

Section on Person-centered Clinical Care

Person-centered child and adolescent psychiatric care

Michel Botbol, Prof., Child and Adolescent Psychiatrist, Consultant on Juvenile Justice, French Ministry of Justice, President, WPA French Member Societies Association, Co-Chair of the WPA Section on Psychoanalysis in Psychiatry

Correspondence to: Michel Botbol, E-mail: michel.botbol@wanadoo.fr

Introduction

This paper presents a person-centered perspective to child and adolescent psychiatric care first through an examination of the particular specificities of diagnosis in child and adolescent psychiatry and then through a review of the importance of empathy to approach subjectivity in clinical care. As such, this discussion highlights some key issues for person-centered care in psychiatry and medicine at large.

Diagnostic specificities in child and adolescent psychiatry

Many child and adolescent psychiatrists consider that diagnosis and classification of psychiatric disorders should attend more effectively to specificities pertinent to children and adolescents. Not attending to these specificities, may substantially distort the understanding and formulation of child and adolescent psychiatric disorders, rendering them a caricature of what is usually presented in a disorder-centered adult psychiatry.

The specificities usually considered in traditional classifications of child and adolescent psychiatric disorders are quite limited. It is often the case that only a small number of specific diagnostic categories are considered, that there is a notable lack of differentiation in dealing with personality conditions, and that there conspicuous inadequacy to reflect the fullness of many real clinical situations.

The specificities that many child and adolescent psychiatrists consider crucial to attend to can be discussed from at least four relevant perspectives: 1) Symptomatic; 2) Developmental; 3) Environmental; and 4) Prognostic.

Symptomatic specificities

There are specific limitations in the type of externalized manifestations as well as in the possibility to have insight-dependent symptoms in childhood and adolescence. More frequently than in adult psychiatry, a specific set of behavioural descriptive symptoms may be related in child psychiatry to quite different underlying psychopathological organizations. Thus, at this age, consideration given to dynamic defence mechanisms and structural organisations underlying the behavioural symptoms leads frequently to profound modifications in diagnostic evaluation and in therapeutic planning.

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 pharmacological prescription, the rest of the treatment strategy, so important at this age, may be more adapted to the patient's particular needs when taking into account the underlying psychopathological organisation rather than only the OCD symptoms. In some cases, this may lead to a therapeutic program much closer to what may be considered for a Schizophrenic patient [1] than to the one usually offered 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, including acting-out and psychotic symptoms. For many authors [2], this also should be taken into account for pharmacological prescription.

Developmental specificities

Developmental considerations are of more importance in child and adolescent psychiatry than they are for 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, and finally to adapt therapeutic responses. Taking into account this developmental dimension allowed a team of French child psychiatrists to describe nearly 30 years ago a clinical condition within a French classification of child and adolescent mental disorders [3] under the name of ‘Psychotic Disharmony’. This disorder appeared to be similar to what Donald Cohen proposed 15 years later under the name of Multiplex Developmental Disorders to differentiate them from other Pervasive Developmental Disorders (PDD) Not otherwise specified (NOS) [4].

Environmental specificities

There is obviously in childhood a specific dependency upon current and past environmental conditions. It is also the case that relational aspects have a bigger impact on the expression of mental disorders at this age. There is therefore, in child and adolescent psychiatry a greater risk that a number of diagnostic labels might be nothing more than a psychiatric reformulation of social impairment (e.g. the conduct disorders category could merely be a psychiatric formulation of delinquency); diagnostic labelling may thus not bring any added value to a social construct.

Conversely, psychopathological disorders may be 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 Disorder or in some childhood undiagnosed OCD) that may be hidden to the child or adolescent himself. It may be observed also in behavioural disorders fitting well social definitions and social responses in specific circumstances. For instance, learning difficulties in schools or delinquency in educational or judicial settings may not be seen as symptoms of psychological distress unless specifically addressed from a psychopathological perspective. Social norms are thus one of the main determinants of diagnostic labelling in childhood.

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. Child psychiatry requires diagnostic processes that take 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 diagnosis to consider psychological functioning and not to limit itself to the description of social symptoms. This approach constitutes a useful basis for multi-focal approaches often needed to deal with psychopathological and social expressions at this age.

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, data show in adolescence the lack or reliability of many diagnostic categories taken alone and a significant increase in reliability when personality categories are added [5] even if they are not supposed to be used at this age. From this perspective too, child and adolescent psychiatry shows a particular need to take into account the underlying psychological functioning of the individual patient, and not to rely solely on descriptions of externalised symptomatic expressions on which current classifications usually base their categorical definitions.

Taken as a whole, most of the specific needs of child and adolescent psychiatry are not addressed by current classifications and diagnostic systems; however, 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 drastic consequences in child and adolescent psychiatry where it can ruin the reliability of data and their usefulness for therapeutic practices. For instance, big differences of prevalence of Attention-Deficit Hyperactivity Disorder (ADHD) in different parts of the world cannot be explained only as cultural or biological variations but rather as resulting from variations in the social use of psychiatric nosography [6].

