



BOLK'S COMPANIONS

ON THE STUDY AND THE PRACTICE OF MEDICINE

From Special Needs to Realizing Your Full Potential

*Working with
Constitutional Pictures*

*Martin Niemeijer MD
Christina van Tellingen MD (Ed.)
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About the Kingfisher Companion Group

The Kingfisher Companion Group aspires to broaden the perspective of science by elucidating the context behind health and disease. To this aim, the foundation strives to pioneer investigative methods to complement and innovate conventional scientific views and research techniques. It examines the exploration of conscious-intuitive study in the research and practice of medicine such as the *4-step* approach employed in the Bolk's series. The Kingfisher Foundation supports this development of new approaches for medical practice both logistically and financially.

The Kingfisher Companion Group started at the Louis Bolk Institute where scientific research to further the development of sustainable agriculture, nutrition, and healthcare has been conducted since 1976. The basic tenet of the Institute regarding the life sciences is that nature is the source of knowledge about life. Through its groundbreaking research, the institute seeks to contribute to a healthy future for people, animals, and the environment.

About Professor Louis Bolk

Louis Bolk (1866-1930) was a professor of anatomy and embryology at the University of Amsterdam. He developed and employed comparative scientific methods of investigation that conveyed new insights into his subjects. With the insights he gained, he was able to place his subjects into a meaningful context. To employ his method, he instructed his students to use the "macroscope" rather than the microscope!

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About the Project

The project *Renewal of Medical Education*, aims to produce Companions that complement medical study by demonstrating how the insights of current biomedical science can be broadened by the insights of inclusive thinking inherent in comparative science. Companion authors apply a scientific methodology that uses four consecutive steps to achieve an integrated understanding of wellness and disease. These steps are described in Chapter 12 as the *4-step* approach. This approach seeks to recapture a coherent and comprehensive understanding of human nature and the environment.

BOLK'S COMPANIONS FOR THE STUDY OF MEDICINE are designed to complement medical education, specifically as it relates to human facets of current biomedical sciences.

BOLK'S COMPANIONS FOR THE PRACTICE OF MEDICINE contribute to a broader scientific basis for the clinical years of medical study and for developing the intuitive facets of medical practice.

BOLK'S COMPANIONS ON THE FUNDAMENTALS OF MEDICINE explore fundamental medical concepts and seek to broaden the medical paradigm.

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Introduction

In our work and in our daily lives we all encounter them: people with striking behavior or an unusual appearance. A person may pique our attention because they are obviously adult but seem to behave like a child; another may need to check five times if the light is turned off or express compulsive thoughts; a third is hyperactive and makes uncoordinated movements; or someone may just have a remarkably large head. And then there are those individuals who have overt mental or physical limitations, are clearly mentally challenged, or spastic. These striking characteristics are often present from childhood.

One would be hard-pressed to find a person with a completely ideal childhood. Hurdles for individuals to overcome seem to be part of normal development. These aberrations mostly resolve over time, with or without some extra attention. Indeed, children may gain a certain degree of resiliency when required to deal with some degree of childhood difficulty or trauma. As such, behavioral science has observed that development is not always impeded, but rather impervious to or even augmented by such challenges.

At the same time, there are people whose lives cannot recover from the tribulations of childhood difficulties, and in these people, developmental limitations may remain and have lasting consequences, both physically and emotionally. Such cases may be classified as disorders.

In this Companion, we mainly focus on those situations in which childhood development has been interrupted to the extent that independent living is challenged, requiring long-term or even lifelong professional help. We will discuss developmental steps in the following chapters that are universal to each individual.

Developmental disorders may manifest in many areas of physical and psychological development. As a rule, children with pronounced problems come to professional care at an early age, after which a lengthy process of research and diagnostics follows. During the diagnostic process, caregivers may experience uncertainty about how to respond to the child's challenges. Often, this ambiguity seems to disappear when the phenomena are clinically classified, like autism, Down



syndrome, or dyslexia, to name a few.

However, in reality, it is common for uncertainty to persist and ambiguity to arise when a child's constellation of symptoms do not fit neatly in to various diagnostic criteria. In addition, it can be difficult to classify a disorder when symptoms are not considered to be serious enough or when a dual diagnosis is indicated (co-morbidity¹). This indicates how multifaceted the known disorders are.

From Disorder Classification to Individual Developmental Perspective: Constitution Typology

Whereas in the past, the focus in the care of children with developmental problems was directed toward the pathology of disorders, the beginning of this century has brought increasing attention to children's individual ability to grow and develop. Nowadays, it is widely accepted that DSM-5² *categorization*, including its *dimensionalizing*,³ the main diagnostic tools for developmental disorders, is insufficient for meeting the individual person's challenges. For these reasons, an individual diagnosis was added to the categorical diagnosis to better reflect the individual situation: the *descriptive diagnosis* speaks to the individual's psychological and social situation to be able to address these with individualized therapy and care possibilities.

This Companion adds to the descriptive diagnosis by also portraying the individual's *developmental potential*. This portraying is based on experiential knowledge (phronesis⁴) of six different constitutional types that we have observed in children. With the aid of this approach, in addition to the categorical and customary descriptive diagnosis, we will take one step further toward individualizing the treatment plan.

We use qualitative language to describe a child's developmental potential, which are "portraits" of what we will refer to as a person's *constitution*. The concepts "constitution" and "constitution

1 comorbidity: diseases or disorders that occur at the same time and are often associated with each other

2 The DSM-5: The fifth Diagnostic and Statistical Manual of Mental Disorders) classifies developmental disorders as part of different categories

3 Dimensionalizing in the DSM V is done with a simple three-point scale that scores the severity or the frequency of symptoms

4 A term derived from *Ethica Nicomachea* by Aristotle, that can be translated as "moral sensibility", or "practical virtue"

typology" concern the person's individual make-up and the (developmental) processes involved with this. These two concepts will be discussed in Chapter 2. The *constitution types* are not fixed, but rather are part of the person's present developmental stage, and indeed, represent a developmental potential. The constitutional "portraits" are presented as images that illustrate next to the *developmental potential* also the *individual need for treatment, care, and support*.

Case histories of six constitutional types in Chapters 3, 4, and 5 offer the possibility to further define the circumstance of these clients.

We have developed a diagnostic approach (*4-step* approach) and an instrument (ICC) to assess childhood constitution, which can be used by physicians and paramedical professionals, as well as by care givers and pedagogical experts. The assessment tool, its development and application in practice, will be discussed as well as the question: how can its outcomes be translated into practices that support the daily life of the person in question and his or her treatment and care? In concise form, we will specify how a person's development can be supported and stimulated with the aid of an individual constitutional portrait.

Chapter Summaries

In **Chapter 1** we explore the problems of diagnosing and treating developmental disabilities and present a case history that will be further developed throughout the following chapters.

Chapter 2 gives an introduction to constitution and the constitution types with examples. It also discusses a polar perspective of health and disease.

Chapters 3, 4, and 5 each discuss one of the three different domains of constitution typology, as well as corresponding descriptions of the six constitutional types.

Chapter 6 discusses the diagnosis of constitution types with the *4-step* approach.

Chapter 7 is an introduction to treatment options for the different constitution types.

Chapter 8 discusses lifestyle implications of having and living with a developmental disorder and various coping strategies.

The subject of **Chapter 9** is the development and use of the instrument we developed for determining the childhood constitution (ICC), including the results of various research with this instrument.

Chapter 10 is an epilogue.

There are two appendices to this Companion.

Appendix One discusses the treatment options for the six case histories of Chapters 3, 4, and 5.

Appendix Two comprises the ICC.

1. **Developmental Disorders**

In this chapter we introduce the case history of Josh. Josh will accompany us throughout this Companion as we will further unfold his history, diagnosis and therapy in pertinent chapters.

