

Michel Botbol, MD, Marco O. Bertelli, MD, PhD,
Luis Salvador-Carulla, MD, PhD, Dimitris Anagnostopoulos, MD,
PhD, Angeliki Christodoulou, BSc, MA
and James Appleyard, MA, MD, FRCPCH

32.1 Introduction

More than the rest of psychiatry, Child and Adolescent Psychiatry has to deal with controversial conceptual and practical issues concerning the nature or nurture question. Neurodevelopmental processes are indeed particularly active in this stage of life. Similarly active is the influence of the environment, particularly in its relational dimension and at the earliest stage of childhood, because, as Winnicott pointed out, “‘There is no such thing as an infant’, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant” [32]. For each of the children they have to diagnose or treat, child and adolescent psychiatrists have then to address both perspectives giving them an equal attention in spite of the inequality of the tools available to evaluate them.

M. Botbol, MD (✉)

Service Hospitalo-Universitaire de Psychiatrie Infanto-Juvenile, Hôpital de Bohars,
29820 Bohars, France; Professor of Child and Adolescent Psychiatry, University of Western
Brittany and Brest University Hospital, EA4686, Brest, France
e-mail: botbolmichel@orange.fr

M.O. Bertelli, MD, PhD

Research and Clinical Centre, San Sebastiano Foundation, Florence, Italy

L. Salvador-Carulla, MD, PhD

Faculty of Health Sciences, Centre for Disability Research and Policy and Mental Health
Policy Unit, Brain and Mind Institute, University of Sydney, Sydney, Australia

D. Anagnostopoulos, MD, PhD

Associate Professor of Child and Adolescent Psychiatry, Department of Child
and Adolescent Psychiatry, University of Athens, General Pediatric Hospital of Athens
“Agia Sofia”, Athens, Greece

Another particularity of child psychiatry, may be more than in other fields of medicine and psychiatry, is the fact that it is at the crossroad of two major concerns:

- The concern for the current child's mental health, which is a crucial dimension of his well-being and of his way to relate to the world and to himself. In this perspective, it is crucial that the approach to the child's health status integrates the specific aspects of his health manifestations and particularly the importance of development and dependency at this age. Child and Adolescent Psychiatry has then to put at its centre, aspects that are frequently considered marginal in other branches of the discipline.
- The concern for his future as the adult he will become, that is to say the protection and the development of his potentiality. In this perspective, it is important to understand that the persons presenting with symptoms of a possible illness is always experiencing not only his current health situation but also the effect of all of their life events from perinatal period, to infancy, childhood, adolescence and adulthood, in their biological, social, psychological and spiritual dimensions.

In both perspectives, child and adolescent psychiatry and medicine have to be constantly integrative in their approach to the child and in the consideration they give to the complexity of his person. The integrative dimension of Person-Centered Psychiatry is particularly crucial to encompass the various aspects of this complexity. Child and Adolescent Psychiatry can then be seen as a good example of the usefulness of Person-Centered approaches across care settings; to the point that it can be considered that, to be efficient and close to clinical reality, child and adolescent mental health care cannot be but person centered.

32.2 Child and Adolescent Clinical Specificities in Psychiatry

Nevertheless, the current clinical references, and particularly the leading international classification system are still quite limited in the way they consider, so far, the specificities for the child and adolescent psychiatric practice. They include only a small number of specific categories and there is a notable lack of flexibility and usability of all the categories related to personality disorder, hindering the definition of many child and adolescent mental health conditions. Moreover, in spite of the

A. Christodoulou, BSc, MA

Psychologist, Scientific Collaborator, Child and Adolescent Mental Health Unit, Department of Psychiatry, Medical School, University of Athens, Athens, Greece

J. Appleyard, MA, MD, FRCPC

Former Consultant Pediatrician, Kent and Canterbury Hospital, Canterbury, UK;
President, International College of Person Centered Medicine, London, UK

differences, these classifications are implicitly recognizing for child and adolescent psychiatry, the diagnostic process is supposed to remain strictly the same as in adult psychiatry, that is to say, based on descriptive items to type the disorders, and the use of comorbidity to correct the ill-effect of this model of the diagnostic process and to bring diagnostic categories closer to real clinical situations. These limited adaptations of the current classificatory systems to the needs of the child and adolescent psychiatric practice, contrasts with what we already have noted: the multiple specificities involved in child and adolescent psychiatry [7].

