the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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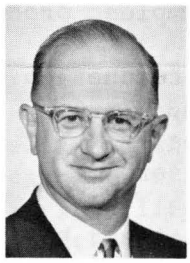
The "Disease" of Hyperactivity



Dr. Robert Mendelsohn

Has your child been diagnosed as "hyperactive"? If so, you shouldn't let another day go by without reading "The Myth of the Hyperactive Child" by Peter Schrag and Diane Divoky (Pantheon Books).

The authors explain that for hyperactive children, chemotherapy (treatment with drugs) has become the "enlightened" answer to spanking. The child who can't sit still in class is now being called hyperactive and is being "managed" by such drugs as Ritalin, which is banned by public health authorities in Sweden.

Even so, the drug, manufactured by CIBA, has current sales in the neighborhood of $30 million annually. Almost one million children now are taking such behavior-altering drugs to make them more manageable in the classroom. Often it is the teacher or the parent who makes the original diagnosis of "hyperactivity," perhaps ascribing to it one of its other names: learning disability, hyperkinesis, minimal brain damage or perceptual handicap.

What are behavior-altering drugs doing to children? Schrag and Divoky quote Dr. Herbert E. Rie, professor of pediatrics and psychology at Ohio State University:

"The kids slow down dramatically and are out of people's hair, but when objective testing is done, they're not performing one bit better. In fact, what we're observing is that the youngsters on drugs are far less responsive and enthusiastic, and are far more apathetic, humorless and zombie-like."

I've long been concerned about excesses in this field. It reminds me of the loud cries of praise that ring through the land whenever some new medication is heralded as a "major breakthrough." Later, as more complete returns pour in, the original enthusiasts begin a strategic retreat, sometimes totally abandoning the therapy or at least carefully limiting its use.

Witness the original excitement over the antibiotic drug tetracycline. Widely prescribed for ear infections, skin conditions and recurring throat infections, the drug produced a generation of children with permanently yellow-stained teeth.

Those enthusiasts who earlier rejoiced in the efficacy of behavior-altering drugs are now beating a similar strategic retreat. Schrag and Divoky provide overwhelming evidence that "there was, in many instances, more scientism than science." They painstakingly document the narrow self-interest of the researchers in this field, and they reveal the inadequacy of much of that research.

The authors warn that "the techniques of medicine are (being) used extensively to serve the purposes of social control . . . An entire generation is slowly being conditioned to distrust its own instincts, to regard its deviation from the narrowing standards of approved norms as sickness, and to rely on the institutions of the state and on technology to define and engineer its 'health.'"

As a parent, I would not allow myself to be intimidated by "experts" who tell me something is wrong with my child's behavior. And I certainly would not accept a diagnosis of "hyperactivity" from anyone who has not read "The Myth of the Hyperactive Child."

Q My 9-year-old son has been diagnosed as an MBD (minimally brain damaged) and hyperkinetic child. For the longest time, I resisted his doctors' and teachers' efforts to place him on Ritalin, but through much pressure I was finally forced to succumb to their advice.

An obvious change was observed in his behavior, and his attention span in school lengthened. However, he soon suffered from side effects of headache, bellyache and general malaise. I since have terminated the medication, and the child has returned to his former behavior patterns.

What therapy would you recommend in place of Ritalin? I realize drugs have their place in treating certain illnesses, but many doctors prescribe them as catch-alls--the line of least resistance. Please advise this concerned mother.--Mrs. R.J.

Avoiding Ritalin

A Once the decision has been made not to use drugs, a variety of alternatives must be explored. The possible alternatives I am going to list for you are common-sense approaches to your child's problem which you might wish to consider. I have listed the simplest procedure first, and the most drastic procedure last:

1) Have a conference with the classroom teacher to explore possible modifications in classroom management.
2) Consult with special education experts.
3) Consider a change in your child's classroom.
4) Consider a change of school.
5) Consider removing the child from school and having him tutored at home, if your state law permits.

