Gilles Julien M.D., O.Q., C.M.

EVERY CHILD AN OPEN BOOK

FONDATION DR JULIEN

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BY THE SAME AUTHOR

Parler pour les enfants, Illustrated by Philippe Béha, Éditions Libre Expression, 2014.

À hauteur d'enfant, Éditions Libre Expression, 2012.

Tous responsables de nos enfants – Un appel à l'action, with Hélène (Sioui) Trudel, Bayard Canada Livres, 2009

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Translated from French by Kathe Lieber

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TABLE OF CONTENTS

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- Dr Gilles Julien

A WORD FROM THE AUTHOR

Why write (yet another) book about children?

Well... Because we talk about children all the time, but even with the best of intentions, we don't always do enough for them. Far too often, we just make recommendations that are a touch too theoretical and pronounce pious wishes that hardly ever lead to concrete actions or measures that bring hope and success.

Because so much remains to be said, and we don't always know how to decode what children need or what they're asking for.

Because we often wonder what to do and how to do it to understand our children at a deeper level.

Because we "lose" too many children, and far too many fall between the cracks.

Because so many children still seem to be suffering, stuck in a holding pattern, which affects their future and the health of our whole "modern" society.

Because we still have so far to go to make their lives fairer and more equitable, with all the respect they deserve.

Because even though Canada is a signatory to the United Nations Convention on the Rights of the Child, this country doesn't perform very well when it comes to applying the Convention in real life.

Because the famous *Québec fou de ses enfants*[1] came out more than 20 years ago, but few concrete steps have really been taken since then.

Because the number of children living in precarious circumstances is not going down, despite our status as a rather wealthy country.

Because we haven't always kept our promises to children...

Because poverty and social inequalities have negative consequences on the health and development of a high proportion of children around the world.

This book is intended for all parents, because they're the ones who understand their children's needs and respond to those needs as the children grow up. The book is also meant for professionals, researchers, decision-makers, politicians and everyone who cares about our children. This book also advocates that children be made part of the discussion so that they can express themselves freely and suggest solutions of their own.

We hope it will serve as an instrument for rethinking how we help and support our children, from the perspective of "it takes a village to raise a child," in full cooperation with families and the community.

And so I present a model for action that's entirely based on the needs and rights of children, based precisely on gaining a greater understanding of children, their roots, their aspirations,

1. *Un Québec fou de ses enfants* a report published by the Quebec Ministry of Health and Social Services in 1991, is still considered an important reference for everyone with an interest in children and families living in difficult situations. http://publications.msss.gouv.qc.ca/msss/document-000205/

and most of all, the great value they bring to our society. That's what I call fully RESPECTING our children.

Let's start by looking at children themselves, their emotions and their secrets. We'll explore their multifaceted needs and the way they see and endure the world around them – what makes their eyes shine, how they understand the world, how they interpret adults' attitudes and how they react to the global environment around them. With this close-up view, we'll soon see what it takes to fully respect our children.

We'll try to interpret what we can't see – what's hidden behind the temper tantrums, the deep sadness, the troublesome behaviours and the failures at school. Based on those observations, we can proceed with a fuller understanding of the real reasons behind children's discomfort, frustrations and even the diseases they develop.

Through their dreams and desires, children share their visions of a better world, a world centered on what's most essentially human. They express their fears and anguish, their joys and hopes. Their messages are subtle but can certainly be seen with the naked eye, especially by parents and professionals who are willing to devote their time and enthusiasm to listening to the children.

"When the parents (or other adults, I would add) speak for us, the kids, we become invisible..."

An eight-year-old's

Of course, parents aren't always objective, and neither are professionals. All too often, they think for the child, reasoning as adults rather than as parents or allies. They tend to interpret what their offspring say and do based on their own perceptions and their own needs. They want to do the right thing, protect and guide the child, but at the same time they may be too distant, too invasive

and protective, with the negative result that the child feels silenced.

Many parents fail to realize that their child, even at a very tender age, is extremely sensitive to everything that happens in the home, the parents' relationship and everyday family life. The child's reactions are spontaneous, sudden and often paradoxical. A child who doesn't have a bowel movement for several days, sleeps poorly and has tantrums may be expressing her fears, anguish and the feeling of being unloved. When the parents argue, even while the child is asleep, what she fears most is separation or abandonment. The child's whole life revolves around her relationship with her parents. Everything the child perceives as a threat hanging over that unique relationship leads her to overreact and send signals that are hard to interpret. At this point, we need to step back. And that's the premise of this book, which we hope will inspire everyone who works for the good of children.

To fully understand our children and find inspiration for decisions that involve them, we need to spend time together. Closeness is an essential condition for creating a bond. While parents are best placed for that, this approach is not only intended for parents. Professionals who work with children can also foster a sense of closeness and intimacy to make their interventions more effective. Teachers and doctors, among others, also need to work together to understand and help the child. The interaction that emerges from this approach will help them grasp the children's emotions and real needs, with the goal of finding an appropriate level of support.

To interpret this properly, we also need to pinpoint the backdrop against which the child is growing up. Issues such as poverty and social inequalities that victimize the child, along with the abuse and trauma the child suffers, can have dire consequences for their health and wellness in the future. All of these aspects are part of the reflection and analysis process.

So welcome, everyone: parents, friends, neighbours, professionals from every field, politicians and decision-makers of every

stripe. Let's really look at our children, decode their messages and appreciate their wisdom – seeking a new and better world and building it together, hand in hand.

"So this is a book about actions, about how actions become gestures, and about how gestures transmit messages. As a species we may be technologically clever and philosophically brilliant, but we have not lost our animal property of being physically active; and it is this bodily activity that is the primary concern of the peoplewatcher[2]."

Note: The case studies in this book are based on actual facts. The names have been changed, along with some identifying details. In several cases, stories have been combined to maintain confidentiality.

2. Desmond Morris, Peoplewatching: The Desmond Morris Guide to Body Language, Vintage Books, London, 1977.

CHAPTER 1

THE IMPORTANCE OF REALLY UNDERSTANDING AND DECODING WHAT CHILDREN ARE TELLING US

"Yes, everything is in the eyes.
Or perhaps in the unfathomable that lies behind the eyes?"
Heretics, Leonardo Padura

Finding inspiration in our children means having the will and the ability to observe them so that we may understand them better. We need to have faith in their abilities and consider them fully formed people in their own right. We need to spend time with them and love them for their depth and their spontaneity. We need to really see them and adore them as unique beings who express themselves in various ways, explicit or implicit.

This essential base, respecting the child as a full-fledged human being and citizen, is the cornerstone of all our interactions with children. On that basis, everything is allowed as we move to take action, whether it be prevention when there is a real or suspected risk or with the goal of treatment when harm has been done.

For example, if we observe attitudes or behaviours that lead us to believe that a child is being sexually abused but won't talk about it, or a teen is talking about suicide, we need to step in and act with the greatest of respect. We need to get closer to the child to create a bond of confidence and clear a space for the child to trigger an opportunity for conversation.

For example, one may suspect sexual abuse if the child is showing sexualized behaviours that are not age-appropriate,

excessive modesty out of context or grown-up attitudes when in contact with an adult, whether a family member or someone else. Here are some concrete examples:

– A grandfather wants to make up for lost time when he sees his granddaughter after nine years apart. She's now ten years old. He has visitation rights and decides to sleep with her in the same room, to be closer to her. He gives her sloppy wet kisses that she finds disgusting... It's time to ask questions... and get involved!!

– A six-year-old girl is showing her vulva to strangers or members of her family, and trying to touch boys' penises in the school yard, without the slightest inhibition. Abuse, exposure or precocity? We need to join forces to find out.

It is crucial to understand and decode what a child expresses in different situations if we hope to take action. The most appropriate way to start the process is to draw closer and let the child guide us.

I just saw a ten-month-old child with the most magnificent blue eyes. He was all smiles, beaming. We'd been brought together for a photo session on the theme of hands – their role, their beauty, their effect on others.

With his mother in the room, the photographer took pictures of our hands and the baby's feet for a good hour, to our great delight.

The hands as first contact, as a way of bonding, as a protective device that makes people feel secure... The hands hold so much love! This was yet another wonderful discovery, the kind I make every day as I spend time with children.

We arranged our hands every which way, front,

back, hand in hand, fingers laced, in a protective position or just on their own.

We have two hands and they're always in motion, often together, in harmony, but also independent, supporting each other or sometimes in competition, as in the expression 'to give with one hand and take away with the other.'

I could feel a close bond with the child. He seemed to be reassured and fully present, he seemed to have everything he needed to develop properly as a healthy human being. Attachment, confidence, identity, security, motivation: he had it all, full tilt. You could feel it, you could see it in his eyes and the way he moved.

We kept looking at each other, and our glances guided us in everything we were doing, because we couldn't use words. What luck to have our eyes, and our hands, to show us what was really essential!

The eyes are probably the best indicator of each person's experience, everything that's going on, inside and outside. We narrow our eyes when glaring or when angry. We close our eyes when we're afraid or trying to escape from something that's unbearable. A vacant look may be upsetting or appealing. Veiled eyes are intimidating or make us fear the worst.

And then there's the whole interior world, the deep, secret "me," which can often be detected in a person's look if we take the time to find inspiration.

And so we can interpret children's reactions through the effects of their human warmth, their expressions and glances, the sounds they make and the attitudes they show. That is the broad intention of this book: to help us understand our children better and give them the respect they deserve.

Chapter 2

THE ORIGIN OF CAPACITY

After practicing social pediatrics in various settings for more than 40 years (1974 to 2020), I've learned a great deal about children. Best of all, I've had the opportunity to experiment with different ways of decoding them, child by child, by making meticulous observations of their everyday life.

It's been a long road, but so fascinating – since every child is different. I've constantly needed to adjust my approach. What a wonderful challenge it's been to find ways to draw nearer and find the particular vulnerability or openness in each child, to understand their individual needs through such varied modes of expression.

I recognize most of the children not by their names, which I soon forget, but by their eyes, and by the small gestures they make, the special looks, the way they smile, even the way they walk. In a way, I become close friends with all these children, with the ability to see what is unique in each of them, sometimes including what's wrong with them. I can see strengths and weaknesses, talents and opportunities that will fill in the blanks for a supportive action plan.

Sometimes they have a particular "aura" that I find fascinating. That stays with me for a long time because it's a form of attachment, inimitable and unwavering. Some children undeniably leave more of a mark on our memory, and that aura certainly has something to do with this stronger connection.

My "expertise" probably comes from a kind of natural gift combined with a learning process that's developed over the years through observation and practice, but mainly from my passionate

interest in children and my fervent desire to understand them better so we can help them. Sometimes I almost forget about the grown-ups in the room...

Every child is different, with different nuances and reflexes and traits. Their genetics, temperaments and characters do indeed make each and every child "special and unique." However, in terms of their essence and their spirit, their spontaneity and intrinsic purity, they are fundamentally alike.

I really hope that all the parents who read this will see themselves in these pages, and that some will learn to watch and listen to their own child with closer attention. It would make me proud and happy if that were to happen.

Happily, children behave consistently when they share what they feel and what they know. We can see that through their favourite expressions, their physical features and their distinctive body language. We can understand them better by looking at the emotional nature of their signals, which translate into common feelings related to fear, anger and happiness – all equally intense.

I've rubbed elbows with many children – here in Canada, of course, in various milieux, but also in Africa, Europe, even in the Arctic. Despite the difficult living conditions most of them struggle with, to me they look similar, straightforward, spontaneous, warm and full of laughter. Background, skin colour, status – those are just tiny things that don't really matter. In my eyes, every child is different and unique, and that's the beauty of it.

I feel at ease with all these children, whether they come from African villages, deepest Albania, Inuit communities, remote villages

in Quebec or migrant populations.

The borders that exist are not of children's making; they are barriers created out of thin air by adults blinded by more sombre considerations of human nature. We certainly see great insensitivity to children: neglect, abuse, forcing children to work under inhuman conditions or using them as cannon fodder. This is an undeniable fact. We must never stop fighting this shameful trend.

All children bond in much the same fashion, easily and naturally. All you have to do is play with them, play the clown, show your unconditional love with a look or a kind word, or simply reach out your hand to help them along the way. That's all it takes.

When a child is happy, we know it and we can feel it. When a child is sad, we feel that too, and so we reach out. When a child is scared and anxious, we can see right away as he loses his self-control and coping mechanisms. The child runs away, reacts, protests. That's when we need to stop and console him, learning to understand the child so we can really help.

However, getting to know them at a deeper level takes a great deal of time and patience, as well as an essential attitude – the ability to get down to their level and look them eye to eye, nose to nose, quite literally.

Early on in my pediatrics practice, when I was working at the nursery, I discovered children's distinctive styles, body language and personalities. At first glance they all seemed to be the same but for the colour of their blankets, blue for boys, pink for girls.

But it soon became clear that each baby was different, with a distinctive personality, even at that early age.

Since I was there to examine the babies, I soon discovered through attentive observation that some babies were anxious, some relaxed; some smiley, some more serious; some making chatty noises, some quite silent. Most of them were clearly enjoying life, although a few seemed to have some hesitation about coming into the world. Some cried as if they were in pain, as if, perhaps, they were remembering a past life or anticipating what was to come in this life.

Our young pediatrics patients don't have much to say in the beginning, with an extremely limited vocabulary. The older they get the more expressive they become, often in an atypical manner, most often beyond traditional language.

In the first few months of their lives they may be calm or agitated; they may sleep or cry to show their very basic needs. Then they begin to babble, and in a little while they start to talk, using their own jargon. Words finally appear, followed by rudimentary sentences, and their language becomes more complex over a period of several years.

Some children don't speak at all because they have some block, disorder or lack of interest in using this form of oral communication. And so we need to learn to decode their needs by setting aside normal language and trusting to their many different forms of expression. This has been my practice over many years, a constant and ever-fresh pleasure, going from discovery to discovery.

For some children who don't talk, some children with autism for instance, spoken language may not start for several years. So we can't use words to communicate with them. However, they may be great communicators in other areas, such as rhythm, touch and music, and that's how we can reach them. Once we find the right door to knock on, real communication can start.

As children take their time to start talking – even once they're talking, in fact – non-verbal language is the primary

way we communicate with them, the way we learn to understand them better so that we can guide their development and shepherd them on their search for wellness.

Children can communicate in different ways, and verbal communication is not the only path to follow. The structures and nuances of spoken language are difficult to master. Children have a great need for intimacy, they have their secrets and their mysteries that words can never fully express.

Everything speaks volumes, whatever the child's age or background. From the first moment of contact, we observe how they laugh and cry, their body language and expressions, their attitudes and tantrums, when they're feeling sulky, when they run away, when they're feeling oppositional or aggressive. All these signs and attitudes have meanings that we need to analyze and discover

"Children try to make us understand what they're feeling and what they want through their body language, their tears, their stubborn, provocative or oppositional behaviour. We need to learn how to decode their language, which may seem obscure at times but is generally astonishingly clear and simple[3]. »

3. Gilles Julien, *Aide-moi à te parler ! La communication parents-enfants*, Éditions du CHU Sainte-Justine, 2004, p. 87.

Chapter 3

THE IMPORTANCE OF CONTEXT

The context in which children grow up is also extremely important, as context is frequently the major determinant of what puts the sparkle in their eyes, what holds them back, and what contributes to their development and well-being.

"Context" has to do with the global environment of the child, like fish in the sea. It is life-sustaining, extremely influential and a kind of blueprint for their global development.

Context involves families and friends, cultures and identities, living conditions and security, as well as human relationships, attachments to significant people and access to all the tools needed to ensure a complete and harmonious development.

The notion of context also refers to genetics, individual abilities, integrity and resilience.

For example, a warm environment in which the child feels secure is reassuring and helps the child to fight various forms of stress, which can soon become toxic without this form of immunization we call "resilience."

Resilience is the ability to offset states and events that can be harmful to our health or development. It helps us to control these stressors and protect ourselves through our own sheer strength of will.

By contrast, an environment in which the child feels insecure, living in doubt and fear, can only create anxiety, which inhibits the defense mechanisms under the influence of uncontrollable stresses that are incompatible with harmonious development. Children who are left to their own devices and lack this capacity for resilience, innate or acquired, are at immense risk of losing control.

Meticulous observation of non-verbal signs linked to the multiple stressors children have to cope with is a powerful tool for understanding their emotions and behaviours. Through observation, we can decide upon the best preventive support to give the child a greater sense of security and a greater capacity for resilience in order to do well in life.

We need to recognize these contexts and fully grasp the emotions at play and the behaviours that are manifested, so that what we do is really designed to provide help, support and care in a sensible way, so that these actions are successful. This recommendation applies to everyone: parents, friends, professionals. It's part of the art of being a good parent and a good professional. Fully understanding what's at stake before taking impulsive steps is the key to giving children the support they need.

MAËL

Maël was one of those children who makes a strong impression. He'd been sent to us by the team at the elementary school he'd been going to for less than a year. He came in with his mother and the educational psychologist from the school. They were a family of three at home: Maël, his Mum and his little sister, who was four years old and the apple of his eye. There was no father, according to the mother. He was "unknown," a term we hear frequently at the clinic that can have

several shades of meaning and different consequences.

The father may really be unknown or simply not declared on the birth certificate. He may not even be aware that there is a child or be kept away deliberately for various reasons. In Maël's case, he just wasn't there, for no specific reason but surely with some negative effects.

When I asked why he had come to see me, the boy said, "I've come for my feelings," which is a pretty unusual and intriguing thing for an eight-year-old to say. Feelings related to emotions, impressions and reactions. Right from the start, I realized I'd need to find the deeper meaning of that sentence during our meeting.

Since starting elementary school, he'd been to three different schools. The first year he was in a "classe d'accueil" (a welcome class for new arrivals to help them learn French), which was somewhat surprising because he was born in Canada to a mother from the French West Indies, who made sure he was exposed to French from birth, as well as Spanish and English.

By the age of four, he still wasn't talking. His mother had been advised to speak only Spanish with him, but that had made no difference. At five, he entered a kindergarten classe d'accueil, but still wasn't saying a word – in fact, he'd never said a single word in any language. By the age of six he was saying a few words, but his speech was unclear and he still wasn't putting together whole sentences.

The story of his birth provided no clues to specific events of a traumatic nature that could have played a role in the absence of his language development. His mother said her pregnancy had been normal, but in the last few weeks in the womb, the child had had heart problems that could have caused complications, so he was delivered by Caesarian section, a little early.

Maël had spent the first week of his life in the hospital for heart problems and respiratory difficulties, but there did not appear to have been any lingering effects to worry about.

He went to daycare around the age of one, but his mother soon had to pull him out due to his erratic behaviour. He had stopped eating, begun to have eczema and always seemed to be sick. He refused to go to daycare and had tantrums all day long, so his mother kept him at home and left her job to look after him.

When Maël was three, his mother tried to put him back in daycare, with the same results: major tantrums, refusal to eat, constant crying, weight loss. She took him out of daycare again. Was he just temperamental by nature, or was there some insecurity or discomfort? Our assessment yielded only hypotheses. Could it be an attachment disorder?

Then, just when he was pulled out of daycare, his mother became pregnant again, accidentally, she told me. During her pregnancy, the boy became her caregiver, attentive to his mother and the baby-to-be. His moods were much improved and he stopped having tantrums. His mother said he was the perfect child and she could count on him, though he still wasn't talking.

