I - Once upon a time, there was the 'hyperactive' child[1]…

They would show how, misunderstood and often ill 'treated', they nonetheless open up many new horizons…

Misunderstood, ill analysed, ill treated - if not mistreated - hyperactive - or at least described as such - , they are presented more and more often under this word, which is now so common that it has become an identity :

'My child is hyperactive, hyperintelligent, dyslexic, dysorthographic, dyscalculic'… There are so many new words ! They could only leave the doctor attentive if the spectre of a form of mistreatment - and the word used is not the least - did not loom.

'Mistreatment'… The prescription disconnected from any individualising approach concerns the medical field as much as the relationship with the child : stimulated, hyperstimulated, pressurised or else without sufficient benchmarks in a world in the grip of 'Quickly, still more, still better, still more quickly', they suffer… The necessity for all kinds of achievements often worries parents but not always the child…

All-powerful children, children without any 'limits' and subjected to the violence of words and to that inherent in the difficulty of certain parents in forcing themselves : their stimulation which oscillates between 'too and quickly' and 'not enough' or also, very often, 'disorganised' poses a different problem.

There would be much to say about the family with whom the 'hyperactive' child is confronted. Constraining because of 'too' and 'quickly' or 'not enough then quickly', they very often leave them only their body language and fidgetiness to 'say' what, contrary to all appearances, is not heard - but which they have nonetheless 'heard' about their family history, the unsaid and coded messages.

Hyper-active, misunderstood, ill analysed and yet, paradoxically, they represent an opening for the future.

Behind the dis-order, the order of the evolutionary system which is central to the miasmic process of 'Luèse' with its capacity for adaptation and innovation is at work : what comes from the homoeopathic approach shows prospects capable of helping understand the very essence of 'hyperactivity'. It offers an open field to reflection - if not research - and permits a specific and individualised treatment.

The fact of being a homoeopathic psychiatrist trained in psychoanalysis is a plus in this case. It makes it possible to incorporate the process into a space where the psyche and soma meet to throw light on the problem in its complexity and in a perspective which helps understand more subtly its genuine meaning and biological aspect.

Invaluably helpful to explain certain little-known if not unknown aspects, the Hahnemannian view is doubly interesting. Combined with that coming from psychoanalysis,

[1] From the book *De l'hyperactivité aux nouvelles pathologies*, Editions homeopsy.com and the first part of a twofold article published in November 2015, Homeopsy.com site, and presented at the Congress of Homoeopathic Paediatricians, Montpellier, November 2015.

it permits to see points which are all the more interesting as they find a form of coherent answer in a space where they engendered contradictory positions. The bringing out of an analogy between certain homoeopathic types and certain molecules to which they responded more specifically and more quickly - like a form of responding type - makes it possible to illustrate the reality of it : it allows one to initiate reflection about what - genetically or epigenetically present - may confirm certain points concerning the level of expression of the illness and that which must be reached to give effective information through the appropriate medicine and useful dilution.

So, misunderstood, ill analysed, ill treated… the hyperactive child

Although they are about different points, many of the problems that are linked to it concern allopaths and homoeopaths.

The 'classic' view stemming straight from the DSM[2] presents an over-simplistic picture of it:

To develop before the age of 7, to pose problems at school and at home and not to show symptoms linked to an existing pathology are the three criteria to be met for the name of 'hyperactivity'. It must be differentiated from fidgetiness.

Inattention, hyperactivity, impulsiveness :

These are the three essential keywords for its diagnosis, even if one of these characteristics is predominant or there may exist attention disorders without hyperactivity.

Three types of hyperactivity would be spottable :

Two of them are considered types of pseudo-hyperactivity originating from psycho-educational or reactive causes : unlike the third which, originating from psycho-organic causes, would justify their use, they contraindicate or do not respond to the prescription of psychostimulants.

The diagnosis should not be established too quickly and from a behaviour problem :

It necessitates the prior elimination of any associated pathology : underperformance at school and exclusion, learning disorders and oppositional behaviour or behaviour linked to sleep problems or an anxiodepressive disorder - hidden behind the 'noisy' aspect of the disorder - should be searched for.

The explanation advanced to give an account of the disorder varies according to its author:

Brain dysfunction, genetic predisposition with more or less bipolar disorder, ante- and perinatal factors, disorders in the family - a depressive mother, split family - are mentioned.

However, it is important to stress that all types of hyperactivity are not necessarily ADD[3].

