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Identification and management of the hyperactive child

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IDENTIFICATION AND MANAGEMENT OF THE HYPERACTIVE CHILD

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CHAPTER I

INTRODUCTION

A New Phenomenon?

Children, by their very nature have a great deal of energy. They like to move about and explore their world; they live and learn with their feet, arms and muscles--not just with their eyes and ears. They are eager to examine their environment; they are curious and creative human beings. This innate curiosity and creativity imply movement. The child is constantly in motion: touching, tasting, walking, running and jumping to explore and analyze the world in which he lives. Movement, then, is a natural quality of childhood.

When a child's almost constant movement begins to annoy an adult, whether the adult be a teacher or parent, he is requested to be still and silent. Most children will resent and will somewhat resist such an obvious encroachment upon their desire to move about. The majority of them upon request can be silenced completely or at least somewhat subdued by various bribes and threats from the adult world. An authoritative teacher can coax a child into "sitting still" and "listening"; a frazzled parent can convince a child to "be quiet and watch T.V."; the family pediatrician can calm a child's

anxieties with an offer of a lollipop or other "surprise after an examination or shot; the local librarian can threaten exclusion from the library unless there is "silence"!

Such passive activities as watching, listening and sitting still are highly prized by most adults; these qualities can be forced upon the majority of children because we teach children to respect and obey adult authority. Most of our children can and generally will (if somewhat reluctantly) comply with adult mandates such as the above.

Three to five percent of all children, however, are unable to cope with such directives. This type of child can be found in homes and schools all over the country.

> He has a short attention span, engages in an excess of random and purposeless activity. He's distractible, excitable, unable to tolerate frustration. He can't stay in his seat, has difficulty finishing assignments, talks out of turn and has trouble keeping his hands to himself. He upsets his parents who feel responsible for his behavior; frustrates his teacher who's convinced he has 'potential'; and is frequently shunned by his peers who can't stand his impulsivity.[1]

You might ask: "Isn't this just another child attempting to explore his environment?" "Aren't all children (and adults) more active at one time of their day or week than they are at other times?" "Doesn't this child just have more curiosity and desire to learn about his world than others might have?" "Won't he settle down as he matures?" The answer is yes. . .maybe! Maybe he is just a

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[1]Joel A. Darby, "All the Things You Should Know About Drugs and the Hyperkinetic Child," Early Years, (November, 1974), p.40.

normal child who happens to be a bit overactive or overeager to explore. Maybe he is an average child who just needs to have some reasonable limits set for him. Maybe learning about a certain concept in school or at home tends to make him overlyexcited for the moment. Or maybe he is hyperactive!

Hyperactivity in children is not a new phenomenon. It has been with us as long as children have. In the days before sophisticated psychiatric, medical and educational practices appeared, children who exhibited this ultra-active and sometimes bizarre behavior were looked upon as insane or possessed by the devil. They were consequently locked in an asylum or put to death for the protection and sanity of family and community. Our attitudes and technology have advanced since then. We no longer institutionalize or kill those who exhibit bizarre behavioral characteristics. We do our best to bring them to their full potential. New medical and educational methods are used to bring about this desirable and oftentimes drastic change.

We can change the physical educational environment of the so-called hyperactive child; we can modify his behavior; we can do psychosurgery; or we can use chemotherapy. These advances are no wonder in a society that takes the slogan "Better Living Through Chemistry" seriously.

Overview of the Problem

Let's take a look at Steve. Steve is a hypothetical eight year old boy who is presently have difficulty coping with the activities in his second grade self-contained classroom. He is not doing well academically, he has no friends, and his teacher, though she tries to help him, easily loses her patience because she thinks he isn't trying as hard as he could. A brief look at Steve's reading lesson will give us a better idea of Steve's functioning:

> Steve, instead of reading, 'Once there was a boy and a horse,' said 'One there was a little boy and a house.' This, while elaborately tangling his right leg over his left. At the next sentence, 'They lived on a farm,' Steve groped to scratch his neck, the book slid down and he lost his place. By then, the whole class was tittering.[2]

Steve scored 120 on verbal I.Q. tests. This means he is especially bright, probably smarter than the majority of children who made fun of him. Still, he's behind in writing, reading, spelling and arithmetic. Researchers who have observed Steve's classroom behavior question whether he might be mildly retarded, lazy or just undisciplined. With a verbal I.Q. of 120, he isn't retarded. Lazy? Poor Steve tries hard to please his teacher and struggles to keep up with his classmates.[3] Upon closer

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[2]Dr. Sidney Adler, "I Know I've Got All My Marbles--I Just Can't Use Them," Early Years, (April, 1973), p.53.

[3]Ibid.

examination, observation and testing, Steve will be labeled hyperactive.

Hyperkinesis will be used synonymously in this paper with hyperactivity. Both the concept and the definition of these terms are at times ambiguous and elusive. Virtually every piece of literature read was found to contain that particular author's own unique viewpoint of the definition and consequent rate of incidence. It was therefore difficult for the author to decide upon a definition and corresponding rate of incidence for the subject being dealt with. Rates of incidence as low as 1.5% and as high as 40% were mentioned in the literature. The majority of authors seemed to place the percentage of hyperactive children in our society somewhere between 3 and 5 percent. A respected source was therefore arbitrarily chosen by the author in order to supply a realistic rate of occurance.

> It has been estimated by the U.S. Federal Office of Child Development that three percent of elementary school children demonstrated enough traits (mild and severe) to be classified as "hyperkinetic". Such a percentage implies that in a group of 30 to 35 pupils, one might expect to find one such child.[4]

Hyperkinesis, a popular and often misused label is often used synonymously with minimal brain dysfunction (or MBD) or is described as a result of MBD. The hyperkinetic child is often described in medical literature as being driven by a kind of inner tornado, his activity completely beyond his control.

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[4]Sherwood O. Cole, "Hyperkinetic Children: The Use of Stimulant Drugs Evaluated," American Journal of Orthopsychiatry, (January 1975), p.29.

It is generally agreed that the super-activity with which this paper deals has only two basic causes: (1.) It can be environmentally based or generated by some emotional conflicts in the environment. Technically when this is the case, the problem is referred to as hyperactivity. When the cause of the emotional conflict disappears, so will the hyperactivity. (2.) Hyperactivity that is physically based is called hyperkinesis. This type of hyperactivity is due to pathological dysfunction in the brain and usually requires special educational techniques and/or medical management.[5]

No matter what the cause, the hyperactive child suffers. Life at home and life in school needs to be better for children who have spent most of their lives being scolded, punished, corrected and reminded for failing academically, misbehaving, and not living up to parental and teacher expectations in general. Because of these types of failures, hyperkinetic children have a very poor self-image. Their egos are damaged and self-esteem is low.

Is there hope for the hyperactive child? Can he be educated to his fullest potential? Does he need medication to help him control his inner impulses? If he is put on medication will he become addicted and consequently end up in more trouble? Will psychosurgery help him? Is psychosurgery morally right? These issues and many more are the focus of the research included in this paper.

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[5] Darby, "All the Things You Should Know About Drugs and the Hyperkinetic Child," p. 41.

Statement of Purpose

It was the purpose of this paper to present and explore an overview of the hyperactive child, how he can be identified and possible means of managing his behavior to assure his development as a whole person and a contributor to society.

Recent literature from 1965 to the present was reviewed. Only one article was noted in the 1965 Education Index; the majority of articles are concentrated in the period from 1967 to the present.

