

## The fidgety child – bane of both parents and teachers but an opportunity for your BRT practice

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### INTRODUCTION

They were different times. It was shortly before Christmas 1844 when Dr Heinrich Hoffmann wrote and illustrated the story of Struwwelpeter (shock-headed/slovenly Peter) because he could not find a suitable picture book for his 3-year-old son Karl.

They were different times yet, even in 1844, he still existed: Zappelphilipp, the fidgety child. And the man knew what he was writing about: he was a psychiatrist in Frankfurt. There was something else as well in 1844: helplessness to treat the condition. The lines of the verse tell it all: "... And the mother looked very grave / To see Philip so misbehave." But the father does not achieve much either with his words which attempt to heal the situation: "Let me see if Peter can / Be a little gentleman. / Let me see if he is able / To sit still for once at table. / Thus spoke, in earnest tone, / The father to his son." [Translator's note: reference to Die Geschichte von Zappelphilipp – The Story of Fidgety Philip. English translation from Slovenly Peter or Cheerful Stories and Funny Pictures for Good Little Folks. Philadelphia, John C. Winston Company.]

The continuation to the story is well-known: immediately after his father's warning, Philip brings the midday meal to an abrupt end.

So helplessness to treat the condition back in 1844 and far greater helplessness on my part in 1993 in the face of the many hyperactive children brought by equally helpless parents to my large Duisburg general practice dealing in internal medicine. Now (2001) looking back on the considerable number (109) of hyperactive children I have treated mainly successfully and some even very successfully, I am glad to agree to the request to report on my experiences and to explain the route

which has brought me to this point. My report is deliberately ordered chronologically as I believe it will make my experiences more vivid.

### INITIAL EXPERIENCES

So let us go back to 1993. In the years up to this time I had frequently referred hyperactive children to the (child) psychiatrist. Probably not the wrong approach either in view of traditional medicine's helplessness to treat the disorder. Let us remember: at that time treatment with Ritalin was all the rage. What made me rethink my therapeutic practices in 1993 and look for a promising therapy? Well, it was experiencing the amazing success of BICOM therapy in other fields. I began using bioresonance therapy in early 1993 and it filled me with real euphoria and virtually boundless optimism as to the possibilities for therapy. I was particularly taken with Dr Schumacher's method of treating allergy. I had become familiar with the biophysical allergy tests. Based on these techniques, I had succeeded in developing a test method for determining patients' current vital substance requirements. It was actually just an inverted allergy test. While allergy tests ask about intolerance, in my vital substance test I specifically ask about tolerance. I have had, and continue to enjoy, considerable success with this method in sports medicine. It would take an entire lecture to describe the method in detail. But I would like to explain this much: taking the example of Dr Schumacher's allergy test set, I created a test set containing a total of 66 vital substances: trace elements, macro- and micro-minerals, vitamins, enzymes and combined preparations. This test set is then "worked through" on the individual patient, as with the Schumacher test set, only with conditions reversed. A complete list of this test set is available from REGUMED.

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Colloquium staged by the International Medical Working Group BICOM Resonance Therapy and BICOM Resonanz-Therapie-Gesellschaft from 3 to 5 May 2002 in Fulda

But let us return to the hyperactive child. Although orthodox medicine may have no effective treatment, there is still general consensus in the extensive literature as to the aetiological factors surrounding hyperkinetic syndrome. I shall attempt to summarise them here.

In hyperkinetic syndrome:

1. certain vital substances are deficient
2. there is an oversupply of disturbing substances
3. an essential factor exists which has so far not been defined in more detail
4. there are diseases which typically frequently accompany hyperkinetic syndrome
5. there are prevailing conditions which aggravate the intensity of an existing hyperkinetic syndrome.

The optimism which overcame me in 1993 was based on the following considerations: I had valid test procedures for the aetiological factors mentioned in 1 and 2. So I could optimise the current and individual situation as regards vital substances and, with the cooperation of the parents and the child, eliminate harmful substances.