When his little sister arrived, he fell instantly in love with the baby, becoming her protector and taking care of her as if he were the father. Was he trying to replace the "unknown" person in his life, play an important role within the family, fill the gap? Well, that was just one of several hypotheses.

The rest of the questionnaire showed clearly that the problem was a simple language delay, with no associated disorders. The remaining developmental markers were in the normal range, except for continence – he wasn't fully toilet trained until he went to school at the

age of five.

Apart from the episodes of severe separation anxiety when he entered daycare, there were no other signs of a deeper attachment problem between Maël and his mother. However, their relationship seemed to exist on two levels. Sometimes their rapport was quite mature, and they were like two grown-ups – sometimes like mother and son, sometimes more like siblings, each playing their respective role in the family. We really needed to dig deeper to find more specific causes for his behaviour and lack of verbal language.

During the first few years of his life, the boy would occasionally have major tantrums out of sheer frustration. He'd have an outburst over nothing, especially if his mum refused him something he wanted or there was some change in his routines and habits. The screaming could go on for hours. Was it just a matter of temperament? Was he simply an irritable baby?

His mother described her son as relatively independent, saying that he usually preferred to play on his own. But he didn't seem able to maintain eye contact, and would even zone out sometimes. When he was three or four, autism even seemed a likely diagnosis, given his language delay and social communication problems.

Against all expectations, between the ages of five and six when he entered school, there was a minor miracle: Maël began to speak spontaneously, without ever receiving specific language therapy. He made rapid and continuous progress, and by the age of eight he was speaking quite normally and doing well at school.

Maël had always been in a regular class except in kindergarten, when he was placed in a "welcome class" due to his language delays. From grade two on, his language skills improved by leaps and bounds – quite impressively, in fact. Perhaps having regular contact

with other children awakened the desire to learn and fostered his spoken language skills. Perhaps being away from his family responsibilities could also explain this surprising progress: less stress and more opportunity to learn and behave like a normal child. We could come up with all sorts of hypotheses, but there was still no proof for any of them.

In grade three, according to his mother, he seemed to be doing quite well. His expressive language was pretty good, his level of understanding was mature and his social skills were impeccable, although he would still space out occasionally. In two years, his language and personality had made extraordinary progress.

At school, however, the picture seemed to be somewhat different. He was not very clean, according to teachers and professionals we met from the school. Some rigid behaviours and phobias were observed, especially when he had to deal with any form of failure. When asked to redo something, he would become irritable and sometimes even throw a tantrum. His impressive imagination would lead him to make unusual connections and inferences. His answers were sometimes quite irrelevant. However, his lively intelligence meant that he could conduct a complete conversation, even if his references were unusual.

He would generally refuse to take gym class or play with the other children in the schoolyard, explaining that he preferred to be left alone to relax between learning sessions.

When I asked him what he wanted to do later, he said, "I want to stay with my mother." The mother seemed surprised to hear that and opened up, saying her child was very protective of her, to the point of monitoring the smallest things she did sometimes. He would frequently copy her and mimic her behaviour, to the

point he would even dress like her at home. She was beginning to feel uneasy and guilty about this particular behaviour, which she could not explain. On the other hand, he would willingly do chores around the house and never refused to help when he was asked.

Notably, he would go off into his own world, into his own bubble, fairly frequently. Someone would have to bring him back, but he never fainted or had convulsions. There didn't seem to be any neurological causes for the situation.

Our first impression at that point, a bit far-fetched perhaps, was that the problem was a form of pervasive developmental disorder (autism spectrum disorder) that initially affected socialization, overall communication and language, with atypia and severe rigidity.

The background, with a father who was physically absent and Maël's self-appointed roles as substitute husband and father, certainly went some way to explain his failure to develop fully during his early years. This "parentification" had not only invested him with duties that required great maturity, but also seemed to have given him an ambiguous sense of security.

Maël's progress over the next three years suggested a sort of "emergence" from a complex and atypical situation, with developmental delays, communication problems, immature relationships offset by assuming adult responsibilities, intolerances that appeared to be anxiety-related, and atypical and rigid behaviours at school.

And so we made the joint decision to perform the appropriate medical and psychological checkups, primarily to support the mother and child in the process they had begun to foster Maël's well-being.

A speech therapist tested his level of understanding to try to explain his problem with making connections

in language, resulting in the diagnosis of a serious comprehension and decoding problem. Targeted activities at our clinic were suggested to help him with socializing in a small group. Follow-up in music therapy was planned to help him manage his feelings, which had been the main reason for the consultation in the first place. We also wanted to channel his imagination to foster his creativity.

An ADOS (Autism Diagnostic Observation Schedule) assessment was also recommended by the school to rule out autism spectrum disorder. Maël's mother and I had decided not to have that test performed right away for fear of having a negative label applied to the child at a time when he was making good progress. We'd take care of that later if necessary.

We decided to do regular follow-ups to validate our hypotheses and make sure the boy was continuing to make progress. The closeness and intimacy we had developed with the mother and her son would help us gain a deeper sense of what he needed without jumping to premature conclusions. For us, it was a matter of respect, because Maël needed individualized support adapted to his particularly complex situation.

He had come in to see us because of his feelings, and he seemed to be reassured, now that he felt he was better understood and free to express his emotions. "When will we see each other again?" he asked me at the end of our first consultation. We continued to offer different services, including art therapy, speech therapy, psychoeducation and a personalized link with our team over the next few months, observing steady progress at school and at home.

At a follow-up appointment one year later, we were able to take a closer look at some of our hypotheses. He was finally tested for autism, given the pressures of

the school environment, but the result was negative. He had continued to make good progress in both language and socialization. Today, he's surrounded by friends and involved in various sports. He's stopped worrying about his mother, but remains helpful and obliging with her. He has all sorts of ambitions and is getting average marks at school, even though he has a receptive language problem. He's really on the right path now, less anxious and more focused on success and happiness, with no serious threats to his development.

Gaining a better understanding of children so that we can better support them in their development is something we all can do. It requires a positive attitude and keeping an open mind to more effectively help those who are suffering in deepest secrecy, hiding their anguish behind bewildering manifestations, notably tantrums, blocks and oppositional behaviour.

Closeness and intimacy provide a deeper observation of the context, helping us to determine the causes we can act upon to redirect and soothe a child in distress and prevent that distress. It takes time and patience, as well as setting aside rigid judgments and standards. It also takes a high degree of openness to start from scratch when a troubled child is expressing his needs in an awkward way.

A young teen had just committed an offence but was refusing to admit it. This was not his first episode of delinquency and he showed no apparent remorse. He agreed to participate in an activity on children's rights with our organization.

Against all expectations, he was shattered by the suffering of some of our kids, and soon decided to become deeply involved as a natural caregiver. He beseeched us to trust him and asked to be trained as a mediator.

A few months later, he had all sorts of projects in mind. He'd gone back to school, ambitious to succeed and go on to university. He'd found a real *raison d'être* and a sense of belonging.

NICOLE

I'd been seeing Nicole for about a year. She lived alone with her mother, who initially saw me as a saviour for her eight-year-old daughter with several serious diagnoses. Several specialists had come up with a range of hypotheses to explain the severity of her symptoms, from the worst tantrums to the most atypical behaviours, going as far as self-mutilation and severe regressions. Oppositional disorder, severe ADHD, mental illness and other hypotheses were developed, but we didn't feel that any of them could fully explain Nicole's whole set of symptoms and problems.

For a year, we'd been actively observing Nicole in various settings: at play, drawing pictures, participating in sports and when she was attending school. None of the hypotheses that had been advanced had held up. Her mother kept on asking us for help, saying that she was at her wits' end and couldn't go on. She begged us not to drop her, as we were her last recourse. Her daughter's behaviours were not improving, even growing worse at times.

After a year or so, the child's messages were getting clearer. Starting from scratch, making no judgments, listening to her and validating her messages in various settings, noting some more subtle signals, we'd come up with a new hypothesis. We told her mother it could be a severe attachment disorder with extreme manifestations. For the first time in ages, she softened and began to cry. What she hadn't wanted to hear and

had been hiding deep inside now became clear when she said, "*Quick – tell me what I should do and how I should do it. I don't want her to go through what I went through!*"

She later admitted that she had had a very stressful life. She'd been an unwanted child, her mother had been absent a great deal, and she'd suffered rejection and psychological abuse. She was intensely worried about repeating this toxic connection with her own daughter, and felt she'd failed completely, repeating the pattern she'd suffered with her own mother. She admitted she felt so guilty that she just couldn't face this reality.

Nicole was acting out, manifesting her distress through all kinds of behaviours and begging for love and security. She had no need for medication or behavioural therapy. All she needed was a loving mother with a secure link between them. We offered art therapy for both of them together to re-establish their connection and learn to deal with all their suffering over many years.

He'd discovered how proud it made him to excel at activities designed to support other kids and felt fulfilled in his new leadership role. His life had changed for the better.

We often find ways of solving problems by finding out where it really hurts, taking however long it takes, really listening and clustering our observations. To complement our own information, we need everyone around the child to get involved. Teachers, grandparents, social workers, educators and community groups are invited to participate in the evaluation process, contributing their own information and opinions. This teamwork is necessary in such complex clinical cases.

The process can be arduous and the slope very steep,

but once we know what to work on we can see the light at the end of the tunnel. It can change the rest of the child's life. In Nicole's case, starting from a pathological relationship in which the roles were confused and ambiguous, we could begin to help build a normal, healthy relationship, letting both child and mother develop fully.

Chapter 4

THE ART OF BONDING WITH A CHILD

The definition of bonding is "the formation of a close relationship (as between a mother and child or between a person and an animal) especially through frequent or constant association." The French word "apprivoiser," used in the original French edition of this book, has the subtext of making someone more sociable, gentler, more affable, winning someone's trust.

In other words, bonding means beginning to get close to the child. And the first phase in a real rapprochement is certainly to foster a sense of intimacy and decode attitudes and behaviours.

It's also the initial stage in mutual understanding, with the goal of creating the confidence needed for the helping relationship we wish to initiate. It's not really all that difficult. There's an element of "courtship" involved as well.

For us, bonding with children is based on the simplest of strategies, with the single objective of learning to understand them at a deeper level, understanding their overall needs and their environments. It's a matter of becoming friends who help each other on the way to a successful life.

ARTHUR

At at the clinic, a family with a 22-month-old boy I'd never seen before was waiting to be seen for a minor emergency. He was playing with a toy truck on the floor.

I went up to him and got down to his level, on the floor, calling him by name. "Where's Arthur?" I asked. He turned towards me and looked at me for a full minute, his big eyes full of amazement. "Are you Arthur?" He continued to observe me silently without moving.

I began to play with a little car without saying a word. He was still staring at me. Showing me his little truck, he said, "Red." "Your truck is red," I answered. He smiled, obviously feeling reassured. I invited him to play with the cars too so we could become friends. I went up close, face-to-face, and he made a movement towards me. I touched his nose with mine, and voilà, we were already friends!

Finally, I said hello to his father and mother, then asked Arthur to come into my office. He put his hand in mine, and we asked his parents to follow us to treat the minor emergency, which proved to be nothing serious. But I had made a friend.

The "courtship" aspect of a case like this first of all involves being pleasant so you don't scare the child. We use games, diversions, sometimes even magic, as we get to know each other. Then we grow closer and suddenly, we're friends and accomplices. The ice has been broken.

It's not always that easy, of course, but this kind of trick does work most of the time. If the child is anxious or traumatized in some way, we'll need to take a different approach until we succeed in creating a bond. It takes patience and perseverance.

There are essential attitudes involved in approaching a child, some of which I will suggest along with the case studies. They may seem obvious and simple, but they are fundamental to making

a good start with any child. The idea is to propose and adapt the approach to each child at first sight and not miss the point. That first step demands imagination and creativity, using skills and intuition. Eye contact, gentle touch, language and non-verbal communication, attitudes, and getting down to the child's level are all based on our feelings of how the child is doing.

The same week, I met a five-year-old who was grumpy and resistant. He took refuge in the play area of the waiting room right away, hiding behind big stuffed animals, growling and giving me dirty looks whenever I glanced his way. I tried to approach him but he was clearly having none of it, so I decided to leave him and go talk to his mother. He continued to growl from time to time, as if he was following the conversation at a distance.

His mother was finding it hard being alone with this controlling child all the time. "He even follows me into the bathroom," she told me, a note of exasperation in her voice. Clearly overwhelmed, she shed a few tears, and I could see she didn't understand this behaviour and even felt a bit guilty. "It's annoying and it makes me feel like I'm not a good mother," she added. "I just can't stand this situation any longer!" she wound up, shamefaced.

The boy went to cuddle with his mother, still hiding but perfectly in control. The minute I looked at him, he turned his head the other way. He didn't want to have any contact with me so he could keep his hard-won security around his Mum. He didn't want me to interfere with his special relationship with her. Perhaps he even thought I was trying to take his place.

This had already gone on for too long, and I had to find a way to break this untenable opposition. I went up to the mother and began to stroke her arm–the arm that

was around the boy. He looked at me incredulously, but I could feel him relax. For a few seconds, he'd abandoned his defiant attitude.

I kept on talking to the mother, pretending to ignore the child. Out of the corner of my eye, I could see him observe me intently when I wasn't looking. As soon as I tried to look at him directly, he'd avert his eyes again, but more slowly now. He was letting me win him over... and when I asked him to join me in the play area he beamed, clearly delighted.

I could tell he felt he'd been freed, at least for a while, from his too-heavy role with his mother, as if I were relieving him of an undue burden. We talked about his dreams and talents, his needs. But we didn't say a word about his immense insecurity or the conflicts his mother had come to see us about.

He seemed happy enough, telling me all sorts of things, and even confided some of his dreams. He wanted to build bridges or be a fireman who saved lives. We kept on playing, away from his mother, gabbing away like old acquaintances.

It was nearly time to say goodbye, and now that we knew each other better, I suggested they come back in a few days to do some drawing with the art therapist. We'd get back to the game we'd just begun and I'd come to say hi. Mother and son both agreed. We'd be able to start to repair the parent/child relationship that had become so insecure and destructive. By the end of the session, the boy had agreed that we were really friends and we'd see each other again soon.

Creating a bond fosters this kind of rapprochement, making the child feel more secure, which essentially means we can pursue the relationship with the goal of offering treatment or support, as in an "official" helping relationship. With this little boy, we were able to work on developing the distance and autonomy he and his mother needed to have for a more mature parent/child relationship.

Using different treatment models, in this case art – specifically, art therapy – we can approach two people who are in distress or conflict in different ways. We can also mobilize the subjects to create a shared work of art based on the knowledge and creativity both of them bring to the exercise. With this boy and his mother, the idea was to use their different strengths to help them discover something different, something better than dependency or control. This is often how we learn to set ourselves apart and have a more independent and mature parent/child relationship.

> " ...art is power [...] It is the power to touch the souls of men and, incidentally, place there the seeds of their improvement and happiness..."
>
> Leonardo Padura, *Heretics*, 2014

A successful meeting like this takes us to the true essence of the problems the child and family are experiencing. It takes us beyond the symptoms to the deep feelings and toxic environments that harm the child's health and development and create unhappiness in the family and those around them.

Decoding the child and paying attention to the parents' signals are crucial steps in the very beginning of the helping relationship, opening crucial pathways to grasp the full dimensions of the problem. This kind of creative connection helps us work together to

find customized solutions. The net result is both preventive and curative at the same time.

Insecure relationships are unhealthy and lead to great anxiety, which affects the child's development and the family's well-being. The situation will develop quite predictably: if nothing is done, there's a risk of breakdown or abandonment, as well as potential for great emotional immaturity, leading to problems both physical and mental. This is a sizeable challenge, and we dare not fail.

For this child, the door was open wide but the work ahead would be long and arduous. Little by little, the magic would work and grow as we put in place the tools to enable both parent and child to build a more mature, healthier relationship that would make them feel secure. This would have a huge impact on their overall development, substantially improving their quality of life.

Generally, a parent who's caught up in this type of difficult relationship feels trapped. Although these insecure connections are formed in all good faith in the beginning from a desire for a comfortable level of rapprochement dependency and constraints still appear. This makes everyone unhappy and unable to see possible solutions. We often see parents getting discouraged, reacting badly and even giving up. This kind of catastrophe is always avoidable.

Bonding between the parents and child, even if they are mistrustful, is crucial if we hope to take effective action.

Some additional pathways

I always make a point of going into the waiting room ahead of the kids. I play with them, then take them into my office, by the hand or in my arms, in front of everyone, as if they were the only people in the world. I give them my full attention before I even speak to their parents. Right off, they feel that they're the most important person to me, the person I'm interested in, the person I want to help.

Kids are smart. They get this. They intuitively understand the rituals we try to customize for each individual. Parents and

professionals who come in for the first time frequently feel destabilized by this perceived lack of "manners." However, the parents soon come to understand what's at stake, and I like to think that they appreciate the closeness we establish with their child, who in my eyes is always the kindest, most gentle kid.

We meet many different types of children, and their attitudes to us are just as varied. They have different temperaments, different characters, so we trust to first impressions to figure out how to proceed. Many kids have already absorbed toxic influences and often have no idea why they're being brought to see the doctor. Others are flat-out suspicious of adults and strangers, so the first meeting can be a big challenge.

With a fearful child, who likes to run and hide, we need to be patient, keep our distance, pretend to fool around, throw a ball or send a toy car moving in his direction. He'll laugh and get into the game soon enough. A little laugh or an attentive look that shows a sense of trust beginning to form takes us to another stage as closeness begins to develop.

With an agitated child who wants you to run and catch him, you can try to play his game, head him off or let him get away as if he's winning. Sometimes you'll need to seem to forget about him or pretend he isn't there. He'll soon come back to you out of curiosity, because he craves your attention. You could also try impressing him with all your toys or make a stuffed animal appear to speak or growl. The idea is to find some sort of appealing diversion that will help him focus so you can approach him more easily.

With an anxious child, it can be difficult. Sit down next to him but don't talk to him directly. Ask the parent how old the child is, compliment them a bit, but not too much, because kids know when we're laying it on too thick. Don't rush. Take the time to find the right word, compliment or expression to reassure the child just enough so you can go on. Sometimes you need to destabilize the child a little to elicit a more positive contact, which takes a lot of finesse and patience to accomplish elegantly.

Sometimes, in more complex situations, for example when the grown-ups are pouting or joking around in the waiting room, I go back to my office and ask everyone to follow me. Then I tell the child to come in, but not until he's ready. This provides a welcome buffer period. The child already feels understood, because this isn't the first time this has happened. He'll come and join us soon, because he knows we'll be talking about things that matter to him.

Sometimes it's better to remove the child from a difficult situation by inviting him to come and play with us, no grown-ups allowed. Some kids prefer to "run away" like this, even with a stranger, and soon feel complicit enough to find a solution to this complicated stress, even if it's temporary.

I'm always surprised to see how much intuition kids have, and how they can grasp the connections that lead to their "problems," especially when their parents are involved.

They have front-row seats when things go wrong, and they witness first-hand everything that goes on behind closed doors. The messages they convey help us understand the issues and what triggers their problems and anxiety. Don't miss their messages. They provide invaluable information.

KARIM

Karim, who was 11, had some learning disorders that were partly documented – dyslexia and dysorthographia, with associated attention deficit hyperactivity disorder (ADHD).