Such specificities can be considered from at least four relevant perspectives: (1) Symptomatic; (2) Developmental, (3) Environmental; and (4) Prognostic.

a. Symptomatic Specificities

In childhood and adolescence there are specific limitations in the type of externalized manifestations, as well as in the possibility to have insight-dependant symptoms. The relation between observed symptoms and underlying psychological organization are then particular in child and adolescent psychiatry. More frequently than in Adult Psychiatry a specific set of behavioral descriptive symptoms may be related to quite different underlying psychopathological organizations. Thus, at this age, consideration given to dynamic defense mechanisms and structural organizations underlying the behavioral symptoms, leads frequently to profound modification in the diagnostic evaluation and in the therapeutic indications. This perspective can lead, for example, to consider some Obsessive Compulsive Disorder (OCD) patients much closer to Schizophrenic or Narcissistic patients than it is to those suffering from other Anxiety Disorders. Although this perspective may not generally call for a change in the pharmacological prescription, the rest of the treatment strategy, so important at this age, will be more adapted to the patient specific needs when taking into account the underlying psychopathological organization rather than the sole OCD symptoms. In some cases this may lead to a therapeutic program much closer to what would be proposed to a schizophrenic patient [21] than to the one we would generally offer to other anxiety disorder patients.

Conversely, a particular psychopathological constellation may have very different symptomatic expressions. Depression in adolescence, for instance, can be expressed in very different ways: through acting out or psychotic symptoms more often than in adult psychiatry. For many authors, this should be taken into account for the pharmacological prescriptions at this age [15].

b. Developmental Specificities

Developmental considerations are of more importance in child and adolescent psychiatry than they are in adults. They are crucial to differentiate pathological symptoms and developmental conflicts, to appreciate developmental breakdowns, regressions or fixations, to recognize disharmonies on the different developmental lines, to integrate biological and environmental dimensions of development and finally to adapt therapeutic responses. Taking into account this developmental dimension allowed a team of French Child Psychiatrists to describe nearly thirty years ago a clinical condition they include in the French Classification of Child and Adolescent Mental Disorders [20] under the name of “Psychotic Disharmony”; this

disorder appeared to be very similar to what Donald Cohen proposed fifteen years later under the name of Multiplex Developmental Disorders to differentiate them from other Pervasive Developmental Disorders Not Otherwise Specified (PDD-NOS) [28].

c. Environmental Specificities

There is obviously in childhood a specific dependency upon current and past environmental conditions; this implies that relational aspects have a bigger impact on the expression of mental disorders at this age. There are therefore in Child and Adolescent Psychiatry greater risks that a number of diagnostic labels might be nothing more than a psychiatric reformulation of a social impairment (e.g., the Conduct Disorders category could merely be a psychiatric formulation of Delinquency), when diagnostic labeling does not bring any added value to the social construct.

Conversely, psychopathological disorders are ignored or denied when covered by hyper adaptation to local or global social norms, even when this hyper adaptation is mainly a way to deal with underlying psychological distress (as shown in some stabilized high functioning Pervasive Developmental Disorders or in some childhood undiagnosed Obsessive Compulsive Disorders) that may be hidden to the child or the adolescent himself. It may be observed also in behavioral disorders fitting well social definitions and social responses in specific circumstances. For instance, learning difficulties at school or delinquency in educational or judicial setting have less chance to be seen as symptoms of psychological distress unless specifically addressed from a psychopathological perspective. Social norms are thus one of the main determinants of the diagnostic labeling in childhood.

Finally, in every day practice, there is a great risk in child and adolescent psychiatry that the choice between a social or a psychiatric definition of a disorder, and the assistance it will generate, would not be based as much on the disorder characteristics as it is on its social context and on the type of interaction between the child and his environment.