The psychic and physical causes which lead to the symptoms should always be searched for as well as differentiation from bipolar disorder :

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[2] Classification of mental disorders.

[3] Attention deficit disorder.

The analogy of certain initial symptoms, hiding of depression by certain signs analogous to those of ADD and frequent concomitance of the two pathologies make it somewhat difficult. However, it is essential given that 20 to 32% children and teenagers become bipolar, which contraindicates the use of psychostimulants by them.

Combined with antisocial restlessness, hypersexuality, addictive behaviours, waves of depression and mixed or alternating manic episodes, bipolar disorder is often related to behaviour problems. Its depressive aspect sometimes appears only in surly expressions or eating disorders evoking those of ADD.

However, it is different from it by various criteria : in ADD, there are no mood disorders in the family history, there is incessant fluttering and, in spite of its reactive and violent aspect, hyperactivity remains uninterrupted but manageable. Moreover, there are no psychotic-looking elements (hallucinations, etc) and Tourette's syndrome is frequent.

At a general level, the therapeutic approach which is customarily advocated for ADD is made collegially.

It combines several approaches : CBT, art therapy and psychotherapy are recommended, as well as a stable and calm environment.

The child should not be rejected but encouraged and should be given few orders at the same time so as to help them master their attention and reactions…

At the medicinal level, hyperactivity, whether it originates from psycho-emotional, reactive or organic causes, unfortunately often finds the same response :

That is, only one treatment which is considered to be principally active but whose limits are minimised and sometimes even more or less passed over in silence[4] !

Ritalin® - methylphenidate - and its by-products : Concerta®, etc are recommended more or less providentially most of the time. More palliative than curing, this amphetamine would have tranquillising properties but also many contraindications : tics, anxiety, psychosis, glaucoma and hyperthyroidism are the best known, with awkward inconveniences like visual or tactile hallucinations, repercussions on growth (?) and potential induction of drug addiction (?).

Less known than its short-term ones, its long-term effects engender a prescription which is all the more disputed as the variable results pose, after the evaluation of the symptoms, the essential question whether ADD should 'always be treated'.

There are various non-conventional treatments :

Fatty acids, Fe, Mg, vitamin B6, massage, Tomatis Method, Biofeedback, phytotherapy - Ginkgo biloba - , Pycnogenol, various dietary regimens notably as regards sugar, and homoeopathy are the main ones.

The homoeopathic approach of ADD is not easier.

[4] Given the reappearance of the disorder when the experiment was stopped while the medication was still taken, a study carried out on 2000 cases showed - but this was quickly concealed - that it was not Ritalin® which had been active but the attention and support given to the child and their parents. See, on this subject, *De l'hyperactivité aux nouvelles pathologies*, Ed. Homeopsy.

Even if it throws light on the problem, it is, paradoxically, a source of complication :

More subtly established, the diagnosis and therapeutic approach nonetheless offer an open field to reflection on many points.

Certain of the most significant elements show the complexity of a problem which cannot be either dealt with in an unequivocal way or given an automatic and final response.

The obvious and proven impact of food - notably sugar - therefore makes one think about many Lycopodium subjects or Argentum Nitricum ones ; the permissiveness or hidden violence of the family environment reminds one of the role of 'Luèse' and its problematic effects ; the impact of the relationship explains certain pseudo-types of ADD generated by an 'absent' and non 'containing' mother of the Medorrhinum type, or by a mother of the Arsenicum Album, Cyclamen or Argentum Nitricum type : she gives the child a place in a constraining way and therefore allows them no movement except gesticulation and rushing ahead.

To spot it and understand it - this is the advantageousness of the homoeopathic approach - permits a more appropriate response…

All these elements show that many factors come into consideration : the somatic, relational and psychic aspects each have a role to play to indicate the meaning of the disorder and the way of alleviating it in the most appropriate manner.

So, ADD is ill analysed, even by homoeopaths :

- Even if certain homoeopathic types emerge, very few of them have <u>all</u> the characteristics necessary for the 'hotchpotch' diagnosis of 'hyperactive' child[5] :

It seems therefore difficult[6] to make the three elements which define its place in this category coincide with a particular type.

Behind 'hyperactivity', there is a physical history and, added to it, the expression of the several faces of a psychological problematics in which the diathetic marks impose their stamp ; as it is different for each of them, it prevents any approach from reaching the following conclusion : ADD = a particular medicine.

