severity. Its clinical importance comes from the way it interacts with the injury and the history. A delay can be understandable, or it can sit uneasily beside a presentation that requires explanation. The psychiatrist should avoid transforming this indicator into an accusation about care-seeking. Instead, it should prompt careful clarification of what was noticed, when concern arose, what changed, and how the family understood the child's condition.

The same discipline applies to the absence of an explanation. “No explanation” may mean that nobody asked in a way the child could understand, that the available adult does not know, that communication is difficult, or that an account has not yet emerged. It is an important clinical state, but not a completed conclusion. A quiet, non-leading approach protects the integrity of what the child says and avoids making the consultation into an interrogation.

> **PITFALL**
>
> Do not let an unremarkable skin examination create false reassurance when the clinical presentation raises concern about internal injury. Visible and invisible evidence do not have the same relationship in every case.

29.5 Behaviour, preoccupation, and the meaning of a disclosure

Behavioural indicators demand particular restraint because behaviour is meaningful but rarely self-interpreting. A behavioural change may signal distress, but it is not an abuse determination. The psychiatrist should ask whether the change fits the child's broader presentation and whether it is accompanied by other concerning information. Its value is often as a reason to listen more carefully, rather than as a label placed on the child or family.

A **disclosure** is itself a high-risk clinical signal. It should not be dismissed because it is difficult to hear, incomplete, or not immediately corroborated in the consultation. The clinician must distinguish the child's communication from the clinician's interpretation of it. Detailed evaluation of a possible sexual-abuse disclosure belongs to the child sexual abuse assessment and psychiatric sequelae section; the present task is recognition without premature conclusion.

In a **pre-pubertal child**, **repeated or coercive sexualised behaviours or preoccupation** should raise suspicion of maltreatment, particularly sexual abuse. The term requires careful use. It does not refer to a clinician's discomfort with a child, a family, or a topic. It describes behaviour or preoccupation whose repetition or coercive quality makes it a protection indicator in the relevant

developmental context. The child should not be shamed, labelled, or treated as responsible for the concern raised by their behaviour.

There is a vital distinction between recognising an indicator and conducting a sexual-abuse assessment. The latter is a specialised safeguarding evaluation and is addressed in the child sexual abuse assessment and psychiatric sequelae section. The general child psychiatric assessment framework is set out in the assessment section of this chapter. Here, the responsibility is narrower and earlier: notice the signal, take it seriously, avoid contaminating the account, and do not reduce it to a disorder label.

MNEMONIC

See, hear, separate, preserve

See the finding, **hear** the account, **separate** observation from inference, and **preserve** the child's words and the clinical uncertainty.

29.6 Integrating indicators without overreach

Integration means asking whether different pieces of information support, contradict, or leave unanswered the working account. Physical findings, behaviour, the child's communication, the reported mechanism, and the timing of presentation should not be pooled into a dramatic narrative merely because each is concerning. They should remain distinguishable. A strong formulation names what is known, what is reported, what is inferred, and what remains uncertain. This form of precision is clinically protective: it permits later reviewers to see the reasoning rather than inherit an unsupported conclusion.

The psychiatrist should also be alert to diagnostic overshadowing. A pre-existing developmental, behavioural, emotional, or physical difficulty can become an all-purpose explanation for new concerns. It should instead be treated as context. It may affect communication, examination, emotional expression, and the way adults understand the child; it does not make the child less deserving of a safeguarding formulation. For normal temperament, developmental norms and milestones, see the Normal child development and milestones notes. For childhood disorders themselves, see the Child behavioural, emotional and other disorders notes.

Conversely, safeguarding concern must not become a substitute diagnosis for every presentation involving adversity. The child may need a psychiatric formulation for distress and impairment while the facts around possible abuse remain incomplete. Holding both truths prevents a false choice between “mental health problem” and “protection problem.” It also prevents the clinician from allowing a familiar diagnosis to close inquiry into a newly concerning sign.

REASONING ERROR	WHY IT FAILS	BETTER CLINICAL POSITION
One sign is decisive	Indicators are not equivalent to proof.	State the concern and the evidence that supports it.
One benign possibility ends inquiry	Possibility is not explanation.	Test whether it accounts for the actual presentation.
Behaviour explains the injury	Psychiatric formulation can obscure physical evidence.	Keep physical and psychological observations in view.
Inconsistency explains motive	Clinical observation cannot infer intent from discrepancy alone.	Record the discrepancy and retain uncertainty.

Language matters. “Alleges,” “claims,” and “admits” can insert judgement into the record. Neutral attribution is usually better: “the child said,” “the caregiver reported,” “the clinician observed.” Such wording does not weaken the seriousness of a concern. It makes clear whose information is being recorded and protects against an assessment becoming more certain on paper than it was in the room.

29.7 Indian clinical use of recognition guidance

IN INDIA

The indicator set used here is clinical recognition guidance drawn from **NICE** guidance. It should not be presented as an Indian statutory or national standard. The clinical signs remain useful because recognising concern precedes the locally governed protection response; the legal and service pathway is addressed in the protection sections of this chapter.

For the Indian postgraduate reader, the practical implication is modest but important. Use the indicators to improve recognition and documentation, not to borrow a foreign legal framework. A psychiatrist may encounter the child in a general hospital, outpatient setting, school-linked service, or mental-health service. The setting changes access to collateral information and the immediate clinical environment, but it does not change the need for careful observation, respectful listening, and disciplined language. What happens after recognition belongs to the management and statutory sections, not to the indicator list itself.

Cultural humility is part of clinical accuracy. Family practices, language, privacy, and power differences affect what can be asked and what will be said. They must not become reasons to lower the threshold for attentive listening, nor reasons to pathologise unfamiliar family life. The clinician should maintain the same evidentiary discipline across families: attend to the observed presentation, evaluate the suitability of the account, and acknowledge uncertainty where it remains.

29.8 A defensible clinical formulation

A concise protection-oriented formulation can be written without claiming more than the evidence permits. It identifies the presenting concern, the material indicator, the account offered, the degree to which that account fits the presentation, and the child's current emotional or behavioural state. It then states the level of concern in neutral language. This helps the next

clinician understand why the case could not be treated as routine, while avoiding a forensic conclusion beyond the encounter's scope.

It is equally important to make absence visible. If the child has not provided an account, say so without implying that this reassures. If an explanation is unavailable, say that it is unavailable rather than inventing a reason. If a medical possibility is under consideration, distinguish it from a confirmed explanation. Precision at these points prevents a later reader from mistaking silence for denial, delay for proof, or uncertainty for lack of concern.

- Record what was observed without converting it into a conclusion.
- Record whose account is being reported and where the account does not fit the presentation.

> Clinical indicators of abuse require recognition, not premature conclusion: preserve the finding, test the explanation, hear the child, and keep uncertainty explicit.

30 · Child sexual abuse assessment and psychiatric sequelae

Why this matters clinically. An assessment after suspected or disclosed child sexual abuse is not an exercise in extracting a complete account. It is a psychiatric encounter conducted in the presence of possible trauma, compromised safety, family conflict, and a legal process that may later scrutinise the record. The clinician's first task is to create enough psychological safety for the child to be heard without turning the consultation into an investigation. The second is to identify the child's current needs and formulate a plan that protects both care and the quality of the child's account.

Marks in this area are earned by showing that one understands the distinction between a clinical assessment and a forensic investigation. The psychiatrist contributes careful listening, mental-state assessment, developmental understanding, risk formulation and treatment planning. The psychiatrist does not need to prove the allegation, determine credibility by demeanour, or repeatedly seek detail in the hope that certainty will emerge. For the general child psychiatric framework, including the developmental history and multi-informant approach, see the child psychiatric assessment section.

Listen	Assess	Formulate	Document
THE CHILD'S WORDS	CURRENT SAFETY	PSYCHIATRIC NEED	OBSERVATIONS CLEARLY

30.1 The purpose and stance of the assessment

The useful opening question is not, “Did this happen?” but, “What does this child need from me now?” That question keeps the assessment clinically anchored. A disclosure may be direct, partial, withdrawn, communicated through behaviour, or reported by another person. None of these forms authorises the clinician to infer an event from a single sign. Equally, an apparently calm child, an inconsistent sequence, or an absence of dramatic affect does not settle the matter in the opposite direction. Children communicate under developmental, relational and emotional constraints; the task is to understand those constraints rather than treat them as a test of truthfulness.

A **trauma-informed stance** means that the interview is paced around the child's capacity to participate. It gives the child a sense of control over pauses, clarification and the limits of what can be discussed. It uses language the child can understand, accepts uncertainty, and avoids disapproval, shock or leading reassurance. The clinician should be steady rather than neutral in the cold sense: the child should experience belief that their distress matters, without being supplied a narrative that is not their own.

The assessment has several linked purposes:

- to establish immediate safety and the need for medical or protective action;
- to understand the child's account sufficiently for clinical care while preserving spontaneity; and
- to assess consequences, risks and supports for the child and caregiving system.

RULE **Ask enough to care safely, not enough to conduct the investigation yourself.** Open prompts and reflective listening can clarify the child's immediate needs. Repeated, detail-seeking questioning can overwhelm the child, blur the source of information and make later accounts harder to interpret.

This boundary is clinically protective, not evasive. The psychiatrist may need a concise account of what the child says occurred, when there may have been contact, whether the alleged source of harm remains accessible, and what the child fears will happen next. Those questions serve safety and treatment. A fuller evidentiary account belongs in the appropriate safeguarding and legal pathway. The statutory duties and child-friendly procedures are addressed in the section on the POCSO Act, and the clinical safeguarding response is addressed in the management of child abuse cases section.

30.2 Preparing the setting and beginning the conversation

The setting communicates before the clinician speaks. Privacy, an unhurried pace and a predictable structure reduce the sense that the child is being examined for a performance. Before meeting the child, obtain the referral account, identify those present, and consider whether an accompanying adult may be a source of fear, pressure or information contamination. The child's preference about who remains nearby matters, but it does not replace clinical judgment about safety.

Begin by explaining one's role in plain language: the clinician is there to help with feelings, safety and health; some information may need to be shared to keep the child safe; and the child may say when they do not know, do not remember, need a break, or do not want to answer a question. This is assent-sensitive communication. It is not a legal consent tutorial. It is an everyday clinical method for restoring agency after an experience in which agency may have been compromised.

Rapport should not be mistaken for prolonged informal conversation designed to “win” disclosure. Ordinary topics, play, drawing or an activity may help a younger child regulate and communicate, but they are not diagnostic tests and should not be interpreted symbolically as proof of abuse. The psychiatrist notices how the child uses the activity: whether it permits

engagement, reduces arousal, supports language, or reveals an immediate concern. The methods of play assessment are covered in the play assessment and interviewing children section.

When the child begins to describe an experience, invitation is preferable to suggestion. “Tell me what you mean,” “What happened next?” and “Tell me more about that” preserve the child's language. Questions that offer the answer, supply body terms the child has not used, or repeatedly contrast alternatives can create pressure to agree. Clarification is legitimate when it affects immediate safety, but the clinician should be able to state why each question was necessary.

TRAP **Do not confuse a coherent adult-style chronology with a reliable child account.** Trauma, fear, developmental language and loyalty conflicts can all affect how an account is told. Conversely, apparent detail is not a substitute for careful assessment. The psychiatrist records what was said and the context in which it was said, rather than grading the child as believable or unbelievable.

30.3 Eliciting the account without contaminating it

The core interviewing skill is **narrative invitation**. Let the child start with their concern and follow their language. If the child makes a statement that signals possible sexual abuse, acknowledge it calmly and use open invitations before narrowing where a clinical decision requires it. The distinction is crucial: “Can you tell me more?” invites recall; “Did he do this?” imports a proposition. It is a disciplined interview in which the child's account, rather than the clinician's hypothesis, does the work.

Observe the conditions of disclosure. Note whether the child speaks freely, whether an adult answers for them, whether the child checks another person's reaction, and whether there are interruptions or visible distress. These observations provide context; they are not credibility verdicts. A child may disclose and later minimise, deny, become silent or ask that the matter be kept secret. Such shifts should be recorded with care and explored for their emotional meaning, particularly fear of consequences, attachment to the alleged person, shame or concern about family disruption. They should not be labelled manipulation.

It is useful to separate information into three streams in the notes:

- the child's own words, preferably marked as a direct statement where possible;
- the collateral history and the identity of the person giving it; and
- the clinician's observations, formulation and actions.

This separation prevents an inference from acquiring the appearance of a quotation. It also protects the team from a common drift in complex cases, in which repeated handovers transform a concern into a purported fact. If the child uses unfamiliar words, unusual labels or a gesture, describe them faithfully and avoid translating them into a more definite sexual act unless the child has made that meaning clear. If a physical examination or specialised forensic interview is indicated, the psychiatric record should state the clinical reason for referral rather than attempt to replace that assessment.

PITFALL

Writing “history of abuse” when the information is an unverified report erases the source and certainty of the statement. A defensible record distinguishes disclosure, allegation, collateral report, observed affect and clinical opinion. That precision protects the child as well as the clinician.

30.4 Psychiatric examination and formulation

A **psychiatric formulation** is more useful than a checklist of symptoms because it asks how the child's present difficulties relate to the alleged experience, developmental stage, relationships, prior vulnerabilities and current environment. It should cover affect regulation, sleep, appetite, concentration, fears, avoidance, intrusive experiences, dissociation, anger, behaviour at home and school, peer relationships, bodily concerns, sexualised behaviour, substance use where relevant, and thoughts of death or self-injury. The assessment should also identify strengths: a protective adult, capacity to seek help, meaningful routines, school connection, interests, or a prior ability to recover after stress.

The mental-state examination is adapted to developmental communication. Observe play, movement, speech, attention, facial expression, engagement, thought content and the child's ability to make sense of their feelings. Avoid translating a developmentally typical limitation into psychopathology. A young child may express trauma through clinginess, irritability, regression, nightmares or changed play rather than verbal fear. An older child may present with anger, self-blame, risk-taking, emotional numbing or withdrawal. These are possibilities to examine, not signatures that establish abuse.

Formulation should keep causal language proportionate. The child may have symptoms associated with the experience, symptoms worsened by the response of adults, difficulties that predated the concern, and difficulties produced by the ongoing crisis. The clinician should resist the false choice between “all due to abuse” and “unrelated to abuse.” A formulation can hold several pathways at once and describe what needs treatment now without overclaiming causation.

CLINICAL DOMAIN	QUESTION FOR THE PSYCHIATRIST	REASONING VALUE
Safety	Is there continuing access, intimidation, coercion or fear of return?	Determines urgency and the need to coordinate protection.
Trauma response	What has changed in arousal, sleep, memory, avoidance or sense of safety?	Connects current distress to a treatable pattern without assuming a diagnosis.
Development	How does language, understanding and dependence shape what the child can describe?	Prevents adult expectations being imposed on the account.
Relationships	Who comforts, pressures, disbelieves or protects the child?	Shows whether the environment is buffering or perpetuating distress.
Risk	Are there self-directed, other-directed or escape-related risks?	Links assessment directly to a safety plan.

Why formulation matters. The diagnostic label is only one possible output. In the early phase, an accurate account of distress, risk, functioning and supports may be more clinically useful than premature categorisation. The treatment plan can then address regulation, sleep, family response, school support and specialist referral while diagnostic understanding develops over time.

30.5 Psychiatric sequelae and clinical discrimination

Child sexual abuse can be associated with both immediate and enduring **psychiatric sequelae**. The clinical task is to look actively for harm without assuming that every child will show the same pattern or that the absence of one expected pattern is reassuring. The consequences may sit across health, emotional regulation, behaviour, relationships and development, and may become clearer only as the child's circumstances change.

The health consequences associated with child sexual abuse include **STI**, **traumatic injury** and **unwanted pregnancy**. Their possibility is a reason for integrated medical assessment, not a reason for psychiatrists to make physical findings the sole arbiter of concern. A psychiatric consultation should ask what bodily symptoms mean to the child, whether there is pain, fear, shame or confusion, and whether medical care has been arranged through the appropriate pathway.

Psychiatric and behavioural associations include **substance misuse**, **major depressive disorder**, **PTSD**, **complex PTSD**, **anxiety disorders** and **antisocial behaviours**. These associations should guide enquiry, not become a diagnostic shortcut. The disorders themselves are dealt with in the Child behavioural, emotional and other disorders notes.

There are several discriminations worth making. First, symptoms may be trauma-related without fitting a settled syndrome at the first interview. Second, a psychiatric disorder may be present alongside a normal-range response to extraordinary stress. Third, a symptom may have predated the alleged abuse and still have been exacerbated by it. Fourth, treatment should not wait for a perfect causal model when risk, distress or impairment is evident. The formulation should

therefore describe temporal relationships, maintaining factors and current priorities in plain clinical language.