#### THERAPEUTIC APPROACH

The approach in detail.

**1<sup>st</sup> factor:** In the first 4 weeks of treatment the current vital substance requirement for two weeks is determined from the patient using EAV and kinesiology or from drops of blood using the biotensor. The substances are prescribed on private prescription or under the social health insurance system. Where substances are available over the counter, suppliers are indicated. Parents are asked to ensure that the substances are taken and report any intolerances (very rare!) immediately. These extremely rigorous arrangements substantially reinforce compliance. In the first few days the patient and family are still often reluctant to cooperate. However, this situation improves when the first signs of improvement appear, generally very soon. And it is not just parents and teachers who welcome the improvement. The children themselves almost always experience the improvement as an inner release, in other words, they too suffer as a result of their disorder.

**2<sup>nd</sup> factor,** i. e. the attempt to eliminate disturbing substances. The approach is twofold: firstly general rules of conduct must be explained in detail to the parents, and also, most importantly, to the child itself. As there is no doubt that phos-

phates, sugar and food colourings and preservatives increase the intensity of hyperkinetic syndrome, the foodstuffs which, as a rule, contain these substances, should be named in general terms. In addition, the parents are given a list of foods which are allowed and which to avoid. As well as these general recommendations, individual intolerances are also tested using an extended test set based on that of Dr Schumacher.

The test method is extended as follows: small quantities of the child's favourite foods, treats and drinks are placed in small glass test tubes with plastic stoppers (available from Regumed). Examples: children's chocolate (very often triggers severe exacerbation), jelly babies, lemonade, etc. The extended test set is ready. The actual testing is performed as described earlier. When the test results relating to vital substance requirement and intolerance are rigorously implemented, a marked improvement in the symptoms can be observed in most patients.

#### COMBINED THERAPY

However, a breakthrough in therapy came only when the above measures were combined with BICOM therapy, which I shall now talk about.

Let me go back to my list of aetiological factors at this point. No. 3 mentions an essential factor. Now orthodox medicine talks about an essential aetiological factor when it considers it obligatory but does not know what it is. Well, I do not want to presume to know this factor and/or be able to place it in a context which can be described with scientific accuracy. However, in the course of my work as a doctor, I have developed a sort of "pathophysiological model" of the hyperactive child and, in this "abdominal model", two factions are in conflict in the CNS : one inhibiting and one accelerating. And the inhibiting faction loses, i. e. the accelerating impulses prove dominant in the CNS.

The efficacy of Ritalin therapy supports my model: Ritalin is a central analeptic. From the viewpoint of formal logic, an analeptic, i. e. a drug which stimulates the central nervous system, should make a hyperactive child even more hyperactive. Since, however, the effect is the opposite, the only logical explanation can be that, in the model with its inhibiting and accelerating factions, the inhibiting faction is activated more strongly, thus gaining the upper hand over the accelerating faction which is already over-activated patho-

genically. More recent anatomical and physiological ideas about the functioning of our CNS appear to confirm this model.

Transferred to a very basic model in bioresonance medicine, this means that oscillations might possibly be too weak, too strong or disturbed. Can bioresonance therapy be capable of eliminating the essential factor or at least of inhibiting it without this factor necessarily being precisely defined? Is there in fact anything to “clear”? I know that the idea that something is cleared using bioresonance therapy is no longer very popular. But remember: this was back in 1993 and I knew little about bioresonance. However: let us put aside whether my model idea is right or wrong. The results are what is important and they are good. And I am sure you can easily convince yourself of this if you treat your patients using the following method. I will not go into the details of my search for effective therapy. Using the principle of trial and error, the following therapy plan was found to be highly effective:

The patient sits with their left hand connected to the input and their right to the output via ball or plate electrodes<sup>1</sup>. Therapy type Ai, all frequencies, constant amplification: beginning with 0.05 (= attenuation) and increasing by 0.05 at each therapy session; so 0.10 at the 2<sup>nd</sup> session, 0.15 at the 3<sup>rd</sup>, etc. If so-called initial exacerbation occurs, resume “old” amplification or even reduce it further.