1.1. **Case History: Josh**

Josh is eight years old. He is the second child in a family of five. His sister Clara is two years older, his brother, Harry, is three years younger. Josh's parents are concerned about him. They find him very active, notice some strange behaviors, and realize he does not play in the way other children do. He wanders around their home aimlessly, and frequently just stands staring and laughing strangely. Sometimes he flaps his arms erratically. He is not interested in his toys, his cars or his blocks. Everything he encounters he touches for a moment and then wanders on again. This is especially true for light switches and insects. He must turn light switches on and off a few times when he encounters them. He

can catch flies in midair, and when he does, he squeezes them until they are dead. He pets the cat hard and so firmly that it runs away from him. When Josh's brother was born, Josh did not seem to notice him at first. He only reacted to him when Harry started to stand upright and walk. Now, when Harry comes near Josh, he pulls on him and pushes him over, but he does not play with him. He cannot sit quietly on someone's lap to cuddle or listen to a story. When Josh speaks, he mainly asks questions about what he sees. He does not delve deeper into the questions. When he does not understand the answer, his reaction will clearly demonstrate this: he becomes restless, walks back and forth, his breathing becomes faster, and he turns red. When he cannot take it any longer, he



throws a tantrum, shouting, stamping on the floor, and hitting and kicking.

His was a much wished for, uneventful pregnancy except that in the last few months his mother had high blood pressure. He had a quick home delivery that was unexpectedly three weeks early. The midwife arrived just in time and Josh was able to remain in the home postpartum because his Apgar scores were good.⁵ Josh's mother bottle-fed him. He did not drink very well but had adequate growth. As a baby, Josh panicked easily and would stiffen up when there were loud noises. When his mother would pick him up to feed him, he seemed to startle, arching his back and throwing his head backwards and his arms sideways. Feeding him was difficult as Josh would always turn his head to the side and let the nipple slip from his mouth. In years afterwards, Josh could not sit comfortably on anyone's lap; he would often turn away, drop to the floor, and walk away. During his first few years, Josh was often snotty and frequently had a cold. He had repeated ear infections, sometimes accompanied by a high fever and delirium.

Josh was able to stand when he was a year and a half old. At two years he could say his first words: mummy and daddy. Josh has no problems eating. He has been potty-trained since he was three years old. Going to bed is difficult for him since then he is alone in his room; it is hard for him to fall asleep at night. He is anxious, especially during thunderstorms and when it rains.

In the months and years that followed his second year, speech development stagnated. He would often sit on his knees on top of his bed swaying back and forth while repeating daddy/mummy. Josh was a loner in kindergarten as well. He would walk round and round, looking at other children, and hardly played. At home, he only would speak about kindergarten when asked. And frequently his answers turned out to be fantasy stories, such as about a cat that was in the classroom and thrown out of the window; or that there had been a mouse in his boots and that he had played outside barefoot; and that a child ran away and could not be found anymore.

Josh was examined at the age of six by a child psychiatrist. This visit resulted in several classifications to be considered: ADHD because of his over mobility; a developmental psychosis because of his strange behavior and fantasy stories; an autism spectrum disorder was also considered. Eventually, Josh was diagnosed with a developmental disorder, not described in detail, and a mild intellectual disability. The parents were offered parental counseling following the visit to the psychiatrist to help them cope with Josh's angry spells and in choosing the right school for their son.

We will revisit and explore Josh's history throughout this Companion. His story is a prime example

⁵ The Apgar score is a method to quickly summarize the health of newborns. It measures Appearance, Pulse, Grimace, Activity, and Respiration.

of the experience of children with developmental disorders and their parents. It also helps us to understand how an individualized constitution typing as set forth in this Companion can aid us to recognize individual developmental potential and choose the specific treatment options that fit the family's unique situation.

1.2. Introduction into Different Developmental Disorders

Developmental disorders include a wide range of psychological and physical phenomena that all deviate from what is considered normal. These disorders pervasively affect child development and can permanently disrupt it. They can manifest before birth and continue in to adulthood. Healthcare providers are trained to be watchful for the signs and symptoms of such phenomena, especially in young children who have not (yet) been diagnosed. When the person concerned or his or her caregivers come to their family physician to ask whether something may be wrong, such as in Josh's case, further investigation is warranted to ascertain the nature and severity of the complaints, comorbidities, and course of the symptoms. This diagnostic track may lead to *identifying, classifying, and dimensionalizing*⁶ a disorder, which would give insight into the significance and possible further course of the symptoms. The labeling or categorization of a disorder provides direction for the person's care and may suggest possibilities for medication and therapies.

1.3. Categorical Diagnosis

Developmental disorders constitute a heterogeneous and incomplete group of illnesses. They manifest as a broad spectrum of psychological and physical phenomena that differ from normal development. Developmental disorders include (examples in brackets):

- Language/speech communication disorders (such as stuttering, deaf-mutism)
- Sensory disorders

⁶ Dimensionalizing in the DSM V is done with a simple three-point scale that scores the severity or the frequency of symptoms.

- Learning disorders (dyslexia, dyscalculia, NLD⁷)
- Motor disorders (dyspraxia, DCD⁸)
- Autism Spectrum Disorders (ASD)
- ADHD⁹
- Conduct disorders (CD¹⁰ and ODD¹¹)
- Eating disorders (Pica¹², rumination disorder¹³)
- Excretory problems
- Anxiety disorders
- Mood disorders/depression
- Tic disorders (Tourette Syndrome)
- Intellectual disability
- Congenital and genetic syndromes (Down syndrome, Turner syndrome, Prader-Willi syndrome, Noonan syndrome, Angelman syndrome, Cornelia de Lange syndrome, PKU,¹⁴ Fragile X syndrome, Lesch-Nyhan syndrome, VCF,¹⁵ Sotos syndrome, Williams syndrome, Tuberous Sclerosis, sex chromosome-related syndromes such as Klinefelter syndrome, Rett syndrome)
- Attachment development disorder due to early trauma
- Congenital and acquired brain injury (with or without motor or cognitive limitations; with or without epilepsy)

7 NLD: Non Verbal Learning Disorders

8 DCD: Developmental Coordination Disorder

9 ADHD: Attention Deficit Hyperactivity Disorder

10 CD: Conduct Disorder

11 ODD: Oppositional Defiant Disorder

12 Pica is characterized by an appetite for substances that are largely non-nutritive, such as ice (pagophagia); hair (trichophagia);[1] soil (geophagia); or feces (coprophagia) (Wikipedia)

13 Rumination syndrome, or Merycism, is an under-diagnosed chronic motility disorder characterized by effortless regurgitation of most meals following consumption, due to the involuntary contraction of the muscles around the abdomen (Wikipedia)

14 PKU: Phenyl Ketonuria

15 VCF: Velo-Cardiofacial Syndrome

Josh has symptoms that coincide with several of these disorder categories, such as a language disorder; ADHD because of his over mobility; an autism spectrum disorder; intellectual disability.

All of these neurobiological disorders impact normal development and can permanently influence the course of a person's life. In recent decades, physicians and researchers have "discovered" and described many developmental disorders, which led to their formal classification. Clinical descriptions have been published with information about cause, course, and life expectancy for particular developmental disorders, which are often written in cooperation with (representatives of) parents and family support networks. These descriptions also provide information about possible additional disorders and the likelihood of complications occurring later in life. In addition, general advice for treatment and care is available.¹⁶

The categorical diagnosis with dimensionalizing provides highly relevant information about disorders and has proven its value in daily practice. Often one or more diagnoses can be made at the same time as in Josh's case, and it is undisputed that setting standardized diagnoses is important and useful. Yet, the strict definition of a disease or disorder in and of itself usually lends insufficient insight into the *personal* care needs and often fails to answer to questions specific to each individual case.