The school speech therapist had met with Karim, but hadn't had time to perform a full assessment. She'd come up with a hypothesis, but it was not sufficient to obtain adapted services. The school, in all good faith, gave Karim permission to use a computer occasionally to make things easier for him, even though there was no firm diagnosis to support its use in the classroom.

The mother, who came in with the child, had refused to put him on medication for ADHD. Somewhat obsessed with seeing her son succeed, she insisted that she could help Karim with his homework and lessons herself.

The boy was behaving pretty well at school. He was not disruptive and he took part in sports. However, I was told he spent a lot of time daydreaming and was rather introverted, shut away "in his own world." Agreeable, polite and obliging, he often passed unnoticed under the radar, easily falling through the cracks in the system. He got poor marks in the main subjects despite trying very hard. He was on the verge of failing.

Without an official diagnosis, the bar would probably just be too high when he went to high school the next year. Since he was already having major problems, a new stage adjusting to the transition to high school could only further exacerbate his anxiety level, which was already high. He probably wouldn't get the help he needed or have access to the technology that was essential for his success.

A little while before, he had told his case worker that his mother regularly beat him when he brought home a failing mark. He was afraid of going home every day, afraid of homework and lesson time. This was a real nightmare for him, since he already felt pretty anxious all day at school. Fearful by nature, he sometimes felt terrorized. He really wanted to do well and please his mother, but he just couldn't seem to do it. He was sleeping badly and becoming more and more closed-in. There was a real and imminent risk that he would drop out, rebel or even think about suicide. There were real grounds for anticipating such a catastrophe.

There'd been a report to youth protection a few months earlier based on all these factors, but the file was closed, as the situation was not considered sufficiently high-risk. Karim's mother had made a commitment to stop beating the boy. She'd admitted that she put enormous pressure on her son, but said she did it for his own good. She said he was obligated to succeed.

He presented well during the clinical exam. He was interesting, asking a lot of questions, and when I asked him what he saw in his future he told me he wanted to teach. I asked him to read me a short text. He concentrated and tried to pass the test, but stumbled over several words.

Suddenly he burst into tears, inconsolable. He just couldn't do this any more. He told me frankly that he was sick of being beaten, adding that he loved his mother more than anything. He confirmed that he had had dark thoughts lately. I asked him if I could discuss that with his mother, but he refused, saying he wanted to keep this secret. In the end he said, "You can talk to her a little…" He wanted to succeed, everyone was encouraging him, but he just couldn't manage it. He felt really powerless. What could we do?

I did talk to his mother, noting that he had a learning disorder and mentioning that I was sure he was trying very hard and he was super-anxious because he wanted to please her and succeed, but he just couldn't. I suggested that he stop doing his homework at home so they'd have fun together – quality time. We made an agreement with his teacher so he could get help with homework at school, and offered the services of a volunteer tutor one evening a week at our centre. She agreed, and Karim gave me a huge grin.

At the follow-up visit a few weeks later, I could see that their relationship had really improved. They told me about the good times they had together after school. They cooked together, went out to the park, and the stress and distress had vanished. Curiously, Karim's marks were better too.

So we continued with our initial plan, offering ongoing reassurance and adapted support, while waiting to receive a more precise diagnosis and appropriate treatment. The mother/son relationship was going much better, and Karim was feeling much less pressure. The risk level had been turned down a notch.

Kids usually become very alert as soon as we show an interest in them, in their well-being and health. They're afraid we'll intrude on their hidden feelings or jeopardize their loyalty to one of their parents. They have a tendency right off the bat to distrust unknown grown-ups who are meddling in their personal business and people who are a bit overwhelming, because they know all too well that they'll have to deal with the consequences.

Out of simple loyalty to one of their parents or from fear of the effects, they may derail the consultation, even if they know it's

for their own good. Afraid of things changing or of making their parents sad or mad, they also fear losing some hard-won gains.

For example, if the child is allowed to sleep with his parents because he's having tantrums and crying incessantly, he won't let anyone jeopardize the false sense of security this gives him. If the mother decides not to take a new lover because she doesn't want to displease her child, the son will oppose anyone who would keep him from having his mother all to himself, even though he knows this will cause severe emotional disruption.

Creating a bond with a child is a delicate process that can sometimes go awry, but fortunately, this is quite rare. You need to keep watching and know when to stop. Stop talking about things that are just too sensitive or try some simple tricks such as changing places, talking to a neutral person, or making everyone laugh and relax.

When the time's not right for whatever reason, postpone the visit and cut short the bonding attempt. Being too insistent can only do harm.

The children who come to see us generally have a lot of "history," in fact, too much history in many cases. They also have a huge array of fears and apprehensions, even if they hope with all their hearts that all this stress will stop disrupting their lives.

Complex stories of repeated abandonments, frequent episodes of violence or repeated abuse are not at all unusual in our practice.

Some of the children who come to see us may have experienced serious and traumatic situations very recently – over the last few hours. We need to learn to decode the unmistakeable signs. By the age of five or six, many children already have more "sad stories" to tell than several adults have had in their whole lives. We must respect their level of distress.

This chapter speaks to the art of bonding and decoding. There are essential attitudes to develop when we approach a child and try to understand why he is hurting so much.

An eight-year-old I was meeting for the first time, with both parents and his teacher, at first refused to see me, even before our meeting began. He complained that they had brought him to see me without his permission, and started to throw a tantrum. I went to greet him in the waiting room right away and told him to come back whenever he felt like it. There was no point in insisting right then.

I learned the real story later on. At the time of our first visit, he'd just had a horrible night witnessing a particularly awful episode of conjugal violence between his parents. He'd had to hide in the closet for most of the night with his fingers in his ears, trying not to hear the brutality of the situation.

As soon as I greeted him in the waiting room, before I could even apply my bonding strategies, his terror from the night before began to resurface. He started to swear at everyone and called me every name in the book, to the great distress of his parents and support workers. He'd seen me come in and he'd told me there was no reason for him to be there, saying that he'd refused to come but had been forced. He was so angry and overwhelmed that there was no way to stop him from spiralling.

I told him very calmly that I wouldn't see him until he asked to see me, but he could come back if he wanted my help. I ended the session without even asking him to come into my office.

My first real encounter with the boy took place several weeks later. He was in a very different state, calm, polite and ready to see me with no reservations. He asked to see me, just him and me, first, and have his parents come in later.

He felt ashamed and kept trying to make up for the last time, apologizing and begging me to forgive him. "I don't know what came over me, I'm not usually like that, and yes, I want to see you."

I remained neutral, just giving him a questionnaire with medical questions to find out what illnesses he'd had and what he was afraid of physically right now. After 15 minutes, I told him I was finished. He asked when we could meet again – "as soon as possible, please." The bond had been created, and that gave him enough time to express what he'd clearly been concealing for a long time.

Third time lucky. He told me openly what he was afraid of and what he really needed. He told me how scared he felt when his parents bickered and how afraid he was of losing them. He told me he felt powerless in this situation, which sapped his motivation at school. Sometimes he felt responsible for his parents' fighting, as if it were his fault. He wanted all this to stop, and he was asking for my help.

Together, we hammered out a plan. We decided what I would say to his parents, what he would say to them, and what we'd keep between ourselves. He accepted my offer to consult with a worker from our clinic who could help him control his emotions. It was a productive meeting, even with the parents, who were hoping to find some answers and solutions. In a few weeks, with a little patience and good faith on all sides, we were able to embark on a process of reparation and healing, without a single tantrum.

- First, use all your intuition and creativity. Feel free to use rituals and games.
- Stay in contact with the parents as you get close to the child and observe their reactions and attitudes, which speak volumes. Continue to reassure them to make sure they don't feel targeted or guilty.
- Focus directly on the child right from the start as the most important person you met today. Frequent eye contact is a good tool. Don't hesitate to talk about their talents at any time during the meeting.
- Let them set the pace, don't move too fast, be patient and dance around the child, figuratively speaking.
- Stay alert to any signs of fear, boredom or opposition and adjust your manners accordingly.
- Make the child your partner. Let him decide whom to invite, where they sit, even when to talk. They often like to introduce the people around the table.
- You are now ready to proceed.

Bonding means appealing to the child so you can work together to make things better by giving him the right to speak freely. It also means sowing the seeds of the child's happiness by respecting his dreams and aspirations.

To win the child over, we need to be willing to please, avoid alarming the child and make him feel secure in this budding relationship. This involves creating the closeness required to see beyond the child's symptoms and open the doors wide at the right time. This is the only way to see how the child is suffering, figure out where the blockages are and truly touch his soul.

To decode, understand, support and guide the child, we need to create a strong bond.

Chapter 5

THE ART OF LISTENING WITH VIGILANCE

There are many ways to lighten up the atmosphere and attenuate the effects of unbearable distress, especially at the beginning of a meeting or when you observe that the child is finding the intensity of the conversation rather intimidating.

Don't forget that in a community social pediatrics interview, where there's a great deal at stake and there are often many people in attendance, the child may soon start to feel quite uncomfortable. At the first signs of discomfort, it's time to change the subject, go into reassurance mode and take control of the situation so the discussion can continue later on.

Signs of discomfort are plain to the eye. The child is uncomfortable, he stops playing or drawing, goes to the parent for consolation, gets up to leave or makes threatening gestures. You absolutely must deal with these signs of disturbance right away.

Keep your eyes wide open all the time. Don't let the child out of eyeshot, even for a second. When we talk about real things, the child goes through a range of emotions, feeling guilty, disloyal, sad or mad, perhaps betrayed or distraught by turns, which can lead to unpredictable reactions that you need to see, prevent or manage as soon as they happen. Stay alert.

The same goes for the parents, who aren't always happy about letting a stranger know about their business. After all, they came to see a doctor, and now here they are with a bunch of people who are observing and perhaps judging them. They don't want to feel trapped when they broach subjects that relate to their private

family life. We need to explain why we work as a team, so that they can be supported too if they want to be. We always need to state clearly that our role is to take good care of the child and that it's important for us to know as much as possible about them, not to judge them but so we can help.

We need to acknowledge when the parents feel oppressed or guilty in specific situations or feel their way of life is being attacked, and defuse the slightest sign of disagreement on their part. They may also overreact, get angry, flee and slam the door. Working in social pediatrics in the community, we need to be careful to respond and act in a measured way, even when we have very strong feelings about the families we are engaging with.

When emotions are running high and there's a very real risk of things going off the rails, movement and laughter are wonderful ways to break the tension.

In such situations, get moving, stand up and move around the table, change places, go up to the child or move away. Sometimes I pretend to ignore him or I get behind him, rub his shoulders or ask him to draw me a picture.

I also take care of the parent who's crying or suddenly feels cornered, using the same methods I use with my young patients. When it comes to emotions, we're all equal. We all feel like children again when emotional subjects come up. What we need as adults is the same: to be reassured, comforted and consoled. So I get up, touch them on the shoulder, pay them a compliment or give them something to laugh about.

Lightening up the atmosphere gives us a chance to take a break, step back and make adjustments – on both sides.

Moving around creates a diversion and can serve as a breath of

fresh air, giving the person a chance to relax and temporarily step back from anything they find too painful or threatening.

Don't forget to use this precious tool. Under certain circumstances, you could even leave the room with the child to give him a break. Take him out to the garden or the back yard. Show him a book or some games other kids are playing. This attitude will give the parents a chance to regroup and talk to other adults without the child in the room.

Movement is always a win-win because it surprises everyone. It's like pushing the reset button when things aren't going well.

Laughter is also a great way to create more positive vibes. When times are tough and emotions are strong, when things are getting tense or worrying, when a parent bursts into tears, a little laughter makes a welcome change of pace.

Telling stories, making faces, launching a paper airplane or a ball in the middle of an "interrogation" can relax the atmosphere and make the child laugh, thinking that we're also capable of playing, not only taking seriously. He'll get right into the game and stop worrying about all the serious subjects you've been discussing.

You can also try tickling the kid, throwing a paper ball at him, asking him to draw a picture or mocking someone at the table (with permission, of course). Nothing is too ridiculous when it comes to changing the ambiance at a crucial stage in the bonding process.

The preliminaries for a successful clinical meeting in social pediatrics have been some of the very best moments in my practice and in my life working with children. So many things come into play in this "discovery" period. This is when we get an initial impression of the child's character and some of his feelings, which will often serve as recurrent threads later on. There could also be some "stage fright" for fear of not being able to find solutions, awakening our own feelings, like an actor who enters stage left petrified about giving a good performance. Sharing emotions is a good tool to use on specific occasions. There's no harm in trying to look more human; on the contrary, it helps bring people closer.

Chapter 6

THE THREADS THAT CONNECT US TO A SUFFERING CHILD

We can trace the **connecting threads** right through from the initial contact to the assessment process. It's crucial to pay attention to these connections and let them guide us, as they lend meaning to the process and help us decide what to include in the questionnaire. These "moments of truth" provide a unique advantage, helping clinicians to discover the essentials so that we can fully grasp the underlying causes and make more accurate diagnostic hypotheses.

Frequently, the parents are in the best position to understand the true essence of their child. Mothers and fathers, each in their own way, can predict and explain their child's behaviours and feel the strong emotions their child may be going through. Their words and reactions in the heat of the moment are valuable indicators to help us understand during the evaluation process.

When a parent stops talking, is overcome by emotion, tries to change the subject or suddenly begins to confide in us, we need to listen, respect and try to understand what he or she is doing. Console or sympathize, let the parent cry or express anger when needed.

To understand what is going on, professionals need to put themselves in the parent's shoes to follow the very same connecting threads and use them to define a problematic situation in an objective way. It's essential to partner with the parent to make sure you stay on the right path. A wink, a nod or some show of emotion will encourage us to stay on the same page. Saying a few

words to assure them that we completely respect their own culture and ways of raising their child is a good way to ease the discussion.

The following story of the 12-year-old I observed during a clinical supervision rotation springs to mind by way of illustrating the concept of connecting threads.

Creating a bond with a child is part of a healthy human relationship, whether for the parents or for anyone else who comes

MARIO

Mario had come to the clinic because he was having headaches, possibly migraines. His mother was a frequent migraine sufferer herself and was afraid her only son shared her affliction. After giving the teen and his mother a warm welcome to put them at their ease, the clinical team proceeded to administer the appropriate questionnaire for this diagnostic hypothesis.

There were questions about how the headaches felt and what could be causing them. After more than half an hour of questions, nothing concrete had emerged that we could base an official medical diagnosis on.

Mario had headaches at various times of the day, lasting for various lengths of time. There didn't seem to be any known triggers. He had headaches every day, so he would spend a lot of time in his room, missing school many days a month.

Trying to make things better, Mario's mother had signed him up for different sports, karate, even Scouts. He would go once, then systematically withdraw from the activity the next day and hole up in his room, his "retreat."

When we asked about the family situation, we found that he had been quite close to his mother in his childhood. Far from being a disturbed child, he was

actually quite well-behaved and did what he could to help his mother, who worked hard to provide the odd treat for her only son. He saw his father once a month without expecting anything from him. His father had never been a real presence in his life. He'd left when his wife was seven months pregnant, reappearing two years later without a word of explanation. Mario wasn't angry with his father; his attitude was rather neutral, in fact.

The clinic visit was going around in circles. After 45 minutes, Mario still hadn't had much to say. He was polite but neutral, as he was with his father. He answered all our questions with "yeah" and sometimes, "I dunno." His mother would take over from her son at that point, but he didn't seem concerned or anxious or particularly interested. He was doing what he had to do, which he must have negotiated with his mother.

From the start of our meeting, his attitude had been – not negative, but resigned. He gave us to understand that he'd come in with his mother and she was the one who needed help, not him. He didn't seem to care much one way or the other, hoping all this hassle would be over soon without being too much of a pain for his mother, who'd taken a day off work for the meeting, which had been going on for an hour at this point.

When the doctor took Mario into his office for the physical examination, the rest of the team and I were left alone with his mother, who burst into tears. She told us she was tremendously concerned about her son, saying she hardly recognized him over the past few months. She felt shattered, even guilty about this radical change in Mario. He was retreating from her and from the rest of his life with his so-called headaches, which gave him a chance to go off by himself. His mother was trying to convince us that he was in

real pain, but we could find no medical explanation for this phenomenon.

The medical exam had revealed nothing and Mario hadn't said a word, even when he was alone with the doctor. He would need to have more advanced tests and assessments. The visit was almost over...

I was only an observer this time and I was reluctant to step in, but a glance at the social worker convinced me not to let it go. I asked if I could speak and I asked Mario to please look me in the eye, because I wanted to ask him the question that had been going around in my head since the start of the interview.

"Do you want to die, Mario?"

Continuing to look at me fixedly, he said without a moment's hesitation, "Yes, always, every single minute."

Since the start of the meeting, Mario had thrown out a clear connecting thread. He wasn't interested in his headaches. He was bored with all these futile questions for which he had no answers. His whole body was telling us we were on the wrong track, but we were stubbornly looking at the tree while ignoring the forest all around that was threatening to swallow him up.

Mario was too sad to speak, yet he had managed to make an enormous effort to show us the real problem, despite his apparent neutrality. The connecting threads weren't leading us astray. We couldn't ignore the real problem because we wouldn't have another chance. The headaches were only a pretext for descending into an even deeper depression and serious isolation, with suicide a serious risk.

Now we could treat the boy and his mother with a plan based on a plausible diagnosis. It was time to act–we had no time to waste. Astonishingly, Mario was speaking a bit more now and even making choices on where to go from here for his own protection. We didn't

have to press him to sign a contract promising not to commit suicide.

But it was a pretty near thing...

into contact with the child in everyday life. At birth, the child knows only the sounds and murmurs of his mother, which he's heard in utero. Then he progressively discovers that he has a mum, a dad, a family and other people in the family circle. Each in their own way, they bond with the child through words, cuddles and caring.

On the other hand, the more anxious the child is due to fragile or stressful relationships or toxic environments, the less confident he will feel and the harder it will be – perhaps even impossible – to have any kind of rapprochement. Hence the importance of creating and promoting a solid bond as a tool for developing resilience and confidence.

The more positive experiences like this the child has, the more confident he'll be, and the more at ease he'll feel when people approach him in positive environments.

When it comes to understanding children through these connecting threads, the point is to form a successful ongoing bond, in which the child can establish a trusting relationship that allows him to show his needs and fears in different ways. Obviously, bonding is useful for everyone, but especially for the parents, who need to learn how to decode their child in order to establish a healthier relationship.

Chapter 7

BEYOND STANDARD PRACTICE

In the practice of community-based social pediatrics, we can't use only conventional tools to measure children's health and development patterns. Our approach really involves what is not said and what cannot be measured. We could easily miss something essential if our observations and hypotheses are not sufficiently flexible. A standard or preconceived form of observation or evaluation is not sufficient, even though we base our work on a scientific process and on best practices. We need more intuition, more flexibility and a broader perspective to learn more and to understand better.

I have always been reluctant to use screening or assessment questionnaires in the clinic. In theory, questionnaires, which let us draw the line between what's normal and what is considered pathological, are used as screening methods. But we should not count only on these tests to make our own diagnosis. These tests should be used when we wish to support our own opinion, when in doubt. They are too often used as proof of diagnosis. This holds true especially in cases where it is suspected that the child has ADHD or even autism. In community-based social pediatrics, assessment should be based on active observation, intuition and decoding all the signals given by the child. Then these tools can be used for support.