Therapy is extremely straightforward and can also easily be delegated to an assistant. Obviously it is extremely important that the BICOM user (i. e. the doctor or naturopath) personally carries out the initial consultation and examination and keeps an eye on the patient during the individual therapy sessions and speaks to the accompanying parent.

Frequency: 1 or, at most, 2 sessions per week.

There is generally a marked improvement after 6–8 sessions. Therapy can usually be terminated after 12–20 sessions, almost always with good to excellent results.

On completion of BICOM therapy, vital substance substitution therapy should be maintained. Here *restaging*, or testing out the individual vital substance requirement again, every 2 – 3 months is sufficient. This renewed testing has two essential advantages:

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<sup>1</sup> This applies to all BICOM devices up to BICOM 2000. BICOM 2000 users proceed as follows:  
input: left hand on ball or plate electrode  
output: modulation mat

1. To avoid a relapse through the individual and ongoing needs of increasing adapted vital substance substitution in most patients according to my experience.
2. You have the patient “on a loose rein” and can resume BICOM therapy again for a few sessions should a relapse occur.

At no time did any patient relapse by “lurching” into the type of hyperactive behaviour exhibited before the start of treatment. General and specific dietary recommendations should obviously continue to be observed once BICOM bioresonance therapy is complete. It is not generally necessary to test out individual intolerance again. In my experience the likely outcome is that, during and after therapy, existing intolerances improve significantly, rapidly and permanently. Only in very rare cases do new ones appear.

#### FREQUENT ACCOMPANYING ILLNESSES

As already mentioned at the start, certain diseases are typically frequently associated with hyperactive syndrome, without a direct causal connection being observed. These are diseases such as neurodermatitis, intestinal mycoses and severe amalgam stress. By taking careful note of the patient’s case history and conducting a thorough clinical examination prior to starting the therapy itself, these can either be ruled out or confirmed. These serious accompanying illnesses must be treated separately and they should be treated successfully at least before starting the actual hyperactivity therapy. I cannot go into more detail about treating these accompanying diseases at this point. They are treated according to the well-known rules of BICOM bioresonance therapy.

#### UNFAVOURABLE PREVAILING CONDITIONS

At the start I mentioned prevailing conditions which can adversely affect an existing hyperkinetic syndrome. These are often conditions which cannot be changed, especially in areas representing social focal points. Here are just two examples:

1. Children left entirely to their own devices as both parents work full-time.
2. Children who attend schools where, for example, the percentage of pupils from so-called problem families exceeds 50 % or where over 80 % are foreign. If, moreover, their classmates’ knowledge of German is only rudimen-

tary, this alone means that the teacher is hopelessly overstretched and there is no chance of creating a functional class unit.

Even if these prevailing conditions can only rarely be changed, the therapist should still be aware of them, if only because they are extremely significant for prognosis. Unfortunately, if these adverse prevailing conditions are combined, the prognosis is extremely unfavourable even before therapy begins. Let me put it this way: there are cases where you should seriously consider whether you should even begin therapy. If, for example, a severely hyperactive child is brought to you by relatively indifferent parents simply because they are under a lot of pressure from the school to seek therapy for their child. The parents' involvement is extremely important. However these considerations should not make you pessimistic about therapy. There is no need.

#### REVIEW OF MY TREATMENT

Indeed my case rates, which I should now like to present to you, are cause for considerable optimism.

Total number of cases: 109 hyperactive children (84 boys, 20 girls, aged between 4 and 15). In all cases, in addition to hyperactivity, children exhibited attention deficit syndrome to a greater or lesser extent, very often also pronounced congenital alexia.

Patients were initially recruited solely from my own general practice dealing in internal medicine. Later huge influx due to word of mouth.

