Restless Children

Treating Attention Deficit Disorders from an Anthroposophic Perspective

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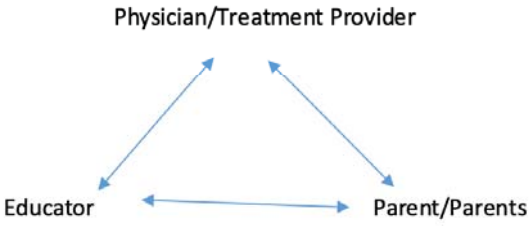
The new definition, in the latest *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5),[2] for attention deficit disorder as a "neurodevelopmental" disorder is meant to acknowledge the fact that the roots of ADD/ADHD are usually deep within the innate anatomical and physiological construct of a child's nervous system. This insight greatly attests to the difficulty in reaching a definitive treatment for ADD/ADHD, which is likely the reason why none of the therapeutic approaches has fully worked so far. The estimate today is that for only one third of the children treated with a conventional approach will ADD/ADHD become significantly more moderate in adolescence. Despite this pessimistic view, it is estimated that most of the patients treated with an anthroposophic approach will see great moderation of the disorder even before adolescence, at a percentage of 40 to 50 percent of cases. This is expected to happen not by means of Ritalin or other stimulants, but by means of medicinal and artistic anthroposophic treatments, and through the application of recommended behaviors within the family and in the classroom.

There are a number of guidelines to treatment using the anthroposophic approach for ADD/ADHD; some are specific to this approach, and some are shared with other approaches:

- In the majority of cases, there is not one single medicine or treatment that is capable of treating the disorder. An effective treatment takes place in a combination of the following: the educational plane (in elementary school or kindergarten); the medical plane (medicinally and therapeutically—with arts or psychological treatment); the familial plane; and the nutritional plane. There is no set protocol for a child suffering from ADD/ADHD, and it is important that the combination and dosage of these treatments are individualized and personally fitted to the child.
- Until the child is diagnosed with ADD/ADHD, he generally receives warnings and reprimands from parents, teachers, and friends—a fact that can cause social rejection, low self-esteem, and an acceleration in the intensity of the symptoms. The earlier the treatment starts, the more it can meaningfully "repair" the disorder, therefore, it is very important to try and diagnose a child demonstrating any kind of restlessness and treat him or her as quickly as possible.
- Because most of the children suffering from ADD/ADHD have special skills concealed within them, it is imperative that parents and educators make a concerted effort to "feel the child"; to take more interest in him than is typical; to try and identify his fields of interest, his skills and his areas of positive initiative; and to give him strong positive reinforcement when necessary.
- Communication between the parents, and between the parents and the child's teachers and therapists is a basic and essential condition for beginning therapy and must be done on a daily basis. More than just improving the treatment's effectiveness, with these conditions in place, the child will unconsciously feel that the adults "see" her and "feel" her, and her response to treatment will thrive accordingly. In order to do so, the following educational-medicinal treatment must be adopted:



A number of questions arise in connection with the treatment of children who suffer from ADD/ADHD:

- How can a better integration be formed between the three soul forces: thinking, feeling, and willing?
- Can one strengthen a child's ability to create inhibitions, how?
- How can we bring about a strengthening of the ability to imitate (through which the child transforms his inherited body into his individual body)?
- How can the experience of boundaries be strengthened?

1 This article is adapted from the author's book, *Restless Children: Coping with ADHD and Anxiety Disorders Using an Integrative and Anthroposophic Approach*, published in Hebrew in 2020. An English translation of the book will become available through Amazon on January 2023.

2 American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).

- How can an appropriate family life be formed for these children? How can an appropriate educational and social environment be designed for them?

In order to address these questions, we will start with general recommendations meant to help all children suffering from ADD/ADHD and then move onto individual suggestions.

General Recommendations

Nutrition

Many theories were presented in the past, some of which were research-based, asserting that certain foods, such as sugar, food coloring, and preservatives, were likely factors in the appearance of ADD/ADHD. But when research indicating genetic factors emerged – such as those tied to pregnancy and other environmental factors – the nutritional factor was pushed to the sidelines. Today, the idea that nutrition can influence the progression and strength of ADD/ADHD is accepted, but the idea that it is a factor or a means of therapy is not; at most, nutrition is considered as a way to mitigate and minimize symptoms.

A healthy process of digestion entails the investment of significant life forces, because the food must undergo a fundamental breaking-down to the most basic particles before it can be absorbed by the digestive system into the blood and then reach its first destination in the liver. Coordinated activity of the digestive organs (the liver, gallbladder, pancreas, stomach, and others) and forces of will are necessary for the breakdown process. They are guided by the unconscious activities of the "I" in the metabolic system. Therefore, appropriate nutrition, the right eating habits, and an optimal functioning of the digestive system all carry great significance for a strong presence of the "I" in the metabolic system.

Evidence of low availability of neurotransmitters in the brains of children suffering from ADD/ADHD indicates a general metabolic disruption in the body, with a disorder in the availability of neurotransmitters serving as one of its expressions. Indeed, research has shown that one-third of children and adolescents suffering from obesity (a metabolic disorder) also suffer from ADD/ADHD, and that those of them who were treated for ADD/ADHD also lost weight accordingly.[3] In this context, it is important to point out that diabetes is closely tied to obesity and is likely to appear in great frequency in adults who suffered from obesity during childhood. An additional finding that strengthens the importance of cultivating the digestive system of children suffering from ADD/ADHD is that the vast majority of the main neurotransmitters involved in ADD/ADHD are created in the digestive system (like serotonin) and in the adrenal gland, located above the kidneys (dopamine and noradrenaline), and only a few of them are created in the nervous system.

