

From “ready to wear” to “custom-made”: the benefits of multidimensional approaches to tailor targeted interventions

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The approach to best practices in child and adolescent psychiatry is now widely developed, and evidence-based guidelines have been established in many European countries [12]. In France, scientifically-based intervention research, highly supported by an increasing number of informed clinicians, continues, nevertheless, to raise concern and controversy [8]. Meanwhile, in developing countries dissemination of manual-based practices and training of professionals and parents are in progress [7].

Light shed by the various articles in this issue of the journal spurs us to incorporate gold standards and national and international guidelines into our medical clinical training [2], daily practice, and the development of effective services [1]. However, average references established by studies conducted on large or small groups do not exclude, in practice, taking into account the complexity of disorders. It is indeed important to identify past or current factors influencing pathophysiology or psychopathology that need to be considered in comprehensive multidimensional therapeutic interventions, as in interpretation of their results [11].

From this viewpoint, very pertinent data are presented in the field of early intervention in autism spectrum disorders (ASD) [6]. They highlight the necessity of identifying co-existing medical and/or genetic conditions including epilepsy in ASD that affect outcome. Likewise, it is true for disorders of basic day-to-day functions such as sleep for which a specific pharmacological approach is needed [4, 9]. The need of individualized and tailored intervention fits

in with this wide range of clinical and neurobiological situations.

Another factor hindering patient's improvement is non-response to recommended evidence-based treatments such as psychological/behavioral interventions, medical therapy, and pharmacotherapy. In such treatment refractory clinical situations, alternative strategies must to be defined and tested. Using electro-convulsive therapy may be considered, for example in cases of severe self-injurious behavior and aggression [3].

Lastly, according to the biopsychosocial model of child and adolescent psychological disorders, environmental factors linked to current and past experiences should be considered when implementing comprehensive and global psychiatric treatment strategies. Observations of bidirectional relationships between adolescent and parental mental health may have implications for clinical and therapeutic practice [14]. The impact of adverse childhood experiences on psychopathology later in life is also under study, opening perspectives in risk identification, prevention, and research on protecting factors [10].

Unfortunately, to this day valid pathophysiological, psychopathological, and aetiological models do not reliably support our therapeutic practice in child and adolescent psychiatry. Research offers immense perspectives in this field. New hypotheses rise from studies of very early events characterizing the dynamics of child development on somatic and psychological levels. In the case of ASD, the perinatal period and the first 2 years of life constitute target windows for studying growth [13] and acquisitions [5].

In the near future, the move should be from “standardized” to “hand tailored”. All of us will be striving to make intervention, based on the most recent findings in neuroscience, as effective as possible, and according to each patient's and each family's needs and individuality.

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References

1. Ayyash H, Sankar S, Merriman H, Vogt C, Earl T, Shah K, Banerjee S (2013) Engagement of commissioners, primary and secondary care for developing successful ADHD Services. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0321-6](https://doi.org/10.1007/s00787-012-0321-6)
2. Carballo JJ, Garcia-Nieto R, Perez-Rodriguez MM, Lopez-Castroman J, Blasco-Fontecilla H, Mata-Iturralde L, de Leon-Martinez V, Baca-Garcia E (2013) Longitudinal trends in diagnosis at child and adolescent mental health centres in Madrid, Spain. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0322-5](https://doi.org/10.1007/s00787-012-0322-5)
3. Consoli A, Cohen J, Bodeau N, Guinchat V, Wachtel L, Cohen D (2013) Electroconvulsive therapy in adolescents with intellectual disability and severe self-injurious behaviour and aggression: a retrospective study. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0320-7](https://doi.org/10.1007/s00787-012-0320-7)
4. Doyen C, Mighiu D, Kaye K, Colineaux C, Beaumanoir C, Mouraëff Y, Rieu C, Paubel P, Contejean Y (2011) Melatonin in children with autistic spectrum disorders: recent and practical data. *Eur Child Adolesc Psychiatry* 20(5):231–239
5. Ekinçi O, Arman AR, Melek I, Bez Y, Berkem M (2011) The phenomenology of autistic regression: subtypes and associated factors. *Eur Child Adolesc Psychiatry* 21(1):23–29
6. Eriksson MA, Westerlund J, Hedvall A, Amark P, Gillberg C, Fernell E (2013) Medical conditions affect the outcome of early intervention in preschool children with autism spectrum disorders. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0312-7](https://doi.org/10.1007/s00787-012-0312-7)
7. Fayyad JA, Farah L, Cassir Y, Salamoun MM, Karam EG (2010) Dissemination of an evidence-based intervention to parents of children with behavioural problems in a developing country. *Eur Child Adolesc Psychiatry* 19(8):629–636
8. Forgeot d'Arc B, Cortese S, Pinabel F, Purper-Ouakil D (2013) Manifest for evidence based child psychiatry in France. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0324-3](https://doi.org/10.1007/s00787-012-0324-3)
9. Guenolé F, Baleyte JM (2011) Melatonin for sleep-disturbed children with autism spectrum disorders: can we really speak of a substitution treatment? *Eur Child Adolesc Psychiatry* 20(9):493–494
10. Isohookana R, Riala K, Hakko H, Räsänen P (2013) Adverse childhood experiences and suicidal behaviour of adolescent psychiatric inpatients. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0311-8](https://doi.org/10.1007/s00787-012-0311-8)
11. Mesibov GB, Shea V (2011) Evidence-based practices and autism. *Autism* 15(1):114–133
12. Rothenberger A, Minderaa R (2013) Recommendations for a better patient care in daily clinical practice: a joint column of ESCAP and ECAP. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0323-4](https://doi.org/10.1007/s00787-012-0323-4)
13. Schrieken M, Visser J, Oosterling I, van Steijn D, Bons D, Draaisma J, van der Gaag RJ, Buitelaar J, Donders R, Rommelse N (2013) Head circumference and height abnormalities in autism revisited: the role of pre- and perinatal risk factors. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0318-1](https://doi.org/10.1007/s00787-012-0318-1)
14. Wilkinson PO, Harris C, Kelvin R, Dubicka B, Goodyer IM (2013) Associations between adolescent depression and parental mental health, before and after treatment of adolescent depression. *Eur Child Adolesc Psychiatry*. doi:[10.1007/s00787-012-0310-9](https://doi.org/10.1007/s00787-012-0310-9)