We run the risk of overlooking all this by using a "standard" form, a technique that is more and more common in more and more clinical fields. Some people see data collected in a standard way as certainties, though they are only indicators. These questionnaires have little if any place in social medicine, especially in

the exploratory phase where nothing is certain and everything needs to be validated.

A good example is the use of the Conners Scale and similar measurement tools. The Conners Scale is a screening test for ADHD designed for parents and teachers. The questionnaire yields a score for each category, and then the results are compared. The objective is to distinguish children who do meet the criteria from those who don't meet enough of the criteria.

In many cases, what is only a possibility becomes a diagnosis without looking deeper. Some children are considered to have ADHD when they only have certain obvious signs. The consequences can be dramatic and counter-intuitive.

In fact, this subjective questionnaire only describes the three major symptoms of attention deficit disorder – hyperactivity, impulsivity and inattention, along with variations on the themes. It's not a diagnostic test in any way; it's just an indicator that should only be used in combination with several others to arrive at a real diagnosis.

How many kids are sent to classes for students with behavioural disorders based on a quick and superficial diagnosis when what they really have is emotional problems or learning difficulties that have somehow gone undetected? Imagine the consequences!

A child may be agitated for all sorts of reasons: worry, anxiety, temperament, eating too much sugar, strong emotions... you get the idea.

You may be impulsive because you're fearless, because you

need someone to keep an eye on you, or because your natural reaction to trauma is sadness or anger, causing overreactions.

You may be inattentive because you're having trouble decoding a task, you don't understand it, you don't like it or it's just too hard for you. You may appear to be absent, your head in the clouds, because your mind is elsewhere due to perfectly valid concerns or for some other reason altogether.

All these behaviours could add up to a positive score on the Conners Scale and therefore a false diagnosis of ADHD.

The situation is similar for autism or Tourette Syndrome (TS). These highly specific conditions have become more and more prevalent in recent years as screening and diagnostic criteria have been broadened, but the same nuances apply as for ADHD.

You can be rigid for various reasons, asocial because you really don't enjoy social activities, and living in your own world because you've experienced severe trauma. That doesn't mean you have autism.

Same for Tourette syndrome. A child may have frequent tics, especially when her anxiety levels are high. The tics are also associated with a form of agitation that may resemble ADHD, but not all tics are symptoms of TS.

In all these cases, be extremely cautious. Context is crucial in the assessment process, and serious ongoing observation is needed before arriving at an overly hasty conclusion.

Observation, going deeper, decoding the child and the milieu – all of these are crucial stages in our process. You need to find the loopholes without proceeding too quickly; active patience will bring results. The diagnosis can wait for a while; the point is to figure out what the child really needs without causing further harm.

A child's overall development and mental health cannot be measured by "standards," as they are influenced by multiple factors related to various skills that are highly individual at the physical, mental and environmental levels.

The assessment process sometimes yields surprises that we

simply can't ignore. A child who's not speaking by the age of two may have a keen intellect, with no language disorders. He may be deciding not to speak in reaction to a severe traumatic experience or to protest some serious frustration. A child who's late in starting to walk may not have motor problems – perhaps the child is simply not motivated or too fearful from having overprotective parents. A child may be agitated, impulsive and off in the clouds without having ADHD. He may even want to die at an early age because he feels strong anger.

In social pediatrics, right from the initial contact with the child we start to look for connecting threads that will guide the process, making constant adjustments to the process as we go along.

As we've seen, connecting threads are a sign, a signal, even a command the child is offering us, and we simply must figure out the connections along the way. This requires ongoing observation and constant attention, because the signs are discreet, crude and sometimes half hidden.

Perhaps it's a glance at Mum, who seems troubled by a delicate question. Perhaps the child makes a comforting gesture to the parent when faced with a sudden emotion. Sometimes, if we let the child do a drawing while we're talking, he'll draw how he's feeling, then tear up the drawing or scribble all over it in a fit of rage. Then we know we're on the right track, and that's the connecting thread to follow.

When things get tough during the interview, the child may start moving around or doing something destructive. Perhaps he'll retreat into a corner or move away to avoid hearing things he finds unbearable. Or he may draw nearer, as if seeking reassurance, to finally hear the "real" stuff we're saying about him.

Always let the child interrupt. Feel free to explore different paths to find the connecting threads. Set aside the logical order of the questionnaire and try to discover the hidden facets of the story. Let the child and his attitudes be your guide.

Recently, I was supervising a clinical team. A 13-year-old was the subject of an evaluation meeting with multiple case workers

from her school, the youth protection agency, the CLSC and the CPS team. She decided to sit between her doctor and me and offered to introduce everyone around the table.

Everyone had a lot to say about her behaviours, attitudes and performance. She followed the beginning of the conversation closely, in silence. She also had a secret book open to take notes. Her attitude was open and completely alert, even hyper-vigilant. She clearly wanted to participate fully.

She raised her hand to speak but nobody seemed to care or notice. I had to interrupt and give her the right to speak. She mentioned that she disagreed with her educator at school, who she said had "reported some behaviours from the past that were no longer going on." She had worked on them, she said, with a grimace of frustration. Further requests to speak were ignored several more times, to my complete amazement. It was as if nobody was looking at her and they had no interest in her comments or opinions.

I interrupted again to ask her why she had not yet written any words in her precious book. She answered that she intended to do so, but only when we gave her tools for changing her behaviour so she could comply with our expectations, but there had been no suggestions yet.

Despite having so much pain and suffering in her life, having been abandoned or displaced so many times, she still had full energy to change her life and to succeed. We all realized how resilient she was and that she had her own plan to attain her goals.

Children have such reserves of strength and so much energy to change their life. All they want is to be listened to and to gain our support to go ahead. And they will. They know best what needs to be done.

If you really want to help, always give them every opportunity to express themselves.

In the clinic, they need to stay with us the whole time to do this properly. They need to listen to what the adults have to say because it concerns them first. There are no risks as some

may think that they are not ready to talk about grown-up things, because they usually know everything. When we open the conversation to discuss real things, they already feel better because we are addressing the real issues that cause them so many problems.

Sometimes it's the parents who want to hide a truth that's just too hard for the children to handle. Other times, it's the case workers who don't want to talk about real stuff in front of them for fear of hurting them.

I keep the kids with us most of the time for two good reasons. First of all, they are usually the victims of adults' stories and they're not learning anything new by hearing us talk openly. Also, it makes them feel understood and heard when we discuss real questions in front of them. It's almost like starting therapy when we start to discuss the origins of their suffering. Believe it or not, the very fact of discussing painful things that involve them in front of the child makes them feel some reassurance and a sense of security.

Having the child there as an active presence means we can learn even more about what he's experiencing at a deeper level, because we can observe the appearance of essential signals that show the child's sensitivity and spontaneity. That will help us analyze the situation properly.

There's nothing more damaging for a child with an affective disorder than being diagnosed with a behavioural problem because all the plans will focus on behaviour and not really on emotional support. Treatments and follow-ups for these problems are completely different, and using one that's not adapted to the real problem may cause even more harm.

MARCO

Marco, age 10, came to the clinic with his parents and a guidance counsellor from the school. His parents seemed to be wary, irritated and withdrawn.

I learned later that the case worker had explained the conclusions of her assessment of Marco in the waiting room. She had gone so far as to suggest medication, because the school just couldn't cope with the boy's behaviour any more. She had even floated the threat of sending their son to a special school in a few weeks if medication was not prescribed. What a great way to start the consultation!

I suggested to the parents that they start again from scratch and take another look at their histories and the child's, implying subtly that I had no preconceived diagnosis in mind. I mentioned that Marco seemed rather quiet to me for a boy who was supposed to have a behavioural disorder. Right away, the parents became more voluble and relaxed, ready to cooperate. The counsellor seemed a bit irritated, though.

Their family life was difficult, they were living in appalling squalor, and the father had been out of work for months. They also admitted that there was conjugal violence "on both sides" and that they had thought about splitting up. Marco, their only child, had always admired his father. He often followed him to work and seemed to idolize him.

Everything turned upside down when the father lost his job, and with it his pride. He fell into dark moods, he said, started to drink and became violent again, after several years of calm.

The mother told us frankly that the situation was intolerable and the bickering was constant. Well aware

that her son had changed over the past few months, she was worried and had no idea what to do. Both parents assured us that their child's only problem was being so sad.

It turned out that the behaviours Marco was accused of went back only a few months. Before that he was certainly a strong-minded child but nothing more, easily manageable at home and at school, too. There seemed to be a clear link between the stress factors in the family and the changes observed in the child, so we hesitated to speak of an ongoing disorder that had gone on for some time. It seemed to us that the change in behaviour appeared to arise more from a stressful situation than a chronic neurological problem.

When I met the child alone, he filled in the gaps. He said he was angry about losing his special connection with his father, and that he was afraid his parents would separate and he would lose his bearings. He saw the situation as abandonment, which naturally made him feel extremely anxious. He'd lost interest in school and didn't give a damn about anyone, expressing extremely strong feelings. He was actually very much aware of the link between how he was feeling and how his behaviour had changed. Luckily, he was able to talk about all this.

It would take a gentle, loving approach to make Marco feel secure again, to appease his conflicting feelings and emotions. Perhaps he would also need a class with emotional support, where under supervision he could learn to manage his emotions, rather than by coercion. But now there was a great deal to do to make his parents and his school aware of the need to take a different approach with Marco. We were a very long way from an ADHD diagnosis.

Prescription medication is a possibility for behavioural disorders, along with providing more formal supervision and setting boundaries. For Marco, that would have been a disaster, making him feel even more guilty and abandoned. He needed reassurance, needed to be told he would not be abandoned and he was not responsible for his parents' fights. He needed to have his attention diverted from the grown-ups' problems and use his talents to help him go on to other things. He would also need to be kept informed of any changes he might have to face, addressed with clarity and with the help of a third party in whom he had full confidence.

Marco's parents understood what their son needed and accepted our plan right up front. The school representative was initially disappointed, but soon came to understand that this type of support could certainly do no harm, and in fact had the potential to change the child's life for the better.

Chapter 8

OBSERVING A CHILD RESPECTFULLY

Creating a bond with the child is part of the preliminaries, like setting the table for a special occasion. We prepare everything with a personal touch, we decide with the child where everyone should sit and we make sure they have everything they need to feel at ease.

The same holds true with the social pediatrics approach. Before sitting down to eat, we need to prepare everything, because as the assessment meeting takes place around a table, where everyone has their seat and no one is left out. When everyone is seated comfortably, the child can do a drawing, play a game, even eat, but we ask that he be given priority to speak at all times. Once the table is set, we can begin.

NICOLAS

Nicolas was quite reluctant after being told he had to come to the clinic. However, All it took was an initial straightforward contact in the waiting room: a handshake after making brief eye contact, a "Hi, I'm Dr. Julien," a vague question about how old he was and what grade he was in. In short, I showed a clear interest in him as an individual before greeting the others, as though that were since he has the priority, as though he was the one who had set up the meeting.

He agreed to follow me into the room with a big smile and he was the one who invited the people who'd come with him, his mother and the school social worker, to join us. He was free to sit where he wanted: at the table with the grown-ups, on a little chair to do a drawing or on the floor with a book. He decided to sit at the table with us. He seemed to be at ease, which is essential to any productive exchange. We were ready to begin the dance.

The child is the one who gets to choose where to sit for his own comfort and according to his own preference, because he's the one who needs to feel fully comfortable. He can then change places as often as he wants, but for sure, he will always be included.

Right off the bat, movement around the table is encouraged. If I see that a child seems uncomfortable or bored, I immediately invite him or her to get up and go to a different place, to play or to do something for me. As for me, I choose a seat from which I can see everything and make my observations, especially observing the child, who is at the centre of this entire process.

Observation may then be deployed, although in fact it already began with the very first contact. Since observation is the key to the story and to our analysis of facts and solutions, it needs to continue throughout the meeting so that no cues from the child are missed and to direct our analysis.

Through observation, we can collect information on everything that will be done or said. Observation is the way we discover the subtext, what is not said and what constitutes the most important information

That specific observation makes our task much easier and

has the great advantage of letting the child be heard. In fact, that is one of the child's fundamental rights – the right to speak. This makes the child a full participant in what is happening and a true partner.

Section 12 of the United Nations Convention on the Rights of the Child[4] affirms children's right to express their views freely on all matters affecting them, their views being given due weight in any judicial or administrative proceedings that involve them. This is also true in community social pediatrics.

A child will hardly ever say he's been the victim of sexual abuse or physical or psychological violence, nor will he say what he felt when he was duped or abandoned. He won't say clearly why he hates it when his parents fight. We have to guess all of this and validate it as we go along

Successful observation involves paying attention to everything the child is doing – attitudes, body language, sighs, glances, even tears. Thus begins the true scientific process born of observation. The result will depend on this key period in the assessment process, which helps us decide what to do to target the real issues that affect the child's health or development.

Throughout the visit, all I do is observe my young patient,

4. Article 12: 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. 2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

while participating in exchanges and interventions by the adults in attendance. Everything is happening, nothing is static. Based on everyone's words, stories and reactions, we try to create movement, a lot of movement, as we collect information. Nothing is static.

It's like a game of chess in which the aim is not to checkmate the child but to use every possible strategy to fully understand her needs.

The two important pawns, the ones who move around the most in this situation, are of course the child, by his very nature, and the "conductor" of the meeting, whose role is to elicit the contexts and motions, which are the most potent working tools we have in social medicine.

The conductor guides, concedes, aligns, provokes, qualifies and verifies. It's the conductor's role to open paths, put procedures in place, elicit ideas and hypotheses, and set the scene for all the actors and players around the table.

This is not an easy thing to manage. Success is the only possible outcome: finding causes and effective ways to support a troubled child. This complex process plays out in a strict framework of respect for the child and family, and a fair-minded "co-construction" mode, where all the players are important and must be heard.

The conductor's leadership qualities are essential, requiring refined professional skills and a remarkable capacity to co-construct with the team. The conductor is also the timekeeper and overseer of the style of the interview. The conductor's duty is to synthesize the information, propose hypotheses, mobilize everyone and obtain a form of consensus on the overall diagnosis and on what happens next.

This role generally falls to the doctor, since the approach is medical to start with. In some cases, it may also be the social worker, nurse or another professional, depending on that person's credibility, experience and skills, but also the choice of the child and the parents.

The contexts are the major sites where the child's various problems originate. Sure, genetics enters into it, playing a particular role in certain predispositions (major health concerns, for example), but the milieux and living conditions are the primary primarily influences on health, development and motivation. These are the prime determinants of general well-being on which we can take action, whether through change or prevention.

From embryogenesis through pregnancy to birth, during the early years of life, at school, with the family, friends and neighbours, depending on the air we breathe and the food we eat, different events occur and shape who we are and what we will become.

These factors trigger observable emotions and behaviours in the child that we have a duty to decode. They are also at the origin of toxic stress that will harm the child's health and overall development. The stress may take the form of physical manifestations, such as headaches or stool retention, or emotional signs, such as explosive tantrums or withdrawal behaviour. We must then go into decoding mode to understand and determine the causal links, to explain the problems and dysfunctions of the child we're trying to help.

Seeking out the contexts that influence health and development is absolutely essential to this approach, as it helps us move towards a better understanding of where the child's health problems have originated.

What makes us human is our "passion": moments of heat and cold that determine who we are in the moment. We may freeze or burst out, dissolve in sadness or explode in anger. We may dominate, abuse and embody the darkest kind of violence. In our best moments, we are also capable of empathy, generosity and great kindness. We depend greatly on our self-esteem and our capacity for love, which provide essential balance to calm our apprehensions.

Children as humans represent passion in its pure state. They have no barriers and few inhibitions. We can see them as true

mirrors of what they are and what they are going through. It is much easier to decode a child in this raw state than to decode adults, who cover themselves in multiple thick and thin layers of skin to mask their feelings and camouflage their secrets.

The child is transparent right from the start – a book that's open to several different pages and several different chapters, all at the same time. We must proceed from page to page and from chapter to chapter to fully understand a child.

Chapter 9

STORIES THAT SPEAK VOLUMES

It's worth following a million tangents to learn the story of the child and family.

You can often trace various indicators in a person's history and life path that help us to understand the situations and motivations that have led a person to behave in certain ways and do things that we're attempting to explain. There is also a world of discovery, helping to explain the developmental patterns and physical problems that are frequently the initial reasons for consultation.

The deepest suffering stems from past events or chronic injuries. What we often call "polytrauma" can be the precursor for many illnesses we are trying to cure. The more there are, the more they become entrenched in the very foundation of the person, even in the genes, and the harder they are to dislodge.

A child who has suffered repeated episodes of trauma or has not had a secure attachment when very young will present behaviours that are directly related to that deprivation or abuse. The child's socialization will be deficient or erratic if the problems are related to attachment, for example, with explosive and unpredictable anger resulting from a childhood marked by abuse.

To help the child, the healing approach must reflect these causes and effects. There is no point in dwelling on details, but making these connections does help us find codes that explain things and take appropriate actions to cure.

A child who has not been loved will need care, but most of all will need ongoing and intensive doses of love. A child who has known nothing but violence and rejection will need a different

and more lengthy bonding process. A girl who's been abused and deeply injured will generally be wary of men and require an extremely respectful approach before she will accept support.

I often need to tell parents who worry about our invasive questions that an in-depth knowledge of the family history helps us gain a fuller picture of what the child needs now. We don't pass judgment. There's no voyeurism or pity here. We're simply trying to find the most effective thing to do, because we won't get a second chance.

The key moments in our life's path shape what we are and who we become. Many of our behaviours and reactions are triggered by our life story and encapsulated in that story.

As with the contexts, learning each person's story helps pinpoint triggers and impulses, as well as the deepest anguish, which lead to the serious problems we want to work on.

The story is not unrelated to the origins of some somatic or psychological illnesses. That's why it's so important to listen closely to everyone's unique life experience when making an in-depth assessment.

The story we tell extends well beyond risk factors and medical history. It specifically targets injuries along the way and current traumas, looking at the influences and constraints the child may have experienced.

When it comes to learning more about the child's experience, words are not enough. We need to pay close attention to the child's body language, unexpected reactions and what is left unsaid.

The story tends to unfold quite naturally. It plays an integral role in shaping the child's personality, leaving its traces on what the child will become. It's a sort of blueprint showing the high

and low points in our trajectory. In Quebec French, we have an expression "Être né pour un petit pain," which illustrates the enduring impact of this such a map of our existence. It's a self-deprecating expression, meaning loosely to be born into certain (poor) circumstances, powerless to rise above our start in life. A whole society can suffer from such crushing blueprints resulting from collective low self-esteem. Our history is of great value in understanding many barriers and blockages from our own environment.

For generations, many people have said that they were "nés pour un petit pain" as though it was a dire fate that would follow them throughout their lives. People would say it, believe it, and in some cases it was even taught to them. You had to be humble, keep your head down and accept that you were of lesser value, so you could not possibly succeed or aspire to great things, due to this sense of self-belittlement and fake enforced humility.

And then, in the 1960s, the story changed, the world changed and everything became possible, as the Baby Boomers at last reclaimed control over their lives. Gone was the perceived obligation to be born and live in poverty. Suddenly, everyone could aspire to success and even wealth, if they wished. I was a witness to and beneficiary of this striking period in history myself.

