

# Learning Disabled Adolescents' Perceptions of Resource Room Experiences

A. Geoffrey Abelson, Ph.D.<sup>1</sup> Barbara Donery, M.S.<sup>1</sup>

## **Abstract**

*Nearly 300 learning disabled adolescents, in grades 7 to 12, being served in resource rooms responded to a questionnaire designed to identify the respondents' perceptions of resource room experiences. Four orthogonal factors characterized their responses: Positive Value of Resource Room, Negative Social Connotations of Resource Room, Perceived Reactions of Nonhandi-capped Peers, and Positive Personal Feelings Towards Resource Room. The results indicated learning disabled high school students place higher value on resource room service than do learning disabled junior high school students. Learning disabled high school girls appeared more sensitive than others regarding negative social connotations of being served in a resource room.*

The purpose of this study was to investigate adolescent learning disabled students' perceptions of their experiences in resource rooms. To date, researchers have examined how parents (Bell, 1971; Hurley, 1967; Strickler, 1969), peers (Bryan, 1974; 1976) and teachers (Hohenshil, 1975; Scranton and Downs, 1975) respond to handicapped youth, and the impact of being labeled handicapped

on self-concept (Abelson and Check, 1981; Abelson and Staley, 1982; Larsen, Parker and Jorjorian, 1973; Rosser, 1974). However, little is known regarding adolescents' views of experiences in special education.

In our society, the development of adolescence is associated with ongoing change and confusion. Adolescents have been viewed in the process of separating themselves gradually from the nuclear family concurrent with establishing stronger ties to a peer group. The former is demonstrated via rebellious behavior to show independence. The latter requires conformity to group norms and behavior patterns beyond the family which may be in conflict with parental values, attitudes and experiences. At the same time, adolescence is a time of profound physiological transformations frequently taxing the individual's ability to internalize and accept a new sex role image. There is constant need for peer approval from both sexes. Upon entry to high school the adolescent begins the process of making a career or vocational choice, often with little prerequisite information on which to base that choice.

1. Iowa State University Ames, Iowa

Accompanying these strivings for independence is an ambivalence characterized by a continuing reliance on the nuclear family for economic and psychological supports. The adolescent is not prepared "yet" to separate, but neither are parents willing to "let go." This is a gradual process marked by apprehension, dissention, and conflict. Parents frequently try to hold on to preconceived notions and expectations of how the adolescent should perform in various areas of his life. The inability of most adolescents to meet or conform to parental expectations results in friction and confrontation. Of course, there are gradations of parental demands. Thomas and Chess (1977) attribute biogenetic endowments and predisposition as affecting individual offspring and subsequently affecting parent-child relations.

Other than the family, the school provides the most profound influence on all students. The school is where children spend most of their waking hours and is their main occupation when away from the family. The role of the school is more than to teach academics. The school also relates to children a range of cultural and social experiences and helps students assume larger increments of responsibility for their lives.

For handicapped students, the total school experience can be quite bitter and provides little reinforcement for efforts or reaffirmation of acceptance. For the learning disabled student, the secondary school experience may be one of continued frustrations and failures in academic areas.

Typically, the learning disabled student is served in the resource room model. Over the past decade, the resource room has become the most parsimonious approach for providing remedial and habilitative education. Students spend a minimum of two hours a week to several hours per day in the resource room, and are integrated into general school activities for the remainder of the day. This approach conforms to "the least restrictive alternative" or mainstreaming criteria of Public Law 94-142.

At the secondary level, resource rooms generally provide a tutorial service, and help the individual student survive, culminating, hopefully, in graduation. With few excep-

tions, the remedial and habilitative aspects of the resource room rarely go beyond the elementary school level. In fact, there is no evidence in the literature of systematic efforts to program for the learning disabled adolescent. Special services to learning disabled teens are almost exclusively in the form of academic tutoring which is content oriented, rather than individually oriented (Cruickshank, Morse and Johns, 1980; Irvine, Goodman and Mann, 1978).

Considering the disruption of the normal socialization processes occurring in school for learning disabled adolescents, the literature is void of the perceptions and attitudes of learning disabled teens. These writers have developed a questionnaire to ascertain how learning disabled teens perceive their experiences of being served in a resource room.