In 9 cases out of the 109, therapy was cut short though never due to so-called undesirable side effects. In all remaining cases (= 100) results were at least satisfactory, generally however good to very good. In a total of 10 cases, existing accompanying diseases (neurodermatitis, intestinal mycoses, severe amalgam stress) had to be treated separately. In 4 cases kinesiological exercise therapy was also administered successfully in addition to the standard therapy described. I am not (yet) able to make a general claim regarding the effectiveness of kinesiology as I have only recently included this, undoubtedly excellent, therapy in the range of treatments I offer.

#### DISCUSSIONS WITH PARENTS

Finally I must make the following point. It is very important, both before and during therapy, to discuss the issue with parents or guardians. Parents very often experience feelings of guilt about their child's syndrome. It is extremely important to remove these guilt feelings because it is often suggested to parents by those around them that their child's hyperactivity is the result of a failed or incorrect upbringing. This is all the more worrying for parents when they have to experience painfully that this syndrome cannot be overcome solely by changing the way the child is brought up. Indeed that a style of upbringing marked by severity rather than loving care has an extremely counter-productive effect on the fidgety child. And finally I should like to dispel a "myth". It is not true that the fidgety child is "not quite right in the head", or has minimal cerebral dysfunction. Two of my former patients are already successful students, one taking a physics course, the other in electrical engineering. One of them was awarded a grant for highly gifted students!

#### CASE STUDIES

Let me now present a few case reports. I will describe two typical cases which also illustrate two remarkable features.

##### Case 1

8-year-old boy with pronounced wheat allergy. The child was to be sent to a special school due to severe hyperactivity which was particularly disruptive at school and also pronounced congenital alexia. This patient was my first ever hyperactive child.

I hoped to be able to achieve an improvement in his hyperactivity simply by treating the wheat allergy. This was 1993 and I was using the BICOM 3.2. I was extremely successful in clearing the wheat allergy, as it was then known, after a total of 22 therapy sessions.

Therapy data: plate electrodes, program 999 (Ai, amplification 8, all frequencies, therapy time 4 minutes), no strict abstinence but patient to reduce wheat consumption overall.

Unfortunately this treatment did not succeed in controlling the hyperactivity as hoped. Follow-up treatment of the neurodermatitis which had flared up again after around six months (now with ball electrodes, amplification 64, 4 x 5 minute ther-

apy sessions) finally got rid of the dermatitis yet had only a marginal effect on the hyperactivity.

The patient's mother, now absolutely convinced of the astonishing effect of bioresonance therapy, persuaded me to search for a special BICOM therapy for hyperactivity. Quite rightly, as I now have to admit, although at the time my courage was merely born of desperation.

I have already described in detail the thought processes which guided me in finding a therapeutic approach. So I shall now simply indicate the details of that particular treatment. As the patient had already responded with an exacerbation of his condition during neurodermatitis therapy, I selected data very carefully for the

1st therapy session: Ai, all frequencies, amplification 0.05 (= attenuation), therapy time 3 minutes.

With hindsight, the sensitivity of my first patient was a stroke of luck. It led me to use high attenuation, obviously an approach which is universally valid.

Following vital substances to be taken daily for the first two weeks: ½ bottle Vitasprint in the morning, 1 Folsan tablet midday, 1 Magnesiocard sachet in the evening.

2nd therapy session (one week later): no change to data, but amplification now 0.10.

3rd therapy session (another week later): two changes to data: amplification 0.15, therapy time 4 minutes.

Vital substance substitution changed in line with biotensor testing: 1 tablet Neurotrat S forte in the morning, 500 mg calcium midday, 1 sachet Magnesiocard in the evening.

At end of this week of therapy, hyperactivity symptoms clearly abated while at same time growing confidence and relief as well as first tentative hope on the part of the therapist, i. e. me.

The extremely reliable and cooperative mother monitored the only two dietary recommendations as far as possible: no sweets (applied also to drinks), no ready meals, in other words: preservatives and flavourings. These two dietary recommendations practically eliminated phosphates and colourings. However it meant more work for the mother: cooking each day using fresh, preferably unprocessed, foodstuffs and also strictly supervising what the child spends his pocket money on to prevent him buying sweets at the shop near the school or from the vending machine.