Consequently, a categorical diagnosis holds restrictions (Rutter, 2011; Hudziak, Achenbach, Althoff, & Pine, 2007). Because classifications generalize, not all questions about the individual person will be answered. Questions come up such as: which of the criteria for the disorder are met in this case and to what extent? What is the meaning of non-disorder-related symptoms? Are there significant comorbidities? What does *this* patient need *at this time*? What is the most appropriate assistance and the most effective approach to his or her limitations?

1.4. Individualizing; Descriptive Diagnosis

From behind the question regarding individualized care, the child's own unique story emerges.

¹⁶ See websites of for instance the Autism Parents and Family Support Association, Down Syndrome Association, Society for Mucopolysaccharidosis and Related Disorders, CanChild (www.canchild.ca) for parents of children with DCD

Developmental problems and disorders have a rather heterogeneous symptomatology; they often do not fit in to the categories of a classification system. Moreover, usually not all criteria of the disorder are met and the severity profile differs from person to person. Additionally, children continue to develop and live with or in spite of developmental problems, and in time, the disorder may disappear or recede into the background. Alternatively, it may persist.

A categorical diagnosis names the signs and symptoms; it does not focus on the individual. By its nature, categorization is a quantitative method. Nonetheless, the question of care for a child with developmental problems always requires personalization while categorization above all gives insight into the more general developmental *problems* of a child.

The question *in practice* is ultimately how to address the individual situation and how to focus on providing the child with the support he/she needs within his/her environment. How can we find the means to aid *this* particular child in his/her development? How do we recognize the specific limitations and as well as the developmental *potential* of this individual?

To answer these questions, first a descriptive diagnosis which includes the child's specific social system, living situation, and available therapeutic and care possibilities was developed (Ruijsenaars, Van de Bergh, & Van Drenth, 2012; Whitcomb & Merrell, 2013; Miller & Rosenbaum, 2016). The descriptive diagnosis is in common use and is indispensable for the practitioner. It describes the social situation, living conditions, and available care and treatment options. In a descriptive diagnosis, the results of the study of empirically observable symptoms and behavioral phenomena, such as words spoken or actions taken, in the child's history and examination are brought together and ordered. When they are subsequently combined with data on the etiology (the categorical diagnosis with or without dimensionalization), then the combination of these two approaches will lead to a provisional diagnosis of the disorder (Wikipedia).

This still leaves one area unexplored: the child's treatment options in the light of their *individual developmental potential*. How do we identify the specific limitations and opportunities for this child's development?

1.5. Additional Approach: Assessing Constitution Typology

The need for further individualization in diagnostics and additional therapeutic options in practice encouraged the author to further develop an approach that characterizes the child from a developmental perspective and not only through the lens of disease and disorder. The author felt the need for an approach that provides language to portray the individual developmental *potential* of the developing child: this proved possible by doing it *pictorially*. He found this approach in the constitutional typology that was first described by Dr. R. Steiner (Steiner, 2015). On Steiner. On the basis of his own experience and the expertise of fellow health professionals in facilities for children with a developmental delay he also developed an instrument for assessing childhood constitution (ICC). This assessment tool for individualized constitution typology uses a *qualitative* portraying terminology. It is intended to complement the usual diagnostic methods and classifications, and can be used in parallel with it in daily practice.

In the following chapters we will further explore constitution typology.

Literature

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2. *Three Areas of Development and Three Core Principles in Constitution Typology; Polar Perspectives*

2.1. Introduction

In (medical) literature, the term "constitution" often refers to the genetic make-up of an organism, which is thought to determine the organism's form and function. In this paradigm, the person's constitution is considered static. The term "constitution" is derived from the verb "to constitute" (Latin: "*constituere*" means building). This is a dynamic concept that presupposes the organism's emergence, development, and functioning as well as possible environmental influences and epigenetic¹⁷ processes that may or may not be pathogenic. All of these may affect the organism's development of form and function and are often in addition to one's genetic disposition. As such, we expand the (medical) concept of "constitution." Basic constitutional patterns in this sense may be identified as developing physical or behavioral characteristics, but can also be appreciated in thinking patterns, in the psyche, or in biographic aspects. We will use the word "constitution" in this extended sense to refer to the person's full bio-psychosocial make-up.

A child's constitution may be characterized as a basic pattern that colors its individual make-up as well as its health problems by way of a risk profile or the "susceptibility" to certain illnesses. Patients develop various symptoms and complaints over time. Each of these can (and should) be treated one at a time. However, *recurrent* health problems may only be solved satisfactorily when treatment also focusses on management of the underlying constitution including its one-sidedness. A well-known example is the attempt to aid a person change their lifestyle when he or she has diabetes II and/or hypertension. Constitution typology aims at describing a useful conceptual framework with which the treatment can be directed at the individual's condition.

¹⁷ Epigenetics describes the apparent difference between inherited genetic traits (for example diabetes II in the family) and their expression in individuals. Many of these genes appear to have "on" and "off" switches. Methylation of these genes may occur during the course of life, causing them to be expressed ("on") or not ("off"). Lifestyle (such as diet, movement, sleep, or rhythm) and living conditions (such as safety, bonding, and stress) prove to be decisive in the expression of methylation.

Constitution *typology* orders facts concerning the person's constitution based on "typical" phenomena. When we speak about constitution typology in this Companion we refer to characteristic components of physical, psychological, and social functioning of the child.

2.2. Three Domains in Constitution Typology and Their Essential Principles

Psychology and psychiatry employ three developmental domains that are identified as the affective, cognitive, and conative¹⁸ domains. The cognitive domain relates to the person's capability to think, the affective domain to the person's feeling life, and the somewhat unusual term "conative" refers to the person's behavior. We purposefully chose these three domains from psychology and psychiatry: in practice the trifold domain paradigm "cognitive, affective, and conative" proved convenient; and various authors precede us in writing and researching childhood and adult psychological development and psychiatric diagnostics in terms of these three domains (Hilgard, 1980; Pervin & John, 1999; Hengeveld & Schudel, 2003; Dennis et al, 2013).

To characterize childhood constitution in this Companion, we will employ three *developmental principles* that we consider essential in the three developmental domains identified in psychology and psychiatry. Each principle is connected with one of the domains: in the cognitive domain "form" is a leading principle, in the affective domain this is "connection," and in the conative domain "movement" is essential. Constitution typology is based on these three fundamental concepts, as we will elaborate on in Chapters 3, 4, and 5.

Constitution typology can aid us in ordering the bio-psychosocial phenomena that children present us with. In organizing these, we will use qualitative descriptions, and research

- *how* a child functions, perceives, and thinks,
- *how* the child feels and acts,
- *how* the child's biological processes function.

¹⁸ The conative domain describes how one *acts*.

The choice for an approach linking the three developmental principles of “form, connection, and movement” to the three well-known developmental domains is primarily based on the work of Steiner (Steiner, 2015). More than 90 years of experience in describing developmental problems have validated using this perspective. It has been found to provide an apt framework, as well as a useful approach for professionals in practice. It is beyond the scope of this Companion to expound on the background of the coherence between the three domains and these three developmental principles. For this, reference is made to the literature (Steiner, 2015).

Summary three developmental domains and their leading principles

Constitution typology is derived from three known developmental domains: the cognitive, affective, and conative domain. These three domains are described in conjunction with three fundamental concepts: the “forming,” “connecting,” and “moving” principle respectively.

2.3. The Perspective of Polarities in Health and Illness

In section 2.2., we mentioned that we will make use of *qualitative descriptions* as we organize the bio-psychosocial phenomena of the child. The clustering around the three developmental principles shows us that in each of them a polarity may be observed, specifically of a relative “excess” and a relative “lack.” For example, in the conative domain we may see the polarity of “excess movement” and “lack of movement.” There is a continuum of varying tendencies to move in children between these two extremes. The bio-psychosocial phenomena in a certain domain will be described *qualitatively* at hand of this continuum (fig. 2.1.).