At most, it is possible to put forward the frequency of such a type to illustrate such an aspect of ADD.

- Clinical observation nonetheless makes several types emerge, for apparently different reasons :

Tarentula, Medorrhinum, Argentum Nitricum, Stramonium, Hyoscyamus, Cina, Lachesis, Lilium Tigrinum, Iodium, Calc Phos, Ferrum Phos, China, Silicea, Lycopodium.

- Repertorisation is more prolix :

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[5] Which shows the limits of any classification, including that of DSM-5 (Classification of mental pathologies), whose usefulness is to permit a language common to all and the pinpointing of pathologies.

[6] As shown by what comes from repertorisation.

As regards the inherent characteristics of ADD, Kent's repertory lists under the heading 'impulsiveness' : **Argentum Nit**, *Arsenicum Album, Aurum, Cicuta Virosa,* Camphora, Ginseng, Merc Sol, Nux Vomica, Rhus Tox, Staphysagria, Thea.

It is important to stress that this particularity of the behaviour does not have the same meaning at all for each of them and they may partially appear under the headings : inattention, concentration difficulties, excitement, fidgetiness.

'Inattention' lists : Aurum met. , Cicuta, *Merc Sol,* Rhus Tox ;

'Concentration difficulties' : **Nux Vomica, Rhus Tox**, *Merc Sol, Staphysagria*, Argentum Nit, Thea ;

'Excitement' : **Argentum Nit, Aurum met. , Nux Vomica,** *Arsenicum Album, Cicuta Virosa, Mercurius Solubilis, Thea,* Rhus Tox ;

'Fidgetiness' : **Argentum Nit, Arsenicum Album, Camphora, Merc Sol, Rhus Tox, Staphysagria,** *Aurum,* Ginseng.

- Broadened repertorisation mentions 60 impulsiveness remedies, 553 fidgetiness remedies and, as regards concentration difficulties, 385 under one heading and 22 under the other.

Certain types show +++ considerable fidgetiness

- linked to emotionalism, with concentration difficulties which are significant in Pulsatilla and less serious in Ignatia ;
- linked to reactiveness caused by nervosity, with few concentration difficulties in Cicuta Virosa, who is ++ impulsive (epilepsy) and without any impulsiveness in Colocynthis because of the +++ pains and also in Camphora[7] (?), Rhus Tox ! (because of tension ?) and Staphysagria (humiliation)[8] ;

Considerable fidgetiness may also be :

- linked to a +/- marked depressive disorder in Arsenicum Album, who is anxious and ++ impulsive ; combined with considerable impulsiveness in Argentum Nit, Anacardium, Aconite, Cuprum, Hyoscyamus, Merc Sol and Sulphur or minimal impulsiveness in (little concentrated) Lac Caninum and Sepia or (++ moderately concentrated) Medorrhinum.

Certain show ++ moderate fidgetiness and more or less marked impulsiveness :

Among the +++ non-concentrated impulsive ones, Nux Vomica as well as Causticum and Lachesis - although they are not impulsive (?) - can be found ;

Among the moderately concentrated impulsive ones, Aurum and Aurum Mur, and Chamomilla and Natrum Mur, who are not impulsive, can be found ;

Among the little distracted and non-impulsive ones, Iodium and Agathis ;

Others show + minor fidgetiness :

[7] Heading 1 of ADD… ?

[8] Headings 1 and 2 of ADD.

Phosphorus and Alumina, who are not concentrated and not impulsive, are among them.

This can only engender several comments :

As regards their prescription, can they all be categorised into ADD for the same reasons ? (Cf. Colocynthis).

As regards the understanding of the disorder presented, two questions also arise :

On what is the pathology of ADD based ?

What might justify the taking of Ritalin® ?

From an allopathic perspective, one may point out that, whereas the therapeutic approach depends closely on the diagnosis in question, the imprecise frontier between ADD and bipolar disorder shows that the limits of DSM-5 clash with the clinical reality.

As regards the homoeopathic perspective, unless one abandons the idea of linking the illness to the medicine - which was never advocated either by Hahnemann or Kent - , the temptation to confine oneself only to repertorisation, that is to say, without taking into account the whole picture, is as problematic…

It is therefore as difficult in both cases to make the chosen treatment coincide with the classification established.

Yet, homoeopathy can shed light on different points which are very useful to study.

To be continued…

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