There is then in Child and Adolescent psychiatry a specific need to avoid diagnostic processes strictly limited to individual approaches as much as those focusing only on the adaptation to the environment; instead child psychiatry requires diagnostic processes taking into account the subjective aspects resulting from the interaction of individual and environmental dimensions. In other words, there is at this age a specific need for diagnostics to consider the psychic functioning and not to limit itself to the description of social symptoms. Moreover this approach constitutes a useful basis for multi focal approaches always required to deal with such psychopathological social expressions at this age.

d. Prognostic Specificities

Prognosis has a specific value in child and adolescent psychiatry, where the main concern is not only the current status of the disorder but its continuity into adulthood.

From this viewpoint, research data [16] shows in adolescence the lack or reliability of DSM-IV's Axis I general disorders categories alone and a significant increase in the prognostic reliability when DSM-IV's Axis II personality disorders

categories are added even if they are not supposed to be used at this age. From this perspective too, child and adolescent psychiatry shows a specific need to take into account the underlying psychological functioning of the individual patient, and not to rely solely on descriptions of externalized symptomatic expressions on which current classifications base their categorical definitions.

In summary, most of the specific needs of child and adolescent psychiatry are not addressed by current classifications and diagnostic systems; the main issue is not their lack of specific categories but the diagnostic process they adopt that do not take into account what seems crucial in child and adolescent mental disorders classification: an overall evaluation of the mental functioning of the child and not only a description of his/her symptoms. To a smaller extent, this difficulty is also found in adult psychiatry, but it has more serious consequences in child and adolescent psychiatry. For instance, big differences of prevalence of Attention-Deficit Hyperactivity Disorder (ADHD) in different parts of the world can not be explained only as cultural or biological variations but rather as resulting from variations in the social use of psychiatric nosographical labeling [12].

To address these issues, classifications and diagnostic processes require conceptual modifications, such as: (a) Better integration of individual, relational and environmental dimensions; (b) Stronger references to developmental dimensions and longitudinal aspects of disorders; (c) Greater need to take into account psychic functioning and defense mechanisms to define as much the personality patterns as the process leading to the symptom.

There is then a need to introduce more complexity in the current classification systems to allow them to get closer to the clinical situations we face in child and adolescent psychiatry. The problem is that the introduction of more complexity implies necessarily more room for the psychiatrist interpretation (that is to say, for his theoretical background) while we need also to maintain common references to a universal nosographical frame.

32.3 The Impact of Early Life Experiences and Disorders on Health and Well-Being

There is now good evidence that problems in the early years of childhood may foreshadow problems in adolescence and adult life. Obviously, these problems can be of various environmental nature but can be schematically classified under two main headings: Traumatic Experiences and/or impairment of early relationships. In both cases a longitudinal approach to a patients narrative is essential in this field [14].

a. The Adverse Childhood Experience (ACE)

In a retrospective and prospective analysis in over 17,000 middle-class Americans, Lanius et al. [18] studied the effect of early traumatic life experience on later well-being, social function, health risks, disease burden, healthcare costs and life expectancy. The average starting age of the subjects was 57 years old. The study

has, approximately a half century after the fact, retrospectively matched an individual's current state of health against adverse events in childhood, and then followed the cohort forward to assess the relationship of ACE Score prospectively against future doctor office visits, emergency room visits, hospitalization, pharmacy costs, and death.

The adverse reference points were grouped under the three main headings of Abuse, Household Dysfunction and Neglect. Each participant was assigned an individual ACE Score, a count of the number of categories of adverse childhood experience encountered in their first 18 years.

These are: (1) emotional abuse, (2) physical abuse, and (3) contact sexual abuse; (4) mother treated violently; (5) household member an alcoholic or drug user; (6) or in prison; (7) or chronically depressed, suicidal, mentally ill, or in psychiatric hospital; (8) the subject not being raised by both biological parents; (9) physical neglect and (10) emotional neglect.