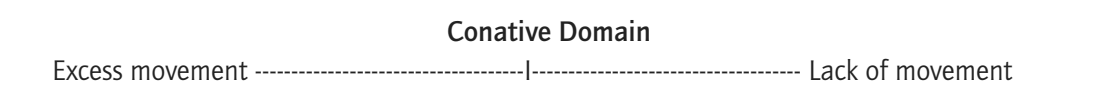


Figure 2.1. Example of plotting the constitution of an individual child

Before we delve deeper into the three domains and their leading principles in section 2.4., we will



first discuss the perspective of polarities in health and illness.

We use the perspective of polarities and a spectrum between the two extremes in the description of the three leading developmental principles. Articulating polar images at the ends of a continuum conforms to the biological principle that the healthy functioning of an organ, organ system, or of organisms can be set out on a continuum with polar pathologic conditions on each end and a healthy equilibrium that oscillates around the middle position (Van der Bie, Scheffers, & Van Tellingen, 2008). Following are a few examples.

Think, for example, of an over or underactive thyroid as in hyper- and hypothyroidism; or of immune system dysfunctions such as leukemia or leukopenia. As long as an organ (system) functions in harmony with the need of the organism, it is healthy. In medicine, we therefore speak of hypo- and hyperglycemia, hypo- and hypertension, hypo- and hypersensitivity, hypo- and hypermania, and so forth. In a similar way, human behavioral functions like eating, defecating, internalizing impressions, and externalizing one's feelings are based on maintaining a healthy balance in the vicinity of a virtual equilibrium. Health is the result of the organism's ability to dynamically maintain biological, psychological, and social equilibrium on various levels in permanent interaction with the environment (heterostasis). This is a continual process of adapting to the constant changes in physiology, in the psyche, and in the environment.

In health, organs are able to respond to the environment, for example, when we consume food, insulin is secreted by the pancreas to allow blood glucose to enter body cells, or when we enter a state of relaxation, our kidneys stop secreting renin and our blood pressure drops. If an organ's function starts to deviate too much from the balance point and at the same time loses the ability to adequately adapt to the needs of the system it is embedded in, a *disproportionate and fixed one-sidedness* may ensue. The manifestation of pathology is directly associated with the occurrence of such inability to adapt and consequent off-balance function (Van der Bie, Scheffers, & Van Tellingen, 2008, p. 28). This situation can be plotted on the continuum between two polar organ pathologies (Fig. 2.2.):

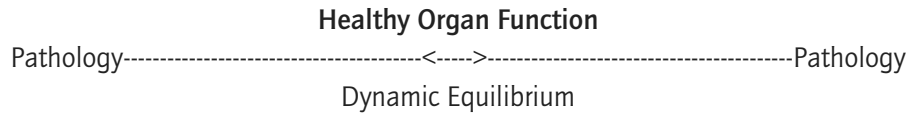


Figure 2.2. Healthy organ function as a dynamic equilibrium

Summary of the polar perspective

From a polar perspective, health is the result of the ability of all organs and organ systems, as well as of the psyche, to constantly adapt to the need of the whole organism. If this ability were lost, organ-, organism- and/or psychic function will get stuck in a one-sidedness that can no longer be adjusted, and has become fixed. The healthy, dynamic balance is lost, and pathology ensues.

2.4. The Polarities in the Three Developmental Principles

In constitution typology we use the three developmental principles of *form*, *connection*, and *movement* that were derived from the three previously mentioned developmental domains. These developmental principles are used to acquire a *qualitative pictorial language* by which typical manifestations can be described in bio-psychosocial functioning: we describe *how* the child functions, acts, etc. (section 2.2.). A comprehensive explanation and elaboration of how the principles working in the three developmental domains can be described using a qualitative pictorial language follows in the upcoming three chapters on the abilities of providing "form, connection, and movement."

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3. *The Ability to Form*

3.1. Introduction

In the following chapters of this Companion, we will outline and define the terms of the descriptive language we use in constitution typology to render an approach that is learnable and verifiable. We will describe constitution typology in terms of three developmental principles derived from the three domains as introduced in section 2.4., and characterized as a child's abilities to give form to, to connect to, and to move their organism, psyche, and/or environment in the world. In order to do this, we will take a conceptual leap for those of us trained in a conventional medical education setting. We will use the terms "giving form," "connecting," and "moving" to describe bio-psychosocial phenomena of child development. In healthcare institutions around the world, this approach was long found to be useful and suitable for describing child development and designating therapy (Steiner, 1996). In everyday speech, we often use qualitative and figurative terms to refer to bio-psychosocial phenomena, although usually in an unstructured, non-diagnostic manner. Examples of this kind of practice-based terminology include "someone having *crystal clear thoughts*" when they express themselves well, or "*a warm heart*" when they are helpful and nice for the people around them.

In this chapter and the next two, we will explore the themes of giving form, connecting, and moving. First, we will give a short characterization of the "ability to give form" as a developmental principle. The ability to form is a leading principle in the cognitive domain (section 2.2.). Then we will explain how to recognize a strong one-sidedness in this category in how it relates to human functioning and to development in general. This will provide us with an initial understanding to characterize childhood constitution. The chapter concludes with two case histories illustrating the described dynamics.

3.2. Characterizing Phenomena in Terms of "Form"

In this chapter we will discuss bio-psychosocial phenomena in terms of "form." For example, we may speak of the "symmetrical form" of the teeth and about "forming structured thoughts," or

of a "limitless imagination." Constitution typology employs the ability to give form as one of the three development themes that we can use to characterize our observations of children. We can start by looking to nature as a way to better understand the notion of "giving form." Modelling and shaping can be found everywhere in nature. All of nature's substance has shapes that are more or less durable. Wind, weather, and the sea "groom" the sand on the beach. The river's water "polishes" its stones for many years. Rocks consist of such dense substance that they often appear unchanged after centuries. The clouds in the sky, however, change all the time; they continuously appear and dissolve again.

Consolidation happens when substance solidifies, often in a centripetal fashion. Substance becomes more compact, denser and firmer. **Dissolution** has a centrifugal dynamic: substance disperses, becomes light, dissolves, and disperses into the periphery like dissolving clouds.

We can also describe organic and psychic phenomena of the child's organism *qualitatively* as the conceptual twin pair "compact" or "light" (see also section 3.3.).

Organic, physical form processes can "model" substance into organs: brain, sense organs, skeleton, muscle, heart, lungs, liver. The organism as a whole and each organ separately receives their own form and structure according to a specific archetype. Some tissues consolidate more than others like the bones. Other parts of the organism remain lighter and more diffuse, like the heart.

Organic, physical form processes can "model" substance into organs: brain, sense organs, skeleton, muscle, heart, lungs, liver. The organism as a whole and each organ separately receives their own form and structure according to a specific archetype.¹⁹ Some tissues consolidate more than others like the bones. Other parts of the organism remain lighter and more diffuse, like the heart.

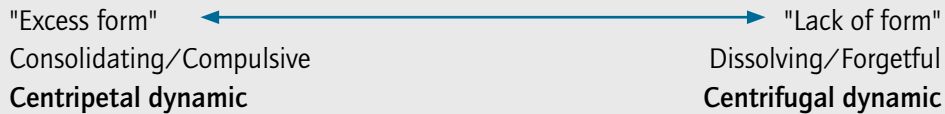
Analogous to how we speak of the modelling of the child's organism as a whole, we can describe how organs fall prey to excessive consolidation, such as sclerotic processes, deposits, or stiffness: a centripetal dynamic – physiologically this is dominant in the elderly; on the other end of the continuum, we can observe excessive weakening and dissolution, such as connective tissue weakness, diarrhea, hypotonia, or tendency to inflammation, all with a centrifugal dynamic – this

¹⁹ For now, it remains a mystery as to how organs 'know' what their particular shape, size, and structure is to be (Travis, 2013).

is physiologically dominant in young children.