CHAPTER II

REVIEW OF RESEARCH

Diagnosing the Population

Since the beginnings of time humanity has been plagued by diseases and maladies that have been difficult to understand and almost impossible to diagnose. Crude forms of healing or alleviating disease were employed by primitive man. Those unfortunates who exhibited any exceptionality--mental or physical--were often looked upon as possessed by the devil or as insane and were locked in an asylum for the duration of their lives.

In the twentieth century individuals look upon themselves with great pride as intelligent and highly sophisticated beings who are conquering disease and eliminating the world of its pain and suffering. Today there are highly specialized people in all fields; there are technical machines, specialized drugs and specific forms of therapy to cure ailments or at least reduce pain. Diagnosis and treatment of almost every known malady is possible.

There do exist, however, a number of medical and/or behavioral problems for which diagnosis is uncertain due to

conflicting opinions in regard to symptoms and treatment is controversial due to moral beliefs and differing schools of thought.

Hyperactivity (hyperkinesis) is a set of symptoms rather than a disease that falls into this category. Although hyperactive children have always been a relatively small percentage of the human population, it was not until about fifty-eight years ago that interest was shown in their problem. Up until that time those who exhibited the symptoms of what is today called hyperactivity were thought to be "possessed" and were burned at the stake or were put in an insane asylum and disowned by their families.

> Clinicians developed an active interest in the syndrome during the 1918 epidemic of encephalitis in the United States. Among the children who were striken and recovered from the acute phase of the attack, many later showed a catastrophic change in personality: they became hyperactive, distractible, irritable, unruly, destructive and antisocial.[1]

Since 1918 the syndrome known as hyperkinesis has undergone many name changes as doctors, psychologists and educators have investigated it.

> The term "hyperkinetic syndrome" is of recent origin. The disorder was first described by Kahn and Cohen in

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[1]Mark A. Stewart, "Hyperactive Children," Scientific American 222, (April, 1970), p.94.

> 1934 and labeled "organic driveness". Bradley later referred to it as "hyperkinetic behavior disorder". Two less frequently used labels have been "post-encephalitic behavior disorder" in 1959 and "association deficit pathology" in 1962. The majority of recent authors such as Anderson, Klinkerfuss and Knobel, however, prefer "hyperkinetic syndrome," possibly because this represents a label which is descriptive yet void of inherent etiological implications.[2]

The hyperkinetic syndrome today exists as one of the many medical and/or behavioral problems mentioned above for which etiology, identification and management are controversial and uncertain. Several theories exist regarding its causes, characteristics and the best way to manage the problem. Due to its recent recognition as a valid, treatable problem none of these theories has had adequate time to be properly researched and proven. All aspects of the hyperkinetic behavior syndrome are presently under further study.

The author, therefore, has not stated any conclusions in this paper in regard to hyperkinesis but has rather explored its various proposed causes, characteristics and possible means of management.

The task of describing the characteristics of hyperactive children is in some ways a difficult one--not because their attributes are unusual, but because many of the symptoms

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[2]Samuel J. Marwit and Jack A. Stenner, "Hyperkinesis: Delineation of Two Patterns," Exceptional Children, Vol. 38 (January, 1972), p.401.

are present in all children to some degree at some particular time. The characteristics listed below are not abnormal in themselves; they are only abnormal when they are excessive in degree. All children exhibit these characteristics at one time or another while they are growing up; "what characterizes hyperactive children is the intensity, the persistence and the patterning of these symptoms."[3]

Finally it must be noted that not every hyperactive child exhibits all of these traits.

Hyperactivity

The most common abnormality is, as the name suggests, hyperactivity. Many of these children have been excessively active since infancy. Parents often report that the child was "different" from the beginning of his life. Frequently such infants are restless and feeding and sleeping are problems.

> From birth he shows distinct signs of difference: excessive rocking, wiggling and climbing; the rapid wearing out of furniture, toys and clothes; experiencing repeated close calls , such as accidental household poisonings and falls from trees.[4]

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[3]Paul H. Wender, The Hyperactive Child: A Handbook for Parents, (New York: Crown Publishers, 1973), p. 8.

[4]Diane Divoky, "Toward a Nation of Sedated Children," Learning (March, 1973), p. 7.

As these bundles of energy become toddlers parents frequently report that the child stood and walked at an early age. After learning how to walk, the hyperactive toddler is always on the go, always into everything, always touching and usually by mistake always breaking every object in his path. Again it must be emphasized that the above description might be that of any young toddler; keep in mind that it is the intensity, persistence, and pattern that set the hyperactive child apart from his normal peers.

As the hyperactive child grows older the description changes: he is constantly in motion, drumming his fingers and shuffling his feet and incessantly fidgeting. He pulls all his toys off the shelf, plays with each for a moment and discards it. He cannot color for long or be read to without losing interest. At school his teachers complain that the child is fidgety, disruptive and unable to stay in his seat; he gets up and walks around the classroom, talks out, and fools around; he bothers and annoys his fellow pupils and is doing poorly in academic work. In short he is a human tornado both at home and in school.

> Regardless of any labels that might be used to identify or classify the hyperkinetic child, one major symptom predominates and is highly apparent even to the untrained observer--hyperactivity. In comparison to other children, the hyperactivity is not simply a matter of degree but also one of quality. The hyperkinetic child appears to be driven--as if there were an 'inner tornado'--so that the behavior is

beyond the child's control.[5]

It is important to emphasize that what is different about the hyperkinetic child is not his activity level while at play. He probably couldn't be detected on the playground. What is different is that when he is asked to turn his motor off, he is unable to do so for very long, if at all! A hyperactive child may be able to sit relatively still upon receiving individual attention from an adult.

Of special interest here is the fact that not all hyperactive children are overactive. There are a few children who have many of the problems listed below but are not over-active at all. "Hyperactivity" therefore is an unfortunate inaccurate label. Also noteworthy is the fact that overactivity is often the first syptom in this complex syndrome to disappear as the child grows older.

Distractibility

A second characteristic many times found in hyperactive children is distractibility or short attention span. While this difficulty is not so obvious as overactivity it is of great practical importance.

Young children, when compared to adults, are

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[5]Cole, "Hyperactive Children: The Use of Stimulant Drugs Evaluated," pp. 28-29.

relatively lacking in the ability to concentrate and follow through on a task. The hyperactive child acts like a child younger than himself. He is the opposite of the child who can sit for 30 to 60 minutes putting puzzles together or building with blocks. Instead he goes from one activity to another in a frenzy.

> As a toddler and nursery school student the hyperactive child rushes quickly from activity to activity and then seems at a loss for things to do. In school his teacher reports: 'You can't get him to pay attention for long . . . He doesn't finish his work. . . He doesn't remember what you tell him'. At home his mother notices that 'he doesn't listen for long. . . he doesn't mind. . . he doesn't remember'. The parents must hover over the child in order to get him to do what they want. Told once to eat with his fork and not his hands, he complies, but a few seconds later he is eating with his hands again. He may begin his homework as requested but fail to complete it unless the parents nag him. The child may not necessarily disobey instructions, but in the middle of an assigned job he starts doing something else. Tasks begun are half done.[6]

Distractibility proves to be frustrating for the child as well as for his parents, friends and teachers. Like hyperactivity, however, distractibility need not be present in all hyperkinetic children. Often when the child receives individual attention he can attend to the task at hand for a relatively long period.

