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The Hyperactive Child and the Family: A Procedural Approach to Evaluation and Treatment

Marian Maria Sofia van Dooijeweert

Western Michigan University

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THE HYPERACTIVE CHILD AND THE FAMILY:
A PROCEDURAL APPROACH TO EVALUATION
AND TREATMENT

by

Marian Maria Sofia van Dooijeweert

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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Department of Psychology

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The purpose of the present thesis is to evaluate the hyperactive child in a manner that true hyperactivity will not be confused with hyperactive behaviors which are caused by illnesses, stress at school, stress at home, and with normal childhood energy.

No two hyperactive children are alike. They vary in personality, problems, strengths, weaknesses, and environment. In general, hyperactive children are said to have several common characteristics such as poor performance in school, short attention spans, impulsiveness, poor motor control, low frustration levels, and an inability to delay gratification of needs and demands.

Clinical experience reveals that most hyperactive children have multiple problems. Hyperactive children usually have a combination of metabolic, nutritional, or allergy problems along with motor and perceptual difficulties, poor discipline methods, and environmental stress.

A multi-approach to treatment is recommended in order to increase the feelings of self-worth within each member of the family.
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Thanks to all of you.

Marian Maria Sofia van Dooijeweert
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CHAPTER I
INTRODUCTION

Hyperactivity is difficult to define. There is little agreement among academic, medical professionals, and mental health workers as to its exact diagnosis, causes, and best approaches to treatment. Due to the lack of clear understanding of hyperactivity parents will receive conflicting opinions from professional helpers in various fields.

Hyperactivity is a term that describes a number of disturbing behavioral characteristics that are described in Chapter III.

Being the parent of a hyperactive child is hard work and it is a very emotional experience. Being a parent of a hyperactive child is demanding and challenging and requires patience and understanding. It is common for the parents of a hyperactive child to blame themselves for their child's "bad" behavior. The parents believe that they did not give the child enough attention or were not firm enough, etc. Unfortunately, family, teachers, physicians, who see the child act up, reinforce the parents' guilt by mentioning that the child is neglected or spoiled.

The parents' failure leads to shame, embarrassment, and anger. It puts a strain on their marriage; they grow apart, and there are times they blame each other. Family relationships are more in turmoil than not. Life is painful and pleasure is gone with the wind.
What happens to the child in this turmoil? The child has the inner need to be on the go all of the time. The child feels misunderstood, especially by his parents. Often people seem to be angry with him, and he feels he did not do anything really wrong. The child feels frustrated, angry, sad, because he believes that people do not even try to understand him, and he asks himself these questions: "Will my life always be in turmoil?" "Why me?"

An attempt is made to write a new format for the evaluation of hyperactive children.

Much of the material presented in the thesis relating to evaluation must be credited ultimately to the Grand Rapids Child Guidance Clinic.

A multi-approach to treatment is recommended in order to increase the feelings of self-worth within each member of the family. The focus is on the child's self-image, the child's effect on the parents' marriage, family relationships, and rebuilding family harmony.

Only what parents positively instill in their children through acts, words and feelings, will accomplish the longed-for miracle; "a happy child."
CHAPTER II

REVIEW OF THE LITERATURE ON THE CAUSES AND TREATMENT OF THE HYPERACTIVE CHILD

The Feingold Diet

During the past 50 years, reports have appeared which linked hyperactivity, irritability and other nervous system reactions to allergic conditions, particularly to food allergies.

Feingold (1973) has suggested that chemicals that add color and flavor to food may be a causative factor in some cases of hyperactivity and learning disabilities. His interest in food additives stemmed from the case of a woman who was referred to Feingold for allergic problems while she was also under psychiatric care for compulsively frenetic behavior. Feingold decided that the patient might be sensitive to aspirin and other salicylate compounds and he prescribed a diet free of those chemicals. The results were dramatic; both the allergic symptoms and her frenetic behavior disappeared within a few weeks. Feingold concluded that the allergic symptoms of the patient, and others who responded equally well to the salicylate free diet, seemed to be symptoms provoked in some way by an unexplained biochemical mechanism that interfered with the central nervous system. The mechanism by which the salicylates cause the adverse reactions has not been identified. Feingold then began to consider the prevalence in food additives of salicylates.
and other chemicals similar to salicylates, but unrelated to them and found that the compounds were in 34 food colors and 1610 synthetic food colorings, all of which have been classified as safe by the Food and Drug Administration. When 194 hyperactive children were put on diets free of these compounds, 58 children showed a dramatic response; 35 responded favorably, half of the children were able to discontinue stimulants and other medication within 10 days. The response to the Feingold Diet has to do with age; the younger the child, the more rapid and complete the improvement. Although the reports are impressive, Feingold had not yet conducted a controlled study of his hypothesis.

A major study under the direction of Conners (Goyette, 1979) is still underway to test the Feingold hypothesis. The study is set up as a double blind crossover experiment in which each patient is placed on either the Feingold elimination diet, or a controlled diet. The parents maintain the child for two weeks without medication. During this period, and throughout the experiment, the parents are expected to keep a careful dietary diary. The final data on this study are not yet available.

Weiss (1980), a behavioral toxicologist, is trying to work around the problems of testing the diet for vague symptoms of hyperactivity by monitoring its potential impact on specific kinds of behavior. For example, the tendency of children to have nightmares, throw tantrums, bite their nails, or to have sleepless nights.

More private pediatricians are recommending the Feingold diet not only for the classic aggressive hyperactive child, but also for
children who are just cranky and unhappy for no apparent reason.
The author has found in discussion with pediatricians that very often the parents are nice people and are successfully raising other children.
The diet often does wonders for the rest of the family too.

Meanwhile, it is hard to suggest what should be done about the situation with food additives. On the one hand, it may seem obvious that chemicals that condemn some children to misery should not be sold from every supermarket in the land. On the other hand, it is unlikely that a public accustomed from birth to 48 flavors of cereal, and to beautifying its food with suspected carcinogens would give up these indulgences for an undisturbed group of children.

Environmental Stresses

The possibility that hyperactivity can develop from environmental stresses has been suggested by McNamara (1972). McNamara described the environmental conditions, demands and stresses that he viewed as causative factors in the onset of hyperactivity in lower class Puerto Rican children in New York. The picture that he presented was a bleak one of high density slums, over-crowded schools, a lack of green space, no recreational outlets, and a high crime and accident rate. In this setting parents were fearful for the safety of their children. The combination of this fear and the non availability of recreational services caused them to keep the children indoors. According to McNamara a typical day in the life of one of these children consisted of going to school, trying to learn in an overcrowded classroom, returning home, doing homework
and watching television. Many children responded to this general lack of exercise with a pattern of behavior, especially in school, that was characterized by hyperactivity, attention problems, and indifference, and that resulted in a referral for neurological evaluation and often, drug intervention. In fact, McNamara concluded that the only remedy needed for this hyperactive child was obvious one of adequate and safe outlets for normal physical activity of childhood.

There are many environmental determinants of hyperactive behavior. Children are constantly subjected to varied stimuli at home, school and play that distract them and interfere with attention and learning. Obviously, it is difficult to concentrate in a noisy house with loud music, people screaming, where the only place to study is at the kitchen table. Here the child is caught in the midst of constant confusion, interruption, and chaos. If a child tends to be hyperactive, it is essential that he has a quiet place at home to call his own, or a place and time with minimal interruptions.

Chronic marital problems and differences in child raising practices have negative effects on children, but even more so on hyperactive children. If a child feels neglected or treated unfairly or unreasonably, the child resists by sudden unprovoked attacks on other children. To treat such cases, the parents must establish a more positive home-family environment.

The difficulty in controlling the hyperactive child's impulsivity has several disturbing effects.
1) The child is a disappointment.
2) The child's misbehavior is making the parents angry.
3) The parents may see themselves as inadequate.

These feelings bring again emotional complications because the parents believe that they are not supposed to feel always angry toward their child. The parents are not supposed to feel hate toward their child. Such feelings do arise, and when they do, parents tend to suppress them. Every now and then, however, such feelings break through, and when they do, the parents are apt to feel bad, guilty, and that makes the parents feel even more inadequate, and depressed as well. These feelings are most likely aggravating the hyperactive child's problems. Frequently the inadequate feelings of the parents lead to harsh discipline and permissiveness, there is no consistent atmosphere, and a hyperactive child needs a consistent and firm hand, in order to get hold of his own confusion.

Drug Treatment

The use of drugs to quiet restless children is not a recent phenomenon. In fact, drugs have been used for this purpose for hundreds of years. Galen (a Greek Physician), prescribed opium for restless infants, medical blends with alcohol have been used for centuries to sedate irritable infants.

However, the central nervous system stimulants that have been most frequently used with hyperactive children are dextroamphetamine (Dexetrine) and methylphenidate (Ritalin). Antidepressants such as imipramine (Tofranil) tend to be longer lasting in their effect than stimulants. Antidepressants are sometimes prescribed so that only
one dose is required each day, in contrast to the two or three doses per day required of stimulants.

Stephens (Sprague and Sleator, 1973) conducted a questionnaire survey of 700 Chicago physicians who were asked to estimate the dose and frequency of medication that they prescribed for school-age children. The major findings were that in 1970-71, approximately two percent of elementary school children received medication for hyperactivity. The stimulants were preferred medication with methylphenidate being the stimulant of choice; the average dosage of methylphenidate was 17 mg. per day as compared to 11 mg. per day of the dextroamphetamine; and the average period of medication was 9 months. Stimulants were the medication of choice and methylphenidate was the preferred stimulant with twice as many children using it as were using dextroamphetamine.

**Prediction of Response to Treatment**

No basis exists for predicting whether a specific hyperactive child will benefit from drug intervention or for determining which medication will be most effective, and what the minimum effective dosage is for him (Sroufe, 1975). The fact that there is no known method for predicting response to medication led to a study by Barcai (1971).

The 53 selected children were students in two public elementary schools, serving a predominantly black population of low social-economic class. Most of their problems were associated with overcrowding, broken families, and poor physical surroundings.
The teachers of the fifth and sixth grade referred for treatment all students who had difficulty in academic achievement, or classroom behavior. The 53 children were interviewed individually for thirty minutes, after the interview a prediction as to how the child would respond to drug treatment was made and put in a separate file. The children were divided randomly into two groups and treated for two six-week periods. The first group received dextroamphetamine (20 mg. daily, at 8 a.m.), the second group received a placebo. In double blind crossover this study was done to measure the effect of dextroamphetamine on children's academic achievement and behavior.

The teachers, who were ignorant of Barcai's methods, were asked to evaluate the children's response to medication. Every six weeks the teachers reported behavioral changes and described the student's present status as compared with the original problems. One month after the study was over, the medication had been discontinued for four weeks, teachers were asked to re-evaluate the children.

Two staff members were asked, who were not connected with the study, to make the final determination of each child's response to amphetamines. The staff members reached their decision by examining the teachers' questionnaires which were completed during the study, with the follow-up data (inter observer agreement was 95%). The findings were:

Of the 53 subjects, 23 were found to be amphetamine responders. These children improved more on the drug than on the placebo and demonstrated gross deterioration following the discontinuation of medication.
The second group of 16 children became worse while taking the drugs, improved on placebo, or did not change at all; these children were considered non-responders (p. 74), i.e., of the 37 children who could be clearly categorized by their responses to stimulants, the clinician's predictions were found to be correct for 21 of 23 responders and for 15 of the 16 non-responders (p. 75).

This indicates that Barcai was able to differentiate with a high degree of accuracy between stimulant responders and non-responders on the basis of the child's history, teachers information, clinical interview, and finger twist test. Although the finger twist test is simple to use, the method is limited because the only norms available are for 12 year old boys. However, in this study the children with behavior problems or learning difficulties, the above method was found to possess a predictive diagnostic value in connection with their response to the stimulating drugs.

Some hyperactive children show dramatic responses to daily doses of amphetamines of methylphenidate. Usually within a couple of days after receiving the first pill, the children concentrate better and do more of their school work. They are less restless, less likely to fly off the handle, and more agreeable in the classroom and around the house. The child who used to be an out-cast on the playground is more accepted, the teacher welcomes him and the parents can enjoy him.

For children who benefit from stimulants, there may be drawbacks in the form of side effects. The common ones are loss of appetite, pinched face with sunken eyes, sadness, with the tendency toward crying spells, cold hands and feet.
Two major long term side effects that have been identified are increased heart rate and growth suppression. Why the child's heart rate has increased is not clear.

Growth suppression was reported by Safer (1973) who noted a mean loss of expected height of 5 percentile points in 20 children using dosages of more than 20 mg. per kg. of methylphenidate for an average of three years.

Weiss, Hechtman, Perlman, Hopkins and Wener (1979) also confirmed Safer's findings that children who had taken methylphenidate (Ritalin), even in moderate doses and with "drug holidays," failed to grow at expected rates.

Most of these potential side effects can be controlled by adjustments in dosage or by a switch to a different type of medication. Appetite loss can be countered by having the child eat meals before rather than after taking the medication. Skin rash can be stopped by discontinuing the medication for a few days, until the rash disappears, then begin with the medication again.

Additional side effects are possible for any child, on top of that, little has been done about systematic long-term side effects.

Parents who worry about drug abuse are appropriately concerned for their child. When they accept the child's need for chemical controls, hopefully they are informed to be careful and responsible with the medication and on the lookout for side effects. Their fears will return with each magazine or newspaper report that they could apply to their child. This follows that they need to discuss such concerns again and again with their doctor or counselor.
writer feels that it is important for parents to be concerned about possible harm to their child from drugs, from disease, from non-education, etc. This is the role and task of parents on this earth. The parents will need informed reassurance and together with the counselor or physician go carefully through the current findings regarding possible side effects on children in general, and their child in particular out of this concern the child will get regularly scheduled check-ups.

Many times when a child is on medication it is thought of as "the cure all," "the magic pill," etc. The truth is far from it. Medication cannot reverse specific learning difficulties in writing, reading, speech disorders and so on. Careful observation and additional assistance and treatment are needed to secure a good outcome.

Theoretical Explorations

The most current psychological theory regarding the cause and treatment of hyperactivity has its roots in learning theory. Learning theorists accept the developmental lag theory of hyperactivity, and accept that hyperactivity may be linked to a variety of other conditions. Regardless of the internal cause, this approach emphasizes the environmental stimuli which elicit and reinforce hyperactive behaviors. The hyperactive child is viewed differently from normal children only in the frequency with which he exhibits certain behaviors.

This form of therapy involves the application of respondent and operant learning principles. Behavior modification with hyperactive
children relies heavily on the use of environmental control and re-
inforcement techniques in order to shape and extinguish the hyper-
active child's behavior. Using operant techniques, Anderson (1964)
was able to reduce the frequency of out-of-seat behaviors by making
teacher attention contingent on sitting behaviors.

A common complaint by parents and teachers is, that the child
does not finish his work on time. Teachers often assign independent
work only to find the hyperactive child does not get beyond the
first three problems. Such students are labeled irresponsible,
laZY, forgetful or other damaging terms.

Behavioral modification techniques can be helpful in the struc-
ture of time. Rewards or reinforcers that follow completion of
tasks within a selected time period serves to structure conformity
to time. It is not necessary to use reinforcers such as tokens.
The exchange of one type of time—work time—for another type of
time—play time—is effective. Classroom teachers have always used
this type of exchange by depriving the child who did not complete
his work, of a recess period. This reinforcement was in the form of
punishment—negative. More behaviorists are encouraging a positive
approach by instructing the child that when his work is completed he
gets play time. In this approach, the child who completes his work
in a short amount of time is rewarded with a longer play time than
the student who uses a longer period of time to complete his work.
Successful use of this contingency model requires planning to con-
trol the expectations of the work period.
The importance of structure of time for hyperactive children can not be overstated. Schedules and routines give the child a feeling of consistency and security.

History and Prognosis of the Hyperactive Child

In view of the comparatively high percentage of hyperactive children, it is surprising that there are so few systematic follow-up studies of the hyperactive child. Literature contains many suggestions that hyperactivity diminishes with age, but attention and concentration remain major problems.

Laufer and Denhoff (1957) tended to emphasize that hyperactivity was a time-limited condition which disappeared as the child grew older. Though, the symptom of hyperactivity may diminish with age, several investigators suggested that hyperactive children were prone to develop a variety of serious personality disorders as adolescents and adults.

Follow-up Studies

Menkes, Rowe and Menkees (1967) have undertaken a twenty-five year systematic follow-up study on eighteen hyperactive children. The children were selected from the Johns Hopkins Hospital Child Psychiatry Out-Patient Department. The hyperactive children had been seen during the years 1937 to 1946. All of the children were diagnosed hyperactive from the clinic records on the basis of a defined behavioral syndrome. Menkes et al., (1967) stated:

Under "hyperactivity" we included the accompanying elements of distractability, short attention span, emotional lability, impulsivity, and low frustration threshold. (p. 394).
None of the children had seizures. None of the children had IQ's below 70. None of the children had been diagnosed as being psychotic. All children did have indications of soft neurological signs, (poor coordination, difficulty in or delayed speech, visual motor dysfunction). The mean age at the first clinic visit was 7 years, with a range from 2 years, 7 months, to 15 years, 6 months.

Menkes et al., (1957) assigned a social class rating, to each child based on the occupation of the father at the time of the out-patient visit.

Of the original eighteen children (11 boys, 3 girls) who were selected, 14 were available for follow-up, and 11 of these were examined by the authors. Examination included, personal interview to determine interval history and current mental status, brief psychometric testing (Ammons Full Range Picture Vocabulary and Bender-Gastalt Test), and a neurological evaluation. The follow-up interval ranged from 14 to 27 years, with a mean of 24 years. Clinical status at the follow-up was as follows:

At the time of re-examination, four patients were in institutions, diagnosed as psychotic; two were clearly retarded and living dependent lives with their families; eight were self supporting. Of these eight, four have in the past spent some time in an institution; two in institutions for delinquent boys, one in a hospital for the retarded, and one in jail.

Of the 11 patients examined neurologically, eight had definite evidence of neurological dysfunction, one had equivocal evidence, and two had none. In most cases, the abnormalities found included terminal intention, tremor and minimal incoordination (p. 395).
In addition to Menkes et al., (1967) findings: Three still demonstrated evidence of restlessness and distractability, an age and range of 22 to 23 years. Psychometric testing revealed that only one patient performed at an average or above average level on the Bender Performance.

The results of this retrospective study are quite bleak. The studies that have followed are also not hopeful.

