In *Diagnostic Assessment in Child and Adolescent Psychopathology* (eds D. Shaffer, C. P. Lucas & J. E. Richters), pp. 167–205. New York: Guilford Press.
Wechsler, D. (1989) *Wechsler Preschool and Primary Scale of Intelligence – Revised*. San Antonio, TX: Psychological Corporation.
—— (1991) *Wechsler Intelligence Scale for Children – III*. London: Psychological Corporation.
—— (1993) *Wechsler Objective Reading Dimensions*. London: Psychological Corporation.
—— (1996*a*) *Wechsler Objective Language Dimensions*. London: Psychological Corporation.
—— (1996*b*) *Wechsler Objective Numerical Dimensions*. London: Psychological Corporation.
—— (1997*a*) *Wechsler Adult Intelligence Scale* (3rd edn). San Antonio, TX: Psychological Corporation.
—— (1997*b*) *The Wechsler Intelligence Scale for Children* (3rd edn). San Antonio, TX: Psychological Corporation.
—— (1999) *Wechsler Abbreviated Scale of Intelligence*. San Antonio, TX: Psychological Corporation.
Wing, L. & Gould, J. (1979) Severe impairments of social interaction and associated abnormalities in children: epidemiology and classification. *Journal of Autism and Developmental Disorders*, **9**, 11–29.
World Health Organization (1993) *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: WHO.

Multiple choice questions

1. A high-quality developmental history:
   a requires the interviewer to get descriptions of the child's behaviour
   b is the best source of information for making a diagnosis
   c is easier to obtain for details concerning whether, rather than when, something happened
   d can be structured to focus on specific phases of development.

2. Psychometric testing of presenting children:
   a may be impossible
   b is useful for diagnosing specific cognitive disorders
   c may be all that is required to make a diagnosis
   d is not always necessary.

3. Observational assessments:
   a help confirm details obtained by report
   b can provide information about context specificity
   c have been developed for the assessment of pervasive developmental disorders
   d are best done in a very structured way.

4. Autistic spectrum disorders:
   a have diagnostic criteria extending more widely than previously
   b are always characterised by social aloofness
   c can be difficult to differentiate from reactive attachment disorders
   d warrant intensive medical investigation.

MCQ answers

1	2	3	4
a T	a T	a T	a T
b F	b T	b T	b F
c T	c F	c T	c T
d T	d T	d F	d F

Commentary

M. H. Bellman

Growth and development are at the core of paediatric practice and are the fundamental factors that make medical work with children different from adult medicine. All paediatricians must have an understanding of the basic science of growth and development and how to measure them. This is fairly straightforward with regard to physical characteristics, but more difficult for mental development. However, it is a skill that must be familiar to children's doctors working in the fields of neurological

Martin H. Bellman is a consultant neurodevelopmental paediatrician at Camden and Islington Community Services and the Royal Free Hospital, London (Greenland Road Children's Centre, 4 Greenland Road, London NW1 0AS). His main interest is assessment and management of long-term developmental disorders of children.

https://doi.org/10.1192/apt.7.1.40 Published online by Cambridge University Press

disease and mental health and, arguably, to all paediatricians.

Bolton describes development assessment from the point of view of child psychiatrists in a very erudite and practical way. He lays great emphasis on getting a good history, which, again, is one of the core skills in children's medicine, particularly for those working in the area of mental health. The parents, in practice usually the mother, are invariably the best source. Doctors who work with children know that a mother's worry must always be taken seriously, especially if she has experience of older children; however, 'gut feelings' should be translated into hard facts, if possible.

Memories are notoriously frail and must be regarded with suspicion, especially if they refer to events more than a few months ago or are judgements rather than straight descriptions (Hart *et al*, 1978). Hanging milestones onto a framework of anchor points, as suggested by Bolton, helps parental recall and improves reliability a little, but remains unsatisfactory if accuracy is required (e.g. in the case of suspected developmental regression). The validity of historical developmental milestones is much improved if they are derived from written records made at the time the event occurred. For a long time a few parents have used commercially available 'baby books' for this purpose, but fortunately the Personal Child Health Record (PCHR) is now universally used in the UK and can provide an excellent source of developmental information (Hampshire *et al*, 1999). The PCHR contains pages for parents to record important events in their child's life, dedicated pages on which professionals record routine information (e.g. birth details and results of child health surveillance checks) and blank pages for comments and consultations. All health professionals should make an entry whenever they see a child, so that the PCHR becomes a cumulative record of health-related information. This will be invaluable for constructing a profile of past medical history.

