

Hyperactive children – a major challenge for all involved

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There have always been hyperactive children. Such children drive parents and primary school teachers to despair because they are unable to concentrate on anything. Incapable of distinguishing between what is and what is not important, they constantly interrupt other people, walk around and cannot turn their hand to any clear-cut task. As far back as 1845, neurologist Heinrich Hofmann clearly outlined the behavioural characteristics associated with attention deficit disorder and hyperactivity disorder in his description of a "Zappelphilipp" or fidget.

Definitions

We need to give a few brief definitions to start with.

- ADS = Attention Deficit Syndrome
- ADHS = Attention Deficit Hyperactivity Syndrome
- ADD = Attention Deficit Disorder = ADS
- ADHD = Attention Deficit Hyperactivity Disorder = ADHS
- HKS = Hyperkinetische Störung (Hyperkinetic Disorder)
- HK = Hyperkinetic Disorder = HKS

We must always remember that not every lively child is hyperactive. The children are often highly intelligent and are therefore under-challenged in school. They then become bored and display signs of hyperactivity disorder because of the boredom. ADHD children run and jump around and fidget all day long. They are always on the go and behave as though they are driven by an internal "engine". Boys are affected approximately 4–5 times more frequently than girls. The difficulties mentioned are often exacerbated when the

children start school. The children then have to concentrate for long periods, which they find difficult to do. The problems in school obviously continue when the children are doing their homework. This constantly tests the patience of parents, carers and children alike.

Overall, a distinction can be made between the essentially hyperactive-impulsive type, mainly seen in boys, (boy: girl ratio of 5:1) and the attention deficit type mostly seen in girls (girl: boy ratio of 2:1). The hyperactive type tends to be associated with the description of "fidget" whereas attention-deficient girls have to overcome the "daydreamer" tag.

Origin of the term

The abbreviation ADHD, namely "Attention Deficit Hyperactivity Disorder", a seemingly highly scientific sounding term, was in fact introduced by a show of hands in 1987 by the American Psychiatric Association without having first drawn up the usual scientific principles underlying it. The ADHD concept branded poor concentration and motor unrest in children as psychiatric disorders. Within a period of just one year, ADHD was subsequently diagnosed in 500,000 children in the United States. The number of children stigmatised with this questionable psychiatric diagnosis has meanwhile reached alarming proportions. In the USA, Ritalin is regularly prescribed for 6 to 8 million children and this trend seems to be on the increase.

Psychiatric diagnostic criteria

In respect of psychiatric diagnostic criteria, let me give you a few extracts from the "Diagnostic and Statistical Manual IV" of

the American Psychiatric Association, Washington.

A Either 1. Attention deficit, 2. Hyperactivity, or 3. Impulsiveness

1. Attention deficit

Six or more of the attention deficit symptoms outlined below have, over the last 6 months, reached such heights that they seem inconsistent and thus incompatible with current developments.

- 1a Often fails because of sloppy work and lack of attention to school work, tasks or other activities.
- 1b Often has concentration difficulties at work and at play.
- 1c Often seems to pay no attention when addressed.
- 1d Often fails to follow instructions through and does not complete school work, duties or work commitments. (Not because of resistance or an inability to understand the instructions.)
- 1e Often finds it difficult to organise activities and tasks.
- 1f Refuses, is unwilling or avoids participating in tasks that require constant mental effort (e.g. school work or homework).
- 1g Often loses things that are needed for activities and tasks (toys, school work, pencils, books or tools).
- 1h Is easily distracted by external influences.
- 1i Can easily forget routine activities.

2. Hyperactivity

Six or more of the hyperactivity/impulsiveness symptoms outlined below have, over the last 6 months, reached such heights that they seem inconsistent and thus incompatible with current developments.

- 2a Fidgets or constantly moves the hands and feet, or fidgets around on a chair.
- 2b Often leaves his/her place in the classroom or in situations where the pupil is expected to sit still.

2c Runs around more frequently or clambers around far too much in situations where this kind of behaviour is inappropriate.

2d Often finds it difficult to be quiet at play and at leisure.

2e Is often "wound up" and acts as though driven by an internal engine.