GOOD TO REMEMBER

Ask about the child's own explanation of change. “What has been hardest since this began?” often reveals sleep disruption, fear of places or people, guilt, worries about pregnancy or infection, and family tensions that a symptom checklist can miss. It also tells the clinician what the child most wants help with.

30.6 Family work, collateral information and confidentiality

The caregiver interview has two functions: it gathers context and it assesses the caregiving environment. Ask what changed, who first noticed it, what the child has said, how adults responded, and whether anyone has coached, threatened, blamed or isolated the child. The clinician must remain alert to the possibility that an apparently supportive adult is also distressed, disbelieving or unable to keep the child safe. Conversely, a caregiver's anger or confusion may reflect fear and helplessness rather than hostility to the child. Assessment should clarify this rather than moralise it.

Confidentiality needs to be explained as a relationship practice, not as a bureaucratic warning. The child should know that private feelings are respected but that information relevant to safety cannot simply be kept between child and clinician. Where information must be shared, tell the child what will be shared, with whom, and why, as far as safety permits. This preserves trust better than making a promise that later has to be broken.

Collateral information from school, relatives or other services should be used purposefully. It may establish changes in functioning, identify a safe adult, or clarify practical risk. It should not become a broad search for character evidence. A child who is struggling academically, behaving aggressively or avoiding school needs support for those problems whether or not the collateral source agrees about the allegation. That distinction keeps the psychiatric role therapeutic.

IN INDIA

Indian practice often requires the psychiatrist to work at the intersection of family dependence, school pressures, medical services and protection systems. Keep the clinical note readable across those settings: record the source of information, the child’s own words, observed distress, immediate risks and the action taken. For the statutory reporting framework and child-friendly legal procedure, see the POCSO Act section; for protection, reporting, referral and treatment coordination, see the management of child abuse cases section.

30.7 Documentation and communication with other systems

Forensic-quality documentation does not mean writing like a lawyer. It means producing a contemporaneous clinical record that another responsible professional can understand without guessing which parts are observation, report or opinion. Use the child's language for key disclosures, record questions that materially shaped the response, identify who was present, and describe affect and behaviour without embellishment. Write “became quiet and looked away”

rather than “appeared guilty”; write “said she was afraid to go home” rather than “home is unsafe,” unless the latter is your clearly stated formulation based on recorded facts.

Document negative findings with the same restraint. “No suicidal thoughts disclosed in this interview” is different from “no suicide risk.” A child may be unable, unwilling or unsafe to disclose. The risk formulation should show what was asked, what was observed, what remains uncertain and how the uncertainty is being managed. Avoid copying language from another professional's record unless its source is attributed. Repetition can make an error look corroborated.

Communication should be need-to-know and clinically purposeful. The psychiatric team may need to coordinate with medical, protection, legal and school systems, but should not casually circulate sensitive details. When handing over, separate the immediate concern, the child’s current mental state, the risks, the supports already in place and the requested action. The precise legal mechanism is outside this section; the psychiatrist's contribution is a clear clinical account and timely coordination.

MNEMONIC

LISTEN

Let the child lead; **I**dentify immediate risk; **S**eparate report from observation; **T**rack trauma and functioning; **E**xplain confidentiality; **N**ote words and actions clearly. It is a memory aid for the clinical posture, not a substitute for safeguarding procedures.

30.8 A practical psychiatric plan after assessment

The assessment should conclude with a plan that answers the child's practical question: “What happens now?” State the immediate safety concern, the mental-health priorities, the support needed from carers, the referrals or coordination required, and the follow-up arrangement. A plan that merely records “counselling advised” fails to show what problem is being addressed or who is responsible for the next step.

Psychological treatment should be matched to the child's presentation, developmental communication and capacity for stability. Early work may focus on safety, emotional regulation, sleep, routine and helping caregivers respond without blame. More focused trauma work requires safety and a shared formulation. When a child presents with a disorder requiring treatment, its disorder-specific management belongs in the Child behavioural, emotional and other disorders notes; this section does not convert abuse assessment into a disorder chapter.

Follow-up revisits both symptoms and context. A child may initially minimise distress, become more symptomatic after disclosure, or deteriorate when contact, family conflict or legal proceedings change. The clinician should invite the child to say what has become easier or harder and re-check risks without making every visit a repeated interview about the alleged event. Continuity itself can be therapeutic when it demonstrates that adults can hear difficult material, act predictably and remain available.

In suspected or disclosed child sexual abuse, the psychiatrist listens carefully, assesses safety and psychiatric need, documents source and uncertainty, and does not turn clinical care into a repeated forensic interview.

31 · POCSO Act 2012 (provisions, mandatory reporting, child-friendly procedures)

Why it matters clinically. A disclosure, a worrying account from a parent, or information suggesting that a child may be at risk can place the psychiatrist at the boundary between therapeutic work and a statutory process. The central examination point is not whether the clinician can prove an offence. It is whether the statutory threshold for **mandatory reporting** has been crossed. In India, the **POCSO Act 2012** makes this a legal duty and sets out a deliberately child-sensitive route from information to investigation and trial.

The Act should be understood as a procedural protection, not as an alternative diagnostic or therapeutic framework. It regulates the public response to suspected offences against a child; it does not ask a psychiatrist to decide guilt, conduct a criminal investigation, or replace the court. Its design matters to clinical practice because a child who has already been frightened, coerced, or disbelieved can be harmed again by a process that demands repetition, confronts the child with the accused, or turns the child's account into an adult summary. The provisions below are therefore best learnt as one coherent pathway: report on the statutory threshold, preserve the child's own account in the appropriate legal process, and protect the child during evidence and trial.

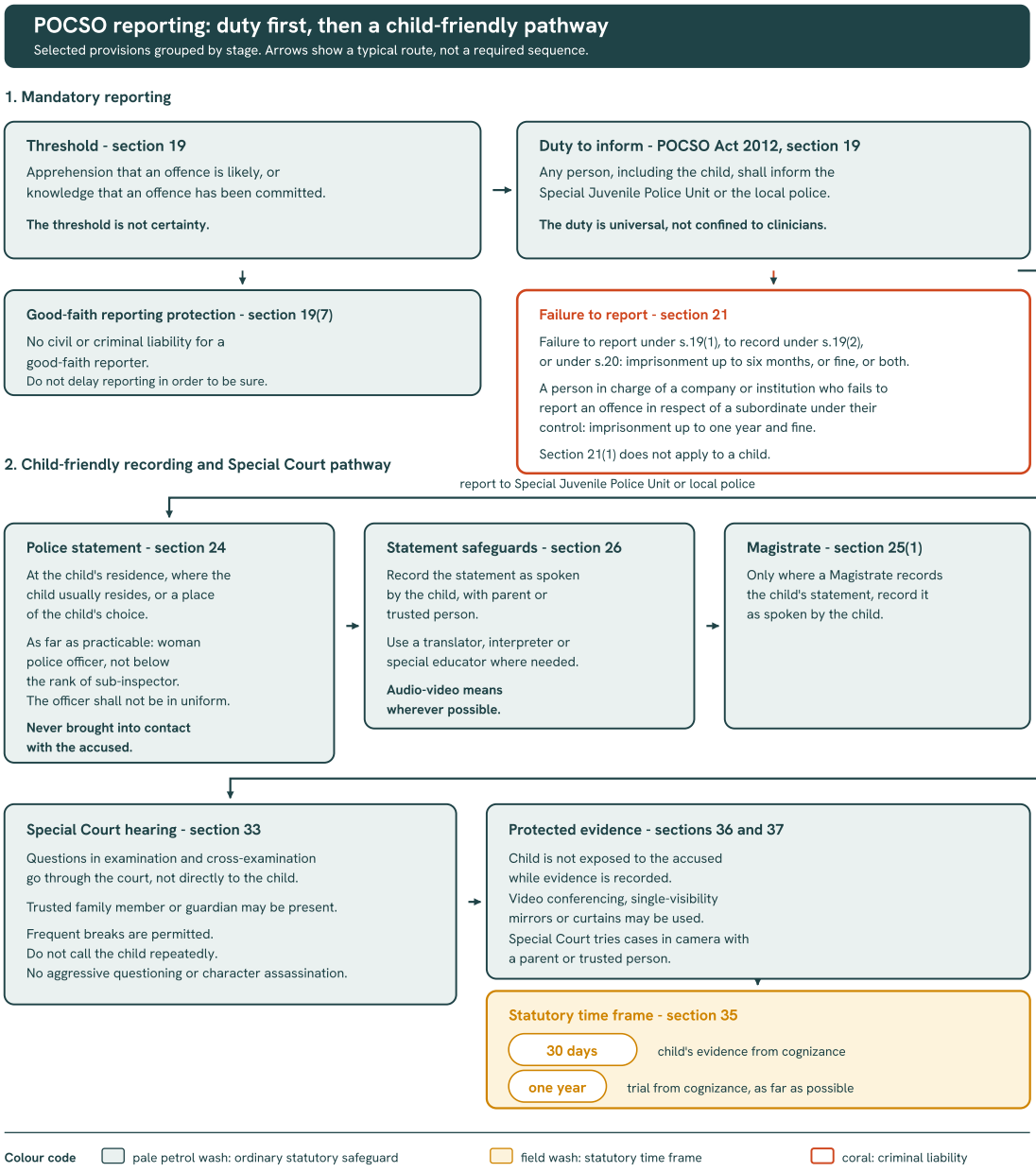


Fig 24.9. POCSO reporting is triggered by apprehension or knowledge, not certainty, and applies to any person including the child. After information reaches the Special Juvenile Police Unit or local police, the statute requires child-friendly recording and a protected Special Court pathway.

31.1 The reporting duty: threshold, person and destination

Mandatory reporting is often wrongly remembered as a duty that starts only after a clinician has reached diagnostic or forensic certainty. That is not the statutory structure. **Any person**, including the child, who has apprehension that an offence is likely or knowledge that one has occurred must provide the information to the **Special Juvenile Police Unit or the local police**. The threshold is thus framed around apprehension or knowledge, rather than a private conclusion that the allegation has been proved.

RULE **Under POCSO, report at apprehension or knowledge; do not wait for certainty.** The legal question is whether information has brought the statutory duty into operation, not whether the psychiatrist can resolve every inconsistency, establish intent, or predict the result of a future trial.

This distinction has practical force. Children may speak indirectly, may use developmentally idiosyncratic language, or may reveal information in fragments. Adults around them may be uncertain, distressed, defensive, or divided about what has occurred. None of those features gives the clinician a licence to convert the statutory threshold into a requirement for proof. Conversely, reporting is not a declaration that an accused person is guilty. It is the act that enables the legally constituted process to receive information and determine what follows. Keeping those two ideas separate protects both clinical thinking and legal compliance.

The duty is universal. A psychiatrist is not exempt because the information arose in a consultation, because the child is reluctant to speak further, or because a family member asks that the matter be kept private. Professional confidentiality remains important in ordinary care, but it cannot be used to erase a statutory reporting obligation. The therapeutic task is to communicate honestly and calmly about the limits of secrecy, without making promises that the law will not permit the clinician to keep. That stance preserves trust better than later disclosure that the clinician had silently made an assurance that could not be honoured.

IN INDIA

The statutory destination is specific: information goes to the **Special Juvenile Police Unit** or local police. The Act does not make the psychiatrist the final arbiter of whether an offence has been established. A good-faith reporter has statutory protection from civil or criminal liability, reinforcing why hesitation while seeking certainty is the wrong legal frame.

There is a useful distinction between *clinical ambiguity* and *legal inaction*. Clinical ambiguity may appropriately remain in a formulation: the psychiatrist may not yet know the meaning, reliability, context, or consequences of the information. Legal inaction is different when the reportable threshold has been reached. Candidates should be able to say that the Act makes room for uncertainty in the facts while refusing to make certainty a precondition for passing information to the designated authority.

- Do not convert the reporting threshold into a requirement for corroboration.
- Do not treat a child's reluctance to continue talking as a reason to promise secrecy.
- Do not treat reporting as a clinical finding of guilt or as a substitute for treatment.
- Do not confuse a lawful report with a licence for indiscriminate discussion of the child's account.

31.2 Failure to report: a statutory offence, not an ethical lapse alone

The legal character of the duty is made plain by the provision on **failure to report**. Failure to report or record the relevant information is itself a punishable offence. For a person who fails in

this duty, the Act provides imprisonment that may extend to **six months**, or fine, or both. The point for clinical practice is direct: a delayed report cannot be defended merely by saying that the clinician was still trying to become sure.

The Act also distinguishes institutional responsibility. A person in charge of a company or institution who fails to report an offence in respect of a subordinate under their control carries a more serious statutory exposure, with imprisonment that may extend to **one year** and fine. The first of those offences, the failure to report or to record, does not apply to a child. The exemption is written against that offence alone rather than against the section as a whole. The heightened exposure is confined to that supervisory relationship, but it remains relevant in hospital, school, residential, and child-care settings, where uncertainty about who should act can become a mechanism of delay. The individual clinician's responsibility does not disappear into a committee, hierarchy, or internal inquiry.

TRAP **"I need to be certain before I report" is the classic wrong answer.** It imports a proof standard that the reporting provision does not require. The Act places the decision about proof within the legal process, while making non-reporting a punishable omission.

The statutory offence should not be taught as a threat alone. Its purpose is to prevent a child's access to protection from depending on an adult's confidence, personal relationship with the family, or fear of being mistaken. It also makes clear why an institution should not use a private fact-finding exercise as a holding pattern. Internal processes may have their own legitimate purpose, but they cannot be allowed to displace the reporting route required by the Act.

In India, **mandatory reporting** under POCSO is a legal duty: any person with apprehension or knowledge must inform the designated police authority, and failure to report is punishable.

31.3 Child-friendly investigation: preserving the child's account

The reporting duty is only the entry point. The Act attempts to prevent the investigation itself from becoming a further source of injury by requiring a **child-friendly investigation**. A child's police statement is to be recorded at the child's residence, at the place where the child usually resides, or at another place chosen by the child. As far as practicable, it is recorded by a woman police officer of the required rank. Separately, and without that qualification, the recording officer must not be in uniform. The child must not be brought into contact with the accused during examination.

Each element has a clinical logic. A familiar or chosen setting may reduce the sense that the child is being taken into an adult-controlled system. The absence of uniform reduces the symbolic pressure of formal policing. Separation from the accused protects against fear, intimidation, and the contamination of the child's ability to speak. These are not therapeutic techniques, and they do not guarantee that the child will be comfortable. They are procedural safeguards that reduce avoidable pressure at a point when the child may be highly vulnerable.

For the psychiatrist, the important conceptual boundary is that the legal statement belongs to the legal process. A consultation may contain clinically relevant material, but the psychiatrist should not try to create a substitute forensic record by repeatedly testing the child's narrative, seeking a polished chronology, or forcing the child to rehearse details for adult reassurance. The child's welfare remains central, but the statute has assigned the formal recording function to specified officials using specified safeguards. The forensic and psychiatric assessment of child sexual abuse is addressed in the chapter section on child sexual abuse assessment and psychiatric sequelae.

PROCEDURAL POINT	STATUTORY SAFEGUARD	WHY IT MATTERS
Threshold for information	**Apprehension or knowledge**	Reporting does not await private proof.
Receiving authority	**Special Juvenile Police Unit or local police**	The statute identifies a formal destination.
Setting for the police statement	**Place chosen by the child**	Procedure is adapted to the child rather than institutional convenience.
Form of the record	**As spoken by the child**	The record should preserve the child's own expression.
Protection from confrontation	**No exposure to the accused**	Evidence can be obtained without compelled face-to-face contact.

Additional provisions protect the integrity of the child's words. The statement is recorded as spoken by the child in the presence of parents or another person in whom the child has trust or confidence. Where needed, a translator, interpreter, or special educator is to be provided, and audio-video recording is to be used wherever possible. These are not mere courtesies to be extended when a system has spare capacity. They recognise that communication access, language, developmental needs, and trust affect whether a child can participate meaningfully.

The same emphasis applies to the magisterial statement. Where the child's statement is recorded by a Magistrate under the current criminal procedure code, the protective requirement is that it be recorded as spoken by the child. The essential teaching point is the safeguard itself, not a recital of general criminal procedure. A psychiatrist who understands this can recognise why the legal process should not replace a child's words with an adult's interpretation, even when that adult is well intentioned.

GOOD TO REMEMBER

The phrase **as spoken by the child** is a safeguard against adult paraphrase. A child may need support to communicate, but support must not become substitution of the adult's language, meaning, or theory for the child's account.