The two Neglect categories were added part-way through the study when these began to emerge as "surprise" significant issues amongst the subjects. The scoring system took account of only one incidence in any given category, so if a subject had been raised in a household containing both an alcoholic and a drug user, this would count as one not two experiences [18].

Whenever a study participant was found to score 1 on the Adverse Childhood Experience Score, there was an 87 % probability of more such experiences. Seventeen percent of the sample tested had scores of four or above.

There is a strong relationship between ACE Score and self acknowledged chronic depression and a similar, but an even stronger, relationship between ACE Score and later suicide attempts. This relationship between ACE Score and depression is borne out by analysis of prescription rates for antidepressant medications, now 50–60 years after the fact. It appears that depression is common and has deep roots, usually going back to the developmental years of life.

The most common contemporary health risks (smoking, alcoholism, illicit drug use, obesity and high level promiscuity) are widely known to be harmful. Such unhealthy behaviors may be coping mechanisms to sooth-submerged pain and difficult to give up even though they know these things are bad for them. The higher the ACE Score the greater the likelihood of later smoking, alcoholism, intravenous drug use, etc.

The authors of the study conclude that "all told, it is clear that adverse childhood experiences have a profound, proportionate, and long-lasting effect on well-being," whether this is measured by depression or suicide attempts, by protective unconscious devices like overeating and even amnesia or by what they refer to as "self-help attempts," the use of street drugs or alcohol to modulate feelings. They say that these are misguidedly addressed solely as long-term health risks, "perhaps because we physicians are less than comfortable acknowledging the manifest short-term benefits these "health risks" offer to the patient dealing with hidden trauma." As Felitti states "it's hard to get enough of something that almost works" [14].

b. Impaired Early Relationships

Another example from developmental psychopathology demonstrates the short- and long-term effects of impaired early relationships on children's long-term development [9]. A good illustration of this phenomenon is the effect of maternal depression on infant development. Relative to control mothers, depressed mothers express less positive and more negative affect, are less attentive and engaged with their infants, and, when engaged, are more intrusive and controlling and fail to respond adaptively to their infants' emotional signals [11]. Their infants have shorter attention spans, less motivation to master tasks, elevated heart rates, elevated cortisol levels, and reduced EEG activity in the right frontal cortex, all of which correlate with the experience of negative affect in adults [11]. Longitudinal data on infants of depressed mothers indicate that elevated heart rates and cortisol can persist and may represent a functional programming of the child's autonomic set point. If true, this may explain in part that after controlling for the maternal depression status when the child was four years old, maternal depression during an infant's first year of life was predictive of the child's cognitive ability at that age [10].

Even where damage from their early years is internalized, young people and adults can become the self-destructive or depressed parents of what will become a new generation of emotionally damaged children. Untreated postnatal depression can have serious long-term consequences for the mother's ongoing relationship with her baby and for his or her mental and emotional development. Postnatal depression is thought to affect approximately 13 % of women during the early months following childbirth [22]. Yet frontline service providers, such as health visitors may only be identifying about 10 per cent of those postnatal depressed women.

Very young children need a high level of emotional responsiveness and engagement, which a severely depressed primary carer is unable to give, however much she might want to. Her baby might look well fed and clean, but might be emotionally neglected all the same. The intergenerational nature of this is underlined by the estimate that 30 to 40 per cent of abused or neglected children (versus two to three per cent of the total population) go on to abuse or neglect their own children. 56.

Reduced attention to faces of care givers, and more specifically to the eye region, may underlie traits that lead to reduced responsiveness to others distress, a lack of empathy [3].

From a stratified random sample of 213 participants drawn from a population-based sample of 1233 first-time mothers, infants' preferential faces tracking at 5 weeks and maternal sensitivity at 29 weeks were entered into a weighted linear regression as predictors of Callous Unemotional traits at 2.5 years. Controlling for a range of confounders (e.g., deprivation), lower preferential face tracking predicted higher CU traits ($p = 0.001$). Higher maternal sensitivity predicted lower CU traits in girls ($p = 0.009$), but not boys.