There are other myths whose origins are anchored in the mists of time, of course. I still hear parents say "Like father, like son" or "Like mother, like daughter," as if it were an inescapable fate, when they're trying to explain the deficiencies or behaviours of their children, the subtext being that they can't change a thing and they'll have to live that way their whole lives. When a child hears his parents speak those words, there's not much hope. The child already feels condemned to follow in his family's footsteps, and there's a real risk of repeating bad habits that are not his own, when the cycle could in fact be broken.

For a while, Marise thought she could succeed, possibly due to the pressure I was putting on her. But for a girl raised in poverty, "née pour un petit pain" with no support from

her family or community, the gap was just too great. She quit school and unfortunately, our connection petered out.

After staying away for years, she came in with her boyfriend

MARISE

Marise had quite a history. When we met, she had just turned five and was living in extremely precarious circumstances, in a "poor" family with few resources.

The little girl was extremely vulnerable, and I was very worried about her, given the risks that hung over her in everyday life. She was living alone with her mother, who wasn't really protective, and boarders who came and went all the time. She would often be "babysat" by unreliable people.

Her living conditions were toxic: a filthy apartment, a morbid environment, violence, few boundaries between her and the adults in her life. Yet somehow she was doing well in school when she was able to attend, and she was popular with her peers.

Marise had a sparkling personality and enormous potential, obviously beyond her circumstances. Lively and intelligent, she was caught in a conflict of loyalty to her mother, whom she forgave for everything and even worshipped. When we asked sensitive questions in an attempt to help and protect her, she would defend her mother fiercely.

Over the years, we had succeeded in maintaining close connections with the family and her mother had given me permission to take care of Marise, since she trusted me as her doctor.

In view of her great potential, we decided to enroll her in a private school that offered free tuition on a humanitarian basis. She was given a great deal of help

with passing the entrance exam and supported through her first year of high school, which was in a completely different milieu and clearly more competitive.

I believed she would succeed, and I think Marise believed it too, at least for a few months. But towards the end of the school year her behaviour changed and she stopped working so hard. She told me this was just a passing thing and she would get back to it, but we had to face the truth: the step between her background and the private school was just too steep.

In her world, everyone kept saying that she was changing too fast and one day she'd look down on her origins. She told me tearfully that it was just too hard for her. She didn't feel she was in her rightful place and she wanted to go back to her mother's. She'd rather be the best in her little corner of the world than struggle to keep up with the rich girls. She believed she was "née pour un petit pain," and for me that was the saddest part of her story.

I could really relate. I'd been through a rough patch myself when my parents got a scholarship to send me to a private high school. One day when I was hanging out with my friends they told me, "You're going to change. Soon you won't even recognize us and you'll lose us." It was very painful. I told them awkwardly that that would never happen, but of course they didn't believe a word. I must confess that I did in fact lose touch with them a few months later, but not because I'd become a snob. I was lucky enough to have a supportive family, but alas, that was not the case for Marise.

one day to say hi, happy to tell me that she'd finished high school and found a job in a store. That was it for her.

For Marois, another patient, things were quite different. She came from a different milieu and her family aspired to her success, as well as constantly encouraging her to do better.

The family history, culture, living conditions and community support make all the difference in a child's ability to succeed.

For Marise, life was a series of hurdles and reasons to lack motivation, while Marois' mother had confidence in her and would help her live a better life.

Our history shapes us to a large extent, but we know now that it need not hold us back, and if we decide not to play out our "fate" we can develop fully. We can change and transform our history, even reinvent it for our own good.

As we document our history, we come to understand it.

MAROIS

Marois also had quite a history. We met when she was 11. She came from Lebanon and was living in relative poverty with her brother, who was older, and her mother, who wanted her kids to succeed in Montreal.

They had immigrated two years earlier, fleeing war and violence in their native country. The father had stepped on a landmine just before they were set to leave for Canada and they had quickly been granted refugee status.

Marois was getting good marks in elementary

school, except when she was having one of her frequent post-traumatic episodes. I believed that she would find high school extremely hard to manage, so we suggested private school, with free tuition, so that she could study under more supportive circumstances, given her history. Mother and daughter were jumping for joy.

She has since completed high school with excellent marks and is now getting ready to go to CEGEP (junior college). She wants to be a doctor "so I can help people."

It proves useful in many ways as we try to decode the influences and inspirations of the past. It need never be a determining factor in our health or developmental status.

At a local event organized for teens, young Diego made a monumental error: he stole a friend's cell phone. It was quite easy to find, thanks to new technology, which leaves no one in peace. Diego denied taking the phone and swore that friends of his were the guilty parties, but he finally agreed to work it off by joining the team at the Garage à Musique.

Diego was on track to be a delinquent, with scant support from his

Together, we can't change the past but we can certainly influence what is to come for the well-being of the children. The future belongs to each individual, and the constraints of the past should never stand in the way of our success.

family. He'd practically dropped out of school and had no hope of success except as a petty criminal. When he came to the Garage à Musique, we discovered that the young man had many talents.

A year later, he'd become a terrific musician, was mentoring younger kids and had great ambitions, including going to university. He was now a positive role model for his brothers and sisters. No longer would he be tied to the role his environment had seemed to predict for his future.

CHAPTER 10

A FOCUS ON VULNERABILITY

Few of us are born vulnerable, except in very specific cases. For example, if your mother took drugs for most of her pregnancy, you were deprived of oxygen at birth, or you were born with a genetic defect, you run a real risk of being very fragile.

Brain injury can weaken your overall capacities; repeated injury can lead to debilitating pathologies. Any sort of abnormality can affect your self-esteem and confidence. Chronic poverty and the related toxic stress have a serious impact on children and their potential for full development.

Vulnerability is personal and measurable up to a point during a sound clinical assessment. It clearly provides a backdrop for determining the precise nature of problems, especially for designing an effective action plan to counter or reduce their harmful effects.

Factors for vulnerability include severe poverty, deprivation, neglect, abuse, abandonment and all sorts of abnormalities. The issue of emotions, however, remains the major determinant of that vulnerability, which causes such great harm to children. For the purposes of this discussion, we will limit ourselves to this crucial factor.

If we start from the principle of equality of opportunity that we staunchly defend and the human potential we so strongly believe in, the actions we take will attempt to repair the vulnerabilities of the past and prevent those that may occur in the future.

Emotions as determinants of vulnerability

We often speak of emotions, how they manifest, and how they can help to explain various problems we encounter in children at the clinic.

We humans are bundles of emotions, and most of the time that's a good thing. Under the best circumstances, it helps us to be creative, to be liked and loved (there is passion along with emotions) and to carve out our place in life. It's also an important base for creativity. In less ideal situations, emotions may become a barrier to development and well-being, and their destructive effects on human beings are well known, mainly when associated with anger or deep sadness.

When strong emotions, such as sorrow or anger, overcome us, we normally react in one of two ways: either by withdrawing into a state akin to depression – going off alone or letting dark thoughts into our minds – or by letting our vengeful or violent side show, which no one likes to see.

Emotions are the mediators and channels for the jolts we all encounter along the way. They provide all sorts of information on the nature of children's development and behaviours. Children are especially sensitive to overwhelming emotions.

Emotions are also a nesting place for anxiety, good or bad. Good when immersed with love and joy, bad when associated with sorrow, painful experiences or sadness, and toxic for health and development when too strong and recurrent.During the assessment, it's important to analyze all the emotions shown by the child and members of

the family. Whether they're flagrant or extremely subtle, each emotion is important and needs to be considered. Emotions expressed by tears and glances are the easiest to observe, while those that are manifested in silences and tantrums are the hardest to decode.

When a child cries inconsolably in the arms of her mother or father, that tells us a great deal about the stress the family is experiencing. The child who throws a parent a dirty look is sharing a well-kept secret, conveying that he knows a lot more than we think. If a child goes over to her parent, perhaps she believes it's her mission to protect the parent.

Children feel very connected to their parents and they're extremely loyal to them. They feel everything that's going on, even through closed doors. They hear what happens at night when they're supposed to be sleeping soundly. From a sense of solidarity, they'll often refuse to reveal anything about their father or mother for fear of displeasing or losing the parent. They express themselves more freely by what is left unsaid.

The child who retreats to a corner as though he wasn't there at all clearly has something to hide. He listens and accepts what's said in silence, but will react later on at home. Here and now, he will block all contact to protect himself from overwhelming emotions or simply out of loyalty to his parents. It's crucial for the child to pause and retreat. Let it be – he'll find his way back soon enough. Make sure that part of your approach and action plan guarantee the child has been heard completely in the end.

An angry child, one who runs away, swears or lashes out with his fist, is really hurt. We must stay neutral at all costs, reassure the parents and ignore the outbursts when possible.

To break this very real tension, one member of the team, generally the least threatening, might want to suggest playing a game, meeting at another time or touring the centre. Students, medical residents and social work interns are often in the best position to play this role. They're clearly less intimidating, as they're often

simply there to observe.

It may be necessary on occasion to provoke an emotional response to elicit hidden secrets or specific events that may have made a difference. Starting from the principle that people in the family know the causes of the child's problems, which are often concealed or unacknowledged, emotion is the only way to bring things out into the open.

We need to let these things emerge in the clinic to perform a proper assessment. It's not at all unusual, after the first few minutes of normal "shyness," for many different emotions to come out spontaneously, especially if the bonding has been successful in a climate of mutual confidence. When everything is going well, we soon discover deeper things, secrets, frustrations, and all sorts of things the adults have buried without saying a word to anyone. This is a great opportunity for the child who wants to be heard, and if they're confident, they'll feel quite at ease expressing themselves.

Having a place to speak freely is just as important for the parents as it is for the child. We need to set aside some time for this as part of the full assessment process. That's when a mother will say quietly and tearfully that she "just can't manage any more" and is thinking about "placing" her child even though she loves her. A father will confess shamefully that he's felt on the verge of hitting his son for a while now and something must be done to avoid the worst. These are precious words that we must accept with humility, swearing never to divulge them to anyone without that person's permission.

When the process isn't working, when nothing emerges, it's time to change pace. Sometimes I'll say that I don't understand, I see no explanation for the change in behaviour, sudden sleeping problems or new difficulties at school, for example. There's always a parent or a team member who can take over, setting the tone for what happens next.

I may go off to play ball with the child while the rest of the team discusses deeper issues with the parents. By the time I come

back, we have new ways to approach things, or the team will have pinpointed other key aspects to help us target the assessment.

It may be necessary to ask the parents more direct questions to bring out their emotions. "Were you like that as a child?" "Do you see yourself in your child?" "Is he like the father who disappeared from your life?" "Were you abused when you were little?" This type of question generally helps to relaunch the discussion on real issues, provoking exactly the emotions that are so hard to conceal.

NICOLAS

Eleven-year-old Nicolas was in fifth grade. The school had sent him in to see about his lack of self-confidence, anxiety and isolating behaviour. Nicolas avoided making eye contact with members of the team. He was described as an extremely sensitive child, easily set off, given to crying, inattentive and unmotivated in class. He had frequent tics of various kinds and would make strange noises with his mouth. His marks were average, but he was especially weak in math.

When I went to meet him in the waiting room, he was sitting on a chair looking at a book while his father snored away on the couch. The two of them followed me obediently without speaking or looking at each other.

The father seemed a bit discouraged, still thinking his son was immature and overly sensitive. He really didn't know what to do, though he described Nicolas as the apple of his eye.

Nicolas had a little sister at home who was five. They got along quite well, but he didn't pay much attention to her. He played alone, never went out, watched TV and spent a lot of time playing video games. On Sunday

he went to church with the family, but had little to do with the other children when there were activities. Socialization was not his strength, which worried his father as well.

At home they spoke English, not the parents' native language, Tagalog, which the boy didn't understand anyway. Nicolas' neonatal story was normal and his development was nearly normal, except for language. He had stuttered when he was little, and he still tended to hesitate when engaging in conversation.

The father said the family didn't have much money, despite the fact that both parents worked long hours. The father worked on the boats and had to go away for weeks or months at regular intervals. He would come back for three weeks and then be available for his son, whom he clearly loved, then go away again. This had gone on for years.

The mother worked 10- to 12-hour shifts at night, but didn't earn much money. She was too tired, exhausted really, when she came home to make herself available. The father described her as a rather cold person.

According to the father, the boy became anxious when asked to do several things at the same time, both at home and at school. He would then , so he would panic and block. He told me again that Nicolas would suddenly burst into tears over nothing. He thought the boy was childish and mentioned not being proud of him, clearly wishing that his son would be more of a "guy," more masculine.

Strangely enough, as this whole conversation took place in front of the child, Nicolas who didn't seem to be concerned. He continued to look at his book, and I was unable to see any surprise or wonder or any other emotion, although he was certainly entitled to react

to what his father was saying about him. He wasn't even looking at his Dad while he was recounting these events.

Since the father had returned from his last trip, he said he'd been even less available, since his own mother (Nicolas' grandmother) was sick in the hospital. The father told me, "I have something to eat, I sleep, I work. That's my life, every single day."

A babysitter – a cousin – took care of the children most of the time, but the father said she did the bare minimum.

By all the evidence, these people were just trying to hang on under bare survival conditions, which were driving them apart and especially distancing them from their son, who seemed to have given up on many things. To me, he seemed to be a refugee within his family, neutral and silent, which protected him from the anguish he felt due to distance and isolation.

His parents were involved, they both had jobs, and the children had a roof over their heads and the necessities of life. Their apartment was small but decent. They all slept in the same room. In this situation, which was beyond their control, they somehow managed to pay the bills and survive.

When I took the child away to examine him, I observed a radical change. Throughout the conversation with his father, he'd been quietly drawing, answering my few questions in simple words, even after many reminders from me and without ever looking at me or showing any emotion at all. He'd behaved as if he were hearing an old refrain that held no meaning or interest for him, despite the drama that was clearly at play between the boy and his father.

When I sat down at his feet, as was my habit, with him sitting above me on the examination table, he

suddenly came out of his shell and became voluble and animated, looking at me directly. He said he even felt he was a little childish, as his father said, and added spontaneously that he was afraid of growing up.

Then he began to talk about how much he loved watching videos on YouTube, and how he wanted to make videos himself when he was older. He said a few things about his mother: she mostly ignored him, spent a lot of time sleeping, and wasn't really interested in him as a person. He also revealed that he loved to sing, but not in front of other people.

I asked him if he'd like to join our activities. "Yes," he said. I asked whether he'd like to see our music therapist. "Yes." Whether he'd like me to register him for camp. "Yes." He was expressing his ideas very well, ready to come out of the shadows and away from the family problems.

We'd contact people at the school to reassure them and get them involved in building his self-esteem and maturity. Next, we'd reassure his parents about "not having any time," and we'd help to motivate this isolated child, who was accustomed to muddling through on his own but unable to make any progress.

The dad was delighted with his visit, telling me again that he really loved his son but the situation had been bothering him. He seemed to feel better for having discussed things openly. He said he'd try to take a little time to get closer to his son, and acknowledged that our help had come at just the right time.

Over the next few weeks Nicolas, clearly reassured, took full part in all the activities we suggested.

He'd been waiting for just such an opportunity to emerge from his state of latency. He certainly benefited from shaking it off and taking his life in a different direction. Socialization was no longer a problem for him. He

was able to show his talents in music therapy and put his parents' lack of availability in perspective. At school, his teacher couldn't get over his changed behaviour and fresh motivation.

In this particular situation, we needed to "level up." That's the best way to avoid any form of dominance, minimize the child's fears and get him talking. Which is what we did here, obviously to the boy's benefit.

In Nicolas' case, his passivity made it hard to fully interpret his state, though his inactivity was quite telling. I knew things were getting better when Nicolas took the opportunity to tell me about his dreams and aspirations. That's when everything became more clearer. Once he was in a position of dominance, he could talk more easily. Because I was "smaller" than he was, the situation was less risky.

Levelling up is a physical action. When a child is sitting on the examination table, I position myself at their level or even lower, by sitting on a child-sized chair. The child feels less overwhelmed and more in control, which is perfect because that makes him much less fearful and more open and available.

I often have residents asking to only do a physical examination. That's what they know how to do best, but they usually miss what's most important: getting a sense of how the child feels. Everything becomes clearer on the examining table. We can test

our hypotheses, feel the vibrations and emotions when we talk about real things, and use this unique state of intimacy to encourage the child to confide in us.

It usually takes me a few minutes with the child to get an idea of who he is and what he's experiencing. Based on his reactions and behaviours, I try to guess what is disturbing him and what he wants me to do. The rest of the examination is routine and technical.

When I ask residents to give me their conclusions after the physical, they tell me everything is normal, when often that is not the case at all, especially when it comes to the child's experiences and emotions.

Place a gentle hand on the child's belly and you can find out what they're afraid of. Whisper in the child's ear after using the otoscope and you can ask questions that can't be said out loud. Listen to the heartbeat and you can start to learn about their painful emotions.

Don't let these special moments go by, these times when you're alone with the child in a closer relationship. Now's the time to ask the big questions and find out what's rubbing them the wrong way in their lives.

We have to learn to use these moments that are so conducive to confiding closely guarded secrets. The child will be surprised the first time, but soon he'll look forward to being part of this special exchange. On later visits he'll be waiting for this moment, which he knows is so important.

A teen who may be slightly oppositional when his mother and

care workers are around is more likely to confide in this unique private moment, when the focus is on what he really needs.

A younger child may be wary for a few seconds, but in the relaxed atmosphere of the examination, when he's an active participant, he'll answer questions quite spontaneously. Try giving him permission to listen to his own heart or use the giraffe-shaped reflex hammer to pave the way for a much deeper exchange.

Chapter 11

THE CHILD AS A PARTNER

At the first meeting and throughout the process, the child is our most important partner. It's crucial to consult and involve the child during the assessment process and the action plan – it's all about him or her, after all.

Children are full-fledged human beings, full citizens, not just small grown-ups or some kind of inferior being. They live, breathe, think and aspire to the full development of their personality and talents. Love and tenderness are excellent motivators, placing the child in a fine position to be listened to.

It would never occur to us to treat an adult without consulting the person as we seek to form an alliance for her benefit. In the same way, the child is a true partner, in the same way, a person who can and should provide feedback on the support system we're assembling. To fully involve the child, we need to create a real bond.

The exchange starts with the first contact, intensifying over time at a pace that's different for each child. Bonding and observation help to determine the mode and intensity of that exchange.

Once you see some sign of openness from the child, you can get very close in a very short time. Take a baby in your arms when the time is right, tickle a slightly older child, perhaps even pretend to chase the kid or pick a fight – anything to make a connection.

If you feel some resistance, try acting more cautiously, holding back a bit. Use some kind of transition object – a ball or a paper airplane. Start playing with Lego or toy cars, then ask the child to

Some children will let you touch them gently or perhaps allow you to rub their back to reassure them and strengthen the bond. If you can, this will help you see where they're literally tied up in knots and feeling fragile, as well as gauging their physical and sensory reactions.

join you.

You'll soon learn what they're afraid of and how to calm them down. You'll discover the deep discomfort and crying needs they can't express in words, instead reacting by withdrawing, throwing quizzical glances or shuddering. There are so many subtle ways to develop the sense of complicity and confidence that's so essential to successful exchanges.

The exchange may be verbal, with sudden trick questions that seem to come out of left field, breaking the routine wording of the questionnaire and destabilizing your audience. It can be helpful to keep inviting the child to join the conversation. Ask what he thinks about a comment or a look from a parent or even why he was crying just now, and you may get just the explanation you were looking for. Using provocative key words is also a good tactic for getting them to say things that are hard to admit.

