In the early 1970’s in San Francisco, Dr. Feingold was developing an understanding of the ability of toxic chemicals to disrupt brain chemistry and worsen symptoms of hyperactivity and attentional issues. He treated nearly 1200 children and kept careful notes on the effects of insulating them from exposure to toxic chemicals. His bold pioneering efforts launched a method of treatment for numerous psychiatric and medical conditions that has blossomed over the years and is safe and effective.

Dr. Ayres launched sensory integration treatment, a method of treating what is now known as sensory processing disorder. Nearly all persons who have ADHD, autism, learning disabilities, significant brain tissue damage, Tourette syndrome, and fetal alcohol syndrome have many symptoms of sensory processing disorder. At its core, sensory processing disorder amounts to the brain’s inappropriately muting or magnifying the messages it received from the sense organs, causing the person to over-respond or under-respond to sensory experiences. The vast majority of persons with sensory processing disorder merit an additional psychiatric or medical diagnosis, the most frequent of which is probably ADHD.

Sensory Integration

Our brain is constantly telling our muscles what to do, so we can be in the right place, assume the right body position, and make the correct body part movements at any given time. With messages from the sense organs, the brain mutes thousands of them and magnifies a few hundred. The brain tries to find the shortest and most direct road to self-actualization and safety. The muting and magnifying of messages from sense organs is part of the brain’s effort to find the best positions and movements for the body parts.

With the most important sensory messages highlighted, the brain prioritizes them so that the body can give an organized, relevant response to whatever is the sensory reality at the time. It sends messages to the muscles about making all necessary body part movements. The person pays attention, stays sufficiently focused on the intended activity, and attains a sense of fulfillment and goal accomplishment with minimal, if any, distraction. Three results occur when the brain is successfully muting and magnifying messages from sense organs: successful task accomplishment, without distraction, and with sensory fulfillment experienced as pleasure of some sort.

Response Geared to Sensory Intensity

To attain pleasure or fulfillment from a sensory experience, the brain adjusts the level of sensory awareness and consequent response to whatever is happening at the sense organ. The adjustment of the person’s awareness of a sensory experience is automatic and seldom involves extended pondering about the matter. The intensity of the sensory stimulus is scientifically referred to as its salience. A bright light is more visually salient than a dull one. A scratchy fabric has more textural salience than a smooth one.
If a sensory stimulus is of high salience, the brain will try to buffer the intensity of the experience. A bright light will trigger automatic constriction of the pupils in the eyes, for example. If the intensity of the sensory stimulus is too slight, the brain will increase the person’s awareness level in order to attain the three results. A dull light will automatically trigger widening of the pupils.

In other words, the brain mutes and magnifies awareness in accord with the intensity level of the stimulus. High intensity combined with muted awareness can provide sensory fulfillment and successful task accomplishment without distraction. Low intensity combined with heightened awareness accomplishes the same three results.

This process of preventing distraction to aid in attaining task accomplishment is sensory adaptation. Successfully adapting to the level of intensity impinging on sense organs over a period of time leads to a sense of sensory fulfillment or balance, a state commonly referred to as sensory integration. Think of sensory integration as successful sensory adaptation over an extended period of time.

Making Sense of Senses

The senses that the brain distorts messages from are:
- Proprioception (muscle position and movement),
- Equilibrium (vestibular sense or sense of balance)
- Touch (tactile sense)
- Hearing (auditory sense)
- Vision
- Taste (gustatory sense)
- Smell (olfactory sense)
- Interoceptions (internal body states such as hunger, emotional states such as anger, and handling of thoughts such as word selection when speaking)

Dr. Ayres was also an occupational therapist, and the field of occupational therapy has stepped to the forefront in refining methods of treatment for individuals whose brains distort sensory inputs. Physical therapists and speech and language therapists also use sensory integration treatment methods along with others specific to their professions. The senses that most occupational therapists focus on when providing sensory integration treatment, their “pet” senses, spell the acronym PET. They are the first three of the listed senses (proprioception, equilibrium, and touch). In fact, one of Dr. Ayres’s early published journal articles detailed how she brushed the skin (touch) and gently spun around (equilibrium) children with learning disabilities, with the result that their reading scores improved.