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[6]Wender, The Hyperactive Child: A Handbook for Parents, p. 11.

Demand for Attention

In order to adjust and develop normally, all children require adult interest and attention. As they grow older they require less but still need the interest of those whom they love and respect. The hyperactive child demands immediate and constant attention to his needs. His demanding attitude for attention is insatiable; no matter how much he is given he wants more. He must be the star in the center of the stage; he tries to monopolize the conversation and clowns and jokes in the classroom much to the dismay of teachers and parents.

A child as much in need of attention as this child seems to be lacking in parental love and attention. Parents try to give him more of their time and attention and he in turn demands only more. Anger results on the part of the parents when even a generous amount of attentiveness on their part produces only the demand for more. A feeling of inadequacy and failure finally overcomes the fired and frustrated parents.

> The demand for attention can be distressing, confusing and irritating to parents. Since the child demands so so much they feel they have not given him what he needs. Since they cannot understand how to satisfy him, they feel deficient. Finally, because the child may cling and poke simultaneously and endlessly.[7]

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[7]Ibid., p. 13.

Impulsivity

A fourth characteristic frequently ascribed to hyperactive children is impulsivity or poor impulse control. All young children want what they want when they want it. The ability to tolerate a delay or to think before acting develops with age. The hyperactive child in this case, as in many others, behaves like a child several years younger than his chronological age.

He becomes quickly upset when others fail to behave as he thinks they should. Toys, games and sometimes chairs are kicked, thrown and broken when siblings and classmates don't do what he thinks they should

He acts on the spur of the moment without forethought. He rushes into the street or up a tree. As a result he receives more than his share of cuts, bruises and trips to the doctor. He wears out clothes and toys unthinkingly rather than maliciously.

Impulsivity also shows itself in poor planning and lack of judgement. Whatever amount of poor planning and lack of judgement the normal child has, the hyperactive child has substantially less. He is more likely than most children to run off in several directions at once. Disorderliness and disorganization are the key words here; impulsivity teams up with

distractibility to produce untidy rooms, sloppy dress, unfinished classwork and careless reading and writing.

Perceptual Problems

In discussing the perceptual and learning difficulties that sometimes afflict hyperactive children, it is important to note that hyperactivity does not affect intelligence. The proportions of bright, average and slow are the same among hyperactive children as among children who are not hyperactive.

However, some hyperkinetic children, not all, do have certain problems in intellectual and perceptual development; an "uneven" development in these areas is noted on intelligence tests. A normal 7 year old child will score at or very near the same age level on all subtests of a particular I.Q. test; the hyperactive child who exhibits uneven development would achieve scores at age level on some subtests, far above his chronological age in others and far below his age in still other subtests.

> Intelligence tests measure abilities and skills in a number of separate areas, such as vocabulary, arithmetic, understanding, memory, and certain forms of problem solving. Usually a child's performance is pretty much the same in each of these separate areas. If a child's vocabulary is normal for his age, his memory and problem solving are usually age-normal as well. Hyperactive children seem more likely to have uneven development. The child may be superior in vocabulary, average in memory, and somewhat slow in problem solving. His intelligence, which averages his ability in all these areas may then be

advanced in some regards and behind in others.[8]

This uneven development naturally produces difficulties in school placement and adjustment. A hyperactive child of chronological third grade age may be capable of doing fifth grade mathematics, but only second grade reading. If the school does not make allowances for these inconsistent abilities, the child's problems will be accentuated. He cannot be moved to a regular fifth or second grade; he will be too slow for one and too fast for the other. Unless the school can arrange a program to take his abilities and special needs into account, he will not fit into any class and even further frustration on the part of the child, the parents and the teacher result. During their primary school years hyperkinetic children are generally referred for testing and consequent special school services.

> Checklists provided by school systems and pediatricians to help teachers identify children with hyperkinesis, M.B.D. or similar learning disorders include these 'symptoms':
>
> Talking out of turn in class.
> Telling tall stories to create an important impression.
> Not getting work done in school.
> Rather silly and immature.
> Has trouble sitting still.
> Doesn't get along well with classmates.
> Impatient.[9]

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[8]Ibid., p. 16.

[9]Divoky, "Toward a Nation of Sedated Children," p. 8.

The kindergarten, first or second grade teacher recognizes that some problem exists; she fills out and submits a checklist similar to the one above and at this point parental suspicions have been confirmed. Parents of a hyperkinetic child may often believe that their lack of love, patience or tolerance makes the child seem worse than he is. Different expectations of the child are required at school. The atmosphere is more restrained and more quiet is demanded; this is where the hyperkinetic child's problems are really outstanding.

> Children who may have shown previously mentioned signs in a somewhat milder form or have had especially tolerant parents are first recognized upon entering kindergarten or first grade. When compared to others their own age, they are found to be more difficult to manage because of their restlessness, inattention and immaturity.
>
> This is undoubtedly related to the fact that children usually have to conform in a classroom more than at home. They must sit still longer, must concentrate more and receive less individual treatment. It also means, however, that quite a number of hyperactive youngsters (approximately 65 to 75%) are not brought to any doctor with this complaint before school age.
>
> The average parent tries to live with the situation at home or may even have been told by friends that 'John will outgrow this stage and everything will be just fine.'[10]

An area that John will not outgrow unless given special attention however is that of perceptual difficulties. Perception is difficult to define. It is more complex than seeing or hearing. It includes the abilities to distinguish between similar

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[10]Kenneth Minde, A Parents' Guide to Hyperactivity in Children,(Quebec, Canada: Quebec Association for Children With Learning Disabilities, 1971), p. 7.

sights or sounds and the ability to put together sensations in a meaningful way. Distinguishing between right and left is a perceptual task that gives a hyperactive child trouble. Right-left orientation is associated with reading and writing tasks. The letter "b" is different from the letter "d" because the circle in the letter "b" is on the right and the circle in the letter "d" is on the left. If a child cannot easily distinguish a "b" from a "d" it's not surprising that he may have difficulty sounding out letters to read. All very young children have this problem; the writer again emphasizes that in many ways the hyperactive child functions like a much younger child.

The right-left reversal can be a problem in words as well as letters: "rat" might be read as "tar" and "was" might be read as "saw". Reversal problems can cause spelling errors also: "read" may become "raed". This difficulty in distinguishing right from left obviously makes learning to read and write very difficult if not impossible. Distinguishing between similar sounds such as "pat" and "pet" is another perceptual problem as is the child's memory and inability to synthesize sounds.

Many hyperactive children have none of these perceptual problems but are still marked underachievers. School personnel, however, because of their training, are very likely to be unaware of the problems of hyperactivity and to

attribute the child's difficulties to emotional or psychological difficulties or problems at home. Regardless, school is a frustrating place for the hyperactive child to be.

> School is his worst affliction. He has trouble with his schoolwork, not because he does not have the ability to learn the work but because he cannot concentrate on it and cannot show what he does know. He loses his books, fails to complete tests, forgets to do his homework. Because of his tendency to guess at answers rather than puzzle them out, he has trouble with reading and math.[11]

School problems are intensified for the hyperactive child who has a set of frustrated, guilt-ridden parents and a teacher who thinks she's a failure in her profession. These people can affect a change in this child's life once they realize that they are not the immediate cause of the problem.