Nutritional guidelines for children suffering from ADD/ADHD are very general and appropriate for most children:

1. **A relatively large breakfast,** made of quality carbohydrates (such as whole-grain flour and legumes), as well as orange and green vegetables and proteins, improves the ability to concentrate during the first hours of the morning. It is important—especially in the morning—to stay away from foods that have any sort of sugar, other than carrots and fruits that have a relatively low amount of sugar (such as apples). The rationale for this comes from the fact that the levels of glucose in the blood are lowest in the morning. Sugar consumed in the morning is therefore immediately absorbed in the blood, without serving an actual purpose in digestion, and instantly raises the blood sugar level. This sudden increase results in an intense reaction by the pancreas of secreting insulin in an attempt to lower the elevated sugar level. These extreme fluctuations in sugar levels are bound to negatively influence the child's mood and the ability to concentrate during the morning hours.
2. **A set rhythm of meals during the day** — Mealtimes that are more or less set "write" the biological rhythms of the digestive system and of sleep. So, for example, a child who becomes used to eating late at night is likely to develop sleep disorders and/or obesity, because a high absorption of food from the digestive system to the blood takes place during the night.

It is estimated that most of the patients treated with an anthroposophic approach will see great moderation of the disorder even before adolescence, at a percentage of 40 to 50 percent of cases.

3 L. D. Levy et al, "Treatment of refractory obesity in severely obese adults following management of newly diagnosed attention deficit hyperactivity disorder," *International journal of obesity (2005)* vol. 33.3 (2009): 326-34. Retrieved from: www.ncbi.nlm.nih.gov.

3. **Meticulousness as to the quality of food** — Our food, especially food from a plant source, contains life forces. During the digestion and breakdown of food, these life forces are released and absorbed into the life force system in the body. Therefore, organically grown food—in particular, food grown through a biodynamic process—will release a very high amount of life forces into the body, while processed food made biotechnologically will release very few life forces and actually will only provide the organism with chemical ingredients that lack life forces. This recommendation is doubly significant for children who take Ritalin, because the life forces in the metabolic system are already weakened by the medication.

4. **Abstaining from food coloring and other allergens** — In the beginning of the 1970s, Dr. Feingold asserted, on the basis of his clinical experience, that children under his care experienced an improvement in ADD/ADHD when they refrained from preservatives, food coloring and flavorings (taste and smell). Additional research was done in which the influence of four types of food colorings and sodium benzoate (preservative number E211) was tested on 277 three-year-old children. The results showed a moderation of hyperactive behavior in children suffering from ADD/ADHD after these substances were removed from their diet.

   Children with ADD/ADHD have a higher occurrence of allergies to certain foods. One research tested the influence of certain food ingredients on ADD/ADHD symptoms by eliminating the following foods from some of the participating children's diets: tartrazine food coloring, peanuts, soy, chocolate, and cow's milk. Results showed an improvement in these children's behavior. It is recommended, therefore, that children with ADD/ADHD undergo allergy testing and receive treatment for the allergy itself, because even if the allergy does not directly influence the nervous system (something that has not yet been proven), the symptoms of the allergy alone—such as itching of the skin or the eyes, sneezing, chronic colds, or disruptions in the airways—can cause restlessness and exacerbate ADD/ADHD.

5. **Vitamins and fatty acids** — Research on the fatty acids Omega-3 and Omega-6 has shown that a large portion of children suffering from ADD/ADHD has a low level of these fatty acids, while other research noted behavioral improvement in children who took Omega-3 and-6 supplements.

   These fatty acids are thought to be necessary for the body, including for proper brain function and various metabolic processes. Given that the body cannot create these acids on its own, such children should take a daily supplement of Omega-3, and their diets should be augmented by food rich in Omega-3 and -6 such as walnuts; different types of seeds; avocado; fish such as salmon, tuna and mackerel; flaxseeds; flaxseed oil; and chia seeds.

Children who suffer from ADD/ADHD also have been shown to have a relatively higher incidence of Vitamin D deficiency, as well as deficiencies in iron, zinc, and magnesium (sources of vitamin D are exposure to the sun and a diet of fish, eggs, and dairy products). It is recommended that children who suffer from ADD/ADHD have blood work done to determine if there are indeed deficiencies of these four components, as remedying these deficits has shown a certain improvement in symptoms of the disorder.[4]

> Today, the idea that nutrition can influence the progression and strength of ADD/ADHD is accepted, but the idea that it is a factor or a means of therapy is not.

To sum up, it is recommended to take great care of these children's nutrition, to insist on food from a bio-dynamically or organically grown source, and to significantly reduce their sugar intake, whether from brown or white sugar. It is recommended that they eat many root vegetables,[5] orange and green vegetables, foods with Omega-3, Omega-6, Vitamin D, iron, zinc and magnesium, and that they have a proper level of Vitamin B12 and folic acid, which constitute ingredients necessary for the operation of the nervous system.

Treatment Within The Family Framework

A child who suffers from ADD/ADHD presents his parents with extreme emotional situations, which very often constitute a significant challenge for them,

4 Amelia Villagomez and Ujjwal Ramtekkar, "Iron, Magnesium, Vitamin D, and Zinc Deficiencies in Children Presenting with Symptoms of Attention-Deficit/Hyperactivity Disorder," *Children (Basel, Switzerland)* vol. 1,3 261-79. 29 Sep. 2014, Retrieved from: www.ncbi.nlm.nih.gov.

5 The root part of the plant has an affinity for the nervous-sensory system and it carries within it a combination of strong, shaping forces, together with life forces. Therefore, consistent, long-term consumption of root vegetables may strengthen the life forces of the nervous-sensory system as well as the integration of the shaping forces.

especially if one of the parents suffers from the disorder as well. It is important to remember in this context that there may be many conflicts between the parents and the child, and among the rest of the family members, because of the relatively high tension in such families. Therefore, parents in a family where a child suffers from ADD/ADHD are at a higher risk of divorce. Additionally, because the average child (of elementary-school or kindergarten age) spends about half of her waking hours within the family unit, having a supportive home environment and parents who can be empathetic is of utmost importance for the child's chances to overcome his ADD/ADHD.

Evidence of low availability of neurotransmitters in the brains of children suffering from ADD/ADHD indicates a general metabolic disruption in the body.