Polar Qualities of the Developmental Principle of the Ability to “Give Form”

One-sidedness of the qualitative principle of giving form in the organism is characterized by the polar opposite concepts:



We can use a similar process for describing **mental processes** using qualitative language. For example, some thoughts barely take form, resolve quickly, and are soon forgotten. Thinking about an idea or plan may help form the thoughts and can result in a crystal-clear assessment. Our feelings, too, may be qualified in such terms: feelings can be vague and undefined, but also differentiated and clear. Similarly, our actions can vary from unfocused and chaotic to consistent and purposeful.

The next sections will describe the ends of the spectrum designated as “giving form” in the organism and in the mind as well as employing some examples.

3.3. Polar Qualities in the Ability to Give Form

3.3.1. Manifestations of an Unbalanced Consolidating or Compulsive Dynamic

Qualitative description

We speak of a one-sided “consolidating” tendency when we mean a contracting, centripetally



Figuur 3.1. This is an example from nature showing a centripetal dynamic in the "forming" process: hundreds of individual birds moving towards each other until a compact flock is formed, moving as one organism

directed momentum with geometric forms and a degree of compactness, symmetry, and straight lines in the biological and/or psychosocial presentation of children. The constitution as a whole gives the impression of a lack of vitality and flexibility.

Consolidation as a biological tendency

A one-sided consolidating tendency physically and biologically leads to a strongly shaped body with straight lines and dominant symmetry. Minimal rounding, filling, and/or vitality develops in the body, and the entire appearance gives an impression of being "arid" and "dry." The skin tends to become parched. These children have rigid mimicry and speaking tends to be staccato. Movements are tight and stiff with repetitive motions, and they have a tendency towards tics and typecast behavior. In their metabolism, the balance between anabolism and catabolism has shifted in favor of breaking down.

A psychosocial consolidating tendency

These children tend to be nervous and tense. They have a hard time accommodating other people's preferences. Their contact is formal and business-like, egocentrically focused on their own themes with a tendency to repetition and "getting hooked" on a subject. They are overly aware in their perceptions and thoughts and have a strong memory. This may lead to preoccupation in their thinking in relation, for instance, to their own body. They have fixed topics on which they persevere. This can take the form of an obsession that is characterized by fear and tension associated with a compelling idea.

The child may also have his/her particular preferences in relation to food, eating like a bird in very small bites. Being overly aware of his/her body easily leads to physical complaints about little pains here or there. This inflexibility can extend to his/her conduct as well when the child becomes compulsive and, for example, turns the light switch on and off repeatedly or may have the urge to control. The compelling nature of things can lead to tempers with additional repetitive behavior, which tends to increase in vehemence and may lead to aggressive and destructive behavior.

Clinical examples of a one-sided tendency to consolidation

Clinical examples of a one-sided consolidating tendency are a rigidity and stiffness in appearance, in body shape, and/or motor skills. We may also recognize the principle of consolidation in a susceptibility to constipation or stenosis.

A more persistent imbalance may manifest as stone formation in organs such as the kidneys or gall bladder, or as the solidifying phase of rheumatic disease. In the embryo, we see an excessive consolidating tendency in conditions such as craniosynostosis.²⁰ In the mind it may manifest as static thinking with pigeonholed and fixed thoughts, feelings that may become fixed, and behavior perfectionistic and compulsive.

The consolidating and compulsive tendency has a centripetal dynamic.

²⁰ Craniosynostosis is a disease in which the joints of the skull bones ossify prematurely during embryonic life, hindering the growth of the skull of the child.



Figure 3.2. This is an example from nature of a centrifugal dynamic in the process of "forming:" a flock of birds loses its form, the birds fly in all directions

3.3.2. Manifestations of an Unbalanced Dissolving or Forgetful Dynamic

Qualitative description

A one-sided "dissolving" dynamic can be observed when the child has an inability to give form to its body, mind, or actions, and the formlessness of an egg shape or a chunk of soft clay predominates. The dynamic orients centrifugally with a tendency to "crumple" into formlessness and chaos, fall apart, and dissolve like a pill that dissolves in water or gas that rarifies in to the air. Development and growth are untargeted, there is little maturation and differentiation, and a predominating lack of inner structure.

Dissolution as a biological tendency

The physique of these children tends to be pasty with round shapes. Their skin color is light, they tend to perspire easily, their gaze is staring, their facial features smooth, and their general

movement pattern is aimless and without purpose. They have a good appetite, but digestion may result in diarrhea. Their disproportionate vitality can result in inflammatory symptoms.

Dissolution as a psychosocial tendency

Psychosocially, the child is dreamy and his/her attention drifts away; his/her ability to apply himself/herself and concentrate is limited. The child's awareness is diffuse with little focus and it is difficult to hold a train of thought. He/she tends to stray from a given conversation topic. These children live in their own dreamy inner life, which then can come out in unexpected and imaginative pictures and activities. They find it hard to learn habits, often forget appointments, have a tendency to be sloppy and untidy, and they tend to lose their belongings. This may be accompanied by inner tension and unrest but be outwardly expressed as annoyance.

Clinical examples of a qualitative one-sided tendency to dissolution

We may find clinical examples expressing this unbalanced dissolving tendency in functional disorders and diseases such as organic malformations like rickets and a persistent fontanel. In the nervous system, hydrocephalus and spina bifida are cases in point. Other structural disorders such as palatoschizis,²¹ defective heart valves, caries, or pedes planovalgi ²² fit the dissolving trend, as well as excessive inflammatory foci in the skin and other organs.

Psychosocially, the dissolving tendency manifests as a difficulty concentrating, or as burnout, but also more serious disorders such as psychosis and dementia demonstrate a disintegration that points to excessive dissolution.

The dissolving and forgetful tendency has a centrifugal dynamic.

3.4. Case Studies

The following brief case histories will illustrate the qualitative one-sidedness in children with these two opposite constitutional types. It should be noted that the imbalance is never complete as we

²¹ Palatoschizis is when the palate has not closed in the middle, resulting in a cleft between the two sides.

²² Pedes planovalgi are flat feet.

show how a predominantly one-sided dynamic manifests itself.

3.4.1. A Consolidating/Compulsive Constitutional Dynamic: Mark

Mark, 11 years old, is standing at the door of his school. He is well-groomed, his hair tightly combed back, a crease ironed in his pants, and polished shoes. His slightly forward-stooping posture and raised shoulders convey tension, which is also visible in his face. His backpack is clamped against his chest with his left arm. His right hand brushes along his coat to check if it is all buttoned up. Mark looks around, a serious look in his eyes. When two people pass him to enter the school, he addresses them, interrupting their conversation. "Have you heard about the accident?" On the way to school he saw a car drive through a red traffic light and collide with a cyclist. Mark stopped to look until the police came. "That is not allowed does he have to go to jail? It was a yellow car do you also have a car?" All the while Mark scans the school yard with a nervous gaze. When he sees his own teacher coming, he abruptly ends the conversation and walks toward him. Without greeting his teacher, Mark begins to talk; his voice is harsh and intense. He repeats his story about the accident. The teacher listens carefully, and compliments him with his attentiveness. Then the teacher places himself in front of Mark, looking at him, requesting eye contact. "Mark, we're going to class now; the lessons are starting."

In the classroom, Mark walks to his desk. He frowns when he sees that his belongings are not where he left them. He mumbles to himself that the cleaning lady is not to touch his personal effects. He puts his things in the right place, his pencil and paper neatly in front of him and is the first to be ready to start the lesson.