"Do you love your mum? I don't think you do – you hit her and threaten her every time you feel the least bit frustrated."

"Why are you still sleeping in the same bed with your mother? Are you still afraid of monsters at your age?"

"Who do you love most in the whole wide world?"

"What makes you really angry, more than anything else?"

"Do you have bad dreams sometimes?"

"Where were you just now when you drifted off?"

One time when I asked that last question, an eight-year-old girl told me, "I was on a planet where there were unicorns!" That may be hard to interpret, but for her it's true.

You'll be surprised at the spontaneous answers you can get by using these simple strategies – not just from kids, but from their parents too. You may need to speak in a slightly provocative way at times, asking straightforward questions when people want our help and just can't hide the truth any more.

"I didn't know he was having bad dreams – he never told me," said one single father who couldn't understand why his son had behaved so inappropriately lately. Since the couple usually argued at night while the child was asleep, his father thought the boy wouldn't suffer any consequences.

"I feel more secure when he sleeps with me," said one mother, visibly moved by her own answer. She'd wanted to know why her six-year-old had so much trouble separating from her when it was time to leave for school.

These exchanges can be quite subtle, with all sorts of nuances, looks, darting around other children. This is one way to create a non-invasive ambiance that will foster fruitful conversations.

A child who stays glued to his mother, hides his face and only looks at us from time to time isn't ready to talk. All he wants to do is block out the painful process that has invaded his private life or his exclusive relationship with his Mum or Dad. The message is clear: "Don't touch!" Be prepared to beat around the bush and be patient. Sometimes it will take another visit to create a certain level of acceptance and the beginning of a real exchange, at last.

Try to be creative, patient and persistent. Some children expect you to give up in the face of their withdrawn, passive or oppositional behaviour. Refuse to play that game, which could block the exchange for a long time.

One mother reported that a psychiatrist sat behind his desk and told her child, who didn't want to talk, to come back when he was ready... because there was no time to lose. Surprise surprise

– he never came back!

Throughout the process, aim for clarity, even at the risk of displeasing or provoking someone. Our goal is to discover the real issues, causes and triggers. In this framework, when you come to an impasse, it's a good idea to test your questions or hypotheses, openly and unabashedly.

When things don't work, we change track, get up and try something different. Each exchange is made of small things, different attitudes, trial and error. Don't be afraid to get your feet wet.

With eight-year-old Martin, we'd hit a dead end. We could find nothing to explain his recent change in behaviour. So I took the initiative with a flurry of questions for all the participants, but especially the mother.

"I don't understand why your child is having so many tantrums, especially at home. I'm sure you love him, but there's something not quite right. How's his appetite? Is he sleeping all right? Is he sick often? Do you think he's in pain? Is someone making promises to him that aren't being kept? Is he being bullied at school? Is it possible that he's being abused by a babysitter or a member of the family?"

In general, we do get answers to this type of tangled questions. The people around the table sometimes weigh in with explanations for the impasse. An older child may repeat some of our affirmations to confirm a hypothesis or at least get us back on track. The child's eyes or attitudes can tell us a great deal when we speak this way, openly, in the heat of the moment, without fear of being silenced. A real partnership is now being formed.

Martin took the opportunity to tell us, "It's true, my father's always making me promises he doesn't keep. He says he'll come

to get me but he doesn't show up. He didn't even call me on my birthday. I hate him."

At last we had an explanation for some of the boy's reactions. I turned to him and said, "That must make you very sad, but perhaps you're also angry with him." He shot back, "I love my dad, but I don't want to tell him anything about my life any more." He'd felt confused and conflicted for some time, and now he was asking for help.

It's not always easy to support a child in this type of situation, but we start with a small opening and help the child to find explanations he can understand. This is a good way to create a bond of confidence with the child, discuss his dreams and try to "rehabilitate" the father in his mind despite his absence. "Balancing" like this helps the child face up to adversity.

KEVIN

Kevin was only seven when he came in to meet me at his mother's request. She was living on her own with the child and told us she was very worried about him. After much hesitation, she'd finally decided to take us into her confidence. Her neighbours had advised her to talk to us, and she knew that people at Kevin's school were also worried about his behaviour.

Kevin was often chided on the bus for talking too loud. He told us that a boy his age was always beating him up. He also reported that he couldn't stand the noise in the classroom or other places where kids got together.

He said his regular "supervised" visits with his father were going well, but his Dad often failed to keep his promises. He'd never been a real presence in the home.

The main problem soon emerged: recently, after his mother punished him for fighting on the bus, he went to his room and tried to choke himself with a headband.

His mother, in the next room, heard a strange noise, as if Kevin was having trouble breathing. She ran in and found him tightening the headband around his neck, suffocating!

Worse still, this was his second attempt at strangling himself under similar circumstances. A few months before, there'd been a similar episode after she and her son had a fight. That time, he'd tried to suffocate himself with a scarf.

Things seemed to be going well at school. Kevin's marks were in the 90s in most subjects. But his teachers found that he had changed over the last few months.

From his medical history we learned that he was born in distress at 30 weeks' gestation, weighing around one kilo, and had spent the first two months of his life in the hospital. His mother said his development had been a little slow overall, but with no major delays.

Right off the bat, the mother admitted that she felt powerless in the face of this incomprehensible situation. She went on to tell us her own story: a victim herself, she was still feeling the lasting effects. She wondered about the connection between her own victimhood, which she had trouble hiding from her son, and his suicide attempts. She'd been abused and dismissed by her father for many years, although they'd never lived together. His visits were short, irregular and generally traumatic.

Kevin was certainly aware of his mother's own suffering, feeling emotionally conflicted and immensely insecure. He slept with her – otherwise, he couldn't sleep at all. He was aware of her every word and gesture. She in turn was unable to sleep unless her son was by her side.

Under the circumstances, their relationship had become symbiotic and dependent, full of pain and

anguish. "Our life is hell," the mother soon confessed.

She told us she'd do anything for him. He said that he wanted to protect her and thought about her all the time. The world had become unlivable for mother and son alike. The mother lived only for her son and he lived only for his mother. They were totally trapped together.

Kevin was beginning to find everything intolerable, on the verge of heartbreak all the time. The slightest irritant was enough to set him off and cause extreme tension; he was so unhappy that he could see no other option than to end it all.

There'd been violent tantrums, during which Kevin would destroy everything in sight or hit the nearest person. The situation had become so dire he'd tried to end his life, and at this rate, he might well succeed the next time.

There was no time to lose – we had to take swift, intensive action. Our meeting lasted for 45 minutes. Everything was put very bluntly. Clearly, time was running out.

We agreed on a plan, first aiming to attenuate the intolerable stress factors. Kevin would be set up with a Grand Ami[5] and an art therapist to give him some space and activities away from this unhealthy situation. All of us would keep a close eye on things: Kevin's mother, our team and the school, to head off further unpredictable attempts.

The mother would be accompanied and supported intensively, so her son wouldn't feel undue pressure to try to save and console her. Later, she would receive follow-up with a social worker or psychologist from the

5. The Grands Amis is a program that matches volunteers with a child from our community pediatrics centres. The matches are designed to build a solid relationship of friendship and trust to give these children positive role models and an open view of the world around them.

local community service centre.

A lawyer would speak to the mother about finding a way to keep the toxic father away, as his visits were making mother and child feel totally insecure. A meeting would be arranged with the father to share our concerns about his son, hoping he'd get involved in the future.

To wind up the meeting, the boy signed a no-suicide contract, which made everyone feel somewhat reassured.

A few weeks later, Kevin came in for a visit with his Grand Ami. The two of them had already formed a more mature relationship. His mother was breathing better and was beginning to talk about her projects. Mother and son had learned to manage their everyday lives better. The father refused to talk to us, but his visits, when they did occur, would be under better control. The way was now clear to appease their suffering and improve their lives.

Children need an adult partner to guide, protect and motivate them, whether that person is a parent or someone else who plays a significant role in the child's life. Clearly, when parent and child are too close, to the point where their roles are confused or boundaries have disappeared, the situation can do great harm. A child who receives poor or no guidance, who has to play the role of confidant or adult caregiver for his parent, runs the risk of losing himself totally, his development, and perhaps even his life, totally derailed. For Kevin, as for Christine, whose story we will now look at, the situation had become intolerable and pathological. To help these children, a new partnership had to emerge to redistribute the roles and correct an unsustainable reality.

Christine remained a mystery to us. She may have had a form of high functioning autism, given how difficult she found it to socialize with other children generally, and also due to her rigidity and lively intelligence. Her symptoms could also have been connected to her pathological relationship with her father.

The time had clearly come to find a solution to the situation. It was reassuring to see that both of them wanted to change the

CHRISTINE

Christine was a gentle soul, but a bit odd. I'd known her for two years, since her dad brought her to see me after the family went through a rough patch. He wanted to find a doctor for his daughter, even though she wasn't really sick.

He'd just been awarded custody, as Christine's mother, a drug addict, was endangering her daughter by not being available most of the time and failing to provide stimulation. The father, who was worried about being on his own with a young child, had recently been staying in a family shelter with her. "The workers are nice to me, and I'm learning a lot about how to be a father," he told me.

He was an educated, well-spoken man, with a great deal of knowledge and life experience. He'd gone to college and seemed to be making his way in life, but felt worn out, resigned and passive. Clearly, things had not been easy for him. His daughter had obviously sparked something in him, and he had only kind words, protective feelings and love for her.

From her very first visit, I'd been amazed at Christine's capability. Her language and motor skills had improved by leaps and bounds. She was still rather frail, but generally in good health. She was eating enough

to grow at an appropriate rate, and she was sleeping well – no more nightmares, as in the past.

She was deeply attached to her father, who spared no efforts to take care of her as best he could. They'd developed an exclusive sort of relationship, but the girl still remained open to contact with other adults in general. She always rose to the occasion and answered every question with an unusual level of finesse.

She had no interest in other children and preferred parallel play on her own when she spent short periods in child-care settings. Her father took her out of daycare after a few days, saying that they weren't taking proper care of Christine. The other reason, he admitted freely, was that he missed her too much.

Every time we met, I was amazed at the girl's maturity and her behaviour, which was quite unusual for her age. When I asked her about various aspects of her life, she always replied slowly and seriously. She was certainly very intelligent, above average in fact, but still strange, deep and far away, all at once.

As soon as I stopped asking questions, she'd take a pause without starting to speak again. The silence sometimes lasted several minutes, and she would remain extremely passive. I could read nothing in her eyes. Her expression was blank, hard to gauge, and made me feel slightly uncomfortable.

The last time we met, when Christine had just turned six, her unusual maturity struck me even more. As usual, she stuck close to her dad, but it seemed to me that there was no emotion. He swore that they could not be apart, confessing that they slept together because she couldn't sleep unless she was by his side, and anyway, they were fine that way.

I suggested to the father that we find a full-time daycare centre so that Christine could learn to socialize

with other children and the two of them could find a certain degree of separation. I told him frankly that the situation could become problematic and added in a semi-serious tone that he needed to assume his role as the girl's father, not her friend or partner. He said that wasn't necessary because she was already going to daycare two half days a week and that was enough. "She wouldn't want to be away from me any longer," he said. And vice versa...

During the physical examination I asked her if she had dreams. Her reaction was posed and silent, so I thought she hadn't understood what I meant, and I asked her what "dream" meant to her. She paused for a moment, looking off to the side vaguely, and then, after taking a deep breath, she told me: "Dr. Julien, a good dream is a dream with princesses and sunshine!"

"So then what's a bad dream?" I asked

Another deep breath, and then: "A bad dream is when Daddy hits me... and I don't like it!"

Her father, who had heard everything, said spontaneously that he didn't know why she'd said that. He admitted that he would sometimes scold her in a loud voice but swore he'd never hit her.

I asked Christine where her father hit her. "On my hands, and I don't like that," she said.

Christine, the perfect partner, had just opened the curtain on her perfect world. She was stuck, too perfect, too mature, playing a role that was intolerable for her age. At last she said she could no longer tolerate the situation. The violence may or may not have been real, but the girl was finally giving us a precious tool to help her. And she was telling us that changes needed to be made.

When I met with the father alone a few days later, it was clear that he'd got the message. He asked us to

help him build a healthier father/daughter relationship with his little girl.

way things were going. After a few weeks of mind-body therapy, Christine already seemed less anxious and was beginning to come into her own. Her father found it difficult, but he was persistent and really wanted to get through this.

The child as partner, aware of her unhappiness, managed to talk with a caregiver who inspired confidence and would provide a level of consistency to bring about the radical change that was needed.

In both these cases, the key point was to discover the real issues and create a break in the unhealthy relationship caused by the parent's "pathological" need; without dismissing them, help the children to form a more secure attachment with significant adults; and reassure them that doing this would have a great effect on their overall well-being.

Children have the right to share all the necessary information so we can help them stay healthy, and to have full knowledge of the situation to improve living conditions that are harmful to their well-being. This is what we mean by forming a real partnership, and it's the best way of making sure that the child is fully respected in an authentic way.

CHAPTER 12

ESSENTIAL DECODING

To decode is to interpret, understand, and draw conclusions. It's a pivotal moment, when diagnostic hypotheses are formed and facts are prioritized, a time for collecting information that leads to constructive statements that can help move things along.

Through observation, we set the table, find promising pathways and gather evidence that emerges from historical facts and clinical histories. The partnership with the child and family grows stronger, and now the scientific approach can begin in earnest. It's time to move on to rational decoding, without abandoning the intuition and feelings that add nuance to the process.

Never overlook the importance of evidence derived from experience and undeniable historical facts to maintain a global vision of the child's pathway in life. We haven't lived all these millennia only to start from scratch over and over again. Histories, be they short or long, are extremely helpful in correcting the scientific vision and recent discoveries.

Knowledge evolves, of course, but some laws of nature are quite inflexible, especially when it comes to emotions and life experiences. Humans haven't changed all that much over the years.

Humans, large and small, are quite consistent in terms of feelings and survival. Our animal side is still present, and surges of adrenalin will always provoke strong reactions – control, fight or flight. This kind of evidence does not change over time. We all base our actions on predictable factors that we have seen before and that will be repeated in the future.

Where there is great vulnerability and serious stress, the

animal side soon rises to the surface with all its mechanisms, reflexes and tools for self-defence. That would includes aggression, violent behaviours, vengeance and defence strategies in the wake of multiple traumas. It should come as no surprise that children make use of all these mechanisms. It's the same for feelings. Attraction, envy, love, hate and vengeance are always top-of-mind and often poorly controlled, despite all the progress made by modern medicine. Only adapted therapies and some last-resort drugs can succeed in putting the brakes on emotions and behaviours that have become harmful or dangerous for ourselves or for society. Unchecked, they can come galloping back.

If all the pathways opened during the assessment process are valid, it will be easy to find connections and constants we can use to foster understanding and act on the meaning and origins of the problem. The gestures, moods and behaviours we observe are easier to interpret at this stage.

I believe that the parent remains the best guide as we try to cure the child of all ills. The alliance between parents and professionals, both listening closely to the child, can only be stronger than the sum of its parts. This is the very best way to respect all the rights children are entitled to enjoy.

When we add intuition to evidence, it's easier to prioritize a broad-based interpretation, a wider path and other minor ways to bolster the hypothesis. This shows the importance of combining science and art – the science of observable knowledge and the art of what is felt, what is not felt, and what is not obvious or palpable.

The ability to use both these methods is a valuable asset for anyone who hopes to fully understand children in every dimension of their being.

There are so many books and guides, so many standards and rules, but most of all there is intuition and good sense, which are – and must be – the most valuable tools for parents and professionals. A combination of the two is better yet, and so we need to form an alliance between parents and professionals, all listening with respect.

THREE CHILDREN AND A BABY

The parents came in with their three children and an intern from the youth centre, in a heightened state of anger and on the verge of collapse. This would not be easy...

We could feel the mother's frustration, the father's irritation and the disarray of the three small children. They obviously had no desire to be here, but they'd been urgently summoned to this meeting by the youth protection office, as a last resort.

I'd known the parents for several years. Despite all their problems, I knew they were making some efforts to compensate for their deficiencies, as described in a series of psychosocial assessments. I also knew that the children were in a difficult – unacceptable, really – situation. They loved both their parents, but their living conditions left a great deal to be desired. The father and mother would go back to doing drugs again and again, and nobody in the family was a stranger to violence.

Things had been very rough over the past few months. The family had had more than their fair share of problems related to drugs: depression, serious financial worries, debt, and loss of welfare payments.

The report to youth protection mentioned serious neglect, and a situation that had reached the point of trying to decide on measures to protect the children, who were still very young.

The atmosphere could not have been more tense. Both parents felt trapped, and they were trying to explain the situation, which they admitted was extremely difficult.

All the same – as I pointed out to them – the parents were sitting side by side, calm, close and on the same side for once. I told them it was the first time I'd seen them being so affectionate. It was a strange way to start and not everyone was happy about it, but why not give our meeting a more human touch, since we all wanted it to be a constructive session that would focus on the children's needs.

They'd come in for a follow-up on the children's development, but there were obviously major underlying issues. I asked for an update on the legal situation, and most important, how much the children's situation had been compromised.

Two weeks earlier, there was supposed to be a court hearing to discuss youth protection's request to place the children in foster care on the grounds of "risk of neglect," according to the social worker. But the court had not proceeded and the judge had postponed the case for two months.

This was a complex case. There had been very real concerns for some time about the couple's ability to provide proper stimulation for the children, despite the various services offered by our own professionals. The parents had missed several appointments, and the neighbours were apparently worried about the family situation and the effect on the children, who were not in danger or abused, but were certainly neglected and

sometimes left alone.

The father had made great efforts to take better care of his kids. He had stopped using drugs more than a year before. He told us he had "discovered" his children and they had inspired him to change his life. "What a shame I didn't discover my kids sooner!" he said ruefully.

The mother, a victim of violence in the past, had also lost her bearings and her ability to organize things for her children. She had recently given birth to a fourth child and was having trouble recovering, both physically and mentally. Her overall state and health had clearly deteriorated over the last little while. She confessed that she felt overwhelmed and told me that she just couldn't do all the things a mother should do right now. She said she needed help herself – a real cry for help, which I certainly believed. The children were living in turmoil, which was greatly affecting their behaviour and their overall well-being.

They were living under precarious conditions in a chilly, poorly insulated apartment. The father had to fill in holes in the kitchen walls to stop the rats from running all around. The kids had never-ending colds and there were bugs all over the apartment. The parents were hoping to find a place in a public housing unit, but they were far down the waiting list. They had no money and few resources.

I met the children, one by one. The eldest, who was six and in first grade, was doing very well. He was lively and intelligent. His parents brought his report card to show me. His marks were very good and his teacher was proud of him. The report from the stimulation workshops at the Assistance d'enfants en difficulté (AED) centre also mentioned that he was making excellent progress and noted his many good qualities.

The boy was helpful and attentive to others.

The second boy, four years old and in pre-kindergarten, didn't even know his colours, according to the worker who attended the meeting. When I asked him a few simple questions, he got the colours in a drawing all wrong. He gave confusing answers and didn't really seem to understand. His mother interrupted to confirm that she really wondered how much her son understood.

