EDITORIAL COMMENT

It is well recognised that the birth of a hyperactive child often places enormous strain on the emotional and physical resources of its family.

Once considered a rare condition, recent research suggests that as many as 6% of the nation's population may be identified as hyperactive between birth and the first years of school.

For many children, hyperactivity is often accompanied by other problems such as mental retardation and sensory handicaps. The relatively high likelihood that these attendant problems may be identified means that such children will most often be assisted in specialised environments.

However, for many other chilldren hyperactivity is not so easily diagnosed. All too often the condition is not recognised until such children become continually disruptive or incorrigible at home or in the school environment. Such children are often labelled as emotionally disturbed and likely candidates for psychiatric or even correctional treatment.

This article, by Mary Reistroffer, Professor of Social Work at the University of Wisconsin-Extension and Helen Zuber McVey, a former lecturer at the same University, discusses the developmental problems associated with such youngsters

In Part 1, published below, the authors discuss how hyperactivity may be identified and its behavioural manifestations in the early years of childhood.

In Part 2, to be published in the next issue of this journal, problems associated with the middle years of childhood and the teenage years are examined. The article concludes with a section on therapeutic options for the treatment of hyperactivity.

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PARENTAL SURVIVAL AND THE HYPERACTIVE CHILD

INTRODUCTION

If you are the mother of a youngster victim of the hyperactive child syndrome, you need to have certain resources, qualities, and characteristics if you are to survive. You need, for example, the wisdon of a Solomon, the patience of a Job, the physical stamina of a stevedore, and the calm and control of a saint. You will also need some information, some support and understanding from others, and a refuge to which to flee when you have been pushed to the ragged-edge of your endurance and coping. These are the basics, but as your hyperactive child moves along the path of childhood, the additional things you need to be will become readily apparent. You will feel elation with an accomplishment, near despair when your efforts seem abortive, and through all, an overwhelming fatigue and exhaustion. Some will try to understand and to help; others will not even try. Indeed, you will suffer subtle and oblique comments suggestive of the thought that some shortcoming in your mothering ability has caused the problem. Any confidence you had as a mother will be shaken each day. And, as if it were not enough to live and be mother to a difficult child who resists your efforts, you will find yourself in serious contention with your husband and, perhaps, other members of your family. You will feel isolation and live with the suspicion that you are, in some way, a slightly defective mother.

The feelings of almost total isolation and of near despair are common feelings for the mothers of youngsters identified as hyperactive. Some mothers *do* reject the child, or give up trying, or surrender to the compelling emotional and physical depletion the problem prompts.

If you are the father of a hyperactive child, you likely swing between being confused and concerned about his behaviour, to being purely angry about it. Often you find yourself in conflict with your wife about the *best* way to handle the child's behaviour. Over the years, physicians and others have given you explanations about the condition but the explanations were really not that clear. More often than not, your home life and family relationships are in turmoil and life is more painful than pleasurable.

If you are the hyperactive child, most people – especially your parents – do not seem to understand your world and your need to be on the go all of the time. Often people seem to be angry with you when you haven't done anything *really* wrong; it makes you mad because you feel they don't even *try* to understand.

And what is this mysterious and confusing condition which so grossly complicates your lives? Will life *always* be turmoil and need it be so?

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ABOUT THE CONDITION

More than two decades ago Alfred A. Strauss did the pioneering work in identifying the youngster known by many labels but, most often, as the hyper active child. Doctor Strauss and his colleagues in experimental programmes in Racine, Wisconsin, and Evanston, Illinois, clearly identified the whole group of indicators of symptoms of the child victim of the "Strauss Syndrome".