## METHOD

### Subjects

A total of 291 subjects comprised the sample group. From the junior high school level, there were 150 males and 43 females for a total of 193. From the senior high school level, there were 72 males and 26 females for a total of 98. All subjects were obtained from junior and senior high school resource rooms in central Iowa. Only those students identified as being learning disabled were included. Students with any other diagnostic label were excluded. No age or grade levels were gathered for descriptive data. In the state of Iowa, a criterion for being diagnosed as learning disabled is to have an IQ score within normal limits or above 85.

### Instrument

To ascertain the learning disabled students' perceptions and attitudes of being served in resource rooms, a 24-item instrument was developed. In designing the instrument, two separate areas of concern served as major guidelines: the learning disabled students would have limited reading abilities, and the lack of uniformity of resource room programs.

Thus, all items were written to correspond to a third grade reading level. The content of the items is general enough to be relevant and of interest to any learning disabled adolescent. In addition, it was felt normative data or a

**Table 1**  
**Learning Disabled Adolescents' Perceptions of Resource Room Experiences**

	<b>Factor I</b>	<b>Factor II</b>	<b>Factor III</b>	<b>Factor IV</b>
Resource teacher helps with problem	0.10282	0.41470	0.13333	0.48470
Others make me attend resource room	0.45506	0.26020	0.12926	0.10355
Resource room is a place to goof off	0.07700	0.53671	0.12566	0.15830
Others call me stupid because of resource room	0.01844	0.11729	0.85594	-0.01920
I would fail courses without resource room	0.49140	0.08276	0.04961	0.21840
Resource teacher cares about me	0.20826	0.41042	0.17315	0.40403
Parents feel resource room helps	0.26114	0.35214	0.02159	0.01943
I like coming to resource room	0.70950	0.17589	0.15559	0.21917
Teacher likes me	0.15341	0.29581	0.07824	-0.07847
Friends would like resource room	0.31367	-0.15644	0.02870	0.47006
Resource teacher makes me work too much	0.15194	0.42092	0.19375	0.20011
Others make fun of me because of resource room	0.04580	0.10023	0.84200	-0.06763
Other teacher expects too much	-0.04438	0.34547	0.14205	-0.08995
I need help on assignments	0.48089	0.22619	-0.02291	0.20766
Resource room is for dumb kids	0.26796	0.53232	0.18804	0.25915
My parents want me in resource room	0.19890	0.27291	0.16754	-0.04695
I will always need resource room	-0.01545	-0.13771	0.07454	0.03410
Resource room is embarrassing	0.15165	0.11446	0.43030	0.15217
Behavior is better in resource room	0.17577	-0.12415	0.00514	0.41809
Understand why I am in resource room	0.32386	0.46933	-0.08521	-0.06228
I like resource teacher	0.38763	-0.02465	0.03726	0.48904
I prefer resource room to other classes	0.58138	0.25930	0.23530	0.20426
Resource teacher helps me	0.15797	0.45537	0.07722	0.56541
I prefer resource room all day	-0.00317	0.00151	0.00824	-0.07785

cumulative score would preclude a sensitivity to varying individual experiences. Thus, subjects were offered only three types of responses to each statement: indicate agreement by circling "yes"; indicate disagreement by circling "no"; and indicate hedging by circling "sometimes".

**Procedure**

The 24-item instrument was administered to all subjects by the resource room teachers on a group basis. Resource rooms in Iowa

serve a maximum of eighteen students, who spend time in the room on a staggered basis of three or four at a time. The resource room teachers were instructed to read the items aloud to the group while the students read the items silently and responded. No separate answer sheet was provided, but rather room for circling the preferred response followed each item. In this way, deficient readers were aided, although a number of

subjects still failed to complete all items or responded incorrectly (e.g., circled two responses). Subjects were instructed not to place their names on the questionnaire but were asked to indicate their sex by circling the appropriate symbol.

**Statistical Analysis**

Previous to the actual analysis of data, the most desirable response to each item was determined by polling 25 graduate students also working as resource room teachers. The most desired response was given three points, the least desired one point, and the hedging or "sometimes" response two points.