Phenomena that point to a consolidating/compulsive tendency in Mark's constitution are Mark's attention to his appearance, the way he presents himself, and his tense posture. Also, the compelling, repetitive way he ruminates on the "accident theme" and the way he is stuck in his habits and routines, specifically, the way his coat is buttoned and how he positions his belongings on his desk. In addition, his characterization of the car accident and the person who caused it suggest a tendency toward inflexibility

The **dynamic** of too much of the form giving principle shows itself as centripetal, inwardly directed tendencies, which lead to consolidation and stiffening.

3.4.2. A Dissolving/Forgetful Constitutional Dynamic: Robert

Near the speech therapist's office, Robert, 13 years old, is slouched in a chair. He has a staring gaze. He has curly hair and rosy red cheeks. His skin is slightly shiny from perspiring. He is late for his appointment even though he arrived on time because he saw an airplane flying overhead on the way in the door and stopped for several minutes to look at it, getting lost in his reverie. At home, his mother helped Robert to get ready for his appointment, organized his clothes, gave him a clean shirt, and combed his hair. Robert could have done all this himself, but is easily distracted or caught in a daydream, and then does not get ready on time. Robert gets up when the speech therapist stands in front of him and asks him to come along. She reminds him to take his backpack along, which is sitting on the floor beside him. In the therapy room, the speech therapist asks Robert to stand straight and look at her. They practice articulation exercises. Robert needs this therapy to learn to speak clearly and intelligibly.



Phenomena that point towards a dissolving/forgetful dynamic of the form giving principle in Robert are a dreamy consciousness, his staring gaze, and lack of focus. Other behavioral examples are the effort he has to make to take care of himself and to articulate his speech and the fact that he needs to be reminded of his appointments and what to bring along. The expression of a centrifugal dissolving tendency may also be seen in his rounded, somewhat unformed physique, his curly hair and red blush on the cheeks, the perspiration, and his slouched posture.

The **dynamic** of too little of the form giving principle shows itself as centrifugally-directed tendencies that lead to dissolution and formlessness.

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4. *The Ability to Connect*

4.1. Characterizing Phenomena in Terms of "Connection"

In constitution typology the "ability to connect" is the second of three developmental principles we can use to describe development. The ability to connect is a leading principle in the affective domain (section 2.2.) In this chapter, we will discuss bio-psychosocial phenomena and processes in terms of the ability to adequately connect for instance to one's organism, emotions, or the environment. At the end of the chapter will be some case studies again.

The "ability to connect" is one of the primary or archetypal principles that are essential to living, as the "ability to form" is also. As we explore the "ability to connect" in living nature, we may appreciate in how many varied ways organisms are connected to their environment, and realize the numerous links between organs and organ systems within the organism. Plants are connected to each other as well as the environment, including animal life and soil life. Animals and humans have a continuing need for establishing and maintaining psychosocial relationships and connections.

Connecting ability requires reciprocity between two entities. This reciprocity can occur between two distinct organisms or within the same organism and implies crossing boundaries between an inner and an outer world such as in the exchange of oxygen and carbon dioxide in the lungs, or nutrition uptake and excretion in the gastrointestinal tract. Warmth (through the skin) and information (through the senses) are also examples of how organisms are in continuous exchange with the environment.

In nature, exchange requires the *ability to adapt*. At the same time, exchange must occur without compromising the *singularity* or *wholeness* of an organism. The organism's singularity is represented for example by its inner milieu, its body fluid make-up, which must be kept within certain healthy boundaries. For instance, excess or shortage of salt intake can generate illness if the body doesn't respond by restoring its homeostasis; illness may also occur if too little or too much salt is excreted by kidneys that have lost their connection with the organism's needs. In both

of these cases, the organism has then lost its ability to adapt. In order to respond adequately, organs or organisms need to *exchange* information or substance with their environment.

Another instructive example of "connecting" is how musicians play together in an orchestra. Each musician needs to play in tune with the other orchestra members to create symphonic harmony. If one musician fails to connect to the whole, the harmony of the whole orchestra is disturbed. At the same time, all orchestra members need to focus on their own part, without being distracted or overwhelmed by what is happening around them. This requires a healthy ability to adapt to the environment including a continuing focus on one's own score.

Healthy organisms can open or close off to the environment without endangering themselves. This is often done automatically and unconsciously, for example in breathing. We may also initiate the exchange more consciously, such as when we squeeze our nose closed to an unpleasant odor, or run away from a situation that frightens us. In a healthy organism, this response and adaptation process is receptive and often rhythmic in nature. It may occur on a physical or physiological level, but can also occur emotionally. We may feel drawn to or repulsed by something, but either way, we act on it by connecting or withdrawing ourselves from it.

In a safe, harmonious environment, it is easier to be open without compromising one's individuality. Young children have a physiologic tendency to be open to the environment on different levels. In a threatening situation, the healthy reaction would be to close off (as much as possible). Physiologically, the elderly tend to become more closed to the environment.

As we speak about the ability to connect, it becomes clear that as a concept, it is applicable to a broad context. We can open up to our environment in a healthy way if at the same time we can keep an inner poise. A healthy balance of *inner* processes gives a sense of wholeness and supports the ability to connect with the *environment*.

Another important element in this discussion is the permeability of the aforementioned boundary between inside and outside. Depending on the properties of this boundary, one's internal environment can be more prone to "enclosure" or "disclosure." This brings to light the polar aspects of this theme when the ability to connect becomes one-sided: "closed" versus "open." The above

examples aid in studying the qualitative aspects of the connecting principle: being closed has a centripetal tendency; being open a centrifugal tendency.

Polar qualities of the developmental principle the "ability to connect"

One-sidedness of the qualitative principle of connection is characterized by the polar opposite concepts:

"Lack of connection" ←

Congesting/Closed

Centripetal dynamic

→ "Excess connection"

Out-flowing/Open

Centrifugal dynamic

The term "connection" as we use it in *Constitution typology* entails both connecting an inner and outer world as well as preserving and tending to (inner) coherence, or the wholeness of the own organism.

4.2. Polar Qualities in the Ability to Connect

4.2.1. Manifestations of an Unbalanced Congesting or Closed Dynamic

Qualitative description

We can use pictures to clarify a closed tendency, such as the image of a dam in a river, which threatens to break through; or of a flower bud just before it opens up; or of a balloon that is almost bursting; or of an approaching thunderstorm. These images call to mind an overly adequate boundary between two dynamic forces, leading to instability.

Being closed as a biological tendency

Children with a closed dynamic tend to have a stocky, compact physique and their posture betrays tension and inner turmoil. Their skin tends to be thick and dry, and their hair bushy and brittle. Attracting attention and making contact is difficult for them and their speech is hesitant, prone to stammers and stuttering. They have problems initiating movement, but once they are moving, they cannot be stopped because their inertia is so strong. They have coarse, underdeveloped motor skills that are out of sync, which can lead to bumping into or breaking things. They find it hard to wake up in the morning and tend to have a dull awareness throughout the day. As they breathe, the emphasis is on inhaling. Similarly, they take in a lot from a psychological point of view, much of which is not adequately processed. Their skin is poorly perfused, which results in heat congestion and insufficient perspiration. They tend to gobble up their food without tasting it well or being aware of their satiety. Digestion and excretion may be accompanied by cramps.



Figure 4.1. Example from nature of a centripetal dynamic in the process of "connecting:" a flower bud just before it opens up

A psychosocially closed and congesting tendency

Children with a closed and congesting one-sidedness tend to have a dull awareness. In contact with other people, they tend to be self-centered, which makes personal connection more difficult. They are not aware of how others perceive their conduct and their empathy tends to develop slowly. Targeted eye contact and a listening attitude are limited. One can notice an inner unrest as well as an edginess, which manifests as a non-verbal message to stay away. When someone does cross their boundary, it can give rise to emotional blockage that can discharge as a passionate outburst.