The best available information indicates there are *very* many hyperactive youngsters in the nation's child population. Some experts suggest as many as one in every seventeen youngsters will be so identified and confirmed as hyperactive some time between birth and the first years of school attendance. Some of this great number of children will have additional problems such as mental retardation, motor impairments, and sensory handicaps. Because those additional problems will be more easily observed, they are considered by sources making evaluations as the *primary* problem with the hyperactivity a regrettable added dimension. Those youngsters with additional handicapping conditions should be dealt with by others, we are discussing the child who *apparently* is not retarded or otherwise handicapped who will be in his own home and attend his local school, probably in a regular classroom.

Your Peter, if a hyperactive child, is an atypical child but because he *looks* like other children he is seen by others as a typical child. Close observers including yourself will soon know he is a youngster someway different because he is one who spins about, who does tasks later than most children and he is one who seems to hear his own drummer. Unfortunately, hyperactive children are often not identified until they are in big trouble in the home, the neighborhood, or the school. Too often, because their condition is little understood and is recognized late, such children become candidates for tags of emotionally disturbed, incorrigible and other such treatment or correction labels. When they have these tags, hyperactive children become candidates for treatment and correctional settings. And often those in the helping professions of medicine, education, and social work further confuse parents by using the term "hyperactive" descriptively to denote behaviour or their observations such as the excessively busy child, the action-oriented child, the nervous or sensitive child, and the slow learner, or the youngster "turned-on by odd things". Your Peter may be all of these things but he is much more, and parents as well as those who seek to help you and to help him must consider the totality of the condition.

But what is this condition we call a syndrome and particularly the Strauss Syndrome? Essentially, it is a condition of the central nervous system which causes polar, or extreme, reactions to internal and external stimuli. These reactions lead to behaviour and learning disorders atypical of other children of the same age and require specific care and management techniques. The cause or "why" of it is unclear, and the research incomplete. Very often the labels professionals use reveal their professional discipline as well as their point of view on the cause. The educator may identify the child as the class-room disrupter, or the child with cognitive defects, the slow learner, or the child with perceptual problems; the psychiatrist or other medical specialist may identify the child clinically as the child with central-nervous system damage or the chronic brain-syndrome child, or the brain dysfunction child, or the hypertonic child or the hyperkinetic child, or the brain-injured child.

The labels are important only in so far as they suggest cause and the degree of the problem. The phrases *usually* suggest brain injury or some malfunction in the nervous system of the body, they suggest the injury or the malfunction is small or minimal, even subtle.

Another factor is the degree of severity as the condition may be in the mild, moderate, or severe range. Usually those youngsters classed or rated as mild are children well within the range of home care and regular school; those rated as moderate are also in this same range of home care and school but may require specific additional helps such as individualized learning opportunities and medication; those in the severe class will likely require some medication to bring them into the range of home management and group education experience or even individualized instruction.

Because of the very nature of the condition, the symptoms and behaviours typical of the disorder may be in clusters and no one hyperactive child is exactly a match of another. The child may, for example, show aggravated problems related to the gastro-intestinal tract (eating, digesting, elimination), or show aggravated symptoms or indicators clustered around coordination and locomotion, or some clustering in the various senses – speech, taste, smell, touch, sight. It is likely he will show *some* of these symptoms from each cluster but in varying levels of severity as he moves along the path of childhood.

Because each hyperactive youngster is at once unique and like all others, as one looks at commonalities of the condition, cause and effect can get very confusing. Perhaps an allegory will help to fix this varied-cause idea in your mind's eye.

All individuals are born with a central nervous system which is much like a fine electrical circuit system. Assuming that system is intact and not harmed by injury, infection or by being short-changed genetically, the system matures by acquiring "insulation on the wires". This insulation helps the impulse, message or "charge" go through to its destination, the brain, where it is read or interpreted and translated into action. Consider the baby, attracted to the bright toy, who makes random hand stabs to grab the toy. The infant's eyes convey the message to pursue it but the whole network is too immature for the hand to receive and act competently on the message. Or consider the 4 year old who wants so much to color within the lines. He holds the crayon so tightly he has white knuckles as he strains to be exact, then that old hand jerks outside the lines. Such is the situation for the hyperactive child. His senses deliver a message to the brain but enroute or thereafter the message is diluted, garbled, or short-circuited. The short-circuit is the reason his world is confused because his world as he perceives it or sees it in his mind's eye is "different". Imagine how difficult it would be to learn to read if you think one reads from the right to the left and you cannot grasp the left-to-right idea. In addition to having his message system awry and thus having outside messages garbled, your child is bombarded from inside with the need to move and to be active. He is, in effect, fighting on two fronts – inside and outside – so he often feels put-upon or misunderstood. And so this condition for your youngster is a mixed problem and the mixture makes him, his behaviour, his management, and his growth a complicated problem with many facets.