> Happily parents and teachers can do more than sigh and hope for the best. They can recognize that even though they did not cause the child's problem, they can do much to solve it. They can be assured that inadequate parenting or teaching did not make this child hyperactive--but that super-parenting and super-teaching can make things better. As one mother put it, 'A hyperactive child requires hyper-parenting.'[12]

Coordination

A great majority of hyperactive children show various difficulties in this sixth characteristic of hyperkinetic behavior: coordination. Limited fine-motor control causes trouble with coloring, cutting with scissors, tying shoelaces, buttoning buttons,

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[11]Mark A. Stewart, Raising A Hyperactive Child, (New York: Harper, 1973), p. 9.

[12]Ibid., pp. 9-10.

and writing. Poor eye-hand coordination shows up in awkwardness in throwing and catching a ball or in playing baseball or tennis. These coordination problems usually cause more difficulty and embarassment for boys than for girls because a boy's athletic prowess is an important source of acceptance by others. A clumsy, awkward girl is, however, usually not a credit to the parents who wish that their daughter would try to act like a "little lady".

Social Aggressiveness/Interpersonal Relationships

The next characteristic and "probably the single most disturbing feature of hyperactive children's behavior"[13] and the one frequently responsible for their referral for treatment, is the difficulty many of these children have in complying with the requests and prohibitions of parents and teachers.

> Most hyperactive children manifest interpersonal behavior that has several distinctive characteristics: (1.) a considerable resistance to social demands, a resistance to "dos" and "don'ts", to "shoulds" and shouldn'ts" (this is a frequent cause of difficulty with parents and teachers); (2.) increased independence; (3.) domineering behavior with other children.[14]

Because of their independent attitude and resistence to requests this special child appears almost impossible to

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[13]Wender, The Hyperactive Child: A Handbook for Parents, p. 21.

[14]Ibid.

control. In some respects he can be described as not having outgrown "the terrible twos" explained by Dr. Spock. He is obstinate, stubborn, negativistic, bossy, disobedient, sassy and uncaring. All the techniques of discipline seem unsuccessful: rewards, removal of priveleges, punishment--none seem effective against this stubborn obstinate child.

In accord with his resistant negative behavior toward those in authority are poor social relationships with siblings and peers. He is a tease and quite an expert at annoying and bothering. As he grows older he shows a marked tendency to become bossy, quite contrary to his refusal to be bossed by adults. When he plays he always wants to be the leader and make (or change) the rules to suit his needs. After awhile other children tend to avoid him.

This child who is desperately in need of social approval and acceptance drives his peers away from him.

> The hyperactive child is usually aggressive socially and initiates friendships successfully, but his style drives others away. He will tell his parents that he is talked about, rejected, and perhaps even bullied. These reports are not excuses and they are not inaccurate. They are correct reports of what his own behavior compels other children to do. He makes friends easily but cannot keep them.[15]

All of the above mentioned social relationships, school problems, coordination difficulties, inabblity to concen-

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[15]Ibid., p. 23.

trate etc. are contributors to perhaps the longest lasting and most personally penetrating characteristics of the hyperkinetic child: emotional difficulties.

> Unfortunately, the pain of rejection by parents, teachers and peers, and the frustration of his felt inadequacies, combine to lead him to further 'acting-out' behavior. And a vicious, vicious cycle begins. By the time the hyperkinetic child physically matures out of the disorder (in late adolescence), irreparable psychological damage has been done.[16]

Emotional Lability and Immaturity

Mood swings and cycles are unpredictable as is just about all of this kind of child's behavior. All people have good days and bad days. These moods, however, are usually easily linked to certain experiences whereas the hyperactive child is in a good mood or a bad mood for no understandable reason. These sudden shifts in mood are not psychologically caused; rather they are due to the cumulative effects of a frustrating childhood, worries about why they are different, inability to accept others and be accepted and a poor self-image in general.

> The child, meanwhile, is convinced not only this his parents do not love him but that he is unlovable. Aside from his feelings of rejection, he is burdened with guilt, since he knows what he is doing to distress them. He may hear his parents quarrel over him all the time and feel sure that if it were not for his existence the household would be happier.[17]

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[16]Darby, "All the Things You Should Know About Drugs and the Hyperkinetic Child," p. 41.

[17]Stewart, Raising A Hyperactive Child, p. 8.

The final major characteristic that is under discussion here is immaturity. Lack of social, athletic and academic skills, as mentioned previously, are all characteristic of younger children. Inability to tolerate frustration and the lack of preseverance in a task are normal in the young child. An inability or unwillingness to tolerate change in routine is also normally seen in preschool children.

> From a practical standpoint it is often helpful for parents to remember that emotionally, not intellectually, their hyperactive child may behave very much like a child four or five years younger than he is. Remembering this often makes it easier for parents to handle their child; many parents do not know how to act toward a nine-year-old with problems but do know how to deal with a normal four-or-five-year-old.[18]

Because adult expectations and demands are different for children in various stages of their lives, those certain behavioral problems that are conspicuous in a toddler are very different from those that are conspicuous in an adolescent.

In adolescence hyperactive behavior per se is often channeled into more socially acceptable activities. A different environment and altered expectations produce different kinds of behavior in the post school-age adult.

> Until very recently, psychiatrists believed that hyperkinesis ran a developmental course, diminishing in later childhood and disappearing in adolescence. But now they are tending to the conviction that the syndrome persists

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[18]Wender, The Hyperactive Child: A Handbook for Parents, p. 26.

> through adolescence and well into later life. It is simply less apparent once the individual is not required to meet the stringent behavioral norms imposed in most classrooms.[19]

Other symptoms of the hyperactive syndrome may disappear or at least diminish in severity as the child grows older. Some of the previously mentioned characteristics of the hyperactive syndrome are actually an asset in the adult world.

> The hyperactivity syndrome is not confined to children. Many adults exhibit the same cluster of symptoms. In adult life, however, certain of the basic characteristics--high energy, aggressiveness, lack of inhibitions--may be helpful in one's work, whereas in childhood, when one is required to sit still at a desk and concentrate on studies for long periods, the restlessness associated with the syndrome may be a great handicap and give rise to severe problems.[20]

Etiological Theories Concerning Hyperactivity

Since it was not the major thrust of this paper to explore and define the causes of the hyperactive syndrome, only a relatively small amount of time will be devoted to it. The author does see fit to present, not explain in detail, the major etiological theories. This brief explanation is given because the writer believes that some understanding of causality should be included to further comprehend the subject under

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[19] Divoky, "Toward A Nation of Sedated Children," p. 8.

[20] Stewart, "Hyperactive Children," p. 94.

discussion.

Nine rather clear-cut and well-defined characteristics of the hyperactive syndrome were named and explained above. Etiological theories, however, have not yet been clearly defined or even agreed upon. There do exist several speculative theories; those are presented here.

Beginning with a very logical explanation, the author discusses inborn temperamental differences as causative. Everyone is born with a certain temperament or level of tolerance for certain situations. Particular kinds of temperament are noted to run in families. In some families children and adults tend to be "high strung" whereas in other families they are more placid. These differences in temperament are as natural as differences in hair or eye color.