The 24 items were intercorrelated using Pearson Product Moment correlation coefficients. A principal components factor analysis was performed on all items, followed by a varimax rotation. Ten orthogonal factors were initially explored, but only four orthogonal factors were rotated for interpretation. These four factors are presented in Table 1.

In interpreting the factor matrix, only those factor loadings were chosen which were quite high and relatively close to one another. No arbitrary cutoff point or criterion for choosing factor loadings was utilized. Quite succinctly, only the highest loadings were picked for each factor. Items that loaded in more than one factor were excluded. Such items only serve to increase the correlations among factors and increase the ambiguity of the interpretations.

Factor 1, labeled Positive Value of Resource Room, included items reflecting personal gain from the resource room service (e.g., like coming to resource room, prefer resource room to other classes, get help with assignments in resource room, would fail courses without resource room). Coefficient alpha was .75786.

Factor II, labeled Negative Social Connotations of Resource Room, included items reflecting how learning disabled peers view the room (e.g., a place to goof off, for dumb kids, resource teacher gives too much work). Coefficient alpha was .65911.

**Table 2**

**Analysis of Variance of Factors**

Factor	Source	df	MS	F
<b>I</b>	Sex		.877	1,599
	School		1.178	
	Sex x School		.424	
	Error	287	.549	
<b>II</b>	Sex		1.249	2.318
	School		.070	
	Sex x School		.035	
	Error	287	.539	
<b>III</b>	Sex		.334	.583
	School		.468	
	Sex x School		2.846	
	Error	287	.573	
<b>IV</b>	Sex		.744	1,492
	School		.321	
	Sex x School		.185	
	Error	287	.499	

Note: Factor I=Positive Value, Factor II=Negative Social Connotation, Factor III=Perceived Reactions of Peers, and Factor IV = Positive Personal Feelings.

Factor III, labeled *Perceived Reactions of Nonhandicapped Peers to Resource Rooms*, included items reflecting how peers treat resource room students (e.g., call me stupid, make fun of me). Coefficient alpha was .86213.

Factor IV, labeled *Positive Personal Feelings Towards Resource Room*, included items reflecting reinforcing attitudes toward the resource room (e.g., like to talk to resource teacher, friends would like resource room, behavior is better in resource room). Coefficient alpha was .59371.

The four factors were studied further using analysis of variance to determine if there were significant differences between junior and senior high school students and between the sexes. In Table 2 are presented the results of the analysis of variance.

For factor scores derived from Factor I, *Positive Value of Resource Room*, the analysis of variance indicated a significant effect of school level ( $F = 3.970, 1/287$  df,  $p < .05$ ). Thus, students in high school resource rooms viewed those rooms in more positive terms than did junior high school students in resource rooms. Factor I accounted for 58.6 percent of the variance.

For factor scores derived from Factor II, *Negative Social Connotations of Resource*

Rooms, the analysis of variance revealed no significant differences between school levels or sexes. Factor II accounted for 20.6 percent of the variance.

For factor scores derived from Factor III, *Perceived Reactions of Peers to Resource Rooms*, the analysis of variance showed a significant interaction effect of school level by sex ( $F = 4.970, 1/287$  df,  $p < .03$ ). Thus, high school girls in resource rooms perceived more negative reactions from peers regarding resource room involvement than did all other students. Factor III accounted for 12.4 percent of the variance.

For factor scores derived from Factor IV, *Positive Personal Feelings Towards the Resource Room*, the analysis of variance indicated no significant differences between school levels or sexes. Factor IV accounted for 8.5 percent of the variance.

The final analysis of the data was an analysis of variance of each of the 24 items. The procedure determined differences between junior and senior high school students and between the sexes. The results are presented in Table 3. Since the assumptions of analysis of variance cannot be reasonably well approximated using variables having only three levels, only significant differences of  $p < .01$  are included.