In a disorder-centered perspective, child and adolescent psychiatry is rendered a caricature of what is observed in adult psychiatry. It increases the inadequacy of disorder-centered diagnostic approaches, not only because, as in adult psychiatry, it ignores the subjective dimension, but because it does not take into account the multiple specificities of psychiatry at this age. It also increases the inadequacy of disorder-centered therapeutic perspectives because, as in adult psychiatry, this point of view favours a pharmaceutical approach, and tends to ignore specific concerns about this type of treatment for children.

From description to empathy for a person-centered approach

Child and adolescent psychiatry perspectives are confronting us with the need to take into account the person of the child and not only his symptoms. To address these issues, classifications and diagnostic processes require conceptual improvements, such as: a) Better integration of individual, relational and environmental dimensions; b) Stronger references to the developmental dimensions and longitudinal aspects of disorders; and c) Greater attention to psychological functioning and defence mechanisms to define personality patterns and the processes leading to symptoms.

In other words, these conceptual advances should give attention to the child's subjectivity, his inner dimension, as well as to his context (social and developmental) and the way it affects the child objectively and subjectively. They should attend to complexity better in classification systems to render them closer to the clinical situations we face in child and adolescent psychiatry.

To approach these subjective dimensions in the child more attention should be given to the subjectivity of the psychiatrist, even when accepting that objectivity is needed to maintain references to a universal nosographic frame. But this encompassing approach is required to recognize the psychological distress underlying common social expressions or to deal with challenging clinical situations, such as those of infants and dysfunctional adolescents.

In these situations the sole observation of the symptoms connected to a disorder-centered perspective is clearly insufficient. Something else is required to go behind the screen of the visible, and this is usually called *empathy* (the capacity to recognize and understand *another's* state of mind or emotion). In the clinical context, empathy should be a holistic way to approach subjectivity [7].

The therapist empathy is triggered by the attention he gives to the patient's subjectivity through the multiple channels he can use and among them, not only a close observation of the patient's behavior but also by attending to the patient's and his family's narratives. The inclusion of narrative formulations in person-centered integrative diagnosis, a component of a psychiatry for the person [8], is an important step forward to be incorporated in child psychiatry.

Triggered by these multichannel inputs, the therapist's representations and affects can then be used to understand the patient mental health in its multiple dimensions. Here again it is important to access the therapist's representations and affect and to explicitly include this process in a person-centered diagnosis to rendered it more than just a mere intimate feeling. The therapist's metaphorization (the way he transforms his intimate feelings into a meaningful story) is a potent way for him to approach his empathy and to reflect it into a narrative [9]. Metaphorizing empathy [10] may be then the best way to access the empathy of the therapist and both his and the patient's subjective dimensions. Metaphorizing empathy can then be seen as the royal path to the subjectivity and the complexity of children and adolescents beyond what is visible, and even beyond words. Person-centered diagnosis should, therefore, also encompass the therapist' narrative and idiographic formulation.

The above concepts, which are of paramount importance in child and adolescent psychiatry, should also apply to adult psychiatry. Leaders of the European Federation of Associations of Families of People with Mental Illness strongly advocated at the Paris Conference on psychiatry for the person [11] that psychiatrists should extend themselves as full human beings to bridge the gap between professionals and users of mental health services.

References

1. Nechmad A, Ratzoni G, Poyurovsky M, Meged S, Avidan G, Fuchs C, et al. Obsessive compulsive disorder in adolescent schizophrenia patients. *American Journal of Psychiatry* 2003 May;160(5):1002–4.
2. Jeammet PH. Les prémices de la schizophrénie [The premices of schizofrenia]. In: De Clercq M, Peuskens J. editors. *Les troubles schizophréniques*. Bruxelles: De Boeck Université; 2000. [in French].
3. Mises R, Quemada N, Botbol M, Burzsteijn C, Garrabe J, Golse B, et al. French classification for child and adolescent mental disorders. *Psychopathology* 2002 Mar–Jun;35(2–3):176–80.
4. Tordjman S, Ferrari P, Golse B, et al. Dysharmonie psychotique et multiplex developmental disorder: histoire d'une convergence [Disharmonic psychotic and multiplex developmental disorder: history of a convergence]. *Psychiatrie de l'enfant* 1997;2:473–504. [in French].
5. Johnson JG, Cohen P, Skodol AE, Oldham JM, Kasen S, Brook JS. Personality disorders in adolescence and risk for major mental disorders and suicidality during adulthood. *Archives of General Psychiatry* 1999 Sep;56(9):805–11.
6. Diller L. Coca Cola, Mac Donald's et Ritaline® [Coca Cola, Mac Donald's and Ritaline®]. *Enfance et Psychologie* 2001;14:137–41. [in French].
7. Berger DM. *Clinical empathy*. Northvale: Jason Aronson, Inc; 1987.
8. Mezzich JE. Psychiatry for the person: articulating medicine's science and humanism. *World Psychiatry* 2007 Jun; 6(2):65–7.
9. Ricoeur P. *Time and narrative*. Chicago: University of Chicago Press; 1984. (Original title: *Temps et récit*, 3 vols. translated by Kathleen McLaughlin and David Pellauer).
10. Lebovici S. *Le bébé, le psychanalyste et la métaphore* [The baby, the psycho analyst and the metaphore]. Paris: Ed. Odile Jacob; 2002. [in French].
11. Filliol S. EUFAMI perspectives. Paper presented at the Paris Conference on Psychiatry for the Person, February 6–8, 2008.