> There is scientific evidence supporting what everyone's grandmother knew: there are inborn temperamental differences among children. Studies of the growth of children from infancy to preadolescence reveal that children differ from their earliest days and that some of these differences tend to be associated with behavioral problems as the child grows up . . . What causes these temperamental differences? Child psychiatrists are not certain. A very good possibility is that they are caused by chemical differences in the brain.[21]

This chemical imbalance may be due to genetics as is hair and eye color or to "anomolies in the development of the

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[21]Wender, The Hyperactive Child: A Handbook for Parents, pp. 32-33.

baby before the time of birth."[22]

This chemical imbalance makes it difficult if not impossible for the child to deal with the great amount of auditory and visual stimuli he has to cope with daily. He is being bombarded by sights and sounds that he can't sort out; and therefore cannot deal with in the way parents and teachers expect him to.

Another possible cause is simply the lack of development or maturation or a "developmental lag" in the physical or emotional areas. Some doctors and researchers believe that a certain percentage of children simply mature slowly in these areas; some more slowly than others. A nine year old, therefore, may act like a three year old because that is the stage of emotional development he is at. By the time of puberty, emotions usually catch up to chronological age and the child's symptoms of the hyperactive behavior syndrome have dissipated.

> Hyperactive behavior may also be a consequence of a maturation lag; the child is physically or emotionally developing more slowly than his peers.[23]

Another delay of maturation theory concerns itself

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[22]Ibid., p. 33.

[23]Divoky, "Toward A Nation of Sedated Children," p. 8.

only with the delaying maturation of a portion of the brain in comparison to the chronological age of the child.

> There is, at present, no universally accepted theory about the cause of true hyperkinesis--one widespread idea is that children suffer from a delay in the maturation of that portion of the brain which inhibits or screens impulses. As a consequence, the theory goes, the cerebral cortex is continually flooded with a stream of impulses that the child can't control, sift or integrate . . . In the case of the hyperkinetic child, the screen is broken. The physical sensations, the sounds, the words--everything comes at once, and with equal impact. He attempts to attend to them all at the same time.[24]

A rather recent theory is that of Ben Feingold, a California doctor, who purports childhood hyperactivity to be caused by an allergy to the chemical dyes and additives in certain foods.

> Ben F. Feingold, M.D. Chief Emeritus of the Department of the Kaiser-Permanente Medical Center in San Francisco, indicates that his studies show a strong link between hyperactivity in children and the consumption of artificial flavors and colors used in food processing.[25]

Dr. Feingold sees his theory as the answer to those who question why there exist so many more hyperkinetic children today than 50 years ago. The answer is simple: many more additives are in the food we eat today and many people (especially children) are sensitive or allergic to these modern-day additives.

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[24]Darby, "All the Things You Should Know About Drugs and the Hyperactive Child," p. 41.

[25]Beverly Small, "The Hyperactive Child," Today's Education, Vol. 63 (January/February, 1974), p. 34.

A fourth possible cause is an emotional rather than a physiological one. This theory proposes that a child with a poor self-concept who finds it difficult to live up to the expectations of his parents and teachers will act and react to the people and situations in his environment more violently or in a more exaggerated way than will a normal child. He tries to avoid further failure with negative behaviors.

> Many children are emotionally hyperactive. They can't meet the demands of parents or teachers, so they respond with negative behavior. In a real sense, they're doing their best to avoid failure and, lacking interpersonal skills, they use only the means at their disposal: defiance, restlessness, aggressiveness.[26]

Brain dysfunction or brain damage is the last of the major causes briefly discussed here. Pathological brain damage as a possible cause of hyperactivity seems to be the exception rather than the rule. Brain damage was in years past believed to be the syndrome's major cause. Clinicians and researchers now believe that some brain damaged children may be hyperactive; but not all hyperactive children are brain damaged.

> On many occasions, misleading terms such as 'minimal brain dysfunction' or 'cerebral dysfunction' have been used to classify these children when, in fact, there is no evidence that brain damage is a necessary condition for the appearance of the behavior or that brain damage is found with a particularly high frequency in such cases.[27]

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[26]Thomas G. Banville, "How to Cope With the Hyperactive Child In Your Classroom, Without Making It Impossible for Him to Cope," Early Years, (November, 1974), p. 42.

[27]Cole, "Hyperkinetic Children: The Use of Stimulant Drugs Evaluated," p. 28.

While any of the above may cause the characteristics of the hyperactive syndrome to flourish in a particular child, we cannot point to any of them with certainty as the basic underlying cause for all hyperactivity in children. The only conclusion to be reached here is that much more research needs to be done.

Hyperactivity and Learning Disabilities

Regardless of etiology, the hyperkinetic child must be properly diagnosed and specific learning disabilities should be defined. Diagnosis is at its best in a multidisciplinary team situation. This team approach should be employed in order to avoid a narrow one-discipline management system for the child.

Once diagnosed, the hyperactive child and all of the learning problems that he evidences must find a place somewhere in the schools. His behavior here is disgusting and frustrating to his peers and to his teacher. He is not intellectually retarded but he has more than his share of learning difficulties.

> When the hyperactive child hits the classroom, his problems multiply. He irritates and frustrates his teacher, and he quickly develops a reputation as a 'bad actor'. Because he interferes with their attempts at productivity, his classmates turn away from him. And then, to boot, he has trouble acquiring basic cognitive skills: his poor attention span, impulsivity and perceptual motor problems cause him to fall further and further behind.[28]

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[28] Darby, "All the Things You Should Know About Drugs and The Hyperkinetic Child," p. 41.

This child must be dealt with on two levels in school: the academic and the emotional. He needs to be taught the basics of academics and of his emotionality. He has to be met on an individual basis in both areas. The teacher must meet the hyperactive child where he is at the moment he arrives in the classroom and teach him the fundamentals of what he needs to know to survive in his world. Teaching strategies and management techniques are of utmost importance in dealing with this type of child. Organization and structure are key words.

Without the help of chemotherapy or an elaborate behavior management system the teacher can be most effective in dealing with the hyperactive child if a few organizational and structural techniques are used.

> We should first look at our teaching strategies to see if we are meeting the needs of this child. Have we provided the structure he needs so desperately in order to organize himself? It is imperative that the child know exactly what is expected of him. A daily schedule placed on the board or on his desk will help him organize his day.
>
> He requires short assignments that are interesting and a schedule that provides for physical movement with direction and specific purpose.
>
> The teacher can also provide opportunities for pupils to move about by setting up individual centers around the room for specific learning activities. Language Masters, tapes or other equipment or materials can provide individual instruction and programming. If the children understand exactly where they are to be at a given time and what they are to do, they will probably benefit from such a classroom set-up.[29]

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[29]Small, "The Hyperactive Child," pp. 34-35.

It is obvious that this hyperkinetic child with his academic and emotional problems needs help; he usually needs more help than even loving parents and a concerned teacher can give. This malfunctioning child can and must receive some kind of help. . .help provides hope for his future as a productive, adjusted member of society.

> Before Laurie began treatment at the age of seven, our whole family felt as if we were sitting on a barrel of gunpowder that would explode at any moment. Temper tantrums, sleeping problems, insistence and persistence, inability to follow directions or take corrections, intensity and just plain stubborness marked our every day. Her work was above average in second grade. But when we realized how short her attention span was, how she wandered aimlessly about the room singing while others worked, and what peer-relationship problems she was developing, we kne she needed outside help.[30]

"Outside help" is the next topic to be considered.

