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ABSTRACT

Speeches presented at the international convention of the Council for Exceptional Children in Chicago, 1970 are reported. Papers are concerned with medical views of children with minimal brain dysfunction by C. Arden Miller, medical intervention in maladaptive classroom behavior by Kenneth Zike, medical intervention and the pediatrician's role in the behavior of learning disabled children by Roger V. Cadol, and the evolution of the drug problem by F. Gerald St. Souver. (JM)

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Medical Intervention and the Problem of Drugs

Papers Presented at the
48th Annual International Convention
The Council for Exceptional Children
Chicago, Illinois
April 19-25, 1970

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Medical Views of Children with Minimal Brain Dysfunction

C. Arden Miller
University of North Carolina
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Presenting a report on minimal brain dysfunction is reminiscent of a man walking down the street of a strange city. He is approached by an exuberant stranger who expresses enthusiasm at their meeting. The stranger beams effusively, "I know you. Your name is Ivan, you come from Pinsk, and you recently made a fortune in furs."

Our friend responds warmly, pleased at being recognized, but obliged to correct his companion in a few details. "My name, he says, is in fact not Ivan, but Joseph; and I am not from Pinsk, I am from Minsk; and I did not work with furs, it was lumber. And, as a matter of fact, I did not make a fortune; I lost one."

Details are troublesome. They certainly are with relation to minimal brain dysfunction. Even with several decades of conferences and reports on children with minimal brain dysfunction, we never quite seem to know for certain what we're talking about. We never quite sort fact from fancy, observation from conjecture.

For these reasons, thoughtful men speak about minimal brain dysfunction with infrequency and trepidation. I am not an expert at these problems; it's a sad commentary for the children of the world that it's so easy to pose as an expert.

My pose today is fortified by an administrative assignment some years ago to chair a task force which would prepare a report on programs of medical and health related services recommended for children with minimal brain dysfunction. I accepted the assignment in the same spirit as a college friend of mine, who was noted for his agnostic proclivities. A professor of religion who was exceedingly fond of students and who possessed a missionary zeal, attempted to convert my friend. There were many discussions on the nature of faith, and particularly on the efficacy of prayer. The professor instructed my skeptical friend about prayer in the following way. "You should kneel in just such a way, oppose your palms, look upward, and then begin, 'Dear God, if there be a God...', and then proceed with the supplications."

A similar faith is required to discuss minimal brain dysfunction. I am not certain it is a useful medical concept. I know there are children whose learning and neurologic functions appear to perform in mysterious and uncertain ways. I suspect these children are different for many different reasons; and I am not certain our understanding of them is improved by burdening them all with the same label. But I am convinced that more medical help and better understanding are available than these children ordinarily receive.

At the time the task force began its work, I was persuaded that health services for children with learning disabilities needed to be improved, no matter how inadequate might be our understanding of them and their problems. It was in this spirit that we began work to recommend programs for children with minimal brain dysfunction -- if there be such a thing.

My presentation today is taken largely from the report the task force prepared, with added comments of my own for which the committee should not be obliged to share responsibility.

Even though the task of chairing a committee of different health related professionals is viewed as an administrative assignment, I brought to the sessions some biases of content. These are epitomized by a statement prepared a decade ago on multiply handicapped children. At that time, I wrote with feeling that in many respects the worst handicap of all that could befall a child was to have a label attached to him.

> "What of the other multiply handicapped children, those about whom we are in ignorance of cause and even of what the defects may be? These are the children with bizarre behavior or defective communication, unlike 'normal' deaf children, 'normal' retarded children, or children handicapped by known and recognizable defects of the central nervous system. These children lend themselves to any of a variety of descriptive diagnoses which we can term 'weasel words.' Like the eggs sucked by the weasel, these 'diagnoses' appear intact and useful, but are really hollow of meaning: aphasia, organic brain damage, circumscribed learning defect, chronic brain syndrome, autism, and so forth. These descriptions have virtue only in that they may designate a child with behavior similar to that of other children described by other clinics. These are really multiply handicapped children, and their most real handicap may be our ignorance of what is wrong with them and what to do about them."

Recent experience suggests that even though the same labels may be used in different clinics, the children they describe differ enormously.

The task force with which we worked was made up of the following experts:

- Dr. Sam D. Clements, Department of Psychiatry, University of Arkansas Medical Center
- Dr. Miriam Pauls Hardy, Department of Environmental Medicine, Johns Hopkins Hospital
- Dr. David Yi-Yung Hsia, Children's Memorial Hospital, Chicago, Illinois
- Dr. Leslie Knott, Stanford University
- Dr. Henry J. Mark, Children's Medical and Surgical Center, Johns Hopkins Hospital
- Dr. Edward F. Rabe, Clinical Unit of Tufts-New England Medical Center

Dr. Henry H. Work, Department of Psychiatry, UCLA, and
Myself as Chairman.

I am grateful for the privilege of having worked with these people and I apologize for any violence I do their views.

We began our work in relation to two other efforts. The first was a report by Dr. Sam Clements defining Minimal Brain Dysfunction. It will be helpful to quote from that report.

> "A clouded issue reflects uncertainty regarding the very existence of a condition such as 'minimal brain dysfunction' in the types of children with which we are dealing. For convenience, the extreme views will be categorized and labeled according to the sentiments of their proponents.
>
> "1. The purist point of view is that 'minimal brain dysfunction' is in most instances an unproved presumptive diagnosis. Therefore, the concept can have little meaning and acceptance until such time as our knowledge is greatly increased and our diagnostic skills remarkably refined. Brain dysfunctioning can only be inferred until physiologic, biochemical, or structural alterations of the brain are demonstrated.
>
> "2. The pragmatic case might be presented in the following manner: With our limited validated knowledge concerning relationships between brain and behavior, we must accept certain categories of deviant behavior, developmental dyscrasias, learning disabilities, and visual-motor-perceptual irregularities as valid indices of brain dysfunctioning. They represent neurologic signs of a most meaningful kind, and reflect disorganized central nervous system functioning at the highest level. To consider learning and behavior as distinct and separate from other neurologic functions echoes a limited concept of the nervous system and of its various levels of influence and integration.
>
> "We cannot afford the luxury of waiting until causes can be unquestionably established by techniques yet to be developed. We cannot postpone managing as effectively and honestly as possible the large number of children who present chronic differences we feel are more related to organicity variables than others."

The children in question are these:

> "The term 'minimal brain dysfunction syndrome' refers to children of near average, average, or above average general intelligence with certain learning or behavioral disabilities ranging from mild to severe, which are associated with deviations of function of the central nervous system. These deviations may manifest themselves by various combinations of impairment in perception, conceptualization, language, memory, and control of attention, impulse, or motor function.
>
> "Similar symptoms may or may not complicate the problems of children with cerebral palsy, epilepsy, mental retardation, blindness, or deafness.
>
> "During the school years, a variety of learning disabilities is the most prominent manifestation of the condition which can be designated by this term."

The report goes on to describe the symptomatology of distractability, short attention span, hyperactivity, and emotional lability which characterize many of these children.

The second effort which served as a background for the committee's work was a survey of twelve experts from assorted professions, who had endorsed the quoted definition. We asked these experts a deceptively simple question. "What happens to these children as they grow up?" We received an astonishing assortment of responses, few of them documented by objective data.

Some respondents believed that most of these children grew to adulthood as normal people without handicap except perhaps a fragility to stress. Others reported that the defects were permanent, and even associated with such serious sequellae as a high incidence of adolescent schizophrenia.

The truth is that we know very little about what to expect. Most observers are optimistic about life-long adjustment patterns.

Our task force early in its deliberations agreed on a number of guidelines.

First, we agreed that for children with minimal brain dysfunction, specialized educational and psychological services would, in most cases, carry major responsibility for modifying behavior, and for improving skills of communication and learning. Medical experts have a place in this process, but it fundamentally is a problem for continued management in the schools -- not in hospitals and physicians offices.