Below are a number of guidelines and practical ideas from therapists experienced in working with the anthroposophic approach for appropriate parental presence, which can help within the family framework:

1. **Positive Reinforcement and Definition of Clear Boundaries**

   It is important that the parent be highly aware of the child's positive initiatives, even the smallest ones. In these sorts of situations, the parent needs to be aware of the child's need to receive specific positive reinforcement (even more than the reinforcements given to a child who does not suffer from ADD/ADHD), and that these are repeated over the course of many days and also before the child goes to sleep. Giving positive reinforcement at the proper time creates a positive "tailwind" and strengthens the child's self-image; the child is in danger of developing a low self-image to begin with because of the spontaneous tendency of many educators to scold children suffering from ADD/ADHD. On the other hand, parents must define and spell out very clearly and concisely the red lines that they do not want the child to cross.

   Many of the children suffering from ADD/ADHD will demonstrate a marked difficulty in getting organized in the evening before going to bed, as well as in the morning before going to school. A practical way to improve their conduct is through drawings in which a parent, together with the child, draws the stages of the necessary activities (e.g., a drawing of the child waking up, a drawing of the child getting dressed, a drawing of the child brushing his or her teeth, etc.). These drawings are then hung on the child's bedroom door in order to direct the child during the actual morning activities, enforcing them without emotional reactions, as much as possible.

2. **The Inner Attitude of the Parent**

   Because many of the children diagnosed with ADD/ADHD try to express a certain uniqueness which the parents and/or educators sometimes have a hard time identifying, the main internal attitude that parents must take is the effort to *be interested in* the child as much as possible, on all levels, in order to identify and give appropriate acknowledgement of his uniqueness. Therefore, there is great importance in parents' interest in the child's physical appearance, emotional world, unique skills, fields of interest, positive initiatives, and in the ideals the child believes in. It is also important to be aware of the factors that impede such children from expressing their uniqueness. Two ways that have proven worthy in attaining these goals are:

   Parental Guidance: Parents of children who suffer from ADD/ADHD are often challenged with complex family situations, which greatly raise tensions in the life of the family. Faced with the irregular behavior of their child, many parents experience feelings of anger, embarrassment, frustration, and guilt that could sometimes cause them to feel helpless. The goals of parental guidance are:

   - To help parents (and through them, the child) to deal with situations in which the child displays violence, lack of confidence, difficulty in accepting authority, low self-image, or when the child experiences social rejection, etc.
   - To create a more realistic image of the child for himself and his parents with the help of a professional (psychologist or psychotherapist), with an emphasis on his individual strengths and abilities.
   - To help parents deal with the hard feelings that arise in these instances.

   Observation and/or Meditative Work on the parents' part, in connection with the child. Examples of observational exercises and meditative blessings are described in the appendix to this book, under "Exercises and Blessings Given to Parents for their Child."

It can be added in this regard that the creation of a spiritual and ceremonial environment in the family enables the child to sense the spirit that is living within her and strengthens her ability to believe in herself and in those around her. This environment can be created in the family rhythmically, through blessings before meals, a celebratory meal on the Sabbath Eve, a blessing before sleep, suitable blessings recited on the birthdays of family members, and the like. These practices could also be used to address questions that many children have about life and death (e.g., "Where was I when my older brother was born?") or at memorials for loved ones who have passed away. It is amazing how natural it is for a child to accept spiritual images connected to questions of life and death.

3. **Fewer Screens, More Handcraft**

The guiding principle here is to protect the nerve-sense system, on the one hand, and to strengthen the will forces, on the other.

These days, we know without a doubt that screen exposure strengthens the symptoms of ADD/ADHD and causes many other disorders. Clear recommendations were made by the medical establishments in Europe, the United States, and Israel a number of years ago to significantly decrease screen watching for children and for adults. However, one cannot demand from children growing up in the 21st century to avoid watching screens without giving them an alternative—which can prove no less challenging.

Giving positive reinforcement at the proper time creates a positive "tailwind" and strengthens the child's self-image.

Therefore, parents face an additional challenge in creating multiple opportunities for children to do handcrafts, which would involve a cheerful experience as well as one that awakens motivation. Such activities lessen the desire for screens and protect the nervous system, which is already overcrowded with stimuli; and, most importantly, they strengthen the child's will forces. The rationale that such activities operate on is that through the practices of handcrafts, a deeper process of the incarnation of the "I" and the "soul body" occurs in the metabolic system, and the will forces then become stronger and receive *direction and meaning* (as opposed to the hyperactivity that constitutes a will lacking in direction and meaning). When the child invests himself in activities and gives himself over to them in full, he is rewarded with moments of "being in the present" (in which his consciousness is not directed toward the future or the past) and with a relative calmness of his nervous system.

Practically, it is a good idea to propose activities during a child's free time on a set, rhythmical basis, one to two times a week. Such activities could include playing a musical instrument appropriate for the constitution of the child (preferable to start in third or fourth grade); riding and taking care of horses (it is better to challenge the child to *work*, to take care of the horse and feed it, and not just ride it); boating; rock climbing; surfing; cultivating one's own vegetable garden; after-school activities in nature; hiking and navigation; tennis; ping pong; fencing; taking care of a pet at home; or participate in an after-school workshop working with clay. Different age-appropriate handcrafts are also recommended, such as baking bread or any baking that emphasizes kneading of dough; cooking; knitting; sewing; embroidery; spinning thread; carpentry. Physical free-time activities recommended for children who suffer from ADD/ADHD are one-on-one activities. This kind of activities cut down on the background noise that exists in group play, which tend to be loud and could cause stress. It is important to take into personal consideration which of the free-time activities above are appropriate for the child – specifically, which will awaken a motivation to continue with the activity – and then try to stay away from competitive and stressful activities as much as possible.

These activities, especially challenging sports like horseback riding, rock climbing, surfing, etc., demand effort from the child and create an extensive integration of the child's executive functions (which work via the frontal lobes of the brain) and the will forces (expressed via the metabolic system).