The development of sensory integration involves experience over time of body movement in a balanced harmony with the senses. Experiencing movement enhances sensory-motor awareness and skills. Every time the muscles move, input from the senses is involved. Being physically active is how a child develops the PET senses. The most interlocked sense is equilibrium, because the vestibular system is involved with bilateral coordination—getting both the right half and the left half of the body to work together. It is also connected to the language center of the brain, eye movements, hearing, and the digestive tract. A child might throw up if experiencing too much vestibular stimulation, as in car sickness.
Under-response and Over-response

Under-responding by the brain can occur in two directions. One is to be un-under-aware of sensory inputs, which I refer to as afferent under-response. An example is the child who doesn’t respond to the alarm clock (hearing) or has a bowel or bladder control problem during the day and reports, “I didn’t realize I had to go.” The other is to under-respond when sending directive messages out to muscles, which I refer to as efferent under-response. Examples include sloppy handwriting and poor large-muscle coordination. Dr. Feingold often commented that children with ADHD often show either a large-muscle or a small-muscle form of efferent under-response.

Over-responding results in hyper-awareness, which can be either positive or negative. Examples of positive hyper-awareness include profound enjoyment of the taste of a food or of feeling the gentle back-and-forth movement when riding a horse. Over-response causing over-awareness of pleasure from having the sensory experience can then lead to a compulsion to seek it. Sensory seeking examples include a constant apparent need to squirm, or a compulsive need to chew things. Not all compulsive sensory seeking is a reflection of over-response, however. Sometimes it is a reflection of under-response, so that the person seeks extra stimulation in order to attain sensory fulfillment. The person is stuck in muted awareness, for which heightened salience is needed in order to attain sensory fulfillment.

Examples of negative hyper-awareness include being overly conscious of the sounds intruding into the classroom from outside and overly aware of the texture and temperature of food in the mouth. Such hyper-awareness can lead eventually to a sensory overload characterized by pain, terror, or annoyance. The person would then attempt to avoid such a sensory experience. Sensory avoiding is reflected in such phenomena as phobias or being a fussy, picky eater with food aversions, a trait of many children who have ADHD. Sensory seeking and sensory avoiding, when problematic and thus reflective of sensory processing disorder, tend to be compulsive and obsessive in degree.

Often a state of emotional and physical exhaustion can occur, which then becomes another form of sensory overload. An example is the student with a learning disability who finally stares out the window rather than continuing to attempt to take notes from teachers’ lectures.

Thus there are four major categories of sensory processing disorder symptoms: afferent under-response, efferent under-response (sometimes called “sensory-based motor problems”), compulsive seeking, and compulsive avoiding. There are hundreds of symptoms that involve under-awareness of, impaired muscle coordination during, compulsive seeking of and compulsive avoiding of sensory experiences.
Four Key Interventions

For any person with these kinds of distortions of sensory inputs, four interventions are wise to invoke. They are to use chemical toxinsulation treatment by following the Feingold Program, to assure that the person gets enough sleep, to assure adequate nutrition to the brain, and to prepare the person to cope calmly with daily stresses. These measures will usually decrease symptoms, if done diligently. The sensory-based treatments typically performed by occupational therapists, physical therapists and speech and language therapists are usually enhanced in their effect if these four measures are also invoked simultaneously. Thus the Feingold Program should be at the very heart of treatment for many of these children, teens and adults.

Learn How a Sensory Disorder Works and What You Can Do to Help Your Child

Interview with Dr. John Taylor
from www.BestOfYouToday.com

Traditionally, the 4th grader who won’t pay attention in class or the kid who fidgets and squirms too much might earn them a scolding. John F. Taylor, Ph.D. says these kids may not be able to help themselves, and he wrote a book to help them understand themselves. Regarded an innovator in the field of ADD, Dr. John Taylor is author of *Have Fun with Your Senses: The Sensory Avoider’s Survival Guide*.

