

## Letter to the Editor:

Dear Editor,

I perused with interest Volume 16, Number 2 *Journal of the Canadian Academy of Child and Adolescent Psychiatry*. However, the overall impact left me wondering why is there so little attempt to understand the mind of the child? They are described in terms of test results, responses to intervention and medication but I saw almost no indication that those writing these articles attempted to understand why the child was behaving as they did from the child's perspective. What is it like for a child to be constantly hassled with "sit still", "be quiet", "get on with your work" or "talk louder", "speak up", "what did you say?" The closest anybody seems to have gotten to this was a brief statement "she insisted that she had no problem" in the article on *Selective Mutism*. What happened to the practice of listening to children or to play therapy as we once knew it. Are child psychiatrists uninterested in how children think? Are they afraid of what they might say?

There seems to be little consideration of the fact that some apparently pathological states may in fact be a variation of the normal, especially when it comes to attention deficit. Many years ago I discovered<sup>1</sup>, that at least one-quarter of hyperactive children, especially boys, were very much like their fathers and grandfathers. In class it was difficult for the child and for the teacher but out in the woods or on the playing fields their impulsivity, distractibility was an asset rather than a liability. Is it possible that for many boys having to learn from their seats rather than on their feet is much to their disadvantage? In one situation we provided overactive children the opportunity to stand at a desk while in class. We soon found that, although they kept walking around the desk, they were much better able to concen-

trate on the school work. Is there any credence to the idea that anthropologically females have learned sitting or squatting concentrating on central vision and being painfully corrected when their attention was distracted by some movement in their peripheral vision. Boys on the other hand learned moving through the environment. It was to their credit and survival when they were distractible and impulsive.

When constitutionally hyperactive distractible children are barraged with demands to listen and conform, it is a small wonder they become non-conforming even anti-social. After all these injunctions fit their blueprint so poorly.

It is possible that autism is not primarily a pathological condition but one where the child is born with a hypersensitivity which is so great the environment is extremely painful. We have found<sup>2</sup> by attenuating the sensory and emotional stimulation of the autistic child's environment allowing them to be free of the constant bombardment of adult coercion that there were changes in the child's attitude that allowed them to learn in their own way.

I suppose that as long as there are so many incentives for discovering pathology, it is very unlikely that psychiatrists, child psychiatrists in particular, will attempt to understand the child's thinking or perceive their unusual behaviour as a generic variant of the normal.

Yours sincerely,  
Philip G. Ney, MD FRCP(C) MA

### References

1. Ney, P. G. (1974). Four Types of Hyperkineses. *Canadian Psychiatric Association Journal*, 19:543-550.
2. Ney, P. G. (1979). A Psychopathogenesis of Autism. *Child Psychiatry and Human Development*, 9:195-205.

### Response to the letter to the Editor

The Guest Editors of the special issue of the *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, ADHD: Sharing Knowledge and Extending Care, would like to thank Dr. Ney for his commentary on the articles in the issue.

Dr. Ney's point is that the special issue lacked a child - patient perspective. He asserts that the child's perspective is crucial to the understanding of the very nature of the disorder.

In response to Dr. Ney we point out that there is a difference between understanding and knowing, between understanding symptoms and knowing the pathology behind the symptoms. In order to transform understanding into a systematic and shared knowledge we must track down the causes of the pathology behind the symptoms. The causes of a behaviour may well be different from its reasons. ADHD children might have reasons to behave as they do. Dr. Ney lays out some of these reasons - one of them being their poor adaptation of the typical child with ADHD to the typical classroom in which they find themselves. But, is the classroom context the cause of ADHD? Science and scientific inquiry must always look for causes in order to produce knowledge. What causes ADHD? What causes this behavioural "variation on the normal", as Dr. Ney asserts? The school system can reveal or aggravate ADHD expression, but does not cause it. If the school system was the cause, then ADHD children should return to "normal" as soon as they are removed from the offending context. But that is not the case. In the cases cited by Dr. Ney, ADHD and Autism, removing an environmental condition results in an improvement of the symptoms; this is an indication on what aggravates the symptoms but not on what are the causes of the pathology behind the symptoms. Understanding does not go behind the symptoms while knowing has to go deep into the hidden causes of the pathology behind the symptoms.

However, in the patient-physician relationship, the knowledge of the disorder has to be

understood within the perspective of the child and his family. This is why the child's perspective is so important. We want to reassure Dr. Ney that looking for causes does not prevent a scientist who cares from taking on the task of investigating, in a scientific way, the child's perspective. As we underlined in the title of the special issue, our goal was to share scientific knowledge on ADHD seen as a social, psychological and biological handicap, with specialists, school personnel, and parents, in order to extend and enrich our practices. This is why we devoted more than half the issue to articles related to the child's perspective while taking this perspective on a knowledge level, not only on an understanding level. Jan Panksepp's article on play, Russell Schachar and Philippe Robaey's article on defining the disorder as a variation to normal, Barry Schneider and Sébastien Normand's article on the role of friendship, or Jassy and Johnston's paper on families, attempt to take the child's perspective on a systematic and scientific level.

Finally we would like to highlight that understanding is personal while only systematic knowledge can be shared and communicated in an objective way. We acknowledge the fact that every care-giver has a specific understanding of the child or the group of children with specific needs he is caring for and that this understanding is constructed through interactions and observations in a clinical setting in which relationship with the child-patient is direct and used as raw material to draw conclusions. This is essential and has to be added to the shared and basic clinical scientific knowledge we must work with and use if we are to improve the lives of children with ADHD.

Sincerely,

Philippe Robaey MD, PhD  
Department of Psychiatry, Children's Hospital  
of Eastern Ontario, Ottawa, Ontario

Russell Schachar MD  
Department of Psychiatry, Hospital for Sick  
Children, Toronto, Ontario