Secondly, we agreed that interaction between educators and providers of health services was essential -- and in most instances was not adequate. We viewed the evaluation of children with learning disabilities as an extended process, to be carried on in the context of special educational management, and not a process which lent itself easily to the pattern of a single diagnostic workup in the prevailing medical fashion. We urged that schools and school systems strengthen their school health programs to incorporate medical experts who could facilitate the concept of extended evaluation which is designed to identify functional assets and strengths as well as handicaps.

Third, we urged that no national effort be established to support special medical clinics of a categorical nature for children with minimal brain dysfunction unless these clinics are offered in the context of comprehensive health services which include the participation of special educators. These children require from time to time expert medical diagnostic services. Some of these services are not readily available except through major regional health care centers. We urged that the staffing for these centers be improved with respect to expertise in learning disabilities, but we discouraged further fractionation of health services into categories for certain kinds of children or for children with certain kinds of labels. We preferred to seek ways for improving health services for all children.

The report deals at some length with the early identification of children with minimal brain dysfunction -- children who may be expected to demonstrate learning disabilities in later years.

"Often antedating the manifestations of minimal brain dysfunction in primary school are a number of behavioral hallmarks. Among these are slow maturation and unusual behavior. An especially important cue is delayed or atypical language development. If judged in the light of environmental example and stimulus, language can be expected normally to advance from infantile levels through graded levels of complexity. Aberrations deserve study, even in the very young child." Such a child deserves thoughtful observation as he enters school. If he begins to have difficulties, special programs should be initiated before he experiences academic frustrations and failures.

Knowledge of a child's early developmental deviations is ordinarily available to physicians more readily than to schools. The pediatrician is especially well situated to anticipate and forestall serious academic difficulty. He should be sensitized to realize that "failures specific to the development and use of language will identify a large number of children eventually fitting the definition for minimal brain dysfunction; little else is available to predict reliably evolution of the syndrome in a child less than three years of age."

The committee described the medical evaluation of a child with learning disabilities. All of this is well known and may not seem very special; for the most part it means only that we must bring usual and well known medical skills to these children. This is an important emphasis. In my view, pediatricians tend to underestimate the worth of their own evaluations, judgments, and interpretations to parents. Physicians are caught up from their days as students in an emphasis on curative medicine, and tend to feel inadequate and uncomfortable in situations where medical cures are not possible. In most instances, if pediatricians will observe children carefully, listen to parents, exercise those routine skills which they have developed so well, but which are not consistently made available to deviant children, and if they will consult with school personnel to exchange impressions, they will be performing far better services than can be fully appreciated.

Because the problems are difficult, we tend to look for help from experts -- usually unknown people who live and work someplace else. The expertise we seek is not readily available. Physicians who are consulted about children with learning disabilities are obligated to assume a large portion of the expert responsibility. And they, of course, need to know other experts in neurology, language development and learning who can provide necessary, but often incomplete insights and recommendations.

Physicians, in addition to performing their own valuable services, may very well prevent tragic dis-services. They can prevent the frustration and anxiety which make it possible for faddists to do violence to the child and his family with services which are inappropriate and possibly damaging.

Special attention was given in our report to the electroencephalogram because of misunderstandings surrounding it. I would like to share with you the summary prepared by Dr. Edward Rabe.

> "Children with minimal brain dysfunction are diagnosed from a summation of results of examinations by professional persons in several disciplines, and there is no single physical, neurological or laboratory datum which, alone, substantiates the diagnosis. Despite this fact, there is one test which is widely and erroneously regarded as a _sine qua non_ for the identification of minimal brain dysfunction, i.e., the electroencephalogram (EEG). Misuse of the EEG arises from misunderstanding of its value and limitations. There is no electroencephalographic abnormality which is diagnostic of diffuse brain damage, of minimal brain dysfunction, or of behavior disorders of any kind. Patients with the syndrome of minimal brain dysfunction may have EEG abnormalities, as may normal children, but when they occur, problems arise of defining the relationships between the EEG abnormality and the clinical picture. This is not always easy.
>
> "The greatest value of the electroencephalogram in patients with minimal brain dysfunction is to corroborate a suspicion that paroxysmal symptoms may be due to cortical seizure discharges. It is important to realize that some clinical seizures may be difficult to recognize."

The electroencephalogram is sometimes a device of refuge for teachers and schools that are either unwilling or unable to cope with the problem child. By requesting an electroencephalogram and finding it abnormal, educators may mistakenly feel excused from striving to render indicated educational services. Physicians must be diligent that this refuge is not allowed.

A second aspect of the report to which I wish to give special attention is that related to language. I reported earlier that deviations in language development could be important clues to the later occurrence of learning disabilities. Here is the justification for that view as prepared by Dr. Miriam Hardy.

> "Communicative Evaluation. Our culture places a high premium on a child's ability to communicate on an abstract, symbolic level. In order to do this, the child must master an organized system of linguistic symbols (words), as well as the rules of syntax by which these words are put together in phrases and sentences. He will use these words and this syntax in listening, speaking, reading -- 'in talking to himself'; as well as in expressing his feelings, communicating his needs, presenting his ideas and sharing the ideas of his fellows.
>
> "It is a complex task with many biologic and social factors contributing to its development. The child himself must have achieved the mental age for the emergence of the anticipated steps in the developmental process. He needs relative intactness of the sensory systems, particularly hearing, and he, himself, must be an organism capable of receiving, storing, retrieving, formulating, and expressing the language code. He must have adequate control of the articulation and the phonatory mechanisms. He must live in an emotional and experiential environment that is conducive to such learning. He must have the motivation and ability to attend to a complex task, if he is to learn language and to talk at an anticipated developmental rate.
>
> "There is good clinical evidence to support the concept that delayed or retarded language and speech development is one of the earlier and more sensitive indicators of a child with a disability and for any of a number of different reasons. Therefore, a significant delay in the acquisition of language and speech should be a warning signal, not only for the parents, but for the professional workers. There tends to be uncertainty as to what are normal developmental expectancies for the emergence and development of language and speech; a 'wait and see' attitude often prevails to the detriment of the child.
>
> "A useful tool to assist in the early detection of children with serious developmental delays, is the Denver Developmental Screening Test. It is not designed to obtain a measurement: i.e., a developmental age, or a mental age, or an intelligence quotient. Its sole purpose is to alert professional child workers to the

possibility of developmental delays in four areas of performance (gross motor, fine motor, language, personal-social), so that appropriate diagnostic referrals may be made. Its major advantage over other developmental scales is that it delineates the age when 25%, 50%, 75%, and 90% of children pass each item of the test. Therefore, a failure to pass an item at the 90% point clearly indicates a developmental lag that should be investigated. This is particularly critical in the language area; for it is in the pre-school years that oral language should become a reflexive tool. Until a child achieves adequate language facility, academic learning is seriously impeded, or cannot be undertaken at all.

"Retardation in the auditory learning of language is often a precursor of similar kinds of difficulties in the visual learning of language: Reading and Writing. Speech onset may occur at the usual time, but may be slow in expanding; or onset may be delayed until 24-36 months of age. An encouraging spurt usually occurs in the third year of life, but articulation is defective. These errors of articulation tend to persist, and not infrequently are severe enough to interfere with intelligibility. There is little or no self-monitoring, and speech is best described as 'cluttered.' Language slowly expands but remains immature in form, content, organization and level of abstraction. These symptoms are usually related to interferences in the processing of auditory information, (attention, memory and recall of the details of acoustic experiences) rather than to hearing loss. However, the possibility of a hearing problem should not be ignored and hearing acuity should always be verified.

"Most children with minimal brain dysfunction require specific language and speech therapy aimed at improving their listening, discrimination, and audio-perceptual skills, as well as vocabulary building, concept formation, and the formulation and expression of verbal language.

"Detailed hearing, language, and speech evaluations should be made by a specialist, or specialists in communicative disorders. The audiologist undertakes the audiologic test battery that is necessary to measure and describe the nature, shape, and depth of any hearing impairment. He should also determine if one or more hearing aids are indicated, the most appropriate kinds, and in general provide the long-term guidance and management of a child with a hearing loss. The physician should examine the ear, nose and throat to determine if there is a condition that is amenable to medical or surgical intervention.