It is generally true that, as soon as therapy first shows signs of being successful, dietary recom-

mendations are followed more readily both in the family home and by the child. A detailed information leaflet which I hand out serves more as a general affirmation and to improve awareness as regards dietary change rather than describing what action individual patients should take.

From 5th week of therapy: amplification 0.25, therapy time 5 minutes.

Vital substances: ½ tablet vitamin B6 Vicotrat in the morning, 1 sachet magnesium Diasoral in the evening.

From the 6th week of therapy I selected amplification 1.0 (i. e. no more attenuation) as an experiment and in the

7th week of therapy amplification 2.0.

Result: therapeutic success now resembled the Echternach procession: 3 steps forward, 2 steps back.

I returned with regret to my original logic whereby I even kept to 0.25 amplification (= attenuation) in the 8th and 9th week and only increased to 0.30 in the 10th week.

After a total of 12 weeks I ended bioresonance therapy at 0.40 amplification (so still with attenuation). I kept up vital substance substitution for a further 6 months.

Meanwhile the young patient had developed so well that there was no more talk of making him change schools. The congenital alexia had also improved substantially. After a further six months it was possible to relax the dietary restrictions to allow occasional sweets, whereby individual tolerance had to be discovered by trial and error.

The former patient is now a trainee electronics engineer with Bayer AG. He is one of eleven selected from over 500 applicants!

However treating hyperactive children does not always run so smoothly and neatly. I now come to my 2nd case study.

## Case 2

12-year-old boy (this was 1998, I had dealt with nearly 100 cases), pronounced hyperactivity with severe aggressive tendencies (just one example: tried to kick his pregnant mother in the stomach). As you can easily see: a real "darling".

I was immediately uneasy. My premonition appeared to come true like a self-fulfilling prophecy: after 6 weeks' therapy nothing had happened although I had treated the patient similarly to the 1<sup>st</sup> case study. Also "playing around" boldly with

therapy data in 7<sup>th</sup> and 8th week brought me up against a brick wall. Attempted daily therapy sessions, Ai amplified up to 64 times, therapy time up to 12 minutes: all efforts were frustrated.

Clinical examination and case history also appeared to rule out the well-known therapy blocks. Naturally I had thought of amalgam stress but the child did not have any fillings. I was at my wits' end! Not just me but the assistant I had trained specially and assigned to bioresonance therapy had her nerves stretched to the limit. Indeed, I even refused to allow her to treat this extremely aggressive patient unless I was there.

"Inspiration" came suddenly and unexpectedly: the mother cancelled the child's treatment session because she had a dentist's appointment for amalgam cleansing. Believe it or not, she had 13 amalgam fillings, most of which were already in place at the time of her pregnancy. The knowledgeable and very cooperative dentist handed all 13 fillings over to the patient. You can guess what happened next. The child was treated with the toxin elimination program (no. 970) and all 13 of his mother's fillings were placed in the input cup. Now therapy started to progress. After initial exacerbation – if it was possible for the condition to get any worse – the overall symptoms dramatically improved. After just 6 toxin elimination sessions at 3 to 4 day intervals, the severe aggression, in particular, subsided to a completely tolerable level. After a total of 10 toxin elimination sessions the whole horrific episode was more or less over.

During the following year, five so-called preventive therapies were carried out which were possibly not necessary. The boy was and remains normal.

This case stands out from the large number of remarkably successful results I have achieved in therapy.

After about a year the family moved north from the Duisburg region so that now, three years on, I have no definite information as to how things progressed. However, I am quite sure that the family would have been in touch if there had been a relapse.

### Case 3

8-year-old boy, pronounced hyperactivity, extreme hyperkinesia, can only ever remain seated for a few minutes at school, no increase in aggressiveness, pronounced congenital alexia. Agitated from the first few days of his life onwards, indeed pronounced

"hyperkinesia" in the final weeks of pregnancy. Hyperactivity aggravated by passive smoking.