**Table 3**  
**Analysis of Variance of Individual Items\***

Item	Source	df	MS	F
High school students attend resource room willingly (Factor 1)	School	1	5.990	7.659
High School girls feel they are called stupid (Factor 3)	School x Sex	1	5.319	8.792
High school students would fail without resource room (Factor 1)	School	1	5.471	7.724
High school students feel resource teacher cares	School	1	2.558	6.786
Girls feel other teachers like them	Sex	1	3.734	7.823
High school students need help on assignments (Factor 1)	School	1	3.419	7.014
High school girls feel parents oppose resource room	Sex x School	1	3.745	7.891

\* All items  $p < .01$ .

**DISCUSSION**

The results of this investigation reveal the attitudes and perceptions of learning disabled adolescents toward involvement in resource room services form a multidimensional configuration of general and specific evaluations. The multi-dimensional nature of attitudes and perceptions indicates high school students place a higher value on resource rooms than do junior high students.

The data suggest secondary age students in resource rooms evaluate those rooms in both positive and negative terms. A general Positive Value factor appears to exist, as does a general Negative Social Connotation factor, perhaps similar to positive and negative perceptions that people have to any alternative educational program. Furthermore, more circumscribed positive and negative items emerged focusing on the social and emotional concerns of adolescent students in resource rooms.

The findings that emerge from this study suggest that the dimension of perceptions and attitudes shifts differentially as students become older. That is, the Positive Value of Resource Room factor improved markedly for high school students. On the other hand, the Perceived Reaction of Peers to Resource Room factor, as well as individual items, reflects increased negative social perceptions of resource rooms among high school girls served in those rooms.

Perhaps high school students in resource rooms have more positive perceptions of their experiences because they have come to rely on supplementary resource room services to pass courses. Also, high school students generally are aiming to graduate, and without resource room assistance, graduation may not be a realistic goal.

High school girls in resource rooms appreciate the value of the resource room, but it seems they may be more sensitive to perceived negative social connotations of peers regarding resource rooms. This represents a certain ambivalence despite the pragmatic value of the resource room. Part of this ambivalence may be a function of feeling their parents are not supportive of their resource room placement (see Table 3). These findings suggest high school girls

served in resource rooms are more sensitive to reinforcement from peers and parents than boys. In contrast, perhaps boys in resource rooms do not feel their personal identity is tarnished and may be more concerned about future vocational success. This rationale is not directly reflected in the data but is plausible. This does not preclude high school boys in resource rooms requiring overt approval of others, but their need may not be as dire.

As already indicated, special education to learning disabled adolescents is primarily in the form of academic tutoring with little concern for the contra-indications resulting from being labeled handicapped. Rarely are interventions psychotherapeutic and focused on a bruised ego resulting from many failure experiences and unsatisfactory relationships. The existence of variability in affect toward these programs suggests the inclusion of therapy or support to lessen the negative feelings students have as a result of membership in an "undesirable" group.

A real danger for the learning disabled adolescent is that a negative identity will be confirmed by the way the individual is treated by authority figures and peers. If this negative identity brings the individual in contact with excessively punitive parents, teachers or law enforcement officers, then energy is likely to be expended in confirming the adolescent's perceptions of how others view him. In addition, the learning disabled adolescent may develop what Erikson (1968) refers to as a historical perspective or the fear that earlier events in one's life are irreversible and limit future choices and directions.

In this study, senior high girls in resource rooms felt their parents were not supportive of their receiving special services and were more concerned than other subjects about negative social connotations. Kronick (1974) wrote that parents are often at a loss to know which of the learning disabled child's functions are impaired. Uncertain as to what the child really is and is not able to do, the parents may either deny the existence of a learning disability or fail to see the child as a whole person. Thus, there is a diffuse family image of the learning disabled person, instead of someone in possession of individual abilities and interests who happens to have a learning disability.

It is critical to realize the adverse effect that labeling a youngster may have in regard to peer interaction. Conformity to the peer group during adolescence is of the highest importance. As a result, identification through association with learning disabled adolescents may result in a devaluation of the individual in the eyes of peers (Kronick, 1974). Whether this devaluation actually takes place may not be as crucial as the fact the learning disabled teen feels devalued by peers.

### Limitations

The data in this study cannot be compared to similar research literature, since to our knowledge no other studies of this type are published. Consequently, additional studies must be done to either replicate or contradict our results.