Weiss, Minde, Werry, Douglas and Nemeth (1971) conducted a five-year follow-up study on hyperactive children. The children were selected from these two main sources: from the pediatric and psychiatric out-patient departments of the Montreal Children's Hospital and from private pediatricians. All were attending regular schools. The initial group consisted of sixty-four hyperactive children (60 boys, 4 girls) and had sustained hyperactivity from four to six years after their initial referral. When seen first this group of children ranged between six and thirteen years of age, had no evidence of major brain damage such as epilepsy or cerebral palsy, had no evidence of psychosis, and had W.I.S.C. IQ's greater than 84, were living at home with at least one parent.

A variety of interviews, rating scales, psychometric techniques were used in initial and follow-up examinations. Follow-up results indicated that the children, as a group, had improved in the main symptoms of hyperactivity, excitability, aggressivity and distractability. Though they were rated higher in these areas than a normal group matched for age, sex and IQ. Distractability, rather than hyperactivity was the major complaint of the mothers.
Psychiatric examination concluded no cases of psychoses, three did show schizoid personality traits.

The most common pathological trait, reported by 70% of the mothers, was emotional immaturity. The second most common were lack of ambition and severe lack of ability to maintain goals, this being a complaint of 30% of the mothers concerning their children (p. 412).

The examining child psychiatrists were also impressed by this lack of ambition, changing of mood during the interview and low self-esteem.

Psychiatrist noted the unexpected sadness of mood which developed during interviews as the children talked about themselves. This sadness appeared even in some adolescents who were described by their mothers as "happy-go-lucky" or "completely care-free." Although it was not possible to evaluate this mood formally, it was apparent that the children were now highly aware of their many past and continuing failures and had a markedly low self-esteem. Many had very low expectations of any success in the future which often appeared to prevent their making any real effort (p. 412).

Educational difficulty was present in a significant number of children. Seventy percent had repeated at least one grade, thirty-five percent two or more grades. Ten percent were in special classes and five percent had been expelled from school.

Teachers were asked in a questionnaire to compare the hyperactive children with the control group (33 in each group) on distractibility, aggressivity, excitability, psychopathology and social adaptation. Teachers reported that the hyperactive children were: significantly more restless, unable to concentrate, more aggressive, and to have a greater tendency to show anti-social behavior than the controls (p. 412).
Psychometric evaluation revealed no significant changes in the W.I.S.C. Performance IQ or in the Good Enough Draw-a-Person Test, a significant improvement in W.I.S.C. Verbal IQ and a significant deterioration in the Lincoln-Oseretsky Motor Development scores.

In summary: Hyperactivity seems to diminish with age, but the children are more restless, excitable, impulsive and distractable than their peers. Attention and concentration remain major problems. Severe underachievement in academic areas is a common finding. Low self-esteem, depression and a sense of failure are common. Anti-social behavior occurs in 25% and a significant number have had police contact and court referral.

**Hyperactives as Young Adults**

There are a few studies that have followed up hyperactive children into adult life, and it has become important to know more about the outcome of healed and unhealed children.

Weiss, Hechtman, Perlman, Hopkins and Wener (1979) conducted a ten-year study on a variety of outcome variables from 75 hyperactive and 44 matched control subjects. The young adults were initially assessed at the Department of Psychiatry, Montreal Children's Hospital, 10 to 13 years previously.

When seen first this group of young adults ranged between 17 and 24 years of age, with mean ages of 19.5 for the hyperactives and 19.0 years for the control group. The two groups were matched on the basis of social-economic class, age and sex. Follow-up results indicated that:
1. Current Living Arrangement. Significantly less hyperactive than control subjects were still living with their parents.

2. Number of Moves. Significantly more moves were made by hyperactives than by control subjects.

3. Current Activity. There was no difference between the two groups with respect to the number of subjects "doing nothing."

4. Driving Licenses. There was no significant difference in the number of subjects in each who had driving licenses.

5. Car Accidents. A significantly larger number of hyperactive subjects had car accidents, and the mean number of car accidents in the hyperactive group was significantly higher.

6. Sexual History. There was no significant difference in the two groups with respect to age at first intercourse.

7. School History. Hyperactive subjects completed significantly fewer years of education than controls, but the mean difference was less than one year. Significantly more hyperactive subjects were still in high school. The average academic mark in high school was significantly lower for hyperactives, and significantly more of the latter subjects left high school for this reason. Significantly more hyperactive subjects were expelled from school.

8. Work History. There was no difference in job subjects who were forking full time, nor with respect to discrepancy between these other's work status and their own as measured on the Hollingshead Scale. The vocational plans judged on this same scale were similar in the two groups, and there was no difference between the groups as to whether vocational aspirations were judged (by the psychiatrists) to be realistic.

9. History of Court Referral. There was a trend for more hyperactive subjects than controls to have court referrals in the past five years.

10. History of Non-medical Drug Use. A significantly greater percentage of hyperactive subjects had used non-medical drugs in the five years before follow-up, but there was no difference between the groups with respect to non-medical drug use in the year prior to follow-up. There was no difference between the two groups with respect to severity of drug use (slight, moderate, or abuse) in the five years or in the one year prior to follow-up. However, significantly more controls than hyperactives used hallucinogens within the year prior to follow-up (pp. 678-679).
Other findings were that anxiety, tension, grandiosity, impulsivity, low self-esteem, and hostility were significantly higher in the hyperactive subjects when they were asked: "What had helped them most during their childhood?" Common response was one parent who believed in their success, or a teacher who discovered that they had some special talent, etc. When asked: "What made things worse?" common responses were family fights, feeling different such as, inferior, dumb, being criticized. Significantly more hyperactives than controls rated their childhood as unhappy.

**Treatment with Chlorpromazine**

No differences were found on any measure of outcome between hyperactives who were healed with chlorpromazine for 18 to 48 milligrams, (25 to 200 mg. daily) and those who received no drugs (p. 680).

Again, this study shows that a minority of hyperactive young adults have a poor outcome, a finding which indicates to the writer the importance of screening programs at preschool or kindergarten level to identify the thousands of children at high risk and who need further evaluation and treatment planning.

While hyperactivity is not yet preventable, hyperkinetic reaction of childhood is treatable. If the basic endowments of the child include an average intellect, his chances for healthy adult adjustment are favorable.

When the intellectual and social family structure are unstable, the problems for the hyperactive child are many.
Recent studies (Cantwell, 1972; Stewart, Deblois and Cummings, 1979) have shown that in some cases the syndrome may be a precursor to psychosis and other types of psychopathology in adulthood. Cantwell (1972) conducted a systematic psychiatric examination of the parents of 50 hyperactive children and 50 matched control children. Each parent was interviewed separately. The data indicated that:

most of the interviewed parents in the control group were free of any psychiatric illness, whereas nearly half of the parents of the hyperactive children had some psychiatric diagnosis (p.<005). The fathers in both groups tended to be ill more than the mothers. The specific differences between the groups are in the greater prevalence of alcoholism, sociopathy, hysteria and probable hysteria in the parents of hyperactive children. Suicide attempts and psychiatric care were also more frequent in the parents of the subgroup (p. 415).

Eight of the fathers of hyperactive children were thought to have been hyperactive as children themselves. Six of these were diagnosed as alcoholics when they were seen as adults; one was given a diagnosis of sociopathy; and the other one had an undiagnosed psychiatric illness with heavy drinking as one of the symptoms. One father in the control group who had been hyperactive as a child was given the diagnosis of alcoholism when seen as an adult. Two mothers of the hyperactive children, who were hyperactive themselves were diagnosed as hysterics as adults.

These data suggest that the hyperactive child syndrome is a precursor to significant psychiatric problems in adulthood and also that alcoholism, sociopathy and hysteria are the likely psychiatric outcomes in adulthood. This is supported by the findings of the
following studies of hyperactive children that anti-social behavior and drinking are prevalent by adolescence.

In a similar study Stewart, Deblois and Cummings (1979) systematically evaluated the parents of 126 hyperactive boys. The boys were selected from the University of Iowa Child Psychiatric Clinic or Ward. The children's age ranged between 5 and 15, IQ greater than 55, all should be living at home with at least one natural parent, and had no evidence of epilepsy or cerebral palsy. The hyperactive boys were divided in sub-groups depending on whether they were also aggressive, non-compliant and anti-social. The clinician who diagnosed the parents had no idea of the boy's problems, and specifically asked the parents not to mention the boy's problem. Parents were interviewed separately. The interview consisted of: marital and medical histories; family history; their work; their childhood; a review of common psychiatric symptoms of adult life and also part of the interview was concerned with whether they had ever been physically hurt by their spouse, had hurt their spouse, or hurt their children.

The 126 boys were diagnosed as follows:

- 25 unsocialized aggressive
- 33 unsocialized aggressive and hyperactive
- 16 probable aggressive and hyperactive
- 20 hyperactive
- 32 with other diagnoses such as phobic neurosis, depression, enuresis or encopresis and undiagnosed

Interesting findings of the parents of hyperactive boys were:

Total number of boys diagnosed as hyperactive was 69: 20 who were hyperactive and 49 who were also unsocialized aggressive. There were no significant differences between these boys and the 57 others on variables such as their age, their IQ, and the
social-economic status of the family. When the distribution of diagnosis in the parents of hyperactive boys was compared with that among the parents of other boys, the only significant finding was that a higher proportion of the fathers of hyperactive boys were diagnosed as definite or probable alcoholics (18 out of 69 vs. 6 out of 57). However, when all fathers with probable and definite alcoholism were counted, the prevalence of alcoholism in the two groups of fathers (24 out of 69 and 14 out of 57) did not differ significantly. Mothers of hyperactive boys tended to have hysteria more often than those of the remainder (9 out of 69 vs. 2 out of 57), but the proportion of mothers with any neurosis did not differ between the groups (p. 286).

Interesting findings were: The 74 boys who were diagnosed unsocialized aggressive had significantly lower social-economic status than the 52 boys with other diagnoses. The two groups differed also in the number of children in the family, which was higher for the unsocialized aggressive group. There were significant differences between the two groups of fathers when the number of the children was controlled among families. For example, for families with three children, 23 out of 35 fathers of unsocialized aggressive boys were antisocial or alcoholic in comparison to 13 out of 30 fathers of the remaining boys. For a family with four or more children, the figures were 12 out of 23 vs. 1 out of 8. For families with one child, the rates of disorders in the two groups of fathers were the same.

Wife abuse was more common between the parents of unsocialized aggressive boys in the family with two, three, or more children and occurred more often in families of low social-economic status. In this study wife abuse was very strongly related to antisocial personality and alcoholism in the fathers. Thirty-nine out of 54
fathers with the above diagnosis had abused their wives compared to 20 out of 72 fathers with other diagnoses. Among the 126 families, spouse abuse had occurred in 59 families.

Another interesting finding: Fathers of the unsocialized aggressive and hyperactive boys tended to be antisocial or alcoholic more frequently than fathers of boys who were diagnosed only hyperactive (20 out of 33 vs. 7 out of 20).

The above indicate that Stewart et al.'s (1979) data do not support the idea that hyperactivity is a specific syndrome related to specific behavior in the family because most of the aggressive boys were also hyperactive, and the disorders in the parents were related to the aggressive conduct disorder in the boys. Whether they were hyperactive or not, it is not clear in which way psychiatric disorders in the parents influence the behavior problems in their sons, although, there are many ways in which antisocial fathers might instill similar behaviors in their sons.

Stewart et al., (1979) conducted this study with a small sample to validate his findings; it takes a much larger sample to determine whether there are differences between relatives of children who are hyperactive, and those who are aggressive and hyperactive or those who are aggressive only.

**Prognosis of the Hyperactive Child**

It is commonly held that hyperactivity diminishes with age (Laufer and Denhoff, 1957). In one of the follow-up studies of hyperactive children, Menkes et al., (1967) found that in all but a minority, hyperactivity had disappeared, usually by adolescence.
However, the prognosis for hyperactivity may be good, the prognosis for overall social adjustment may not follow a similar road. For example, follow-up studies of children with behavior disorders, which include a significant number of hyperactive children, suggest that many have serious social problems as adults. There is reason to believe, that antisocial symptoms, and certain family factors such as disturbed family background, particularly alcoholism or antisocial behavior in the father and an absence of inconsistency of discipline, are clues of poor prognosis. Such symptoms, by all means, don't have to be commonly accompanied by hyperactivity.

Prospective and retrospective follow-up studies of hyperactive children also indicate that they are prone to develop poor self-image, depression, serious academic problems, and a sense of failure in later life. Lack of attention and concentration seem to be a major common outcome in adolescence.

Evidence of the long-term outcome with the hyperactive child are limited, mainly because studies showed contradictory findings and samples were small.

So far, it has not been demonstrated that treatment of any type significantly affects the long-term outcome of the hyperactive child.
CHAPTER III

PROCEDURAL APPROACH TO EVALUATION

The term hyperactivity is used so frequently by such a wide variety of individuals responsible for the growth and development of children that one may have the impression that hyperactivity is commonly understood. Actually this is quite far from the truth.

Hyperactivity is a term that describes a number of disturbing behavioral characteristics. Hyperactivity is most often applied to children with associated learning and emotional disorders.

Many children do not evidence hyperactive behaviors to an uncomfortable degree until they enter the formal education program which places them under stress. The teacher may notice the child's inability to adjust to the usual expectations and to the children who are in contact with him.

Quite often, hyperactive children are sensitive to their condition and are aware of their lack of self-control.

Hyperactive
by Tom Fairchild (De Gecombineerde, 1980)

I like to run and jump and play,
tumble, roll, and swing
Everything's important ... so I attend to everything
I like to play with treasures in my desk,
I like to watch it rain,
I like to taste the snow, to smell the leaves,
to hear the whistle of the train.

26
School is fun at lunch and recess,
but I do get kinda sad
'Cause all the time I'm in the class
The teacher thinks me bad.

She says I never pay attention.
Calls me messy
Calls me lazy.
Since she can't do nothing with me,
I gues she thinks I'm crazy.

The teacher thinks I'm naughty
'cause I'm different from the rest.
What the teacher does not understand
I'm being at my best.

She says I'm rude 'cause I interrupt,
 calls me mean because I'm scrappy.
I guess I can't do nothing
to make my teacher happy.

I try to listen, I try to sit.
 I really, really try.
If she would only understand.
But she don't! I wonder why?

What she sees is really me,
I wish she could accept that
I'm not naughty, bad or mean.
Even though I'm hyperactive
I'm still a human being.

As with any problem, the first step in dealing with hyperactivity is to understand it as fully as possible which requires defining hyperactivity precisely and then evaluating the behavior to determine its causes. A treatment program can then be developed for the child being considered. Hyperactive children are best identified through careful observations by their parents and their teachers. The most common method is for those hyperactive children to make notes and keep cumulative records of the child's behavior. For the purpose of the present thesis, the operational definition of hyperactivity in children between the ages of five and sixteen years

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of age employed by the writer is stated in the following paragraphs. The behaviors most commonly considered to describe hyperactivity are:

1. Excessive Body Movements: The child appears to be constantly moving, hitting, jumping and walking.
2. Poor Attention Span: The child cannot concentrate even for a short time, does not pay attention to directions, and has problems with completing assignments and projects.
3. Impulsiveness: The child acts on the spur of the moment.
4. Inconsistency: The child has an enormous amount of different behavior responses.
5. Emotionality: The child frequently overreacts to stimulation with temper tantrums, tears, aggression such as hitting others, or complete withdrawal. (Kauffman, 1974)
6. Poor Memory: The child forgets instructions, lessons, directions, or assignments.
7. Poor Visual-Motor Coordination: The child has difficulty with drawing, writing, cutting, and tracing. The child's balance is poor and when he plays he shows an awkwardness in his movements. (Alabiso, 1977)
8. Arithmetic Difficulties: Many of the errors the child makes are commonly associated with paying attention and memory. (Alabiso, 1977)
9. Proneness to Failure: The child has a poor self-concept or low self-esteem, and gives up easily due to a long failure record.

The child who is diagnosed "hyperactive" has an inability to sustain control of his ceaseless movements; he overreacts to humor;
feels frustrated when someone tries to correct him; he experiences episodes of sadness and depression which may fleet at one time but returns; has right-left confusion; a pseudo-deafness due to inattention; he fails to complete tasks which increases his low self-esteem; he cannot keep friends because he is unable to engage in constructive play; his IQ is lower than true capacity due to distractability and inattention at time of testing; he is unable to screen out important from unimportant things; he avoids gym due to coordination problems, and has a disruptive behavior on the playground because of his inability to play or failure to learn games.

All the above characteristics apply to most children; the degree of severity determines whether the diagnosis of hyperactivity can be rendered.

The above behaviors characterizing hyperactivity comprise an integration found in the relevant literature and knowledge based on the writer's own clinical experience in the treatment of hyperactive children and their families.

A thorough evaluation of the child is recommended before a diagnosis is made. Evaluation procedures call for gathering of detailed information.

*Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (D.S.M. III, 1980) American Psychology Association describes hyperactivity as follows:

**Attention Deficit Disorder with Hyperactivity**

The essential features are signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. In the classroom, attentional
difficulties and impulsivity are evidenced by the child's not staying with tasks and having difficulty organizing and completing work. The children often give the impression that they are not listening or that they have not heard what they have been told. Their work is sloppy and is performed in an impulsive fashion. On individually administered tests, careless, impulsive errors are often present. Performance may be characterized by oversights, such as omissions or insertions, or misinterpretations of easy items even when the child is well motivated, not just in situations that hold little intrinsic interest. Group situations are particularly difficult for the child, and attentional difficulties are exaggerated when the child is in the classroom, where sustained attention is expected.

At home, attentional problems are shown by a failure to follow through on parental requests and instructions and by the inability to stick to activities, including play, for periods of time appropriate for the child's age.

Hyperactivity in young children is manifested by gross motor activity, such as excessive running, or climbing. The child is often described as being on the go, "running like a motor," and having difficulty sitting still. Older children and adolescents may be extremely restless and fidgety. Often it is the quality of the motor behavior that distinguishes this disorder from ordinary overactivity in that hyperactivity tends to be haphazard, poorly organized, and not goal-directed.

In situations in which high levels of motor activity are expected and appropriate, such as on the playground, the hyperactivity seen in children with this disorder may not be obvious.

Typically, the symptoms of this disorder in any given child vary with situation and time. A child's behavior may become dysregulated in a group situation or in the classroom; or home adjustment may be satisfactory and difficulties may emerge only in school. It is the rare child who displays signs of the disorder in all settings or even in the same setting at all times (pp. 41-42).

