Treating Children with Hyperactive Syndrome: A Memoir

M.C. Giammatteo Ph.D., Ed.D.[1]

Introduction

I had a joint practice with offices in Oregon and Washington during the late 60s and up to 1974. My partner retired and I went into a multidiscipline practice in Oregon and Washington.

Our treatment for alcoholics was a simple use of all B series vitamins and ascorbic acid. We noticed patients reacted within weeks in a more positive manner and were focused on problem solving rather than problem blaming, fixing situations rather than fixing blame. We began to teach others the protocol as well as to broaden the scope to self-destructive behaviors and techniques for cures. The AA people did not seem to feel we were on the right track. The Oregon Council on Alcohol Problems and the Mental Division of Oregon did and wrote one complete newsletter about my theories in their 1967 Mental Health Newsletter. These were taught under the heading of Self Defeating and Self Destructive Behaviors Workshops for Medical and Helping Professionals. They were taught in Oregon, Alaska, Washington, California and Hawaii for about six or seven years. A number of participants asked if we worked with children of alcoholics and we responded indicating we were using the same techniques slightly modified for the 3rd through 6th grade clients. We also worked with a family treatment models.

Our model for children was simple and easy to use for the years we had a co practice.

The children were administered 1.5 g to 3 g vitamin B_3 daily for 90 days along with ascorbic acid, about 5 g daily, along with one clove of garlic in with the vegetable meal recommended per day. We went by weight and feedback from the child and the parents to adjust the dosage of the Vitamin B_3 and Vitamin C. Usually the flushing experience and the slight potential for diarrhea were the only problems our patients reported. We also had the parents give a cup of coffee to the child before their first visit. We suggested a Saturday morning and asked them to notice the behavior of the child. When parents reported that the child seemed to calm down and was more focused we knew we had a child that was having problems with hyperactivity behaviors. This worked up to about age 12 for boys.

They were asked also to start on an exercise program with a small trampoline and other perceptual skills training techniques available upon request.

The parents were given eating behavior handouts which asked the child to discuss the color of the food, the size of the food, the smell of the food and to place their fork and spoon down after each bite before chewing. Green leafy vegetables and fruits were recommended and added sugars were to be cut from their diets for the next three months. Yogurt, kale and spinach, along with bran cereals were recommended for their food sources and were also to be recorded in their food diary kept with the parents.

They were asked to list and talk out the things that caused stress. (*Insights about Your Outsides*, ACRO Press, Vancouver WA. Publishers 1970, (available from the author)

They also kept a journal with words and pictures telling about their self-reported changes which they shared with me once every week for month one, and every other week for month two and a

1. 509 NW 80th St., Vancouver, WA 98665 Retired

three week span before the last or next to last visit depending on feedback and progress. Due to private practice, the program took about 90 days and 7–9 visits for that part of vitamin treatment.

The children had my phone number in case they felt weird or excited. One chap moved during treatment due to his dad's job transfer and we talked for over 20 minutes only to have his mother get on the phone asking who I was. And when I told her, she said "Oh my God we are in Florida." Needless to say she had a large phone bill and wanted to know what doctors there used my method.

Each visit in my 20 x 22 foot office used for kid patients with stuffed toys, had three mirrors. One at the far right, one centered and one to the far left. The child was asked to face mirror one (far right) and tell what they wished to change about their behavior, thinking and feeling...then with each of the six or seven steps to the mirror number two they would tell one small change required to meet with wanted and desired change. Self reported at mirror number one...with each of the remaining six steps or so they focused on their positive feelings resulting from their changed attitude and behavior. The motto was do that which is justified rather than Justifying that which you do.

They were asked to have a parent call me every month or so for any signs or concerns. The parents were sent to local colleges to take courses in parenting if we thought it was a major part of the problem.

Treatment Model

The general model of the overall treatment concepts were presented:

Physical stressors (external and bodily; e.g. environment, living conditions, broken bones).

Nutritional stressors: A food diary was started and eating habits were discussed along with general meal time consumptions. We would show the parents the equivalence of sugar in each item on their typical breakfast list. As we talked about each item on the list we would have the child drop in a sugar cube into a glass bowl, which was about equal to that item's amount of sugar.