The subject pool used in this study should have included a larger number of high school girls to add power to the results. In addition, the inclusion of the grade level of each student would have permitted other analyses and offered more delineated results.

The finding of a more positive value of the resource room service among high school learning disabled adolescents probably corresponds with increased maturity and future goals. However, more detailed study is required to better understand the dynamic changes in perception and attitudes. Such a study should be longitudinal in design, rather than cross-sectional.

The authors express their appreciation to Leroy Wolins, Ph.D. for his assistance in the statistical analysis of the data.

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# Letters

*The following was sent to the New York Times in November, 1983. We reprint it here with permission from Dr. Cott.*

The New York Times 229 West 43rd Street New York, N.Y.

## **To the Editor:**

Jane Brody's article on Personal Health which appeared in The New York Times on October 26, 1983 appears to be loosely researched. The reports on hair analysis which she chose to quote were those which would best serve her continuing attacks on megavitamins, on holistic and orthomolecular medicine, on chiropractors and anyone else doing something with which she disagrees.

Hair analysis is not used for determining vitamin levels. She states that the reports on the value of hair analysis giving a more reliable record than blood or urine of the nutrients and toxic substances in the body have not been substantiated by proper scientific research.

The July 31, 1982 issue of the Lancet published an article by Martin Laker of the Department of Child Health, Royal Hospital for Sick Children, Bristol, England. It is stated quite clearly that for testing for heavy metals where the cumulative intake needs to be known, blood reveals little.

The article quotes a report in the Archives of Environmental Health by H.G. Petering et al., in which they concluded that "blood is not a suitable material to analyze for cadmium since the metal remains in the blood only very briefly and in consequence the levels are extremely low." Blood can be used only for immediate measurements of exposure to lead and cadmium as it gives no indication of cumulative levels of these elements. Similar arguments apply to testing for arsenic and

mercury. When a factory released some arsenic compounds into a residential area, for example, it was some time before residents were examined and blood levels had declined to normal but hair was successfully used to determine those who were contaminated by the release. In a paper at the International Atomic Energy Agency Symposium on Nuclear Activation Techniques in the Life Sciences in Vienna, May 1978, G.F. Clements reported that in Italy blood was found to be a less reliable index of exposure to mercury than hair.

Frances H. Maugh II, writing in the journal Science, Vol. 202, December 1978, stated that hair has the potential to become a remarkable diagnostic tool because trace elements in particular are accumulated in hair at concentrations that are generally at least 10 times higher than those present in . . . blood serum or urine and may provide a continuous record of nutritional status and ' exposure to heavy metal pollutants.

The list of names of qualified researchers who have proper credentials in the field is a long one but Jane Brody dismissed their work by stating that the above claims have not been substantiated by proper scientific research.

Jane Brody seems to allow her antagonism to megavitamins and orthomolecular treatment to carry her far past the point of reasonable criticism. She has casually evaluated and disregarded important research and scientific documentation of efficacy in the diagnosis of many conditions. Her resistance has indeed become ritualized.

Sincerely,

**Allan Cott, M.D., P.C.**

### To the Editor Case Report

Regular medical approaches can be the key to treatment of some patients with bulimia, in spite of the obviously behavioral character of the symptom: uncontrollable binges of eating to the point of throwing up. Here is a brief summary of a case where the key to therapy was in microbiology and nutrition.

NR, a 42-year-old housewife, began bulimic episodes at age 32, two months after stopping birth control pills. In the next ten years, they occurred during her premenstrual two weeks, and after consuming coffee or sweets. She had always suffered premenstrual tension and repeated vaginal yeast infections. Because this pattern so resembled the yeast problem described by Truss (1), she was placed on an anti-Candida program of a sugar-free yeast-free diet, Lactobacillus, and nystatin USP powder by mouth. A month later she reported "incredible" improvement, with her energy back instead of being constantly tired, and without hunger or nausea except when exposed to a moldy wine cellar or consuming caffeine, sweets, or cheese. For the first time, she was free of premenstrual tension. A variety of lesser symptoms subsequently cleared up on treatment for food allergies, which are often present with the yeast problem. Six months after being first seen, she reported being essentially well, except for times of humid or rainy weather (when the mold spore count increases enormously), when she became hungry for carbohydrates and cheese (molds and yeast utilize only carbohydrate for their nutrition).