The focus on trusted presence is also nuanced. A parent or trusted adult may help the child feel sufficiently safe to participate, but the statute does not turn that adult into the author of the account. In a clinical setting this distinction is valuable: adult distress, anger, fear, or a need for

immediate certainty can easily dominate the encounter. The child-friendly framework returns attention to the child's voice, communication needs, and protection from avoidable exposure.

31.4 Special Court procedure: evidence without intimidation

The Act carries the same protective logic into the **Special Court**. In examination and cross-examination, counsel communicates questions to the court, and the court puts them to the child. A family member, guardian, or another trusted person may be present. The court may permit frequent breaks, should avoid recalling the child repeatedly, and must not allow aggressive questioning or character assassination.

This does not mean that the child's evidence is insulated from scrutiny. Rather, scrutiny is structured so that the adversarial contest does not itself overwhelm the child. Direct confrontation by an adult advocate may be frightening or confusing even when the words used are technically permissible. Court mediation provides a protective filter: it does not predetermine the answer, but it places responsibility for the manner of questioning with the tribunal that has a duty to protect the child's participation.

The provision also helps candidates articulate why a child-friendly court process serves justice rather than competing with it. A child who is exhausted, terrified, humiliated, or repeatedly summoned may be less able to give a coherent account. Fair process is not achieved by maximising distress. It is achieved by allowing relevant questions to be put in a manner that preserves the possibility of reliable participation while respecting the procedural position of the accused.

- Questions reach the child through the court rather than directly from counsel.
- A trusted person may be present while the child gives evidence.
- Breaks may be permitted when the child needs them.
- The child should not be repeatedly called merely because adults have not organised the process well.
- Hostile questioning and attacks on character are not permitted.

A psychiatric report, when one is relevant to proceedings, should therefore be written with a clear understanding of role. It may assist the court on mental state, communication, or the impact of procedures, but it does not authorise the psychiatrist to decide the legal issue. Plain language, careful distinction between observation and inference, and fidelity to the child's actual communication are especially important where the report may become part of a process intended to minimise further harm.

> **PITFALL**
>
> Do not describe the protective procedure as though it prevents testing of evidence. The safeguard is that the **Special Court** mediates questions and controls the manner of participation, not that relevant questions disappear from the process.

31.5 Time, visibility and privacy during evidence

Delay can extend the burden on a child witness, particularly when the child remains uncertain about repeated attendance, future questioning, or possible contact with the accused. The Act therefore states that the child's evidence should be recorded within **thirty days** after the Special Court takes cognizance, with reasons recorded if there is delay. It further provides that the trial should be completed, as far as possible, within **one year** from cognizance. These are procedural commitments to reduce avoidable prolongation, not a reason for clinical care to become rushed or superficial.

THRESHOLD	EVIDENCE	TRIAL	HEARING
APPREHENSION OR KNOWLEDGE	WITHIN THIRTY DAYS	AS FAR AS POSSIBLE WITHIN ONE YEAR	IN CAMERA

The child must also be protected from seeing the accused while evidence is recorded, while the accused remains able to hear the child and communicate with counsel. The statute permits methods such as video conferencing, single-visibility mirrors, or curtains to achieve that balance. The educational point is not to memorise technology as a checklist. It is to understand the paired commitments: the child is protected from direct exposure, while the process retains the features needed for a fair hearing.

Finally, cases are tried **in camera**, in the presence of the child's parents or another person in whom the child has trust or confidence. Where the court is of the opinion that the child needs to be examined at a place other than the court, it shall issue a commission for that purpose. Privacy here is part of the architecture of participation. It limits unnecessary public exposure while allowing the court to obtain evidence in a setting more responsive to the child's needs.

The psychiatrist's role is to understand these protections well enough not to create false expectations. It is reasonable to explain that the legal system contains child-sensitive safeguards; it is not appropriate to promise a particular procedural outcome or to present a clinical opinion as a direction to the court. Honest explanation lowers anxiety without blurring the boundary between care and adjudication.

31.6 An integrated way to answer and practise the statute

A strong short answer begins with the legal duty, not with a catalogue of offences. State that mandatory reporting applies to any person with apprehension or knowledge, identify the Special Juvenile Police Unit or local police as the destination, and state that failure to report is punishable. Then show that the Act is child-friendly throughout its procedure: the statement is taken in a child-sensitive setting, preserved in the child's words with communication support where necessary, and followed by protective Special Court arrangements.

The deeper clinical lesson is one of disciplined role boundaries. Psychiatry contributes careful listening, humane communication, assessment of the child's mental state and needs, and treatment within its proper remit. The statute supplies a reporting obligation and a protected legal pathway. Neither role should swallow the other. When a clinician mistakes private uncertainty for permission to delay, the child may lose access to the statutory process. When a

clinician mistakes reporting for proof, the family may be misled about what a report means. When a clinician tries to become investigator, therapist, and adjudicator at once, the child's account may be burdened by adult needs rather than supported by a structured system.

For this reason, the provisions are best remembered as an ethic expressed in law: act when the threshold is met; preserve the child's voice; minimise coercive contact and repetition; protect the child in court; and maintain fairness without demanding that the child carry the full weight of an adult adversarial process. That is why this statute belongs in child psychiatry. It tells the clinician not only that protection is required, but also what a child-sensitive public response is meant to look like.

32 · Management and intervention in child abuse cases

Management begins by changing the question. Once abuse is disclosed or suspected, the immediate clinical task is not to obtain a fuller narrative for its own sake. It is to help the child move from exposure and uncertainty toward protection, care and a pathway that can be sustained. The psychiatrist brings a particular contribution: a calm, developmentally sensitive therapeutic stance, attention to safety, formulation of the child's current distress, and coordination with the adults and services that must act around the child.

These cases attract marks because they test clinical priorities rather than recall alone. A good answer separates the response to danger from the assessment of symptoms, separates treatment from investigation, and recognises that protection cannot be delivered by one professional in isolation. The detailed forensic assessment belongs with child sexual abuse assessment and psychiatric sequelae, and the statutory reporting duty and procedures belong with the POCSO Act. This section addresses the clinical response that follows recognition: **safety planning**, coordinated care, and trauma-focused intervention when it is indicated.

SAFE	TEAM	TRAUMA
PROTECT BEFORE PROCEEDING	COORDINATE THE RESPONSE	TREAT THE CURRENT NEED

32.1 The management frame: protect, organise, treat

The clinical response has several linked tasks, but they should not be confused.

- **Protection** asks whether the child can be kept safe while the next steps are arranged.
- **Organisation** asks who must communicate, who will remain a reliable therapeutic contact, and how the child will not be passed from room to room without explanation.
- **Treatment** asks what the child is experiencing now and what help is appropriate.

These tasks overlap, yet they have different purposes. Confusion between them produces a common failure: the clinician becomes absorbed in reconstructing events while the child's immediate environment remains unsafe or the family has no clear plan.

Safety is not an administrative prelude to mental health care. It is the condition that makes mental health care possible. A child who expects renewed exposure, retaliation, disbelief or chaotic handovers may be unable to use a therapeutic relationship freely. Conversely, a plan that

is formally protective but incomprehensible to the child can itself heighten fear. The clinician should therefore work in language the child can understand, avoid promises that cannot be honoured, and explain the next step before moving to it. The child does not need to carry responsibility for adult decisions; the child does need a coherent explanation of what is being done to help.

RULE **In an abuse response, safety planning comes before diagnostic neatness.** The working formulation can evolve, but the clinical encounter should immediately reduce avoidable danger, confusion and exposure.

A useful mental model is to ask, at every handover, whether the next action increases protection, preserves the child's sense of control, or makes later care easier to deliver. If it does none of these, it deserves scrutiny. This does not mean that care is passive or that difficult decisions are postponed. It means that the clinician distinguishes necessary action from hurried action, and uses the least disruptive route consistent with the child's safety.

32.2 Safety planning as an active clinical intervention

Safety planning is an active, child-centred process rather than a note stating that somebody else will manage risk. The immediate plan should make clear:

- where the child will be and which adults can be relied upon;
- how contact with a suspected source of harm will be prevented while protection arrangements are considered; and
- whom the child can approach if fear or pressure returns.

Its content must remain responsive to the child's circumstances and to the capacities of the adults around them. A plan that assumes a supportive adult without examining whether that adult can actually protect is fragile.

WHO's guidance places action to enhance safety and reduce harms associated with disclosure among the **first-line** clinical responsibilities in responding to child sexual abuse. This includes attention to **visual and auditory privacy**. Privacy is practical as well as relational: conversations should not be audible to people who have no clinical role, the child should not be made to repeat sensitive material in public spaces, and the setting should not permit a potentially unsafe person to control the exchange. These small features communicate whether the service understands the child as a person needing protection rather than as a source of information.

Safety planning should be revisited when circumstances change. A plan may look adequate during a supervised clinical contact and fail during transport, school attendance, family visits, or communication between adults. The psychiatrist need not personally control every setting in which the child lives. The responsibility is to make safety a visible clinical priority, identify uncertainty clearly, and ensure that the relevant protection pathway is activated rather than assumed. When the child's account and an adult's account differ, the child should not be asked to resolve the discrepancy by further exposure or confrontation.

GOOD TO REMEMBER

Ask the child what would make the next few hours and the next contact feel safer. The answer may reveal a practical risk that is invisible in a formal record, such as fear of a particular handover, a place in the home, or being left alone with a particular adult.

The clinician's language matters. It is helpful to validate that the child has done the right thing in seeking help without making the child responsible for proving anything. It is equally important not to create false reassurance. Statements such as "nothing will happen without your permission" may be untrue where protective action is required. A more trustworthy stance is to say that the adults will explain what has to happen, will try to involve the child in a way that feels manageable, and will continue to care even if the process is difficult.

32.3 Preserve the therapeutic space without duplicating the forensic task

The management consultation is neither an interrogation nor a substitute for the safeguarding-specific evaluation. The detailed assessment of child sexual abuse, including its psychiatric sequelae, is addressed in the section on child sexual abuse assessment and psychiatric sequelae. Here, the psychiatrist's task is to listen sufficiently to understand current safety and distress, then to organise care without turning each review into a demand for a more elaborate account. Repeated, uncoordinated retelling can leave the child feeling disbelieved, observed or responsible for the adult process.

A therapeutic conversation can therefore remain focused on immediate experience: what the child is afraid of now, whether sleep, concentration, mood, bodily distress or relationships have changed, and what support feels possible. The clinician can record what is clinically necessary in a clear, restrained way and avoid interpretive excess. When uncertainty is present, it should be documented as uncertainty. The discipline of saying "not yet known" is clinically safer than filling a gap with assumptions, whether those assumptions minimise harm or enlarge it.

TRAP **Do not mistake a compassionate clinical interview for a licence to conduct a fresh forensic inquiry.** The urge to obtain a complete story can crowd out safety, fragment the response, and blur the psychiatrist's therapeutic role.

There is a second reason to preserve role clarity. The child may need the psychiatrist over time, after external processes have moved on. If the child experiences the clinician primarily as another adult collecting an account, later work on fear, trust, shame, anger or relationships may be harder to establish. A reliable therapeutic stance is not neutral about harm. It is clear that the child deserves protection, while remaining careful about the limits of what the clinician knows and what the current consultation is for.

Families may also press the psychiatrist to decide who is telling the truth, to arbitrate a conflict, or to certify that no further action is needed. Such requests should be recognised as pressure on the clinical frame. The psychiatrist can acknowledge the family's anxiety and return to the child's welfare: safety concerns require a coordinated response, and symptom care requires a relationship in which the child is not made to manage adult disagreement.

32.4 Coordinated multidisciplinary management

Abuse cases commonly demand **multidisciplinary management**. The value of a team is not merely that several professionals are involved. It is that their tasks are made complementary. A coherent team can reduce contradictory messages, prevent unnecessary repetition, arrange the right referral at the right time, and keep the child's clinical needs visible while other processes unfold. A collection of professionals acting independently is not yet a team.

Structured clinical practice guidance can support complex work by **multidisciplinary teams**. In practice, the psychiatrist should establish a shared formulation of the immediate problem, identify the person responsible for coordinating communication, and clarify what information needs to travel with the child and what should not be casually circulated. Coordination is especially important when the child's home, school, clinical setting and protection pathway give different adults partial pictures of the situation. A shared plan should make these partial views usable without making the child retell the same distressing material to every service.

CLINICAL QUESTION	PURPOSE OF COORDINATED ACTION	PSYCHIATRIST'S CONTRIBUTION
Is the child safe for the next step?	Make protection explicit rather than assumed.	Keep safety planning central to the formulation.
Who needs to act now?	Avoid diffusion of responsibility.	Communicate the clinical concern and identify the needed links.
What should the child be told?	Reduce uncertainty and preserve trust.	Use developmentally understandable explanations.
What needs follow-up?	Prevent care ending after the first crisis.	Review distress, functioning and the safety plan.

Teamwork should not erase confidentiality. Information sharing should be purposeful and limited to what is needed for protection and care. The child and caregiver should be told, as far as possible, why information is being shared and what the next contact will involve. When a caregiver's interests conflict with the child's safety, the clinician's primary orientation remains the child's welfare. This is not hostility toward the family. It is the ethical discipline needed when the family system cannot be presumed to be a safe container.

IN INDIA

Management in India must join the clinical plan to the child-protection and legal pathway rather than treating psychiatric care as a parallel, private service. The statutory duties and child-friendly procedures are set out in the POCSO Act section; the psychiatrist's role here is to ensure that safety, communication and continuing care do not disappear while those processes are being activated.

32.5 Formulation after abuse: treat the child in front of you

Protection and treatment are related but not interchangeable. Removing an immediate source of danger may reduce distress, but it does not automatically restore sleep, trust, concentration, affect

regulation or a sense of bodily safety. Equally, beginning psychological work without attending to ongoing exposure asks therapy to compensate for an environment that remains unsafe. The psychiatrist should formulate the child's present difficulties in context: the meaning the child gives to what happened, the current relational environment, the responses of important adults, and the practical conditions under which treatment will occur.

Formulation protects against two opposite errors. One is to see every reaction as evidence of a psychiatric disorder and to medicalise an understandable response to danger. The other is to assume that distress is simply transient because it follows a known stressor. The child may need support even when a formal diagnosis is not the immediate clinical question, and may need more focused treatment when symptoms are persistent, impairing or organised around traumatic reminders. The clinician should follow change over time without requiring the child to demonstrate suffering in a particular way.

Caregiver work is often central to the formulation. An adult who can believe, protect and remain emotionally available can help the child recover a sense that relationships can be safe. An adult who is overwhelmed, disbelieving, dependent on a suspected source of harm, or preoccupied with blame may require support and careful boundary-setting before being treated as a therapeutic resource. This is why involvement of family cannot be automatic. The relevant question is whether a particular adult can safely contribute to the child's care.

PITFALL

Do not treat the presence of a caregiver as proof of protection. The clinically relevant issue is whether that adult can reliably support the child without exposing the child to pressure, disbelief, divided loyalty or renewed risk.

32.6 Trauma-focused psychological intervention

For children and adolescents who have been sexually abused and are experiencing symptoms of PTSD, WHO recommends that **trauma-focused CBT** be considered. The wording matters. It points to a focused psychological intervention for a defined clinical presentation, not to a generic requirement that every child who discloses abuse should be placed into the same therapy immediately. The psychiatrist should connect the intervention to the child's current symptoms, readiness, safety and ability to attend, rather than treating a therapy label as a complete formulation.

Trauma-focused work is organised around helping the child approach distress in a planned, tolerable way rather than leaving reminders to govern the child's life. It requires a therapeutic relationship in which the child has enough predictability to engage and enough choice to communicate limits. The work should neither compel disclosure on the clinician's timetable nor collude with complete avoidance of the child's experience. Its clinical value lies in giving experience a form that can be thought about, linked to present safety, and integrated without defining the child's identity.

Psychiatric review remains important during psychological treatment. Symptoms may change as memories, fears and family tensions become more discussable. The psychiatrist monitors whether the treatment setting continues to feel safe, whether the child is becoming more isolated or pressured outside therapy, and whether additional support is needed around functioning and relationships. This is not a reason to fragment care by adding multiple unrelated interventions. It is a reason to keep a coherent formulation alive while treatment proceeds.

When trauma-focused CBT is being considered, the explanation to the child should be plain: the work is intended to reduce the hold that frightening memories and reminders have on present life. Children should not be told that they must revisit everything at once, nor should they be led to believe that recovery depends on producing a particular account. A respectful explanation protects engagement and makes it less likely that therapy will resemble another process imposed by adults.

32.7 Involving the non-offending caregiver

WHO further advises considering **trauma-focused CBT for the child and non-offending caregiver** when it is safe and appropriate to involve that caregiver. The intervention is for **both** child and caregiver, rather than treating family participation as an optional afterthought. It recognises that the caregiver's emotional response, protective capacity and understanding of the child's distress can shape the child's treatment environment. Caregiver involvement can help the adult respond more steadily to fear, anger, withdrawal or reassurance-seeking without making the child responsible for the adult's emotions.