For some children, the modern classroom may simply be more than they can handle, which is why I've included the fifth alternative.

Q As a teacher of learning-disabled, emotionally disturbed and hyperactive children, my observations on the subject of medication are warranted. I do not believe that medication is a cure-all for these children's problems, but without medication some of these children could not even sit still long enough to learn to read or write. I have seen these same children after they are on medication, and the results are astonishing. For the first time in their lives, they are experiencing success in learning and are able to control themselves.

If, as you say, the medication makes the children "apathetic, humorless and zombie-like," it is obvious the medication is too strong or another medication should be tried. The teacher or parents can report these observations to the doctor. Medication is as vital to some of these hyperactive children as insulin is to a diabetic.--E.K.

Medication and Academic Performance

A There is no conclusive evidence that stimulant drugs improve academic performance among hyperactive children. While some previous studies have reported that this is the case, a review of these studies by Russell A. Barkley, Ph.D., and Charles E. Cunningham, Ph.D., done at the Medical College of Wisconsin, Milwaukee Children's Hospital, and the Child Development and Rehabilitation Center, University of Oregon Health Sciences Center (Clinical Pediatrics, January 1978) concludes that stimulant drugs appear to have little, if any, effect on the academic performance of hyperactive children.

Your analogy to insulin and diabetes is particularly timely in view of recent scientific evidence that links some diabetic blindness to the long-term use of insulin. It has taken half a century of insulin

therapy to discover this linkage. The evidence of damage to health by Ritalin, a popular drug for "hyperactive" children, is accumulating much faster. Let's hope we're not too blind to recognize it.

Q My 9-year-old daughter is hyperactive. She is in third grade and has been taking Tofranil for one year. I've had to increase the dosage to two pills a day because she wouldn't settle down in class, and this caused her teacher problems. She seems to be under control now, at least until this medicine stops working. I worry because she has a male teacher for the first time, and I hope there won't be more problems.

I asked my daughter's pediatrician how long hyperactivity lasts, and he said children outgrow it. But when? What about the Feingold diet?--Mrs. J.W.

A You and many others have written me about the dietary management of hyperactivity advocated by Dr. Ben F. Feingold, chief of Kaiser Foundation allergy clinics. The concept of eliminating food coloring and other additives is sound, and many parents of hyperactive children have enthusiastically and successfully substituted this kind of diet for drugs.

Side effects of Tofranil

Since your daughter is on Tofranil, I presume you have looked into the possible side effects of this powerful medication. The chief indications (reasons for giving the drug) are depression and bedwetting in children 6 years old and older. Interestingly enough, the manufacturer, Geigy, does not even list hyperactivity among the indications. But the company does state that "safety in long-term chronic use by children has not been established."

I become concerned when a drug prescribed by your doctor for your child has among its adverse reactions "restlessness, agitation, insomnia, nervousness, anxiety, emotional instability, incoordination, tremors, seizures and alterations in EEG patterns." You note that you've already had to increase the dosage because your daughter wouldn't settle down in class. Will you have to increase it still further because its side effects are the very symptoms you're trying to control?

Q Our year-old grandson could be classified as hyperactive. I say "could be" because the literature we find on this subject begins with children of school age. Yet we are certain that this condition does not materialize overnight and must have manifested itself in some children before they reached school age.

We are at out wits' end! This baby is highly excitable and at no time seems calm and rested. His days and those of his immediate family are a constant misery, and the nights are even worse. He awakens and cries or screams several times each night, and he has never slept a full night.

My daughter and son-in-law have run the gamut in attempts to solve the problem and are worn to a frazzle. Their doctor has told them to shut the baby in a back room and let him cry. If this is attempted, my grandson's whole system seems to go into total shock, and it takes days before even partial peace returns. Despite the fact that my daughter is four months pregnant, she still nurses him as this seems to be the only method of calming him.