"The speech and language pathologist not only evaluates the developmental level of the child's language and speech, but determines if there is a specific language or speech disorder.

> He is concerned with not only how much, but how a child hears. Auditory discrimination, as well as the child's ability to process, pattern, and retain auditory and visual information are assessed. The child's ability to comprehend verbal language is evaluated, as well as his ability to formulate and express a linguistic code. Phonation, articulation, and voice quality are analyzed and a careful appraisal is made of the speech mechanism to determine if there are any anatomic abnormalities, or motor problems to interfere with speech production. The objective is to delineate the nature of the problem, describe what it is the child can and cannot do, and undertake the necessary guidance to help him communicate more effectively."

What are some of the other health services required for these children?

They and their families will need expert counseling. Parents expect a certain amount of reward from all of their children. They prefer these children to grow, to develop, to learn, and to become models of behavior that will be complimentary to the family. Very often in talking with parents of children with minimal brain dysfunction, one senses a lack of reward in the performance of the child. To be able to talk about these feelings, in either an individual or group setting, can be most helpful. Guilt often arises in parents because of their presumed mishandling of these children. Anger, uncontrolled aggression, or depression may be the results. Parents need an opportunity to ventilate some of their anger.

Whatever can be done in the emotional sphere to reduce a sense of failure is crucial. Part of it depends upon modifying the child; part of it depends upon modifying the expectations of the society which surrounds him. When this involves school and teachers, there

there is a real need to understand the ultimate capacity of the child and to adapt remedial and academic as well as social expectations to these capacities.

One approach to the modification of symptoms in minimal brain dysfunction has been the use of medications. This effort has been directed almost exclusively to reduction of hyperkinesis and prolongation of attention span. The paradoxical observation that amphetamines, stimulants of the central nervous system, were effective in reducing hyperactivity was made by Bradley over 30 years ago and these continue to be one of the most used drugs, although their mechanism of action is obscure. About the best generalization that can be made on the use of medications in efforts to influence behavior and learning is that the results are variable and in part unpredictable. Stimulants, depressant, tranquillizers and anticonvulsants in the presence of seizures all have their place. But in the view of the committee, not a very important one of the overall management of children with learning disabilities. Therapy must be highly individualized and there are not many well-established principles to guide in selection of children and selection of drugs and dosages. The best principle may be to be exceedingly wary. Our society is now paying a dear price for easy solutions we have sought to difficult problems by fostering a culture dependent on drugs.

Families of children handicapped by learning disabilities need help in other ways: They may need baby sitters, they may need help with the child's socialization, recreation, and vocational counseling. In all of these matters, the physician or the school may be helpful in finding and developing community resources. Whether we like it or not, the physician is often the gate keeper to important community services. That role can be readily assumed by anybody else who can do a better job of it.

All responsible citizens -- parents, physicians, and teachers -- must participate in forcing schools to fulfill legal obligations to render many essential educational and learning services already well established and well identified. We need to know a great deal more about these children; but more is known than is commonly utilized. Neither educator nor physician should fall into the trap of feeling that because his own resources are inadequate, the problem belongs to someone else. It doesn't. My concern is for the provider of health services, the physician. He needs to be involved early in the management of these problems, but he need not shoulder sole responsibility; he should in fact see to it that special educational resources are available when they are appropriate. Parents may need help in order to seek educational rather than medical solutions to their child's problems.

Recommendations for the improvement of health-related services for individuals compromised in learning and behavior by minimal brain dysfunction including the following:

1. Broad extension and expansion of health-related services from the prenatal period through the school years. Increased emphasis should be put on the introduction of health-related services into all situations where children commonly congregate and where they can be readily observed. These include well child clinics, Headstart programs, day care centers, and schools. No opportunity should be

lost to increase the contacts of infants, children, and adolescents with experts in child development.

Every community should in fact have one or two systematic procedures whereby children with minimal brain dysfunction will be identified. At the very least there should be a systematic preschool screening program, preferably at the beginning of the kindergarten year, when some children with potential learning disability due to minimal brain dysfunction could be recognized, and as a result of which, some special preschool program might be provided. Another systematic review, utilizing well-known processes of screening and evaluation should be invoked for every child who experiences school failure, whether it be manifest by truancy, behavior disturbance, or slow learning.

2. Educational programs for the preparation of personnel in the health-related professions have emphasized diagnostic and curative methods to the neglect of preventive and long-term care. Many chronic disorders, including minimal brain dysfunction, do not lend themselves to dramatic curative medical procedures. Neither does our present understanding of the disorder lend itself to precise definition of etiology and pathogenesis. These deficiencies do not diminish the importance of rendering health-related services to the full extent of our knowledge. Many studies and reports have urged medical education to adopt a new emphasis on continuing and coordinated care rather than on episodic and intermittent care. This is an emphasis which we believe to be desirable in the interest of children with minimal brain dysfunction.

3. Continuing education for health, education, and welfare professions assumes great importance in distributing new information about resources and scientific developments. Continuing education is mandatory for upgrading general professional understanding of a disorder, such as minimal brain dysfunction, which is not widely understood by many professional groups. Continuing education, which is multidisciplinary in nature, is a realistic and useful emphasis when considering disorders such as minimal brain dysfunction and learning disabilities which require the services of a number of disciplinary groups. These disciplines require cross exposure in their educational as well as in their clinical functions. Any agency which shares responsibility for the care of large numbers of children, especially clinics and schools, must also assume responsibility for the continuing education of its staff. In large systems this can be arranged by means of in-service training programs. Otherwise, arrangements must be made through regional universities and professional organizations, nearly all of which welcome support and guidance for their efforts in continuing education.

4. Must national attention is directed toward the importance of developing and demonstrating the usefulness of paraprofessional groups in the management of disabilities. In this way, services can be extended and the influence of highly trained and experienced professionals can be broadened. This concept is of special importance for the delivery of the many and varied services required by children

with learning and behavior deviations due to minimal brain dysfunction. Use of health aides, patient advocates, teacher aides, health visitors, physical therapy aides, and aides in child development all may be means of improving the quality and availability of complete services. Such personnel can be trained in larger numbers and at less cost than more completely prepared professionals who are in short supply and concentrated in population centers. Schools and clinics sponsored by large agencies should incorporate in-service training to prepare such aides. Mechanisms of support are available through the manpower training programs of the Department of Labor and its regional offices. Smaller communities and agencies should participate in similar training programs through Cooperative Area Manpower Planning Systems. These, too, are sponsored by the Department of Labor. Except for a few well-established and widely accepted programs of training, the participation of regional universities and professional societies should be sought in order to assist with development of new training programs and with definition of roles. A significant part of such efforts will be the education of professional people to accept and make use of lesser trained colleagues.

5. Special clinics and service centers of a categorical nature are frequently advocated to cope with clinical problems not adequately cared for in the usual patterns of medicine and education. This approach is seldom helpful except to the relatively few clients within the service areas of a few clinics. Categorical programs are necessary as demonstration, as research and training centers, and to

provide consultations, but they seldom extend services sufficiently to meet public need. A categorical approach to health and educational services fosters a kind of tokenism of service. It also ignores the well-documented observation that handicaps tend to be multiple. Much grief attends the family with a child whose problems cannot be easily labeled in a setting where labels are tickets for access to special services.

Whenever possible, special health and educational services, and an admixture of the two, should be improved on behalf of all children in all appropriate settings. These include comprehensive neighborhood health centers, school health clinics, prepaid group medical practices, and pediatric clinics operated by health departments, community hospitals, and universities. Agencies, both educational and medical, which offer only limited services to children are obligated to screen for handicaps, and to assist with access to other agencies which provide complete services. No greater accomplishment than this could be achieved on behalf of children, including those with minimal brain dysfunction; nearly all children require at one time or another some of the special services that these handicapped children require on a more or less regular basis.