The result in this case was so clear-cut that it seems to merit reporting, with the comment that we will do well to keep in mind that there is more than one road leading to the final common pathway of the bulimia syndrome.

**Karl E. Humiston, M.D.**  
**104 East 40th Street, Suite 906**  
**New York, N.Y. 10016**

*(1) The Missing Diagnosis by C. Orian Truss, M.D. P.O. Box 26508, Birmingham, AL 35226*

### To the Editor

In response to Christine East's reply to Sally

Rockwell's Letter to the Editor, Vol. 11, No. 4 1982, pp. 275-6, Christine speaks of hypoglycemia (hyperinsulism) as a disease. Reactive hypoglycemia is a symptom, not a disease.

I have a history of alcoholism, some call it a disease; in 1975 I was diagnosed 'hypoglycemic' and thought it was a disease; 1978 my food allergies were uncovered and I knew that that was the disease; fall of 1982 I began treatment for Candida, the yeast infestation — perhaps now we're getting down to the cause of all of these "dis-eases".

What causes food allergies? Mal-nutrition? Exhausted adrenals? Vitamin and mineral deficiencies? Candida infestation?

Any one of these symptoms may be just the tip of the iceberg.

Food allergies can be responsible for mal-absorption which results in nutritional deficiencies. The offending foods can actually flatten the brush border villi of the small intestine so not only the absorption surface is lost, but lost also are the enzymes produced by those villi, which in turn contribute to vitamin, mineral, and various other deficiencies.

Decreased secretion of digestive juices, especially Hydrochloric acid and pancreatic enzymes, results in incomplete digestion of foods which leads to "foreign proteins" in the gut. These can leak through the wall of the intestine and elicit allergic responses (See Vol. 11, No. 1, pp. 114-5 1982, Letter to the Editor from Dr. Wm. Philpott). If Christine and her husband still need to eat every three hours to avoid low blood sugar symptoms, I urge them to explore two areas: (A) hidden or 'masked' allergies; (B) Candida albicans yeast infestation.

(A) Hidden allergies may be the problem. Eating the same foods day after day after day 'masks' our symptoms, so we don't know that we are allergic to them.

If the offending food (to which we may be addicted) is not eaten we experience actual withdrawal symptoms (i.e. depression, cravings, headache, tremors, confusion, hot flashes, and so on.) Thus we only feel good when the substance (food) is in our system.

**Simple Test:**

1. Fast on diluted juice, 8 oz. of juice per quart of pure water, each day for five days (drink plenty of additional water). If you feel rotten, especially on days 2 and 3, you are probably experiencing withdrawal symptoms. Generally by the fifth day the foods clear the system and a welcome sense of well being occurs. If fasting is not appropriate, try plan #2:

2. **The Cave Man Diet.** For 10 days eat lots of fish, meat, poultry and vegetables of all kinds. Omit all grains, dairy, peanuts, soy, sugars and caffeine.

Then introduce the omitted foods, one each day. Record foods and symptoms. The daily diary will reveal the offending foods. (See pp. 16 and 17 in *The Rotation Game* for detailed instructions).

Rotating foods is vitally important, both as a diagnostic and a healing tool in this detecting process. The foods which are keeping you hypoglycemic will emerge by elimination, rotation, and re-introducing, one at a time, back into your diet.

(B) Explore *Candida albicans*, the yeast infestation responsible for perhaps the majority of our sensitivities — both food and environmental.

See back issues of this journal for articles by Orian Truss, M.D.: Vol. 7, #1 - **Tissue Injury Induced by Candida Albicans**; Vol. 9 #4 - **Restoration of Immunologic Competence to Candida**; Vol. 10, #4 - **The Role of Candida Albicans in Human Illness**.

Christine's statement is full of *Candida* symptoms: "I've evaded genetic alcoholism, anorexia bulimia, diabetes, nail fungus, schizophrenia, vaginitis, etc."

By wisely omitting sugars and increasing the fiber in her diet, she unknowingly stopped feeding the yeast their favorite foods: sugars and refined flours.