After 40 years and five children of my own, I can only tell you that I have never seen anything like it. Could you possibly tell us who would have more knowledge and information on this subject?--A Very Concerned Grandma

Hyperactive one-year old

A Your daughter has shown much wisdom in continuing to nurse her baby. Since he may require even greater contact, she might consider having him sleep very near to her. A book that should prove helpful in this regard is Tina Thevenin's "The Family Bed" (P.O. Box 16004, Minneapolis, Minn., 55416).

I cannot agree with the doctor's advice to leave your grandson crying by himself.

You are fortunate to live in California where many excellent physicians have researched hyperactivity in both children and infants. Among them are UCLA's Dr. Herbert Grossman, who has written for "Pediatric Clinics of North America" (Yearbook Publishers), and Dr. Benjamin Feingold of the Kaiser-Permanente Medical Center in San Francisco.

I think these sources can be a useful starting point for the kind of information that will enable your daughter and son-in-law to raise a fine son.

Q I am surprised that you were so willing to accept the diagnosis of "hyperactive" for the 1-year-old boy whose grandmother wrote about his screaming and crying. Hyperactive children are just that--on the move excessively. What was described to you was obviously a baby in physical pain, and you should have referred his parents to the pediatric section of a university medical center before you referred them to a specialist in hyperactivity.

It seems to me that "hyperactivity" has become the diagnostic wastebasket for doctors who are too irresponsible, lazy or incompetent to pursue an accurate diagnosis.

I understand that in some medical schools one of the first things medical students are taught is, "When you hear the sound of hoofbeats, think of horses before zebras." Often the most obvious explanation for a child's behavior is the simplest: physical pain. These parents should run, not walk, to a university medical center.--Fresno Mother

More on one-year old

A If you reread that letter on the "hyperactive" 1-year-old, you will see that the baby was under a doctor's care. Furthermore, at the end of the column I recommended two outstanding California university-based physicians who certainly know how to probe for the many other physical and emotional conditions that are often masked these days by the catch phrase "hyperactivity."

The medical community, abetted by the educational community, has converted a diagnosis of something that once was as rare as a zebra into something that is now as common as a horse. Future generations may well decide that the sounds of all those hyperkinetic hoofbeats were merely the products of our own hyperactive imaginations.

Q Our 2-year-old grandchild is very active, intelligent and advanced for her age. The pediatrician says she is hyperactive and wants to treat her with medication. Is there a test to make sure she is hyperactive? --Worried Grandma

Testing for hyperactivity

A Some medical tests are conclusive, such as those that positively identify the tuberculosis bacillus in cases of TB. The list of tests for hyperactivity is at least as long as the number of names assigned to this syndrome (22 at last count), but there is no single diagnostic test that will label a child as hyperactive. A doctor, therefore, makes his diagnosis on the basis of an educated guess, the guess of someone who has had a long education. "Longer" education is not necessarily "higher" education.

In my opinion, the statement of an experienced grandmother that her grandchild is intelligent, active and advanced for her age deserves to be taken seriously. And before accepting any medication for your granddaughter, you should make sure that the liquid or pills do not carry a warning that they are contraindicated in small children.

Two of the most commonly prescribed drugs for hyperactivity, CIBA's Ritalin and Abbott's Cylert, carry a warning that their safety and efficacy in children under 6 years have not yet been established, therefore these drugs are not recommended for preschoolers.

So many children are being called hyperactive by the experts that I wonder whether many of them actually are perfectly normal in contrast to the "hypoactive" children who serve as the reference base. If we're not careful, we'll soon find the non-hyperactives being drugged with prescriptions for "hypoactivity" to arouse them from their lethargy!

Potpourri

Q A

Jaundice and phototherapy

Are there any dangers of phototherapy for jaundiced newborns?--N.A.

Even though use of phototherapy (bilirubin fluorescent lights) as a treatment for jaundiced newborns is only a few years old, the dangers to babies are being identified already. These include irritability and sluggishness, diarrhea, lactase deficiency, intestinal irritation, dehydration, feeding problems, riboflavin deficiency, disturbance of bilirubin-albumin relationship, poor visual orientation with possible diminished responsiveness to parents, and DNA-modifying effects.