Colorful and easy to understand, it’s a book for parents to read to a child who has ADD/ADHD to explain human senses and what can go wrong when the brain inappropriately magnifies the messages the senses send to it. Dr. Taylor is a family psychologist and father of eight children, three of whom with ADD/ADHD.

*Have Fun with Your Senses: The Sensory Avoider’s Survival Guide*
This book represents an introduction to the human senses for kids. It might be your child’s first “read about your own problems” guide. It explains what can go wrong when the brain inappropriately magnifies the messages sense organs send to it.

Please share with us what inspired you to write *Learn to Have Fun with Your Senses*?

Dr. Taylor: I entered this through the ADHD door. Virtually all symptoms of attention deficit disorder, with or without the hyperactivity, involve sensory distortion. I was one of the few authors of major works in ADHD to point out that we can treat them with sensory motor intervention and we have to pay attention to them being over or under reactive to sensory input. It’s a part of their symptom clusters. Because of my years and years of focusing on ADHD, I just recognize that in ADHD. There weren’t really good books out there to read for kids with sensory avoiders or sensory seekers. I decided to write a practical guide for them to read.

"Virtually all symptoms of attention deficit disorder...involve sensory distortion."
What conditions or diagnoses in children have you found to be particularly sensitive to receiving sensory messages?

Dr. Taylor: We’re talking about the brain muting and magnifying sensory inputs inappropriately. What kind of people would do that? Everybody with autism has a lot of those distortions. Everybody with Asperger syndrome has a lot of those distortions. Obsessions and compulsions, by their very nature, are the brain magnifying those inputs to the level where they refuse to adjust. Obsessions and compulsions are qualified sensory distortions. Being scatter-brain and being distracted are the key symptoms of attention deficit disorder. The brain is muting awareness of appropriate signals and magnifying awareness for inappropriate signals coming in. So the kid is looking outside the classroom’s window instead of listening to the teacher speaking. That is a misdirecting of sensory inputs. That’s a classic sensory processing disorder. Then we have brain injuries—anytime there is a massive injury to the brain for any reasons, rare medical conditions, hallucinations, and psychotic syndromes.

How can a parent recognize a sensory sensitivity in a young child?

Dr. Taylor: I divide sensory problems into four categories. So right away, you should hunt for the four.

1. The first is under-awareness of the sensory messages from the sense organs. So the child is bleeding and he doesn't realize that he is bleeding, can't control bowel and bladder, is unaware of bowel needs or bladder's signals, can't tell you whether he's hungry, shivering and not realizing that he's cold and someone has to tell him he's cold, and more. The brain is not registering the inputs from the sensory.

2. The second category is the brain’s directive messages to the muscles are messed up. Here we have the sloppy handwriting, poor coordination, and poor sense of balance.

3. The third category is sensory seeking—excessively going after sensory stimulations. Our little squirmy child in the classroom is constantly fidgeting. What is he doing? He’s experiencing his muscles moving. His muscles are out of whack and are interfering with his life.

4. The last category is sensory avoider—terrified, afraid, bothered by ordinary sensations, can’t stand to be touched, or bothered excessively by sensorial troubled things like fire alarms, sirens and so forth.

How do these children turn out as adults?

Dr. Taylor: The phrase in the field is that you don’t outgrow sensory distortions or sensory processing deficit. That is not totally true. This is a claim made by some author who wrote a book on sensory processing. I made no such claims. My claim is that some of these are outgrown. Some symptoms are automatically outgrown and others are not. As adults, generally they will have fewer symptoms then when they were kids. It's true for many conditions.
When a child overreacts to a certain situation, what can the parent do to help?
Dr. Taylor: Get them out of the situation immediately. Reduce the intensity of the stimulus if you can. Turn down the lights. Turn down the sound. Stop having them wear the scratchy pajamas and get them into softer pajamas. So we decrease the intensity of the stimulus coming in. Also warn them about it if you can’t avoid it. Give them foreknowledge about it.
In the long term, you try to desensitize them to it. The child who is afraid of the fire drills at school, for example. You can tape record the fire drill and have the child sit there with a bowl of ice cream or something he likes. Have him listen to the fire drill while self-nurturing over and over. This will desensitize him. But before he has a meltdown, get him out of the situation and calm him down.