As we discuss your youngster, we will most often say "he" for more first-born male youngsters suffer the condition than girls. The added problem of your hyperactive youngster being your first born, thus the testing ground of your parenting competence, is another dimension of a complex problem.

BABYHOOD AND THE EARLY YEARS

For most hyperactive youngsters, the indicators of the disorder are apparent in infancy, become exaggerated during the toddler and pre-school years because of training or learning tasks, are marked during the elementary school years, and ease-off or abate during the teen years.

If your recall your pregnancy with Mary Jane or Peter, you may remember some things – amusing at the time – which were different from your other pregnancies. You might recall, for example, that you felt life earlier than usual, that throughout the pregnancy your baby moved and was "a kicker";

you may even had the unnerving experience of your unborn baby having hiccups now and then. Perhaps too there was infection, bleeding or some stress which made your pregnancy with this youngster other than a benign, uneventful one. Similarly, you may recall the birth of your child where "something different" happened. Perhaps your baby was very large, was a face presentation, came too fast or too slow through the birth canal with a too short or too long second stage of labor or instruments, such as high forceps, were used. Other mothers report *something* before or duing birth which was somewhat different than the usual. The frequency of these kind of recollections reported by mothers tend to support those who take the position the cause is found in genetic, toxic or brain-injury possibilities. However, in the prenatal and birth histories of many of these youngsters, there seems to be nothing atypical or different which contributes to consternation, confusion, and adds to the mystique about cause.

Most times, newborns with this condition behave very differently from other newborns. Your child, for example, may have seemed to reject you. Instead of cuddling, your baby may have become *very* agitated with touch stimulation. He arched or stiffened when you attempted to feed or handle him. You were stunned to find him cot travelling from the first, to be *very* agitated with his bath, and to seem to overreact to even small noises. As the weeks passed, you may have been astonished to find your baby scratching himself to the point of rawness.

Some or all of these things may be in your recollections. Despite the frustration of those early weeks or months, you likely discovered ways of accommodating the baby. You learned your body warmth tended to set him "off" when you held him to feed him so you fed him his bottle while he lay on a pillow on your lap. Despite his resistance, you became acquainted by talking to him through these rather long bottle-feeding periods. If he gagged and spat, you just took longer with the feeding. The soft talking was a gratification to you both so the feeding was not as much of a chore to be endured as one might expect.

You learned the immersion bathing had to be put-off for a lot longer period than for most babies. You accommodated Mary Jane or Peter with sponge-baths because water was wildly stimulating. Then, as later, the warm bath was *not* a relaxing experience so you decided the baby was a natural morning bather. You discovered this by evening bathing several times and then the youngster was wide awake until the wee hours.

The cot travelling *really* frightened you because you thought the child might suffocate in the bed clothes. Since Peter was a light sleeper and slept for short periods from the very start, you solved your concern about suffocating by having him "wear his warmth" in zippered sleepers. By the time he was eight months old, you realized there was no real danger because he moved with such ease and rapidity. Fortunately, you used cot bumpers from the first so his little head didn't get bruised as he moved about the bed.