I also am quite concerned about the threat to normal bonding between mother and child which may result because light therapy necessitates that the infant's eyes be bandaged, often for several days. My fears are based on important animal studies conducted years ago by Konrad Lorencz and Eckhard Hess. In those studies, ducks which were placed in darkness immediately after birth failed to develop the "imprinting" which leads to normal maternal-offspring relationships.

Now one might think doctors would be extremely cautious before exposing tens of thousands of babies to this still-experimental technique. After all, modern medical care of newborns does not have an unblemished record, as witness the history of mistakes which have been made over the past few decades. These include blindness resulting from oxygen therapy, brain damage from hexachlorophene soap, sensitization due to intramuscular blood injections, convulsions after consumption of SMA formula, and hypoglycemia caused by routine starvation of newborn infants. Yet these bilirubin lights continue to shine, with all their known risks and still-to-be-identified ones, even though proof remains lacking that light has any effect at all on the prevention of the form of brain damage (kernicterus) associated with severe jaundice.

If your doctor wants to turn on the bilirubin lights, be sure to ask him whether he has re-checked the laboratory blood reports to rule out any technologic error. Also ask him whether, in the absence of Rh or ABO blood incompatibility producing jaundice, the remote chance of kernicterus is greater than the risks of phototherapy.

The recognition and management of jaundice has become a growth industry in pediatrics, and I for one tend to view the entire scene with a jaundiced eye.

Q Many of our local doctors advise temporary, and sometimes even permanent, weaning from the breast in newborn infants who are jaundiced. Most parents are frightened by this usually benign condition, and they tend to follow their doctor's advice blindly. Please help them understand that breastfeeding may continue, no matter what the cause of the jaundice or how high the bilirubin count goes.--D.C.

A *Breastfeeding and jaundice*

If your doctor wishes to switch off breastfeeding, ask him the following questions:

1) Can you point to a single case in the entire medical literature of a baby with either physiologic jaundice or breastmilk jaundice who developed kernicterus?

2) When you advise me to discontinue breastfeeding, even for a few days, have you considered the known hazards of formula milk?

There never has been any evidence that breastmilk increases jaundice levels in the first few days of life, and, as a matter of fact, early and frequent breastfeeding tends to reduce the degree of jaundice. Jaundice levels are increased when contraceptive pills are taken before or following conception, by aspirin and sulfa drugs taken by the mother in late pregnancy or just before delivery, by certain diuretics given the mother during pregnancy, by oxytocic agents used to induce or speed up labor, and by epidural anesthesia. Excellent information on this subject is available from a group which conducts AMA-approved seminars for physicians--I refer to La Leche League International, 9616 Minneapolis Ave., Franklin Park, Ill. 60131.

DEPARTMENT OF DELIBERATE OBFUSCATION

"Infections that occur in an institutional setting, e.g., hospitals, convalescent centers, nursing homes, are nosocomial infections. The term nosocomial (Greek, nosos, disease + komeion, to attend to=nosokomeion, hospital) is preferable to hospital-acquired because the latter may imply a culpability which does not necessarily exist." (Infectious Diseases, Paul D. Hoeprich, Ed. Harper & Rowe, 1977, p. 27)
Ed. note: So a rose is not a rose is not a rose?

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Your questions about the medical problems that trouble you most, will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, 664 N. Michigan Ave., Suite 720, Chicago, Ill. 60611.

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Robert S. Mendelsohn, MD, Editor
Vera Chatz, Associate Editor

Medical News

A new study shows a declining use of oral contraceptives by women in Britain's top socio-economic group. The survey discovered that only 21 per cent of university educated women used oral contraceptives, as compared with 43 per cent of the female population as a whole. (American Medical News, April 28, 1978)

New warnings have been issued against Darvon (propoxyphene). The drug, which is already contraindicated for use by pregnant women, has produced cases of withdrawal syndrome in newborns. The symptoms include tremor, irritability, high-pitched cry, diarrhea, weight loss with ravenous appetite, and seizures.

