

# CHILD BEHAVIOR PROBLEMS

A Research Study

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Research involving the Edgar Cayce readings can be generally divided into three categories: (1) medical research, (2) voluntary application of concepts from the readings by various interested individuals, and (3) the controlled testing of specific non-medical concepts from the readings as to their general applicability.

The first category, medical research, is being coordinated by the A.R.E. Clinic in Phoenix and by some 250 doctors in various parts of the United States. Most of this work is concerned with testing specific medical treatments prescribed in the readings as to their applicability for individuals other than those who actually received the readings.

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*For information about medical research mentioned in this article, write to the A.R.E. Clinic, 4018 N. 40th St., Phoenix, AZ, 85018. A list of cooperating doctors is available to members by writing the Membership Dept., A.R.E., Box 595, Virginia Beach, VA, 23451.*

Research of the second type is being implemented by all those who are testing the validity and effectiveness of concepts from the readings (e.g., working with their dreams) in their own lives. Additional examples of this day-to-day informal sort of research would include following dietary suggestions from the readings and regularly practicing meditation as described in the readings. Regularly meeting in a *Search for God* group and working with the concepts in the *Search for God* books would be another example of this non-laboratory type of A.R.E. research. Our only data from this individual type of research are informal anecdotal reports of the benefits (and sometimes problems) that the experimenters (i.e., primarily A.R.E. members and Study Group members) attribute to the particular concept being worked with.

The third research category involves the controlled, systematic testing of non-medical suggestions (formulated as hypotheses) in the readings (e.g., a combination of castor oil packs, pre-sleep suggestion and spinal massage, applied for 28 days, will significantly change specific behaviors of children in a positive direction). As in the medical research, the general question is the applicability of the suggestions for others than those who received the readings.

The following study would best fit our third research category. However, a primary concern in this particular study was to create a beneficial experience for each child and his parents. The control group procedure and the pre- and post-treatment questionnaire did not eliminate a number of unmeasured factors which we suspect may have affected the results of the study. These factors and possible future control of them are outlined in the Discussion section.

#### *Description of Methods*

This project was initiated in response to many requests from parents whose children had difficulties ranging from bed-wetting to mental retardation. An examination of the readings given for children between the ages of four and sixteen revealed that at least four specific procedures were recommended often: castor oil packs, pre-sleep suggestion, spinal massage, and the radio-active appliance. Although there is no single reading that refers to all four of these, several readings have various combinations of two or three of the procedures. For purposes of the research study we decided to eliminate the radio-active appliance because of the expense involved. We felt safe in assuming that the other three could be combined without any ill effects upon the child. The project, therefore, consisted of a "treatment period" involving the

packs, massage and suggestion, which were to be carried out for 28 days. While assigned to the control group, a child received only the pre-sleep suggestion for a 28-day period.

Subjects were obtained in two ways: (1) unsolicited letters from parents requesting help, and (2) an article describing the project which appeared in the *A.R.E. News* in February and November of 1973. Only those inquiries from members of the A.R.E. who were willing to work with their own children in the home were accepted. The project was not designed in such a way that it could be carried out by a teacher or social worker.

Subjects were alternately assigned to one of two groups as inquiries arrived. Approximately half the children were placed in the group which completed all three procedures for the first 28 days and received only the pre-sleep suggestion for the second 28 days. The other subjects were placed in the group which received the pre-sleep suggestion for the first 28 days and all three procedures for the second 28 days.

An evaluation questionnaire served as a measure of changes in the child. This questionnaire consisted of 37 items for which the rater specified a score from 1 to 7. For example:

anxiety towards	1	2	3	4	5	6	7
peer relations	<i>very</i>						<i>no</i>
	<i>anxious</i>						<i>anxiety</i>
bed-wetting	1	2	3	4	5	6	7
	<i>daily</i>						<i>never</i>

In addition to these 37 items, each subject was rated on several other behaviors that were described by the parents in the background questionnaire. These additional ones (typically from three to seven behaviors) were designed specially for each individual case. Each child was rated by two individuals. Preferably, these were the father and the mother; but in one-parent homes, another relative or close friend participated as a rater. Raters were asked to respond to the items in terms of the child's *current* behavior.

Each family went through the following steps to complete the entire project:

1. Requested first inquiry packet from Youth Activities Department.
2. Received a packet containing materials describing the project, a copy of an example reading (given for a child with

- behavioral problems), a background questionnaire, and a release form.
3. Filled out the background questionnaire, signed the release form, and requested further information.
  4. Received a packet of information giving a detailed description of those procedures to be completed during the first 28 days. Each parent completed a copy of the enclosed evaluation questionnaire on the day that application of the procedures was begun, and mailed them back immediately.
  5. Near the end of the first 28 days, the parents received a description of the procedures to use during the second 28-day period and two more copies of the evaluation questionnaire. These were to be filled out on the twenty-eighth day and mailed back immediately.
  6. Near the end of the second 28-day period, a third round of evaluation questionnaires arrived. On the last day of the study, these were filled out and returned to the A.R.E.