During the first months you likely observed certain self-consoling movements in your baby. These may have been one or all of the following: body rocking, leg or arm thumping, hair twisting, head banging, or scratching. If Peter scratched himself, this was probably the first of these repetitive motions you noticed. You found him scratching his leg raw and you feared infection so you found it helped to keep his nails well trimmed and have him wear soft mittens. Most importantly, you discovered these movements *must* be pleasurable sensations; that if you "took-the-action-for-him" by patting him on his back as you sat by the cot, he did them less and the repetitive action did not become entrenched.

By the time your baby was eight months old, you decided the cot travelling required some restraint as you feared he would climb out or fall out of the cot. You found that a sheet strip, three to four feet in length tied to the middle side cot slat and to his ankle, served well. At first you though this might be hazardous, but then you decided that at eight months he had such facility for movement, the benefits far outweighed the hazards.

When the hyperactive youngster beings to move about on the floor – crawling, creeping, walking – he usually earns himself the nickname "Flash". At that point, as later, he will never walk if he can run. Many youngsters like your child omit steps in the preliminaries to walking, that is, go from rolling or flipping to walking, and do this earlier than most children. Your Peter, for example, may have walked early, perhaps at eight months. At this time you were pleased but later felt you had broken all track records in pursuing him continuously.

Two other facets of the early walking bit may be a part of your experience. The first is running on tip-toes, that is, stepping without bringing the heel down with each step, the second is the problem in change-over from soft to hard-soled shoes. When hard soles are donned, the child arches his foot, curls his toes, and develops blisters on the ends of his toes. Some of the problem can be solved by wearing socks only and introducing the hard soles later and for brief periods until the child becomes accustomed to hard soles. Peter wore his hard soles for an hour each afternoon and you managed, but the suede-sole knit socks were easier on your ears!

Even though parents learn early to keep a tight hand on the child when on the street, the footpath, or when near traffic areas, a body-harness is recommended. While you had always been annoyed when you observed a youngster in a body-harness, you overcame your negative feelings and bought one. Peter's movements were so fast, so impulsive, you realised it was the only way to protect him from cars.

Sometimes between the toddling and talking stages, the parent often discovers the youngster's reaction to changes in the barometer, even impending changes, and his very strong reactions to colour. Many parents connect the child's "bad days", now and later, to the barometric changes. On such days, the child's reactions seem sharper and more rapid; he may be whining, out-of-sorts, short-tempered, and especially hard to be around. On Pete's bad days, from infancy to school enrolment, you learned to be almost constantly available to Peter and to let the housework and other chores wait.

You likely first noticed your youngster's strong reaction to colours when, as a baby, he seemed agitated with brightly coloured toys or bright-coloured clothing you wore or he wore. After you began to watch for it, you realized bright hues in wallpaper, furniture, and other things, not worn but near, set him off in a near frenzy of motion and agitation. You soon developed a fondness for white, dark, and pastel colours for both Pete's wardrobe and your own apparel when around him.

Often hyperactive children are especially attractive and appealing so it is difficult for parents not to play with them in the typical ways which please please parents. The father, for example, who likes to "rough-house" with his hyperactive toddler or preschooler ends the play quickly and sometimes angered and frustrated when the child rapidly becomes overstimulated and clearly out of control. Similarly, parents learn early to avoid tossing the child in the air and avoid such things as elevators, swings, even escalators, because of the child's sense of terror and panic over gravity changes. It is usually during these early years that parents need to begin to develop the self-control and self-discipline which must characterize their life style and functioning for years to come.

While new foods are easily a point of contention between the mother and the child, this seems especially true when the child is a hyperactive youngster. As a baby, your hyperactive child may reject more than accept any new food. He

seems to do this more because of the texture of the food than the taste. Peter, for example, showed a great fondness for smooth foods, and spat out grainy or stringy foods well beyond the age you felt most youngsters would *really* object. He was consistent, he *always* rejected or objected to foods which required any effort like chewing. You found many foods of very comparable nutritional value and solved some of your problem by leaning on those which did not require a lot of chewing.