Physiologically as well as emotionally, infants need a stimulating, accepting environment in which they feel safe and loved. It has been said that "the greatest gift for a baby is maternal responsiveness." The more positive stimuli a baby is

given, the more brain cells and synapses it will be able to develop. “The child’s first relationship, the one with the mother, acts as a template that permanently moulds the individual’s capacity to enter into all later emotional relationships” [26].

When this stimulus is accompanied by the type of parental attunement that fosters the development of empathy, the infant will be able to take all the needed advantages from the significant “sensitive windows” existing in the first three years of life using the brain plasticity.

The innate flexibility in sculpting the young brain has enormous survival value, because it is what enables infants to adapt to their particular environment [25].

When human infants are born they are immediately aware of and ready to be programmed by their adult carers. From our first moments of life infants are “tuned” into the facial expressions of those around them, as can be seen from the infant reflex to mimic.

At birth there are 100 billion neurons and 50 trillion synapses. By age three, the number of synapses has increased 20-fold to one thousand trillion. Because this is too large a number to be determined by genes alone, many new synapses are formed by experience [25].

The synapses are strengthened and reinforced by these experiences and the early life defines which of them live and which die. Synapses become “hard-wired,” or protected, by repeated use, enabling very rapid learning via early life experience. Conversely, just as a memory will fade if it is hardly ever accessed, unused synapses wither away in what is called “pruning.” This indicates that it is the nurture that infants receive based on their genetic nature that plays the lead role in creating the human personality.

Physiologically as well as emotionally, infants need then a stimulating, accepting environment in which they feel safe and loved. It has been said that “the greatest gift for a baby is maternal responsiveness.” The more positive stimuli a baby is given, the more brain cells and synapses it will be able to develop. When this stimulus is accompanied by the type of parental attunement that fosters the development of empathy, the result will be a socially adapted child who is likely to be happier, healthier and more intelligent than one who has been deprived of these essentials for positive growth [1].

32.4 The Person-Centered Health Model in Intellectual Developmental Disorders

Intellectual Developmental Disorders (IDD) or Intellectual disability (ID) is one of the severe neurodevelopmental disorders, affecting both intellect and adaptive behaviors. It is a permanent condition, associated with a high comorbidity of physical and mental disorders worldwide. Consequently it is associated with high levels of care giving burden, and implies high service provision and produces high health and societal costs [5, 24]. Despite this, ID is a neglected area both in the field of general health and mental health. These challenges are more evident in Low and Middle Income Countries (LAMI).

32.4.1 Nosological and Functioning Distinctions

The case of IDD/ID is particularly challenging for multidimensional person-centered care, covering both ill health and positive health along the levels of health status [19]. In fact, there is no international consensus on whether ID is a health condition that should be classified in the International Classification of Diseases (ICD) or if it is a disability that should not be coded in the International Classification of Functioning (ICF). The fact that the international community has not reached an agreement in such a basic question and that there is an ongoing debate on its placement at the WHO Family of Classifications reflects the complexity of this construct. As a matter of fact, many national agencies follow the approach of the American Association of Intellectual and Developmental Disabilities that defines “Intellectual disability” as “a disability characterized by significant limitations both in intellectual functioning [IQ > 70] and in adaptive behavior, which covers many everyday social and practical skills. The timeframe for age of onset is defined from birth to 18 years. This has oriented the recommendations made by this group for naming and conceptualizing this condition at ICD [27, 31]. Other organizations such as the World Psychiatric Association have defined it as a group of health condition, namely developmental conditions, characterized by a significant impairment of cognitive functions, which are associated with limitations of learning, adaptive behavior and skills [23]. This definition was extended by the ICD Working Group in 2011, under the new term of “Intellectual Developmental Disorders”: a group of etiologically diverse conditions that are present from birth or that arise during the developmental period, characterized by a marked impairment of cognitive functions necessary for the development of knowledge, reasoning, and symbolic representation of the level expected of one’s age peers, cultural and community environment. IDD was also defined as a life span condition requiring consideration of all developmental stages and life transitions [6, 24]. Furthermore, the ICD Working Group proposed revised diagnostic criteria for ICD-11 based on an articulated model of cognitive impairment. This approach should complement measurement of IQ with assessment of specific cognitive functions and a contextualized description of consequent adaptive and learning difficulties. Within this new approach, cognitive skills should be assessed in the most comprehensive way as possible. The measurement should be done through tests, semi-structured observations, and direct clinical examination. The tests should combine measurement of IQ with that of complex aspects of executive functioning, including perceptual reasoning, processing speed, verbal comprehension, as well as specific aspects, such as attention, perception, and working memory. The evaluation should aim to identify the cognitive dysfunctions that have the greatest negative impact on the person’s lifespan, not only in cognitive skills but also in terms of associated behavior, ability, adjustment, autonomy, and all other factors that rely on person-centered health [6, 24].