2f Often speaks too much.

3. Impulsiveness

3a Often bursts out with answers before the person has finished asking the question.

3b Often finds it difficult to wait until the question has been asked.

3c Interrupts or disrupts others by entering discussions or games, for instance.

B A few symptoms of hyperactivity/impulsiveness or attention deficit disorders that can have adverse effects are already apparent before the 7th year of life.

C Some of these symptom-related adverse effects can appear in two or more ways (e.g. in school, at home or at work).

D There must be clear-cut evidence of clinically significant adverse effects on social, academic or professional obligations.

Questions relating to treatment

When we examine these diagnostic criteria, we cannot but ask the following question: "Is childhood a disease?"

What problems must and should be discussed?

We have problems. There are always children with severe motor unrest or who fidget, have learning difficulties, poor concentration, a tendency to display over-impulsive reactions and aggression. An analysis of the amount of harmful substances in these children's cells coupled with an evaluation of their eating habits shows that, from a biochemical perspective, many cases of attention deficit disorders

with or without hyperactivity, are caused by an excess or a lack of certain substances. One thing is crystal clear: the cause is neither congenital nor due to an acquired methylphenidate deficiency (Ritalin, Medikinet amongst others).

Children are obviously lively – and rightly so. If we look at children just before school or at break, during a bus journey to a “cool” destination or just before they arrive at or during a birthday party – we would have to chain them up to keep them still. Healthy children are full of vitality and joy of life. They are full of curiosity, excitement, enthusiasm, liveliness, energy and fantasy. In such cases care should be taken not to label these children all too quickly as ill.

A multi-modal approach is essential in order to treat patients with ADD and ADHD correctly.

Elements of the multimodal approach for ADHD/ADD:

1. Correct diagnosis
2. Clarification of aetiology
3. Explanations and advice for affected children, their parents, teachers and guardians
4. Implementation of adequate bioresonance therapy using examination and test results
5. Parent training and, if need be, family involvement
6. Motor learning using clear-cut methods and other learning/training measures

Treating the causes of ADD/ADHD

1. Correct diagnosis

It's obviously important to obtain an adequate diagnosis before starting treatment. The Ancient Greeks used to say that the Gods placed diagnosis before treatment. We should start off with a detailed discussion of the patient's history, interviewing one of the parents and the child himself/herself. This will clarify the child's anomalies, lifestyle and eating habits, etc. in the family setting.

We also invite the child and his/her parent to attend a thorough morning naturopathic examination (biorhythm), which, depending on the case in question, we will begin with a kinesiological explanation, e.g. if scar interference, blocks or the like are suspected. A test is then carried out using the CTT or Schumacher kits in order to detect and check stress and intolerance in the children.

2. Explanation of the aetiology

Two major groups cause ADD and ADHD:

- a. Physical causes
- b. Non-physical causes

Re. a. Physical causes:

- The child's diseases, e.g. visual impairment, hearing difficulties, cerebral diseases, amongst others.
- Impaired partial performance or minimal dysfunction with impaired understanding of speech, inability to express oneself or to follow a logical and mathematical train of thought, to read and spell, to comprehend visual form and space, diminished powers of observation, attention, concentration and creativity
- Exposure to harmful chemical substances, e.g. food additives, certain medicinal products such as certain antibiotics and possibly antipyretic medication
- Interference from harmful substances due to changes in the intestinal flora, conditions caused by pathogens
- Vaccinations and conditions due to vaccines
- Poor diet, e.g. excessive sugar intake
- Lack of important nutrients including vitamins and minerals
- Noise stress
- Electro stress
- Not enough sleep

Re. b. Non-physical causes:

- Unfamiliar with how to learn: e.g. incomprehensible words or symbols, unclear lessons at school

- Boredom during lesson time because of a high level of intelligence or creativity resulting in the child being under-challenged at school
- Inability to communicate
- Inability to face confrontation
- Lack of set rules for co-existing with others
- The child has done or failed to do something, which the child himself feels is not right, and this is not explained adequately within the family.
- The parents/guardians do not have enough time/show enough love for the children
- Television, video and computer games
- No meaningful goals
- No role to play in the family circle

The discovery and subsequent removal of the causes will really help the child. The symptoms will disappear and any "need" for medication such as Ritalin or Medikinet will become superfluous.