Other recommendations found to be helpful in the recruiting of the child's will forces and motivation are setting a time each week for the child to do one of the above activities just with his or her father, and a different day just with the mother. In addition, it is recommended to encourage the child to take on appropriate responsibilities within the household (like taking out the garbage, cleaning one's room, etc.).

4. **Quality of Sleep**

As previously mentioned, disruptions during a night's sleep occur in approximately 50 percent of children diagnosed with ADD/ADHD; sometimes, just improving the quality of sleep and lengthening its duration bring about a significant improvement in symptoms. Most sleep disorders stem from a breathing disorder or an emotional disorder—mostly related to anxiety-inducing situations.

Disturbances in sleep due to a breathing problem (typically with a history of enlarged tonsils and/or adenoids and/or a chronic cold) are usually expressed in breathing through the mouth, cessations of breathing, snoring, hyperactivity during sleep, light sleep, and early awakenings during that light sleep. Besides the negative consequences of ADD/ADHD, a breathing disorder is bound to cause distortion in the development of the jaw bones, which will necessitate expensive and unpleasant orthodontic treatment. Therefore, it is important in the first stage of the evaluation to counsel parents to observe their child when sleeping, in order to confirm or reject the need of an evaluation for blocked airways. If an evaluation is needed, the parents should refer their child to his or her primary care physician or to an ENT.

Disturbances in sleep due to an emotional disorder (usually anxiety) will usually manifest in difficulties falling asleep, waking up early, nightmares, talking and screaming in one's sleep, and somnambulism.

Of course, one must consider a combination of the two factors (breathing problems and emotional problems), in order to get further clarification regarding sleep disorders with a history of anxiety. It is important to examine such symptoms in comparison with symptoms of anxiety displayed when the child is awake.

Sleep disorders can also stem from external factors, such as a bedroom temperature that is too high or too low; mosquito bites, pinworms, or parasites; noises and the like. All of these must be taken into account during the evaluation. If there is doubt as to the reason for the sleep disturbance, it is recommended that the child be tested at a sleep lab or with a home sleep test in order to explore the possibility of neurological reasons such as epileptic episodes or heart problems.

In the context of quality of sleep, it is important also to pay attention to the recommended sleep duration, which gradually decreases with age. It is also important to note that sometimes even an extra half hour of sleep is enough to significantly improve symptoms during the day.

Here are the *total* recommended sleep hours (from the moment of falling asleep to the moment of waking up in the morning) in accordance with different ages:

Child's Age	Recommended Daily Sleep Hours
3-5	11.5-13
6-8	10.5-11.5
9-11	10-10.5
12-14	9
15-18	8-8.5

A child experiences the falling-asleep stage as a transitioning from a condition of awareness and conscious life, in which she controls what goes on around her, to a condition of unconscious life in which she experiences a lack of control. That is why many children experience some sort of anxiety during this stage. To remedy this, it is recommended that an appropriate and calm environment be created for the falling-asleep stage, one in which the parent can dim the lights, read an age-appropriate story, and, if possible, say a blessing for the child before or after she falls asleep.

> The main internal attitude that parents must take is the effort to *be interested in* the child as much as possible.

It is recommended that children who have a hard time falling asleep be referred to and treated by a doctor with experience in the field, in order to find an appropriate individual treatment for them. At the same time, recommended supports include massaging the child's body (hands, feet, chest, and abdomen) before sleep with lavender oil diluted to 10 percent concentration. If parents feel that their child is overwhelmed by daily impressions, Solum oil (extracted from peat soil and creating an enveloping protection for the skin) is recommended for a four-to-six weeks' use. Similarly, in certain situations, plant extracts such as *humulus lupulus* (hops), valerian, Passiflora (passion flower), and *Avena sativa* (oat) can be helpful before sleep for a period of between one and six weeks. (It is recommended to consult with a physician first.)

Support In The Classroom

A strong empathic connection between a child suffering from ADD/ADHD and his or her educator is a necessary condition for the success of supporting the child, as part of the communication described in the multidimensional model at the beginning of this chapter. One of the options for establishing this communication is a "correspondence notebook," in which the teacher reports to the parents and the parents report to the teacher each day about both out-of-the-ordinary and positive incidents experienced by the child. Under such circumstances, the child will trust the teacher, and therefore cooperate better with the teacher. In order to avoid classroom reprimands, the teacher can establish ways to communicate with the child without words; for example, by agreeing on a sign that the teacher can use during class when the child is restless. The child can then go out to the yard, do a physical activity previously agreed upon (such as running a certain route or walking on a beam), and then immediately return to the classroom. If the child responds by doing what was agreed upon, it is important that he or she receive positive reinforcement from the teacher after class.

Because many children diagnosed with ADD/ADHD feel like outsiders in their classroom, it is important that teachers make sure to set up *empowering* activities for them. Giving them a specific responsibility tied to the classroom activities and space, such as assigning cleaning volunteers and/or reminding the students of the schedule, is a good example of an empowering activity. During morning circle, the child should be placed in the center of the circle (it is preferable in second and third grades to have two or three other children with the child diagnosed with attention deficits) and given the opportunity to lead rhythmic exercises with help from the teacher (depending on the age of the child), either alone or with another child, while the other children in the circle offer their encouragement. It is important that the teacher is aware of the child's successes and give him or her appropriately emphasized positive reinforcement. It is preferable for the praise to be stronger than the praise given to the other students who do not suffer from ADD/ADHD, and sometimes the more praise the better. The teacher can also summarize for the child each week's meaningful incidents and experiences and lay out expectations for what the child could achieve the following week.

Parents face an additional challenge in creating multiple opportunities for children to do handcrafts, which would involve a cheerful experience as well as one that awakens motivation.