Starving out the yeast is an important step in reducing the number of *Candida* organisms responsible for emitting and admitting toxins into the system. These toxins overwhelm the immune system causing allergies, hypoglycemia, and any number of other diseases.

Additional symptoms (clues) listed on the jacket of Dr. Truss's new book **The Missing Diagnosis** include: depression, anxiety, irra-

tional irritability, bloating, diarrhea, constipation, heartburn, indigestion, loss of self-confidence, inability to cope, lethargy, symptoms from contact with foods and chemical odors, acne, migraine headaches, cystitis, premenstrual tension, and menstrual disorders.

Current therapies for yeast control: (This is not medical advice, it's information only. Consult with your physician before trying any of this.)

1. Starve the yeast with a low carbohydrate diet (60-80 gms of carbohydrate per day), better yet, none at all for the first weeks.

2. Kill them with antifungals such as nystatin powder or Pau d'arco (taheebo) tea or garlic.

3. Replace the good bacteria — acidophilus. A pure, freeze-dried powder is now on the market.

The yeast feed on B vitamins and sugar. Restrict the B vits to 3 days a week, unless they serve a vital health need. Again, check with your doctor.

*Candida* seems to be a major contributing factor in an alarming number of degenerative diseases. The overwhelming incidence of *Candida* in my clients who experience hypoglycemia, allergies, obesity (compulsive eating), alcoholism, mental disorders and depression prompted this lengthy reply. The past six issues of my newsletter, **Allergy Alert** has been devoted to *Candida* updates.

I'm completing a handbook, **Coping with Candida**, or **Don't Feed the Yeast**, due to the growing interest in this dilemma. A straightforward, simple explanation of the tenacious beast; plus recipes containing **no** grains, dairy, starches, sugars, or yeasts; menu plans; carbohydrate counts and more.

The demand has 'pre-empted' my soon-to-be-released cookbook, **Rotation Game Allergy Recipes**, which will be totally free of the above foods, and also be color-coordinated with the master chart of my **Rotation Game**, the self-help-survival-kit for food allergies.

More new literature on *Candida*: Dr. Wm. Crook's new book:

**The Yeast Connection**, Professional Books, PO Box 3494, Jackson, TN. 38303. **The Missing Diagnosis**, Dr. O. Truss, PO Box 26508-B, Birmingham, Alabama 35226.

**The Human Ecologist:** five page article **The Candida Yeast, Some New Perspectives.** Summer 1983, #22. Box 1369, Evanston, IL. 60204.

Please feel free to contact me for further information on any of the above.

**Sally J. Rockwell, B.S.N.**

PO Box 15181  
Seattle, WA. 98115  
(206) 527-0877

### **Call for a National Conference To Form The American Federation of Primary Health Care Societies**

#### **Time for a Primary Health Care Profession**

The evidence indicates that most illnesses in modernized societies result from synergistic life-style factors rather than deep biomedical causes. These life-style factors involve radical deviations from the evolutionary baseline in respect to diet, exercise, psychosocial stress, smoking, drug and alcohol abuse plus powerful synergistic multiplier effects operating between them.

The apparent magnitude of the resulting damage combined with the controllability of these factors makes it prudent to seek correction now, even before formal proof is available, since the risk costs of inaction far exceed those involved in reversion to the traditional life-style, in so far as possible. To achieve this, professional aid can be useful. However, no formal profession dedicated to this goal exists. Although the medical profession has assumed tangential control through default, its activities in this area are unsatisfactory for several reasons. First, the medical profession is trained at great expense to provide high tech, high risk, high cost crisis intervention treatment. As a result, its services are generally less effective and far more costly than need be. Above all, provision of both services by the medical profession creates a major conflict of interest, for success in dealing with life-style factors reduces the need for its special services.

Therefore, two separate competing sectors of health care, primary and secondary, should comprise a complete, cost-effective health care industry in modernized societies.