DRUGS AND MALADAPTIVE CLASSROOM BEHAVIOR

Kenneth Zike, M.D.
Assistant Professor of Pediatrics
UCLA School of Medicine

Drugs have been used for almost thirty-five years in attempts to alter hyperkinetic, aggressive, withdrawn or distractible behavior. However, this use has been sporadic and in relatively small numbers of children until about 1960. Since then the growth curves showing use of certain medications have been logarithmic.

As with almost any hyperbolically increasing use of "a pill for a disease", there has been a less rapid increase in the knowledge of the prescriber. He has too often treated the presenting symptom without knowledge of the underlying pathology. An old adage in medicine which states "all that wheezes isn't asthma", could be paraphrased to state, "all the wiggles, squirms, acts out or is otherwise hyperkinetic, is not necessarily brain damaged or emotionally disturbed". In fact, he may be overtly psychotic, genetically hyperactive or may just have worms.

Another adage in medicine states that "in evaluating a patient, if the lab work is late and the x-rays misplaced, before all is lost, do a complete history and physical". This is especially true in the "hyperkinetic" child. Whatever he is to whomever applies the term, he is almost never the same as the last one, similarly labelled.

It is then, important to establish the cause of his symptoms before prescribing medication. When this is accomplished, he may be found to have both pin-worms and emotional disturbance--or any other combination of several etiological factors which will generate his symptoms.

In some cases the child and/or the physician are lucky: a medication is prescribed and success achieved without any delay. Unfortunately, this is like treating pneumonia with sulfadiazine--it only works in about forty percent. The rest get worse.

This is not to say that one can always establish the cause maladaptive behavior or to always predict the effect of medication prescribed. It is also not to say that medication plays more than a supporting role in the child's management. However, medication is often helpful and at times almost miraculous in its effect.

The three patients who were studied and medication effect noted in the graphs below are students at the Los Angeles County Harbor General Hospital Experimental Education Unit in Torrance, California. The studies were conducted on children in a stable class of twelve, in which there are a teacher and an instructional assistant. The educational method used in this particular classroom is modified from Hewitts "engineered classroom". The children were observed through one-way view observation windows. Both teachers and children were unaware of the initial baseline observations in an effort to prevent the development of anxiety on the teacher's part when they were told that the child would be taken off of medication following the baseline studies. The following definitions of specific behavior were used:

1. Attention to task: Child does not look away from boundaries of his desk, ignores surrounding stimuli unless physically involving and is carrying out task assigned. May raise hand for assistance from teacher. Observations were recorded by stop-watch as minutes per thirty-minutes of attention to task.
2. Talk-outs: Speaks without raising hand for teacher's attention; speech is inappropriate to task assigned or vocalizes in any other way which is not acceptable. Number of talk outs per thirty-minute observations were recorded.

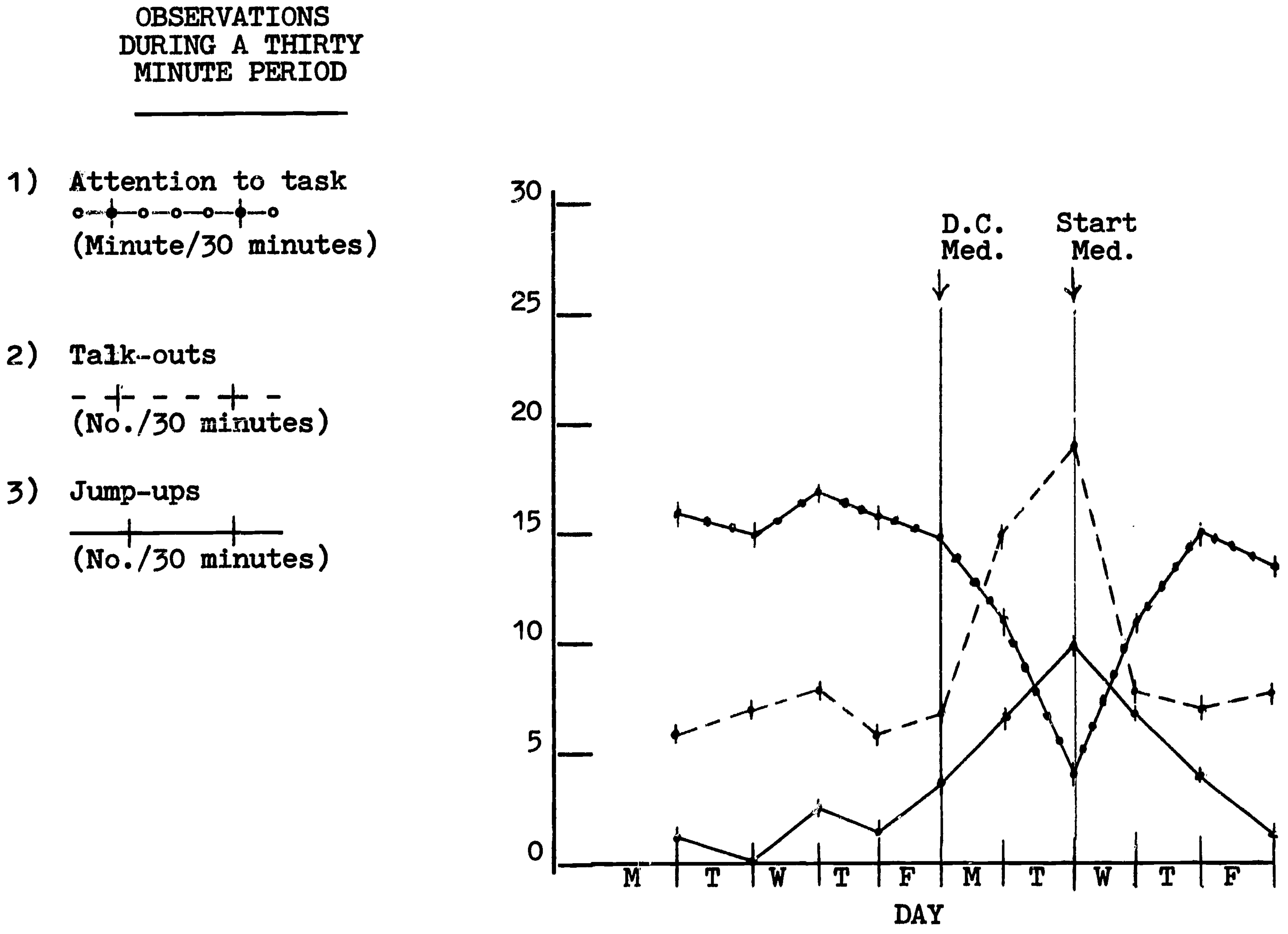
3. Jump-ups: Child leaves seat without permission or direction from teacher. May not stand at desk but may stretch occasionally without being scored. Number of jump-ups per thirty-minute observations were recorded.

The observations were made by the author from 9:30 to 10:00 a.m. on Monday through Friday for one week. After this, one child per week was taken off his medication for Monday and Tuesday then placed back on drugs Wednesday morning. He was then continued as before without further interruption of dosage.