Singing in at least two voices or a round are good exercises that could improve the child's ability to concentrate and focus. Rounds or singing in two voices are usually very difficult for such children, because they have to, on the one hand, develop inhibitions toward the song they are hearing but *not* singing, and, at the same time, focus on the song that they *are* singing. Beyond the fact that the child is exercising concentration and focus, she is also experiencing being a complementary part of the class that is singing one musical piece, comprised of many voices. The essence of this exercise, which can be called "exercise in two voices," can be applied not just to singing, but also to various movement exercises, such as rhythmic movements, Bothmer gymnastics exercises,[6] rhythm exercises using the limbs, playing instruments, and in recitation, whether at home with a parent or at school—this has proven to be very effective.

Because children with ADD/ADHD have shown great sensitivity to the measure of interest invested in them, the level of consciousness the teacher dedicates to them during class is essential; it is important that the teacher make an effort to consciously hold in his mind the children with ADD/ADHD. In any given class, on average, there are about three or four children with ADD/ADHD and two or three children with an anxiety disorder. The teacher can choose to dedicate a certain amount of time (for the duration of a month, for example) to truly be conscious of one child, giving full attention and conscious awareness to this child, to his or her level of attention during class, and focusing the teacher's own at-home meditative activities on this specific child.

Another important guideline is to take the complex assignments given to the class and break them down for the child with ADD/ADHD into smaller assignments—all of which make up the bigger, more complicated assignment. Complex assignments will overwhelm the child emotionally and will keep him from doing the task.

It is important that the teacher is aware of the fact that about one-third of children suffering from ADD/ADHD also suffer from learning disabilities (or also from a sensory and/or emotional regulation disorder), and, therefore, that difficulties in writing, reading, or math

6 Bothmer Gymnastics consists of special exercises developed in the context of Waldorf education.

could be tied to learning rather than to the child's lack of willingness to learn.

Medicinal Treatment

Medicinal treatment plays a central role in the treatment of ADD/ADHD. As mentioned previously, the most accepted and most common treatment in conventional medicine is Ritalin (methylphenidate) and other stimulant drugs of the same family. Anthroposophic medicine does not categorically reject the use of these medications, but their usage is a last therapeutic resort. The use of Ritalin and other similar drugs is recommended when the child becomes socially rejected, and/or when previous treatments have not helped, and/or when there is no treatment adherence on the part of the school or the family. In instances in which the child suffers from isolation and social rejection, it is preferable to use Ritalin for a defined amount of time, despite the fact that it is fully a symptomatic medication accompanied by side effects, since prolonged social rejection during childhood can cause irreversible emotional damage in adulthood. In these instances, one may supplement the treatment with anthroposophic cures intended to reduce the side effects of Ritalin and the harm it does to the life forces in the organism. Accordingly, the need to continue using stimulant drugs for treatment must be revisited every few months. If use of the stimulant drug leads to side effects, it is recommended to refrain from taking it on weekends and during school breaks, in order to allow the brain's metabolism to recuperate and function on its own from time to time.

Because many children diagnosed with ADD/ADHD feel like outsiders in their classroom, it is important that the educator makes sure there are *empowering* activities for them.

Individual Recommendations

As a basis for individual recommendations, one can use the viewpoint of anthroposophic medicine to evaluate three main manifestations observed in children who suffer from ADD/ADHD. These three typical manifestations are based on the image of the three systems: the Nerve-Sense System, the Rhythmic System, and the Metabolic System.

First Type: Children with Hypersensitivity in the Nerve-Sense System

Most of these children (but certainly not all) are endowed with the constitution of a smaller head, they are thin and often pale, and their facial features and limbs seem relatively sharp. They tend to have a lower body-temperature than the norm and a relatively weak metabolic system, and their will forces tend to be weaker than normal (though they display great restlessness of the limbs). Some of them will be hypersensitive to noise, smell, or touch, and some of them will even be diagnosed with a sensory regulation disorder. Many of them will give off the impression that they are a little older than their biological age, an impression that occasionally attests to relative weakness in their life forces. Some of these children will have a history of being born prematurely (about 20 percent of premature babies suffer from this disorder, seemingly because of an immature development of the nervous system) or of a "failure to thrive," in terms of their body-weight during their early years. A substantial number will be diagnosed with a sanguine or melancholic temperament.

Because many of these children's body-temperature is lower than average, rhythmical massage can be beneficial to them, as it stimulates the body-temperature and the life forces. Another reason for this kind of treatment is that the skin, the receptor of the massage, is the largest sensory organ and is integral to the nerve-sense system. Because these children suffer from hypersensitivity within the nerve-sense system, a treatment such as this can "thicken" or desensitize the life forces within this system, becoming a protective shield and strengthening the barrier between their nerve-sense system and the external world. Massage oils specifically recommended for these children include hypericum (or St. John's wort), especially when the child also suffers from anxiety, or lavender in the evening and rosemary oil in the morning. If there is a history of head trauma or any kind of past injury, it is worthwhile to add arnica oil. If a skilled rhythmical massage therapist is not available, one may be able to find a nurse who has undergone training in rhythmical oiling.[7]

In many instances, craniosacral therapy has also been shown to be beneficial, as it balances the life forces and releases blockages in the system of life forces within the nervous system.

It is recommended that when a teacher approaches such a child, the teacher should do so from the periphery and not in a direct, frontal way. It is advisable to

7 Further reading on the rationale of the rhythmic massage treatment can be found in this book's appendix.

speak to the child in a low voice, and sometimes even in a whisper near the child's ear.

The Foremost Recommended Treatments for Children of the First Type

Music Therapy: Because the input pathway for this treatment is a sensory organ (the ear), and because some of the children suffering from ADD/ADHD are also hypersensitive to noise, or alternately may experience hearing loss (usually due to a buildup of fluid in the middle ear), music therapy is meant specifically to mitigate the hypersensitivity to noise, or, alternatively, to sharpen their sensitivity to specific sounds in cases of hearing loss. Because the anterior spatial input is processed through the sense of sight and the posterior spatial input through the sense of hearing, and because the anterior spatial input is emphasized in most cases with these children and the posterior spatial perception is "blurrier" or duller, the children can become attuned to their posterior space via therapeutic stimulation of the sense of hearing. This creates a more balanced spatial experience and even strengthens their sense of equilibrium, which is anatomically tied to the inner ear. In this kind of therapy, a song should be rehearsed in two voices or in a round, a practice that has been proven effective for children with attention disorders. Playing the cello is highly recommended for such children, as it is a string instrument with a propensity to the rhythmic system and also to the metabolic system, due to its warm sound and to its placement in relation to the body when played. One can read more about music therapy in this book's appendix.