Social stressors: We listed all losses such as healthy child to sick, smart kid to slowest in the class, geographical losses, moving to a new district, school, state, parent divorce losses, value losses, belief losses. We usually found out that one parent was more in tune with the child than the other and that some times an older child could clue us in on what the patient sensed as a real loss. Often loss of being the tallest child to being average hit my 10 and 11-year-olds as one that created concern.

Organizational stressors: Moving from class to class experienced by some 4th grade students, lighting in the class rooms, amount of noise allowed by the teacher, amount of group vs. individual learning, structured class room seating arrangements vs. desks any place in the room; open class room structures where children could hear the class next to theirs being taught.

Self-talk stressors: I cannot do this...it will always be this way...nothing is going to work...and so on. We would tell them they were not victims of negative thoughts forever. Mrs. Faulkner, R.N or Mrs. Carr, M.S would say the positive templates or phrases to them while keeping a set rhythm...You are lovable and capable. you have talents awaiting discovery. We also would have them think a negative thought and then my nurse or I would yell stop as loud as we could disrupting the child's thought . This was one of the techniques Joseph Wolpe, M.D. would use with the clients.

Poor performance usually reported by the school or from other group functions.

Case Studies

Three case histories in condensed form are presented illustrative of the process and results.

Case 1. Robert: A psychiatrist had seen Robert, a seven year-old child, and his parents were told the child would require institutionalization. The special education people where he resided were making no headway with the child. His younger brother manifested none of the behaviors Robert exhibited. The parents had tried several forms of treatment in the time between Robert's fourth and seventh birthdays. A graduate student in psychology working in the district had been made aware of the treatment format I used at the clinic. She met with the parents explaining some of my techniques. They scheduled an appointment, which later I found out the father resented because he felt he was wasting his money on this child. On his first visit, Robert oriented almost immediately to what we were doing and when I placed my hands under his and looked him in the eye and said are you ready, he nodded. We threw him a beanbag and he said his name. This was done each time as he caught the bean bag. We then moved to having him spell each letter timed to the catching of the beanbag. By the end of the first session Roberts was taken to the other room where the parents were being given the nutritional and food information required. Robert asked the nurse if he could spell his name. We used the bean bag technique and when he spelled his name, the mother was excited. The father, an engineer, saw the demonstration as a weird non-scientific approach and when he was told about the vitamin therapy along with the food intake concepts he balked at additional treatment. The mother said he had filed for divorce two months prior to our first visit with Robert. Robert was given part of the vitamin therapy under our control the first visit. We started him out with1.5 g of B_3 and 5 g of C while a staff member watched him for the next half of an hour. During that time a staff member made suggestions for exercise, home activities and meals to both parents. The clients were told the child could call me at home if they felt uncertain or had treatment questions. Robert responded with "Neat."

Each visit thereafter we would introduce more stress into his activities until he was doing many things approaching the low end of the normal range. His visual acuity changed so that his myopia was now also opening up and we used near and far point accommodation exercises, more or less standard in developmental optometry.

On Robert's second visit he reported he felt like he could jump out of his skin and that he wanted to say so much... would we listen? He was then given 2 g daily of vitamin B_3 along with the same mealtime ideas and the vitamin C, 5 g per day and one clove of garlic included in his daily salad. He had a sense of humor and wanted to know if he would turn green from all that green stuff. We had several sessions with the mother and began to wonder why such a diagnosis was given to their child. She reported the child was always upset at meal times and was fearful of not being perfect and that he started to get clumsy by age three to such an extent that the father thought he was retarded. It seemed obvious that by association Robert had learned to be a behavior "problem". He knew his mother would try to rescue him and as long as he was silent, everything was ok. He did however present all the signs of the hyperactive child. He was unable to really focus on tasks, was unable to socialize, was disruptive and would just get up and move quickly from the front of the room to the back. When put in special education his behavior continued to be disruptive. The district wanted the consulting psychiatrist to do a

final analysis since the educators and the father had reached their wits end.