"Non-offending" should not be treated as a sentimental label. It names a clinical and safeguarding question: can this adult participate without compromising the child's safety or making therapy unsafe? The answer may differ across caregivers and may change with circumstances. The clinician should avoid inviting an adult into the therapy space simply because that adult is available, socially expected to participate, or distressed by exclusion. Involvement is justified by the child's welfare, not by adult entitlement.

Caregiver sessions can create room for the adult's confusion, guilt, anger or grief while keeping the child free from having to regulate those reactions. They can also clarify what supportive responses look like in everyday life: believing the child without demanding repeated details, protecting routines where possible, and keeping conflict away from the child. If the caregiver cannot safely take this role, the team must not pretend otherwise. A stable therapeutic frame is more valuable than nominal family participation.

MNEMONIC

SAFE TEAM TRAUMA

Safe environment first, a coordinated **team** around the child, then **trauma**-focused work when the child's presentation calls for it. The phrase is a sequence of clinical priorities, not a substitute for formulation.

32.8 Continuity, review and the endpoint of care

Continuity is a therapeutic intervention in its own right. Abuse may leave the child expecting adults to become unavailable, disbelieving or preoccupied with procedure. A service that offers one sympathetic consultation and then disappears can unintentionally repeat that experience. Follow-up should therefore review safety, the child's experience of the plan, current distress, the availability of a protective adult, and whether the various parts of the response are still communicating. The question is not simply whether symptoms have reduced. It is whether the child now has enough safety and support to resume development without being defined by the abuse response.

Ending care should be planned, not allowed to occur by default after the crisis has quietened. The child and supportive adults should understand what has improved, what difficulties may recur, and how to seek help again without having to reconstruct the entire story. A clear ending acknowledges recovery while leaving the door open to return. It also prevents the false binary in which the child is imagined as either permanently damaged or completely unaffected.

For the psychiatrist, the enduring discipline is to resist both rescue fantasy and procedural detachment. One clinician cannot repair every consequence of abuse, but can ensure that psychiatric care adds safety, clarity and a sustained therapeutic relationship to the wider response. That is the practical meaning of child-centred management.

> In child abuse management, protect the child first, coordinate the adults and services around the child, and use trauma-focused intervention for the child's current clinical needs.

33 · Juvenile Justice (Care and Protection of Children) Act 2015

Why it matters clinically. The **Juvenile Justice (Care and Protection of Children) Act** 2015 is not a diagnosis framework or a substitute for child psychiatric formulation. It decides which authority receives a child, what question that authority must answer, and when a psychiatrist may assist. It prevents an alleged act by a child from obscuring vulnerability, and vulnerability from being mistaken for criminality. For legal wording, read the primary Act rather than a paraphrase.

The safest way to learn the Act is through its offence route and protection route. They can meet in the same child, but begin with different questions and are handled by different statutory bodies. Identify the route before naming the forum.

ACT	VULNERABILITY	BOARD	COMMITTEE
ALLEGED OFFENCE BY THE CHILD	NEED FOR CARE AND PROTECTION	FORUM FOR THE OFFENCE ROUTE	FORUM FOR THE PROTECTION ROUTE

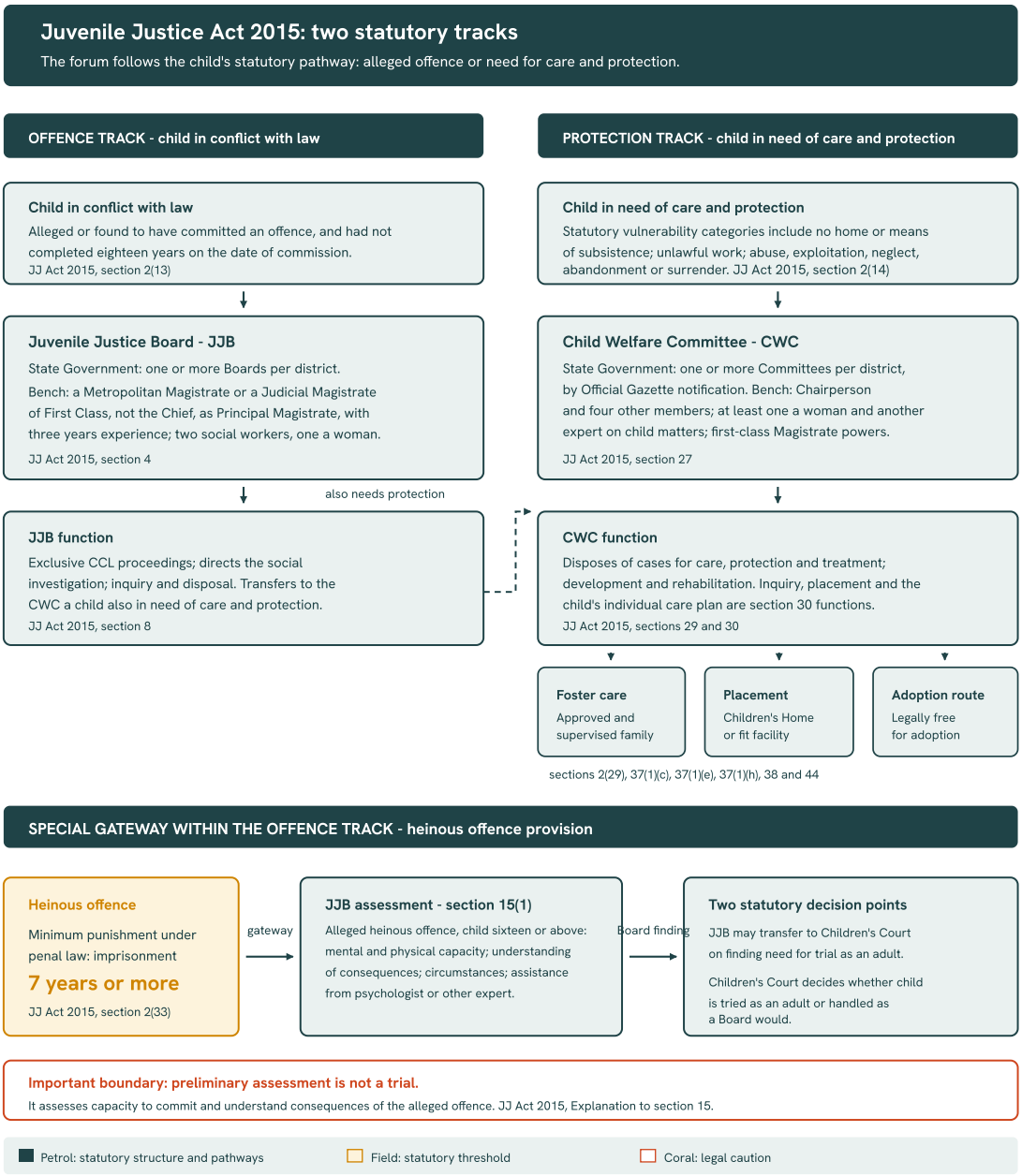


Fig 24.10. The JJ Act 2015 separates the offence-based CCL pathway governed by the JJB from the vulnerability-based CNCP pathway governed by the CWC. Heinous-offence assessment is a capacity assessment by the Board, with a separate subsequent decision by the Children's Court.

33.1 The statutory map: act, vulnerability and forum

A **child in conflict with law** is a child alleged or found to have committed an offence, provided the child had not completed **eighteen** years on the date of the alleged offence. The date of the act, rather than the date of apprehension or hearing, is therefore the legally relevant anchor. This is a narrow, offence-based description. It does not tell the clinician whether the child is distressed, impaired, exploited, traumatised, or unsafe. Those are clinical and protective questions that still need attention.

By contrast, a **child in need of care and protection** is identified by vulnerability. The statutory categories include a child without a home or apparent means of subsistence, a child working

contrary to labour law, and a child who has been abused, exploited, neglected, abandoned or surrendered. The practical distinction is morally important. On the offence route, the system asks what the child is alleged to have done. On the protection route, it asks what danger, deprivation or failure of care has happened to the child.

QUESTION THAT STARTS THE ROUTE	STATUTORY TRACK	PRIMARY FORUM	CLINICAL IMPLICATION
Is the child alleged to have committed an offence?	Child in conflict with law	Juvenile Justice Board	Keep developmental and welfare needs visible during the inquiry.
Is the child exposed to a statutory form of vulnerability or unsafe care?	Child in need of care and protection	Child Welfare Committee	Frame the problem as protection, treatment and rehabilitation, not misconduct.
Does the same child meet both descriptions?	Overlapping need	Board with transfer to Committee where required	Do not allow one label to erase the other route.

RULE **Classify the child by the legal question before discussing the psychiatric opinion.** The Act separates alleged offending from need for protection, and it gives each route a distinct decision-making body.

These labels should not become clinical identities. Anger, withdrawal, substance use, developmental limitations, fear or apparent indifference do not alone determine the statutory track. Conversely, a child alleged to have offended may also need immediate safety planning. The Board can transfer a child in conflict with law to the Committee when the child is also in need of care and protection. This seam allows care needs to be addressed without denying the allegation.

33.2 Juvenile Justice Board: the offence-route authority

The **Juvenile Justice Board** is constituted by the State Government for each district and is a Bench, rather than a lone magistrate making an administrative referral. Its Principal Magistrate is a Metropolitan Magistrate or Judicial Magistrate of the first class, not being a Chief Metropolitan Magistrate or Chief Judicial Magistrate, with at least **three years** of experience. The statutory composition also includes social workers, with a woman member required. The point of this design is not ceremonial. It brings judicial authority and child-welfare expertise into the same decision-making structure.

The Board deals exclusively with proceedings concerning children in conflict with law within its district. It directs the Probation Officer, or where a Probation Officer is not available the Child Welfare Officer or a social worker, to undertake the social investigation and report within **fifteen days** of first production. It conducts the inquiry, disposes of cases, and can transfer to the Child Welfare Committee a child who also requires care and protection. A psychiatrist should therefore understand that a report may inform the Board's work, but does not replace its inquiry or decide the case. The clinical task is bounded by the question put to the expert and by the child's developmental context.

GOOD TO REMEMBER

When a referral comes through the offence route, write the referral question at the top of the assessment. Separate observed symptoms, developmental functioning, the child's account, collateral information and limits of inference. This keeps a clinical opinion useful without allowing it to drift into a judicial conclusion.

For the psychiatrist, the Board is often the point at which a child's mental health needs become legible to the justice system. That does not make the psychiatrist a prosecutor, defence witness, or final arbiter of legal responsibility. It makes the psychiatrist a clinician who can describe relevant capacities and vulnerabilities with precision, including what the available information can and cannot support. Neutrality is especially important where family pressure, institutional narratives, or the seriousness of an allegation makes a quick explanatory label tempting.

33.3 Child Welfare Committee: the protection-route authority

The **Child Welfare Committee** is the statutory authority for the protection route. It is constituted for each district by State Government notification and functions as a Bench with magisterial powers. It consists of a Chairperson and **four** other members, including a woman member and a member with expertise in child matters. Its orders are not merely recommendations: its legal authority is what permits a protective plan to become an operative placement or care decision.

The Committee has authority to dispose of cases concerning care, protection, treatment, development and rehabilitation of children in need of care and protection. It may conduct inquiry and make placement decisions in relation to the child's **individual care plan**. The phrase matters clinically. The child's psychiatric needs are part of the care problem, but they should be considered alongside safety, attachment, family capacity, educational continuity and the feasibility of the proposed setting. A diagnosis alone cannot answer whether a placement is protective or sustainable.

IN INDIA

The Board and the Child Welfare Committee are statutory Indian forums, not informal multidisciplinary meetings. In a referral letter, name the route clearly and state whether the child's presentation raises protection needs in addition to the immediate clinical question. This makes it harder for a vulnerable child to be passed between services with nobody owning the protective decision.

The Committee's remit also corrects a clinical blind spot. A child who has been neglected or exploited may present with disruptive behaviour, school refusal, self-harm, dissociation, substance use, somatic complaints, or a flat account of serious adversity. The clinical formulation must not convert this into an account of individual pathology alone. The statutory route requires attention to the environment that is failing the child. Detailed recognition and management of abuse are addressed in the child-protection sections of this chapter; here, the essential point is

that vulnerability can activate a protection process even when no offence is alleged against the child.

33.4 When both routes are present

The two tracks are distinct, not mutually exclusive. A child may be alleged to have committed an offence while also being homeless, exploited, abused, neglected, abandoned, or otherwise unsafe. The Board's transfer power to the Committee is the statutory answer to this overlap. In clinical language, the allegation must not eclipse the formulation, and the formulation must not erase the allegation. Both statements can be true, and the system has a route for both.

> **TRAP** **Do not treat "conflict with law" as the opposite of "in need of care and protection."** The first phrase describes an alleged offence; the second describes vulnerability. A child can fall within both descriptions, so a protection concern must be surfaced even during offence-route proceedings.

This is where psychiatric language can either help or harm. Descriptions such as conduct problems, impulsivity, intoxication, trauma symptoms, intellectual limitations, or family conflict should be used to illuminate the child's situation, not to shortcut the statutory analysis. The clinician should state what has been observed, what has been reported, whose account is being relied upon, and whether the available material supports an opinion on the question asked. A report that becomes a broad moral explanation for the allegation is both clinically weak and legally unhelpful.

33.5 Heinous offences and the preliminary assessment

A **heinous offence** is defined by the minimum punishment prescribed in the penal law: imprisonment of **seven years** or more. This statutory threshold is the gateway to the special preliminary-assessment process for an older child within the Act's definition of childhood. It is a legal classification of the alleged offence. It is not a psychiatric diagnosis, an index of dangerousness, or a conclusion about the child's maturity.

For a heinous offence alleged against a child who has completed or is above **sixteen** years, the Board conducts a **preliminary assessment**. It considers the child's mental and physical capacity to commit the alleged offence, ability to understand its consequences, and the circumstances in which it is alleged to have occurred. The Board may take assistance from psychologists or other experts. The clinician's contribution is consequently evidence for a statutory assessment, not an independent decision to move the child into an adult process.

The legal formulation deliberately requires more than a label. A diagnosis, a screening score, an intelligence estimate, a history of adversity, or the apparent sophistication of one act cannot by itself answer the entire question. Capacity and understanding have to be considered in relation to the alleged conduct and its context. The assessment should therefore be careful about language, avoid conclusions that exceed the records and interview, and distinguish a clinical observation from an inference about the legal question.

MNEMONIC

Capacity - Consequences - Circumstances

For the preliminary assessment, organise the psychiatric contribution around the child's capacity in relation to the alleged act, understanding of consequences, and the circumstances in which the allegation arose. The Board remains the authority that assesses these matters with expert assistance.

PITFALL

Do not write a report as though the preliminary assessment were an insanity opinion. The statutory question is developmental capacity and understanding in relation to the alleged offence. A report that imports another legal test can obscure the exact issue the Board must decide.

33.6 What the preliminary assessment is not

The Act expressly states that this preliminary assessment is not a trial. This distinction has practical force. The clinician does not determine guilt, assess the evidentiary strength of the allegation, decide the final forum, or pronounce a general conclusion on criminal responsibility. The assessment addresses the limited statutory questions of the child's capacity to commit and to understand consequences of the alleged offence.

General criminal responsibility, the insanity doctrine, the current criminal-law provisions and adult forensic assessment belong in *the Mental health legislation and forensic psychiatry notes*. Cross-refer there rather than importing that doctrine into a juvenile preliminary assessment. The two inquiries can sound similar because both involve mental state and legal consequence, but they are not interchangeable. In an answer, saying that the preliminary assessment is not a trial and not a general criminal-responsibility determination earns clarity because it protects the statutory boundary.

Expert assistance does not make the expert the decision-maker. The Board conducts the assessment, may use psychological or other expert assistance, and retains the statutory role. A well-written psychiatric opinion is therefore disciplined: it identifies the clinical material, explains its relevance to the specified capacity or understanding question, and records uncertainty where the material does not permit a defensible inference. It should not mimic a judgment or use conclusory phrases that collapse assessment, culpability and disposal into one opinion.

33.7 Transfer and the second decision point

After the preliminary assessment, where the Board finds a need for **trial as an adult**, it may transfer the trial to the Children's Court. That transfer is not the endpoint. The Children's Court itself decides whether the child is to be tried as an adult or handled as the Board would handle the case. The Board's finding and the Court's decision are separate statutory steps.