A child's attention to his posterior space can also be strengthened by **curative eurythmy**.[8] Rhythm exercises, practicing consonants such as L and M, as well as the series Steiner describes in his course for therapeutic education: M-N-B-P-A-U, help the child to better inhibit involuntary movement of his limbs and give meaning and direction to his limb movement.

The **curative eurythmy treatments** that have been found effective for children include one of the following homeopathic remedies: quartz, amnion, and conchae (Calcium carbonicum), which are meant to protect the nerve-sense system, and plant extracts such as Cichorium (chicory), Carduus marianus (milk thistle), Taraxacum (dandelion), among others. These treatments or a diluted version of them aim to awaken the metabolic system and thereby enable the flow of life forces to the nerve-sense system. One can read more about the rationale of the anthroposophical medicinal treatment in this book's appendix.

Second Type: Children with Hypersensitivity in the Rhythmic System

Children categorized in the second type will be diagnosed with ADD/ADHD, with leading symptoms being impulsivity and anxiety. Hypersensitivity in the rhythmic system and emotional overload are especially prominent in these cases, in addition to the variety of symptoms of ADD/ADHD. It is especially important to perform a differential diagnosis to distinguish children who display these symptoms from children who suffer from Oppositional Defiant Disorder, who also display temperamental emotional behaviors. Many of the children with hypersensitivity in the rhythmic system are emotionally agitated, and most of them are subjected to prolonged stressful situations within their families and/or within the educational framework. Some of them have a background of having been subjected to recurring bullying or having sustained minor trauma, or having a substantial case of mental trauma. The emotional overload, the tension and the anxiety will stand out in their behavior, and some of them will also exhibit such traits as perfectionism, competitiveness, manipulation, and jealousy in social situations. Low self-image and low self-confidence are certain to be found under the surface. Among some of these children, an arrhythmia and/or a heart murmur may be discerned in a physical exam (most of which will be innocent murmurs, without clinical significance), or a respiratory disturbance, usually asthma. The proportion of respiratory rate (speed of breathing) to the heart rate will be lower in these children; after age ten, it should level out at a proportion of 1:4 (breath to heartbeat) and may be closer to five to six heartbeats per one breath. Therefore, it is important in the first stage of therapy that the treatment focuses on strengthening the presence of the "I" in the rhythmic system. This presence organizes the physiological and emotional processes in this system, especially at the ages of nine and ten, the years in which the sensory system of the child organizes itself with greater intensity.

> In any given class, on average, there are about three or four children with ADD/ADHD and two or three children with an anxiety disorder.

Therapeutic attention to the familial and social environments is extremely important with children of this type. It is highly recommended that parents receive guidance or participate in family therapy, in order to (1) minimize tensions and competitiveness within the family framework, (2) refrain from secrets within the family and

8 The recommendations for curative eurythmy exercises are intended for therapists who have been trained in the field.

from cynicism, (3) encourage authenticity and transparency on the side of the parents, and (4) increase positive reinforcement toward the child. Attention to the child's relationships with his siblings is important, especially when the children are close in age. One may recommend to parents a weekly quasi-celebratory family get-together (preferably outside of the house), where activities such as a listening circle can be implemented, giving each family member the opportunity to speak about what happened to him or her during the past week, as the others listen. An additional recommendation found to be beneficial for these children is weekly rhythmic activities (preferably ones that involve motor skills or arts and crafts of any sort) in which the child enjoys spending one-on-one time with each parent once a week. There is a greater expectation of sleep disturbances with these children, so it is essential to ensure sufficiently long, quality sleep. The emphasis on a healthy family life for these children stems from the need to strengthen their trust, confidence, and sense of belonging, which are most often unstable and comprise the source of their turbulent behavior.

Complex assignments will overwhelm the child emotionally and will keep him from doing the task.

There also must be an authentic connection between these children and their class teacher, as this can influence and support them in their social connections with their peers.

Recommended Treatments and Activities Proven to be Effective for Children of the Second Type

Art therapy is highly advised because it immediately turns the child to the world of emotions, through which the child's own emotional world can be balanced and organized.

Curative eurythmy therapy is recommended for balancing the child's rhythmic system. This treatment is especially beneficial when there is any kind of disturbance in the heart rate or the respiratory system (such as asthma). The L-A-O-U-M sound sequence is very fitting for these children, and it is important to try and evaluate whether the source of the hypersensitivity is the heart (in which case the exercise called Gesture E should be added) or if the source is the respiratory system (in this case, Gesture U should be added).

Music therapy: Playing a musical instrument and joining a band or a choir is recommended and especially practicing singing in two voices or in a round. It is advisable for these children to learn to play a string instrument such as a lyre, a harp, a violin or a cello, which all have an affinity toward the rhythmic system.

Involvement in groups in order to gain social skills.

Psychotherapy for adolescents.

Recommended medications are homeopathic remedies of Aurum (gold) and Ferrum sidereum (meteoric iron) and plant extracts like Hypericum and Bryophyllum, which have an affinity with the rhythmic system.