Diagnostic Criteria for Attention Deficit Behavior with Hyperactivity

A. Inattention. At least three of the following:
   (1) often fails to finish things he or she starts
   (2) often doesn't seem to listen
(3) easily distracted
(4) has difficulty concentrating on schoolwork or other tasks requiring sustained attention
(5) has difficulty sticking to a play activity

B. Impulsivity. At least three of the following:
(1) often acts before thinking
(2) shifts excessively from one activity to another
(3) has difficulty organizing work (this not being due to cognitive impairment)
(4) needs a lot of supervision
(5) frequently calls out in class
(6) has difficulty awaiting turn in games or group situations

C. Hyperactivity. At least two of the following:
(1) runs about or climbs on things excessively
(2) has difficulty sitting still or fidgets excessively
(3) has difficulty staying seated
(4) moves about excessively during sleep
(5) is always "on the go" or acts as if "driven by a motor"

D. Onset before the age of seven.

E. Duration of at least six months.

F. Not due to Schizophrenia, Affective Disorder, or Severe or Profound Mental Retardation (pp. 43-44).

The purpose of diagnosis and assessment is not to label a child, but rather to make an accurate evaluation of his symptoms so as to plan his treatment, and where possible, estimate his prognosis.

This chapter will outline a suggested format for the evaluation of hyperactive children, which can be partly applied to the evaluation of children with other types of psychiatric disorders.

Below are the suggested headings for the evaluation of hyperactive children:

1. Present Problem
2. Interview with Parents
a) Chief Complaint
b) Referral Source
c) Recent Behavior
d) Past History
e) Physical History
f) Developmental History
g) School History
h) Family History

3. Interview with Child

4. Impressions

5. Kinesiology (testing for specific muscle weaknesses and treating them)

6. Testing

7. Diagnosis

8. Recommended Treatment

Present Problem

During the initial telephone contact the parent (most of the time the mother of the child), will describe the child's behavior problem(s) to the clinician. The clinician is able to assess the problem(s) as to indicate and document possible emergency of priority status. During this telephone contact the clinician will inform the mother about waiting periods, fees, the Parents Questionnaire (see Appendix A) and the Screening Checklist for Hyperactivity (see Table 1). The mother is asked to fill out the forms and send back to the involved clinician before the interview. If the parents allow the clinician to contact the school then the school is asked to fill out the School Report (see Appendix C), and the child's teacher is asked to fill out a Screening Checklist for Hyperactivity (see
Table 1
A Screening Checklist for Hyperactivity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Definite</th>
<th>Probable</th>
<th>Possible</th>
<th>None of These</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HYPERACTIVITY</strong></td>
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<tr>
<td>1. Impulsiveness (act on spur of the moment)</td>
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<td>2. Inconsistency (different behavior responses)</td>
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<tr>
<td>3. Poor Attention Span</td>
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<td>4. Poor Memory</td>
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<tr>
<td>5. Distractability</td>
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<td>6. Irritability</td>
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<td>7. Fidgetiness</td>
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<td>8. Excessive Body Movement</td>
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<td>(constantly moving, jumping, walking)</td>
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<tr>
<td>9. Poor Motor Coordination</td>
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<tr>
<td>(difficulty with writing, drawing, cutting, tracing)</td>
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<tr>
<td>10. Restless</td>
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<tr>
<td>11. Disturbs other Children</td>
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<tr>
<td>12. Teases other Children*</td>
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<tr>
<td>13. Excessive Demands for Attention</td>
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<tr>
<td><strong>TOTAL POINTS</strong></td>
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<tr>
<td><strong>AGRESSIVENESS</strong></td>
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<tr>
<td>14. Quarrelsome</td>
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<td>15. Acts Smart</td>
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<td>16. Temper Tantrums</td>
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<td>17. Stubborn</td>
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<td>18. Uncooperative</td>
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<tr>
<td>19. Destructive</td>
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</tbody>
</table>
Table 1 Continued

<table>
<thead>
<tr>
<th>Activity</th>
<th>Definite</th>
<th>Probable</th>
<th>Possible</th>
<th>None of These</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGGRESSIVENESS (Cont.)</td>
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<td></td>
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<tr>
<td>* Teases other Children</td>
<td>20. Fights with other Children</td>
<td>21. Defiant</td>
<td>TOTAL POINTS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26. Anxious to Please</td>
<td>27. Sad, Moody, Happy, Tearful (rapid changes)</td>
<td></td>
<td>TOTAL POINTS</td>
</tr>
<tr>
<td>SOCIAL ADAPTATION</td>
<td>28. Liked by other Children</td>
<td>29. Trouble with Opposite Sex</td>
<td>30. Trouble w/Same Sex</td>
<td>31. Withdrawn (from other children in school and at home)</td>
</tr>
</tbody>
</table>

* Appears in Hyperactivity and Aggressiveness
Table 1 Instructions

A Screening Checklist for Hyperactivity (Table 1) contains thirty-one consistent traits among hyperactive children. Moreover, this is meant for parents, teacher(s), chiropractor or counselor. However, it is not a final proof of any diagnosis or condition. It lists the traits which are likely to occur in hyperactive children.

It is important to note that a given child may not have symptoms in all or even in many of these areas since each child has his own particular cluster of symptoms.

For each of the thirty-one behaviors put an X in one of the four columns. Rate the child's behavior when he is not being supervised, helped and when the child is not watching television.

The score is the total number of items in Column, Definite, 3 points, plus the number of items in Column, Probable, 2 points, plus the number of items in Column, Possible, 1 point. None of these are scored zero points. The range of possible scores is from 0 to 93. The lowest possible score would be obtained from a child who is rated in Column, None of These on all thirty-one items. The highest possible score would be obtained from a child who is noted in Column, Definite, on all thirty-one items.

If the child's score is 45 or less, he is probably not hyperactive. The child can be considered hyperactive if he scores 45 or higher. The child can be considered mildly hyperactive if he scores from 45 to 60, moderately hyperactive if he scores from 61 to 75, severely hyperactive if the child scores from 76 to 93.
Table 1). All the above reports will be studied carefully before the initial interview with parents and child.

Also during the first telephone conversation suggestions are made as to how to prepare the child for the upcoming interview. It should be remembered that an interview with a psychologist or psychiatrist is a considerable emotional experience to a child. It is important to make the initial contact a therapeutically beneficial one.

If the child's present problem is "hyperactive" then the housing condition should be discussed with the mother if it turns out that the house is old, close to slums, etc., or that the family is living in city slums. Advise the mother to go to her physician to check the child's blood lead level as soon as possible.

In general, the normal blood lead level should not exceed .04 mg./100 mg., although clinical symptoms of lead poisoning often do not appear until the blood lead level is .06 mg./100 mg. of blood or higher.

In the United States, lead poisoning is widespread and is sometimes referred to as a silent epidemic. Lead is a trace element that has no known essential role in the body, but it occurs in the environment such as the urban environment and that exposure to it is unavoidable, even for fetuses (Lin-Fu, 1972). Most cases of lead poisoning are associated with the eating of lead-pigment paints in deteriorating urban housing areas by pre-school children. Although lead-based paints are not used anymore, there are many deteriorating urban housing areas where pealing paints still contain lead pigment.
A little piece of paint (like a penny) can contain between 50 and 100 mg. of lead and repeated ingestion of a few chips a day (over three months) can lead to the clinical symptoms of hyperactivity (short attention span, impulsive, and irritable).

Another major source of lead is high octane gasoline. Inner-city and suburban children may inhale lead from this source or may ingest it by eating roadway dust or snow on the streets. Treatment is with compounds known as chelating agents, which remove lead from the body tissues for excretion through the kidneys and liver.

Interview with Parents

In evaluating a child it is important to begin to evaluate the child's family as well. It is essential to see both the mother and the father at the initial interview; this is also a unique opportunity to observe parental interactions and relationships.

Although the parents already filled out the "Parents Questionnaire" (see Appendix A), and "A Screening Checklist for Hyperactivity" (see Table 1), it is necessary to go over important information such as events, behaviors, and happenings. Hence, the clinician has a chance to observe feelings, emotions or attitudes concerning these events and happenings. Attention should be paid to the way things are said by the mother and father of the child as well as to what is said.

The writer cannot stress enough the importance of listening to the differences in tone of voice, intensity of speech, and noticing the non-verbal behavior, such as facial expressions, eyes, posture,
and gestures. Reflecting on what has been said can be very helpful, in clarifying the father's or mother's feelings. For instance, "You feel guilty, because on the one hand you love your son, and on the other hand you can wring his neck." Here, the clinician allows the parents to be honest with him/herself, also the clinician communicates understanding, instead of what society has taught parents, "You don't hate your child, you love him."

A different approach is needed to obtain information about specific events and behavior. In order to understand the events and behavior in the family, systematic questioning about happenings is required. Many times parents are confused, and often quite inconsistent in describing their child's behavior. Mostly due to their own confusion, and lack of making the distinction between the child and his actions. Sometimes a clarification like "You love your son, but you hate his acting out of behavior," will open-up different ways of looking at their problem child.

Even though the family unit cannot be minimized in the life of the child, it is common that he has important relationships outside his family, such as, relatives, friends, teachers, his sibs, and neighbors. The clinician should inquire systematically about the above people. The importance of the child's relationships cannot be underestimated; it is probably the best indicator of social and overall adjustment in the school-age child.

Last point, when a child is referred for a problem such as hyperactivity, it is difficult to disentangle the child's disturbed personality characteristics from the present problem which brought
him in the clinician's office in the first place. The child's own personality characteristics frequently come out in his response to new events, to new people, and in drawings.

Suggestive Outline for Interview with Parents

The interview is divided in seven areas:

- a) Chief Complaint
- b) Referral Source
- c) Past History
- d) Physical History
- e) Developmental History
- f) School History
- g) Family History

Before the initial interview starts, the clinician should ask the parents' permission to take notes. The clinician could say something like this, "What you are about to share with me is important in the overall evaluation of your child, and by me taking notes the chances to forget important information are minimized." "Do you have any reservations or feelings about me taking notes?" The usual responses are: "No, it does not bother me a bit;" or "Oh no, not at all," or "Oh no, please go ahead." Be aware that the parents both respond to the above question.

The value of taking notes for the clinician are good overview, but also, when both or one of the parents express confusion, hesitation, anxiety, and a particular emotion, write an X before the notes, because these are areas the parents need to work on in treatment.

Chief Complaint

There is a constant flow of children referred to Child Guidance Clinics, who are apparently of good intelligence, yet who fail to progress in academic skills at the expected rate. Some of these
children are relegated to special education classrooms designed for slow learners; others are retained in a grade for a year or more in hopes they will catch up; most are passed along automatically with their age group even though the child cannot compete academically with his peers. These children experience learning difficulties, but they exhibit behavioral differences which are a source of irritation and bewilderment to parents, teachers and peers.

A teacher might refer to such a child as lazy; immature; undisciplined; a slow-learner; emotionally-blocked; or an underachiever.

The parental interview usually begins with an inquiry about the difficulties or problems which are the chief cause of concern to the parents and which made it necessary to seek help. The spontaneous complaints offered about the child are significant in their reflection of parents' attitudes. Let the parents tell their story in their own words, and try to obtain a verbatim account of the history. When the parents don't offer spontaneous complaints, then the clinician should proceed with more systematic questioning.

If the child is referred for hyperactivity, the parents comments will generally be around major complaints, such as impulsiveness, activity, irritability, distractability, and emotional lability. If all of these areas are not covered by the parents, specific questions should be asked.

Impulsiveness. Does the child--preferably use the child's name--do dangerous things like: running out into the street? riding his bike in the middle of the road? climbing out of high windows? The parents usually come up with a list of reckless or dangerous events
the child has engaged in. Common complaints are, the child cannot keep from touching and handling objects, especially in a strange or over-stimulating environment; the child speaks without checking himself, being insulting, or eagerly relating the family secrets. The child's impulsivity leads him into conflict with the demands of conformity as established by family, school, and society. Some children may commit anti-social acts such as fire-setting, stealing, hitting children, and breaking windows. This anti-social behavior can be provoked by small incidents.

**Activity.** Is your child more active than his brothers or sisters? Is the child unable to sit through a meal? a haircut? a movie? Does he wear out things fast, such as shoes, clothes? etc. Does your child appear to be in constant motion? Does he go from one object or activity to another? Is your child over talkative? Does he wiggle his hands? Rocks his legs? etc. Does he dominate a conversation?

**Irritability.** Does he have a low frustration tolerance? Is he irritable or hot-tempered? Is he easily upset by small things? Does he get irritated around groups of children? Does he have problems with taking "no" for an answer?

**Distractability.** Does the child daydream? Is he unable to listen to a story? directions? and attend to a T.V. program even for some time? Is he unable to go through a set of instructions?

**Emotional Lability.** Is your child highstrung? Is he easily moved to tears? Does he have quick changes of emotional behavior,
for instance from high temper to remorse? Does he panic under stressful situations?

Referral Source

It is important to find out why parents at this particular point in time seek help with regard to the child's problem. The clinician has to inquire about who initiated the referral, how, and for what reason. If the referral came from someone other than the parents, the parents should be asked how they feel about being referred to a child guidance clinic; also, if they were not referred to the clinic would they have taken the initiative to come themselves.

Present Behavior. The goal is to assess the seriousness of the behavioral disturbance of hyperactivity and any related symptoms in terms of the disturbance they are creating, either to those in the child's environment (peers, parents, teachers), or to the child himself, such as unhappiness or unpopularity. In order to evaluate the symptoms of hyperactivity itself, "A Screening Checklist for Hyperactivity" (see Table 1) may be used as a guide that may also be helpful in assessing the effects of multi treatment. The seriousness of the child's disturbance may be evaluated by the environments such as school and home, in which his symptoms are causing extra friction, and on top of that the number of symptoms additional to hyperactivity.

An important question is: what are those observable behaviors which are actually bringing the child into conflict with his world? The importance of obtaining specific examples of behavior cannot be

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overemphasized. What are the circumstances which seem to provoke certain aspects of behavior? How did the parents deal with the child at that particular moment? What methods have been used to deal with the problem by the parents? Common answers of frustrated parents are: "We have tried everything," or "We stopped even trying because nothing seemed to work," or "We tried so hard, but it seemed that he did not even listen to what we were saying to him, he drives me up the wall." These are all too general. The clinician needs to know the specific examples of methods the parents have tried, in what context and what success, or lack of it, has been obtained. In this part of the interview it becomes clear how the child's symptoms are influencing the family, in particular the parents.

The clinician should take verbatim notes. This will help the clinician later with the recommended treatment plan.

Past History

In case of hyperactivity it is most important to determine the time of onset of the child's disruptive behavior. In general, children who are hyperactive have evidence of disturbed behavior that goes back to toddler years, and often immediately after birth. Parents usually report that the child's hyperactive behavior was already present the first week he was born. Some responses were: "He could not lay still for one minute," or "His crib was always a mess," or "He was all arms and legs," or "I always had to keep one hand on him," or "He always gets into everything," or "I have to watch him constantly," etc. A question like, "Did it ever occur to you that your child was different and maybe needed some special help,"
often provokes this response, "He is different all right, but then we said, he is a boy and boys are a lot more aggressive than girls," or "No, at that time we did not think he needed extra help, but now it seems that his behavior is getting worse every day."

Inquire about the stresses that may have occurred at the time the parents realized that their child needed help.

**Physical History**

In the "Parents Questionnaire" (see Appendix A) the parents already listed hospitalization, operations, emergency room visits and specific illnesses, but the clinician has to know the child's reactions to these. Pay attention to head injuries, hearing or visual problems, allergies and seizures.

**Developmental History**

Since the clinician has already a firm idea of the developmental history of the child (Parents Questionnaire), it is up to the clinician, which area to pursue.

**Pregnancy.** Number of previous pregnancies? Age at the time of this pregnancy? The length of the gestation and the course of the pregnancy? Attitudes during pregnancy? Expectations for infant? Special events during pregnancy? General emotional state of the mother and father?

**Delivery.** Length of labor, course of the labor, type of delivery, birth weight, complications, if any, including such things as RH factors, transfusion, infant distress or maternal distress.

**Neo-Natal Period.** (0-10 days): The responsiveness of the infant, sucking capabilities, activity levels, parental reactions to
infant's sex and general appearance, and mother's emotional state.

**Early Development.** Habit Patterns; feeding—breast or bottle, schedule, appetite, weaning, problem with feeding such as colic, spitting up, food sensitivity, thumb sucking and mother's reactions to all or any of these. Did your child sleep regular or irregular? How old was your child when he slept through the night? What were the early sleep arrangements? Did he have problems such as insomnia? wakefulness, nightmares and restlessness?

**Elimination Problems.** If the parents listed any problems in the "Parents Questionnaire" the clinician has to inquire about it.

**Sexual.** The clinician must note the present level of development and also identify auto-erotic behavior, curiosity, parent's responses to sexual curiosity, attempts at education of the child and the child's level of understanding, as well as traumata in the sexual sphere.

**Physical Development.** Growth; body size, age of teething, inappropriate growths.

Motor development; rolling over at age, age of sitting up, age of crawling, age of standing, age of walking, what is his general coordination?

Communication; age when smile occurred, first words, first sentences, problems with communication either delayed or distorted.

**School History**

What was your child's response to starting school? How many grades did he repeat or fail? Which subjects are most difficult for him? Does he need remedial help? What did you do to help your
child? What is your attitude toward school and what are your expectations? Does he like his teacher? What extra help do you think he needs? Is he felt to be an under-achiever, poor learner? Has he ever been expelled from school? Does he play hooky?

**Family History**

A detailed family history is important for several reasons. A history or a description of the child rearing patterns in the families of origin and how this effects current parental attitudes and management may help the clinician to understand the parents and the hyperactive child's behavior better. The clinician should inquire about the family history of illnesses, such as, hyperactivity, learning problems in school, repeated grades, mental retardation, behavior problems in school, depression, nervous breakdowns, epilepsy, problems with alcohol, drugs, police record, suicide (completed, attempted), more than normal aggressiveness and did anyone need psychiatric care? If so, then explore as fully as possible to allow an evaluation to be made.

For each person living in the home, the full name, age, sex, education, and occupation has to be recorded. Does the family live in an apartment or house? What are the sleeping arrangements? What are the family attitudes toward family size and planning? What kind of birth control has been, or is used? What is the neighborhood like? Who supports the family? Are there financial problems? Has there been any significant loss of relationship or traumatic events effecting the family life. If so, what was the child's reaction, and his age at the time.
**Family Relationship.** This part of the evaluation provides a good opportunity for the clinician to observe positive and negative interaction between the parents. How do the parents get along? How do they spend their evenings and weekends? Are there specific areas of dissatisfaction?