Coping With The Hyperactive Child

As was previously noted, the hyperactive syndrome which afflicts some 3 to 5 percent of school age children is not new in itself. Only its name and the way in which treatment is provided for hyperactive children is new. It has been learned through study and research how to identify and treat these children. Research has progressed in the more than 100 years since

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[30]J.L. Schoenrade, "Help Means Hope for Laurie," Journal of Learning Disabilities , Vol. 7 (August, 1974), p. 414.

a German doctor wrote stories about "Fidgety Phil" for his children. The "Fidgety Phil's" that exist today are no longer looked upon as spoiled or just plain bad. There is greater awareness of the problems that the child who is hyperactive must cope with at home and in school; doctors and educators are now able to help this child with a management system that will suit his needs and help him manage his life.

> There certainly were hyperactive children before, but people had very different attitudes toward them, based largely on ignorance. As long ago as 1848, a German doctor wrote some stories for his children, one of which told a sad incident in the life of 'Fidgety Phil,' surely a typical hyperactive child. Probably the first scientific description was published by an English pediatrician named George F. Still at the turn of the century. Only recently, however, has our society turned its attention toward problems that children have in school because of behavioral, emotional, or perceptual handicaps. The result of this attention has been a great spurt of research and growing understanding. We can now talk intelligently about children who are 'hyperactive' or who have learning disabilities or other problems at home and in school, instead of labeling them lazy, undisciplined, spoiled or just plain bad, as people tended to do in the past.[31]

After a child is identified as having the symptoms of the hyperactive syndrome, the obvious next step is to choose an appropriate means of helping that child manage his own behavior and thus help him adjust in society. This step sounds easier than it is.

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[31]Seymour J. Friedland and Robert B. Shilkret, "Alternative Explanations of Learning Disabilities: Defensive Hyperactivity," Exceptional Children, Vol. 40 (November, 1973), p. 3.

There are three major means of managing the hyperactive child's behavior. They are: (1.) medical; (2.) psychological; and (3.) educational. These three alternatives must be matched to the individual needs of the child. In some cases only one method will be needed. In other cases all three methods might be used in equal combination. In yet other cases one major method will be used and it will be supported and reinforced by the other two.

> Hyperactivity and its associated symptoms are difficult to treat and will usually not yield to a single approach. This is because. . .the hyperactive child has more than one handicap (e.g. low attention span, restlessness, belligerance, immaturity, poor learning styles, etc.) and needs help in all of them from various sources.[32]

It is of the utmost importance that each hyperactive child be treated as an individual. When a flu epidemic is going around, pediatricians uniformly prescribe bed rest, fluids and aspirin as the "common cure". In an epidemic of hyperactivity there is "no one method of treatment that has been found to be uniformly successful with the hyperactive child."[33]

Because of its widespread and increasingly controversial use medical management is discussed here first.

Giving medication to children is a common practice

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[32]Joseph N. Murray, "Drugs to Control Classroom Behavior?" Educational Leadership, Vol. 31 (October, 1973), p. 13.

[33]Ray C. Wunderlich, "Treatment of the Hyperactive Child," Academic Therapy, Vol. 8 (Summer, 1973), p. 375.

in curing physical illnesses. It is quite another matter to control behavior through drugs. The American public is constantly alerted by the media about drug use and abuse. Newspapers are full of stories about drug overdoses, addiction and drug misuse in general. It is no wonder that the parents of a young hyperactive child shiver at the thought of "drugging" their offspring everyday for the next 5 or 6 years of his life.

> Using drugs to control kids is not new. In the late 1800's, harried parents fed their unruly offspring Winslow's Soothing Syrup, an opium-based elixir available without a prescription.[34]

Winslow's Soothing Syrup is off the market. Drugs available to hyperactive children in 1976 require a doctor's prescription and much though on the part of the parents. Aside from Winslow's Syrup, drug treatment or chemotherapy really came into prominence as a useful technique in treating behavior problems about 1937. Amphetamines, or stimulants as they are known, are the most commonly used and have been found to be the most effective in treating the hyperactive child.

> Although the use of chemotherapy to treat children with specific learning disabilities has suddenly achieved prominence, the practice is not new. In 1937 Dr. Charles Bradley first reported the successful treatment of hyperactivity and its resulting disorders through the use of an amphetamine. Since then, both clinical reports and

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[34]Carole Wade Offir, "Slavish Reliance on Drugs: Are We Pushers for Our Own Children?" Psychology Today, Vol. 8 (December, 1974), p. 49.

> the reported results of controlled studies show that hyperkinesis can be controlled by amphetamines as well as other stimulant drugs.[35]

Amphetamines are designed to stimulate the responses of the normal person. The hyperactive child, however, is already subject to constant over-stimulation from his environment. He is unable to cope with this environmental stimulation; this inability to cope is what makes him hyperactive to begin with. How, then are stimulants used to calm him and help him function normally in his environment? Although these drugs have a stimulating effect on adults, medical experience and research reveal that they have a reverse effect in hyperkinetic children and tend to counteract the overt symptoms that characterize these children. Of the amphetamines, Benzedrine, Dexadrine, and Ritalin are the major ones used to treat the hyperactive behavior syndrome.

> Stimulant drugs appear to act paradoxically in cases of cerebral dysfunction and hyperactivity. An explanation for this phenomenon is offered by C.K. Connors and G.H. Rothschild, who state that the drug action in hyperkinetic children is not a pharmacologically true paradoxical effect, but rather a direct stimulating effect which causes an increase in general alertness and excitation, along with an increase in the ability to focus attention. Responses to interfering stimuli are then decreased, resulting in a child who is more receptive to the stimuli presented by teachers and parents. As the child focuses on the meaningful stimuli, he is able to organize his body movements

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[35] James L. Hager, "Educator's Role With Hyperkinetic Children," Phi Delta Kappan, Vol. 54 (January, 1973), p. 338.

more purposefully, this controlling motor hyperkinesis.[36]

Stimulant drugs react directly upon what is known as the reticular activating system in the brain.

A second explanation for the effectiveness of stimulant drugs states that these drugs seem to slow the transmission of nerve impulses in the brain of the hyperkinetic child without actually sedating him. This explanation purports that a chemical imbalance is corrected in the hyperactive child's brain through the use of stimulant drugs.

> Although the activity of the hyperkinetic child appears to be normalized and his attention markedly improved with the use of stimulant drugs such as d-amphetamine [Dexedrine] and methylphenidate [Ritalin], very little is known about the mechanisms by which these drugs bring about such changes. D-amphetamine has potent stimulating effects on the central nervous system, with its primary site of action being in the lower brain centers, including the midbrain reticular activating system, hypothalmus, and limbia structures. Methylphenidate has a similar biochemical structure and pharmacological action to that of d-amphetamine and probably acts on many of the same sites. Since one area of the brain linked to hyperactivity (the reticular activating system) reacts favorably to stimulants but not to tranquilizers, it is possible that d-amphetamine and methylphenidate slow the transmission of nerve impulses in the brain of the hyperkinetic child without actually sedating the child. In a general sense, such a view purports that nerve impulses may be transmitted too rapidly in the hyperkinetic child, and that stimulant drugs act to achieve a chemical balance, allowing the brain to function in a more normal manner.[37]

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[36]Frank Alabiso, "Inhibitory Functions in Reducing Hyperactive Behavior," American Journal of Mental Deficiency, Vol. 77 (November , 1972), p. 261.

[37]Cold, "Hyperkinetic Children: The Use of Stimulant Drugs Evaluated," p. 31.

Regardless of the inability to prove exactly how stimulants work to calm the hyperactive child, the fact remains: they do work. They work for the vast majority of hyperkinetic children which may explain why so many doctors who are unprepared to diagnose a true hyperactive child and are unaware of other forms of treatment immediately (after only a cursory examination) prescribe medication for the child. Stimulants will be effective for almost all hyperactive children unless they develop an allergic reaction to the drug or the side effects are too overbearing.