Third Type: Children with Hyperactive Metabolic Systems

The prominent characteristics of ADD/ADHD in these children are impulsivity and hyperactivity (in movement), and sometimes aggressiveness. These children are characterized by an alert metabolic system; they are full of life, in a way that can give off an impression similar to that of many horses hitched to a cart and running, but each one pulling in a different direction. Most of these children will have a choleric temperament and a strong body temperature (though not above normal). Charisma and leadership traits will be prominent, which, if not channeled in the proper direction, are likely to be expressed as domineering and even terrorizing other children in their environment. It is important to "harness" these children and direct them to positive leadership and assignments involving taking on responsibilities in the classroom and at home with the family. These children need challenges. It is therefore recommended to encourage them to take part in an action sport, such as rock climbing, surfing, or horseback riding. Each of these activities demands that the child concentrate her planning and formative forces within her metabolic and motor system.

Recommended Treatments for Children of the Third Type

Musical instruments recommended for them are the clarinet, the trumpet, and the French horn, since, with these instruments, the musician must integrate his or her formative forces, which flow from the nervous system, with his or her strong will forces coming from the metabolic system.

Curative eurythmy is recommended in order to integrate the vowels A and U as well as the sequence M-N-B-P-A-U. In order to bring the formative forces into the movement of the limbs, this therapy should also make use of rod, rhythm, and skipping exercises, as well as movements that follow the five-pointed star pattern and an inward spiral movement with the consonant B.

An effective exercise recommended for this category of children is to "write" shapes with the sole of the foot.

Effective exercises for all children that cannot be classified in any of the three types:

The sequence D-F-G-K-H, which is recommended to perform while jumping; the exercise called "Iambic-A" (the iamb is a short-long rhythm), and the vowel U, with which it is recommended as an ending for almost every process in curative eurythmy.

If the child is diagnosed with only ADD and not ADHD (ADD + hyperactivity), it is recommended to practice the sequence R-L-S-I mentioned in the course for curative educative, which has been found to be extremely effective, as well as Trochee-A (the Trochee is a long-short rhythm).

Case Study: Mattan's Story

(The italicized words indicate typical traits of ADD/ADHD.)

Mattan (name altered) was born in a spontaneous birth at 40 weeks with a healthy birth-weight; following a healthy gestation, he was the first child of parents in their thirties. Both parents were healthy, other than a diagnosis of *dyslexia and ADD* the father received in his adolescence. During an earlier pregnancy, about a year before Mattan was born, his mother suffered a spontaneous miscarriage in the 22nd week; the fetus was stillborn and was delivered vaginally. During her pregnancy with Mattan, the mother suffered from *anxieties* and sleep disturbances (the anxiety was most likely tied to miscarrying the first pregnancy). She describes her pregnancy with Mattan as characterized by *significant movements in the womb*. A week or so after Mattan's birth, the mother was diagnosed with *postpartum depression.* The mother continued to nurse him, but it was mainly Mattan's paternal grandmother who took care of him during his first three months of life. During these months, Mattan suffered from *infantile colic.* At the end of three months, the mother's depression has somewhat abated and she began taking care of Mattan with help from a babysitter. She continued to nurse him until he was one year old; she then placed him in a day-care twice a week for six hours.

Anthroposophic medicine does not categorically reject the use of these medications, but their usage is a last therapeutic resort.

Mattan's motor and language development was satisfactory, aside from his *speaking before walking.* He spoke his first words at ten months and uttered short sentences at one year old; he began walking at fifteen months. The first three years of his life, Mattan suffered from *sleep disorders* that presented as difficulties falling asleep and waking up multiple times a night.

When Mattan was two-and-a half-years old, his brother was born. At this point, Mattan started attending nursery and after-school care. Mattan was toilet-trained a little while before his brother was born, but a short time after the birth, he regressed and began soiling his pants (*encopresis*). During his first year in nursery, he demonstrated signs of restlessness at mealtimes; he had a *hard time imitating* the activities in the morning circle; and he would cover his ears when the teacher was singing. At age four-and-a-half, Mattan received a diagnosis of *sensory regulatory disorder*, at which point he began occupational therapy; he then began first grade at age six-and-a-half.

Throughout first grade, the teacher noticed Mattan's *hyperactivity*, his *incessant talking, making sounds, and annoying other children* during class, as well as his *difficulty in accepting her authority*. She also recognized that Mattan was not internalizing successfully what he had learned in class, and his notebooks contained partial and chaotic renderings of the letters and numbers taught. At the same time, the teacher noted that Mattan demonstrated great knowledge and high motor skills relative to the other kids in his class, and that he was able to get other kids to follow his lead in activities such as climbing trees, building forts, and playing ball games, but also in organizing a group of children to *annoy other children*.

In the afternoons, Mattan tried every which way *to get screen time* (computer, TV, smartphone) despite his parents' attempts to prevent that—attempts that were accompanied by multiple reprimands. It was during this time that he began to exhibit *difficulty in preparing to go to bed* in the evening and in *preparing to go to school* in the morning. For Mattan, these phases were characterized by distractedness, by annoying his brother, and by many fights with his parents.

Ever since Mattan's grandmother had become involved in raising him, *conflicts* erupted between his grandmother and his father regarding family habits (mostly in relation to the grandmother's child-rearing approach, which supported screen time); and the conflicts grew into prolonged arguments and caused tension between his parents. During second grade, as his behavior at home continued to deteriorate, while the tensions

between his parents worsened and his teacher reported troubling behavior in the classroom, Mattan was diagnosed with ADD/ADHD and Ritalin was recommended. The parents turned to parental guidance specializing in the "Here and Now" style (Present Moment Therapy).

During the course of the therapy, the parents realized that they were at a watershed moment, where they would either separate or make a drastic change in the family's lifestyle. The parents chose the second option. This included: (1) improving their relationship as a couple, which had been replete with tension (and was neglected in the previous two years), (2) relaying a unified message to Mattan and his grandmother, (3) setting clear boundaries to his screen time and to his annoying his brother. The parents also made sure to provide (4) meaningful positive reinforcements, (5) fixed schedules (or rhythms) of bedtime and meals during the day and the week, (6) a nourishing breakfast every morning, (7) conditions for extended sleep time, (8) routine activities for Mattan twice a week – once with his mother (baking bread) and once with his father (rock climbing), (9) daily correspondence with Mattan's teacher, (10) medicinal therapy (anthroposophic and homeopathic), as well as (11) treatment with rhythmical massage, alternated with (12) curative eurythmy, for a period of three months.