The boy seemed to have a comprehension-related language impairment, but it wasn't mentioned in the notes from school. Smart and animated, he'd figured out various ways to hide his disability. At the end of the examination, I asked him again to identify the colours he'd got wrong before and he managed to name them all, throwing me an amused look.

The two-year-old, a girl, was curious and moved around a lot, touching everything with nimble fingers – toy cars, Lego, even big puzzles. Her eyes and body language spoke to us, but she didn't use many words, only a little jargon that seemed significant to her. She seemed to be well-rounded despite her language delay.

Physically at least, all three children seemed to be normal. Overall, their development was appropriate, except for the younger boy's poor comprehension and the girl's failure to use words. Despite the difficult situation, they didn't seem particularly worried or deprived.

There was also a three-month-old baby I'd see the next day. He had already been placed with his maternal aunt while awaiting the recommendations of the court. There was some concern about his basic care and feeding, which was why he'd had an emergency placement.

The team agreed that there was a form of neglect due to the family's poor living conditions. The question was whether we could make one last try to eliminate

the risks of neglect and the consequences for the children's development and safety. We needed to figure out how to make sure the children were respected in this type of situation.

According to the child protection worker, several things needed to be changed to improve the children's living conditions and the parents' contribution to their kids' care overall. She was extremely concerned about them. She spoke to me briefly but never met the parents' eyes, just continuing to take notes.

The parents had very little money and a limited network. They were sick and exhausted, in survival mode. All the same, they said they loved their children and thought they could take care of them with some help. They'd already made some changes. The fact that that the new baby had been urgently placed with an aunt due to the mother's state of health only added to her distress.

This family was clearly in need of intensive support. For me, the question was figuring out how and up to what point we could help.

At this stage, the dreaded catastrophe was still hanging over our heads. Youth protection was maintaining its position of placing the children in different families and communities. The kids would be separated from their parents and siblings, losing the crucial sense of solidarity that had helped them get through so far without too much difficulty, despite the intolerable situation.

Our questions were not about the obligation to act; we wanted to make sure the children's rights and overall needs would be respected, including the parent-child connection and the sibling and family reference points in this context of great social poverty. In an imperfect world, this important ethical and humanitarian

question needed to remain at the heart of our concerns and actions.

There was a great deal to do: move the family, make sure they had a secure food supply, get care for the mother, support the father, continue therapy, stimulate the children. We needed to get everything back on track once and for all, which would probably take a great deal of time and intense effort on our side. The stakes were high, but the potential benefits at the human level would be immense.

From the social pediatrics point of view and in terms of institutional resources, it was also a matter of what type of support to give the parents. Many people in disadvantaged communities find themselves in such a situation. Families trust us, and our mission is to support them as much as possible to set profound changes in motion based on a community model. The institutions apply legislation and regulations in a more objective way, but the bond of trust is often lacking. However, we share the same desire to minimize the risks for the children and help them to succeed.

We often see families trying to improve their situations after going through a rough patch. The resulting chaos is clearly harmful to the children. Often, the arrival of youth protection and serious protective measures encourages the parents to change their living conditions. There is a great need to support them in this change and give them the means to complete the process. For us, this is what a true and fair plan for long-term protection means.

As a last resort, if nothing changes or the changes are purely superficial, the time will come to take action by placing the children temporarily and arranging other support measures to end the

placement as soon as possible. At the end of the meeting I suggested that we provide intensive support for the parents one more time, all working together.

The next day, I met the mother and her baby. The father was also present. The baby was in perfect health and the mother held him in her arms, next to the aunt who had temporary custody. I could sense that they had a close, intense and real connection. The unmistakeable glow on the mother's face showed how much she'd been missing her baby. He was secure for the moment, but she wanted to see him more often, to have time to heal. The infant was doing well in the extended family, and the aunt had agreed to take care of him for as long as necessary.

The parents agreed to a temporary separation from the other children while they got back on track, but they wanted to stay in close contact with them. We needed to believe in them one more time, impossible as it might seem.

The child care worker was reluctant. Her mind was made up. At the court hearing two weeks later, she would still request long-term placement. In front of the parents, who were aghast at the news, she added that she was sorry the judge had postponed the case. The bond of trust was well and truly broken.

In this case, as in so many others, a more up-to-date evaluation of the facts and a mobilizing position needed to go hand in hand. We wanted to preserve family integrity as much as possible and believed in their capacity to change if our ability to accompany and support them was up to the mark. To achieve that goal, we preferred to trust clear indicators and intuitions.

For the good of this family, we were not against a temporary placement; in fact, we agreed it was indicated at this stage. I had even suggested it to the parents myself, hoping to help them to change by providing support.

The judge had finally ordered a short-term placement, suggesting a place where the children would be able to see each other and the parents would be given a new chance to make the changes that were needed.

This example clearly illustrates how several seemingly contradictory ideas can be at play when we focus on the children's well-being. Positions may differ according to our vision of things and our expertise, but we also need to follow the rules of the institution we work for.

Opinions can also range from one extreme to the other when our convictions and our own experience enter the picture. How can we get to that place? How can we make sure that our position is the best for the child, beyond all the norms, beliefs and habits?

This is a key moment. Validation by the children as well as by their verbal and non-verbal messages, alongside confidential validations by the parents, the community and the family circle remain an essential stage for us. This is the most certain and most objective way to respect the child. As always, respect remains the prime motivation for everything we do.

A BIGGER PICTURE

At this stage, when we're making sure, yet again, that we have the right hypotheses, who could be a better guide than the child and parents? As companions or professionals, we have the knowledge, the experience (albeit sometimes limited), and certainly a great deal of emotion and subjectivity, whether we admit it or not.

When we look at individual humans and humanity at large, our version of the facts is ours alone. It is difficult to set aside our egocentric tendencies, but often that is what it takes to conduct a sound analysis. Rising above ourselves is a useful exercise. We can try to validate our impressions with superiors or mentors for comfort's sake, but it's only natural to try to prove that we are right. Objectivity is impossible in the specific context of human behaviours and failings.

I'm convinced that our hypotheses and decisions, serious and expert as they may be, only hold true if they have meaning for the people concerned. They must not be imposed but discussed, considered in depth and validated by the main parties, never in a vacuum – the risk of bias and blunders is just too great. When

such delicate issues are involved, it's easy to get things wrong by trying to go too fast.

This is one of the great strengths of an integrated approach, where the team holds the reins and works together to come up with scenarios that make sense and provide added value. The child and the family circle are the major players, and they are the controllers and decision-makers, up to a certain point.

Without this type of approach, how can we come up with significant and mobilizing actions that will make a real difference in the lives of troubled children? The only way would be to impose solutions that would be relatively successful in the short term, but would be unlikely to change things at a deeper level to benefit the child over the long term.

It's like an iceberg: all we see is a tiny part of the huge real thing. The rest, lurking beneath the surface, will only be revealed with confidence and motivation.

We, professionals and teams in community social pediatrics, are there to share our knowledge, among ourselves and with the children and their parents. The more of us there are of us and the more diverse our specialties, the better the advice and support we provide will be. This is what we call an intersectorial and interdisciplinary approach. We can offer guidance, find solutions, make suggestions, but the real work is to validate on everything with the children and families and committing to a protective action plan that everyone freely accepts protection.

GENEVIÈVE

We saw Geneviève at the urgent request of her aunt, who had had custody of the girl for several years. Some of her brothers and sisters had also been placed after their mother experienced major problems. Geneviève and her family had a hard time in life, but as the youngest she hadn't been terribly damaged, since her older siblings managed to protect her to some degree. The girl we met, barely six years old, was radiant and lovely.

However, there'd been changes over the past month. She was being oppositional and refusing to take a bath or brush her teeth or hair. At home, she'd become irritable and disagreeable, bursting into tears for no reason and having major tantrums on the slightest pretext.

She wasn't following her lessons at school, and her teachers were having trouble getting her interested in learning tasks. Previously very sociable, she was now standing apart and refusing to play games. She'd lost her shine. Everyone was worried and trying to understand what could be happening in her life to cause such a reversal in her situation.

The people in her family circle were reacting, wondering what was going on. Unable to explain this change within the family, they decided to bring her to see us to rally a strong circle of support around the child.

Geneviève and I knew each other quite well. We'd often see each other during the workshop activities she attended. She was even a role model for children who were less advanced in their development. In normal times, she'd always been agreeable and ready to join in the game.

That day, however, she didn't answer my questions or react to my compliments. She was completely different, subdued, and reacted in an unusual way. When

I suggested that she draw a picture she refused, which was out of character since that was part of our ritual on meeting. When I asked her to draw a portrait of me, she finally laughed out loud, but said no. Then she did start drawing, hiding the paper so I couldn't see.

Throughout the meeting, she listened to everything that was said from a distance, sometimes smiling, but mostly with a serious expression I hadn't seen before. For the past month, in addition to the change in mood, she'd had a problem with masturbation, which everyone was concerned about. No one understood what was going on. For the family, that was the main reason for the consultation. She was rubbing up against furniture and constantly touching herself, saying that it stung. She was doing this at home and at school, without embarrassment and almost systematically, as if to provoke – and it was working. There was nothing new in her history, no objective signs that could put us on a different path, medically speaking. There was no suspicion of a urinary infection, a defecation problem, injury or sexual abuse.

When I asked the aunt when she had first noticed these changes and what could have triggered them, the girl stared at us, seemingly angry and impatient.

When I asked if I could perform an examination, which had never been a problem with her under normal circumstances, she refused. She said nothing for several minutes, began to pout and finally accepted, but told me firmly: "Not down there." In other words, "Don't examine my genitals."

When I went to examine her abdomen, she panicked and pulled her tights back up to her belly button. I couldn't continue the exam, so I decided not to proceed for the moment. We kept on talking, she relaxed and drew me a beautiful picture with "I love you" in large letters.

That night at home, she defecated in her panties for the first time in her life; there were stools all over the place. When her aunt reprimanded her, she said, "Please don't tell Dr. Julien."

Her father, whom I didn't know well, was present in the girl's life. Since he lived elsewhere and hardly ever came to her appointments, I knew very little about him, but I did know that Geneviève adored him. I learned that a few months back, he'd begun to have contact with his children again. He saw them together every two weeks, regularly and conscientiously.

He'd had his own share of problems for several years and had only occasionally shown up for visits with his children, showing little interest in them. His life had apparently changed since then. He was living with a new partner, had a good job and even owned a house in the suburbs.

I also learned from the aunt that during their recent visits, the father had told the kids he'd take them back soon and make room for them in his house, at the start of the summer holidays just a month away. They'd each have their own room, he said.

So the father was planning a grand reunification with no preparation, after years of abandonment, promises that were never kept and evident disinterest. Big surprise all round: hit "delete" and start all over again!

Throughout this period, the children had coped with the great divide between their parents each in their own way – making no judgment but grieving for their life as a family. Thanks to the generosity of their aunt, who'd become a parent figure for them, they hadn't been separated.

Strong relationships had been forged between the children and their foster family, and I already suspected there would be serious attachment and loyalty issues

on both sides.

We were extremely concerned about this turnaround. For us, the idea of a real resumption of contact and even custody going to the father was good in and of itself, since we knew there was a strong connection between Geneviève and her father. She would often say that she had a great Dad, and one day he'd take her back. She also had a strong connection with her aunt, which it was important to maintain somehow at her age.

I requested a quick meeting with the father, who told me he was determined to take his children back, saying that he'd wasted enough time being away from them. His boys were already back and proud of the new situation. Soon it would be the girls' turn.

I tried to bargain for more time and more preparation, suggesting that the relationship with the aunt should be maintained and his close connection with his daughter should be gradually rebuilt. He did agree that we could support Geneviève, assuring me that he would bring her to our activities every day if needed, but he said firmly that he would proceed with his plan.

What was the best solution? The girl was the only one who could help us see things clearly, despite the paradoxical situation she found herself in and the break she would have to make. She would have to choose between her Dad, whom she adored, and a mother figure she was deeply attached to. What a conflict... but why not have both?

The aunt had already told me that if she lost the girl, she wouldn't see her again; it would be up to the father to take care of her. He agreed that his daughter and her aunt could stay in touch. He acknowledged everything the aunt had given Geneviève and he was grateful. "But she's my daughter and I want to have her with me," he said.

We checked with the social worker at the youth centre, who had no objection to the girl going back to her father's place. She said that her assessment was valid, and there were no traces of the problems they'd had in the past.

We needed to validate the whole story and the issues with the girl, because the adults' opinions didn't really add up. She alone would be the one to guide the progress of her life, young though she was.

Beyond her understandable bewilderment, her justifiable questions and the ambiguities she was having to live with, Geneviève would have the last word. Meeting her at a party in the lane under good conditions, I took her aside and quietly broached the subject.

"I promised to help you be well when we first met. We're friends now, even though I'm your pediatrician too." She listened to me gravely and agreed, giving me a hug.

"I know you love your Dad and your aunt, and you want to keep both of them in your life. I agree. But where do you want to live now? It's your choice."

Looking me straight in the eye, with not a second's hesitation, she said she wanted to live with her dad and had been thinking about it for a long time. She couldn't wait to go to his place. The message was clear, so we would give her our full support.

I told the father, who agreed that we could continue to support his daughter in art therapy and various activities for a while, since the centre was also one of her happy places. He reassured me by saying that in the end, the aunt would agree to see Geneviève from time to time.

The next weekend, she was at her dad's with her brothers and sisters. A real honeymoon had begun... and would continue.

A few weeks later when I was in the laneway, I saw her run towards me. She was with her dad and her aunt,

all of them proud of how things were working out. She was radiant, and her problems seemed to have melted away.

Astonishing as it may seem to proceed this way with a young child, I've done it many times in my practice – and with considerable success.

Many people still believe that children are unable to understand adult matters or make decisions for their own good. I think just the opposite: the child is a full-fledged person who, even when very young, can express relatively clear opinions and wishes, as long as we know how to decode their questions and their overall needs. Geneviève was only six years old, but her intentions were obvious and she'd been thinking about what she wanted for a long time. Troubled children and those living in precarious situations soon form clear ideas of what is good

Children, even when they're very young, have rights, and one of the most basic rights is to have control of their life. Your parents play a major role when you're little, making sure you stay healthy as you grow up. They may make decisions for you when appropriate, but children always have the right to speak and be heard, through an intermediary if necessary.

and bad for them. Even if they don't have much knowledge, they have vast life experience, instinct and intuition. If they don't feel constrained in any way, they'll tell you what they think quite clearly, given half a chance.

That chance must be accessible at all times. The actions that follow will then be all the more consistent and genuine, fostering well-being for everyone involved.

Chapter 13

DECODING BABIES

Should we listen to babies, who of course are full-fledged people, to find out what they really need? Some say they're too young, they're not talking yet, they're immature and totally dependent. My own belief is that babies have their own language right from birth, and the right to speak applies to them in every way. So we need to listen to them and try to decode their messages when they express their needs in their own way.

As I've previously written, we can find a way to make the light dawn in every child's eyes and come to understand each individual at a very deep level. With babies and toddlers who are not yet able to use words to communicate, we need to explore all the other means of communication, from the simplest to the most complex. The point is to acknowledge them, observe attentively, and interpret them in the spirit of critical analysis, so that we can better understand the needs expressed.

The character and behaviours of each child unfold right from birth. Tears and crying, for example, are spontaneous means of communication that reveal a great deal about the child. Crying fits and movements give us information on how the child reacts to frustration, such as feeling too hot or too cold, wanting something to drink or having a dirty diaper. Other reactions are more persistent or intense, such as the agitation caused by discomfort, incessant crying and refusal to eat, which sets us on the path of more negative emotions that may influence the child's development and well-being.

A baby or toddler who's exposed to an anxious mother or a violent spouse repeatedly and frequently will have an intense

reaction. Occasional crying jags will become continuous and disruptive. The agitated child will protest in his own way by refusing to drink or forgetting how to do things he's already mastered. The child's health and development will be at stake. The message is clear and it's crucial to recognize this as early as possible so that we can take effective action.

Babies cry to express themselves. They cry to manifest their desire for attention and contact, to signal discomfort, to be offered the breast or other forms of nourishment. The child's basic needs are often manifested with frequent and unpredictable crying.

The eyes are very telling too, of course.

A child's eyes are the mirror of his well-being to some degree, and also of his "not-well-being." Look into the child's eyes to see joy and sorrow, hurt and anger, hopes and dreams. The eyes are invariably striking in their beauty, with the odd shadow sometimes tarnishing the surface. Look into the child's eyes to see the depths of a pure soul.

On the surface, we can also see discomfort, anxiety or suffering. Sometimes a single glance is enough to challenge us and set us on a different pathway. We miss this or ignore it at our peril, for it can mean bypassing what is most essential.

Everything in the child speaks volumes. The best thing you can do is listen in a spirit of openness and warm welcome.

CHAPTER 14

ACTING FOR CHILDREN WITH OUR EYES WIDE OPEN

In medicine, especially social medicine, we cannot act alone and risk missing a great deal and committing irreparable errors. Nor can we claim to heal completely, but we certainly can take preventive action and initiate curative measures right on the spot. Together, we can soothe and care for the child quite well, mainly by using our ability to draw out the powers of children and their families. This is probably the greatest contribution we can make to respecting children and keeping them healthy.

I had just met a 12-year-old in my clinic for the first time. He'd been sent to see us by a team from another neighbourhood to follow up on a diagnosis of ADHD. He'd just moved into our area with his family. His mother was with him.

It was difficult right off the bat. His mother, who was originally from Haiti, hardly spoke and didn't really answer basic questions. She seemed remote and exhausted. She never looked at her son and showed no signs of interest in our meeting.

The boy was also wary and distant. He wasn't intimidated or shy, but seemed to be wondering what he was doing here. We appeared to have hit a dead end after many trials and a lot of talking. What more could we

do?

I went up to the mother and asked what we could do for her son, since she found him so deceptive and irritating. I asked whether she was ashamed of him, and she nodded. I thanked her for being so frank. Her honesty would help us find a solution and resolve the crisis.

The boy seemed more inclined to delinquency than to building a healthy life, but he did tell me that he wanted to be a professional hockey player. He opened up even more and confided that he wasn't very proud of the way he was living. Astonishingly, he told me he wanted help so he could change and get back on track. His mother, who overheard this strange conversation, even had a little smile on her face. Obviously, she did not believe that he was really ready to change.

Since we happened to be meeting at the Garage à Musique, he asked me about teens in his age group helping younger kids in our day camp, and wanted to know more about all these music rooms.

Our mentoring program is intended for teens like him who, once they're back on track, come and support other kids as a summer job. He showed great interest in the project, saying that he had a guitar and would like to sign up for the program. We sealed the deal. He hung around for several hours to observe what was happening in this magical place. He also promised me he'd start taking his medication again the next day.

Acting with our eyes wide open requires explanations and attention. This is extremely important in our field, and it's what sets us apart from other places in the institutional or community sectors. We say this in all modesty, without meaning to denigrate

other ways of doing things, since our complementary actions with these other partners are all the more powerful. This brings strong added value to our approach.

This paradigm of care is based on experience, science and advanced skills, as well as intuition and common sense, building side by side with people from different disciplines. The quality, intensity and deployment of care are discussed in constant interaction with the child, family and community. There's no question of excluding those who already feel excluded.

As we've seen, our approach starts with the involvement of the parents, the extended family and the community, as well as the children's own motivation. Hence the necessity of creating bonds and opening pathways, never taking any steps without approval from the parents and the child, except in exceptional circumstances.