STAGE	WHO ACTS	QUESTION ANSWERED	WHAT THE PSYCHIATRIST MUST NOT ASSUME
Preliminary assessment	Juvenile Justice Board, with expert assistance where used	Capacity, understanding of consequences and circumstances in the statutory setting	That expert input decides guilt or adult trial.
Transfer decision	Juvenile Justice Board	Whether transfer to the Children's Court is required after the assessment	That transfer itself converts the child into an adult defendant.
Post-transfer decision	Children's Court	Whether adult trial is appropriate or the matter should be handled as by the Board	That the Board's view is the final legal outcome.

This sequence is a frequent examination discrimination because the language of adult trial can lure the reader into collapsing the stages. It is also a clinical safeguard. The psychiatric assessment may be influential, but it does not erase the child's statutory status or collapse judicial functions into a medical opinion. In reports and oral evidence, keep the limited purpose of the opinion visible.

33.8 Protection decisions and continuity of care

For a child in need of care and protection, the Committee may make decisions that connect immediate safety with longer-term care. Its statutory options include placement in a Children's Home, fit facility or Specialised Adoption Agency, the last for the purpose of adoption, an order for **foster care**, and a declaration that a child is legally free for adoption. The legal content of adoption and the psychiatric aspects of child labour and adoption are addressed elsewhere; psychiatric care must remain connected to the placement decision.

Foster care means placement in the domestic setting of a selected, qualified, approved and supervised family other than the child's biological family. It is not simply an informal arrangement with any available household. When asked to advise, the psychiatrist does not select the placement, but can identify mental-health needs that should shape the care plan.

> The Juvenile Justice Act separates an alleged offence from a child's vulnerability, and a psychiatric opinion assists the statutory forum without replacing it.

33.9 A disciplined examination and clinical approach

In a short answer, proceed in a disciplined order:

- identify the offence route or the protection route;
- name the Board or Child Welfare Committee as the relevant forum;
- state that age on the date of the alleged offence anchors the offence-based definition;

- for the heinous-offence provision, describe capacity, understanding of consequences and circumstances, then state that the assessment is not a trial and the Children's Court decides after transfer.

In practice, the same sequence is a safeguard against role confusion. Identify the forum, obtain the precise referral question, preserve a developmental and trauma-informed formulation, state evidential limits, and flag protection concerns that may require the other route. Where the child is frightened, poorly understood, or embedded in an unsafe family or institutional context, the report should make those needs visible in clinically careful language. It should never offer a shortcut from symptom to culpability, or from allegation to a conclusion that the child has no claim to protection.

34 · Child in conflict with law and child in need of care and protection

Why this distinction matters clinically. A child may enter the juvenile justice system because of an alleged act, or because the child is unsafe, unsupported, exploited or without care. Those are not interchangeable descriptions, and they call for different clinical questions. The psychiatrist's first task is to avoid allowing the presenting label to flatten the child into either an offender or a passive victim. The useful formulation asks what has happened, what the child needs now, what relationships and environments are available, and what information the statutory process needs from mental-health care.

The marks in this area lie in making a clean discrimination before discussing intervention. The legal label supplies a pathway; it does not describe the whole child, establish a psychiatric diagnosis, or determine whether treatment is needed. Disorders, developmental variation and general criminal responsibility are addressed elsewhere. Here the focus is the distinction between an offence-based pathway and a protection-based pathway, and the practical meaning of protective placement for psychiatric work.

OFFENCE	VULNERABILITY	PLACEMENT
ALLEGED ACT PATHWAY	PROTECTION PATHWAY	CARE MAY NEED TO CHANGE

34.1 The distinction that prevents category error

A **child in conflict with law** is a child alleged or found to have committed an offence, provided the child had not completed **eighteen years** when the alleged offence was committed. The anchor is the time of the alleged act, rather than a later procedural event. This is not a diagnosis and it does not establish an explanation for the behaviour. A psychiatric opinion may help describe symptoms, developmental capacity, adversity, substance use, family context and treatment need, but it should not casually transform a legal label into a clinical conclusion.

By contrast, a **child in need of care and protection** enters the protection pathway because of vulnerability, not because the child is alleged to have done something. The statutory idea is deliberately broad. It can apply where a child lacks a stable home or visible means of subsistence, is found working contrary to labour law, or is abused, exploited, neglected, abandoned or surrendered. In clinical language, the question is not simply "what is wrong with the child?" It is

also "who is reliably keeping this child safe, and what setting can support recovery and continuity of care?"

RULE **Start with the pathway, then formulate the child.** The offence-based label is triggered by an alleged act; the protection label is triggered by vulnerability and unmet care. Neither should be treated as a psychiatric diagnosis or as a moral summary of the child.

CLINICAL QUESTION	CONFLICT-WITH-LAW PATHWAY	CARE-AND-PROTECTION PATHWAY
What brings the child into view?	An allegation or finding concerning an offence.	A concern that the child is vulnerable or lacks safe care.
What must not be assumed?	That the alleged act proves a disorder, intent or a fixed character.	That vulnerability means the child has no agency, preferences or strengths.
What is the immediate psychiatric task?	Describe current needs without replacing the legal process with a clinical opinion.	Clarify distress, safety, relationships and the supports needed for stable care.
What is the placement question?	Do not infer a placement answer from the label alone.	Match the care plan to safety, continuity and the child's developmental needs.

Child in conflict with law concerns an alleged act; child in need of care and protection concerns vulnerability and the need for safe care.

34.2 Why age anchoring and language matter

The age element is often tested because it forces attention to the correct clinical-legal timeline. Record the child's account, collateral history and available documentation with their source and degree of certainty. Do not silently substitute the date of assessment, apprehension, remand, referral or hearing for the legally relevant time point. Such substitution can make an otherwise careful report misleading. The treating team does not decide the legal issue by itself, but it must avoid producing imprecise prose that appears to decide it.

Language also changes what the team notices. "Delinquent," "criminal," "bad family," and similar shorthand can obscure trauma, coercion, learning difficulty, acute distress, disability, peer influence or unmet social needs. The converse error is equally important: compassion does not require excusing away all agency, and a psychosocial explanation is not a legal conclusion. The psychiatrist should use person-first, behaviour-specific language: what is reported, what is observed, what remains uncertain, and what treatment or environmental support is indicated.

TRAP **Do not decide status from the child's age at assessment.** The statutory definition fixes the relevant age at the time of the alleged offence. A later age belongs in the chronology, not in place of that anchor.

For general criminal responsibility, adult forensic assessment and the wider legal framework, see *the Mental health legislation and forensic psychiatry notes*. The present distinction is narrower. It

helps the clinician identify whether an alleged act is the doorway into the system, or whether the system is being asked to secure care for a child whose circumstances have become unsafe.

34.3 The psychiatrist's role: formulation without role confusion

When the referral concerns a child in conflict with law, the clinical report should answer the clinical question asked and stay within that scope. It should distinguish observed findings from reports by others, and acknowledge limits imposed by the setting, distress, language, separation from carers or incomplete collateral. A report gains authority by being precise about its boundaries, not by using legal language it cannot support. The general child psychiatric assessment framework is addressed elsewhere in this chapter; this context changes how its findings must be communicated, not the need for disciplined assessment.

When the referral concerns care and protection, clinical work is often inseparable from the experience of disruption. A child may have lost routines, separated from familiar adults, entered an unfamiliar setting, or had prior care marked by neglect or exploitation. Symptoms can be meaningful responses to uncertainty as well as evidence of a disorder. The formulation should therefore account for the child's felt safety, supportive relationships, ordinary routines, fears about change and practical barriers to treatment. This is not a separate forensic battery. It is good child psychiatry applied to a protection context.

The clinician should resist being recruited into a false binary. A child can require protection while also being involved in an alleged offence. Conversely, a child referred after an alleged offence may disclose violence, exploitation or absence of care. The point is not to assign a single identity. It is to ensure that a disclosed protection concern is not overlooked because the referral arrived through an offence-related doorway. The statutory route and the clinical formulation may interact, but they answer different questions.

> **GOOD TO REMEMBER**
>
> A useful report separates facts, the child's account, collateral information, clinical inferences and recommendations. That separation protects the child, makes uncertainty visible and prevents a treating opinion from masquerading as a legal finding.

34.4 Care planning and placement are clinical continuity issues

For a child in need of care and protection, a placement decision is not merely an address. It changes who can observe symptoms, bring the child to appointments, hold medication safely, support therapy attendance, understand triggers, and notice deterioration or improvement. The mental-health contribution is therefore practical: identify the supports that preserve safety and continuity, rather than making a vague recommendation for "rehabilitation." Recommendations should be tied to the child's current presentation and should state what information needs to travel with the child when care arrangements change.

The statutory options include **placement in a Children's Home, fit facility, or Specialised Adoption Agency**, the last of these for the purpose of adoption, for either temporary or longer-term care. These words identify possible care settings, not a hierarchy of emotional adequacy.

Any setting can be destabilising if a child's history, relationships and treatment requirements disappear at the point of transfer. Equally, a stable transition can be therapeutic even when a change of setting is unavoidable. The psychiatrist should communicate needs in a form that a receiving care team can use.

Before a change in care arrangements, the clinician should communicate:

- the child's current emotional and behavioural presentation, including any immediate safety concern;
- what tends to reduce distress and what predictably escalates it;
- the relationships, routines and communication supports that help engagement; and
- the practical plan for continuing medication, psychological work and follow-up.

IN INDIA

Use the statutory language accurately, but keep the clinical recommendation readable by the receiving service. A sentence that names the support needed, the reason it matters and the information that must accompany the child is more useful than a broad declaration that the child requires institutional care.

PITFALL

Do not let a transfer become an undocumented clinical reset. Repeating the full assessment is sometimes necessary, but loss of the prior formulation, current treatment plan and known calming supports can itself create avoidable distress and apparent non-engagement.

34.5 Foster care: an alternative family environment, not an informal arrangement

Foster care is alternate care in the domestic environment of a family other than the child's biological family, where that family has been selected, qualified, approved and supervised. This definition matters because it distinguishes statutory foster care from an informal arrangement with relatives, neighbours or acquaintances. The emotional quality of informal support may be important clinically, but it should not be inaccurately described as the statutory placement option.

For a child declared in need of care and protection, a **foster-care order** is a possible disposal pathway, made under **section 44**. The statutory process is covered in the chapter section on the Juvenile Justice Act. The psychiatrist's narrower responsibility is to help the care plan anticipate adjustment: how the child responds to unfamiliar adults, separations and limits; what supports foster carers will need to understand; and how treatment can continue without turning the foster setting into a clinic.

MNEMONIC

OVP - Offence, Vulnerability, Placement

Use this as a quick organising spine. Identify whether the system entry is an alleged offence or vulnerability, then ask what care arrangement will preserve safety and psychiatric continuity.

34.6 Adoption pathway and respectful clinical handover

A child in need of care and protection may be the subject of a declaration that the child is **legally free for adoption**. The declaration opens an adoption pathway; it is not a psychiatric prediction about attachment, future behaviour or the quality of a prospective family. Avoid language that pathologises the child because the child has experienced separation, institutional care or disruption. At the same time, do not conceal clinically relevant history that a future care plan needs in order to be safe and realistic.

Adoption law and assessment of adoptive-parent fitness are beyond this section. The psychiatric contribution is a careful, minimum-necessary handover: current symptoms and treatment, communication and learning needs, known trauma-related sensitivities where clinically relevant, protective routines, and follow-up needs. It should be written with awareness that records can affect a child's future relationships. Include what helps, not only what has gone wrong. Do not convert uncertain formulation into a permanent label.

The same discipline applies across all protective placements. Explain the child in a way that supports care, preserves dignity and keeps legal decisions in their proper forum. In practice, that is the bridge between child psychiatry and protection work: a report that is clinically useful, developmentally sensitive and exact about what it can and cannot decide.

35 · Child labour and adoption (psychiatric aspects)

Why it matters clinically. Child labour and adoption are not diagnoses. They are contexts that can alter a child's exposure to adversity, the meanings given to symptoms, the people who can provide safety, and the relationship through which treatment is delivered. A psychiatric opinion is useful when it describes the child's current difficulties without collapsing the child into either a legal category or a family story.

Child labour requires attention to the working environment, coercion, abuse and interrupted developmental opportunities. Adoption requires attention to the child's life narrative, relationships and questions of belonging. Neither permits casual assumptions: a working child may be silent without being symptom-free, and an adopted child may have difficulties that are neither caused by adoption nor explained by it.

LABOUR	ADOPTION	FORMULATION	CARE
CONTEXT AND RISK	NARRATIVE AND RELATIONSHIP	BEFORE LABELS	SAFETY WITH DIGNITY

35.1 Psychiatric frame for child labour

Child labour is clinically important not because it supplies a diagnosis, but because work may organise a child's daily life around demand, fatigue, fear, adult control and restricted access to ordinary supports. The consultation should therefore ask what the work means in this child's life. Is it described as contribution to the family, a source of pride, an obligation, a punishment, a means of survival, or an experience the child cannot safely discuss? The answer changes the formulation and the safety response.

The psychiatric task is not to decide the legal status of employment from a clinic interview. It is to identify mental-state symptoms, functional effects, coercion, maltreatment, available support and immediate danger. Symptoms are assessed as symptoms, while the circumstances in which they arose are explored carefully.

RULE **In a working child, formulate exposure and safety before attributing behaviour to character.** A difficult or guarded presentation can be an adaptation to threat, exhaustion, divided loyalties or a learned expectation that adults will not help. It should prompt careful enquiry rather than a moral judgement about the child or family.

A useful formulation separates linked questions:

- What does the child experience during and around work, including supervision, control, injuries, humiliation, threats and contact with adults?
- What is the present psychiatric picture, including distress, behaviour, cognition, sleep, physical symptoms and functioning across settings?
- What protective relationships and practical alternatives are available if the child discloses harm or cannot return to the same environment?

This prevents a common clinical collapse in which social hardship is treated as an explanation that ends assessment. Poverty may be relevant to why a child works, yet it does not make abuse, coercion or treatable distress inevitable or unimportant. Conversely, the presence of work does not establish a particular psychiatric disorder. The formulation must make room for agency and strengths as well as risk: a child may be caring for siblings, preserving school contact, seeking help, or relying on a trusted adult. These features can guide engagement and planning.

GOOD TO REMEMBER

Ask to speak with the child in a developmentally appropriate private setting when possible, while explaining the limits of confidentiality in plain language. The child should know that concern about safety may require the clinician to involve others; promises of absolute secrecy are unsafe and undermine trust when they cannot be kept.

35.2 What the evidence supports, and what it does not

Available multi-country evidence associates child labour with a **higher prevalence of mental and behavioural disorders** than among non-working children, and also links it with **one or**

more forms of abuse. This is an important clinical signal: the working situation should raise the threshold for complacency and make direct, sensitive enquiry essential.

Association is not a shortcut to individual causation. A child may have entered work after prior adversity, family illness, educational difficulty or displacement; the work setting may add new stressors; and symptoms may reflect several interacting pathways. In an examination answer, this is the difference between a contextual formulation and a slogan. The psychiatrist can state that work is a relevant exposure and then show how the child's own chronology, relationships, symptoms and protective factors support the formulation.

Chronology is particularly valuable. Explore what was present before work began, what changed after the work arrangement changed, and whether symptoms vary with particular people, places or demands. Ask about fear of going to work, ability to leave, payment or withholding of payment, access to food, rest, school and healthcare, injuries, sexual boundary violations, violence, and retaliation for disclosure. Use neutral language and avoid leading questions. If the child gives a partial account, do not turn the consultation into an interrogation. Clarify only what is needed for care and protection, document the child's words accurately, and link the child to the safeguarding response owned in the child-abuse management section.

TRAP **Do not diagnose trauma, conduct pathology or malingering from a work history alone.** The work history is a high-value contextual finding, not a substitute for psychiatric assessment. Over-attribution can miss unrelated illness; under-attribution can normalise danger.

CLINICAL QUESTION	WHY IT CHANGES THE FORMULATION	HOW TO RESPOND IN THE INTERVIEW
What is the child expected to do?	Task demands may explain fatigue, fear, injury or absence from ordinary settings.	Invite a concrete account without asking the child to justify the arrangement.
Who controls the work setting?	Control, surveillance and dependence shape both risk and freedom to disclose.	Explore trusted adults and whether the child can speak safely.
What changed in mood, behaviour or sleep?	A symptom timeline tests the proposed link without assuming it.	Ask for examples and variation across settings.
What happens if the child refuses or seeks help?	Retaliation risk determines how safely any plan can be made.	Do not encourage confrontation; activate appropriate protection pathways.
Who can provide immediate support?	Support figures are part of both risk assessment and recovery.	Map safe contacts with the child, not only with accompanying adults.

When a history suggests abuse or unsafe conditions, the clinician must not try to manage the case as a private therapeutic problem. Recognition, protection, reporting, referral and treatment are the clinical safeguarding response taught in the child-abuse management section. Child sexual

abuse assessment has its own forensic and psychiatric framework. General assessment should follow the chapter's Principles of child psychiatric history and examination.