You learned to spoon feed all soft foods and to cut all other foods into small pieces for Pete's own finger feeding. This was something of a frustration to you but necessary for good nutrition. You learned to live with the kitchen-dining area looking like a disaster area.

Most hyperactive children in the high-chair age range need to be fed *before* the family dines. The task of eating with all the distractions of the family table are just too much. Eventually, your child will be able to "attend" the family table but should be there for social rather than eating purposes. The smells and colors of food served, the table talk and the noise activity of the table bombard the child with stimuli and invite giddiness, hilarity, and a loss of control.

In the pre-school years, and sometimes later, the bolting of food with almost no chewing is usual. Some parents contend this relate to the child's elimination problem and should be faced. The finger self-feeding, much later than usual, with very small bites will encourage chewing and the child should be reminded "it tastes better" when chewed. The child should not be given liquids during his meal as this encourages washing food down and using fluids for entertainment such as spilling.

Fatigue and emotional depletion are chronic for the parents, especially the mother, from the time the hyperactive child learns to walk until he enters school. Usually a child handles habit training and controlling his most impulsive play on a day-to-day learning basis under parental guidance, but the hyperactive youngster requires an almost programmed existence if he and his parents are to survive.

Your first tasks as parents during the early childhood years are to keep the youngster alive and to prevent serious emotional scars; later, your tasks and goals will be to help the child become socially acceptable and function in a way compatible with expectations.

During the early years, you will need to protect your toddler by virtually child-proofing your home because *the hyperactive child is accident-prone and has a blunted response to pain.* This is the why of the earlier statement of the task of keeping the child alive. In the hyperactive youngster's world, electrical sockets are meant for fingers, china and glass for breaking, and harsh cleansing agents for eating or drinking. Even with maximum child-proofing through locking up and putting-away, it is inevitable you will frequent emergency medical services. It is likely you will get to first-name basis with emergency medical personnel. Your Peter may be covered with bruises, scratches, even cuts, yet never complains. Because he has a blunted reaction to pain, he rarely reports hurts or complains of illness or injury. Often the youngster will have a raging temperature which you will discover by taking his temperature. When he is *really* ill with something he will be docile, agreeable, and "good-as-gold".

Peter, you will find, is the only child one sees who can have his stomach pumped or washed out *without* the usual frantic screaming and who feels rewarded with a tongue depressor, a bit of plastic tubing, or an emesis pan. Such "presents" from his "friend" in the emergency room are items to be treasured. Usually, such a youngster is well-remembered by emergency medical staff because the child can be stitched-up or have a bone set without objection or pain-killers. Your child will be the most interested observer of their treatment skills that the emergency room personnel have ever seen.

Eventually, usually during the middle preschool years, the hyperactive child learns to cry – most often at the sight of blood. The crying then is learned from other children rather than pain-induced.

Related to accident-proneness, the hyperactive youngster shows a singular disregard for ordinary and important dangers and this places an extra burden of watchful awareness on parents. No home or environment can be completely hazard-free so accidents will happen despite your vigilance.

Generally, accidents, scuffles and emergencies will be fewer if the preschooler is kept near you where you can observe, lead, and direct his activities. Doing housekeeping tasks with the child's "help" usually protracts the tasks, but if you are resourceful and creative, the tasks *will* get finished and you have a better chance of keeping the day accident free. It is hard, for example, to move the hyperactive youngster from one activity to another. This is especially true if the first activity gives him pleasure However, certain play items or activities can be limited to certain areas where you are working. In the bathroom, for example, you can give the youngster a wrung-out washcloth and let him "scrub" the tile or tub; in the laundry he can have an assortment of cardboard boxes for play. The boxes are easily replaced at the supermarket so it matters little that they are smashed. Usually, the *least* safe area inside the house is the bathroom with hot water taps, spray cans, and the medicine chest; the *safest* activity area outside is the sandpit. As you move about you will find other "help" the child can be to you. This proximity to the child will give you an opportunity to preach repetitively on home hazards and safety. You may grow tired of your own voice and the repetitition but the child will learn through this repetition and his poor memory requires this repetition.