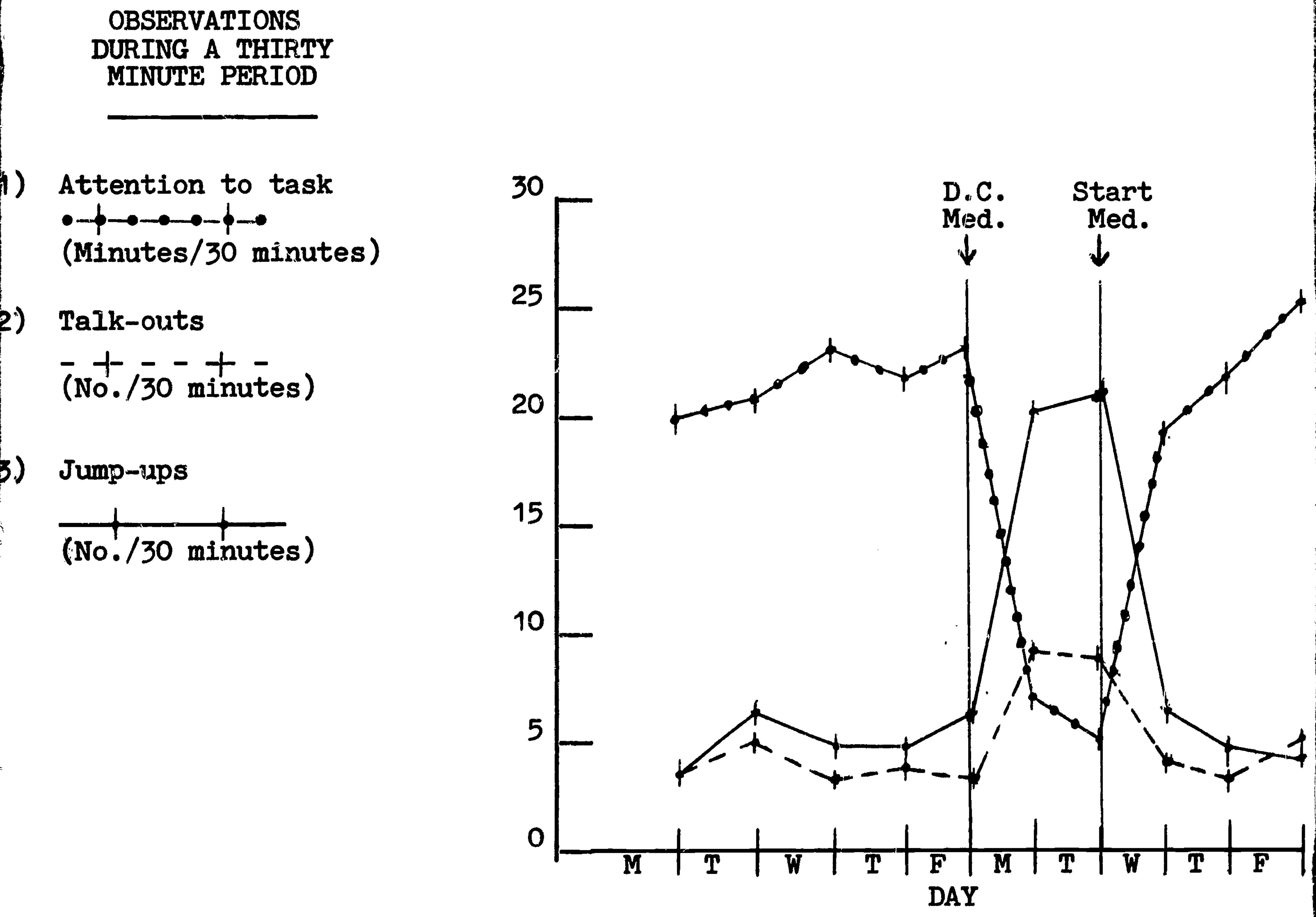
The results may be summarized simply: As measured by attention to task, talk-outs, and jump-ups; all subjects responded significantly better on than off of medication. The children studied were variably impaired in their learning processes, had different etiologies for their problem and were each on different medications. These are not unique or particularly unusual children for those placed in learning disability classes throughout the United States and Canada. This method of intervention could be employed as a part of the management wherever there is good interdisciplinary interaction between professionals concerned in childhood education.

EIGHT-YEAR OLD BOY - E.H. SECONDARY TO EMOTIONAL PROBLEMS

Chlorpromazine - 300 Mg. Each Morning

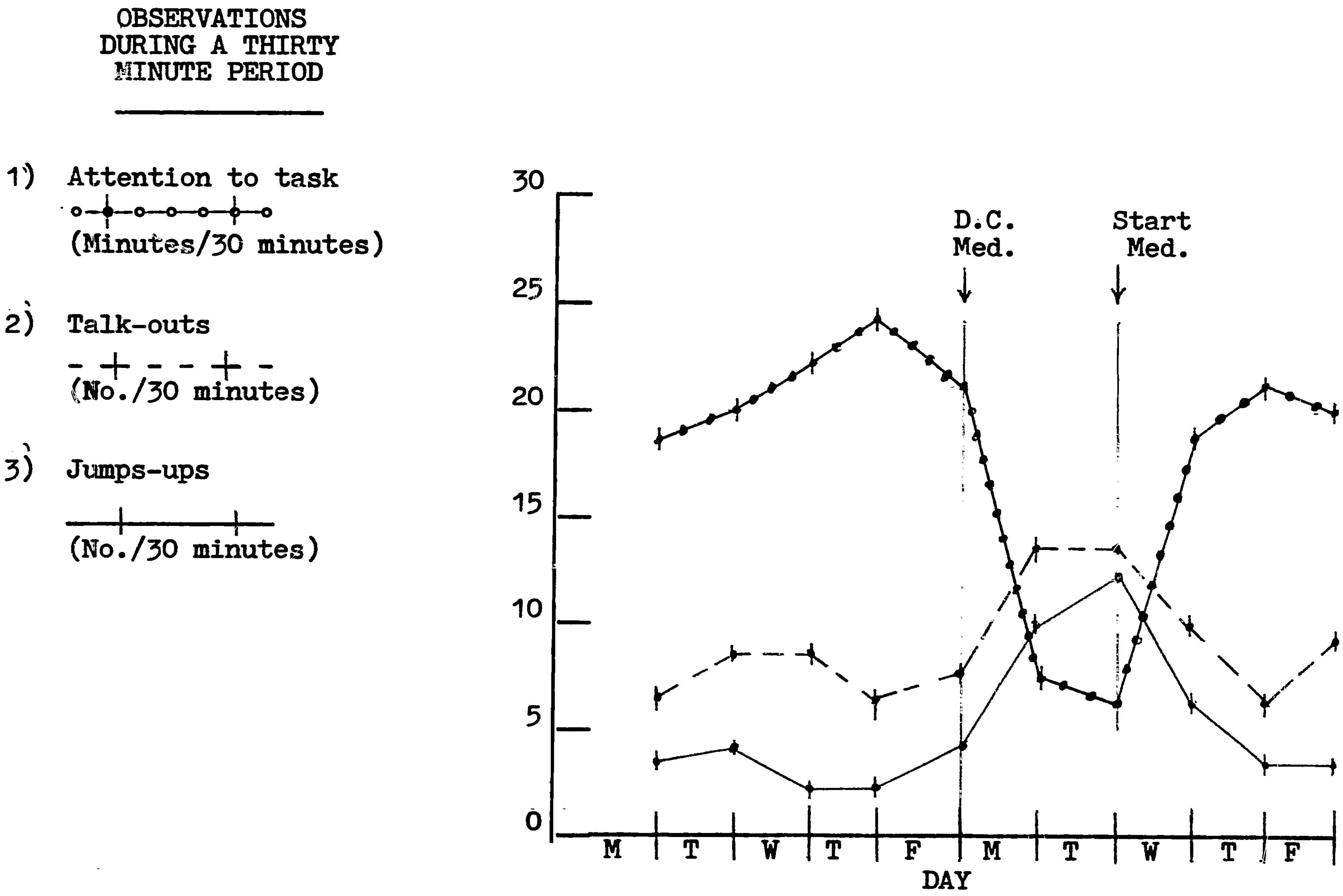


SIX-YEAR OLD GIRL - E.H. DYSPHASIC SECONDARY TO M.C.D.
Methylphenidate - 10 Mg. at 7 A.M. & 11 A.M.



EIGHT -YEAR OLD BOY - E.H. SECONDARY TO SPECIFIC DYSLEXIA

Desoxyephedrine - 10 Mg. Each Morning



MEDICAL INTERVENTION IN MALADAPTIVE CLASSROOM BEHAVIOR

Physician consultants have long been used in regular and special education. The need for sophisticated medical assistance in the evaluation and management of children with special problems has become a necessity if optimal care is to be given. Whereas there has never been any question about his participation in the medical evaluation and care, there is often doubt as he enters the sacred realm of "THE EDUCATIONAL PROCESS".