IN INDIA

The principal statutory reference is **The Child and Adolescent Labour (Prohibition and Regulation) Act, 1986**. Its amendment record includes the **Child Labour (Prohibition and Regulation) Amendment Act**, enacted in **2016**. For the psychiatrist, the practical point is to recognise the statute as a protection context, while leaving legal interpretation and statutory procedure to the relevant legal and child-protection services.

35.3 Adoption as a developmental and relational context

Adoption should be approached as part of a child's personal and family narrative, not as a pathological event. The clinical question is not whether a child is adopted, but how adoption is understood, spoken about and lived within this family. A child may have questions about origins, separation, belonging, resemblance, loyalty, loss or difference. These questions can emerge indirectly through behaviour, schoolwork, peer relationships or conflict at home. They deserve curiosity rather than reassurance that closes the conversation.

Adoption communication openness matters because greater openness is linked to healthier family dynamics and more positive child adjustment. Openness is not merely a disclosure event. It is an ongoing family capacity to answer questions honestly at a level the child can use, to tolerate changing feelings, and to invite the child's perspective without demanding gratitude or emotional certainty. In practice, the clinician listens for whether the child is allowed to ask, whether parents can acknowledge what they do not know, and whether difficult feelings can be held without being interpreted as rejection.

There is a difference between privacy and secrecy. Families may reasonably protect personal information and decide how broadly to share it. Secrecy, however, can make the child responsible for managing adults' discomfort and can turn normal curiosity into a forbidden subject. Equally, disclosure delivered abruptly, as a weapon during conflict, or with excessive detail can overwhelm the child. The clinical aim is not to prescribe a uniform family script. It is to support a truthful, sensitive and revisitable conversation that matches the child's capacity and questions.

MNEMONIC

OPEN

Offer questions, **P**ace information, **E**xplore feelings, and **N**ame what is not known. This is a communication stance, not a rigid sequence or a test of parental adequacy.

Parents may fear that discussing adoption will destabilise the child or weaken attachment. That fear is understandable, particularly when family life has already included loss or uncertainty. The therapeutic conversation can make space for parental anxiety while retaining the child's right to experience and express mixed feelings. Help parents distinguish the child's question from an accusation. “Why was I adopted?” may be a question about belonging, origins, anger, grief,

fantasy or ordinary developmental curiosity. Its meaning must be explored with the child rather than supplied by an adult.

PITFALL

Do not treat a parent's discomfort with adoption talk as proof of poor parenting, or a child's curiosity as proof of psychopathology. Both may be understandable starting points for careful family work. The risk lies in shutting down the conversation, not in the existence of difficult questions.

35.4 Formulating difficulties in an adopted child

Attachment difficulties and **adoption-related attributions** can undermine self-esteem, identity, relationships and well-being. This directs attention to process rather than to a simplistic explanation that adoption itself caused the difficulty. A formulation asks what the child has inferred about self and others, what experiences sustain those inferences, how caregivers respond, and where the child finds safety, continuity and competence.

Some children may carry a painful personal explanation for separation or adoption, such as an idea that they were unwanted, defective, disloyal, or obliged to prove that they belong. Such meanings can influence mood, conflict, help-seeking and relationships, but they should not be assumed merely because the child was adopted. The psychiatrist should test the formulation against the child's language and behaviour, the caregivers' account, school context, current stressors and any relevant history available to the family. Where information is incomplete, say so and avoid inventing a coherent story on the child's behalf.

Work with the family often begins by strengthening reflective conversation. Caregivers can be helped to notice the feeling beneath an apparently provocative question or behaviour, respond without immediate correction, and return to the subject later if emotions are high. Individual work may offer the child a place to make sense of conflicting feelings without forcing disclosure to parents before the child is ready. Joint conversations can then be planned around a shared purpose: improving understanding, not extracting a confession or deciding whose version is correct.

The clinician should also resist diagnostic overshadowing. Adopted children can have the same range of psychiatric presentations as other children, and an adoption history should neither be ignored nor allowed to explain everything. Assess presenting symptoms and impairment using the general child psychiatric framework. Refer to the relevant disorder chapters when a disorder-specific assessment or treatment is indicated, including the Child behavioural, emotional and other disorders notes and the Intellectual disability and autism spectrum disorder notes.

RULE **Use adoption history to enlarge the formulation, never to replace it.** Adoption may shape meanings, relationships and the available narrative, but diagnostic reasoning still depends on the child's current presentation, developmental context and evidence from appropriate informants.

35.5 Boundaries, law and the psychiatrist's role

Psychiatrists frequently encounter adoption questions in situations of conflict, anxiety about disclosure, school difficulty, attachment concerns or a request for a certificate. The clinician's role is to assess mental health needs, support communication and document findings within competence. It is not to make unsupported predictions about family suitability, to validate an adult's account over another, or to convert a therapeutic formulation into a legal conclusion.

India's central regulatory reference is the **Adoption Regulations**, **2022**, notified on **23 September 2022**. Adoption law and the fitness of adoptive parents are addressed in the Mental health legislation and forensic psychiatry notes. In a clinical setting, the safest contribution is a clear account of symptoms, functioning, strengths, risks, interventions offered and the limits of the opinion.

TRAP **Do not confuse a therapeutic opinion with a legal fitness opinion.** A helpful account of a child's distress and family interaction does not by itself answer legal questions about adoption procedure or parental suitability. Stay within the referral question and state the limits of inference.

Child labour and adoption are formulation contexts: assess the child carefully, protect safety, and work with the meanings and relationships around the child without turning context into diagnosis.

36 · Bullying and its mental health consequences

Bullying is a clinical exposure, not merely a school-discipline problem. A child may present with distress or an apparently unexplained change in functioning while the peer context remains undisclosed. The psychiatrist's task is to make that context speakable, formulate its relation to the presenting difficulty, and ensure that risk is not missed. This is especially important when the child is ashamed, fears retaliation, has been told to ignore the behaviour, or assumes that adults will dismiss it as ordinary peer conflict.

This section concerns **bullying** and its mental-health consequences. It does not replace the assessment of the childhood disorders themselves, which is addressed in the Child behavioural, emotional and other disorders notes, nor the general child psychiatric assessment framework, which is addressed elsewhere in this chapter. The useful clinical question is not simply, “Has bullying occurred?” It is: what has happened to this child’s sense of safety, agency, belonging, self-appraisal, relationships, and capacity to function?

36.1 Defining the clinical exposure

Traditional bullying is not synonymous with every unpleasant peer interaction. Its defining structure is **intentional and repeated harm** in a relationship marked by a **power imbalance**. Power need not be overt; explore how it operates in the peer relationship and how it limits the target’s ability to stop or escape the pattern. An isolated disagreement can be distressing; bullying becomes a different kind of exposure when harm is organised around domination and recurrence.

Intentional	Repeated	Power	Digital channel
HARM IS DIRECTED	THE PATTERN PERSISTS	RESISTANCE IS CONSTRAINED	MAY EXTEND EXPOSURE

RULE **Call it bullying only after examining intent, repetition, and power.** This protects the child from minimisation while also preventing the term from becoming a label for all peer conflict. The distinction matters because a child caught in a power-imbalanced pattern may need a different level of protection, follow-through, and clinical attention than a child negotiating an isolated quarrel.

The child's account remains central, but it should not be treated as a forensic contest in the clinic. A child may describe a sequence rather than use the word "bullying." Ask for what happens before, during, and after contact with the peer group; who joins, watches, laughs, excludes, records, forwards, or remains silent; and what the child believes will happen if they tell an adult. This clarifies the lived structure of power without forcing a legalistic vocabulary on the child.

TRAP **Do not dismiss a pattern as "normal teasing" because the children sometimes exchange remarks.** Mutuality at the surface does not rule out a coercive pattern. The relevant question is whether a child is repeatedly positioned to absorb harm with less social power and less freedom to disengage.

36.2 Cyberbullying changes the setting, not the clinical seriousness

Cyberbullying refers to bullying conducted **over the Internet or by text message**. A complementary conduct-based description emphasises **online harassment, defamation, or intimidation intended to degrade, belittle, or harass**. These definitions are useful because they prevent a false split between "real-world" and digital harm. The medium changes how exposure is delivered and witnessed; the clinical work still concerns humiliation, threat, loss of control, and the effects of peer power.

CLINICAL AXIS	TRADITIONAL BULLYING	CYBERBULLYING
Setting	Peer harm in an in-person social environment	Online or text-message channel
Useful enquiry	Ask how the peer pattern operates around school, transport, activities, and friendships.	Ask how messages, posts, group interactions, images, or account access are affecting the child.
Clinical formulation	Attend to repeated harm and constrained escape.	Attend to the same peer-power process and to the child's experience of continuing access to the harm.
Common error	Reducing the account to a quarrel.	Reducing the account to "screen time" rather than interpersonal victimisation.

Digital material may create a painful sense that the audience cannot be contained. Even when the child cannot know who has seen something, anticipation itself can maintain vigilance, shame, and avoidance. Conversely, an adult who focuses only on the device can miss the relational

system: peers, bystanders, group allegiances, and the child's fear of social exclusion. The clinician should ask in ordinary language about where peer contact continues after school, rather than assuming that the child will volunteer this part of the story.

IN INDIA

A defensible prevalence figure for cyberbullying among school-going children and adolescents in India is **not established** by the material available for this section. Do not transfer a figure from a different population into child practice. The exam-safe and clinically honest position is to recognise cyberbullying as a relevant adolescent concern, enquire about it directly, and avoid unsupported numerical claims.

36.3 From victimisation to psychiatric presentation

Bullying can function as a continuing interpersonal stressor. Its psychological force is rarely captured by the visible incident alone. Repeated anticipation of ridicule or attack can reshape attention toward threat; public humiliation can alter self-appraisal; exclusion can turn ordinary school and peer settings into cues for alarm. A child may then look oppositional, withdrawn, "unmotivated," or preoccupied when the more coherent formulation is that they are trying to manage an unsafe social world.

Among Indian school-going children and adolescents who experience cyberbullying victimisation, reported mental-health consequences include **depression**, **anxiety**, and **low self-esteem**. These are not interchangeable outcomes. Each calls for a formulation that identifies the child's dominant experience and its functional impact, rather than treating "stress" as an adequate endpoint. This protects against the common error of using the bullying history as a substitute for understanding the actual psychiatric presentation.

Association is not automatic proof that bullying explains every symptom. Some children have pre-existing vulnerabilities, concurrent family adversity, neurodevelopmental differences, interpersonal difficulties, or an emerging disorder that changes both their peer experience and the way they report it. The appropriate stance is neither credulity without inquiry nor scepticism that makes disclosure impossible. Establish chronology, changes from the child's own baseline, the meaning the child assigns to the events, and whether symptoms fluctuate with contact or anticipated contact. This allows bullying to be placed in a formulation as a precipitant, perpetuating factor, consequence, or a combination of these.

GOOD TO REMEMBER

If the history includes **suicidal thoughts**, **self-harm**, or **suicidal-behaviour attempts**, assess current safety directly and act on the level of risk. Bullying may be the context that opens the conversation; it must not become a reason to postpone a full safety response.

36.4 The consultation: making disclosure possible and formulation useful

Children often test whether the clinician is going to minimise, sensationalise, or immediately take control away from them. Begin with a private, developmentally appropriate conversation when

possible, explain the limits of confidentiality in language the child can understand, and signal that the purpose of questions is protection and help rather than punishment. The child may be loyal to peers, worried about being labelled a complainant, or frightened that adults will make an intervention that increases retaliation. These concerns are clinical data, not resistance to be argued away.

- Invite a narrative: what happened, who was involved, what the child did, and what followed.
- Ask about avoidance, distress before peer contact, changes in self-talk, and the child's sense of safety.
- Ask directly about thoughts of death, self-harm, and harm to others when the presentation indicates risk.
- Clarify what the child wants adults to understand and what outcome they fear most.

Collateral accounts can add context, but they are not a mechanism for overriding the child. Parents may notice changes without knowing their meaning. Teachers may see a social interaction but not the private messages or the group dynamics surrounding it. A careful record separates reported events, observed mental state, collateral information, and the clinician's formulation. This makes later communication clearer and protects against the common drift from a child's narrative into an adult's assumption about what "really happened."

PITFALL

Do not make the consultation a demand for screenshots, perfect chronology, or immediate corroboration before offering containment. A distressed child may have deleted material, avoided looking at it, or be unable to recount it in a linear way. Clinical care begins with safety, validation, and careful inquiry; where safety requires wider action, use the applicable local pathway.

36.5 Treatment principles: restore agency without narrowing the problem

Treatment should address the child's symptoms, meaning-making, and social context. Validation is not the same as confirming every unverified detail; it means communicating that the distress is intelligible and worthy of help. Work can help a child name emotions, notice shame-based or hopeless conclusions about the self, distinguish danger cues from global expectations of rejection, and rebuild activities and relationships that have contracted around fear. The exact psychological intervention is selected according to the child's presentation and developmental capacity, not according to the label of bullying alone.

Parents need help to move between opposing unhelpful poles: dismissive reassurance and intrusive takeover. They can communicate belief in the child's distress, keep communication open, monitor changes in safety, and participate in a proportionate plan. Where school involvement is needed, clinical communication should be purposeful: describe functional impact and the need for a safe response, while sharing only what is necessary. This section remains focused on the psychiatric consequences for the individual child rather than on programme design.

MNEMONIC

PAUSE

Privacy for disclosure, **A**cknowledge distress, **U**nderstand the peer-power pattern, **S**creen for safety, and **E**ngage the child and caregivers in a proportionate plan. It is a consultation spine, not a substitute for assessment or safeguarding procedures.

Medication is not a treatment for bullying itself. When a child has a psychiatric syndrome requiring treatment, prescribe and monitor according to the relevant disorder guidance and the child psychopharmacology sections of this chapter. Avoid using a medicine decision as a way of bypassing an unresolved exposure. Equally, do not withhold indicated treatment on the theory that changing the peer environment alone will resolve every symptom. A good formulation keeps both the clinical syndrome and the social stressor in view.

36.6 Risk, documentation, and the candidate's clinical answer

Risk is dynamic. Escalating humiliation, threatened exposure, social isolation, hopelessness, a recent self-harm act, or a child's belief that there is no safe adult can alter urgency. Ask about what keeps the child going as well as what increases danger: a trusted relationship, a valued role, future plans, or willingness to accept help may inform the immediate plan. Do not promise secrecy that cannot be maintained if safety requires adult action, but do explain in advance, as far as possible, what information may need to be shared and why.

The record should make clinical reasoning visible. Document the child's words where they clarify meaning, the pattern alleged, the mental-health effects, the risk inquiry, relevant collateral, protective factors, and the agreed next steps. Avoid pejorative shorthand such as "attention seeking" or "peer issue." Such language prematurely closes formulation and may influence later professionals to underestimate a potentially serious exposure.

Bullying is defined by intentional, repeated harm and a power imbalance; when it is disclosed, assess its psychiatric impact and current safety rather than treating it as routine peer conflict.

Cross-cutting synthesis

37 · Cross-cutting synthesis

Why the synthesis matters. A child does not arrive in separate assessment, prescribing, therapy, service and protection compartments. The clinician must make one coherent plan from information that arrives at different times, from different people, and sometimes in conditions of risk. Marks are earned here by showing the movement from one domain to the next: not merely naming each domain, but explaining why a finding in one changes the action in another.

The organising question is not, "Which intervention belongs to which discipline?" It is, "What must change for this child, what could prevent that change, and who must know what next?" A

clinical formulation is useful only when it guides the next decision and remains open to revision. The parts of care must **interlock**: assessment directs the initial plan; prescribing creates observation duties; observation may reveal risk; protection obligations alter the order of care; and service access determines whether psychological work can actually be delivered.

FORMULATION	PRESCRIBING	PROTECTION	SERVICES
WHAT CHANGES	WHAT TO WATCH	WHAT MUST HAPPEN	WHAT IS POSSIBLE

37.1 Begin with the decision, not the silo

The assessment is not a prelude that ends when treatment begins. It establishes the decision that has to be made now, the information on which that decision rests, and the information that could reverse it. The general child psychiatric assessment framework, interviewing, developmental testing, screening, rating tools and neuropsychological assessment are taught in their respective sections. Their synthesis value lies in converting their findings into a shared account of the child's difficulties, capacities, relationships, daily setting and immediate risks.

At this point, the clinician should distinguish a **presenting complaint** from a **treatment target**. The former is the concern brought by the family, school or another agency. The latter is the change that the current plan can reasonably try to produce. If the account is incomplete, contradictory, or shaped by an unsafe setting, the correct response may be to clarify the formulation before choosing an intervention. This is not therapeutic delay for its own sake; it prevents an apparently efficient plan from treating the wrong problem or placing an impossible burden on the child.