In a moment that a child is having a strong emotional response that isn’t warranted, what is the best way for a parent to respond? And what are common mistakes in responses that parents make?
Dr. Taylor: The most common mistake is regarding the overload sensory reaction as an act of misbehavior. Scolding him for screaming and holding his hands over his ears when people are talking in the room. Scolding him for looking out of the windows instead of looking at his desk. You’ll be amazed if you approach this disciplinary moment from a sensory perspective and say, “Which of the senses is overwhelmed right now and how can I return him to a sensory balance?” rather than “How can I scold, punish, or criticize him?”

What is happening in the mind of a child who experiences overly sensitive sensory messages and reacts? Are they aware that their feelings are amplified and do the feelings completely overwhelm their reasoning?
Dr. Taylor: They’re aware that they are losing it but they can’t help it. It’s roughly the equivalent to a panic attack in a normal person. They’re aware that they’re shaking but they can’t stop shaking. Why are you shaking? Because it’s a sensory overload. Normal people have sensory overload moments as in when we are terrified or panicking. We are in sensory overload at that time. When we’re extremely bothered or can’t stand the sound that we just heard.

What type of home environment is most soothing for a child who is overly sensitive to senses?
Dr. Taylor: They have routines and they hate surprises. Keep everything orderly, routine, quiet or at least mild in the back with soft music. But chaotic, noisy and intrusive are stepping on his sensory toes.

When someone has a sensory disorder, does it usually include all senses, or is it limited to one type of sense?
Dr. Taylor: They usually have several sensory disorders. It can be from any of the four categories we’ve mentioned earlier. A kid can be obsessed with talking about alligators, can’t read social cues, misinterprets social things, gets impatient, and more. The same kid can accidentally bite his tongue when he chews and not be able to tell you when he’s hungry. He can also be a compulsive chewer of everything and be a fussy eater. It’s very seldom you will find that they only have one sensory disorder. The more symptoms they have, the more likely they’ll have one of the known psyche disorders I’ve mentioned—ADHD, autism, etc.

What is the best way for a parent to explain to their child how to work with, not against, their intensified senses?
Dr. Taylor: Sit down with him, put him on your lap and read the book Have Fun with Your Senses. Try some of the tools I’ve mention in the book. Have Fun with Your Senses, by John F. Taylor, PhD – see: www.ADD-Plus.com
A person who experiences the world differently is going to behave differently. If one or more of the senses is slow to develop it will be difficult for a child to advance.

At our Annual Conference last year, the Developmental Delay Resources (DDR) sponsored a one-day seminar titled, “After the diagnosis what to do next to help children with ADD, LD or developmental delays”. In a workshop DDR’s Executive Director, Patricia Lemer, M.Ed., described ways parents and professionals can recognize the symptoms of possible sensory integration dysfunction.

Sensory integration theory was conceived by a woman named Jean Ayres. It’s based on the premise that when information is processed by the senses either a motor or behavioral response is there result. Whereas educational and medical interventions often treat the output, what should be treated is the problem with how the input is being processed. If the input is abnormal or is not being processed properly then the output is going to be abnormal. The more abnormal the processing of the input, the more abnormal the behavior or the motor response is. Over time, disorganized output can eventually result in developmental delays. For Feingold children who are affected by something physiological such as food, nutritional, or environmental factors, the body’s ability to process that sensory information may already be impaired.

Professionals too often treat the symptoms of sensory processing problems, instead of addressing the causes.

A professional skilled in sensory integration therapy can help a child organize what his/her body needs so he/she can use it in a productive way.

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For some children, being touched is an upsetting experience.