The purpose of the three papers which follow is to outline at least three areas in which a medical consultant can be useful. By the use of drugs, by home intervention, and by psychiatric intervention.

Physicians are not educators of children but often are in a position to influence those who are. It is hoped that the papers given will raise some questions and supply some answers.

MEDICAL INTERVENTION
IN
BEHAVIOR OF LEARNING DISABLED CHILDREN:
THE PEDIATRICIAN'S ROLE

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The role of any physician is primarily to prevent the development of problems, and to apply proper treatment when they do develop in such a way as to minimize the resultant physical, emotional, and sociological disabilities. In dealing with the "learning disabled" child and his family, the physician is faced with the peculiar situation that a learning disability is not viewed as a problem except insofar as it creates anxiety in the child, the parent, or the teacher. It is unfortunately all too often true that children from socioeconomically deprived areas whose parents and teachers expect them to fail in school will not be recognized as having learning disabilities but will be merely labeled as slow learners performing at their expected levels. On the other hand, some children from socioeconomically advantaged areas whose performance may even be in the normal to bright normal range, but not meeting parental expectations, may generate enough anxiety to develop learning disabilities.

The Colorado State Department of Education terms learning disabled children as "educationally handicapped" and states that "an educationally handicapped child is one whose behavior manifests itself in such a manner that it is interfering or is likely to interfere with the child's own education process or the education process of others. Behavior should be thought of in the broad educational and psychological aspects of the term. In most instances, there is an educationally significant discrepancy between his apparent capacity for language or communicative behavior and his actual level of performance." This definition, then, can include children with neurological dysfunctions as well as those whose problems are primarily psychological. All these children have in common a level of performance which is below that which is expected from them. They also have in common the fact that rather sophisticated testing has been administered to them as a result of the anxiety which they have generated in themselves, the teacher, or the parents.

The role of the pediatrician or family physician in this is to attempt to prevent neurological and emotional insults which can occur in all phases of a child's prenatal as well as postnatal life, and which can lead to developmental problems. Due to the complexity of human behavior, the physician cannot expect to function efficiently if he isolates himself from other professions.

The pediatrician and family physician should cooperate with obstetricians in providing anticipatory guidance and information to expectant mothers. While this is being done the physician should be particularly alert to certain danger signs which can manifest themselves during the prenatal years. Obviously malnutrition and severe medical diseases have been known to be associated with neurological dysfunction and should be identified as early as possible in order to avert these complications. Less often recognized, and probably of greater importance, are the feelings that parents may have about the pregnancy. It has been shown by such workers as Caplan, for example, that unwed mothers, mothers who have attempted abortions and failed, those who have severe vomiting into the fifth or sixth month of gestation, mothers who have not formed any sort of identification with the fetus prior to the last trimester, as well as those mothers who have previously raised children with developmental problems are all at high risk for having a child whose educational and psychological behavior will cause him to be termed educationally handicapped later. It is not the purpose of this paper to list all the high risk criteria but merely to point out that all physicians, whether they be obstetricians, pediatricians, or general practitioners, have a very definite responsibility in identifying potential developmental problems in utero. Obviously, what is done about these when they are identified depends on the gravity of the problem and could range from simple anticipatory guidance and counseling to referral to appropriate psychiatric facilities.

The physician must be aware of conditions in the newborn which will result in neurological dysfunctions and eventual learning disabilities. These include such conditions as anoxia, hypoglycemia, hyperbilirubinemia, as well as low birth weight, especially if the child is small for the estimated gestational age. The pediatrician obviously plays a primary role in the early diagnosis, treatment, and prevention of medical complications in the neonate. He must also institute a systematized long-term follow-up procedure on all newborns who present any of the high risk criteria.

The period during which the mother is hospitalized immediately following the delivery affords the physician a special opportunity to evaluate the mother's early adjustment to the child in terms of spoken or unspoken anxieties about the smallness, dependency, or frailty of this newborn child as well as the possibility that the parents may have some problems in adjusting to the fact that the child with which they are presented is really and truly their own. A delay in casting aside the fantasized image of the child that the parents had during pregnancy (the so-called Gerber effect) may prevent the actual acceptance of and identification with the newborn child who may be skinny, wrinkled, and rather bright red. This is often associated with developmental problems later in life. Again in most cases anticipatory guidance and counseling in terms of accepting this child as he is, as well as dispelling the anxiety generated by newly acquired responsibilities may have tremendous therapeutic affects.

Often parents are made aware early and appropriately that their children have had some neonatal problems. When the medical complications are cleared up through proper treatment, the physician can often feel assured that the child is now going to progress normally. This feeling of security is not always shared by the parents whose newborn child has been stigmatized by being treated differently from the others. The physician should be aware that the early stigma may continue to influence the parent-child interactions for a long period of time and should be prepared to rediscuss this problem with the parents whenever it seems appropriate.

Educational agencies generally do not get involved with children before the age of three or four. Physicians who see these children at birth and follow them through the early years as well as through the school years have the unique opportunity of identifying potential learning disabilities and developmental problems before the child even reaches the age for preschool programs. All too often, however, learning disabilities and developmental problems in children are not diagnosed until the child has failed at least one or two grades in school. Unfortunately, by this time, parents and children have been so conditioned to the types of interactions which they have developed around the children's disabilities and lack of performance, and are so accustomed to the behaviors that they trigger in each other, that remediation becomes more difficult. The physician has the unique opportunity of being able to identify developmental problems in their true developmental stages in the early months and years of life, even before the child reaches the preschool age. This can only be done by physicians who capitalize on the opportunity presented by regular appointments with children and their families for immunizations and routine physicals, to constantly reevaluate parent-child interactions as well as the developmental progress of the children.

Parent-child interactions can be evaluated very simply by getting some idea of the expectations that these parents have for the child's abilities and how this measures up to the actual developmental levels of the child and what would be reasonable to expect at this particular age. Frank discussions around behavior modification, special behavioral problems, and fantasies about either great potential or lack of potential in these children should be encouraged. Parents during these discussions should be given concrete information about what developmental gains they should reasonably expect in their children before the next visit and possibly how to promote such developmental gains.

From a more objective standpoint, children should be screened, using such tests as the Denver Developmental Screening Test no later than age six months. Children with questionable developmental progress should be evaluated in depth as early as possible either by the private physician, if he has the capabilities of doing so, or referred to appropriate agencies.

One of the greatest pitfalls to which physicians are vulnerable is that of putting off definitive diagnostic work on children whose development is questionable. The anxiety of the physician in stirring up the feelings of parents around potential developmental lags in their children is only surpassed by the anxiety of the parents. They usually suspect that there is something wrong with the child even before the physician does, but are extremely reluctant to verbalize this, lest their fears be confirmed. All too often the parents who want to avoid facing the reality of potential developmental retardation or developmental problems in their children, find an extremely strong ally in the physician whose anxieties about confronting the parents with this are translated into a "wait and see" attitude. The unfortunate end product of this self-perpetuating cycle is that the physician becomes an easy target for the parents to blame when the school authorities or other agencies eventually confront them with their child's problems. When a child has been identified as having a developmental problem or a learning disability then it becomes imperative that this child be evaluated comprehensively so as to outline his strengths as well as his deficiencies. A thorough evaluation leads to a more complete and meaningful educational prescription. Physicians cannot be expected to be expert in all areas such as administering nor interpreting psychological, educational, language, and other specialized tests. It is important for the physician to realize that his role as a family physician is to act as a resource person who can identify facilities in the community whether they be grouped in a child development center or scattered through consultants' offices, which have the capabilities of providing needed services to the family. In this respect, the private physician becomes the advocate of the family and of the child. His own appraisal of the child's ongoing development, prenatal and perinatal history as well as significant illnesses and physical findings can then be assimilated into the comprehensive evaluation. The physician in effect becomes a member of a multidisciplinary team for the evaluation of this patient.