RULE **Every intervention must answer a question raised by the formulation.** If a proposed intervention cannot be linked to a stated target, a relevant risk or a feasible route of delivery, it is a habit rather than a plan.

- State what the current assessment permits the team to act on.
- State what uncertainty needs follow-up rather than concealment.
- State which person or setting can confirm whether the intended change is occurring.

37.2 Let assessment alter the prescribing decision

Child prescribing is not a detachable response to a label. Its principles, developmental considerations, drug-specific practice, off-label questions and consent framework belong to the psychopharmacology sections. The cross-cutting task is to make the assessment visible in the prescribing decision. A child's developmental communication, physical health context, pattern of impairment, family understanding, competing explanations for change and access to follow-up can each determine whether medication is appropriate now, whether another intervention must lead, or whether a proposed trial needs to wait for safer clarification.

A prescription therefore carries a **clinical rationale**, not merely an instruction. The rationale identifies the target, the anticipated observation and the contingency if the observed course does not fit the formulation. It protects against the common drift in which a medicine becomes the

whole plan because it is the most concrete action available. Psychological intervention, educational support and family work do not become optional simply because medication has been considered. Conversely, therapy should not be presented as a substitute for a review when assessment indicates that a prescribing question requires one.

ASSESSMENT CONCLUSION	HANDOFF TO THE PRESCRIBING PLAN	QUESTION RETURNED TO FOLLOW-UP
The target problem is clear	Link the intervention to that target	Is the intended change visible in ordinary life?
The account remains uncertain	Preserve uncertainty in the plan	What new information would change the decision?
Family or setting constraints are prominent	Test whether the plan can be carried out safely	Who can observe and communicate concerns?
Risk is present or emerging	Reorder care around safety and protection	Has the required pathway been activated?

PITFALL

Do not write “assessment completed, medication started” as though the first phrase has no bearing on the second. That wording hides the formulation, makes later review arbitrary and can obscure why a non-pharmacological or protective action was prioritised.

37.3 Treat monitoring as a new source of assessment

Once a prescribing decision is made, monitoring is not an administrative afterthought. The detailed monitoring-and-consent framework and drug-specific schedules are taught elsewhere. In the integrated plan, follow-up is a **monitoring loop**: it asks whether the target changed, whether the child’s functioning changed in the settings that matter, whether an unwanted effect or new difficulty has appeared, and whether the caregivers can still implement the plan they agreed to.

This loop can validate the original formulation, qualify it, or expose that the team has been looking at only one part of the child’s life. A change reported by one adult may have a different meaning when connected with the child’s own account, school experience, peer context or home atmosphere. The clinician should neither dismiss discordant accounts as nuisance nor automatically average them into a false consensus. Disagreement is often the handoff back to assessment: it identifies where further understanding is needed before escalating, continuing or changing treatment.

The record should make responsibility visible. It should show what is being watched, how the family can raise a concern, and what event requires earlier contact or a change in the plan. This is a continuity task, not a demand that one clinician personally observe every setting. The plan is safe only if its observers understand their role and the team knows how information will return.

GOOD TO REMEMBER

A useful review question is not simply whether the child is "better." Ask whether the observed change supports the working formulation and whether it has made the child safer, more able to participate, or more reachable for the next intervention.

37.4 Allow monitoring to surface safeguarding concerns

Follow-up sometimes reveals more than response to treatment. New information may become a **safeguarding signal**. The types and indicators of abuse, child sexual abuse assessment, and the clinical response to abuse are taught in the protection sections. The synthesis point is that a new concern is not a reason to defer attention until the next routine assessment. It changes the clinical task immediately from simple treatment review to safety-oriented decision-making.

At that seam, the clinician should separate two questions that are often mistakenly fused. One question is what is needed for the child's current mental health care. The other is what must be done because the information raises a safeguarding concern. Treatment uncertainty does not cancel a protection concern, and a protection process does not remove the need to address distress, functioning and engagement. They proceed in a coordinated order, with the child's safety setting the limit on what can be attempted therapeutically.

TRAP **Do not wait for clinical certainty before recognising a possible statutory pathway.** A diagnostic formulation and a safeguarding response answer different questions; confusing them can leave the child without timely protection.

- Reclassify the contact as a potential safety handoff, not only a treatment review.
- Use the relevant protection and reporting route without turning the clinic visit into an improvised investigation.
- Keep a clinical route of contact while the necessary services take their part.

37.5 Put statutory duty beside, not after, treatment

Where a safeguarding concern triggers a **statutory pathway**, the legal duty and child-friendly procedures are governed by the child-protection and juvenile-justice sections of this chapter. The psychiatrist's synthesis task is to ensure that the legal and clinical tracks are connected without allowing either to swallow the other. The protection handoff should tell the receiving service what is known clinically, what requires urgent attention, and how further contact can be made without increasing risk to the child.

Protection also changes the therapeutic frame. A child cannot be asked to practise trust, regulation, disclosure or family communication in a plan that ignores an unsafe relationship or setting. The immediate work may need to focus on stabilisation, engagement and safe contact while the appropriate statutory and service responses proceed. This is not a lesser form of therapy. It is the precondition for therapy that has a realistic chance of being used.

IN INDIA

An integrated plan must connect the clinical team with the relevant local child-protection and child-development services rather than treating referral as a discharge destination. The statutory route, protection response and national service platforms are set out in the dedicated sections; the psychiatrist's role here is to maintain a clear clinical handoff and a continuing treatment plan.

37.6 Make service fit part of the treatment formulation

Therapy is delivered through a child's actual environment, not through the referral letter. Play therapy, behavioural work and parent management, family interventions, cognitive behaviour therapy, educational intervention and early intervention are taught in their own sections. Their feasibility depends on a **service fit**: whether the child can attend, whether a caregiver can participate, whether the school can support a consistent plan, whether communication is possible across professionals, and whether protection arrangements permit the proposed work.

Services are therefore active parts of treatment. A school mental-health pathway may make observation and support possible. A child-development platform may make developmental, family or educational work reachable. A referral to protection services may create the safety and continuity without which therapy cannot proceed. The relevant Indian service platforms are described in the sections on school mental health, the child health screening programme and child-development services. The synthesis is to decide which service changes the child's ordinary environment enough for treatment to become practicable.

The handoff must be specific in purpose even when it is brief: what has been assessed, what the receiving service is being asked to do, what information may be shared, and when the clinical team will reassess the plan. A generic referral transfers neither reasoning nor responsibility. It also leaves families to coordinate systems that were designed for professionals to navigate.

MNEMONIC

TRACE

Track the formulation, **R**elate each intervention to its target, **A**ct on new risk information, **C**onnect statutory and service pathways, and **E**nable the therapeutic work that the child can actually use.

37.7 Close the loop without closing the formulation

Integrated care is iterative. Each contact should return the team to the same chain: current formulation, chosen intervention, observed consequence, new risk information, service capacity and revised plan. The purpose is not paperwork completeness. It is to prevent a child from being lost at the seams - assessed but not followed up, prescribed for but not understood, referred but not treated, protected but then left without recovery-oriented care.

Childhood disorders themselves are cross-referred to the Child behavioural, emotional and other disorders notes; ADHD and its treatment to the ADHD and specific learning/communication disorders notes; intellectual disability and autism spectrum disorder to the Intellectual disability

and autism spectrum disorder notes; and temperament and developmental expectations to the Normal child development and milestones notes. Questions of general criminal responsibility, the Mental Healthcare Act and adult forensic assessment belong to the Mental health legislation and forensic psychiatry notes. These boundaries matter because an integrated plan is not a licence to repeat every domain. It is the disciplined account of how each domain changes the next clinical move.

> The best child psychiatry plan is a visible chain of handoffs: assessment informs treatment, treatment generates monitoring, monitoring can activate protection, and services make recovery work possible.

Apply and consolidate

38 · Applying the chapter

Why these cases matter. A child psychiatry vignette tests whether the candidate can make a safe next move when the story is incomplete. The marks lie in showing a disciplined sequence: hear the child and family, identify what needs deciding now, state the information that changes that decision, and connect the child to the right help. It is not an invitation to display a long differential diagnosis or to recite a service manual.

In a standalone answer, the **clinical formulation** is the bridge between a child's presentation and an action. It keeps symptoms, development, relationships, school context, physical health, risk and strengths in the same frame. The diagnosis may be part of clinician reasoning where appropriate, but it is not a label to be delivered to the child or family in the answer. Explain the difficulties and the proposed help in language they can use.

PRESCRIBE	ASSESS	LINK	PROTECT
ONLY AFTER A DECISION FRAME	ACROSS INFORMANTS AND SETTINGS	NEEDS TO USABLE SERVICES	WHEN DISCLOSURE CHANGES SAFETY

38.1 Reading and writing a clinical vignette

A good response begins by locating the decision point. The presenting complaint is often deliberately noisy: a school concern may conceal unmet learning needs, a request for medicine may be a request for containment, and a disclosure may be offered after the child has tested whether the clinician is safe to tell. The candidate should neither flatten this complexity into a label nor become so comprehensive that the urgent decision disappears.

DOMAIN IN THE STEM	WHAT THE ANSWER MUST SHOW	SAFE CLOSING ACTION
Request for a medicine	What is being treated, what has already been tried, and whether benefit, harm and agreement can be reviewed	A reasoned prescribing decision with planned follow-up
Concern about behaviour or progress	Child's account, developmental context, functioning, observations and accounts from relevant settings	A focused assessment plan and feedback formulation
Family unable to sustain care	Which participation barrier matters most and which agency can address it	A coordinated referral with responsibility for follow-through
Possible abuse or exploitation	Immediate safety, a careful response to disclosure, documentation and the safeguarding pathway	Protection, statutory action and therapeutic support

The following vignette answers use the same spine.

- Name the immediate decision rather than merely naming a condition.
- Give the clinical reasoning that would change the decision.
- End with an action, communication plan and review responsibility.

RULE **Answer the decision in front of you, then show why it is safe.** A broad formulation earns its place only when it clarifies the next action for this child, in this setting, with this family.

MNEMONIC

PAST: Pause, Assess, Support, Take action to protect

Use this as the closing spine of a vignette. **Pause** before reflex prescribing; **Assess** the child in context; **Support** the child through family, school and services; and **Take action to protect** when safety is in question. It is a reasoning aid, not a substitute for the detailed frameworks elsewhere in the chapter.

38.2 A prescribing decision when the family wants a quick answer

Presentation. A school-aged child is brought after repeated complaints of restlessness, conflict and incomplete work. The parent asks for a medicine because the school has said that the child must "settle down". The child looks exhausted, says that lessons feel impossible when classmates mock the errors, and reports sleeping poorly. The parent is angry with the school and expects a prescription at the end of the visit.

Decision point. Should the clinician start or change a psychotropic medicine at this consultation?

Reasoning the candidate must show. The request for medication is not yet a prescribing indication. The clinician needs to distinguish a persistent pattern from a recent contextual

change, understand the child's experience as well as the parent's account, and ask what happens across home, school and other settings. The answer should identify sleep, distress, peer experiences, learning demands, physical contributors, safety and previous interventions as information that could alter the formulation. It should also establish what the family understands and what the child is willing to discuss, rather than treating the child as a passive recipient of an adult decision.

The relevant **prescribing frame** is then applied, not reproduced from memory. If a medicine is contemplated, its target difficulties, expected benefit, possible unwanted effects, consent and assent process, and route for review must be made explicit. If the available account is too incomplete to support a safe choice, delaying the prescription is an active clinical decision, not therapeutic neglect. A clinician may still address immediate distress, coordinate with the school and arrange prompt reassessment while the assessment proceeds.

Answer. Do not prescribe simply to meet the school's demand. Complete a focused multi-setting assessment and discuss the formulation with the child and parent in plain language: "We need to understand what is making school so difficult before deciding whether medicine would help." Offer practical interim support, obtain the information required for a safe decision, and return to treatment selection using the child-prescribing and monitoring frameworks. If the eventual formulation concerns ADHD, its stimulant and non-stimulant treatment belongs in *the ADHD and specific learning/communication disorders notes*; if it concerns another childhood disorder, consult *the Child behavioural, emotional and other disorders notes*.

> **GOOD TO REMEMBER**
>
> A child's reluctance, a parent's urgency and a school's request are all clinical data. None alone decides the prescription. The interview should leave the family with a comprehensible plan even when the medicine decision is deferred.

38.3 An assessment when the accounts do not agree

Presentation. A child is referred because teachers describe disruptive behaviour and falling classroom performance. At home, the caregiver sees a quiet child who spends long periods drawing and has few arguments. In the interview, the child speaks little at first, then says that school feels frightening and that adults assume deliberate defiance. The referral letter asks for a "test" to establish what is wrong.

Decision point. What assessment should be arranged, and how should the disagreement between adults be handled?

Reasoning the candidate must show. Contradictory accounts are not a reason to choose the most authoritative informant. They are a finding that requires explanation. The candidate should seek a **multi-informant assessment**: the child's own narrative, developmental and medical history, caregiver observations, school examples, direct clinical observation, and information about functioning in relevant environments. The question is not whether either adult is correct

but what differs between settings: task demands, relationships, communication expectations, sensory load, peer safety, family stress or the way behaviour is interpreted.

Assessment must be purposeful. A developmental, adaptive, educational or neuropsychological evaluation is chosen only when it answers a formulation question that cannot otherwise be answered. A score should not replace the child's history or be used as a verdict. The candidate should describe the **functional impact** that needs clarifying - participation in learning, relationships, self-care, play, emotional regulation or daily routines - without importing cut-offs or proprietary test content. The child's strengths, including the sustained interest in drawing, matter because they can shape engagement and school planning.

Answer. Explain to the caregiver and school that the assessment will bring together accounts rather than declare either side wrong. Obtain examples of antecedents, behaviour and consequences in each setting; interview and observe the child in an age-appropriate way; review development and health; and select further testing only for a defined question. Feed back a shared formulation that describes needs and strengths without naming a diagnosis to the child or family. For the general assessment framework, see the chapter section on child psychiatric history and examination; for developmental and adaptive screening, and for the formal test batteries, use the relevant assessment sections. Intellectual disability and autism spectrum disorder are addressed in *the Intellectual disability and autism spectrum disorder notes*, and developmental expectations belong in *the Normal child development and milestones notes*.

TRAP **Do not turn a request for "a test" into a test-led assessment.** Instruments answer selected questions; they do not reconcile conflicting accounts, establish context or determine what the child and family need next.

38.4 A services referral that must be more than a name on paper

Presentation. A child has attended intermittently after a recent family disruption. The caregiver can travel only with difficulty, the school is considering exclusion, and a relative says that the family should seek a disability certificate before accepting any other help. The child wants to remain with familiar peers but says that nobody has explained what support might be possible. The immediate symptoms have been discussed, yet attendance and participation remain fragile.

Decision point. Is a generic referral enough, or does the clinician need to build a **service map** around the child's actual barriers?

Reasoning the candidate must show. Referral is a clinical intervention only when it reaches a service that can act on the stated problem. The candidate should identify the bottleneck: access to care, educational participation, family support, therapeutic work, social protection, transport, communication between agencies or an unrecognised safeguarding concern. A certificate may be relevant to future entitlements, but it is not a substitute for asking what will help the child participate now. Likewise, sending the family to multiple agencies without a named purpose transfers the coordination burden to the person least able to carry it.

The referral should link mental-health care with the child's everyday setting. This may include discussion with school, educational assessment and support, family intervention, developmental services, community follow-up or a social-work response, according to the formulation. The clinician remains responsible for making the reason for referral clear, obtaining appropriate agreement to share information, and checking whether the connection occurred. The child should hear a practical explanation: "We are asking these people to help make school and home more manageable," rather than a diagnostic label.

Answer. Make a coordinated referral plan with the caregiver and child. State the target for each contact, identify who will communicate with school, arrange follow-up that reviews participation rather than only symptoms, and address barriers that would make the plan fail. Use the chapter's sections on school mental health, RBSK and ICDS to select the appropriate Indian platform rather than treating services as interchangeable. If the child is at risk of harm or lacks safe care, move to the protection pathway instead of leaving that concern inside a routine referral.

IN INDIA

Families often encounter school, health, developmental and welfare systems as separate doors. The clinical task is to translate a formulation into a coordinated request that each service can understand, while retaining the family's voice and the child's participation.

38.5 A child-protection disclosure in the consultation room

Presentation. During a review attended by a caregiver, an adolescent asks to speak alone. The young person then describes unwanted sexual contact by someone known to the family and asks the psychiatrist not to tell anyone, fearing blame and disruption at home. There is no visible injury at the consultation. The caregiver outside has been pressing for medication because the adolescent has become withdrawn and irritable.