Emphasis on a healthy family life for these children stems from the need to strengthen their trust, confidence, and sense of belonging, which are most often unstable and comprise the source of their turbulent behavior.

In a collaborative decision, Mattan's therapists, guidance counselor, doctor, teacher, and parents resolved to maintain a focused therapeutic effort for three months, both at home and in the classroom. Within two weeks, there was significant moderation in Mattan's impulsivity and an improvement in his ability to concentrate, even though his hyperactivity and distractedness in school continued. Mattan began to recite parts of the morning verse in class and to partially engage in imitation and singing during the morning circle; his notebooks became populated with more writing, colors, numbers, and drawings. A change could also be seen in Mattan's social relations, and he became a charismatic personality in the class. He would lead the group in morning jogging. He meticulously took the responsibility offered to him to lead the rhythm exercises in the morning circle together with the teacher. In addition, he was charged with helping the teacher take attendance, reporting on the state of the moon the previous night, and distributing paper and crayons during drawing class. After three months, the therapeutic team decided to end the curative eurythmy and rhythmical massage sessions, while continuing with the medicinal therapy and parental guidance until the end of the year.

At the end of second grade, it was obvious that Mattan was able to internalize a measured portion of the writing and math taught in class, that there was a partial improvement in his ability to imitate and to delay gratification, along with a significant improvement in his social standing, his mood, and his self-confidence. It was also clear that there was still plenty of room for improvement in controlling his hyperactivity and in the length of time he was able to fully concentrate. In third grade, Mattan needed to continue the anthroposophic medicinal treatment for the entire school year and went through two cycles of eurythmy therapy. His parents continued with the couples' therapy for a full year, which helped tremendously in strengthening and deepening the bond between them, a fact that significantly lowered the tension level at home.

Throughout third grade, it became clear that Mattan was successfully internalizing what was taught in the majority of classes. His ability to stay focused improved, though not fully, and while there was a noticeable reduction in his distractedness, his hyperactivity continued. The main improvements were seen in his social relations, in his impulsivity, and in his ability to delay gratification.

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This case study presents the developmental process of a child developing ADD/ADHD with its known traits, in which it is clear how genetic factors (apparently from the father) and environmental factors (the anxiety of the mother during pregnancy and the damaged pattern of relating to her following the postpartum depression) came together in the development of the disorder.

In a midway review, the treatment was perceived as relatively successful. Mattan did succeed in internalizing and learning, in a satisfactory way, what was taught in class, and to integrate successfully as a charismatic figure in the class' social fabric, with *significant* improvement in his impulsivity. At the same time, it was clear that only a *partial* improvement was made in Mattan's distractedness and the hyperactivity. However, this was achieved without the use of stimulants.

The relative success of the therapy must be attributed, to a great degree, to the substantial efforts of the parents and to the meaningful process in which they decided to set Mattan's wellbeing as a high priority in their daily routine. Their decision to stay together and improve their own relationship, to fill it with meaning, and, in doing so, to contribute to the cohesiveness of the family, served as a significant factor in the improvement of the condition of their son. It is safe to assume that despite the parents' coming together for Mattan's sake, he still would not have improved to such a degree without the various treatments he received—the medicinal therapy, the eurythmy therapy, the massage therapy, and the commitment of his teacher to invest in his treatment.

To summarize this chapter, it is worth repeating that the key to the success of a treatment is first and foremost in the approach of the educators and therapists, meeting the child in a position of great respect, seeing that the child is a spiritual being who is attempting to express itself through a physical body, and in attentiveness to and interest in the child's skills and his or individualized will, which the child strives to realize. Indeed, a close look at successful treatment cases reveals that they involve a significant and consistent investment in the child by the parents and the educational team. Such successful treatments also follow many of the recommendations to the family and educators mentioned here.

Final Note on Attention Deficits and the Culture of Attention Deficits

A common question among parents of children suffering from attention deficit disorder is: How could it be that the child can be so focused while he is watching screens and certainly when he is playing computer games, and yet he cannot listen or concentrate in class? The well-known answer given to this question is that children suffering from ADD/ADHD have a very hard time developing attentiveness and concentration when the assignments bore them – assignments that may not be especially challenging but that allow the majority of children in the class to maintain their focus. Therefore, if the lesson the child is in is not especially challenging, it will be experienced as boring. Neurologically, it is known that the majority of children suffering from ADD/ADHD exhibit under-stimulation in the electrical activity of the brain, and only during challenging assignments does stimulation gain momentum and peak—and only then does it allow the children to engage in effective focus.

This is why these children succeed in forming and attaining a high level of focus in challenging activities such as horseback riding, surfing, rock climbing, and computer games, sometimes even attaining success beyond the norm of children their age. It is clear from this that these children (and this is true to a great degree also about adults suffering from ADD/ADHD) swing from extreme to extreme, from boredom that leads to hyper-distractedness accompanied by under-stimulation of the brain, to a high ability to focus accompanied by high brain stimulation.

A comprehensive observation of the culture forming in our times in the Western world discovers a macrocosmic picture displaying similar traits to the ones manifested in children suffering from ADD/ADHD. Generally speaking, and without trying to offend too many individuals, it can be said that a similar pattern can be seen in many of the adults living in the affluent West today, going from situations of boredom (such as watching television, surfing the internet, etc.) to searching for excitement and challenging endeavors—from extreme sports to increasing usage of psychoactive substances and addictions, among them the new addiction to the social network. Observations of the ADHD culture that encompasses our lives, and then of the steady increase of ADD/ADHD in children, could lead to the conclusion that one of the tasks of these "special" children manifesting ADD/ADHD is to reflect back to us the culture of attention deficit that we adults have created. The question we need to ask ourselves next is: Do we want to deal with this problem?

Translated from the Hebrew by **Sara Davis**

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