Clinical examples of a one-sided tendency to be closed or congesting

The physique of these children appears congested, which reveals itself as thick, dry skin or as a barrel chest in asthma with cramping. Functionally, problems in waking up and tension headaches may occur. More extremely, we can see spastic cramps and colic, stuttering speech, and tonic-clonic seizures.

Psychosocially, the tendency to retract and close off appear as a contact disorder, a paranoid delusion, or as tantrums. In young children breath-holding spells are typical for a closed constitution. This one-sided tendency of the developmental principle of connection leads to a centripetal constitutional dynamic with the key words *congesting* and *closed*.

4.2.2. Manifestations of an Out-flowing and Open Dynamic

Qualitative description

The dynamic of the open one-sidedness is like the river flowing into a floodplain, like melting ice, the dripping of a picture that has been painted with paint that is too wet, or like a leaky tire.

Biological features of an out-flowing or open tendency

These children often have a delicate, fragile physique with cool, moist, and thin skin, prominent veins, bony structures, and thin, shiny hair. Their conduct betrays sensitivity and vulnerability, as evidenced by hunched shoulders and a bowed head. They move with caution, walking on tiptoes, and are often quite indecisive in unfamiliar situations. Their speech is soft and sing-song-y.

Falling asleep at night can be difficult for these children because the anxieties of the day can make sleep impossible. Food is often poorly tolerated. Their breathing is superficial when at rest and inhaling is inhibited or may be limited. They have a weak vitality. They lose body warmth in the periphery and as a result, have cold extremities. In the morning, they have little appetite and resist eating. Potty training can be problematic.

Psychosocial features of an open and out-flowing tendency

These children's attention is focused on the environment. They are sensitive to touch and are vulnerable to panic reactions. Sensitivity can become hypersensitivity with the expression of intense emotions, both laughing and crying. When they make contact, they initially hold back, but once they have crossed the threshold, they can become demanding and clingy. With all activities they commence they also may shrink back and have performance anxiety.



Figure 4.2. Example from nature of a centrifugal dynamic within the process of "connecting:" seeds become detached from the plant and are dispersed by the wind

Clinical examples of a one-sided out-flowing/open tendency

Functional disorders that are an expression of this one-sidedness are excessive sweating and feeling cold due to heat loss; disease states and allergic conditions with copious excretion such as hay fever and eczema. These children are emotionally hypersensitive and hypochondriacal and may have imaginary diseases, eating disorders, and potty-training problems as well as anxiety disorders. This one-sided centrifugal tendency of the developmental principle of connection leads to a constitutional dynamic with the key words *out-flowing* and *open*.

4.3. Case Studies

4.3.1. A Congesting/Closed Constitution: Malva

Malva (age 7 years old) is very angry when she comes home. She is stomping as she enters the house and collides with the dog who walks toward her wagging his tail. As Malva faces her dad, she is red-faced and her eyes are ablaze: she wants to tell him something but cannot find the words. Her dad comes and stands next to her, puts a hand on her back and a little later, they sit side by side on the couch. Malva is a well-built girl, tall for her age. She is strong and robust, but is not very aware of her own strength. As a result, she often hurts other children when playing sports. Her dog, whom she loves, may whimper and yelp while they play as Malva is often unaware of how her strength can injure her playmates. While stuttering, interrupting herself by crying out in anger and helplessness, Malva tells her story. They were playing hide and seek. She was well hidden on her knees behind a bush; they really could not see her! And yet, she was found. How unfair! She had stayed put, being



very quiet—even when they called her! When they started a new game without her, she had gotten up and ran home without saying anything to her friends.

Phenomena of Malva's mostly congesting/closed constitution when making connections are: her pent-up anger, her flushed face and fiery look, and her stomping feet. A congesting dynamic can also be seen when she collides with objects, playing wildly, and unintentionally hurting other children and her dog. She shows little restraint and does not adequately respect other people's boundaries, which indicates a lack of being able to connect in Malva's congesting/closed constitution.

A congesting/closed **dynamic** becomes visible as an inwardly directed (centripetal) energy that is contained by a solid and hard-to-penetrate boundary. The boundary may be broken down with increasing force/pressure from inside.

4.3.2. An Out-flowing/Open Constitution: Angelique

Angelique (9 years old) sits next to her mother in the waiting room, hugging her favorite doll. She keeps a close eye on who is next, yet startles when she hears her name called. She promptly gets up and skips to the doctor's office. She goes to visit the doctor regularly and feels at ease with her. She stands before her radiantly. When the physician sticks out her hand, Angelique puts a cold, slightly moist and weak hand in hers. She holds her doll in her other hand. This time she comes to have her eczema checked. It has gotten much worse since last summer, itching and burning all over just when she started at a new school last fall. After her first few years in a school for special children, she has now been admitted to a



"normal" primary school. She appeared to be learning reasonably well; her language and writing talents were noted to be good. Angelique is very happy with the idea of the new school, but is also rather anxious. She has been upset for weeks, has slept poorly, and cries at the slightest trigger. Her first days at school she could hardly eat; it felt like she had a lump in her throat. Over the last few weeks things have been much better; she has made friends in her class and has made a strong connection with a wonderful teacher. She is also very pleased with her role in the play that the class will perform for the parents. At the doctor's inquiry, her mother indicates that things are going much better. Angelique nods in agreement.

Phenomena that point to Angelique's outflowing/open constitution are a strong focus on her environment, insufficient boundaries, and limited self-confidence, insufficient warmth and a thin skin, her eczema, her sensitivity to touch, seeking external support in the environment, her doll, the one she knows and trusts; and her fear of the new and unknown. All of these indicate an overabundance of connecting in Angelique's outflowing/open constitution. When she receives affirmation, she experiences self-confidence and can shine.

The outflowing/open **dynamic** becomes visible in an organism that has centrifugal tendency and a weak outer boundary, does not experience sufficient support in its own strength, nor offers sufficient resistance to the surroundings.

Literature (recommended)

Steiner, R. (2015). *Education for Special Needs - The Curative Education Course*. Chapter 5. Herndon: Steiner Books.

5. *The Ability to Move*

5.1. Characterizing Phenomena in Terms of "Movement"

In this chapter we will discuss the bio-psychosocial phenomena in terms of children's "movement quality." In constitution typology, the ability to move is the third of the three development themes we may use to describe our observations and is the leading principle in the conative domain (section 2.2.). The ability to move is another of the archetypal phenomena that is essential for life. All of life comprises some form of movement, starting with inner movement such as metabolic processes, blood or sap (in the case of plants) streams, or the flow of signal substances. Because of these forms of inner movement, plants can germinate, grow, flower, and wither away. Animals and humans exhibit, in addition to these inner movements that they have in common with plants, an inner "emotional mobility" and outer physical mobility, in the higher animals with the help of a muscular system. Being inwardly moved may directly lead to outer movement in animals and humans, such as fighting, fleeing, eating, or mating: in this instance, inner movement becomes outwardly expressed.

In the examples mentioned, we may discover that movement qualities are combined with the qualities of the two domains we discussed in Chapters 3 and 4. For example, in fighting or mating, the theme "ability to connect" (see Chapter 4) also plays a role without which no movement could manifest. At the end of this chapter we have added two case histories illustrating the ability to move in children.

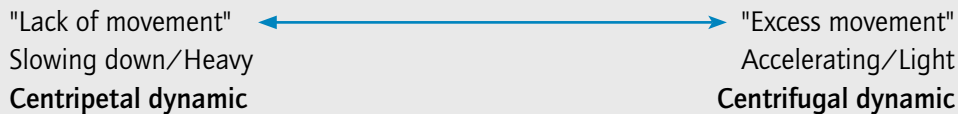
The key to movement is its *impulse*: there is no movement without impulse. When the impulse fails or is not strong enough to overcome the system's inertia, the movement slows and comes to a standstill. On the other hand, movements may become too large, or "overshoot," when the momentum is too strong or repeated too frequently.