The tactile system (the sense of touch) is the only sense that is fully developed at birth. This is why we can use touch to calm an infant or child. The tactile system has two ways of responding: it has a protective mode and a discriminatory mode. The protective is the more primitive of the modes, where a touch is perceived as an assault. As the tactile system develops it becomes more discriminating. We are able to feel whether the sensation is hot or cold, whether the touch is light or heavy; we can discriminate whether the touch is reassuring or threatening.

The senses of touch, hearing and seeing are all related.

Children who have sensory integration problems have difficulty telling the difference between a touch which is a gentle nudge and one which is threatening. Their systems are in the protective mode rather than the discriminatory mode much of the time. This is called "tactile defensiveness," which can result in inappropriate reactions. What happens to such a child who gets pushed in line at school? He may strike back at the kid who touched him because the brain of the tactilely defensive child perceives he was hit, even though it might have been just a light touch. That light touch set off the protective mechanism in his brain that says "I got hit. I’m going to hit back." Tactile defensiveness is not just on the outside of the body. When there is tactile defensiveness in the mouth the child may have feeding problems or reject foods that are gritty or have unfamiliar textures or tastes.
Tactile defensiveness can also relate to hearing and vision. If a child’s sense of touch is not functioning properly the other senses may not be able to develop appropriately.

The sense of touch is more primitive than the visual and the auditory system. If there are tactile problems the child’s ability to move up the ladder of development and use higher level of sensory integration will be affected. He/she may not be able to look and listen normally. If that tag in his shirt is driving him crazy, paying attention to what the teacher is saying will be difficult. How many of you cut the tags out of your kids clothes? How many of your kids can’t wear their socks unless that seam is exactly right? This is tactile defensiveness. [Solve the sock seam problem by turning your child’s socks inside out so the smooth seam is against the child’s skin and the rough seam is on the outside.]

Occupational therapists use a technique of brushing a child’s skin with a special brush to help normalize the information the skin is taking in and develop more normal tactile responses. (The palms of the hand and soles of the feet are the most sensitive parts of the body and brushing should not occur on those places in the beginning. The child will probably not lose the defensiveness in those places.)

The proprioceptive system deals with the information which is coming in through the muscles and joints. It is what allows you to sit in uncomfortable chairs for a long time without leaning on the table, without falling off. Your body’s muscles are giving information to your brain that they are okay. This system allows you to feel comfortable with gravity.

The child who has problems in this area needs to have deep pressure applied to the muscles; the way to get that is by moving. A child whose muscles aren’t giving the needed feedback will wiggle and squirm until he/she feels secure, and can then pay attention to what is being taught. Proprioception is one of the systems most closely related to good self-control.

Some children have difficulty sensing where they are in space.

The vestibular system controls balance and is physiologically located in the inner ear. So what happens when a child has ear infections? The child’s vestibular functioning will be affected. The vestibular system, like the tactile system, is already developing in utero. It’s not as mature at birth as the tactile system, but a child knows when he’s balanced and unbalanced and can detect motion. That’s why kids love to be rocked. Rocking is calming because it stimulates the vestibular system. When a mom is required to stay in bed during pregnancy, the infant does not get the vestibular stimulation it would if the mother were moving around.

Rocking is calming because it stimulates the vestibular system - the system which controls balance.

The vestibular system is also involved with bilateral coordination - getting both sides of the body to work together. It is connected to several important aspects of brain function: the language center of the brain, eye movements and to the digestive tract. That’s why kids throw up when they have too much vestibular stimulation.

A child can have both a hypo and a hyper reaction to the vestibular system. Kids who get motion sickness are having an overreaction; others may crave motion and vestibular stimulation. Both of these reactions are at the abnormal ends of the scale. What sensory integration therapy does is help a child tolerate a certain amount of movement, but not crave it.

The sense of touch, which involves our largest organ, the skin, is the first to develop and is fully functional at the time of birth.
Muscle tone is related to the vestibular system. Kids with low tone need continuous vestibular stimulation. They have trouble sitting still and staying alert at the same time. If you watch them during the day, they gradually fade, slouching down in their chair and may eventually slide off!