Results of biotensor testing on the BICOM device – independent of case history (The assistant who conducts biotensor tests in our practice does not know the patient's case history):

- extremely positive test response to cigarette smoke
- excessive sensitivity (beyond that customary with hyperactive children) to industrial sugar and several colourings with E numbers

Success achieved by testing out and avoiding disturbing substances has shown that the following recommendations apply to all hyperactive children. Avoid:

- cigarette smoke
- sugar
- coloured sweets.

It appears trivial and unnecessary to highlight the consequences for diet/lifestyle arising from testing, yet (unfortunately!) it is essential.

#### Vital substance analysis for the first 2 weeks:

- in the morning: ½ bottle Vitasprint (vit. B12)
- midday: 1 Zinkorotat 20
- in the evening: 1 Magnesium sachet

#### ***BICOM program***

The patient was treated with the BICOM device once a week for 12 weeks.

1st week: Following program must be input manually: Ai, all frequencies, amplification 0.05 (= attenuation), interval, therapy time 2–3 minutes.

In subsequent weeks the same setting was selected but the amplification was increased by 0.05 each time.

Vital substance requirement for the 3<sup>rd</sup> to 6<sup>th</sup> week of treatment tested out:

- in the morning: ½ bottle Vitasprint (vit. B12)
- midday: 1 B1 Ratio tablet
- in the evening: ½ 500 mg Löscalcon effervescent tablet

A marked improvement had already occurred after the 5<sup>th</sup> week.

Vital substance requirement for the 7<sup>th</sup> to 12<sup>th</sup> week of treatment tested out:

- in the morning: 1 Neurotrat forte
- midday: 500 mg Löscalcon
- in the evening: 1 Magnesium Diasporal sachet

BICOM therapy was terminated after 12 weeks. Now therapy consisted simply of:

- continuing to avoid disturbing substances, with sweets even being allowed in small quantities, but exposure to cigarette smoke still taboo!

Vital substances for further 3 months:

- in the morning: 500 mg Calcium
- midday: 1 Zinkorotat 20
- in the evening: 1 Mg effervescent tablet
- and also 3 x week: ½ bottle Vitasprint (vit. B12).

Vital substances were administered for 6 months.

The child's behaviour could then be described as follows: normal behaviour at school, can sit quietly, congenital alexia much improved. Behaviour outside school: can play properly on his own and with other children which was unfortunately not possible beforehand. Overall: teacher, mother (single parent) and child himself are very satisfied. The child was able to eat everything again although care should be taken to maintain a sensible diet.

### **BICOM 2000**

I have had a BICOM 2000 device for 6 months now as well as my old BICOM 3.2. The new device together with its peripheral elements is far superior at treating patients and is much easier to use, all of which is very welcome. The far greater effectiveness of the BICOM 2000 forced me to find a conversion factor, let us say, for its effectiveness. I think I have found it, at least as far as its effectiveness in treating hyperactive children is concerned:

it is around 1:4, if the old and the new device are compared. I have been able to reduce therapy time to 2 minutes and amplification from 0.05 to 0.025 (= attenuation) in line with this factor. For all subsequent weeks therapy time remains at 2 minutes, attenuation is reduced one stage per week, as with the BICOM 3.2.

Ladies and gentlemen, it is absolutely clear to me that vast potential for treating hyperactive children still lies untapped in the new BICOM 2000, simply waiting "to be released". Following the motto "never change a winning team", I have not so far brought myself to experiment, for example, with promotional incentives. I could say, a little pretentiously, there were ethical and medical reservations for I have a tried and tested therapy, a new one would however at very least need calibrating first – with the risk of being less effective. I do not yet know how I shall resolve this conflict. Perhaps I shall start a small-scale study (10 cases?) charging just enough to cover costs. However, there will be no stopping progress here. The therapy plan will definitely be improved through courage and creativity, especially among those users working with the BICOM 2000.

For the more conservative amongst you I can advise you first to use my tried and tested plan.

I wish you every success in your therapy and much enjoyment in your creativity. Thank you for listening.