Possible side effects caused by the use of stimulants are decreased appetite, loss of sleep and possible weight loss.

Generally, however, when hyperactive children are on these drugs, they become calmer and less active, develop a longer span of attention, become less stubborn, and are easier to manage and to live with at home and in school. They frequently become more sensitive to the needs of others and much more responsive to discipline. When stimulant drugs are effective they produce dramatic results. Usually they are effective immediately to make the child more mature in a variety of areas.

> Despite the fact that the psychophysiological mechanisms of stimulant drugs on hyperkinetic behavior are not fully understood, the reported improvement in behavior at school and at home has fostered widespread use of this

treatment.[38]

While the practice of drug therapy has truly grown in popularity the past few years, it is not universally regarded as the ideal method of treatment. Drug treatment represents a convenient but somewhat questionable alternative to other forms of management. There are questions concerning the possibility of addiction and long-term psychological and physiological effects. While the stimulants are extremely effective in helping the child focus his attention in order to learn and behave in school and at home, there are further questions as to the problems the child will experience when he is taken off the drugs around 12 or 13 years old. If he becomes so different while under the influences of the medication, will he recognize his "natural" feelings when he is not taking medication?

These questions in regard to stimulants and their relation to the hyperactive child need long term study and research.

> The only thing lacking in the picture is the solid, systematic research that should have preceeded, or at least accompanied, wide use of the drugs. As a matter of fact, when a subcommittee of the U.S. House of Representatives held a hearing in the fall of 1970 on the use of behavior modification drugs with grammar school children, it was established that although the National Institute of Mental Health alone had granted three million dollars for research in the field, although the drugs had been in use for 30 years, and although at least 300,000 children were then taking the stimulants, no authoritative follow-up studies on long-term effects had been done. The Medical Letter On Drugs

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[38] Stanley Krippner, Robert Silverman, Michael Cavallo and Michael Healy, "Study of Hyperkinetic Children Receiving Stimulant Drugs," Academic Therapy, Vol. 8 (Spring, 1973), p. 262.

> and Therapeutics, a conservative, nonprofit publication aimed at clinicians, describes the data on the use of amphetamine-type drugs on children as 'meager' and goes on to charge that there are no adequately controlled long-term studies of the use of stimulants on noninstitutionalized hyperactive children with I.Q.'s in the normal range.[39]

Stimulant drugs like Ritalin, Dexedrine, Benzedrine and Mellaril can produce unusually dramatic effects when they are prescribed for children who actually need them, and when the dosage is correct.

> In summary, there is a place for stimulant medications in the treatment of the hyperkinetic behavioral disturbance, but these medications are not the only form of effective treatment.[40]

Another alternative management technique is psychological management. One of the techniques of psychological management that has grown in popularity in very recent years is called biofeedback. In this technique the hyperactive subject learns about his internal bodily actions and reactions in order to develop self-control over them. Biofeedback is being experimented with at this point in time. It has potential for widespread use in the future as it has been successful in helping adults develop self-control over a variety of problems such as heart rate and blood pressure.

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[39]Divoky, "Toward A Nation of Sedated Children," p. 10.

[40]"Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children," Journal of Learning Disabilities, Vol. 4 (November, 1971), p. 523-530.

> Biofeedback is a technique developed relatively recently within experimental psychology. It involves the use of electronic equipment to monitor a subject's physiological process (which are normally not attended to and not under 'voluntary' control) and then making these processes known to the subject by means of some external stimulus such as a light or tone. This 'externalization' of information about internal functioning ultimately allows the subject to gain voluntary control over his internal physiological systems.[41]

Another kind of phychological management is the introduction of a psychologist or a psychiatrist who is tuned into the problems of the hyperkinetic child. This psychologist/psychiatrist can be most helpful as a "third party"; one who is knowledgable about the problem but yet has never had a conflict or bad experience with the child. Some parents and educators argue that a child under twelve is too young to see a psychiatrist. Often this is just the person whom the child needs; someone who can discuss and try to explain and/or talk out the consequences of his actions and his feelings about himself. He can help the child cope with the difficulties he is facing at home and in school.

The third means of psychological management is highly controversial, sometimes damaging to the child, and very permanent. It is called psychosurgery. Psychosurgery is

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[41] Lendell Williams Vraud, Mimi N. Lupin, and William G. Braud, "The Use of Electromyographic Biofeedback in the Control of Hyperactivity," Journal of Learning Disabilities, Vol. 8 (August/September, 1975), p. 422.

being used in only the most severe cases; many surgeons refuse to do such an operation.

> The psychosurgeon's goal is permanent behavior modification directed at management, control, and conformity. They have stated their interest in operating on children who require extra effort and time on the part of the parents, teachers, or hospital attendants. They wish to control these children so that they will never require extra care and attention again.[42]

Children who undergo such an operation are left with only a part of their personality intact. Such an operation performed on a young child breaks his spirit much as a wild horse loses his spirit when he is tamed. After psychosurgery the child is no longer aggressive and restless, distractible and disorganized; neither does he have his creativity and natural curiosity to learn.

> In order to accomplish management, many other aspects of the personality must be sacrificed with the loss of brain tissue. The frontal lobes and the limbic system are well integrated with many interconnections throughout. There is no violence center or hyperactivity center in the brain. The amygdala, thalamus, hypothalamus, and other emotion-regulating areas of the brain perform many integrated functions. Removing any of these structures will blunt such aspects of the personality as creativity and learning, in addition to blunting violence, aggression, motion, or restlessness.[43]

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[42]Phyllis Breggin, "Underlying a Method: Psycho-Surgery for Hyperactive Children," Mental Hygiene, Vol. 58 (Winter, 1974), p. 20.

[43]Ibid., pp. 20-21.

Since the hyperactive child spends the greater part of his waking day at school, it is of utmost importance that the school and more specifically the teacher be prepared to cope with him. Even if the child is on medication it is very likely that he will still need a supplemental supportive kind of management to see him successfully through the day. One educational technique being used more and more is the placement of the hyperactive special child into a special classroom with a small class and a trained teacher who understands his problems and who will make an extra effort to help him deal with his problem behavior.

The last management technique might very well be used within the confines of the special classroom. It is a system of rewards and punishments called behavior modification. Again, even though the child might be on drugs to help him cope, behavior modification techniques may be necessary to help him get through the days when everything seems to go wrong. Essentially behavior modification is a system whereby desirable behavior is built and undesirable behavior eliminated through rewarding the child for a proper response and punishing him (usually withholding the reward) for an inappropriate response.

> The other popular treatment approach that has received attention in recent years and offers considerable promise is behavior modification. This commonly involves an operant conditioning technique by which desirable behavior

is conditioned or shaped and undesirable behavior is eliminated through the programmed use of reinforcements.[44]

Of the several major management techniques available, non will be utopia for every child. Generally medication is prescribed for the hyperkinetic child as the main system of management and another technique might be used to support the medication.

Paramount to any technique used is the concern and understanding given the child. He is a human being who has many problems that are not of his own choosing. It is important to keep in mind that he does not control many of his actions and responses. He wants to be a lot better than he is; he needs to be loved and cared for; he longs to be accepted by peers; he tries to pay attention in class and remember at home--but he can't. Parents and teachers must keep in mind that the hyperactive child would be better if he could.