We believe strongly in respecting the child, and this is the best way we have of expressing

Acting with our eyes wide open also means leaving nothing to chance. Digging deep into personal and transgenerational histories, living settings conditions, motivations, injuries and traumas, stress factors in daily life – all this helps us understand and act accordingly. Hence the specific approach of community-based social pediatrics, which makes connecting with children and parents such a huge challenge as we try to offer help.

that belief. An important part of our mission also involves the necessity of defining what we do in a trans-systemic way, ensuring that professionals from all the systems share our way of doing things and our common desire to foster the child's well-being.

This global approach, which is quite complicated, culminates in promising actions that will prove to be really helpful for each child, one at a time, as long as we have the tools to act at all the necessary levels and everyone plays an appropriate role. The "one at a time" is important, since each child is different and contexts vary a great deal. There are no constants when it comes to a child in distress, because each form of pain is unique – hence the importance of accurate decoding.

For parents and others in the inner circle, undertaking this kind of process to help the child contributes to not only develop trust but also to awaken the desire to get involved and make things happen. Parents do not wish problems on their children, and children can serve as a trigger when it's time to take action. This is a win-win scenario from every point of view.

For the professional, this is an incredible opportunity to share our fears and our working tools with experienced colleagues from different sectors. The point of doing this in conjunction with the main parties involved – the child and family – is to spell out an action plan built around an innovative consensual model.

There are several ways to conduct a good assessment of the child's needs at every level (physical, emotional, social, legal and spiritual). Using a questionnaire, development and aptitude texsts, biological and technical examinations and various functional evaluations are all useful ways to discover all the facets of a problem.

When we want to probe deeper and find significant interactions as well as observinge the play of emotions on attitudes and behaviours, we need everyone to validate the pathways to action and fulfil their commitments to succeed.

Our method, based on reconciliation, active observation and exchanges, results in complete, effective and sustainable action.

We now have all the information we need to take action. The

next step is to figure out where to start and divvy up the tasks. To see how this works with greater clarity, let's meet Caroline.

With Caroline, we needed to take immediate action, with her agreement, on things that had not been discussed during her many hospitalizations and procedures. There was absolutely no question of taking pity on her, which would have made her furious. We needed to recognize her strengths and her courage and present her with some challenges. This was not her first struggle,

CAROLINE

Caroline had had complex medical problems from birth, but 25 hospitalizations and 20-plus life-saving operations had left her in relatively good health. She was now eight years old.

She was still being followed by various specialists at a tertiary care hospital. In addition to the nearly full-time treatment she'd received over the first three or four years of her life, she'd received rehabilitation for language, motor function, coordination, balance and muscle strength until the age of five, when the promised services had come to an end as she started school. Despite her parents' never-ending efforts and her still considerable needs, at this point she'd been left to her own devices with her family.

She was still having trouble with speaking, feeding herself, spatial control of her body, and coordination, handwriting and balance. She was no longer entitled to rehabilitation services due to her age, even in a pediatric setting. When I saw her for the first time, her main frustration was not being able to ride a two-wheel bike.

She'd received exceptional treatment for her physical conditions until her treatments were stopped suddenly for no valid reason, leaving her in ignorance about

so many subjects. The work was far from finished.

Caroline's parents had brought her in to see me because nobody seemed to be focusing on the little girl who was suffering in silence from the intense treatment, pain and separations she'd endured during her short life. And she was still suffering from the ridicule of the children and adults she crossed paths with, as well as her helplessness in some areas of her development.

I was impressed by this assertive little girl, who was in full control. She addressed me by the familiar French form "tu" right away, with a serious and resigned look. "Another doctor, eh?" I said. "You must know quite a few." She kept on playing, looking at me sideways while I spoke to her parents. When I addressed her directly, she would answer sometimes but not always, remaining serious and suspicious.

She'd chosen a small teddy bear from the toy box and was hugging it tight as if it belonged to her. I went up to her and asked whether that was her teddy and did it have a name. She stared at me and finally said that no, it wasn't hers, but could she take it home? As soon as I confirmed it was a gift from me for her first visit, her demeanour changed completely.

Caroline let me examine her, but first, seeing the photo of Albert Einstein that had been on my desk for ages, she said, "Hey, that old man! Is that you in the picture?"

As she helped me with the examination, her mood improved and she was clearly having fun. Opening a drawer, she saw a little diary with a padlock, wrapped in plastic. "Is that yours?" she asked me. "No, it's yours," I said.

Her eyes lit up and I could see she was feeling emotional, but then she said, more seriously, "I don't have any secrets to write down." I said I was pretty sure she

must have some, in fact she probably wouldn't have room to write them all down. She finally agreed that she had lots of secrets.

Caroline was even more interested when I suggested that she make music in our Garage. She'd always wanted to play an instrument and she was thrilled. "Let's go right now," she announced.

Later, when I asked her to come with me and be my main partner as we collected funds for our Foundation, her response was pure joy.

Caroline had known a lot of physical suffering over her short life – a hellish mix of emotions due to separations, mourning and emotional unknowns. But no one had ever really talked to her to find out how they could help.

Her main problems were related to her behaviour, her performance at school and her tendency to be impulsive and arrogant. Over the years she'd developed blocks in various areas, especially when it came to food and sleep, and that was spoiling her life. The doctors had found no medical causes, but they hadn't gone looking for psychological or emotional explanations for all this either.

Her strength and resilience impressed me a great deal, and we soon became friends.

Our team began to look after her from that first meeting. She left hugging her teddy and diary. "You're coming with us," she told her new friend.

She kept coming to the Garage and gradually regained her self-confidence. Her parents were listening to her all the time now. When I saw her again recently, she was sure of herself and in much better shape.

Everyone had glossed over her personality in order to take care of her complex physical problems. They'd forgotten the substance of this child, who wanted nothing

more than to express herself, be given some explanations and be loved for who she was – a full-fledged person with challenges to meet and high expectations.

and the point now was to rebuild her confidence and her personality, overcoming her fears by supporting her own strengths.

Melina, whose story we'll look at next, was living in a constant state of worry. She'd had to face so many barriers that what she needed now was encouragement, having someone focus on her to foster her well-being.

For Caroline and Melina, one traumatized by debilitating diseases, the other by war, the same approach would work – to consider their human side, the emotions and hopelessness they'd both experienced, to rebuild their powers based on their own talents.

In medicine, we must always bear in mind the two facets of the human being: the physical on the one hand, the emotional and spiritual on the other. There can be no true healing unless the two kinds of care are complementary, and the mental often outweighs the physical.

This ambitious and fully integrated action plan could only be successful with an organized team working together and building her future together, maintaining strong ties with the family and a close relationship with the child.

MÉLINA

Melina, ten years old, had been referred by her school for learning problems. In 2013, at the age of nine, she'd been transferred to a class for students with learning disabilities, as she was still at grade one level. She was way behind in school, and it seemed the problem was due to traumatic circumstances that had kept her from going to school in the country of her birth.

Despite being in the adapted class, she had developed behavioural problems in the form of passive resistance, and she'd missed quite a lot of school. She would bring comfort objects, like stuffed animals or scrapbooks, from home to school.

Her mother also reported oppositional behaviours at home, sleep problems and for the last few days, dark thoughts and even talk of suicide. Otherwise, Melina was helpful, learning French fast, and taking care of her little sister like a mother.

The family had emigrated in 2011, when Melina was seven. She'd followed the usual procedure by going into a "classe d'accueil" – a welcome class. The members of the family were now under threat of deportation, as they had refugee status. Her father was working under the table, but the family still had very little money.

In 2012, a dramatic event had shaken Melina and her family. The girl was the victim of violence and possibly sexual abuse. She'd been followed by a psychologist since then.

The physical examination was normal. The girl was sociable and assertive. She complained of frequent headaches after school and was disappointed with her marks. She had a lot of trouble following the

sequence of words and syllables. Her teachers said she often had her head in the clouds. I frequently observed her looking about, not following the conversation.

She seemed to have great potential and showed interest in the solutions we suggested. She played the game as long as our attention was focused on her and her future. She wasn't the type to remain uninvolved, and I believe she'd been waiting for this opening for some time.

When the method was working, with bonding, closeness and respect, when everything was stated clearly, when there was laughter, nothing hidden, nothing left unsaid, the rest would follow easily. Now we could share her sense of hope and her desire to feel better. We could see it in her eyes, clearly.

This young girl had suffered great trauma: exposure to violence when she was little, forced and difficult migration, strong presence of toxic stress factors provoked by precarious status, difficult living conditions and deep distress caused by violent trauma. She was also having a great deal of trouble at school. She was so proud, but somehow just couldn't learn. And what about the anguish of living with the threat of expulsion from her new country, which she already loved? So many traumas and so much unfairness on the shoulders of such a small girl!

The action plan we hoped to validate with the group and the girl herself included various aspects, all linked to Melina's potential and with physical, emotional and learning elements, set against a backdrop of motivation.

– Support her many interests: drawing, fashion and music (her mother said she was a good singer), as well as her desire to succeed despite all the difficulties she'd encountered. She wanted to be a fashion

designer.

– Get her involved in promising activities after school and offer personalized support to help her adapt to her new surroundings, such as a Grande Amie or the self-esteem group designed for girls only.

– Mobilize a support family to accompany the new arrivals, who had not managed to integrate and were having a lot of problems.

–Check Melina's vision, since she was having frequent headaches and a great deal of trouble with reading.

– Check whether she might have attention disorder without hyperactivity or a real learning problem like dyslexia.

– Get the music therapist involved in helping Melina use music as a way of managing her emotions.

– Help the girl succeed at all costs and take legal steps to end the risk of deportation.

WHERE DO WE GO FROM HERE?

What we're talking about here is a new paradigm of social medicine that has the potential to change the world in terms of how we care for the most vulnerable children, those who fall between the cracks and are forgotten until it's too late.

Long ago and still today in our modern world, our children, so precious for the future of our society, have found themselves in extremely precarious conditions. These little ones, so vulnerable and suffering in so many ways, are our main concern. This persistent phenomenon is not getting better anywhere in the world.

Community-based social pediatrics was developed in response to a crying need in society to make sure that all children have equal opportunities for success and good health.

Our "one child at a time" approach gives us hope to dream of a better world, a dream that's with us each and every day. We need to share that dream and work towards the changes it will take to improve the lives of all our children. The effects of our approach can be measured every day as well.

Of course, this book proposes an approach designed to help us all to fully understand and care for children with the assistance

of families and communities. Ours is clearly an in-depth approach, based on fruitful exchanges and the respect of human values that make us who we are.

This practice springs from a heartfelt desire to see children of all ages enjoy the happiness and wellness they so deserve.

Wellness is a state of grace that lets us come through terrible events and yet appreciate the beauty of life and all the small, precious moments, despite the hurdles and misfortunes that may lie across our path. Wellness also means the capacity for resilience that keeps us believing in love and hoping that life will get better, despite the most arduous conditions.

For me, happiness and wellness are the great flashes of light that children carry within and offer us so sweetly just at the time when we least expect them. The interest children show in us in every possible imaginable way, their smiles, cries and glances are all part of it, and their spontaneous words reveal a boundless truth.

Children's spontaneous words and the close connections with families from day to day are the great benefit we derive from our practice.

Their words may be tinged with joy or pain, sorrow or fierce anger. They come with shouts and cries and often many, many tears. Nearly always, they come directly from the heart.

When children I pass on the street say, "Hi, Doc Julien," or when a tiny baby, wary at first, gives me a brilliant smile, these moments of pure happiness mean the world to me. This is how we maintain our sense of love and hope, two powerful, supportive and constructive engines to take us through life.

STEPHANIE

Stephanie arrived unexpectedly one morning after staying away for eight years. I'd been told we'd received a substantial donation from a large company and been asked to make a thank-you video with a

young woman who was 20, a former patient who was responsible for obtaining the donation.

The waiting room was full of technical people preparing for the filming. I noticed a young woman sitting a little apart from the group. I vaguely recognized her but couldn't place her easily as she'd changed a lot. She came up to me with a smile and said softly, "I'm Stephanie, don't you remember me?"

It took me a few minutes to locate her in my overloaded memory, with her big eyes and special sweetness. I recalled her at the age of seven or eight, fragile and self-effacing but so endearing.

I asked if she remembered the day when she arrived and saw me smile at her, her eyes beginning to shine, she threw herself into my arms, where she felt safe. She agreed, slightly intimidated. It was that good memory that had brought her back to mind.

"It's been eight years and you've changed so much!" I said. "You haven't forgotten us?"

"I'll never forget the way you and your team were my family at a time when I had no family any more," she replied.

Every day in our social medicine practice, we have the privilege of experiencing what I call the "human actions" of such rare intensity with children and their families.

We come up against the spontaneity, impulsiveness and occasionally the violence of people we welcome, listening in a spirit of compassion as we help them to become resilient.

These situations are often high in drama, impressive and disruptive, but always powerful, bringing colour to the incomprehensible gloom. They're triggered by strong emotions, which we try to

decode and make part of our exchanges.

These shining moments often arrive without warning, in the waiting room, at the clinic, in the park, at home, even in the street. They are the fuel that motivates us to keep going right till the end.

ABRIL

Recently, my dear Abril returned to her country after two years of experimental treatment in the hospital that failed to have the anticipated results to cure her severe disability. She'd spent two years of her life away from her father, her family, her community, living in hope and hardship. This exceptionally brave child had taught me a life lesson I will never forget.

There she was in the waiting room with a great big smile, lovely as ever despite her major problems. There she was, filling my heart with hope, expressing pure gratitude. She hesitated for just a few seconds before giving me an emotional hug. She handed me a letter she'd written, with a note from her mother at the bottom.

Dear Dr Julien.
Thank you for your love and kindness.
I will miss you when I go to my country.
I am very grateful for everything.
Love and with love.
Your friend Abril
See you soon my angel.
Abril

When words fail to say it
When a hug is not enough to express it
Only comes a thank you from the heart

Because God has shown me your love through you
God bless you.

Abril's mother

Such powerful words, straight from the heart, words that bear hope. The girl and her mother had both been touched by the support we gave them, the humanitarian hope that had been the missing link while the experimental treatment tried to solve the medical problem.

Somehow, someone had forgotten that they were also human beings with special needs. Our team was called in as reinforcement to work on their basic needs and wellness. Enough food to eat, a decent roof over their heads, a good school, a social network and lots of consideration, given their isolation and their physical distance – all this was part of the toolkit we all need, things they'd been without for a whole year.

Our team had also taken care to assuage the physical and emotional suffering they were feeling from the treatments and from missing the people they loved.

Very simply put, we loved them, and they were part of an extended family for the last few months of their stay. We found them a place to live, food to eat and a network. Abril was able to go to school and make friends. Everything quite "normal" for a big girl who'd received good treatment, but wasn't really taken care of.

To end this book, I'd like to tell you about two other children whose touching stories prove that a patient and consistent approach can open all sorts of windows. For me, they count as great successes, leading to solutions designed for what really counts.

I was deeply touched that Gabrielle, whose son I'd followed for many years, would send me such an unforgettable message.

MYLENE

Eight-year-old Mylène was so self-effacing that she would sometimes go and hide. Her parents didn't understand her asocial behaviour. In private, she was "normal," but in public she refused to talk to anyone. At school she hardly said a word, which puzzled the other kids. She generally held her tongue with adults too, which meant she was sometimes left out. She was in her own world.

I was having trouble creating a bond with her. No matter what I did – ask questions, pay her compliments, try to engage her in real conversations – there was no real response. All the same, her intense look and a kind of presence and attention made me keep on hoping that in the end, there would be something there.

I persevered and saw her several times, at my clinic and in various activities. The exchange was still one-way, but contact had been made. She agreed to see me, let me talk and even gave me a hug.

One day when we were taking a walk, I took her hand but this time, I refrained from speaking. She was happy and relaxed, and then, all of a sudden, she whispered in my ear, "I don't want to grow up, Dr. Julien." Ah – now, that explained a great deal.

Just a few words, but they spoke volumes, coming from the depths of her being!

She said nothing more over the next few months, but a path had been cleared. She didn't want to grow up so she could stay small and feel secure, and because she was scared of adults.

After many meetings, using drawings as creative models, she expressed her fears and revealed abusive episodes that had made her lose hope, as well as much of her childish naivety. Despite all the evidence, she firmly

believed that not getting older would give her sufficient protection.

Her words had set us on a path, and patiently waiting for that small but significant phrase to emerge had been the right thing to do. The rest would follow, at the right time in the right place.

GABRIELLE

Not long ago, Gabrielle wrote me a very moving letter. She's a mother now, coping with disabilities that mean she can't keep her son with her all the time despite her unconditional love for him. Who wouldn't want to do everything possible to help her?

For Doc Julien. Hi, Doc Julien.

I'm proud that you're Yannick's pediatrician, because you're a very good pediatrician and you knew how to take us, him and me, when I was angry and I'm really sorry cuz its not easy believe me its hard and it hurts. I have total confidence in you when you have a kid you love its hard to work to get him back, but when you really love him like me I love him I'd do anything to have him back. Sometimes I cry and get angry it's been hell.

When Yanick comes to sleep over on the weekend it does me good, but when he goes away again on Sunday I cry.

I'd love for him to stay forever.

To see your kid in misery is hard for the heart of a mother like me.

Its super to have you for a doctor thanks again.

Gabrielle

The letter came out of nowhere, from deep in the heart of a mother in great distress, who would always be a mother, with our support, listening and understanding. I saw her son recently. He's a grown man now. He came to tell me he was worried about her and that he loved her, but it was obvious that he didn't know how to tell her.

It's hard to end here because there isn't really an end – so many things remain to be said and done. But here's a little anecdote that will inspire us to take action.

While I was putting the finishing touches to this book, I went to a meeting in a church hall, where I saw a homeless man being chased away from the front porch. He wasn't doing any harm to anyone, just sitting on the steps in front of the locked door, smoking a cigarette. He'd just helped a driver park her car with no expectation of reward. But then someone came to tell him that here, there was zero tolerance, and he had to leave the premises right away.

I saw the whole thing from my car. The man waved as he passed in front of me. I got out of the car to ask why he had to leave. He replied by congratulating me on my work and confided that he wished he'd had the help and listening we give to children. "I'd never be in this situation today if I'd had your help," he said. He shook my hand and went off with his little pushcart.

That's the message, loud and clear. We all need to really see our children, really understand them, really listen to them to make sure they'll be happy. The better we know our children, the more we love them, the better equipped they will be for life.

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sure they'll be happy. The better we know our children, the more we love them, the better equipped they will be for life.

FOR THOSE WHO CARE ABOUT CHILDHOOD FROM THE PERSPECTIVE OF "THE VILLAGE THAT CARES FOR ITS CHILDREN".

The approach of social paediatrics helps to explore the causes of children's difficulties. Through his daily work and using examples, Dr. Julien proposes a reflection on communication between adults and children. It provides clues to better decode a child's verbal and non-verbal languages at all ages.

In order to create opportunities to connect, it is imperative to understand children and provide them with a space to express themselves. To do this, we must tame them, rub shoulders with them, observe them and love them unconditionally.

About the author

Dr. Gilles Julien is a social pediatrician and founding president of the Dr. Julien Foundation. His practice is based on supporting children who experience precarious living conditions that undermine their well-being and violate their fundamental rights.

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