On our third meeting Robert was reporting, as was the special education department, that he was calming down and participating in the discussions with the other four children. Miss Martin got Robert's mother began to volunteer with children with similar presenting problems and became an advocate for this type of program. When her divorce was final she also volunteered in another district.

On the remaining sessions all outside sources reported the outstanding turn-around that Robert had made. After a year of educative and skills-training sessions without the vitamin approach, Robert's mother relocated to Hawaii. Nine years later we found that Robert had entered the University of Hawaii and was majoring in Biology. A number of years later while in Hawaii for a seminar, a phone call to my room brought me up to date on Robert. He was completing his requirements for an M.D. degree.

Case 2. Mark: a nine-year-old boy, referred by a family practice M.D., had presenting problems similar to the other young patients we were seeing at the time. The father and mother supported the vitamin approach we used during that period of time and had great joy from the first meeting. Mark was started on 5 g of vitamin C daily and 1.5 g B_3 and the garlic clove mixed with his daily salad. He seemed to have a sense of what to expect and within weeks the school he attended reported a major improvement.

As with the child in the other case study, the major difference in treatment was the vitamin approach. After treatment was terminated a phone call was received at my home and it was Mark wanting to talk. When an adult got on the phone and after identifying whom Mark was talking to, she said OH my God was in Florida, we were transferred. Mark and I had chatted for over 20 minutes. In both cases the vitamin approach was the major treatment difference.

Case 3. "G": A brief example of the childhood treatment model's use on G. a 43 year old business man follows: A business man who suddenly begin to hear voice and they told him to kill his 3 children. His minister who had been doing Christian counseling for G over a long period of time referred him. He felt he was in a situation where professional treatment was required and as he said G frightened him with the intensity he showed at the church office.

The amount used in his format was similar that used with alcoholics. All the B vitamins, 3 grams of Vitamin B_3 and 8 g of Vitamin C. In addition we recommended but did not monitor Zinc and iron and magnesium were strongly suggested .He beginning to have once a week sessions with another therapist in our offices. Within six months G was talking calmly and was comfortable with his children. The female therapist working with G also had him work on impulse control and noticing good in a situation. He gave up his auto repair shop and went to work for another garage. This allowed him to be with his family for the weekend. He continued with the staff therapist for over one year and was discharged from a regular scheduled session and called our offices only when in his words he needed a tune up for the summer vacation with his kids. He reported no more ideas about killing the kids and his voices never spoke to him after treatment ended

Several other therapists in town used this approach. One young Psychiatrist had some problems because he was not prescribing as expected. He went back to medication therapy and used the DSMO that almost demand some medication approaches be employed. Our D.C was visited by some officials in the early 1970s

and was told that his dispensing of these vitamins was akin to practicing medicine. He left the area and moved to an Island in northern Washington State to continue his practice. Another MD in Oregon, a pediatric specialist was also asked why his prescription pad was infrequently being used. The bulk of the MD and medical support community understood what we were attempting to do and would ask questions per the model from time to time and then the Oregon Council on Alcohol and Drug Treatment along with the Oregon Lung Association asked me to lead the Self Defeating and Self Destructive Behavior Workshops for continuing education for MDs, Psychologists, social workers and R.N.'s. These were held at the major hospitals in Oregon.Washington, California, Hawaii, Alaska As well as in several trust territories. The Juvenile court schools in one state employed many of the concepts for the youthful offenders who were incarcerated in one of their 14 centers.

Conclusion

At the end of 90 days using the above protocol we had children able to give up medications they had been taking formerly. Teacher reports were indicative of positive observable behavior changes. The parents also would be advised to maintain the vitamin portion of treatment after a 30 day waiting period because Dr. M.M. and I felt that was the only thing added to our treatment protocol that made the in general positive and observable changes

The medical personnel at a local level included one orthomolecular psychiatrist and several family practice clinics. They were all supportive and referred children patients and alcoholic patients to us at a rate that kept our offices fully booked.

Our DC was questioned by the state because of his vitamin therapy. Our nutritionist consultant was never bothered and over all we had positive results in our local community. When the concepts were presented at our Medical Association Meeting in Oregon, the people enjoyed the input but most found reasons why that protocol would not work in their setting. They felt people wanted a "pill" approach or a prescription.