Explanations and advice for affected children, their parents, teachers and guardians

Treatment compliance is important for any child suffering from ADD/ADHD. The child is the focal point. The treating physician, parents, relatives, teachers and guardians must work together to help the child. One of the most important aims of successful therapy is for the child to build/rebuild social relationships with his/her peers.

It also seems to be important to monitor family behaviour towards the child. The parents should initially be informed about the condition and the results obtained during an information phase. This will be followed by an assessment phase during which family behaviour that may have contributed to the abnormal behaviour is analysed. In the concluding training phase, the behaviour of children, parents and schools are emphasised and the results are assessed. The focal point is to inform parents of the importance of the following points:

1. Firm structures and clear instructions
2. Appropriate behaviour throughout life and all of the situations encountered.
3. A reward system for positive behaviour (no sugary foods)
4. Avoidance of distraction
5. Involvement with other children and adolescents

It is very important to structure the day and to give the child various tasks that he/she should carry out.

However, it is also important to highlight material changes that may be needed.

Shortage of cell nutrients

The nowadays generally widespread, insidious shortage of cell nutrients impairs optimal child development, increases the number of allergies, diminishes resistance, increases the predisposition to disease, culminating in impaired powers of concentration and observation. Even the so-called attention deficit disorder, with and without hyperactivity, has a vast number of causes and aetiological complications, most of which can be attributed to mineral deficiency, namely magnesium. Magnesium is an essential activator of numerous vital biological processes. It is responsible for the activation of over 300 enzymes, hence carbohydrates, fats and proteins are only completely metabolised, and physical energy is only built up in the presence of magnesium. Magnesium activates all reactions involved in ATP.

The symptoms of magnesium deficiency include increased sensitivity to noise, unrest, hyperactivity, difficulties in falling asleep, broken sleep, circulatory problems, dizziness, nervousness, irritability, head congestion, anxiety, depression, impaired concentration and memory, sometimes confusion and hallucinations culminating in delusions.

The current daily magnesium requirement for an adult is approximately 500 mg but up to 700 mg per day may be required in

individual cases. It is important to note that magnesium levels are too low in approximately 40% of otherwise normal patients.

Why is there such a widespread magnesium deficiency nowadays?

1. Artificial fertilisers intended to replace the minerals removed from plants mostly contain nitrogen, phosphate and potassium but no magnesium. This leads to a magnesium deficiency in farmland and thus in foodstuffs.
2. Caffeine-containing drinks (coffee and coke) increase the amount of magnesium eliminated via the kidneys.
3. A high sugar consumption together with sugary foods and drinks increase both the need for and the elimination of magnesium. Magnesium deficiency can lead to lower blood glucose levels.
4. A high intake of animal protein increases the magnesium requirement.
5. Stress and noise stress in particular, can lower the body's magnesium reserves.

How can we offset a magnesium deficiency?

1. Avoid drinks containing caffeine
2. Use less sugar, thus avoiding reactive hypoglycaemia at the same time
3. Consume less animal protein
4. Magnesium and preparations containing calcium and magnesium

If we were to be really cynical, we could argue that a diet comprising only coke and hamburgers would be the most likely to cause attention deficit disorder. Eating and drinking in the car with the stereo blaring out and a simultaneous telephone conversation on a mobile phone would be even more likely to cause symptoms.

In our practice we personally recommend a blend of calcium, magnesium and vitamin C prepared for us in a pharmacy (based on a slightly changed recommendation by Regumed) in addition to Bicom therapy.

100 g of the calcium-magnesium-vitamin C blend contains the following ingredients:

- 19.15 g Calcium ascorbate
- 60.00 g Magnesiumcitrat
- 16.60 g Vitamin C powder
- 4.25 g Mannitol

Children over 5 years of age should take 2 teaspoonfuls of the mixed powder dissolved in water or fruit juice every day, preferably with food. One teaspoonful is sufficient for children under 5.