With the rapid expansion of knowledge in the fields of human behavior and education, we are seeing the disappearance of the old-time physician who was the source of all knowledge in his community, whether it had to do with health and welfare of patients, running school boards, or other civic affairs. In order to effectively utilize our greatly expanding technology, it is important that the physician recognize the great contributions he can make without discounting those equally great contributions from other professional disciplines for the evaluation and remediation of children. Herein lies one of the greatest responsibilities of the family physician and pediatrician who must familiarize himself with the types of services and skills available in his community from educational, psychological, sociological, and other agencies. Often physicians who are suddenly made aware that they do not have to be expert in all of these areas feel greatly relieved and are more likely to relate meaningfully to members of paramedical or educational professions.

Once an evaluation has been completed, the physician's role as the advocate of the family is to assist the parents in realistically accepting the results. This may require working through some grieving processes associated with having to give up a fantasized perfect child based on a long history of denial. The issue of medication has to be worked through with the parents both in terms of potential benefits as well as their often unrealistic expectations that chemotherapy can suddenly alter five or six years of life experiences. Lastly, in the process of communicating the diagnoses and their prognostic implications to the parents, more specific advice can be given around the issues of behavior modification. The behavior of the parents should also be considered as it is likely that the parents have learned as much in terms of pathological interactions from the child as the child has learned from them.

When a child has been placed in a special program for educational remediation, the physician will, in all likelihood remain involved around the issues of behavior modification as well as that of medication. It is most important that the physician be familiar with the program in which the child is enrolled. The physician's communications to the parents in terms of his appraisal of the program will have a large impact on the positive or negative expectations that the parents may develop. A physician should engage himself in regular communication with the treatment program of the school in order to coordinate his treatment activities with what is going on in the remedial program. When a child is on medication, it is extremely important that any changes in parental attitudes, school situations, and teachers' attitudes be considered if one wishes to truly appraise the effects of the medication.

Lastly, in dealing with families whose child is educationally handicapped, it is important that anxieties about the families' reactions to a potential psychiatric referral do not delay psychotherapeutic intervention.

The specialty of pediatrics primarily is the specialty of child growth and development and well child care. The pediatrician is in a very unique position in our society in that he has the unparalleled opportunity of identifying and dealing with interactional and developmental problems of children starting at birth. If he is perceptive and interested in the preventive aspects of well child care and child development, he can identify and treat neurological dysfunction and potential learning disabilities in children very early. If he chooses to ally himself with the parents in closing his eyes to these developing problems, he very often runs the risk of losing the trust of the family when these problems have generated enough anxiety in other agencies, such as schools, so that work-up is inevitable and the parents are made to be confronted with the problem. At all levels, the pediatrician can provide much help to his families by developing awareness of community resources, being willing to utilize them, and most of all, be open to exchanging ideas with other professionals as part of a comprehensive child care team.

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The Evolution of the Drug Dilemma

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Knowledge is an aid to understanding. Unfortunately it does not always lend itself to direction and seldom creates empathy. All of these critical ingredients, knowledge, understanding, direction and empathy, are noticeably missing in the prevailing societal attitude toward substance use and abuse.

Toward aiding understanding I should like to put some pre-conceived opinions in proper perspective, expose some long standing myths as being ill-founded, and categorically denounce some blatent falsehoods about this substance abuse phenomenon.

At this point allow me to address myself to the first pre-conceived opinion--drug abuse is a new problem.

Drug abuse is not a new phenomenon. People, attitudes, motivations, and drugs themselves have changed, but the use of substances has been with us forever. One could say that the use of drugs evolved from the awareness of their purposes and effects. Five thousand years before Christ, the Sumerians wrote on clay tablets of the cultivation of a plant to extract its juice. The plant "gil," meaning joy or rejoicing, was the opium poppy. In addition, the prophet Ezekiel wrote, "Beside the torrent on either bank all trees good for food shall spring up. Their leaves shall not wither, their fruit shall not cease; they shall bear early every month. For their water comes from the sanctuary; their fruit is for food and their foliage for enjoyment." [1] Furthermore, in the 10th century, Arab traders took opium to China where it was used medically as a specific for diarrhea. With continued experimentation with the drug, however, it was found that opium could be used as a substitute for food. In that increased numbers of people began using opium, the drug soon became a social disease, and by the beginning of the 20th century mass addiction had spread through China.

By 1900 opium smoking had spread to other countries, including the United States, where many drug problems already existed at that time. Addiction to morphine, an opium derivative, was common due to its uncontrolled use in military medicine during the American Civil War of 1861-65. Diacetylmorphine, also, had been introduced by 1900 and was heralded by many as a cure for morphine addiction. It was used quite freely until 1908 when it was realized that it produced an addiction even graver than morphine. Diacetylmorphine is commonly called heroin today. In 1878 another drug, known as cocaine (from the land of the Incas), was acknowledged and its introduction coincided with the invention of the hypodermic needle. The result of this was an addict population of 150,000 by 1900.[2] After 1909 the smoking of opium ceased to be a problem in this country, as importation for other than medical purposes was prohibited. Our problems with morphine and heroin, on the contrary, continued to grow until 200,000 addicts were reported in 1914.[3] One of four hundred people in the country at that time was addicted. Recognition of the problem brought legislative action in 1914 with the passage of the Harrison Act*, and the addict population began to decline.

Many important changes and discoveries relating to drugs were observed during the years 1914 to 1947. It should be noted, however, that the number of addicts declined steadily during this period. One of the most significant changes was the addition of marijuana to the abuse scene in the 1930's. Although there was evidence of marijuana use in this country prior to that time, "Even the most lurid journalists did not claim that marijuana seeped into society at large until the 1930's and usually the mid'1930's."[4]

Marijuana is rooted in history and most of the legend surrounding its use is responsible for the controls and myths perpetuated to this day. Here is one account by Mr. Harry Anslinger, first Commissioner of the Federal Bureau of Narcotics:

> In the year 1090, there was founded in Persia the religious and military order of the Assassins, whose history is one of cruelty, barbarity, and murder, and for good reason. The members were confirmed users of Hashish, or Marijuana, and it is from the Arabic "hashshashin" that we have the English word "assassin."[5]

That marijuana has become a classic drug of abuse should be obvious to every reader. It has advanced from its use in the early 1930's by a few jazz musicians to estimates of use by 16-20% of high school students in major population areas, and:

> In some large universities, surveys indicate that 10 to 30 percent of the students have smoked marijuana at least once.[6]

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*The Harrison Act controlled domestic distribution by, among other things, establishing a federal tax on narcotic drugs, requiring registration and registration tax on all legal dispensers of narcotic drugs, making it illegal to sell narcotic drugs, not in a stamped package, and making sales pursuant to a legal order form.

The problem with marijuana exploded so rapidly that controls came quickly with the passage of the Marijuana Tax Act of 1937.* Additionally, it should be mentioned that, in 1930, the Federal Bureau of Narcotics was established.

In the same decade (in 1938) there was yet another important occurrence at the Swiss Laboratories of Sandoz. It was here that Dr. Albert Hofman isolated d-lysergic acid diethylamide (LSD-25). Later, in 1943, Hofman accidentally ingested some of the fine, white powder and discovered the hallucionogenic properties of LSD. What the LSD experience is like is manifest in the following description of its effects:

> In general the mood tends to be euphoric and expansive, but labile mood swings are notable. The euphoria can mount to bliss, serenity, elation and joy. This aspect of the state is attractive to those who seek a chemical high. Extremely negative affectual responses are less common. These include tension, panic, fears of going mad or of an unknown, impending doom. A few subjects have remarked that their LSD encounter was marked by a complete absence of emotion, a sort of catatonic inability to feel anything. The feeling tone is reflected onto the other aspects of mental activity. Perceptual beauty is associated with pleasure and gaiety; flatness, drab colors and fearful imagery with dysphoria. [7]

Thus the fortuitous discovery of the illusory properties of LSD introduced a new drug which promised hallucinations and other mental distortions.