And through the early years, you will live with the dread of being regarded as a battering parent because of the frequency and types of accidents which punctuate your child's life. What you have going for you is the youngster's *very* atypical response to pain and his benign, cavalier behaviour when being treated. Medical personnel who wrestle and struggle with the screaming youngster being treated *always* remember your youngster's benign response. Medical personnel, however, because of their reporting responsibility, may ask questions and well they should. The hyperactive child who drives his parents up the wall with his behaviour is a candidate for battering by the ill-informed poorly controlled adult. His behaviour can be interpreted by parents as willful and be so provocative as to invite extreme physical punishment – even battering – and place him in peril.

Toilet-training presents the ultimate frustration during and toddler and preschool years for infrequent elimination and oversize stools are common now and through adulthood. It is common for the hyperactive youngster to wear nappies very much longer than most children. Some parents suggest the peristaltic wave is interpreted as a pleasing sensation and not "heard" by the child as suggestive of the need for elimination. Often, parents who are concerned about impacted, oversize stools only every fourth or fifth day subject the youngster to protracted toilet sitting sessions and frequent suppositories. You will need to learn to live with this, to control your anxiety about it and, if necessary, mark the calendar. If you can be patient, can avoid abortive training efforts and regularise your expectations, the rectal stain will usually indicate when a bowel movement is imminent and necessary. With the three to five year old, some special toys or amusing items (a bubble pipe or book?) may amuse since the elimination business will take time.

Eating can also be an area for real contention for you and the child from babyhood to the school years. Cutlery, for example, is often quite beyond the youngster's capability into the fourth year. Rather than having a running battle with your child, it is recommended that spoon-feeding and finger self-feeding typical of earlier years be continued until your youngster has developed enough motor control to use cutlery with some competence. Your life will be calmer if you can be especially patient about the bowel training and feed rituals.

During the preschool years other aspects of life, especially new experiences and exposures, will have to be managed. The hyperactive child has perceptual problems which cause distortions in his disordered world. Television watching, for example, needs to be limited in terms of type of shows and duration as the child is evidencing primitive fears and the scary television show is almost always frightening. The attraction-repulsion of the scary cartoon prevails for him as with other youngsters but for your hyperactive child, the effects are deeper and more long lasting. *He suffers, quite commonly, a wide variety of sleep disturbances.* Since his world is populated by distortions because of the way his mind reads things, monsters and ogres are common especially as they disturb his sleep. He suffers night sweats and night terrors, sleeps for very short periods and then fitfully. Your child may nightly demonstrate the cot travelling by moving about the bed and frequently falling out of the bed. He may grind his teeth in his sleep, or cry out, or laugh, or do *all* of these things. Sometimes a small light or lamp helps and the child should always be accommodated with this when wakefulness and sleep disturbances are present as it gives him space or location orientation. Usually, afternoon naps are given up at an early age so the nap, like the night hour, presents no respite for mother.

As a part of this disordered and disordering pattern in the ordinary rituals of living, the mother will require some time away from the child if she is to survive. Early in the child's life a responsible sitter should be retained. This *must* be a responsible adult who can take care of the child for brief periods, follow directions to the letter, and be in no way innovative or creative in handling the child. Ritual and routine are security-inducers for the hyperactive child, so despite your absence, it must be "life-as-usual" for your Peter.

The adult sitter should have some awareness of the youngster's condition in order to be sufficiently vigilant. Accidents, rages, and rebelliousness occur suddenly and, at times, without apparent cause so the responsibility is clearly beyond the capability of an adolescent sitter or an older brother or sister. The person must be someone the child sees as adult like his parents and this perception helps him maintain control and some degree of expectable behaviour in your absence. Remember, your child fails to see danger where it exists (thinking he can walk on the water or step off the roof) and often imagines it where it does not realistically exist (the ogres from television).