32.4.2 Person-Centered Medicine and Quality of Life

The current debate reflects the importance of a multifaceted approach to complex health problems and the significant contribution made by the International College of Person-Centered Medicine (ICPCM) and the International Network for Person-centered Medicine through the Person-centered Integrative Diagnostic model - PID [19], which takes into account not only the health condition and the disability but also the positive aspects defined as well-being and good functioning. IDD/ID may not be an exception in health but a prototypical example of how the holistic and comprehensive approach recommended by ICPCM is useful for understanding these complex constructs in health care.

Among person-centered approaches for persons with IDD/ID, in the last two decades Quality of Life (QoL) has increasingly gained a central place, although it is sometimes considered a concept that lacks sufficient precision to have specific usefulness in the field, and that it is more advantageous to focus on clearer concepts or simply on providing practical supports [4].

Yet, a considerable amount of substantive work has been done in the area of QoL and IDD/ID. Numerous thoughtful books, book chapters, and academic articles have been published that not only advanced our understanding of QoL, but have made ID the leading field for substantive work in QoL. It is clear from this work that achieving high quality of living is not the main purpose.

Given that QoL depends on host of individual and environmental factors that persons with IDD/ID either lack or are deprived of, the question of how we can ensure entitlement to a life of quality for people with ID who have mental health problems, is an interesting and challenging one. First it is necessary that mental health professionals value the needs and choices of people with ID, and believe that it is possible to improve their life conditions. This in turn helps them recognize the use of positive interventions that view the health—and indeed the whole life—of people with ID in more holistic and integrated ways. When mental health professionals work with people who have ID, it is helpful to consider three aspects of QoL: personal QoL, shared QoL, and family QoL. All the three are relevant in the context of care and service provision, but personal QoL is more important as ultimately it is the individual's perceptions, attitudes, values, skills and other attributes that determine how his or her life is experienced. At the same time each individual is expected to be a social being and hence shared QoL is assessed taking the social support (e.g., family, work and community) into consideration. But good QoL assessment allows for the concept to be explored at a personal level as well as at the shared level [8]. Similarly, family QoL is relevant in the context of ID for several reasons. One, families can influence and get influenced by the nature of disability in the members [29, 30]. Two, more and more families in the developed countries are living with members with disabilities as entitled by law while cultural practices or lack of residential care facilities demand the same in LAMI.

The WHO definition of QoL as a subjective construct including the self-reported assessment of both positive and negative facets of life is in agreement with the “experience” domain of the PID model of person-centered health [19]. However the

PID has a broader perspective as it highlights the importance of engagement, empathy and partnership in the clinical care process, and sustain the patients' autonomy, responsibility and dignity while advancing the recovery and promotion of well-being. To assess the domain of person's experience and values PID uses descriptive categories, dimensions, and narratives, to cultivate patient–family–clinician partnerships for achieving shared diagnostic understanding and shared commitment to care. The application of this model to the assessment of personal well-being, experiences, satisfaction and aspirations of persons with IDD faces significant challenges in persons with IDD as the self-reported assessment of these complex concepts is limited due to the cognitive and communication impairments [6].