In addition to magnesium, the preparation also contains calcium because children have a high calcium requirement during the growth phase as well as at other stages through life. A slight calcium deficiency will manifest in the form of non-specific symptoms such as fatigue, nervousness, insomnia and irritation, extending to twitches and paresthesia in the arms and legs.

Vitamin C

The mixture we use also contains vitamin C. Unfortunately, unlike our dogs, we are incapable of producing our own vitamin C, and therefore have to add vitamin C to our diet. It should be noted that a vitamin C deficiency will impair central nervous system function leading, amongst other things, to a reduced ability to react and faster onset of fatigue. Vitamin C can also help reduce cadmium, mercury and lead concentrations in the blood and tissue. These heavy metals may also be linked to the onset of ADHD.

Most frequently prescribed medication

Furthermore, I would like to briefly mention the medication most frequently prescribed to treat ADHD, namely methylphenidate (trade name Ritalin or Medikinet). This is an amphetamine-like drug that allegedly works as a tranquiliser in children. The substance methylphenidate resembles cocaine in terms of efficacy and leads to an increase in the duration and impact of noradrenaline in the brain stem. This substance (methylphenidate) poses numerous health risks and is viewed by

experts as a trigger factor in subsequent drug abuse.

Amphetamines used to suppress appetite or act as a stimulant have long been banned in Germany and have been removed from the market due to their hazardous side effects.

According to statistics from the German statutory medical insurance companies, there is a constant rise in the use of methylphenidate (Ritalin, Medikinet amongst others), increasing from a relatively low rate of approximately 400,000 x 30 mg daily doses in 1991 to 13.5 million daily doses in 2000, indicating a 34-fold increase in just 10 years. These rates are still growing exponentially. Ritalin and Medikinet are both governed by the Narcotics Act. Every prescription must therefore be reported. According to the manufacturer's data, Ritalin should be prescribed for children with hyperkinetic behavioural disorders within the scope of an overall treatment approach. Ritalin is not a remedy but merely suppresses symptoms. Hence the fact that methylphenidate is subject to narcotics supervision is entirely justified. The term "subject to medical prescription" should also be viewed in the context that the jurisdiction is based on a physically harmful, non-indicated prescription approach and should not, therefore, be taken lightly.

Side effects of Ritalin

According to the Summary of Product Characteristics issued by the manufacturer Novartis, Ritalin has the following side effects:

Insomnia, lack of appetite and gastric discomfort frequently occur. These undesirable effects mostly disappear as treatment is continued. The following side effects have also been reported in children suffering from hyperkinetic syndromes: fatigue, over-excitability, sadness, anxiety, tendency to cry, headaches, dizziness, weight loss, dry mouth, diarrhoea and constipation. In individual cases psychotic reactions, especially of a paranoid-

hallucinatory type, the onset of tics and stereotypical behaviour, orofacial dyskinesia, hypersensitivity reactions such as conjunctivitis, pins and needles, skin rashes, angio-neurotic oedema, urticaria, alopecia and joint pain. Thrombocytopenia, leucopenia and anaemia have been reported.

Moreover, methylphenidate can also increase the risk of seizures. Abrupt discontinuation can cause rebound phenomena such as a sudden desire to sleep, hunger pangs, depression, psychoses and circulatory problems. Methylphenidate can also trigger severely marked psychic dependency if used incorrectly.

Procedure in our practice

I will now outline the procedure in our general medical-specialist GP practice. We actually work as a two-person team comprising a general practitioner with many years of experience in bioresonance therapy and appropriate training, and our trainer, who also has extensive experience in bioresonance therapy and has completed the necessary training.

1. Initial explanations

Once an appointment has been made, initial preliminary discussions are held involving the doctor and my partner of many years as Bicom therapist and trainer. The paediatric ADHD/ADD patient is also present and is accompanied by a parent, usually the mother.

During this preliminary discussion, the medical history of the affected child is discussed, risk factors are explained within the scope of an on-going naturopathic history and problems arising during pregnancy and at birth (including tocolytic consumption by the mother) are highlighted. Stress, exposure to radiation, intolerance and previous operations, etc. are also discussed. A medical examination is also carried out. The scheduled procedure is discussed with the parents and the child. It is also pointed out that, as a rule,

treatment is not only administered over 2–3 weeks but also over a longer period of 3–6 months, if not more. Once all of the essential important aspects have been discussed, the parents give their written consent for treatment to be administered in our practice. A date is then set to test the child.