A good teacher will know when it’s time to start working those muscles to increase that tone. If you have a mini trampoline at home, it’s a great thing to have your child jump on it for a couple of minutes before going to school. If the teacher is willing, have her put a mini “tramp” in the classroom to give the restless student a break; that will make it easier for him to pay attention. Many tutors are using trampolines to help kids with memory skills such as the alphabet or number facts. The rhythm of jumping enhances the ability to pay attention and remember the information.

Hierarchy of Development

Look at it like rungs of a ladder, where the bottom rungs (basic sensory channels) lay the foundation for development, and each rung provides the basis for the next steps above it. The top two rungs (cognitive and perceptual skills) are what go on in school.

When you have a child who is being treated academically or behaviorally and you approach the problems from the top down, it doesn’t work. You have to work from the bottom up and also from the inside out because you have to teach the system how to monitor itself, how to organize itself and contain itself in an automatic way, rather than structure it from the top.

One of the things that occurs at the top is self esteem; everyone talks about self esteem, as though we can hold it in our hand, like “we’re going to increase his self esteem.” Unless you move up the ladder, unless your body feels comfortable with gravity, unless you feel healthy, there is no way you can work on self-esteem from the top down. All the behavioral and emotional components can be related to one of these lower level sensory processes.

Cognitive Skills:
- Writing
- Spelling
- Reading
- Imagination
- Visualization
- Self Esteem
- Capacity for abstract thought & reasoning

Perceptual Skills:
- Organization
- Attention
- Visual Perception
- Self Control
- Speech & Language
- Concentration
- Auditory Perception

Fine Motor Coordination:
- Speech & Language
- Eye-Hand Coordination
- Controlled Oculomotor Skills

Gross Motor Coordination:
- Balance
- Motor Planning
- Oral Motor
- Visual Motor Integration
- Bilateral Integration
- Lateralization
- Body Percept

Innate Reflexes:
- Tactile Comfort
- Sucking Reflex
- Muscle Tone
- Eye Movements
- Gravitational Security

Basic Sensory Channels:
- Tactile
- Auditory
- Vestibular
- Visual
- Kinesthetic
- Proprioceptive

Physiological reactions which can interfere with the development of the higher senses include:
- nutrient deficiencies, immune system dysfunction, chemical sensitivities, inflammation, allergies.
Let’s try using the Feingold Program to help children who are challenged by Sensory Processing Disorder (SPD)

We all have sensory preferences: like it warm, you like it cold. I like studying with the radio on, you prefer the quiet. I like to chew on my hair while listening to the teacher: you’re fine with sitting still in your chair. I like swinging and running on the playground; you stay close to the teacher during recess. I like baggy-fitting clothes; you prefer tighter-fitting so they don’t rub your skin. I like having the lights on; you like them dimmed. I like crunchy foods; you enjoy softer choices.

Too fast, too slow; too loud, too quiet; too aggressive, too reserved- - could indicate Sensory Processing Disorder.

Most children make adjustments if their sensory preferences aren’t met, without too much fanfare. If it’s too warm, they make a paper fan or drink some water. If someone else wants to be at the back of the line, they ask to walk with the teacher at the head. If the fluorescent lights cause too much glare, they automatically use their hands to shade their eyes. If their surroundings aren’t perfect, they know they’ll be OK. They can regulate, or adjust, the way they react to the world around them.

But for those children with SPD, it’s not so simple. They don’t have preferences, they sensory must-have demands. According the SPD Foundation, one out of every 20 children struggle with this disorder, and symptoms occur within a broad spectrum of severity. While most of us have occasional difficulties processing sensory information, for children with SPD these difficulties are chronic and disrupt everyday life.

How can you tell that a child is struggling with SPD? Behavior is the first indicator that something is awry. Unlike the cast that protects a broken bone, or a rash that indicate an allergy to grass, there’s no physical indication of this hidden neurological disorder, so we rely on the baffling behaviors as red flags. SPD is complex and there are many subtypes. (For a detailed breakdown visit www.SPDFoundation.net.)