32.4.3 Prospects for Implementation

The question of how we can ensure entitlement to a life of quality for people with ID who have mental health problems is an interesting and challenging one. Yet, the emphasis within the conceptualization of QoL on finding uniquely individual solutions to presenting problems suggests that it may be a particularly apt approach to take with this population. People with ID are characterized by lower levels of some cognitive functions, and lower potential for learning and developing logical-deductive skills. For this reason, it is not a sane goal of therapeutical interventions to attempt to provide “normal” intellectual functioning, but rather such interventions need to work within the confines of each individual's particular skills sets. Similarly, it is not a reasonable therapeutic goal to have people with IDD/ID live their lives as close as possible to people without IDD/ID, because ultimately they have to find satisfaction in those aspects of life that are important to them and that they can understand and experience. The more traditional medical approach to therapeutic interventions with people who have IDD/ID and mental health problems have tended not to consider the uniqueness of people with IDD/ID fully and have been more likely to use the general population norm as their point of reference. This has resulted in interventions that have dealt primarily with containing troublesome behaviors and helping to alleviate symptoms, rather than to address the root causes of the problems. Thus, assuming an overall QoL approach to intervention goes a long way to ensuring entitlement to a life of quality.

The conceptualization of ID should shift the traditional over-reliance on the intelligence (IQ) score in favor of the daily life expression of specific cognitive functions and the determination of the levels of severity of intellectual functioning, that was previously based on the person's IQ score, should be reached through a system that is predicated on the person's satisfaction attainment toward life.

The assessment of cognition should be aimed at identifying those dysfunctions that have the highest impact on individual behavior, skills, adaptation, autonomy, and quality of life across the life span, highlighting personal cognitive strengths and weaknesses that can be useful to understand personal functioning and to organize intervention.

Person-centeredness as a model of care provision, care individualization and lifestyle and supports was first developed in the Intellectual disability sector than in many other areas of health and social care. However, and although some agencies have actually implemented PCC over decades in the US, Australia and Europe, the claims of adherence to the PCC goals are larger than its actual application [2, 17].

As a matter of fact and in spite of the aspirations toward a PCC model, the implementation is slow due to barriers in the change in the philosophy or culture of care, power and funding structures, high levels of staff turnover and lack of training, inexperience among service management, inadequate staff supervision, and ambiguity among some stakeholders [13].

Kendrick [17] has provided an extensive review of the main 7 conditions required for such a change in the service delivery system in IDD care. The challenges related to this change include (1) Ethical Partnering With Individuals and Families and Carers; (2) A Social Inclusion/Valued Social Participation; and (3) Effective Address of People's Important Personal Needs.

Building partnerships that work requires a staff that understands ethical conduct and its aware of its absence or perversion, incorporates decision sharing, personal and organizational flexibility and demonstrates respect for persons with ID. The social inclusion/participation approach requires moving out from segregated services to fully community integration and membership, providing support for the acquisition of common social and cultural values as well as health promotion through healthy lifestyles and prevention of stigma and marginalization. The effective address of personal needs requires a monitoring system of care and support gaps, its relation to unmet needs, with an specific attention to "the essential ingredients of a good life such as employment, income, good health, a home of their own, value and respect, interesting leisure, personal growth and development, good safeguarding of vulnerabilities" [17].

To achieve these goals it is necessary to invest in the assistance to establish service user controlled entities to ensure consumer empowerment; independent personal advocacy; oversight and evaluation of services and service quality agreements directed by service users in terms of agency performance; and provide funding on the person-centered approach in education, leadership and to increase population literacy in PCC.

32.5 Conclusions

Particularly exposed to questions crucial for psychiatry in general (nature–nurture debate, dependence to relational and material context, role of subjective and psychological aspects of mental and psychic life) given the importance of developmental processes in earlier life stages, Child and Adolescent Psychiatry has to be integrative in its essence and person-centered in its practices. Whatever the etiological determinants of the mental health status of the patients they treat, psychiatric care has to be holistic, and take into consideration the person of the child and his

context, implying a diagnostic process that has to go beyond the mere nosographical labeling. In this regard, the person-centered perspectives, recently developed in medicine in general and in psychiatry in particular, are particularly promising to build new paths to fulfill this ambition, promoting improvement in the current state of the art in child and adolescent psychiatry.

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