Perhaps you have discovered one of the most attractive yet fearsome facets of your hyperactive child's "ways" is his friendliness with adults. Without exception *every adult is his friend.* You see him as especially exploitable because he is so guileless, innocent and persistent in his overtures to adults. He is markedly more comfortable and at ease with adults than with his peers or children of any age. Because of this unique friendliness you must consistently remind your Peter about riding in cars with people you have not met, going to washrooms alone, and spreading the "news" of your very personal business all over the neighborhood.

Because of your child's easy way with adults, he very probably will be regarded fondly as a born politician or a charming rascal by those *who do not live with him.* Destructive intervention by members of the extended family – doting grandparents, solicitous aunts, etc. – can seriously hamper the program of constant supervision and direction your Peter requires now and in the future. If you are to survive, you must take the initiative in limiting the frequency and duration of contacts by relatives or friends who are seduced by his friendliness or are overstimulating to him in voice, manner, or actions. It will be far from comfortable to explain the "why", but honesty and directness seem necessary and appropriate to the situation

While both parents carry the burden of the hyperactive child, the mother's burden is both emotionally and physically depleting. By now you may have learned to live with the appearance of being "the meanest mother on the block" and the implication of being

neglectful, too. You must, for example, relax standards and expectations where you can because the arenas for doing battle are so many. Perhaps an illustration will make this clearer.

The hyperactive youngster who dresses himself easily prompts a second look. His T-shirt may be inside out or worn backward, his zippers unzippered, and his shoes on the wrong feet. If chided about his thrown-together-look, your child will rage and prepare for a full-scale battle with you. As one four-year-old youngster retorted when his mother mentioned his sneakers were on the wrong feet: "But, Momma, me feets don't care". His disarray may be difficult to live with but it may be a necessary cross as your preschool hyperactive youngster is learning to assume some responsibility for himself. Essentially, the idea is this: *In order to help you child learn and grow in competence – and keep him alive – you will have to be "at him" on many, many matters; you must then be '"at him",* less on unimportant matters.

You will assist yourself and your child in the matter of dressing by purchasing clothing appropriate to his ability. You should purchase pull-on and pull-over garments, that is, those with few closures. Shoes should be buckled rather than tied. And all clothing should be in "sets" so there are few decisions on what item goes with what other item. In addition to keeping clothing as uncomplicated as possible, you should remember the praise on those occasions when he is somewhat better assembled than usual. The caution about color during babyhood continues to apply; your Peter should wear only subdued or neutral colors. This will help him attract less comment and attention, too!

In the preschool years your hyperactive youngster will need protection from comments about his being "cute" or precocious in the matter of speech *for slow speech, word reversal, and seemingly inappropriate, unrelated comments and conversation insertions are typical.* Recently, a little boy in commenting on the temperature drop said: "It sure has cooled-up". This is an example of the word reversal, and word substitutions of these children. Too, having learned a certain meaning for a word, these youngsters hold on for dear life and refuse to accept expanded meanings even when later faced with the same sound, another spelling, and an explanation. English is replete with myriad meanings and this is a complication. *Consider the word bear. It can mean an animal, to endure, or when spelled bare it means nude.* Your hyperactive youngster will tenaciously hold to the first association and meaning he learns. Perhaps an illustration will clarify. The word *engineer* in the young child's mind means the man who "runs a train". Your family may have a discussion about your delight in having a young relative admitted to a school of engineering. Several minutes after you have moved on to another subject for discussion, your youngster may say: "I think I'd like to learn to run a train". This insert usually brings the conversation to a halt as the whole family looks to the youngster in confusion and dismay. While youngsters of all ages make conversational insertions for attention, the hyperactive child *usually* does this because of his unique and isolate mental associations and/or his inability to comprehend and or follow the gist of a conversation. His comments then invite smiles and even harsh, disparaging comments from others, especially his brothers and sisters. The other children should be told (sternly, if necessary) that what he has to say "is important, too" in this kind of troublesome exchange.