Does the hyperactive child take after father or mother? Who is the one he confides in? How much time do the parents spend with the child throughout the week? and doing what? Does the child get along with his brothers and sisters? What do the children do together? What are the roles the children and parents play in their everyday life? What role does the hyperactive child play? Who usually manages him? What methods are used in disciplining him? Are they effective? Does he have a regular bedtime? Is he allowed to go out after dark? Is he allowed to choose his own friends? What are your expectations for your child? and what do you expect from us? In what way do you think we can help you?

**Interview With Child**

General points about the child's interview. The interview with the child should be geared to each child's age, intelligence, interest and presenting problem, a systematic approach of specific areas has to be conducted with each child. This indicates that the clinician builds up his/her own standard for his/her interview with different ages and different diagnostic problems.

The office should not look like a toy store, this will distract the child. Arrange the table and chairs so that the clinician and
child are not separated by the table, for instance, both sit on the same side or corner of the table.

With children below age six, most of the interview consists of nonverbal communications, interactions often occur in play situations.

The interview consists of two parts: 1) structured, and 2) an unstructured part. The initial interview takes about thirty to forty minutes. In most cases the child has been brought for evaluation usually at the concern of the parents or of the teacher, but not because of his concern about his problem. Hence, the child knows that complaints have been made about him, and thus, to bring up major complaints at the beginning of the interview would be catastrophic. The clinician's first concern is to establish rapport. The goal of the interview is to let the child feel relaxed enough, so he can talk about his world and how he perceives his problem.

**Suggestive Outline for Interview with Child**

The interview is divided in three areas?

a) Description of the child  
b) Interpretation of Observed Behaviors  
c) Possible Etiologic Factors

The writer mentioned before that an interview with a psychologist is a highly emotional event for a child, and it is up to the clinician to make that first contact a therapeutic one.

**Description of the Child**

The clinician starts with a life-like description of the child, for instance, his physical appearance, his manners, the way he
dresses, how did the child respond to the separation from the parents? How did the child behave while entering the office? Describe the child's behavior while in the interview with the clinician, also include significant interventions by the clinician. Describe the clinical impression of intellectual functioning, capacity, and the capacity to relate. What is the child's attitude about coming for an interview?

**Interpretation of Observed Behaviors**

It is imperative that the clinician explains to the child, who he is, what he does, such as playing with the child, asking questions, what he is interested in, what the child says and does, that he is not going to "change" the child, or "do things to fix him up," and why children come to see the clinician. Sometimes when mentioning several of the other children's problems, the index child will spontaneously respond with, "I have nightmares too," "I fight with children, too," "I am on the go all of the time too" or "I have trouble with reading too." The clinician's response can be like, "Do you want to talk more about your nightmares?" The usual response is "I am kind of scared," or "no." The clinician should acknowledge that talking about nightmares is scary; if the answer is no, then respect the child's wish to go on to a subject he might enjoy such as a hobby, his pet, his favorite toy, or his best friend. If the clinician believes that the child wants to talk about the nightmare but does not know how to begin, the clinician might say something like this: "Which animal or person was nice in your dream?" or, "It is hard to put a dream in words." Usually the child will
start with the least scary part of his dream and spontaneously go on to the most scary part of this nightmare. The writer cannot emphasize enough to be sensitive and listen, because a whole world of information is unfolding right in front of the interviewer.

At this point the child feels much better and often he says: "That was not that bad after all." Depending on the child's needs, a warm smile is enough or the clinician can say: "This took a lot of courage, and I am glad you shared your nightmare with me."

If the child's problem is hyperactivity, suggest "Let us have a drink of water," or if weather permits it, go outside for a walk. In nature the child seems more relaxed, and the clinician is able to observe a new set of behaviors. Does the child like animals, flowers, trees, or insects, etc. If the child's hobby is insects, for instance, ask simple questions. The child responds eagerly, his facial expression changes, there is a spark in his eyes, his body posture is more open, and his feet are touching the ground in a solid way (building his self-esteem).

Certain specific problem areas need to be covered such as, does he ever feel lonely, get into fights, get teased or picked on? Why does he think he is picked on?

The clinician should switch to a less threatening subject, like his pet; let the child talk about his pet in his own way. The clinician should say, "It sounds as though your pet (name of the pet) is pretty special, and I bet he is a good friend too!"

For a hyperactive child, school is a continuous struggle. What is his teacher's name? What is she like? What is the best and
worst things about school? Do you have any friends in school? What is his name? What games do they play? What is your favorite subject? Are there any subjects you don't like? Most people worry about things. What kind of things do you worry about? Do you ever get fed up? Are there times you feel really unhappy? Could you give me an example? Do you ever get really angry? Like when? Do you sometimes feel so miserable that you want to hide or run away?

Again, the clinician should switch to a more comfortable level like his home. What is it that you enjoy the most in your family? What is the worst thing about your home? Do you get blamed for things at home? Do you believe that you are treated differently from your brother or sister? How come? What is your dad like? What is your mom like? What are the names of his brother and sister? Are they nice to you? Go back to a cheerful topic like games he likes to play.

In order to assess his attention span, his fine coordination, and his persistence, the child is asked to write his name and draw a picture of anything he likes. During this time the clinician makes movements, also walks around, shovels papers around, and coughs.

The child is also asked to draw a picture of a man, woman, and a child and then to make up a story of each to them. There are many ways to assess the child's attention span and persistence, and it is up to the clinician to find appropriate ways that fit the child.

In the last part of the interview the child is allowed to play with toys. In this free play the clinician is able to observe the
child's spontaneous behavior and movements. After the interview with the child, the clinician fills out "A Screening Checklist for Hyperactive Children" (see Table 1) to rate the child. Each item represents the most common behavior disorders in hyperactive children.

Possible Etiologic Factors

What are the major identifications and their contributions to the child's adaptation?

Evidence suggest that the term "hyperactivity" describes a heterogeneous group of children with different etiologies. Hyperactivity can occur in the absence of any parental psychopathology, and hyperactivity can occur in the presence of parental psychopathology. The child gets into a difficult position if there is a combination of hyperactivity and poor parental handling.

At this point the clinician knows the past history of the family, the etiology becomes important if it points the way to treatment or prognosis.

Impressions

In writing up the interview with the parents the clinician should start with a description of the parents' general appearance, manners, and the way they dress.

The initial interview is divided in eight areas, chief complaint, referral source, present behavior, past history, physical history, developmental history, school history, and family history. The clinician follows the suggestive outline and states his findings.
In writing up the interview with the child, the clinician starts with a brief description of the child and there should be included somewhere name, age, sex, race, grade, address, socioeconomic status of the family, place of the child in the family as to whether it is a natural, adopted, or foster child and his ordinal position.

The course of the interview should be outlined in detail, relating what was done and what was said by the clinician and by the child. At the end the clinician mentions the findings of the screening checklists filled out by the teacher, parents, and the clinician. The clinician totals the columns and writes in the respective column the total points.

Table 2
Total Points of the Screening Checklist for Hyperactivity Flow Chart

<table>
<thead>
<tr>
<th></th>
<th>Total Points Hyperactivity</th>
<th>Total Points Aggressiveness</th>
<th>Total Points Anxiety</th>
<th>Total Points Social Adaptation</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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In making the final evaluation the clinician summarizes his findings, states the nature of the disorder in the child, and states his impressions.

Kinesiology

Isadora Duncan brought in a whole new approach to movement, that at all times dance should express something. The movement might be expressive of wind and values, but certainly every little movement had to have a meaning and not be performed merely as technique or as an acrobatic spectacle.

"Every little movement has a meaning all its own, Every thought and feeling by some posture may be shown."

--Otto Hambach (Shawn, 1974, p. 10)

Kinesiology is derived from the Greek Kinesis, meaning "motion" and lofros, meaning "work; knowledge." Kinesiology was originally a study of motion. Aristotle is often called the father of kinesiology; he was the first person who studied, taught, and wrote about mechanical principles relating to performance. The human in performance, a most complex phenomena, has attracted many people. Every one of them has discovered additional knowledge of better methods and how to apply basic laws and principles to performance.

During the 1960's, a new system of evaluation began to develop. Walther (1976), a chiropractor, discovered that tension and muscle spasm may be treated by strengthening opposite muscles. Structural balance is usually thought of as good or poor posture. Structural balance has a great influence on a person's total health picture. The body is held in place and moved by muscles. The muscle moves
two attachment points closer together; this indicates that for every muscle action, there must be an opposing muscle acting to pull back, and this can be illustrated by two muscles pulling equally on an upright post.

![Normal Normal](image1)

Figure 1. Balance in the muscles give structural balance.

When one muscle gets a nerve impulse telling it to contract, the other muscle must relax adequately to play out its length so that the post can move. If something goes wrong in the nervous system which does not allow the second muscle to relax, the contracting muscle cannot pull the post over. This simple principle is present, in a complex way, while walking, moving, and in daily

![Normal Weak](image2)

Figure 2. Balance is lost because one muscle is weak.
activities. If the muscle is contracted or injured beyond the muscle's ability to respond, the muscle will stay in a contracted or relaxed state until something has been done about it. Sometimes a good night of sleep will do the trick.

![Image of muscle showing normal and tight states.]

Figure 3. Balance is lost because a muscle is too strong.

Health consists of a triangle of factors. The factors are supposed to be in equilibrium, making an equilateral triangle. When health is lost, one of the three factors is involved, most often two, or all three. The triangle consists of 1) Structure, 2) Chemical, 3) Mental.

Goodheart developed applied kinesiology in a way that he is able to treat all sides of the triangle and he is able to evaluate the three sides of the triangle.

![Image of Goodheart's Triangle with labels: Chemical, Mental, and Structure.]

Figure 4. Goodheart's Triangle, structure, chemical and mental.
Suggestive Outline for Evaluation of the Child

The evaluation is divided into four areas:

a) Symptoms
b) Posture
c) Muscle Testing
d) Muscle Treatment

Symptoms

Eighty-eight percent of the people go to the doctor for abdominal discomfort, backaches, headaches and pains in arm, shoulder and leg. Children most commonly go to the doctor for stomach aches and headaches. Being in the office of a kinesiologist or chiropractor who uses kinesiology, the parents are asked about the child's symptoms.

The parents common complaints are that he is hyperactive, clumsy and incapable of functioning in the athletic activities, or is even unable to walk around the table without knocking everything off.

Posture

Reading the body language is a way to become aware of what is happening with the body. Kinesiologists believe they can look at the child and intuitively know how the child feels.

In order to recognize deviations from normal posture which need correcting, it is essential to know what constitutes a good posture. The kinesiologist looks for the balance. Both halves of the body should be almost equal.

Front. A line resting right between the feet, should go equally between the legs, through the naval, breast bone, up to the center
of the head. The shoulders dropped naturally, arms same length, hips, shoulders, eyes and ears are all level with the floor.

**Back.** A line should follow straight up the spine and through the center of the back of the head.

**Side.** A line should start, in front of the ankle bone, pass through the side of the knee, the center of the upper arm, center of the neck and ear. The weight of the body rest toward the back of the foot.

![Figure 5. The structure of the normal posture.](image)

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A deviation in the normal posture is the first stage of the problem. Recognizing the distortion is the first step in the healing process.

**Muscle Testing**

A chiropractor, using applied kinesiology, will test many different muscles to determine the structural balance of the body.

Muscle tests are applied to different areas of the body, and the chiropractor isolates a specific muscle for evaluation. Some muscles are strong, others extremely weak. The weakness indicates poor function of the muscle, and possible trouble with the organ and other tissue on the same nerve grouping. Further evaluation reveals which controlling factors are at fault. If correction is successful, then there will be a remarkable return of strength to the weak muscle.

Example by Thie (1973) testing the pectoralis major sternal/liver: The pectoralis major sternal is responsible for moving the arm in, turning and drawing it forward.

**Testing.** Test lying face up with the arms held straight forward and slightly to the side and level with the shoulder, palms out, thumbs toward the feet. Pressure is on the forearm to push toward the head and outward (see Figure 6, next page).

Problems associated with the pectoralis major sternal are spots in front of the eyes and some trouble with the liver. Thie states further:

All the blood that absorbs the food from the intestinal track goes directly to the liver where detoxification takes place. The liver has some 360 known
functions. It breaks down protein and fats and forms enzymes, but it has no external secretions. The liver is one of the few organs which, if damaged or partly removed, can regenerate itself. Poisoning from toxic fumes, alcohol, and rancid foods is detoxified in the liver. Overloading it can produce long lasting headaches which will respond well to repeated treatment of the pectoralis major sternal.

Avoid fried foods and sweets which contain fats, alcoholic beverages, carbonated drinks, and caffeine. Eating liver and foods containing Vitamin A (green leafy vegetables, parsley, green pepper) will be helpful. (p. 34)

If there is trouble with the pectoralis major sternal, check also the anterior deltoid/gall bladder and polliteus/gall bladder. The length of time that a condition has been present determines the speed with which the body can rebuild and regain health.

Children have a remarkable ability to respond to chiropractic care. In obtaining health corrections, chiropractic utilizes the body’s own healing powers. This ability to rebuild diseased or
malfunctioning organs of structures is especially great in children. Since they don't have years of chronicity, the body responds fast.

Hyperactivity can be related to many causes, such as hypoglycemia, neurologic disfunction of the child, e.g., poor nerve organization, gall bladder, intestinal tract (very toxic), poor liver functioning, as well as allergic reaction to food additives, including preservatives and food colorings.

**Muscle Treatment**

Muscle treatment can be done with neuro-vascular holding points, acupressure holding points, massage treatment points and meridians.

**Neuro-vascular Holding Points.** These points are located mainly on the head. These points are for strengthening a muscle, and require contact with the pads of the fingers, such as touching and slightly stretching skin. A few seconds after contact is made, a

Along the hair line about 1 - 1 1/2 inches to each side of the center.

Figure 7. Neuro-vascular holding points for pectoralis major.
slight pulse can be felt. After the pulse has been felt on both sides, then the neuro-vascular point may be held for 20 seconds or up to 10 minutes, depending on the severity of the problem (increase of blood circulation to the muscle and related organ).

**Acupressure Holding Points.** This is similar to the Chinese health philosophy. The Chinese use fine needles to stimulate a specific area. The chiropractor uses his hands.

Figure 8. To strengthen the pectoralis major sternal/liver.

Figure 9. To weaken the pectoralis major sternal/liver.
Massage Treatment Points. To work on the neuro-lymphatic reflexes for a muscle that has been found weak, find the points on the body that are shown for that muscle treatment. Move around the point with the fingers using a deep massage, and keep this pressure for 10 to 30 seconds. The amount of tenderness can be an indication of the seriousness of the problem. The tenderness will decrease as treatment progresses over a couple of days. Once the reflexes have been touched, the blockage in the energy flow to the muscle and organ is relieved, and the weak muscle is improved in strength when retested.

Figure 10. Massage treatment points for the pectoralis major sternal/liver. (p. 35)

Meridians. Are located throughout the body. Every meridian has been mapped. These specific acupuncture points on the meridian have an electro-magnetic structure and are made up of small bon-ham
corpuscles which enclose the capillaries in the skin, the blood vessels and the organs throughout the body.

Every muscle has its own meridian and the meridian can be used for strengthening and weakening of the involved muscle. To trace the meridian use the flat of the hand to make sure that the meridian has been covered sufficiently. Retest the involved muscle meridian

Liver Meridian. From the big toe, up the front, inside the leg, over the abdomen to the lower end of the chest near the side. (p. 35)

Figure 11. Liver meridian.
and if the muscle did not gain strength, try tracing the meridian in the opposite direction.

Hyperactivity can be an allergic reaction to food additives including preservatives and food colorings.

A normal child that has been put on the Feingold diet has to go through days of frustration. Can my child have this permissible food or is he allergic to oranges, etc. And the mother has to watch the child's behavior changes very carefully and write her findings down in the diet plan or diet diary.

In the office of a chiropractor, who uses applied kinesiology, nutrition can be administered and the chiropractor can immediately determine if the substance is correct for this hyperactive child. Chemicals and drugs can be immediately evaluated for their harmful effects by using the muscles to read body language. Certain nutritional products work for this child, while the other products will not, even though the label hyperactive is the same. For example, if the muscle associated with the liver is weak and Vitamin A is indicated for liver support, chewing Vitamin A or a carrot will cause immediate and dramatic strengthening of the pectoralis major sternal. Or, if an artificial sweetener (chemical) is causing a problem in the liver, the pectoralis major sternal will immediately go weak upon chewing the substance.

Every hyperactive child has to be evaluated as an individual because of his own unique system. The writer is thrilled by the amazing new developments for treating the child as a total person.
In summary, the chiropractor will evaluate and treat all sides of the triangle, 1) Structure, 2) Chemical, 3) Mental. The chiropractor will correct structure to effect better support and control of the body. Moreover, nutrition and chemicals can be tested using the child's body to determine the effect.

Emotional reactions can be improved by working with the structure and chemical, by improving emotional nerve circuits. In addition, it saves the family a trip to the neurologist.

Testing

An appropriate psychological assessment is part of the work-up of hyperactive children. The psychological test battery for every hyperactive child consist of the Wechsler Intelligence Scale for Children, Revised, the Bender Visual Motor Gestalt, and the Gray Standardized Reading Paragraphs or similar tests. Specific deficiencies in intellectual, perceptual, or motor functions may be discovered in a hyperactive child, which can be treated.

Information from these tests can be used as a basis for training and planning the child's educational program, since they measure both weaknesses and strengths in learning skills. When the IQ is used too rigidly, the IQ may become the determining factor in diagnosis, evaluation and discipline with the accompanying danger of committing a child to a program below or above his potential.

It is important to remember that reports often begin by describing what the child cannot do. The writer believes that it is important to determine what the child is able to do and where his
strengths lie. A better therapeutic approach can be constructed upon these assets and abilities.

Additional considerations are that intelligence tests have been shown to be influenced by culture, social-economic status, sex, environment and genetic factors.

Sometimes, tests have been misused in school situations to the possible harm of the child (misinterpretation, misapplication). Salvia and Ysseldyke (1978) state:

Tests are so often used to make decisions that will effect a child's future; this assumption of a skilled observer or tester is especially important. (p. 17)

Diagnosis and Recommended Treatment

As the writer stated before, a thorough evaluation of the child is recommended before a diagnosis is made. At this particular point in time, the clinician has gathered detailed information about the family and child.