An additional method for getting information about a child's past development and behaviour is to look at home videotapes. Families that own a video camera invariably have many sequential recordings of their children in various play and social situations and these may offer an invaluable source of 'hard' information.

Bolton describes approaches for obtaining developmental information about the fields that are likely to be most relevant to child psychiatrists – communication skills, social skills, interest patterns, activities and play. However, it is essential to remember that the process of child development is holistic and changes are occurring in all fields simultaneously. It is the professionals who have arbitrarily divided development into discreet fields because that makes our job of observation and assessment easier. Virtually all child development assessment tools describe in one way or another four major fields: gross motor skills; vision and fine motor skills; speech and language; social behaviour and play.

Development in one field is usually dependent on progress in another and, from the child's perspective, it makes no sense to examine each field separately. Thus, it is important to look at the whole child and to get at least an idea of developmental status in all the fields, even if the focus of the assessment is only on one or two.

Detailed cognitive assessment can be carried out by psychologists (clinical or educational) using a variety of techniques described by Bolton. They are usually expert at deciding which tests to use in particular circumstances. As well as those listed in the article, there are several specialised schedules such as the Snijders–Oomen (Tellegan *et al*,1998) and Leiter (Roid & Miller, 1996) non-verbal scales for children with a language disorder (including deaf children) and the Reynell–Zinkin scale (McConachie & Moore,1994) for children with visual impairments . Doctors rarely have the time to perform psychometric assessment, which often takes 2–3 hours plus 1–2 hours for analysis and writing up. However, there are some screening developmental tests that can be administered in about 20 minutes, such as the British Schedule of Growing Skills (Bellman *et al*, 1997) and the American Denver Developmental Screening Test (Frankenberg *et al*, 1992). These are useful for getting a rough profile of a child in order to indicate which children should be looked at in more detail and in which fields. The Griffiths scales are probably the tools most commonly used by doctors who wish to perform a comprehensive developmental assessment. They have recently been revised to bring them up to date, but still take 1–2 hours to administer (Griffiths, 1996).

Bolton clearly describes the features in the history that should be considered when thinking about communication, social and play skills. These observations can be supplemented by assessments by colleagues such as occupational therapists, physiotherapists and speech and language therapists, who may use measurement tools in their own particular area of practice that often include aspects of cognitive functioning.

In conclusion, Bolton has written a very thoughtful review of the techniques of performing developmental assessment. It need not be the province only of developmental paediatricians or psychologists and the best approach is usually by getting a good history from parents and multi-disciplinary opinions from other professionals who know the child. This should be familiar territory to all child

https://doi.org/10.1192/apt.7.1.40 Published online by Cambridge University Press

psychiatrists, who should be able at least to form an impression of a child's developmental pattern so that they can understand and manage behavioural issues.

References

Bellman, M., Lingam, S. & Aukett, A. (1997) *Schedule of Growing Skills*. Windsor: NFER–Nelson.

Frankenburg, W. K., Dodds, J., Archer, P., *et al* (1992) The Denver II: a major revision and restandardization of the Denver Developmental Screening Test. *Pediatrics*, **89,** 91–97.

Griffiths, R. (1996) *Griffiths Mental Development Scales*. Henley: The Test Agency.

Hampshire, A., Blair, M., Crown, N., *et al* (1999) Action research: a useful method of promoting change in primary care? *Family Practice*, **16**, 305–311.

Hart, H., Bax, M. & Jenkins, S. (1978) The value of the developmental history. *Developmental Medicine and Child Neurology*, **20**, 442–452.

McConachie, H. R. & Moore, V. (1994) Early expressive language of severely visually impaired children. *Developmental Medicine and Child Neurology*, **36**, 230–240.

Roid, G. & Miller, L. (1996) *Leiter International Performance Scale*. Windsor: NFER–Nelson.

Tellegan, P., Winkel, M., Wijnberg-Williams, B., *et al* (1998) *Snijders-Oomen Nonverbal Intelligence Test*. Lisse: Swets Test Publishers.

https://doi.org/10.1192/apt.7.1.40 Published online by Cambridge University Press