The third major change during this time period (1914-1947) was a gradual one. While at the turn of the century the addicts had been predominantly Chinese and Caucasian, by 1945 the majority were Negro and Puerto Rican. [8] The classic traffic drugs of that time - heroin, cocaine, and marijuana - were therefore being trafficked in the country's ghetto areas, financially lucrative spots for the operations of the organized criminals.

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*Patterned after the Harrison Act.

To understand more completely the harshness of our drug laws, at this point, it is necessary to realize that, at their inception, they dealt with organized crime. The traffickers who were exploiting the ghettos were indeed criminals. However, our society has evolved, characteristics of drug traffic have changed drastically, and use is no longer confined to classic "criminal" types. The average marijuana dispenser now is the young adult involved in drug use rather than the organized criminal. Unfortunately our drug laws have failed to reflect these critical changes.

In 1947 the most important change to date occurred. After reaching a low of approximately 19,000 addicts, [9] the decline being witnessed for 25 years ceased and the total number of addicts began to rise.

Here, we can advance a different hypothesis for the spread of drug use to all segments of society. A different explanation than those that tell us of a degenerate, immoral generation of young people. Understand the appeal of psychedelic drugs and the impact of their articulate proselytizors. Psychedelic drugs speak of mind expansion, creativity, understanding the universe, and mystic, religious experiences. Encouraged by the writings of Aldous Huxley and the preachings of Dr. Timothy Leary, impressionable, intelligent young people became involved with the hallucinogens.

With the use of these mind altering drugs, the ethnic identification of the user began to change. Drug use first became occasional, then casual, and finally prevalent in social areas other than the ghetto. It was the upper middle class that constituted the greatest number of the users of these drugs. It also became apparent to many by that time that the nation had become, or was fast becoming, a drug-oriented society. Drug use in many forms had become a way of life for most Americans. Along with the great American dream of having a pill for everything came another abuse problem.

As early as 1951, the Subcommittee on Narcotics of the House Committee on Ways and Means, under the chairmanship of Congressman Hale Boggs, explored the problems created by illegal sales and abuse of barbiturates and considered action to correct the situation. [10] In 1954, during the 84th Congress, the House Subcommittee on Narcotics again held hearings to consider the need for additional Federal legislation in this area. By that time, the illegal distribution of amphetamines had become a more widespread problem to the extent that the hearings considered them as well as barbiturates.[11] The "Ups and Downs" pills were prevalent and the issues of their use had to be confronted.

This form of abuse spread with such rapidity that in 1965 Senator Thomas Dodd of Connecticut estimated there were "approximately 200,000 serious dependent pill heads in this country." In that same year the Food and Drug Administration (FDA) estimated that over 10 billion amphetamine and barbiturate capsules were produced during the year (enough to supply four dozen to everyone in the country), and that up to half of those had been diverted to illicit use, representing an income to the black market traffickers of some 500 million dollars annually. One outcome of this was the passage of new Federal legislation--H.R. 2, the Drug Abuse Control Amendments of 1965, which, among other things, gave birth to a new Federal enforcement agency, The Bureau of Drug Abuse Control, operating out of the Food and Drug Administration.*

The present scope of the drug situation is rather difficult to assess. Published figures early in 1969 indicated 62,057 heroin addicts alone,[12] but conservative estimates place that figure closer to 200,000. The most cautious student of the marijuana scene estimates seven million marijuana users and factual estimates on the number of "pill heads" and hallucinogen abusers are just not available at this time. It does not seem unreasonable, for one deeply involved in this particular dilemma, to suggest that eight to nine million Americans are involved in the drug scene.

Furthermore, illicit drug use and sale are rising among all sectors of the population, not just the young. All forms of drug abuse and the corresponding crimes against persons and property are also rising at an alarming rate. The state, using traditional deterrents of jail sentences and fines, is not maintaining even a holding action in preventing drug abuse and drug dependence.[13]

How have we reached this position, we ask? What is the problem? Let us examine our traditional approach. The Harrison Act was passed in 1914, the Bureau of Narcotics formed in 1930 and the Marijuana Tax Act came into being in 1937. In 1952 we passed the Boggs Act and in 1956 the Narcotic Control Act. We implemented the Drug Abuse Control Amendments in 1965 along with the formation of the Bureau of Drug Abuse Control, and in 1968, for better enforcement, the Bureau of Narcotics and the Bureau of Drug Abuse Control were merged and placed in the Justice Department.

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*The Bureau of Drug Abuse Control and the Federal Bureau of Narcotics have since merged and operate as the Bureau of Narcotics and Dangerous Drugs, under the Department of Justice.

We set about, 56 years ago, to eliminate or control social disease by making it illegal. The law itself has equated the user and abuser of drugs by making possession the crime and not consumption. Also, while science has clearly identified some drugs (i.e., marijuana) as being substantially less harmful than others (i.e., heroin) the law continues to equate the possession of the two: the theory being that strict punishment will keep illegal drug use from spreading.

Seldom have so many been so wrong about so much.

It is a problem of communication, a situation where meaningful dialogue has given way to futile argument with neither side debating the same issue. We continually argue about the relative dangers of marijuana use while young people the constitutional validity of a law that prohibits personal use. We will never communicate until we reach common ground.

It's a problem of values, but who's are misplaced? How can a society that spent more on alcohol and tranquilizers last year than it did on education stand in judgment of the value system of another generation?

It's a problem of a society unable to cope with the most aware generation of young people ever produced in this country. Aware of <u>our</u> problems, aware of <u>our</u> social inequities, aware of <u>our</u> mis-directed values and unable to do anything about them.

It's a problem of taking childhood away from young people, through that awareness, but still refusing to give them any related responsibility. This combination results in frustation and is a major contributing factor to drug abuse.

It's a problem of confusion, confusion bred of hypocrisy in our present attitude toward drug use. Consider the challenge hurled by youth that if you are over 30 you are not to be believed and cannot be trusted. Imagine the confusion of the youth who's parents are warning him of the evils of drug use, each with a cigarette in one hand and a martini in the other. Compound this confusion with the exposure he received through the wonder of television. The Drug Establishment's advertising campaigns are among the most impressive in all media. The advertising and promotional budget has been estimated at approximately $800,000,000 per year.

During prime television time the viewer is told on an average of four times per hour that the drugged life is the beautiful life. Dressing our own abuse in the cloak of social acceptability we preach about the evils of indiscriminate drug use. Are we hypocrites, are we not to be believed, can we not be trusted, or worse, are we impotent and unable to control our own media?

Let's tell it like it is. We are the turned on generation and we do use dangerous drugs indiscriminatly. Alcohol is consumed by 80 million Americans and directly causes 11.6 per 100,000 of all deaths.[15] Certainly, the level of problems associated with the drug scene does not compare in scope with deaths from lung and heart disease aggravated by smoking.[16]

The great "American Dream" is truly a pill for everything. We have become a dependent, pill oriented society totally reacting against another form of drug use by a younger generation and most of their reasons for use are the same as the excuses we use to rationalize our own medication madness.

Reaction does not beget reason. If reason does not find its way into our decision making process with regard to our handling of this social problem we will forever close the lines of communication and become a divided people.

With the onset of a new decade there are many suggestions as to what should or could be done to once again alter this problem's course in history. These suggestions must be evaluated and applied wherever practical. Whatever is undertaken, however, must be determined knowing this to be true:

> ...That the attitude of society and the governmental agencies through which society acts may be fairly characterized as one of vengeance and vindictiveness toward the drug dependent person who is treated as an evil person. In the years to come, we will look back at the superstitions and cruel reaction of our society to drug dependence with the same horror and disgust we now reserve for the way another generation misunderstood and abused its mentally ill and, more recently, its victims of alcoholism.

The present attitude of society and its governmental agencies cannot be condemned too strongly. We must undertake a radical policy change with appropriate governmental innovations that will realistically characterize and treat the drug dependent person as an ill person--not an evil person. Governmental agencies must regard drug abuse as a complex illness and a health problem, not an invitation to exact extra-legal and statutory penalties, while ignoring the psychological and physiological causes leading to drug abuse, thereby compounding the personal and social problems attendant on drug abuse.[17]

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