The clinician has in his possession: The Parents Questionnaire (Appendix A); A Screening Checklist for Hyperactivity (Table 1), filled out by the parents, School Report (Appendix C), and School Social Worker's Report. The clinician filled out A Screening Checklist for Hyperactivity (Table 1), wrote up the interview report and stated his impressions. The clinician has the results of psychological assessment, and the chiropractor stated his findings, impressions, and ideas of how to improve the child's health.
Out of this wealth of information the clinician writes an assessment and treatment plan. The recommended Assessment and Treatment Plan (see Appendix D) will be discussed in the interpretive interview with the parents.

Summary

The theoretical approach to evaluation in this chapter should be carried out with every hyperactive child. A careful clinical description of the behavior problem of the child is necessary. This requires detailed, systematic, yet flexible questioning of the parents, receiving reliable information from school and performing a reliable and valid diagnostic interview with the child. The interview with the child takes into account age appropriateness of behaviors, sex of the child, social class of the child, race of the child, culture of the child, father's occupation, and the environment he lives in.

In kinesiology, the chiropractor is able to evaluate and treat all sides of the triangle, 1) Structure, 2) Chemical and 3) Mental.

Malnutrition is an increasing problem due to refining of foods, dietary indiscretion, and the exhaustion of the soil on which foods are grown. Again, the problem proceeds slowly, most often not causing a malnutrition disease, but rather causing a general loss of health. The chiropractor will have the child chew nutritional complexes and test the child to determine the effects of chemicals and drugs on the child's body. Every hyperactive child is evaluated as an individual because of his own unique system.
In testing, an appropriate psychological assessment is important. Information from these tests are often used as a basis for planning the hyperactive child's educational program. Specific deficiencies in intellectual, perceptual and motor functions may be discovered early enough to spare the hyperactive child a lot of frustration and unnecessary hurt.

A thorough evaluation and diagnosis is necessary in order to distinguish between the truly hyperactive child and the child with a high energy level. Unfortunately there has been much confusion. A high percentage of children who are referred to the clinic have been misdiagnosed by physicians, teachers and parents. Diseases such as diabetes, hypoglycemia, and allergies can produce hyperactive states. The child who is nervous because of conflict and stress in the home may become temporarily hyperactive.

The majority of children who are hyperactive show some of these symptoms consistently, day in and day out. There will be dramatic switches in the child's behavior as he goes from one situation to another, for instance he will be consistently fidgety in school or consistently pushy at home.

The severity of symptoms vary, so that each hyperactive child shows a unique pattern of behavior and personality. However, certain similarities among hyperactive children exist such as attention deficit disorder, excessive body movements and so on.

Doing a thorough evaluation the clinician will be able to distinguish between hyperactivity and environmental and/or physical stress and so come up with the correct diagnosis which is important
to establish goals, treatment plans and where possible, estimate his prognosis.

Therapy is essentially directed toward the entire family, aiming to correct the interactions that promote aggressive behavior. Involving the child in his own treatment program by letting him monitor, record and draw graphs of his own response will give a good reactive affect.
CHAPTER IV

PROCEDURAL APPROACH TO TREATMENT

Individual Therapy

One of the first systematic approaches to relaxation training was Jacobson's "Progressive Relaxation" (1974) which contains exercises for self-learning. Gunter (1974) wrote a book with photographs showing exercises through which a person can reduce tension and learn to let go and relax.

A person can learn to relax, attend, and concentrate. Children also can learn to inhibit muscular responses, improve their attention span, and improve their achievements. The goal is to develop conscious self-awareness and control of his own behavior. A child who is tense and too active, learns to relax himself and attend to a task.

It is important that the child learns immediately to monitor and record his own responses.

At the beginning, slow actions are stressed. Much time and repetition should be spent to insure that the child is slowly and accurately completing the exercises. Later on, relaxation training gains importance.

Tasks and exercises must be modified and supplemented to meet each child's special need and developmental stage. Some of the
exercises are taken from the literature. The following tasks and exercises help the hyperactive child gain self-control.

**First Step to Body Relaxation**

**Necessary Materials:** Rug or mat; recording chart; stopwatch.

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Figure 12. Recording chart for body relaxation.

**Process:** The child writes down the date and starts the stopwatch. Tell the child to lie down on the mat, now make yourself comfortable, spread out your arms and legs. Close your eyes, be very quiet, inhale deeply, exhale, and silently say to yourself "relax." Inhale slowly, exhale and relax, just relax.

Now continue to relax, try to remain relaxed without moving as long as you can. When you finally move, open your eyes and write down the time you finished this exercise and the total time you spent.

The next time the child does the exercise, tell him if he is able to remain quietly on the mat for an even longer time.
The child can repeat this exercise while lying in bed before he
goes to sleep. He also can practice at home on the couch, the floor
or in his favorite place.

**Soft Relaxing Music**

**Necessary Materials:** Mat, record player and records, recording
chart, stopwatch.

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Figure 13. Recording chart for relaxing muscles.

**Process:** Child puts the record on the record-layer and the
earphones on his head, and then tell the child to lie down on his
mat, this is soft and beautiful music entitled ..., start your stop-
watch, close your eyes and relax your body. Listen to this soft
beautiful music as long as you can without moving parts of your
body. When you move, open your eyes, stop the watch, and record
your time.

Afterwards, ask him to describe his feelings, his mood. If he
wants to know more about the music, then discuss it with him. Of
course, repeat the exercises with longer musical compositions by
different composers.
After a child has been introduced to the technique, he may have the option to choose the record.

**Massage**

**Necessary Materials:** Mat; table; stopwatch; recording chart; therapist; parent only first part of the massage technique.

**Figure 14. Recording chart for massage.**

The child lies down comfortably on his stomach, with arms and legs outstretched and head turned to one side. Start the watch. Stand or sit on the side and slowly begin to massage the child's back. Start at the lower back, fingers pointing to the head, thumbs crossed to give added strength. The hands move up on each side of the spine at first very gentle pressure. At the neck, the hands separate and stroke over the top of the shoulder and down the sides of the back to the waist. With the third stroke, increase pressure. Then give the seventh, eight, ninth stroke again, very gently. If the child is comfortable, then move both hands to the shoulders and neck, and gently but firmly squeeze and knead the base sides of the
neck. Then move both hands out to the shoulders very slowly. When finished, have the child record the time and the massaged parts of the body.

This is an excellent exercise for the parents to do with their child or children.

As the child learns to relax, the massage can be extended to the forehead, cheeks and nose, the ears and the scalp. Then the next step is: the forearms, upper arm, the elbow, the hands and the fingers. The next step is: the legs, calves, the knees, the upper legs, and the thighs. The very last step is to work on the torso and stomach.

At this point the child has been lying on a mat or table for about forty minutes; this is quite an accomplishment; hence, trust has been built up too.

Remember your physical description of the child (interview and treatment plan). How did the kinesiologist describe the child and what was his recommendation for treatment? Store the information away in your mind.

Before massaging the torso or stomach, take a closer look at the top and bottom halves of the body. The bottom half is the part of the organism that makes contact with the earth, such as moving and balancing etc. The top half has to do with seeing, hearing, thinking, speaking, expressing, stroking, hitting, holding and breathing. When diagnosing a child in this way, it is important to remember that he must be viewed with respect to himself and the way he is proportionately structured; his top half can never be compared
with another child's top half. The child has to be observed in his wholeness, because it is from that wholeness that his unique personality emerges.

If the lower body half is proportionately larger than the top half, it indicates that the child has greater comfort in dealing with grounded and the private aspect of his life. The top half, which has to do with self-expressions, reading and breathing, is under-developed and contracted. The emotions can't find an outlet through the natural channels of the chest, heart, mouth, eyes, and have to bounce around inside until an appropriate way of self-expression has been found.

When the top half is larger than the bottom half (skinny legs and contracted backsides), this child is over-developed in his ability to express himself, has good social abilities, is outgoing, but his skinny legs and hips will reflect a lack of strength with respect to emotional stability and self-support. This indicates that he lives in this world with his back, chest, and head, which are also the parts the child feels good about, and these parts compensate for the weakness in his legs and emotional make-up.

It is obvious that massaging the torso and stomach requires sensitivity and skill. Deep emotions are stored in the stomach and the top half of the body. If the child's top half is larger, then start with hands together in the middle of the chest, palms down, the fingers pointing toward the child's feet. Very slowly move both hands forward, using more pressure on the chest and a lighter touch on the stomach. (Only use this technique if the child does not have
a sunken chest.) At the bottom of the stomach, separate the hands and move them to the child's sides. Grasp the side of the child's body and pull up to the armpits, hands turned around so the fingertips are pointing to the center. Repeat this slow movement six or seven times. If the child looks relaxed, move on to the navel area.

Although the writer has had more experiences with adults, children do react somewhat similarly. The area the clinician is about to work on is the problem area. In general, it seems that the half of the body that is most graceful and alive will suffer from the fewest diseases and injuries; while the half that is rigid and un-integrated will have suffered from stresses, strains, injuries and painful memories. This also indicates that there is no healthy energy flow between top and bottom half. To restore some of the energy flow, the clinician puts the hand on the stomach. With the palm of the hand, circles are made clock-wise from the stomach around the pelvic bone and back (do not touch the navel yet). Repeat this circular movement slowly and gently, watch the child's face. When the child opens his eyes, smile at him, and reassure him that he is doing all right. If some tears are appearing in his eyes, lips are trembling, at this moment speak softly to the child: "It is O.K. to cry, just let go." Make the circular movement smaller, very gently stroke the navel area, and make the circular movement bigger and smaller (the hand stays in touch with the child's body). If movement is felt under the navel area, a painful memory may be emerging.
A clinician must be sensitive and listen because this memory has been stored too long. When the child speaks, his voice may be loaded with pain; thus, be supportive. Afterwards, the child may feel better, the top half and bottom half are a little more integrated, the part of the blocked energy flow is restored. After such a painful process, the child may come up and hug the clinician. These moments of sharing pain, sorrow, tears, and joy are powerful and wonderful for both the child and the clinician. Most of all the child has become a more integrated and happier person.

Willow in the Wind

Necessary Materials: Stopwatch; recording chart.

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Figure 15. Recording chart for willow in the wind.

Process: Tell the child to start the stopwatch. Stand upright, your feet apart and your hands above your head. Slowly move your arms and body, as though you were a willow tree swaying in the wind. Do not move your feet. See how slowly you can move your arms and body in different positions. Slowly bend your body from side to
side and sway back and forth. Now close your eyes and get into the feeling of being a willow tree. Continue as long as you can, then stop your watch and record your time.

Next time the child can imagine that his hands are leaves attached to the tree. Let the child slowly move the hands and arms as though two branches are swaying in the wind. Tell the child to imagine birds in the willow tree. The birds love this willow tree because it is swaying very gently. So gently, that the birds feel like singing in this beautiful swaying tree. The slower the willow tree sways the more beautiful their songs become.

(Hyperactive children move clumsily; the above exercise will enhance graceful body movements.)

Note: Credit belongs to my Grandparents.

Eating

Necessary Materials: Apple or home-made cookie; water; milk; stopwatch; recording chart.

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Figure 16. Recording chart for eating.
Process: It is important to learn to relax and take time while you are eating. Now we are going to see how much time you can take to eat this apple. Sit down, take a deep breath, exhale and relax. Start the stopwatch, take this apple, and start to eat the apple in small bites. Notice how long you can chew it and taste the apple before you swallow the bite. When you have finished eating your apple, stop the watch and write down what you ate and how long it took you to eat the apple. Next time we will try it again and see if you can break your record. (Encourage parents to increase the time the family spends at the dinner table, and give credit to the child if the child only leaves the table twice instead of four times.) Encourage the child to stay at the table during dinner time. Reward the child with his favorite dessert. (The dessert has to be home-made to avoid artificial flavor, colors, chemicals, etc.)

Body Relaxation

The hyperactive child has learned the slow breathing exercise, and is now ready for relaxation training.

Share with the hyperactive child that he is about to learn an important skill, entitled "Relaxation via Tension-Relaxation." If you like to learn how to play baseball, then you know you have to practice. To learn to relax you need to practice too. Sometimes you will experience special feelings like tingling in your face, or even a floating sensation, as if you were moving about through space. This is nothing to be afraid of. That tingling feeling in your face indicates that the muscles are beginning to relax.
It is very important for you to know that you remain in control. If you feel uncomfortable, you can stop the exercise right that minute. The therapist is your guide, but you are in control.

The reason that you are about to learn to relax is to gain control over the movements of your body, and to release the tension within.

Do you have any questions? The following exercise is based on Jacobsonian relaxation training (Goldfried and Davidson, 1975).

I'd like you to lie down on the mat, make yourself as comfortable as you can, close your eyes, and listen to my voice. Inhale very deep, exhale and relax (three times). I put a little ball in your right hand, clench your right hand, squeeze the ball, notice the tension in your right hand (3 second pause), and now relax, just let the little ball sit on your hand, and notice the difference between when you squeezed the little ball and now when your hand is relaxed (3 second pause). Once again now squeeze the little ball, tightly, very good (3 second pause). Now relax, spread out your fingers and notice the difference between tensing your muscles and relaxing your muscles. I am going to take the little ball and put it beside me (3 second pause). Relax, just relax.

Bend both hands back at the wrists, fingers pointing toward the ceiling. Notice the tension in the backs of the hands (3 second pause). Relax, let your hands turn to their resting positions, note the difference between tension and relaxation (3 second pause). Again, fingers pointing toward the ceiling, notice the tension in the backs of the hands (3 second pause). Bring the hands back to
their resting position. Let go even more, just let go (3 second pause). Bring both arms slowly up, fingers pointing toward the ceiling, slowly, very good (3 second pause). Now let your arms go back to their resting position, slowly, very slowly and relax, the best you can (3 second pause). Now I would like you to pick up your shoulders, bringing both shoulders toward your ears, as if you want to protect your ears. Hold it, note the tension in your shoulders and up in your neck (3 second pause). Relax, let both shoulders return to their original position. Relax more and more. Feel the relaxation spreading into your shoulder areas (3 second pause). Once again bring up your shoulders, feel the tension in the shoulders and in the neck. Notice them (3 second pause), now, relax. Let your shoulders come down to a resting position, and be aware of the difference between tension and relaxation (3 second pause) and exhale, very good (5 second pause). You may open your eyes when you are ready.

Hellow, how do you feel? ... Next time we go through the same exercise, but then we elaborate on it. Every time we see each other, we add different parts of the body to it. For instance, next time we add how to relax your facial muscles. What else are you able to relax? Yes, of course, the legs, the belly, and back, etc.

Now you are going to relax the muscles in your face. So what I want you to do now is to wrinkle up your forehead and grow as if you were very angry. Yes, that is it, and now relax. Smooth your forehead. Let those muscles become loose (3 second pause), once more make your forehead and brow look very angry. Study those
tensions in the muscles above your eyes. And now relax, smooth out your forehead, and notice the contrast between tension and relaxation (3 second pause). Now close your eyes tightly, so that you can feel tension all around your eyes (3 second pause). Relax those muscles, note the difference between tension and relaxation (3 second pause). Do that once again now, close your eyes tightly, study the tension. Hold it (3 second pause). Relax, let go and let your eyes remain closed (3 second pause).

Now clench your jaws, bite your teeth together as though you are holding something between your teeth. Notice the tension throughout the jaw (3 second pause). Now relax your jaws, relax more and more (3 second pause). Once again, clench your jaws together. Study the tension (3 second pause). Now let go, further and further. Just continue to relax (3 second pause).

Now blow up your cheeks, nice and round, yes very good (3 second pause). Now relax, let all the air flow away, relax further and further (3 second pause). Once again, blow up your cheeks, hold it, study it, (3 second pause) and now relax (3 second pause). In just a minute I am going to ask you to open your eyes. I am going to count from 5 to 1 and at the count of one you may open your eyes, feeling relaxed and wide awake. 5 ... 4 ... 3 ... 2 ... 1 ... Open your eyes.

Now I'd like you to bring your head forward, and try to bury your chin into your chest. Feel the tension in the front of your neck. Now relax, let go further and further (3 second pause). Once
again now, chin buried into the chest, hold it (3 second pause).
Relax, just relax more and more.

Now we bring our attention to the muscles of the upper back.
Arch your back and imagine a train is going under your back, hold it, it is a long train, the train is gone, now relax (3 second pause). Once again arch your back, feel the tension in your upper back. Study the tension and now relax. Let the body again rest on the mat, and notice those muscles getting more and more loose (3 second pause).

Take a deep breath, filling your lungs. Hold it and study the tension all through your chest and down into your stomach area. Relax, let go, exhale and continue breathing as you were (3 second pause). Let's do that once again, take a deep breath and hold it. Note the sensations. And now exhale and continue breathing as you were, getting more and more relaxed each time you exhale (3 second pause).

Now tighten up the muscles in your stomach. Make the stomach very hard, hold it. I am going to put a book on your very tight stomach (3 second pause). Now relax, let those muscles become loose, let go and relax (3 second pause). I'll take the book from your stomach. Once again tighten your stomach muscles, make them very hard, again I am going to put the book on your stomach, hold it (3 second pause). Now let go. I'll take the book and you relax more and more relaxed. Inhale very deep and exhale, just let go more and more relaxed.
In a few minutes I am going to become silent so that you can practice the following exercise. I want you to think clearly to yourself the word "calm" every time you exhale. Let go a little bit more each time you exhale and at the same time think about the word "calm." Each time you exhale think silently to yourself the word "calm." Go ahead until I talk to you again (3 second pause).

I'd like you to stretch both legs. Stretch them way out, (5 second pause) and now relax. Relax more and more (10 second pause). Once again, lock your knees, stretch out both legs so you can feel the muscles getting hard and tense (5 second pause). Relax those muscles. Let them get loose, relax them to the best of your ability (10 second pause).

Now tense both calf muscles by pointing your toes toward your head, imagine your toes are almost touching your nose (5 second pause). Now relax. Let the legs relax and notice the difference between tension and relaxation (10 second pause). Once more, bend your feet at the ankles, toes almost touching your nose, feel the tension. Hold it (5 second pause), now let go, relax those muscles, further and further, more and more deeply relaxed (10 second pause).

Eyes remain comfortably closed. Now I am going to share a story with you. Some parts of the story are based on real life experiences; and some parts are fantasies. The story is called "Seeing."

Long ago there lived a little girl, she was always busy at work or play. She studied math problems, spelling and music, etc. When the lessons were over, she pedaled her bicycle swiftly along the
paths. In fact, she was so used to rushing around, that when she was not busy, she was bored. She rushed to her father and said, "I don't have anything to do. What can I do?" "Child, must you always be doing something?" he asked. "Yes" and she stamped her foot, and rushed to find her mother. "What can I do?" Her mother asked, "What would you like to do? Go to the circus or go to the zoo," but when she came home, she sighed and said, "There is nothing to do, maybe I'll run away." Her mother became worried and on one bright summer morning her parents talked. Mother mentioned "How can we keep her busy?" She looked at her husband and said, "What is your secret? You seem content." Her husband said, "Our little girl would not sit still long enough for me to tell her my secret. Perhaps a friend of mine could tell her. That friend," and pointed to a big tree in the backyard. "Oh, don't be silly to me" said mother. "You go and I'll talk to the tree."