### *Results*

There are four specific data computations that are necessary in order to analyze our results. The first approach involves calculating a score for each child that represents his or her overall change on the 37 general behavior items that appear on all evaluation questionnaires. This is done by completing the following steps: (1) For both the mother's and father's ratings, determine the difference between the pre-treatment and post-treatment scores for each item. (2) Find the sum of the differences for both the mother's and father's ratings. (3) Calculate the average of these two sums to give the overall change for that child. Once we have such a figure for each individual child, we can compute the average overall change per child, which is labelled "Part 1" in the following table.

A second average score is useful for later comparisons. It is the average change per item (i.e., the 37 general behaviors). This figure is simply the result of dividing the score for Part 1 by 37.

A third meaningful measure involves only those questionnaire items that were specially designed for each child. These should reflect changes in those behaviors described by the parents as significant problem areas for their child. These individually designed items differed greatly from child to child, both in number and in nature. Part 3 in the table below shows the average change per item in which only these special problem behaviors are considered.

Table 1

	<i>Pre-sleep suggestion only</i>	<i>Three procedures</i>
Part 1	+ 7.77	+ 10.88
Part 2	+ .21	+ .29
Part 3	+ .07	+ .72

It should be noted that the scores for Part 3 demonstrate that a combination of all three procedures from the readings is superior to the pre-sleep suggestion alone. By comparing Part 3 to Part 2 we conclude that the special problems of an individual child are more responsive to change by these procedures than the general behavior items are.

The fourth computation that is necessary to our analysis involves determining the average change for each of the 37 general behavior items. For example, there are 14 children who completed all three procedures. Since each child is rated by two people, we have 28 scores for the behavior "temper tantrums." The sum of these scores divided by 28 gives the average change for that item. The second table shows the behaviors that were affected the greatest and their average changes. No behavior changed in the *negative* direction to the magnitude of those listed in Table 2.

Table 2

<i>Pre-sleep suggestion only</i>		<i>Three procedures</i>	
	<i>avg. change</i>		<i>avg. change</i>
going to sleep	+1.16*	temper tantrums	+ .96
soundness of sleep	+ .83	fight with siblings	+ .75
attitude toward possessions	+ .67	orderliness	+ .58
temper tantrums	+ .67	anxiety toward	
punctuality	+ .61	family	+ .58
		obedience	+ .54
		physical complaints	+ .50
		attitude toward	
		possessions	+ .50

\*A positive score means an improvement (i.e., anxiety change of + .58 means that the condition is better or a lessening of anxiety).

For the behavior labeled "bed-wetting" a large percentage of the children had no possibility for improvement because they never wet the bed. If we consider only those scores for children who at least occasionally have this problem, we can compute an average change in the same way we did for Table 2.

<i>Suggestion only</i>		<i>Three procedures</i>	
number of children	avg. change	number of children	avg. change
4	+ .71	5	+ .90

Some of the most interesting results of the study are the reports that were volunteered by the parents. Although this kind of information cannot be used for a numerical analysis, it has encouraged us because the children are apparently being helped. Here are two examples.

Child #1 is fifteen years old. She has been a slow learner in school. Her parents hoped that she would improve her fluency of speech, memory, comprehension, and decrease bodily tension and irregular breathing patterns. The scores on the evaluation questionnaires show an overall average improvement of 8 points during the first 28 days (pre-sleep suggestion only) and an average improvement of 4 points during the second 28 days (all three procedures). These improvement scores are computed by averaging the ratings of the mother and the father. At the end of the second 28 days her mother wrote:

She is better since the past 28 days; it is rather difficult for me to say in exactly what areas — but she is better — all around sort of a general improvement. She is not nearly as cantankerous about many things — also her math is improving. She has learned the multiplication tables (sixes, sevens, eights, and most of the nines). In October she did not understand the word “times,” even three times two. She is now out of Remedial Reading. She went into the regular classroom January 2 [1974]. Yes, we are grateful to Almighty God for every bit of progress.

Child #2 is a twelve-year-old boy. Among those behaviors which the parents hoped to improve were “inner turmoil,” difficulty controlling bowels, fighting with brothers, verbal abuse of mother, and general hyperactivity. The scores on the evaluation questionnaire show an overall average improvement of 20 points during the first 28 days (all three procedures) and an average improvement of 8 points during the second 28 days (pre-sleep suggestion only). At the end of the first 28 days his mother wrote:

In one week there had been such a vast improvement. I couldn't believe it was the same boy. Now, with the completion of the first 28-day cycle, where he was constantly quarreling and fighting with his brothers, he was avoiding situations. Where his terrible all-consuming temper had been, he seemed reflective. His greatest improvement was in his attitude to me. Previously, he'd come from school, change his clothes and go out to play. Then, when I'd start supper the terrible fights with his brothers would begin. Many an evening ended by my being too ill to eat because of

his abuse to me. But now (and I thank God) he comes from school, changes his clothes and *talks to me!* We will sit and discuss a problem or he will follow me around as he tells me his thoughts or asks what I think. I am once again a part of this child I love!