In the current FDA Drug Bulletin, an additional warning has been mandated. Because of Darvon's additive effect on the central nervous system, the medication should not be taken with alcohol, tranquilizers, and sedative hypnotics.

The divorce stigma is fading in corporate life, and some experts are even saying that corporations have found that divorced and single executives are capable of greater devotion to their work while married execs are forced to give priority to their families. Eugene Jennings, a professor of management at Michigan State University estimates that about 20 per cent of those now nearing the top of the corporate ladder in the largest U.S. companies have been divorced. Jennings says that corporate life is a single person's world, and the divorced person often has shown his devotion to his company by the long hours of work which may have contributed to his marital problems. (Chicago Sun-Times, March 22, 1978)

Ed. note: For years I have suspected that corporate practices contribute strongly to the breakup of the American family. Is it any wonder that a classic study by Alice Ladas shows that the majority of husbands of La Leche League families are self-employed?

A $500,000 settlement was reached in a suit by a Newport, R.I., woman who had sued Wyeth Laboratories after suffering a stroke allegedly caused by oral contraceptives. The woman stipulated that the settlement be made public so that other women would learn of her experience. (American Medical News, Feb. 28, 1978)

Another View

by Marian Tompson
President, La Leche League International

The parents of hyperactive children with whom I've been in touch work hard at coping with this difficult situation. They read up on it. They get together with other parents to encourage each other and share new information. And, a growing number are trying the Feingold diet, hoping it will eliminate the cause of their child's symptoms and keep him away from drugs.

Changing eating habits can be very difficult. Expecting one child to eat differently than the rest of the family is harder still. However, all family members might not be ready for a total diet change. So Loretta Schott, founder of the Feingold Assn. of Illinois and herself the mother of hyperactive children, decided to meet that problem a year and a half ago by setting up a series of workshops to which the entire family is invited and during which they are all given step-by-step help. Because of the many problems people have encountered in trying the diet by themselves, Mrs. Schott is convinced that regular group meetings where old members can give support to new ones work best. This is the approach used in La Leche League. After having been on the diet for awhile, it's not uncommon to hear the "healthy" members of the family remark on how much better they feel.

While other locally-based Feingold groups might not offer workshops, they are still good sources of practical help, encouragement, and inspiration. Information on the Feingold group closest to you can be obtained by writing Mike Morrison, Feingold Assn., P.O. Box 11-670, Loundonville, NY 12211.

Yet diet may not always be the answer. The suspected causes of hyperactivity are many. They range from hypoglycemia, which seems to be present in half of the children, lead poisoning, resulting more often from exposure to automobile exhaust fumes than from eating chips of lead-based paint; calcium deficiency; lack of oxygen to the brain cells; sugar; fluorescent lighting; pin worms; allergies; as well as problems with food additives.

Helpful books include: Why Your Child is Hyperactive by Benjamin Feingold, M.D., reporting his experience with the effects of food coloring, additives and preservatives. Supermarket Handbook by Nikki and David Goldbeck, which identifies many additive-free foods. Human Ecology and Susceptibility to the Chemical Environment by Theron G. Randolph, M.D., written in 1962 and ahead of its time in pointing out the dangers of air pollution, chemicals and fumes. Hyperactive Children: Diagnosis and Management by Daniel J. Safer, M.D., mainly for physicians. The Myth of the Hyperactive Child by Peter Schrag and Diane Divoky, worth reading if only for the Appendix. Entitled "The Elements of Self-Defense," it gives useful advice to parents on how they can hold their own and protect the rights of their children in confrontations with school authorities, medical personnel, welfare systems, and the police. Improving Your Child's Behavior Chemistry by Lendon H. Smith, M.D. adds sugar to the list of culprits.

It can take a lot of detective work to get to the root of the problem. Parents being the closest to the scene are really the best suited for this job.