(1) Primary health care can be defined as

professional aid delivered by specializing physicians or, preferably, by subdoctoral personnel who are not paraprofessionals of the medical profession but belong to an independent and competing profession dealing with low tech, low risk, low cost, life-style factors under the control of the client, including mainly reform nutrition, reform sports and physical practices and reform psychosocial counseling. The spirit of this profession may be epitomized by the motto: "Primary health care keeps the doctor (i.e., secondary health care) away".

(2) Secondary and higher health care levels can be defined as those dealing with high tech, high risk, high cost, crisis intervention methods, which properly require a technical monopoly by the physician because of the complexity and poor safety margin of the agents used. The term "secondary health care" can refer to all medical care generically or, more specifically, to general and family medical practice. This practice is now sometimes improperly referred to as primary health care, thereby effectively suppressing the idea of a competing nonmedical primary health care profession. Tertiary health care would then consist of center or hospital based medicine and quaternary health care would consist of ultra high tech medicine, e.g., neurosurgery.

To create a primary health care profession will require a national conference of the representatives of societies now dealing with reform primary health care. Without concern for their present conceptual maturity, these currently go under various names such as preventics, holistics, orthomolecular, ecological, sports "medicine", client-oriented psychosocial counseling and others.

The national conference would form such groups into a federation of primary health care societies for the purpose of creating a scientifically sound bona fide primary health care profession by establishing policies as well as self-enforcement machinery in at least the following areas.

(1) There should be developed professional standards of training, practice and ethics in primary health care to be inaugurated for all new members following a cutoff date prior to which all current practitioners would be admitted under a grandfather clause. Rigorous enforcement machinery for

standards and ethics, far exceeding that currently employed by the medical profession, should be established in recognition of the fact that those who do not regulate themselves will, sooner or later, be regulated by others.

(2) Food and nutrition policies, analogous to existing drug policies, should be developed including an essential nutrient pharmacopeia, a national food formulary and underwriter testing, all based on the scientific principle that induced deviations from the evolutionary baseline in respect to food, diet and the other factors constitute radical high risk uncontrolled human experimentation; and that it is the ethical and scientific responsibility of those who promulgate deviations to prove the safety and efficacy of the deviations using life-cycle primate studies of the total diet and other factors in their full synergistic potency.

(3) A research policy should be developed to seek the formation of a National Institutes of Primary Health independent of the present National Institutes of (Secondary) Health, which is entirely controlled by secondary health care interests and should, therefore, be renamed accordingly. The medical profession has long claimed to have conquered pellagra and beriberi, which decimated entire populations for over 100 years with a wide variety of mental and physical ailments, long erroneously held to be separate diseases of infectious origin. However, in fact, the medical profession has only identified the B vitamin form of these illnesses and has yet to consider the potentially far more serious substrate and modulator forms, which, augmented by lack of exercise and undue stress, may account for the rampant modernization diseases currently dominating the public health picture in modernized societies. For this reason,

the first priority of primary health care research should be to conduct a formal national diagnostic and therapeutic inter-disease concordance study, cutting across the boundaries of current medical specialties, to see if the medical profession is, once again, mainly treating different symptomatic expressions of a single disease — heart disease, schizophrenia, various types of cancer, immune diseases and so on. We may well find that continuing multi-adulteration of the food base now causes a vitamin resistant "Hoffer pellagra" instead of classical vitamin sensitive "Casal-Frapolli pellagra" and related disorders. Epidemiological evidence indicates that, if this is borne out, savings would exceed \$100 billion annually in the U.S. alone, apart from reduced suffering.

(4) Policies should be developed to optimize cooperation as well as competition between the primary and secondary health care sectors. It should be a particular duty of the two professions to develop guidelines encouraging the public to seek the services of the other too early rather than too late. No sector should be granted monopoly rights until it has shown it will increase the total cost-benefit picture for society at large.

Because the Huxley Institute for Biosocial Research, Dr. Abram Hoffer, President, is, by date of origin, the senior reform primary health care institution, it should logically organize the National Conference. To facilitate arrangements for this conference, I urge all interested society officers and individuals to communicate with the Huxley Institute for Biosocial Research at 219 E. 31st Street, New York, N.Y. 10016.

Respectfully submitted,

**Donald O. Rudin, M.D.**  
Bryn Mawr, Pennsylvania  
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