Next day, the little girl raced on her bicycle, and failed to stop in time. She raced into the tree. "Ow!" said the tree. "I'd like to talk to you, sit down on one of my branches." She did. "You don't have respect for trees and humble little creatures," said the tree. "Yes I do, but I did not see you in time." "That is your trouble, you don't see anything," said the tree. "I'd like to give you a magic stone, to let you see better. Put this stone in your pocket and sit very quiet," said the tree. "I don't see anything," said the little girl. The little girl was not used to sitting still, it was very difficult for her. The tree said "cooperate, sit still." After a while she saw a bird. The tree asked, "What do you
see?" The girl said, "a bird." "What else do you see?" "I see the sun shining on his feathers, the feathers are sparkling and have all different colors, just like a rainbow." "Good, come back tomorrow," said the tree, "but give me that magic stone because you cannot keep the stone in your pocket for one minute the way you rush around." "Besides, you can only put your magic stone in your pocket when your duties are done." I am going to count from 5 to 1 and by the count of one open your eyes, and be wide awake. 5 ... 4 ... 3 ... 2 ... 1 ... Open your eyes. Hello.

Next day bored with everyday life, the little girl came back to the tree. Little by little she learned to sit still, keeping her magic stone in her pocket. The girl had seen birds before but never watched them. She had seen butterflies and frogs before but never watched them. She sat wide-eyed when a baby field mouse played with its tail. Never had she watched ants build a house for the whole family. She watched the birds' love dance and listened to their songs.

"I never knew that so much was going on." "The tree said, "You never had your magic stone. Now that you can keep the magic stone in your pocket I'll arrange a miracle." The tree bent down and gave a seed to the girl. "Plant this in your garden, water it, and watch it grow, but keep the stone in your pocket, if not you will never see the miracle." "But how come that a tree like you knows so much about beautiful things," the girl asked. "Trees don't rush around." The girl looked up and saw, kept in a safe place, a magic stone. She said, "You have a magic stone too." The tree smiled. The girl
planted the seed, watered it and watched it grow. She saw tiny green leaves coming out, a little plant began to grow. One morning the girl looked at her plant and saw a yellow flower, yellower than the sun and she said, "this is a miracle." Her father came out and together they looked at the miracle. Then the girl cried, "Father you have a magic stone too." Her father smiled, and showed his magic stone. The little girl saw things she never noticed before like a duckling break out of an egg. One day the little girl mentioned, "Father, even when I am as old as you are I can put my magic stone in my pocket, and I can see wonderful things." Father smiled and the tree said, "You will!" The little girl hugged the tree, both the tree and the girl understood.

Now, when this girl visits her own country, she goes to her backyard and the tree says, "Come sit on one of my branches, I have to talk to you." She does, and they both are happy (10 second pause). I am going to count from 5 to 1 and at the count of one, open your eyes. 5 ... 4 ... 3 ... 2 ... 1 .... Open your eyes, feeling very relaxed and wide awake.

Depending on the child's reaction to the fantasy, the next session go out with the child and discover the miracles in nature. (Bring two magic stones too, at the right time give the stone to the child and discover the meaning of "seeing.")

Objective: To increase the child's fantasy life. Because of the preoccupation with everything if possible at the same time, a hyperactive child's fantasy life does not have a chance. Warning: before a clinician introduces a fantasy, the child has to be ready
for it. Don't forget, even though this child is young, his road has
been bumpy, scary, and scars are left on his self-image.

The next logical phase is, "relaxation via letting go." At
this point the child has become more aware of minor tensions and is
able to eliminate some. The next exercise is similar to "Relaxation
via tension-relaxation" except tensing the muscles.

The focus is on the feelings in the different body parts and
relaxation comes about by letting go of tight feelings more and
more. For instance: Relax the muscles of the right forearm, just
let go further and further, deeper and deeper into relaxation (3
second pause). Relax the muscles of your upper right arm. Continue
to let go more and more. Relax those muscles, just let go (3 second
pause).

At the end of the exercise introduce a guided fantasy or his
own fantasy. If the child is ready for his own fantasy, the clinici-
can say something like this: "Now I want you to imagine that
you are at your favorite place, you are feeling very relaxed, and
thoughts are going through your mind, go with the thoughts or images,
just let yourself be, don't fight your thoughts, go with your
thoughts or images."

Now continue this for awhile. Go ahead until I talk to you
again. Take a deep breath, exhale and relax, deeper and deeper re-
laxed (2 to 4 minutes).

I am going to count from 5 to 1 and at the count of one open
your eyes, feel good and relaxed. 5 ... 4 ... 3 ... 2 ... 1 ...
Open your eyes. Ask the child if he is willing to share some of his thoughts or images with you.

For guided fantasies, the writer refers to an excellent book called "Awareness" by John O. Stenens (1973). The clinician might revise some of the fantasies to fit the index child.

Relaxation via Letting Go is an excellent exercise to practice at home before the child goes to bed or while lying in his bed.

Building Self-Esteem

I know a person small
He keeps ten million serving men
Who get no rest at all!
He sends 'em abroad on his own affairs
From the second he opens his eyes
One million How, two million Wheres
and seven million Whys!

—by Rudyard Kipling (Cooper Smith and Wilson, 1975, p. 219)

Cooper Smith and Wilson (1975) conducted a series of studies of self-esteem, applying the techniques of clinical, laboratory and field investigation. The subjects were middle class, urban boys aged ten to twelve, who were considered normal, in a sense that they had no personality disturbances and came from intact families. The investigators followed the boys from preadolescence to early adulthood. Their findings were:

Youngsters with a high degree of self-esteem are active, expressive individuals who tend to be successful both academically and socially. They lead rather than merely listen in discussions, are eager to express opinions, do not sidestep disagreement, are not particularly sensitive to criticism, are highly interested in public affairs, showed little destructiveness in early childhood and are little troubled by feelings of anxiety. They appear to trust their own perceptions and reactions and have confidence that their efforts will meet with success.... They are much less frequently afflicted

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with insomnia, fatigue, headaches, intestinal upset, than are persons of low self-esteem. (p. 220)

The boys who were characterized by a medium level of self-esteem were similar to high esteem subjects in most of their attitudes and behavior.

The boys tended to be optimistic, expressive and able to take criticism.... They were distinctly different from both high-esteem and low-esteem subjects. They showed the strongest tendency to support the middle class value system and compliance with its norms and demands. They were uncertain in their self-ratings of their personal worth and tended to be particularly dependent on social acceptance. (p. 220)

Findings on subjects with low self-esteem were:

They were convinced of their inferiority, are fearful of social encounters, persons who are unsure of their worth tend to be active in seeking social approval and experiences that will lead to enhancement of their self-evaluation.... The boys with low self-esteem presented a picture of discouragement and depression. They felt isolated, unlovable, incapable of expressing or defending themselves and too weak to confront or overcome their deficiencies... sensitive to criticism, self-conscious, preoccupied with inner problems. (p. 220)

Cooper Smith and Wilson (1975) explored factors that lead to the development of high self-esteem. They looked into the backgrounds of the boys who possess high self-esteem. Their findings were:

close relationships existed between these boys and their parents.... Parents of the high self-esteem children proved to be less permissive than those of children with lower self-esteem. They used rewards rather than corporal punishment or withdrawal of love as disciplinary techniques and their sons praised their fairness.... Parents of low self-esteem boys, tended to be extremely permissive but inflicted harsh punishment when the children gave them trouble. These boys considered their parents
unfair and they took the absence of stated rules and limits for their behavior as a sign of lack of parental interest. (pp. 221-222)

Another finding was:

Parents with high self-esteem boys, were open to persuasion and generally willing to allow the children a voice in the making of family plans. All these factors contributed greatly to the development of the boys' high self-esteem. (p. 222)

It is impossible to understand the child's hyperactivity without understanding the child's feelings about the hyperactivity. It is common for hyperactive children to feel abused by others. The child feels that he is in trouble and blamed for everything. The list of being blamed for is endless (too noisy, too impatient, asks too many questions, whistles too loudly, etc.). When a child understands that these criticisms are based on his actions, he can then deal with them in a constructive way. A hyperactive child hears a constant stream of negative labels from parents, teachers, sibs, and he may believe that the people who say these labels are correct; hence he adopts the role of a troublemaker, and he becomes the black sheep in the family, neighborhood and classroom.

In treatment help the child understand that he acted upon expectation of others. He is now ready to prove to other children and adults that his hyperactive behavior will not occur as much as it did before. At the same time teach a child to talk about his change and his desire to develop new relationships. Being hyperactive is frustrating for the child. The child might hate his clumsiness, or not being able to hand in neat work. Keys are self-applied labels like a misfit, or someone who does not belong in the family.
Moreover, help the child to increase his feelings of self-worth by drawing out the positive sides in him.

To build the child's self-esteem his teacher is in a key position to do so. The teacher who understands the child's distractability is likely to respond in a way that will help the child be productive in his functioning.

Behavioral modification techniques can be helpful in the structure of time. As the writer mentioned before, rewards or reinforcers that follow completion of tasks within a selected time period serve to structure conformity to time. The exchange of one type of time—work time—for another type of time—play time—is effective. In this approach, the child who completes his work in a short amount of time is rewarded with a longer play time. Successful completion of this contingency model requires planning to control the expectations of work time.

The teacher can structure the child's work. She can give the child one page of work at a time; when the child has completed his page, he can go up to the teacher to obtain the next single page. This will encourage completion of each task, and allows at the same time movement discharge within the classroom.

The teacher can help to build the child's self-esteem by avoiding recurrent failure. For instance, she can start with tasks within his level of learning capacity, so he can succeed. Reward the child with smiling faces or a large A++ on his papers. Verbal messages do wonders such as "Your work was well done." "Your work is
getting better and better," "I like your new sweater," or "Your smile is worth a million bucks."

The self-esteem a child has about himself is formed slowly by the whole history of acceptance or rejection which he has experienced in growing older. In therapy, the child learns to remodel his attitudes, especially the attitudes he has toward himself, and to improve the child's self-esteem is the basic goal of therapy.

Nutritional Approach

While the body is remarkably efficient, durable, and self-healing, it has its limits. The writer believes that body malfunctions usually occur at times of stress. Stress can be physical, emotional, chemical and nutritional. Emotional stress is self-explanatory, physical stress occurs when there is too much work and not enough rest, chemical stress is an integral part of our lives, poisons (through air, water, and food) are getting in our bodies. It is impossible to escape the chemicals in our environment, but nutritional stress can be controlled. Failure to control all four stresses gives rise to serious illnesses.

Under too much stress, the adrenal cortex becomes exhausted; the result is that there are not enough anti-insulin factors being secreted into the blood, and this process leads to hyperinsulinium and hypoglycemia.

In later states of development, more organs are involved, the pancreas, the pituitary gland, and the liver. Harmony among all the endocrine glands is necessary before good health can exist.
The concept of controlling food intake to improve happiness and health is an ancient one. Dr. Feingold has developed a nutritional program for hyperactive children. The Feingold program involves the elimination of all artificial colors, flavors, preservatives, substances—based on the degree of the child's sensitivity—like salicylates (acidic substances in many fruits, has a bitter sweet taste) and food additives. A list of permitted and not-permitted foods is listed in Appendix F: The Diet. If the child is old enough to understand the importance of dietary management, the instructions are given to him. The clinician may want to explain the child's new diet in reference to another person he may know who has to live on a diet. Grandma may be on a low-fat diet, his mother is trying to lose a few pounds, etc. Explain that his diet will help him to have happy, calm days. The program's success depends upon the child's cooperation, sometimes this cannot be expected until the diet becomes effective.

The writer believes that in most cases success requires that the entire family be on the diet. The absence of prohibited foods from the home eliminates temptation. Also, when the whole family is on the diet, the child does not have a sense of inferiority and does not feel that he is being discriminated against.

The dietary program requires careful reading of all labels and knowledge of safe brands. Check Appendix G: Safe Brands, and if the parent has any doubts, check with the companies. Making a game out of reading labels and involving the index child in the preparation of the food might help to maintain interest in food selection.
The clinician or parent who is interested in how to apply the Feingold diet is recommended to call the contact person in your area (see Appendix E: Meetings and Contact People). Most contact people are having meetings and discuss the procedure for following the "Feingold Diet." These meetings are therapeutic too, because parents are stimulated to talk about the advantages and disadvantages of the diet. They are allowed to ask any kind of question; sometimes a parent shares her negative feelings concerning her child and how her feelings have changed into more positive feelings. The contact person knows the food stores in your area, and will give worthwhile suggestions on how to cut down on the shopping time and how to cut the grocery bill. For even more information to help the parent in her shopping, she may wish to pursue The Supermarket Handbook by Nikki and Goldbeck (1973). This book gives considerable information on various brands on just about everything.

In general, identifying an improved behavior response can be observed within one to six weeks. There is more time needed to see academic improvement. Sometimes the change is gradual and it takes a reaction to remind the family of the child of how much improvement there has been. Some examples: the child stays seated at the table throughout the entire meal. The child may walk into a room and sit on a chair rather than crashing through the door and attacking the furniture. Maybe a child will say "I'm sorry," instead of telling that it is everyone else's fault. The child's room does not look like a war zone. When the child yawns, and the parent says, "It's bedtime," the parent will be surprised that the child actually goes
to bed without the usual arguments. Sometimes a child will sleep through the night or sleep late for the first time.

Doctors who are practicing preventive medicine claim that our modernized food, full of artificial additives, does not provide the right nutritional environment for hyperactive children. Yet, it is possible to turn the clock back in the kitchen to create an old-fashioned natural food pantry that is free of artificial food coloring, artificial flavoring, and other additives. It is not going to be easy. It may require relearning some cooking techniques and some products will not be able to make the meal preparation faster and easier. It is a small price to pay when the results may help the hyperactive child in the family to feel and behave calmer, and even overcome those feelings of frustration that accompany hyperactive behavior.

A word of caution, at the present there seems to be no way to predict which hyperactive child will respond to the diet. Even Feingold admits that the diet will not work for every child. There seems to be no correlation between children who benefit from medication and those who respond later to the diet. So, for now there is no way of predicting beforehand whether the hyperactive child will be helped. If the child does not respond to the diet at all, at least the parent gave it a good try. On the other hand, the child may surprise his parents with his new ability to cope better.

Eating in restaurants is another problem since no one can possibly see what goes on in the kitchen. Suggestions: try to order
plain items such as chopped steak, roast turkey or chicken, baked potatoes, cottage cheese, etc.

Surprise, there is a restaurant in Pontiac, called "Natural Foods Restaurant" and is located at 5578 Cooley Lake Road, Waterford Township, Pontiac, Michigan. The owner and operator, Jan Sulick, has a child on the Feingold Program. Some families have dined there and reported that the food was great and the children experienced no reactions. Eating out can be used as an extra reward for the whole family for sticking with the diet.

Parental Guidance

Many parents of a hyperactive child sense an invisible wall between the child and all other people, including themselves. The parents are aware that they have never made true contact with the child in the sense of emotional intimacy. A parent can become angry about this wall. The anger is easily aroused when the child defiantly refuses to cooperate.

The anger can be handled in different ways. Make the parents aware that they create their own anger. Anger is a secondary reaction to an earlier emotion that involves hurt or rejection. To handle the anger is to decrease the hurt or rejection. It is important to make the parents aware of the difference between the child and the hyperactivity. It is not the child that makes a parent angry, but his hyperactive behavior.

A common feeling that parents experience is frustration. In reality the parents are frustrated with themselves because they
don't know what to do. Often parents are at the end of their rope. Guidelines in how to discipline the child often result in decreased frustration. Some methods are reinforcement, shaping, consistency, and getting the desired behavior to occur in new situations. Throughout the management of hyperactive children, there must be consistent expectations of acceptable behavior and standards. Positive recognition for effort rather than constant negative attacks from parents finally achieves better results. In fact, hyperactive children want guidance. Their need for guidelines is clearly demonstrated in the memos children wrote to their parents (Newsletters: "Naturally R's", The Feingold Association of Michigan, 1981):

  Don't be afraid to be firm with me. I prefer it, it makes me feel more secure.
  Don't let me form bad habits. I have to rely on you to detect them in the early stages.
  Don't make me feel smaller than I am. It only makes me behave stupidly big.
  Don't correct me in front of people if you can help it. I'll take much more notice if you talk quietly with me in private.
  Don't make me feel mistakes are sins. It upsets my sense of values.
  Don't be too upset when I say "I hate you." It is not you I hate, but your power to thwart me.
  Don't nag. If you do, I shall have to protect myself by appearing deaf.
Don't be inconsistent. That completely confuses me and makes me lose faith in you.

Don't tell me my fears are silly. They are terribly real and you can do much to reassure me if you try to understand.

Don't put me off when I ask questions. If you do, you will find that I stop asking and seek my information elsewhere.

Don't ever suggest that you are perfect or infallible. It gives me too great a shock when I discover that you are neither.

Don't ever think it is beneath your dignity to apologize to me. An honest apology makes me feel surprisingly warm toward you.

Don't forget how quickly I am growing up. It must be very difficult to keep pace with me, but please do try.

Don't forget that I can't thrive without lots of understanding love, but I don't need to tell you, do I?

Don't spoil me. I know quite well that I ought not have all that I ask for. I'm only testing you.

These memos uncover the underlying dynamics; they are eye-openers for the parents as well as for the clinician. The child sets already the stage for parental guidance and discipline.

Discipline, by all means, is not an easy task. It is a slow process of evaluating behaviors, which behavior is acceptable and which behavior is unacceptable, what has to be encouraged and which behavior has to be discouraged. Furthermore, the parents of a hyperactive child need to know that their child needs to be led by his hand over the bumpy road, so that in the end the child walks alone, with self-confidence.
Family Therapy

Each family has its own potentials and limitations. Sudden crises may unite or disrupt family members. So may ongoing, seemingly endless stress. Alcoholism, poverty, gross parental marital conflict, personality problems of one member, are some examples of chronic stresses. A hyperactive child may provide such an ongoing stress.

Although the parents love their child, the opposite is inevitable, because their endurance is, humanly spoken, limited. The child stimulates recurrent negative reactions in parents, who may begin to feel guilty for their frustration and rejections. There is no uninvolved family member in the family of a hyperactive child.