Destructiveness is a way of life for the hyperactive youngster. Because he seems to have ordinary intelligence, most adults assume your youngster is a wilful child who enjoys destroying things, even inflicting pain and disorder. This is perhaps, the least understood matter and most frequent observation made by parents, teachers, neighbors, and the other children. For this reason, it is rare for the hyperactive child such as your Peter to go beyond three years of age without acquiring a "Dennis-the-Menace" or a "Mr. Double-Trouble" label or tag. It is essential that parents and others who have daily contact with the hyperactive youngster understand this child does not destroy for the sake of willfully destroying but for the pleasurablenss of the sound or sensation which the action entails. Your Peter does not smash a window to be ugly and destructive; he smashes the window because the sound of the crashing, tinkling glass is a pleasing sensation. Indeed, in terms of this type of behaviour, the child seems truly impulse ridden. Probably you agree with other parents of hyperactive youngsters in the conclusion that the hyperactive child invented the shrug of the shoulders as a response to the inquiry of giving a "why"; the child will say something like, "I wanted to see how it would feel", or "I didn't mean to smash the vase of flowers, I wanted to see the water splash".

And in every way, *motion is a pleasing sensation for your hyperactive child,* Even though he is very easily distracted by most anything which registers with him, your youngster may not easily tire of a repetitive motor activity. A paddle ball, for example, appeals to most children only so long as it is a challenge or spells a skill achievement; for your Peter, however, the repetitive movement and the sound of the ball rhythmically hitting the paddle is a pleasurable sensation. If he has enough motor coordination to have minimal results, he may stay with this activity much longer than most youngsters. Unfortunately now and later, his lack of motor skills may frustrate him in the very movements and activities which would give him pleasure and respond to his inner need to be in motion.

Because the hyperactive preschool age child is fearless, having little or no judgement despite your often repeated cautions, he is frequently in trouble around pets. In spite of your cautions, he will be attracted to pets, will want to hold (really squeeze!) a pet because it "feels soft or different" and he invites being mauled or bitten by the animals. Often the child is accused of being brutal to animals because of his rough and cavalier handling of them. Again, this is less intentionally brutality or willfulness than it is the pleasure your Peter or Mary Jane derives from the holding and squeezing. Because pets are unpredictable they are a big hazard in your hyperactive youngster's world.

Your hyperactive child's world has its own brand of logic and his message-delivery system is, more often than not, quite askew. He "hears" directions in a way suggestive of much mental editing; essentially, he struggles with so much conceptually that he fails to apply what he learned in *that* situation to *this* situation. For this reason, multiple directions and expectations are a clear impossibility. If your Peter is a preschooler or even if older, you may tell him to "Take out the garbage, wash your hands, and come to the dinner table." This invites disaster. The hyperactive child should be given single directions: "Take out the garbage, then come back to Mother", and so on. He will only complete simple chores such as the garbage trip with great difficulty. Between the kitchen and the garbage can, he will be attracted – and distracted – by other things. It can be said he is, because of this hyperactivity, *very distractible, has a short attention span, and his memory is poor.* You must, when delivering a message of utmost importance to the child ("not riding in a car with strangers"; "staying away from the river"), ask the child to "Tell Mother back". Your asking for this playback of your admonition, direction, or expectation will help you know what has registered with the child or how he has edited it within his understanding and comprehension. A child, for example, may be told not to climb on the family car in the garage when the mother finds him in the garage standing on the car roof. The editing the youngster does is apparent when the mother finds him stan-

ding on the roof of the car parked in the driveway. When reminded of the correction of the previous day, the child will say: "But, Momma, you told me not to climb on the car *in the garage".* A hyperactive child may be eight or nine years old *before* he establishes the ability to apply parental admonitions to *any* situation other than the one in which the child is engaged at the time. This will be most apparent, too, when an activity is one from which the child received pleasure, especially a pleasing sensation, such as climbing, water play, or driving a nail.

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