Summary

Hart Peterson, associate professor of neurology and pediatrics at New York Hospital, Cornell Medical Center, explains the hyperactive child as being 'bombbarded by sights and sounds all his waking hours but, unlike normal children, is unable to sort them out and give priority to any single one. As he sits at his desk, he hears the teacher talking, a classmate whispering,

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[44]D.D. Simpson and A.E. Nelson, "Attention Training Through Breathing Control to Modify Hyperactivity," Journal of Learning Disabilities, Vol. 7 (May, 1974), p. 275.

> a car going down the street, an airplane flying overhead, and they all come through with equal importance. He wants to investigate all of them, immediately.
>
> At school and at home, this child seems to be in perpetual motion, tapping his feet, moving from side to side, shuffling his feet, jumping from one self-motivated activity to another.[45]

The hyperkinetic behavior syndrome does exist. Children who are afflicted with hyperkinesis exhibit one or more of the characteristics defined and exemplified at the beginning of this chapter. Even though the author has clearly defined these characteristics, diagnosis is often very difficult. The quality and intensity of these "symptoms" must be carefully examined by pediatrician, teacher and parent before a diagnosis is made. The child who is simply very active by virtue of his own personality must be distinguished and separated from the child who is truly hyperactive.

Etiology, though not the major focus of this paper, has been briefly discussed. Relatively little is presently known about the cause or causes of the hyperactive behavior syndrome although many theories are currently being researched.

> We know little about definitive causes. The disorder has been ascribed to biological, psychological, social or environmental factors, or a combination of these.[46]

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[45]Small, "The Hyperactive Child," p. 35.

[46]"Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children," p. 525.

Management techniques are of the utmost importance. Finding and implementing the appropriate management system is the key to future success and happiness for the hyperactive child. The management system or systems chosen must be fitted to the specific needs of the individual child. Not all hyperactive children will be able to satisfactorily function and cope under the same management system.

> The fact that these dysfunctions range from mild to severe and have ill-understood causes and outcomes should not obscure the necessity for skilled and special interventions. . .
>
> Several approaches now appear to be helpful. Special classes and teachers can be directed to specific learning disabilities and thus restore the confidence of the child who experiences chronic. Modification of behavior by systematic rewarding of desired actions has been reported to be useful in some children. Elimination of disturbing influences in the family or classroom through counseling, may often tip the balance, and a happier child may show improved control and function.
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> There will be children for whom such efforts are not sufficient. Their history and their examination reveal symptoms of such a driven nature that skilled clinicians undertake a trial of medical treatment. Medication does not 'cure' the condition, but the child may become more accessible to educational and counseling efforts. Over the short term and at a critical age, this can provide the help needed for the child's development. [47]

The single conclusion to be drawn from the preceeding research is that much more research needs to be done in regard to the identifying characteristics and the various

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[47] Ibid., pp. 526-527.

management techniques of the hyperactive child. Hyperactivity is a relatively new subject area in education and medicine. Only recently has it been viewed as an educational/medical problem.

More research studies desperately need to be done in these areas so that the child who has been afflicted with hyperkinesis is able to have the chance to live his life as happily and profitably as any other well-adjusted contributing member of society.

CHAPTER III

Treating the Hyperactive Child At Home and At School

Besides the various means of managing the hyperactive child mentioned previously, there are several less formal ways that are often of great help.

The following are ideas and suggestions to help the hyperactive child cope in the classroom and at home.

(1.) Hyperactive children don't take to surprises. They like to know in advance what's coming first, second, and so on. You can help them by carefully structuring their daily schedules and work assignments, and then, by avoiding unexpected changes in plans or routines.

(2.) You can't hurry a hyperactive child. That would only excite him. So, make sure he has plenty of time to complete every assignment.

(3.) Hyperactive children simply can't stand being in the wrong. If there's a need for discipline, it should be done in a nonpunishing way, keeping in mind the fact that the child can't control his behavior, and assuming, always, that if he could he would behave acceptably.

(4.) A calm and quiet environment is a great help to the hyperactive child. Loud talking, laughter or excessive movement in the room can be very disturbing to him. Any kind of excitement may key him up and result in misbehavior.

(5.) The reason hyperactive children behave (or misbehave) as they do is that they don't have what are generally referred to as 'inner controls'. Since they are not self-controlled, it's necessary for the adults around them to supply the controls externally. One of the best ways to do this is to provide situations in which he can safely be responsible for his own behavior. The teacher should control the situation so that the child's attempt at self-control is fail-safe.

(6.) It's impossible to make the hyperactive child do anything he refuses to do. If you apply force, everybody loses. Fussing, arguing and teasing will only aggravate the situation. Offer the child a choice between your way and his and point out the consequences of each.

(7.) Hyperactive children are very sensitive to 'body language'. They are quick to spot the signs of teacher's displeasure and they may react to it in unacceptable ways. You can get much better results if you can manage to stay on an even keel.

(8.) Physical restraints only make the hyperactive child more hyperactive. Even when he's misbehaving, your approach to him should not involve sudden action. If you keep your cool, you'll help him do the same.

(9.) Unfairness, real or fancied, is enough to set off hyperactive children. By no means, are they always fair. But they expect you to be.

(10.) Hyperactive children usually react very favorably to a reward system such as those used in behavior-modification programs.

(11.) Never, ever contribute to a self-fulfilling prophecy for a hyperactive child. Avoid making comments in his cumulative folder, to other teachers--that will give him a reputation to live up to.[1]

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[1]Thomas G. Banville, "How To Cope With The Hyperactive Child In Your Classroom, Without Making It Im-Possible for Him to Cope," Early Years (November, 1974): pp. 42-43.

CHAPTER IV

SUMMARY

A Look Toward the Future

The medical and educational problems present in today's world are many and varied. Doctors search for cures for cancer, leukemia, muscular dystrophy, and even the common cold. Educators try various methods such as the open classroom concept in order to provide the most comprehensive individualized education for the child.

A current medical/educational problem is the hyperkinetic behavior syndrome. Many children in school today are unable to be attentive and learn due to the symptoms of this syndrome. They are intelligent beings who are in need of the love and warmth of others but oftentimes are denied this love and warmth because of the somewhat obnoxious, disgusting, and frustrating behavioral characteristics they exhibit. Both peers and parents can cope with the hyperactive child's "driven" behavior and seemingly unthinking acts for a certain length of time and then both give up in despair. His teacher is only able to manage his uncontrolled behavior for a certain

length of time and then she, too will tend to despair.

This hyperkinetic child can be helped to adequately handle himself within his environment through various management techniques such as chemotherapy or behavior modification. But are these the most helpful means of helping this kind of child cope? or are there other means as yet unresearched that would be even more helpful?

Hyperactive children will grow to be adults. They have the same right as all human beings to live and grow in the world. Their existence and the work they do can leave its mark on society. This is only possible, however, if doctors, parents and educators are alert to the possibilities of new identification and management techniques. It is possible only if researchers in the field experiment with and study new avenues of help for this special child.

A brighter future is available to all who work for it. This is unfortunately not true of the hyperactive child. He is like a baby whose actions and reactions to the world around him are virtually uncontrolled and highly influenced by others. Just as a newborn baby's future lies in the good judgement and healthy environment provided by his parents, the hyperactive child's future lies in the research and studies yet to be done by concerned and interested educators and doctors in the field.

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