2. Test appointment

During the appointment, initial kinesiological testing for scar interference, interference fields, electromagnetic stress such as geopathy, electro smog, dental focus, vaccine interference, spinal column and joint block is generally implemented. We then use our Bicom optima device to test for any intolerance and interference after establishing the patient's conductivity. We use the electro acupuncture method according to Voll. I prefer Voll's electroacupuncture method because my overall approach is based primarily on acupuncture. Every Bicom therapist is obviously at liberty to decide whether to carry out the tests kinesiologically or using the Tensor method. We carry out the tests either according to the CTT with 191 (Ai) or using the Schumacher test sets with 170 (Ai). Most of the children affected test positive for sugar, honey and food additives such as glutamate and phosphate.

During this examination and testing stage, patients and their families are repeatedly questioned about other potential sources of interference in an attempt to supplement the patient's history, e.g. the use of mobile phones, radio masts, living close to railway lines, etc. We only carry out these tests in the morning because of biorhythm. In the afternoon, many children are tired and are difficult to test. ADSD children generally have low deep energy levels because they use up a lot of energy as they are constantly on the move. During the test, we always offer still water to drink. At the end of the test we emphasise the need for the child to rest and drink a lot on the afternoon of the test, to both the mother and the child. We usually round off our test morning with a

course of basic therapy for the child. We need approximately 1 to 1.5 hours in all for this major test and the kinesiology and bioresonance test.

3. Bioresonance therapy

In subsequent bioresonance therapy sessions, we initially treat interference fields and blocks, especially atlas blocks and major environmental damages before embarking on intolerance and interference therapy. Chakra therapy has also proved extremely useful for restoring energy levels. This can easily be carried out in conjunction with the bioresonance method and is well tolerated by children. If need be, the right or left half of the brain is activated by promoting integration in conjunction with bioresonance therapy.

4. Medication

From the first treatment session onwards, we prescribe the afore-mentioned blend of magnesium, calcium and vitamin C, prepared for us in a local pharmacy, for the patient.

5. Learn training

Since many of the children affected have major learning difficulties and impaired partial performance, we also take these children to learn training sessions via the clear-cut concept during treatment. A special introductory test will establish whether the basis for learning actually exists or whether the child is suffering from impaired partial performance, e.g.

- Integration problems: this means that the exchange of information between the right and left halves of the brain is not fully functional.
- Hand-eye co-ordination poses problems. The eyes say what the hand does.
- Problems with following or fixing the gaze (cannot stay on one line when reading).

This impaired partial performance causes problems with reading, writing, spelling and numeracy. It is therefore important to

initially tackle the root of the problem, i.e. partial performance is activated in order to create a sound basis for learning. In addition, an individual learning strategy is devised together with a learning technique adapted to suit the child's individual needs.

In our opinion, the additional implementation of the clear-cut learning concept in conjunction with bioresonance therapy provides a sound, lasting basis for overcoming hyper-activity-related difficulties by improving the approach to learning. The pupils soon realise that they are capable of learning. This leads to a growing desire to achieve and enhances self-esteem.

6. Intermediate tests

During therapy we continue to investigate whether blocks and other treatment obstacles as well as interference and intolerance are successfully treated or eliminated; if not, additional treatment sessions must be carried out.

7. Prolonging the treatment effect

At the end of the treatment session, we give every patient a stored chip, which can be left in place until such time that it becomes uncomfortable, e.g. irritates the skin, for instance.

Experience, results

Our treatment is carried out as an *IGel* Individual Healthcare service (service not listed in doctors' fee scale and not covered by statutory health insurance). We obtain written confirmation from our patients or the parents in order to avoid any problems later on when it comes to settling the bill.

We have successfully treated around 50 children to date, have discontinued Ritalin or Medikinet in a number of cases and have prevented others from having to take this unpleasant medication and in so doing we have achieved excellent results with the bioresonance method.

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Literature

Sources and literature available from the author.