Over-reactors, under-reactors, and seekers

One subtype of SPD is sensory modulation disorder, or the difficulty in regulating the intensity of how you respond to sensory information. One person will over-react, another may under-react, and yet another might seek out sensations. A sensitive child could over-react to touch, sound, smell, taste, visual cues, movement, or gravity by having a meltdown. Another child could under-react and not notice the smell of smoke coming from the kitchen or hear the teacher calling their name for the third time. And another might seek out sensory experiences by playing loud music, or running into a wall for "fun." What makes SPD even more complicated is the fact that someone with modulation issues might have a combination of these traits, depending on the situation. Trying to understand and help these children is frustrating, to say the least!
Jordan

Let’s meet Jordan: he is 10-years-old and hates school. He covers his ears in class because it’s too noisy and he is overstimulated by posters and other displays on the walls. Jordan never stays in line on the way to the library or the cafeteria because someone is bound to bump into him and it hurts! He always sits by himself at lunch time. He struggles with handwriting and requires extra time on tests because he processes information more slowly than the other children. He’s smart, but can’t demonstrate it because his brain is constantly dealing with a barrage of sensory “missiles” coming his way.

Jacob

Now let’s meet Jacob. He’s 9 and sees the world as his private jungle gym or big-time amusement park. Like Jordan, he hates school, but for very different reasons. The school routine does not provide enough movement for Jacob. He is impulsive and appears to be inattentive because he is always in motion, but it’s this movement that keeps him focused. Jacob loves sports and plays with such gusto in gym class or on the playground that he drives the other kids away. He chews on his water bottle, fiddles with his pencils, and arrives at school with some of his breakfast still on his face.

Like Jordan, Jacob is teased at school, and it’s hard for him to handle the rejection. At home, Jacob loves to wrestle with his Dad and crash into the walls, to his Mom’s dismay. His risk-taking behavior results in many injuries, yet he feels little pain.

Who can help?

Look for a pediatric occupational therapist (OT) who is certified in both sensory processing/integration theory and in techniques to perform an evaluation. Visit www.spdfoundation.net and www.aota.org for listings. An OT diagnoses sensory challenges and designs specific therapy regimens which include challenging play during therapy and a “sensory diet” of activities for home and school. Also: spdcanada.org, fhsensory.com, alertprogram.com, gameslady.com, and out-of-sync-child.com.

Can the Feingold Program help these children?

I always recommend parents try Feingold in addition to the other therapies, like OT (occupational therapy). A therapy session will not be very productive if the child is having a meltdown because of those red dyed licorice treats that were supposed to provide calming, deep pressure input to the jaw.

I don’t believe that removing artificial ingredients will cure a child of SPD, but it may help eliminate some of the behaviors that baffle us and are uncomfortable for our children. Many of the parents in my SPD on-line support group have seen a decline in the intensity of meltdowns after they have removed just the red dyes from their child’s diet. This is very encouraging!
It isn’t easy to figure out exactly what causes a meltdown or what triggers an excessively high energy level. But we can make progress in helping these children by addressing the many areas that might be involved, including diet, chemicals in the environment, social skills, sensory deficits. By peeling away the layers, we can get closer to the core of the problem.

Removing harmful additives is important for all of us, but it’s especially important for a child’s developing body and brain. The petrochemicals used to create those beautiful colors and enticing flavors are damaging to the nervous system. And a child with Sensory Processing Disorder cannot afford that additional stress to their already-compromised system.

Let’s take artificial ingredients out of the mouths of our babes so we can help them succeed.

Ida Zelaya is a Feingold member and President of Sensory Street, a unique educational consulting company that teaches about SPD and strategies for these wonderful children in school, at home and out-and-about. Her toolkit is filled with whole-child approaches including increasing movement, nutritional support, exploring feelings and making connections. Visit www.SensoryStreet.com.