Decision point. How should the clinician respond in the room, and what must happen next?

Reasoning the candidate must show. The immediate task is a **safeguarding response**, not diagnostic classification and not an attempt to prove the account during a routine psychiatric interview. Thank the young person for telling, respond calmly, and avoid leading questions or repeated detailed questioning. Explain the limit of confidentiality honestly: the clinician will involve the appropriate people to help keep the young person safe. Assess immediate danger, identify whether a safe adult and safe place are available, and document the disclosure accurately in the child's own words as far as possible.

The candidate must then activate the hospital child-protection process and the applicable POCSO reporting and child-friendly care pathway. The response includes protection, medical and forensic referral where indicated, and ongoing mental-health support. A visible injury is not required for the disclosure to be taken seriously; equally, the clinician's role is not to make an evidentiary finding before seeking protection. Communication with the caregiver must be planned around safety, the child's wishes where they can be respected, and the statutory process.

Do not name a psychiatric diagnosis to the adolescent or family; describe distress as an understandable response and explain the supports being arranged.

Answer. Remain with the young person, ensure immediate safety, explain the next steps without making promises that cannot be kept, document carefully and initiate the safeguarding, reporting and referral pathway without delay for certainty. Arrange continuity of therapeutic support after the acute response. The detailed clinical response to abuse is in the child-abuse management section, and the statutory duties and procedures are in the POCSO section. General criminal responsibility and adult forensic assessment belong in *the Mental health legislation and forensic psychiatry notes*.

1. Listen without interrogation and acknowledge the disclosure.
2. Make safety, protection and accurate documentation the immediate priorities.
3. Use the formal safeguarding pathway while preserving therapeutic continuity.

PITFALL

Never promise absolute secrecy before hearing what the child needs to say. A promise that must later be broken can feel like a second betrayal. State privacy and its safety limits early, then explain each necessary disclosure as transparently as possible.

In every vignette, show the child's experience, the decision that cannot wait, the reasoning that makes it safe, and the person who will carry the next action.

39 · Consolidation

The final task is not to reread the chapter, but to retrieve it. A child psychiatry answer becomes clinically useful only when the candidate can recognise which part of the system is being tested, select the relevant frame, and state the next defensible action without being handed a menu. This closing section turns the chapter into an active recall exercise. The prompts are deliberately answer-free: pause, write or say the answer, then return to the relevant section only to correct what was missed.

Retrieval is more demanding than recognition. A familiar heading may create the impression of mastery while leaving the clinician unable to organise an assessment, explain a prescription, locate an appropriate service, or respond safely to a disclosure. Use each prompt to construct a brief **problem representation**: what is happening, whose account is needed, what decision is pending, and what could be unsafe if delayed. That habit integrates the chapter without turning its separate components into a blurred checklist.

PRESCRIBE	ASSESS	TREAT	PROTECT
RECALL THE FRAME	RECALL THE SOURCES	RECALL THE FIT	RECALL THE RESPONSE

39.1 How to use the closing prompts

A useful **retrieval cue** names a decision, not merely a heading. Before answering, decide whether the question is principally about prescribing, assessment, psychological intervention, access to support, or safety. Several domains can be relevant, but identify the domain that sets the immediate **decision threshold**. State that priority at the outset, then bring in adjacent domains only where they change the decision.

RULE **Retrieve the clinical action before reopening the text.** The point of review is to detect a gap in reasoning, not to replace reasoning with recognition. A short spoken answer is sufficient when it includes the child, the caregivers, the setting and the immediate clinical responsibility.

Do not treat a weak answer as a reason to copy a paragraph. Identify the missing link instead. It may be an absent informant, an unasked developmental question, a poorly matched intervention, an overlooked school or community pathway, or a safety obligation that should have changed the order of events. Revisit that missing link and attempt the prompt again after an interval. This makes uncertainty visible early, when it is still easy to repair.

- Answer from memory in complete clinical sentences before checking the chapter.
- When your answer is incomplete, label the missing step rather than memorising isolated phrases.
- Use the next patient encounter to test whether the recalled framework changes what you ask, document or arrange.

PITFALL

Passive rereading can feel fluent because the wording is familiar. It does not show whether you can choose between competing priorities when a child, caregiver, school and service system each provide only part of the picture.

39.2 Master spine for the chapter

The chapter can be held together by **PATS**. It is a navigation cue rather than a substitute for the detailed sections. On every revision pass, ask whether the case needs a prescribing frame, an assessment frame, a therapy frame, a service frame, or a safeguarding frame. The same child may require several of these, but the mnemonic prevents a familiar diagnosis from crowding out the surrounding system of care.

MNEMONIC

PATS: Prescribing, Assessment, Therapy, Services, Safeguarding

Use the mnemonic to scan the chapter's linked domains. It is a prompt to ask what remains unaddressed, not a claim that every child needs every component at every encounter.

Why this matters in practice. A technically correct intervention may still fail if it is not grounded in a credible assessment, understood by the caregiving system, workable in the child's everyday setting, or safe to deliver. Conversely, a protection concern can change the sequence of

care even when a therapeutic plan is otherwise sound. The clinical skill is **cross-setting transfer**: carrying the formulation from the consultation room into family, school, community and protection contexts without losing the child's perspective.

GOOD TO REMEMBER

When a case feels complicated, do not add interventions indiscriminately. First ask which PATS domain is driving immediate risk or impairment, then identify the relevant collaborator or setting that must be brought into the plan.

39.3 Answer-free active recall prompts

Attempt the following without looking back. They are written as questions because the act of retrieval is the device. Do not convert the table into model answers: the value lies in exposing what cannot yet be reconstructed from memory.

CLINICAL DOMAIN	RETRIEVAL PROMPT	SELF-CHECK AFTER RECALLING
Pharmacology	Before initiating or changing a psychotropic medicine for a child, what prescribing, developmental, communication, monitoring and follow-up questions must you answer?	Have you distinguished the treatment decision from the wider monitoring-and-consent framework?
Assessment	How would you construct a child psychiatric assessment when accounts from the child, caregivers and other settings do not fully agree?	Did you include developmental context, direct observation and the appropriate role of structured tools?
Therapy	How would you choose and adapt psychological work when the child's needs, caregiver capacity and educational setting pull in different directions?	Have you explained why the chosen approach fits rather than simply named a therapy?
Services	What local health, school and community pathways could support a child whose needs cannot be met by a clinic appointment alone?	Can you describe how referral, collaboration and continuity would work in the child's setting?
Protection	When concern, injury, neglect or a disclosure raises a child-protection question, what must determine the immediate sequence of clinical action?	Have you separated recognition, safety, documentation, reporting, referral and therapeutic follow-through?

IN INDIA

For each services and protection prompt, practise naming the locally available pathway as well as the clinical rationale for using it. A generic referral answer is incomplete if it does not show how the child and caregivers will reach, understand and remain connected with support.

TRAP **Do not answer a systems question by reciting a disorder formulation alone.** The question may begin with symptoms, but marks and patient safety often turn on the next assessment source, treatment adaptation, service link or safeguarding responsibility.

39.4 Consolidating clinical judgement

The strongest final answer does not list every resource available to a child. It explains why a priority action comes first and how the rest of the plan follows. A **safeguarding lens** is especially important: it asks whether the ordinary pace of assessment or treatment is appropriate when safety, coercion, neglect or exploitation may be present. That lens does not replace clinical formulation. It determines whether the formulation can safely be acted upon.

For revision, convert each missed prompt into a small plan for re-learning. Return to the relevant section, identify the rule or distinction you failed to retrieve, and rehearse it in a fresh scenario. Then use PATS to check that the new answer still respects the child's developmental position, the caregiver relationship and the realities of the setting. This is how a chapter on systems becomes a method of practice rather than a collection of headings.

Before you close a child psychiatry case, ask: what must be prescribed, assessed, treated, connected and protected?

Previously asked

Genuine past questions from this chapter's territory, with their board of origin. One catalogued theory question falls inside child psychopharmacology, the child assessment battery, the therapeutic interventions, the service and policy context, or child protection and juvenile justice, and it is printed below exactly as it was set. No question is reconstructed, paraphrased into a new one, or invented to pad the list. The catalogue behind this list is a single board's record and is not a complete account of what has been asked, still less of what may be asked.

QUESTION	MARKS	ASKED
Play therapy	10	MUHS 2013

The shape of that question is worth reading closely. It is a bare noun phrase carrying ten marks, which is the examiner asking for a structured account rather than a definition: what play therapy is and why play is the medium, the non-directive and directive traditions, the technique, the indications and the limits, and the evidence. A candidate who writes four lines on what play therapy means has answered a two-mark question that was not asked.

TRAP **An unasked topic is not a low-yield topic.** The absence of a past essay is a fact about one board's recent papers, not about what an examiner may ask this year. This chapter carries two bodies of material that are examined far more often than the catalogue above suggests, because they are asked in the viva and as short notes rather than as set-piece essays: the paediatric doses, each scoped to its population and its indication, and the statutory duties under the child-protection and juvenile-justice framework. Prepare the discriminations, the doses and the statute, not the past paper.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, lifted verbatim from the section that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Doses are deliberately not restated in this table; a dose is a fact about an indication in a population and belongs with the whole regimen where it is taught.

ASK	HOLD
CHILD PSYCHOPHARMACOLOGY	
PRINCIPLES OF PRESCRIBING PSYCHOTROPICS IN CHILDREN	A child psychotropic prescription is justified by a clear target, a developmental formulation, a proportionate place in the plan and an accountable review process.
DEVELOPMENTAL PHARMACOKINETICS AND PHARMACODYNAMICS IN CHILDREN	In child psychopharmacology, developmental physiology changes the path from prescribed amount to clinical effect, so dose, concentration and response must never be treated as interchangeable.
STIMULANTS IN CHILDREN	Stimulant safety follow-up is longitudinal: periodically record physical parameters, review real-world function, and investigate new concerns before deciding what they mean.
ANTIPSYCHOTICS IN CHILDREN	An antipsychotic prescription for a child is complete only when its target symptom, indication-specific scope, and metabolic monitoring plan can all be read from the clinical record.
ANTIDEPRESSANTS IN CHILDREN	Write the whole regimen sentence: medicine, child population, indication, start, schedule, titration, target, and ceiling statement.
MOOD STABILIZERS IN CHILDREN AND ADOLESCENTS	For paediatric mood stabilisers, the safe answer is the whole regimen: indication, population, dose pathway, ceiling, and monitoring - never the milligram figure alone.
MONITORING AND CONSENT ISSUES IN CHILD PSYCHOPHARMACOLOGY	Monitor the medicine, the child's functioning, and the family's understanding; consent is a continuing clinical conversation, not a form completed before treatment begins.

ASK	HOLD
OFF-LABEL PRESCRIBING, DOSING PRINCIPLES AND START-LOW GO-SLOW IN CHILDREN	Off-label prescribing in children is justified by an explicit individual rationale, transparent discussion, conservative initiation, gradual titration, and review against a pre-defined target.
ASSESSMENT AND RATING TOOLS	
PRINCIPLES OF CHILD PSYCHIATRIC HISTORY AND EXAMINATION	A child psychiatric assessment is credible when developmental history, direct mental-state observation and collateral accounts are integrated without allowing any single source to stand for the child.
PLAY ASSESSMENT AND INTERVIEWING CHILDREN	Use play to open and observe the child's world; use corroboration to decide what the observation means.
DEVELOPMENTAL AND IQ TESTS	Choose the test by the question, interpret the child's performance in context, and never let a score do more clinical work than the assessment can support.
ADAPTIVE AND DEVELOPMENTAL SCREENING	A developmental or adaptive screen is useful only when its pattern is interpreted in context and used to decide the next clinical step.
BROAD-BAND RATING SCALES	A broad-band rating scale is most useful when its score is interpreted as one informant's structured account within a full clinical formulation.
PROJECTIVE TESTS IN CHILDREN	Projective tests can deepen a child assessment only when their observations are kept tentative, explored with the child, and corroborated elsewhere.
MULTIAXIAL AND MULTI-INFORMANT ASSESSMENT IN CHILD PSYCHIATRY	Multiaxial formulation preserves the distinction between symptoms, context, physical health, development, and disability so that clinical planning addresses the whole child.
NEUROPSYCHOLOGICAL ASSESSMENT OF CHILDREN	Neuropsychological assessment is most useful when it explains a functional difficulty through a coherent cognitive profile and turns that explanation into supports that can be tested in the child's real environment.
THERAPEUTIC INTERVENTIONS	
PLAY THERAPY	Play therapy is a formulated therapeutic relationship in which play helps the child express, explore and work through difficulty; the therapist follows or directs the medium only as the clinical task requires.
BEHAVIOUR THERAPY AND PARENT MANAGEMENT TRAINING IN CHILDREN	Formulate the sequence, strengthen the behaviour you want repeated, and help caregivers respond predictably enough that escalation no longer becomes the easiest route out of conflict.
FAMILY THERAPY AND FAMILY INTERVENTIONS IN CHILD PSYCHIATRY	Family intervention changes the conditions around a child's difficulty by helping the family see, test, and sustain a safer and more workable pattern of care.
COGNITIVE BEHAVIOUR THERAPY AND ADAPTATIONS FOR CHILDREN AND ADOLESCENTS	Developmentally adapted CBT keeps the formulation and therapeutic aim intact while changing the route by which the child can understand, practise and own the work.

ASK	HOLD
SPECIAL EDUCATION AND REMEDIAL AND EDUCATIONAL INTERVENTIONS	The educational prescription is complete only when it names the barrier, the support, the responsible partner and the route for review.
EARLY INTERVENTION AND STIMULATION PROGRAMMES	Early intervention succeeds when a child gains meaningful participation through repeated, enjoyable opportunities that caregivers can realistically sustain.
EPIDEMIOLOGY, SERVICES AND NATIONAL CONTEXT	
EPIDEMIOLOGY OF CHILD PSYCHIATRIC DISORDERS IN INDIA	In India, cite the NMHS adolescent result only with its age and sampling limits; for younger children, state plainly that an all-India psychiatric prevalence figure is not established.
SCHOOL MENTAL HEALTH PROGRAMMES AND LIFE-SKILLS EDUCATION	School mental health succeeds when life-skills teaching, a supportive school climate and a clear route to clinical or protection services work as one system.
RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK) AND THE 4DS	RBSK uses the 4Ds to identify childhood health concerns and link them to care; the psychiatrist turns a referral into an individual, developmental and family-centred plan.
INTEGRATED CHILD DEVELOPMENT SERVICES AND CHILD MENTAL HEALTH POLICY IN INDIA	Anganwadi Services are an integrated child-development platform whose mental-health value lies in contextual observation, caregiver partnership and a reliable bridge to appropriate care.
CHILD PROTECTION, ABUSE AND JUVENILE JUSTICE	
TYPES OF CHILD ABUSE	Child maltreatment is best understood as harm or threatened harm within a relationship of responsibility, trust or power: name the pathway - physical, sexual, emotional, neglectful or exploitative - then formulate the child's whole experience.
CLINICAL FEATURES AND INDICATORS OF CHILD ABUSE	Clinical indicators of abuse require recognition, not premature conclusion: preserve the finding, test the explanation, hear the child, and keep uncertainty explicit.
CHILD SEXUAL ABUSE ASSESSMENT AND PSYCHIATRIC SEQUELAE	In suspected or disclosed child sexual abuse, the psychiatrist listens carefully, assesses safety and psychiatric need, documents source and uncertainty, and does not turn clinical care into a repeated forensic interview.
POCSO ACT 2012	In India, mandatory reporting under POCSO is a legal duty: any person with apprehension or knowledge must inform the designated police authority, and failure to report is punishable.
MANAGEMENT AND INTERVENTION IN CHILD ABUSE CASES	In child abuse management, protect the child first, coordinate the adults and services around the child, and use trauma-focused intervention for the child's current clinical needs.
JUVENILE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT 2015	The Juvenile Justice Act separates an alleged offence from a child's vulnerability, and a psychiatric opinion assists the statutory forum without replacing it.

ASK	HOLD
CHILD IN CONFLICT WITH LAW AND CHILD IN NEED OF CARE AND PROTECTION	Child in conflict with law concerns an alleged act; child in need of care and protection concerns vulnerability and the need for safe care.
CHILD LABOUR AND ADOPTION	Child labour and adoption are formulation contexts: assess the child carefully, protect safety, and work with the meanings and relationships around the child without turning context into diagnosis.
BULLYING AND ITS MENTAL HEALTH CONSEQUENCES	Bullying is defined by intentional, repeated harm and a power imbalance; when it is disclosed, assess its psychiatric impact and current safety rather than treating it as routine peer conflict.

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