The emotional reactions of the other children are varied, depending on the personality of the hyperactive child in relation to the personalities of his sibs. There can be positive emotional reactions to the hyperactive child like, a sib may enjoy his sense of humor, another sib may enjoy to try new approaches to tasks. These reactions are helpful to the hyperactive child's self-image.

Hyperactive children have a hard time establishing relationships. The hyperactive child may be accused by his siblings of pestering them. They feel as if their time is manipulated by the hyperactive child, and they don't know a way to improve this situation. What a parent can do is to help the siblings to understand the hyperactive child's feelings.
In a family therapy session the clinician can ask the family to re-enact a recurring scene, discuss the scene, then ask all family members how they would have liked it to happen and then the family acts out the ideal way of dealing with the problem (Robertson, 1980).

In family therapy it is important to recognize each family member as an individual and ask each person to communicate personal concerns, needs and feelings.

In the initial session, ask each family member to state his/her goals for family therapy. The clinician verbalizes each goal, so the family may hear the goal again, and reflects the individual's feelings in an empathical way. Goals emerge from the problems, and the individual is likely to describe some feelings that belong to the problem (Robertson, 1980). Verbalizing these feelings will help family members to become more aware of the struggle the individual is going through in order to survive in this family.

One of the major areas of parenting is that parents need to be consistent. For instance, matching of inner feelings and intentions body language, word choice, tone of voice congruent with actions: In short, the parents act the way they feel. If the parents are inconsistent, doubling would help the parents to clarify their feelings and unexpressed reactions. Another method is for the parents to back up each other when providing discipline and guidance. The successful method of restoring harmony in the family is balanced discipline and genuine love to all children in the family.
As the child's behavior changes and improves, the parents' approach has to change also. It is important to let siblings, teachers, and parents know that the child is making progress. To break up old habits is very hard to do. The expectation that the hyperactive child is the source of irritation is in most cases a difficult habit to break. As therapy continues, the roles of the siblings are becoming more clear. Sculpting would be an excellent exercise to identify the roles of the siblings.

Introducing more love into the family will be easier if both parents share this goal. The marriage is the core of all other relationships in the family. It sets the way in which children will relate to each other. The way conflicts are settled with each other, handle situations together, and communicate love and affection toward each other, is a natural way children learn their lesson. Family strengths, changing stroke patterns, and regular playtime, are good exercises to enhance positive feelings among family members.

In treatment, the state of the marriage should be focussed on in-depth. One of the best gifts a child can receive is happily married parents. However, a hyperactive child can be a danger to every marriage. Each parent undergoes various emotional strains in dealing with the child. In therapy, each parent will discover that they react differently to the same stress from the child (role reversal). Warning: parents try to pin blame on each other. The clinician should deal with the specifics of the situation in a way that creates mutual respect and acceptance. Stress the fact that
there is nothing wrong in being different; the important question in each situation is "What is the best method to discipline the child now," rather than "Who is a better parent." (Communication skills, expectations, entitlements, main strengths, weaknesses as a parent are, Parent Skill Training). The co-therapists may reflect for the family what they see as the family strengths and how they may use these to cope with problems (Robertson, 1980).

Successful management of the hyperactive child requires involvement of the entire family. Important are the basics of behavior modification and principles of structuring the child's environment so that there are regular daily routines and firm limits on his behavior. The importance of avoiding situations known to cause difficulty, overstimulation, and excessive fatigue are emphasized. The presence of psychopathology in the parents may require individual therapy, and a more dynamically oriented family therapy approach, particularly if the hyperactive child has been the family scapegoat.

On-camera observation is a method used to modify parent's behavior and thereby teach them appropriate methods of child discipline. Debriefing of what has been learned and gained has to be done before the end of the session to clarify the importance of what has happened for the family. Also, remind the family of the contracts formed, home work, and the importance of no retaliation.

The family therapy approaches presented are providing basic suggestions on how to rebuild family harmony and are the first steps on the ladder of family therapy.
Summary

The recommended treatment approaches should logically follow from the information obtained in the evaluation process. After a good evaluation of a child's problem, casual factors, such as perceptual problems, eye-hand coordination problems, and balance problems should be worked on. Treatment should be training as a strengthening of basic developmental level skills that are weak. The goal of any treatment is to build the child's self-esteem, and the child's functioning in the world. A good treatment program will help the child to overcome poor self-image, depression, serious academic problems, and a sense of failure in later life. In short, treatment will help the child to grow into a healthy, happy and well adjusted adult.
CHAPTER V

CONCLUSION

Hyperactivity describes a number of disturbing behavioral characteristics, such as excessive body movements, poor attention span, impulsiveness, poor visual-motor coordination, poor memory, and proneness to failure.

Follow-up studies suggest that hyperactivity diminishes with age, usually by adolescence; however, the prognosis for hyperactivity may not necessarily be so positive (or totally hopeful?). Follow-up studies of children with behavior disorders, which include hyperactive children, suggest that they may have serious social problems as adults. There is reason to believe that antisocial symptoms, and certain family factors such as disturbed family background (particularly alcoholism or antisocial behavior in the father and an absence of consistency in discipline), are clues to poor prognosis. Such symptoms do not have to accompany all hyperactive behavior, and not all families become dysfunctional because of a child's hyperactive condition.

Follow-up studies of hyperactive children also indicate that they are prone to develop poor self-image, depression, serious academic problems, and a feeling of worthlessness in later life.

Most hyperactive children are treated with medication such as dextroamphetamine (Dexetrine) and methylphenidate (Ritalin). Some
hyperactive children show dramatic response to daily doses of amphetamines and of methylphenidate; they concentrate better and do more of their work. However, some children may experience negative side effects from these medications. Most of these potential side effects can be controlled by adjustment in dosage or by a switch to a different type of medication.

Often when a child is on medication, it is thought of as "the magic pill." The truth is far from it. Medication cannot reverse specific learning difficulties in writing, reading and speech disorders. Careful observation, additional assistance and treatment are needed to overcome his failure record and his low self-esteem.

A thorough evaluation of the child is recommended before a diagnosis is made. Evaluation procedures call for gathering of detailed information. One of the first concerns in evaluating the child should be a developmental and physical history that includes a prenatal, perinatal, and postnatal history and information on basic skills (walking, talking, creeping). This information gives insight into the child's performance during the sensorimotor evaluation. A family medical history might give some insight to the sensorimotor development of the child as well as on any evidence of diabetes, hypoglycemia and other illnesses.

Information from other professionals, such as the child's teacher, the chiropractor, and a school social worker, who has worked with the child, can help complete the picture of the child's problem.
A detailed family history has to be taken in order to make the
distinction between true hyperactivity and hyperactive behaviors
that are caused by environmental stress such as alcoholism, family
fights, wife abuse, child abuse, depression, hysteria, poor nutrition,
and an absence of consistency of discipline. It is not clear
in which way psychiatric disorders in the parents influence the
behavior problems in their children, although, there are many ways
of dimensions in which anti-social fathers might instill similar
behaviors in their sons.

Recommended treatment should follow from the information ob-
tained in the evaluation process. After a careful evaluation the
clinician knows the strengths as well as the weaknesses of the child
and the family. The goal of treatment is to restore harmony among
family members and build up the feelings of self-worth within each
member of the family.

Why a Multi-Approach to Treatment?

The hyperactive child suffers a great deal; helping the child
with medication does not make sense; how can medication compensate
for the lost years of learning, and practical tasks like skill at
play, games and table manners? How can medication wipe out the nega-
tive labels, the negative expectation of others?

The Feingold Diet has been very effective; however, the diet
alone is not enough. The Feingold Diet cannot provide love, cannot
correct the child's eye hand coordination problems, and build the
child's self-esteem. The Feingold Diet, for instance where a

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scapegoat is essential to the family disequilibrium, cannot repair such destructive interactions. Intensive family therapy will be needed and in addition individual therapy is needed to help the child regain control of his body; a lot of supportive therapy is needed to build this child's self-image.

Limitations of the Study

Most of the literature consists of drug studies. Little is known about how to predict which child will respond to which drug. Not much is known about long-term effects, good or bad. Methodology of follow-up studies can be criticized because of the relatively small samples involved.

Studies of other treatment modalities are few in number and samples are also small.

Recommendations

Involvement of the family is critical to the success of treatment programs. It would be helpful to mention family factors in the studies of treatment. Some questions for future research are: What percentage of hyperactive children recover completely, at what age, how come some children do recover, some don't? Is it true that hyperactive children indeed develop into maladjusted adults? Which treatment modalities are successful in the later development of the child?

In conclusion, the writer hopes that the healing arts of the future will be to assist all of us to acquire the necessary knowledge.
and means through which we may overcome our illnesses, and in addition to this, to give us such remedies that will strengthen our mental states, and our physical bodies. Then indeed are we able to attack disease at its very base with real hope of success.

Finally, my fellow travelers let us not fear to plunge into life; we are on this earth to gain experience and knowledge, and we shall learn but little unless we seek to our utmost.
APPENDIX A

Parents Questionnaire

Name ___________________________ Date _____________________

Age ___________________________ Birthdate _____________________

School Grade _____________________

Mother's Name _______________________________ Age __________

Father's Name _______________________________ Age __________

__________________________________________________________

Please underline the words below that apply to your child. Fill in information where needed.

Family Status

Adopted child at age ___________ Name Age Birthdate

One step-parent

Raised in foster home

Pregnancy and Birth

Pregnancy: Planned, unplanned

Illnesses during pregnancy

____________________________________________________________________

Length: Full term, premature

Delivery: Operative, instruments used, easy, difficult, normal.

Size: Weight _____ lbs. _____ oz.

Length ______________ inches.

Remarks: __________________________________________

111
### Early Infancy - Birth to One Year

<table>
<thead>
<tr>
<th>Feeding Type</th>
<th>Crying</th>
<th>Feeding Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfed to age</td>
<td>Weaning: Normal, difficult, restless</td>
<td>Colic, vomiting, constipation, diarrhea</td>
</tr>
<tr>
<td>Bottlefed to age</td>
<td>Crying: good-natured, cranky, fearful, difficult to manage</td>
<td>Feeding problems: Rocking difficult to manage</td>
</tr>
</tbody>
</table>

**Remarks:**

---

### Infancy - Ages One to Three Years

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>Wanders away from home</td>
</tr>
<tr>
<td>Talking</td>
<td>Dependent</td>
</tr>
<tr>
<td>Toilet</td>
<td>Independent</td>
</tr>
<tr>
<td>Bowel</td>
<td>Shy</td>
</tr>
<tr>
<td>Bowel</td>
<td>Lonely</td>
</tr>
<tr>
<td>Bladder</td>
<td>Easily frightened</td>
</tr>
<tr>
<td>Bladder</td>
<td>Fears: Please list:</td>
</tr>
<tr>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
</tbody>
</table>

**Remarks:**

---

### Childhood - Ages Three to Seven Years

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel</td>
<td>Runs away from home</td>
</tr>
<tr>
<td>Day</td>
<td>Keeps feelings to self</td>
</tr>
</tbody>
</table>
Night wetting to age ______ Fears: Please list:________
Thumbsucking to age ________
Eating difficulties
Temper tantrums Age: __________
Restless sleeper Started school age _________
Sleep walking Reluctant to go to school
Nightmares age ______ Frequency ______________
Sad, moody, awkward, clumsy. Problems with teachers
Remarks: Problems with parents

Childhood - Ages Seven and Older
Runs away from school
Skipping School
Difficulties with teachers
Difficulties with parents
Difficulties with brothers, sisters
Fears: Please list: ________________________________

Menstruation started age ______
Learning difficulties: Reading, speech, other ___________________

Special interests/hobbies: ________________________________
### Remarks:

**Health History**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox</td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
</tr>
<tr>
<td>Exzema</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>Whooing cough</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsions</td>
<td></td>
</tr>
<tr>
<td>Ear infections</td>
<td></td>
</tr>
<tr>
<td>Frequent colds</td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
</tr>
<tr>
<td>Hayfever, hives</td>
<td></td>
</tr>
<tr>
<td>Rupture, hernia</td>
<td></td>
</tr>
</tbody>
</table>

**Accidents**

<table>
<thead>
<tr>
<th>Type</th>
<th>Age</th>
</tr>
</thead>
</table>

**Operations**

<table>
<thead>
<tr>
<th>Type</th>
<th>Age</th>
</tr>
</thead>
</table>

1. What is your child's problem?

2. How long have you noticed this problem?

3. What have you tried to do about it?
4. Are there other things we should know about your child and your family?

5. What do you expect from us?

May we have your permission to contact the school and secure all information, when appropriate, such as, reports from school social worker, psychologist, etc.

Yes _______ No _______

Note: Parents Questionnaire is used by the Child Guidance Clinic/revised by the writer
APPENDIX B

Release of Confidential Information

Date ________________

I, the undersigned, grant permission for: ____________________________

to release information to: ____________________________

regarding:

Name of Patient ____________________________ Birthdate ____________________________

Address of Patient ____________________________

Name(s) of Parent(s) or Legal Guardian(s) ____________________________

Address if other than above ____________________________

Description of information to be released: ____________________________

______________________________

To be used only for the following purpose and time period: ________

______________________________

To be released according to subsection ____________ of Section 748, Public Act 258, (or other ____________).

Signed: ____________________________

Relationship to Patient: ________

Witness: ____________________________

Released to: ____________________________ Released by: ____________________________

Note: This format used by the Child Guidance Center.
APPENDIX C

School Report

Name: ___________________ School: ___________________

Birthdate: ______________ Grade: ______________

Address: ________________________________

Referral Source: ________________________________________

In studying this child, it is helpful to have as complete a picture of his school adjustment and performance as is possible. The parents have granted permission to contact you for this purpose. All information will be considered confidential.

1. Has this child presented any behavior problems either in the classroom or at recess time: if so, please describe situations and frequency: _____________________________________________

2. Check items which describe this child:

   Always on the go _ _ _ _ _ Does not volunteer

   Cries easily _ _ _ _ _ Fights with peers

   Cruel _ _ _ _ _ Frequently asks for help

   Does not care _ _ _ _ _ Gives up easily

   Does not listen _ _ _ _ _ Needs lots of encouragement

   Impulsive _ _ _ _ _ Does not get work done on time

   Temper tantrums _ _ _ _ _ Self-conscious

   Unreliable _ _ _ _ _ Imaginative

3. How does this child relate to peers of the same sex: Opposite sex: ________________________________
4. How does this child relate to the teacher: __________________________

5. What is your best estimate of this child's intellectual capacity? Circle one: Dull, Below Average, Average, Bright Average, Superior

6. List any test results you are aware of:

   Intelligence Tests:
   Name of Test ____________________________________________
   Date Given ______________________________________________
   Results ____________________________________________
   Examiner ____________________________________________

   Achievement Tests:
   Name of Test ____________________________________________
   Date Given ______________________________________________
   Results ____________________________________________
   Examiner ____________________________________________

   Do you feel this child is working up to capacity: _____________

8. Does this child have any specific difficulties in learning? _____ or in specific subjects? _____ If so, please explain:
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________
9. **School Achievement.** Please list grades for past several marking periods.

<table>
<thead>
<tr>
<th>School Year</th>
<th>Reading</th>
<th>Spelling</th>
<th>Writing</th>
<th>Arithmetic</th>
<th>Art</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

10. What additional help, if any, do you think this child needs?

____________________________________________________________________

11. Are you aware of anything within the child's family that would be helpful in understanding this child? _______________________________________________________________________

12. Did parents regularly attend individual parent-teacher conferences? _______________________________________________________________________

13. Please make an additional comment about this child, your handling of him, etc. _______________________________________________________________________

This part of report was filled out by:

__________________________________________

Title ____________________________

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SCHOOL SOCIAL WORKER'S REPORT

14. Have you seen this child in a direct one-to-one casework relationship?  No   Yes
   If no, but there has been work on behalf of this child, please describe: __________________________

15. If yes: When was the child seen, for how long a period, and how frequently: __________________________

16. How does he relate to a helping person? __________________________

17. Is he aware of the nature of his difficulty, is he able to accept his need for help? __________________________

18. What are his strengths and weaknesses? __________________________

19. What do you feel are the explanations of his behavior? __________________________

20. Was the child seen by a school psychologist?  Yes   No
   If yes, please attach a copy of the report.

   Please add any other comments you feel are important: __________________________

   Signed: __________________________

Note: School Report is used by the Child Guidance Clinic/revised by writer
APPENDIX D

Assessment and Treatment Plan

Date of Conference ________________ Date: ________________

Child's Name __________________________ Birthdate ________________

Psychologist's Name __________________________

<table>
<thead>
<tr>
<th>Major Identifiable Problems</th>
<th>Short Term Goals</th>
<th>Long Term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dynamics Causing the Problem: What goes on in the family that might activate the child's problem. Be careful in writing this part, because parents feel easily hurt, and are sensitive to their shortcomings.