### At the end of the second 28 days she wrote:

I really don't feel that I accomplished as much in this "run" as with the first. Perhaps that is due to the remarkable change in him during the first 28 days. Anyway, to me and in me, I felt more attuned when I was giving him the massages. I *felt* my love going out and into him much more.

### *Discussion*

In designing the project and in evaluating its results, we have speculated about two important considerations that are pertinent to any effort to change the behavior of children. The first of these is the question, "What really causes behavior change?" It is conceivable that a child responds only to the attention that he receives and that the specifics of *any* procedure or technique that is used matter very little. We could test this possibility by comparing our results with a group of subjects who received pats on the head instead of spinal massages, hot chocolate instead of castor oil packs, or had a comic book read to them instead of receiving a positive suggestion as they fell asleep. It is hoped that future research will allow a conclusion on this question for the castor oil packs and spinal massage.

The second important consideration relates to the attitudes of the parents towards the child's problems. The readings state that behavioral difficulties may exist not only as karmic conditions within the child, but as an opportunity for the parents to experience responsibility and a growth in self-awareness. For this reason the parents involved in this research were strongly encouraged to prepare *themselves* before starting to apply the procedures from the readings. They were asked to define for themselves their ideals as parents and to consider the reasons why they wanted their child to change. It is impossible to say to what degree this was done, but it was noted that in many of the cases in which the child improved significantly the parents reported in their letters that they had made a positive change in attitude themselves towards the child's problems.

### *Difficulties with Methods*

There are several difficulties with the methods employed for this study which may have had an effect upon the results. Since the procedures which are involved can take as long as two hours daily

to complete, only those parents who were very committed to this work made it through the entire 28-day period. Table 3 shows that the dropout rate was very high for this project — only 18% of the families who were motivated enough by their child's problem to inquire about the project made it through at least one 28-day cycle. Such a dropout rate makes this kind of research much more expensive in terms of staff time, postage and copying costs.

Table 3

	<i>Number of cases</i>	<i>Percentage of total</i>
Received first inquiry packet and did not continue	51	58%
Returned background questionnaire and did not continue	12	14%
Returned pre-treatment evaluation questionnaire and did not continue	9	10%
Completed first 28 days; did not complete second 28 days	9	10%
Completed first and second 28 days	7	8%
	88	100%

There are several possible weaknesses in the evaluation questionnaire. It is difficult to determine what basis parents used to make their judgments for each behavior item. The instructions for completing the questionnaire lack specific procedural directions. We cannot assume that all parents used the same amount of observation time in making their ratings. Some of the fathers are with their children a maximum of two or three hours daily, whereas the mothers usually have at least twice as much contact with the children. It is also possible that the child's performance in one behavior area might contaminate or color the parent's perception of the other behaviors. For example, a parent who notices a significant decrease in the frequency of the child's temper tantrums might begin to pay more attention to other problem areas. An additional weakness in the evaluation questionnaire is that we have no way of measuring the mood of the rater at the time the questionnaire is completed. It is easy to imagine that a mother who has had a trying day is more likely to be critical of her child, or that a father who has just received praise at work might be more likely to overlook the shortcomings of his child.



One factor that is difficult to estimate is the amount of rater bias. In many of the cases in this study, one of the parents is very interested in the work of the A.R.E. and the other parent is either uninterested or hostile. We might expect that the parent who is not actively involved in studying the concepts in the readings would be biased towards reporting no change or a worsening condition in the child. This tendency to discredit the validity of the readings could be either a conscious or unconscious bias.

Ideally, this project would have been run so that all subjects completed the procedures at the same time and with similar environmental influences. We might expect that those subjects who were involved in the study during the Christmas season or summer holidays were affected by factors very different from those present during the times when school was in session.

### *Conclusions*

We were aware of most of these shortcomings in our methods before the study began. However, if we had attempted to control all of the unmeasured factors that have been described, it is reasonable to assume that the inconveniences would have forced many more of the families to withdraw from the research. Our primary objective was to help the children involved, and apparently this has happened in many of the cases. Our secondary purpose was to collect data that would permit us to use scientific methods to make conclusions. We have found enough changes in the children to warrant a more carefully controlled study. Staff members at several residential schools and hospitals have expressed interest in participating in such a project.

In this research study we have tested a hypothesis from the readings for its general applicability and conclude that it does work for some children other than those who received the readings. We hope that our future research will show which procedures are especially helpful for particular behavior problems.