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Identifiable Strengths

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Identifiable Weaknesses (keep this short because parents know a lot about this part)

_________________________________________________________________________

_________________________________________________________________________
APPENDIX E

Meetings and Contact People
As of May - June, 1982

<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
<th>Phone</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPENA</td>
<td>Janice Lowe</td>
<td>517-356-2518</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>ANN ARBOR</td>
<td>Jane Marston</td>
<td>313-665-1317</td>
<td>First Monday of Month at Abbott School, 2760 Sequoia Parkway, at 7:30 p.m.</td>
</tr>
<tr>
<td>BAY CITY</td>
<td>Christ Meyer</td>
<td>517-TW3-2887</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>BIRMINGHAM</td>
<td>Kim Ellis</td>
<td>313-280-1494</td>
<td>First Monday, every other month at Embury Methodist Church, 7:30 p.m.</td>
</tr>
<tr>
<td></td>
<td>Meg Grande</td>
<td>313-341-2380</td>
<td></td>
</tr>
<tr>
<td>BRIGHTON</td>
<td>JoAnn Higgins</td>
<td>313-229-2725</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>DEARBORN</td>
<td>Carolyn Graves</td>
<td>313-336-2194</td>
<td>4th Thurs. of Month at Stout Jr. High, Oakwood &amp; Rotunda Dr., 7:30 p.m.</td>
</tr>
<tr>
<td>DETROIT</td>
<td>May King</td>
<td>313-272-0418</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>EATON RAPIDS</td>
<td>Connie Phillips</td>
<td>517-663-4030</td>
<td>Calls welcome, evenings.</td>
</tr>
<tr>
<td>FIFE LAKE</td>
<td>Ethel Aldredge</td>
<td>616-258-5013</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>FLINT</td>
<td>Marie Pierce</td>
<td>313-233-6161</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>FRANKENMUTH</td>
<td>Sharon Burtrum</td>
<td>517-652-2856</td>
<td>First Monday of Month at Sharon's home, 12:00 noon</td>
</tr>
<tr>
<td>GAYLORD</td>
<td>Margaret Rehkipf</td>
<td>517-783-1428</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>Location</td>
<td>Name</td>
<td>Phone</td>
<td>Information</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------</td>
<td>----------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>JACKSON</td>
<td>Rita Landry</td>
<td>517-853-7733</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>KALAMAZOO</td>
<td>Betty Hartmann</td>
<td>616-382-0788</td>
<td>Scheduled as needed.</td>
</tr>
<tr>
<td>LANSING</td>
<td>Mary Burris</td>
<td>517-321-4463</td>
<td>Second Thursday of Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>in Mary's home, 7:30 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Please call if interested.</td>
</tr>
<tr>
<td>LIVONIA</td>
<td>Marilyn Kramer</td>
<td>313-525-9197</td>
<td>Second Wednesday of Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>at Garfield Elementary School, 7:30 p.m.</td>
</tr>
<tr>
<td>MARCELOMA-KALKASKA</td>
<td>Donna Hillman</td>
<td>616-587-8856</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>METAMORA</td>
<td>Debra Alleman</td>
<td>313-678-2371</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>MONROE</td>
<td>Debra Bert</td>
<td>313-243-9562</td>
<td>Second Thursday of Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>at First National Bank,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comm. Rm., N. Monroe St.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7:30 p.m.</td>
</tr>
<tr>
<td>OKEMOS</td>
<td>Donna Weinberg</td>
<td>517-351-9051</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>ORTONVILLE</td>
<td>Joyce Fry</td>
<td>313-627-4206</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>PERRINGTON</td>
<td>Bunny Semans</td>
<td>517-875-4711</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>PORT HURON</td>
<td>Jan Coughenour</td>
<td>313-985-8534</td>
<td>Third Tuesday of Month at</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YMCA in Port Huron, 7:30 p.m.</td>
</tr>
<tr>
<td>ROCHESTER</td>
<td>Margaret McMinn</td>
<td>313-651-2498</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>SAGINAW</td>
<td>Ruth Wright</td>
<td>517-792-0372</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>TRAVERSE CITY</td>
<td>Judy Herba</td>
<td>616-947-9498</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>Location</td>
<td>Name</td>
<td>Phone</td>
<td>Notes</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>UTICA</td>
<td>Lina Hoffman</td>
<td>313-254-2840</td>
<td>First Friday every other Month at Macomb Inter. School, Dist. Bldg., 7:30 p.m.</td>
</tr>
<tr>
<td>PONTIAC</td>
<td>Karen Dorries</td>
<td>313-338-2147</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>UNION LAKE</td>
<td>Danna Hotra</td>
<td>313-698-2182</td>
<td>Calls are welcome.</td>
</tr>
<tr>
<td>WIXOM</td>
<td>Kay Krzysik</td>
<td>313-685-8887</td>
<td>Calls are welcome.</td>
</tr>
</tbody>
</table>
APPENDIX F

The Diet

The following is a list of foods and other substances usually loaded with artificial colorings and flavorings

Foods Not Permitted

<table>
<thead>
<tr>
<th>Not Permitted</th>
<th>Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chocolate milk</td>
<td>chipped beef, corned beef, sausage, etc.</td>
</tr>
<tr>
<td>Margarine</td>
<td>Frozen fish fillets or sticks that are dyed or flavored</td>
</tr>
<tr>
<td>Most butters</td>
<td>Hams, bacon</td>
</tr>
<tr>
<td>Many cheeses</td>
<td>Luncheon meats, hot dogs</td>
</tr>
<tr>
<td>Prepared gravies</td>
<td>Some commercial soups and broths</td>
</tr>
<tr>
<td>Mustard, mayonnaise</td>
<td>Many prepared pickles are artificially colored</td>
</tr>
<tr>
<td>Soy sauce, if colored, flavored</td>
<td>Kool-Aid and other similar products</td>
</tr>
<tr>
<td>Artificial vanilla (vanillan) Flavouring</td>
<td>Soda pop</td>
</tr>
<tr>
<td>Bum</td>
<td>Diet drinks and supplements</td>
</tr>
<tr>
<td>Most commercial candies</td>
<td>Frozen limeade often contains artificial coloring</td>
</tr>
<tr>
<td>Some bakery goods</td>
<td>Toothpaste--salt and baking soda may be used as a substitute</td>
</tr>
<tr>
<td>Cake mixes, pudding mixes, gelatin mixes, prepared piecrusts, etc.</td>
<td>Cough drops, Lifesavers</td>
</tr>
<tr>
<td>Most commercial ice cream, sherbet, ices, gelatins, puddings, etc.</td>
<td>Mouthwash, throat lozenges</td>
</tr>
<tr>
<td>Flavored yogurt</td>
<td>Vitamin pills, medications--ask your doctor</td>
</tr>
<tr>
<td>All barbecued poultry, all stuffed poultry, all self-basting turkeys</td>
<td></td>
</tr>
</tbody>
</table>

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Foods Permitted

Uncolored butter, colored cheeses (cheese may have other additives)
Homemade ice cream or completely natural ice cream
Plain yogurt
White milk
Honey
Unflavored gelatin
Homemade mustard, mayonnaise
7-Up
Sprite
Team

Foods Not Permitted

—Fruits and vegetables containing natural salicylates not permitted:

Apples
Almonds
Apricots
Blackberries
Boysenberries
Cherries
Clove, allspice
Currants
Gooseberries
Grapes
Mint flavors
Nectarines
Oranges
Raspberries
All tea

Foods Permitted

Avacadoes
Bananas
Blueberries
Dates
Guava, guava nectar
Rhubarb
Non-cucumber pickles okay, but many commercial brands contain artificial coloring, cannot be used

Cereals without artificial coloring and flavorings and without raisins (prohibited in Group Two)
Distilled white vinegar
Homemade candy with no artificial colorings or flavorings
Pure vanilla, lemon, lime extracts
Baking soda and salt for toothpaste
Adult white Tylenol tablets or similar-type compounds (no aspirin) for pain or fever—check with doctor for use and dosage

Adult white Tylenol tablets or similar-type compounds (no aspirin) for pain or fever—check with doctor for use and dosage

Cider and cider vinegar, wine and wine vinegar
Jellies, jams made from any fruits on this list and/or artificially colored or flavored
Cucumbers and cucumber pickle relish
Tomatoes and all tomato products—catsup, chili sauce, steak sauces tomato paste, etc.
Oil of Wintergreen
Peaches
Plums, prunes
Raisins
Strawberries
Gin and all distilled drinks, beer

Nuts other than almonds
Pears
Lemons, Homemade lemonade, pure lemon juice
Cranberries, cranberry juice
All vegetables except tomatoes and cucumbers as noted above
Limes, homemade limeade, pure lime juice
Pineapple, pineapple juice

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Foods Not Permitted

--Omit other additives, in particular BHA and BHT. Avoid bleached white flour which contains bleaching and maturing agents.

--BHA (butylated hydroxyanisole) and BHT (butylated hydroxytoluene) are preservatives and must be listed on labels. BHA and BHT are commonly found in shortenings, oils, potato chips, bakery products, dry yeast, etc.

Foods Permitted

--Unbleached, naturally matured flour.

--Homemade breads, made from this "safe" flour; also homemade cookies, crackers, buns, etc.

--Pure vegetable oils with no preservatives may be purchased in some grocery stores or in health food stores.

--Yeast cakes found in refrigeration case of grocery store or packages of dry yeast with no BHA or BHT.
APPENDIX G

Safe Brands

Although companies may change their ingredients, those whose products are listed have assured that they are "safe."

<table>
<thead>
<tr>
<th>Dairy Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncolored butter</td>
</tr>
<tr>
<td>Uncolored, unbleached Cheese</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ice Cream</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breyer's Ice Cream</td>
</tr>
<tr>
<td>Lady Bordon Ice Cream</td>
</tr>
<tr>
<td>Meadow Gold Old Fashioned Recipe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flours and Breads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unbleached, Naturally Matured Flours</td>
</tr>
<tr>
<td>Pillsbury Unbleached White</td>
</tr>
<tr>
<td>Elam's, El Molino</td>
</tr>
<tr>
<td>Frozen Bread Dough</td>
</tr>
<tr>
<td>Catherine Clark's Brownberry Ovens Home Baking Dough</td>
</tr>
<tr>
<td>Bread Mixes</td>
</tr>
<tr>
<td>Catherine Clark's Brownberry Oven Mixes</td>
</tr>
<tr>
<td>Flako Corn Muffin Mix</td>
</tr>
<tr>
<td>Aunt Jemima Easy Corn Bread Mix, Self-Rising Corn Meal Mix</td>
</tr>
<tr>
<td>Baked Loaves</td>
</tr>
<tr>
<td>Pepperidge Farm (contains calcium propionate to retard spoilage) English Muffins, Wheat Bread, Whole Wheat Rolls</td>
</tr>
</tbody>
</table>

129
| Carob Powder | El Molino Cara Coa Carob Powder |
| Chocolate    | Hershey's Baking Chocolate, Unsweetened |
|             | Baker's Unsweetened Chocolate |
|             | Baker's German Sweet Chocolate |

**Snacks**

| Crackers and Cookies | Nabisco Premium Saltines |
|                      | Nabisco Graham Crackers (in the red box) |
|                      | Nabisco Cinnamon Treats |
|                      | Nabisco Triscuits (have BHA, BHT) |
|                      | Fritos (have BHA, BHT) |
|                      | Venus Wheat Wafers |
|                      | Ralston Pruina Original Rye Crisp |
|                      | Flavor Tree Onion, Cheddar, and Sesame Crackers |
|                      | Pepperidge Farm Cookies |
|                      | Pepperidge Farm Goldfish (Pretzels or Lightly Salted) |
|                      | Nature Valley Honey 'n Oats Granola Bars |

**Candy**

| Candy          | Cracker Jack |
|               | Reese Peanut Butter Cup (chocolate) |
|               | Golden Harvest Pure Carob Swirls |
|               | Joan's Natural Candies |
|               | Cara Coa Candy Bar |

**Potato Chips, Pretzels**

| Potato Chips, Pretzels | Charles Chips |
|                        | Country Oven Potato Chips |
|                        | Crane Corn Chips |
|                        | Wege Hard Pretzels |

**Beverages**

| Soda Pop          | 7-Up, Sprite, Teem (contain no artificial colors or flavors, do contain other additives) |
|                  | Carob, Cocoa |
|                  | Cara Coa Carob Drink |
|                  | Swiss-Miss Instant Cocoa Mix |

**Cereals**

| Cereals          | Cold |
|                 | Post Grape Nuts |
|                 | Quaker Puffed Rice or Wheat |
|                 | Quaker 100% Natural Cereal |
|                 | Pet Incorporated Heartland Natural Cereal (plain) |
|                 | Golden Harvest Puffed Wheat |
|                 | Golden Harvest Corn Flakes |
|                 | Van Brode Special Corn Flakes |
|                 | Nature Valley Granola |
### Cereals Continued

**Hot**
- Quaker Old Fashioned Oats, Quick Quaker Oats, Cream of Wheat (5 minutes)
- Wheatena

### Miscellaneous Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yeast</td>
<td>Red Star Dry Yeast, Fleischmann's Compressed Yeast Cakes</td>
</tr>
<tr>
<td>Coconut</td>
<td>Bakers Southern Style Coconut, Bakers Angel Flake</td>
</tr>
<tr>
<td>Mayonnaise</td>
<td>Kraft Real Mayonnaise, Miracle Whip Salad Dressing</td>
</tr>
<tr>
<td></td>
<td>Hunza, Hain, Hollywood</td>
</tr>
<tr>
<td>Lemon Juice</td>
<td>Minute Maid 100% Pure Lemon Juice (in freezer case)</td>
</tr>
<tr>
<td>Extracts</td>
<td>McCormick's Pure Vanilla Extract, Pure Lemon Extract</td>
</tr>
<tr>
<td>Luncheon Meets</td>
<td>Health Maid Franks and Bologna (frozen)</td>
</tr>
<tr>
<td>Cranberry Jelly</td>
<td>Ocean Spray</td>
</tr>
</tbody>
</table>
The following list of medications do not contain artificial dyes or flavoring. This may prove to be helpful to you in case of illness. We are not personally recommending any of these medications. The purpose of this list is to make substitution (when it is possible) easier for you and your physician. Note: All capsules should be broken open and only the powder inside used.

DECONGESTANTS AND/OR ANTIHISTAMINES AND COUGH SYRUPS

Actidil 2.5 mg. tablet (no liquid)
Actifed Tablets only
Benadryl - powder in capsules only
Brexin Capsules - powder in capsules only
Codeine 1/4 grain - dilute in distilled water
Co-Pyronil - powder only
Fedahist - white tablet (not capsule or liquid)
Hycodan Tablets only
Isochlor - time capsule - powder only
Optimine Tablets
Periactin 4 mg. tablets
Phenergan 25 mg. white tablets
Pyribenzamine w/ ephedrine - tablets only
Rhinosyn DM - cough suppressant/antihistamine
Rhinosyn PD
Rhinosyn Syrup
Rhinosyn X - expectorant/cough suppressant
Ryna-C - codeine
Saline Solution, Normal - nosedrops - pharmacist can mix
Sudafed - 60 mg. only
Terpin Hydrate Elizir - contains orange rind (salicylate)
Vistaril - powder in capsules only

FOR ASTHMA

Elixophyllin Capsules 100 mg. (dye-free capsules)
Brethine 2.5 mg. and 5 mg. tablets
Bricanyl Tablets - white
Elixicon Suspension (has methylparaben as a preservative)
ASTHMA CONTINUED

Elixophyllin S.R. 125 and 250 mg. capsules (capsules are dye-free)
Isuprel 10 and 15 mg. tablets
Marax D.F. Syrup - no dyes
Quadrinal Tablets
Slo-Phyllin 100 mg. and 200 mg. tablets and 60 mg. capsules (powder only)
Slo-Phyllin GG - full capsule
Slo-Phyllin GG Syrup - dye-free with lemon and vanilla flavoring
Tedral and Tedral Expectorant Tablets (no liquids)
Theo-Dur Tablets 100, 200 and 300 mg.
Theophyl 225 mg. tablets
Theophylline (generic) - okay if white pressed tablet
Venataire Tablets

FEVER OR PAIN

Acetominophen
   Tylenol Tablets Only
   Valadol Tablets
   Datril Tablets
   Oraphen Liquid
   Any other white tablet form of acetaminophen
Anuphen Suppositories - acetaminophen
Demerol - white tablet
Meticorten - for severe pain

ANTIBIOTICS

Penicillin G
   Pentids (Squibb) 20k and 400 mg. no liquids
   Penicillin G Potassium (Comer) 400,000 U tablets
   Pfizerpen G (Pfizer) tablets only
   Penicillin G Tablets (Parke-Davis)
Penicillin V
   Penpar V.K. (Parke-Davis) 250 and 500 mg. tablets - no liquid
   Penicillin V.K. Tablets (Comer) - no liquids
   Pen-Vee K (Wyeth) 250 and 500 mg. tablets - no liquids
   (contains magnesium stearate)
   Pfizerpen V.K. (Pfizer) 250 and 500 mg. tablets - no liquids
   Robicillin-VK (Robins) 250 and 500 mg. - no liquids (contains sodium citrate)
   Uticilin V.K. (Upjohn) 250 and 500 mg. tablets - no liquids
   Veetids (Squibb) 500 mg. tablets only
   V-Cillin K (Lilly) 250 mg., 25 mg. and 500 mg. tablets
Ampicillin
   All capsules are OK if only powder is used. No liquids or tablets
Erythromycin
   Ilosene Capsules (Dista) - powder only
ANTIBIOTICS CONTINUED

Erythromycin (Continued)
   Ilotycin Sterile Ophthalmic Ointment #52 (Distal)
   All other tablets and liquids are colored and/or flavored
Other Semi-synthetic Penicillin
   Bactocill
   Dynapen
   Prostaphlin
   Tegopen
   Versicillin
   Versapen
Sulfa
   Factrim D.S. (not regular tablets or liquid; not Septra)
   Gantrisin Tablets 500 mg. - not liquid
   Renoquid Tablets (for those over age 14 only)
Tetracycline
   Not for children under 10 years of age in any form. All capsule forms of tetracycline and various derivatives are okay if powder only is used; not tablets or liquid.
Dephalosporins (Powder from capsules only)
   Anspore
   Keflex
   Velosef
Clindamycin
   Cleocin - powder in capsules only - no liquids
Troleandomycin
   Tao Capsules

ANTICONVULSANTS

Celontin - powder in capsule only
Clonopin 2 mg. tablets only
Cilantin Kapseals - powder only - no liquids
Mebaral - all tablets
Mysoline 50 mg. and 250 mg. tablets (white) no liquids
Pegannone 250 mg. and 500 mg. white tablets
Phenobarbital - white tablets - no liquid
Phenurone
Phenytoin
Tengretol 200 mg. tablets
Tridione
Valium 2 mg. tablet only
Zarontin - powder in capsules only

ANTIFUNGAL - ORAL

Fulvicin - all tablets
Grifulvin - all tablets
Gris-Peg Tablets only
Grisactin - powder in capsules only
Griseofulvin
ANTIFUNGAL - TOPICAL

Mycostatin
Zinc Oxide
Domeboro Soaks
Ilotycin Ointment #90

MOTION SICKNESS

Marezine Tablets

VOMITING

Matropinal Tablets
Matropinal Inserts
Matropinal Forte Inserts
Phenergan Suppositories

ANTI-DIARRHEA AND ABDOMINAL CRAMPS

Donnatal Tablets and powder in capsules - no liquids
Daolin 90 gr/30 cc - must be made up by pharmacist
Lomotil Tablets - not for small children

STEROIDS

Aristocort 4 mg. and 16 mg. tablets only
Decadron 4 mg. tablets only

MISCELLANEOUS

Anterpar Tablets (pinworms)
Thyroid
   Armour Thyroid - all tablets
   Cytomel - all tablets
   Letter 0.5 mg. tablets only
BIBLIOGRAPHY


Robertson, M. Family Therapy: class notes during Spring semester at Western Michigan University, 1980.


Weiss, G., Hechtman, L., Perlman, T., Hopkins, J. & Wener, A. Hyperactives as Young Adults, a Controlled Perspective Ten-Year Follow-Up of 75 Children. *Archives of General Psychiatry*, 1979, 36, 675-681.