Of course, an impulse always has *direction*. "Direction" is by nature an aspect that relates to the "ability to form" (Chapter 3).

Movement may be **slowing down and heavy**, manifesting a centripetal dynamic, or **accelerating and light**, showing a centrifugal dynamic.

Polar qualities of the developmental principle of the "ability to move"

In the organism, the polar one-sided qualities inherent to movement may be characterized on this continuum:



An prototype for the human ability to move is that of horses pulling a carriage, with the coachman who holds the reins sitting on the box. The guidance (*clarity of mind*) that the coachman can give the horses (*the impulse to move*), and the quality of the coach (*the physical health and possibilities*) determine the mobility of coach and coachman.

5.2. Polarities in Movement Quality

5.2.1. Manifestations of an Unbalanced Slowing or Heavy Dynamic

Qualitative description

The following are physical representations of a one-sided slowing/heavy dynamic: the downward trajectory of a ball that was thrown as it is slowing to a standstill under the force of gravity, running on a sandy beach, a falling kite when the wind disappears, an organizational initiative that stagnates, or a clock in need of rewinding that slowly comes to a standstill.

Biological examples of a slowing or heavy tendency

Heaviness dominates the physique of children with a slowing down/heavy dynamic. In these children, it is not uncommon to observe them with their head resting on their hands, arms leaning on the table. A child with this physique may try to hold himself or herself up using the table or doorpost. When walking, his/her shoulders hang and his/her feet may shuffle. There is a tendency to be overweight.

Waking in the morning and rising are often very difficult for these children because of a blunted or missing impulse, often because their metabolic processes are slow. When they eat, they have a good appetite and prefer sweet and easily digestible foods. However, internal secretory glands tend not to function well.



Figure 5.1. Example from nature of a centripetal dynamic in the process of "moving:" landscape in which the wind has subsided, all movement seems to have come to a standstill

A psychosocially slowing and heavy tendency

These children have a dreamy consciousness and their speech is not well articulated. Attention to and awareness of their environment is limited; at the same time their mood resonates with the environment, and although they tend toward heaviness, social contact revitalizes them and they often seem in tune with what is going on around them.

Clinical examples of a qualitatively slowing down/heavy tendency

Functional disorders and disease that we may see in individuals with a slowing down/heavy dynamic are metabolic disorders such as type 2 diabetes and hypothyroidism. These may accompany mild to severe obesity, which may be present in conjunction with these disorders or as a single factor. The dominant dynamic can also manifest in reduced muscle tone and symptoms of paresis. Diseases such as myasthenia gravis and ALS ²³ fit the image, as do excretion problems such as constipation and hypostatic edema.

Psychologically, the one-sided tendency can manifest itself as a gloomy or even depressive mood and sluggish thinking with reduced clarity of consciousness.

The slowing or heavy tendency has a centripetal dynamic and is physiological in the elderly.

5.2.2. Manifestations of an Unbalanced Accelerating or Light Dynamic

Qualitative description

For determining a one-sided accelerating/light dynamic the following examples come to mind: a ball that bounces back and forth in a pinball machine, firecrackers, a birch-leaf in the wind, effervescent bubbles in a carbonated beverage, the dexterity of a magician, or the fast legs of a bird running just before it takes off to fly.

Biological examples of an accelerating or light tendency

The physique of these individuals tends to be slender. Motor movement dominates the general picture due to their sensitivity to stimuli or their own impulsivity. Their stature and posture are

²³ Amyotrophic lateral sclerosis (ALS) is a disease in which progressive muscle paralysis occurs through impairment of the nervous system leading to death within a few years (or months).



Figure 5.2. This is an example from nature that shows a centrifugal dynamic in the process of "moving:" a fierce storm brings everything into movement: the sky, the clouds, the water surface, and all else around it

prone, actively focused on going ahead and action. Their eyes may shoot back and forth, noticing all and reacting to everything. "Ancillary" movements occur: drumming with the fingers, tapping with the feet, grimacing. Speaking is fast and tends to be loud and emphatic. Food intake and potty training may be complicated by a fast metabolism and insufficient patience for eating. They often sleep lightly and wake up easily with the slightest noise.

A psychosocially accelerating or light tendency

Individuals with this constitution find it difficult to sit still; at rest they often move continuously. They have trouble exercising patience and thinking deeply about something for a long period of time; they often prefer to act immediately rather than weighing a decision at length. Seeing is doing: "what the eyes see the hands must seize." They often present as busy bodies and tend to talk a lot, often without waiting for a question or request. They frequently have varying initiatives,

jumping from one thing to the next both in activity and in speaking. Before something is really completed, the next activity is already begun. The attention span of these people is short and they often react before another has finished speaking. They may have vehement emotions.

Clinical examples of an accelerating/light tendency

Examples of functional disorders and diseases associated with this imbalance in the ability to move are mania and ADHD, hyperactivity, as well as hyperthyroidism, addiction problems, type 1 diabetes, nystagmus, gastric reflux, tremor, reflexive bladder, and Gilles de la Tourette syndrome. The accelerating/light tendency has a centrifugal dynamic and is a more physiologic tendency in childhood.

5.3. Case Studies

5.3.1. A Slowing Down/Heavy Constitutional Dynamic: Carline

Carline (age 12 years old) is coloring in mandalas in the waiting room of the doctor's office. She is bent over and deeply engaged in her work. Her hair is hanging down in her face. Although she works methodically, she has trouble keeping the color inside the lines, likely due to thick hands and fingers. On the table are a few pencils with broken off tips because she has been pressing too hard. She does not look up or around at her surroundings until the secretary puts a hand on her shoulder and speaks to her. Carline slowly looks up at her and a smile appears. When she receives a compliment for her mandala drawing, she begins to shine. Carline is awaiting a blood pressure check because of her excess weight. When she hears that



she also needs to be pricked to check her blood sugar level this time, big tears start streaming down her cheeks. She gets up laboriously and walks along slowly with an uncertain step. She is used to having her blood pressure measured and this goes effortlessly. And, when she is distracted for a moment, the glucose test prick is done before she is even aware of it. She stays seated until she hears she is done.

Phenomena that refer to a one-sided balance in the ability to move, with a dominantly slowing down/heavy dynamic, are the predominance of heaviness in Carline's posture and movement, the obesity that hinders her motor skills, her dreamy consciousness, her mood that resonates with her environment, becoming unhappy when faced with a challenge, and a subsequent change in mood with a friendly word and some encouragement.

The **dynamic** behind the manifestations of a slowing/heavy one-sidedness in moving manifests as a lack of moving impulse; and when an impulse does occur, it quickly extinguishes. This indicates a centripetal dynamic: each impetus to movement slows down and falls still into heaviness.

5.3.2. An Accelerating/Light Constitutional Dynamic: Tim

Tim (10 years old) launches into the exam room. Unsolicited, he plants his right foot on the examination table. Just underneath his knee, he is bleeding from a wide gash. Tim plays soccer and he is fast. He is super enthusiastic and with his slender build and eyes that see everything around him, he is in the vanguard on the field, ready to score. But restraint and control sometimes fail him and he stumbles over the ball, scrapes his knee, bumps on his head, or sprains his ankle. Equally likely, he pushes someone coming his way as has happened with this injury. His story is incoherent, he talks in a pressured way that he was so close to scoring



and it would definitely have been a hit, when someone tackled him. The doctor examines the wound, while Tim continues to rattle on about the magnificent goal he had scored just before, his left foot kicking the ball in the far right corner of the goal. The wound requires stitches. Tim startles when he hears this, promptly stops talking, pulls his leg back and takes a step towards the door. He is soon convinced to stay and have the wound stitched and as the secretary praises his soccer prowess, Tim lets the wound be sown up, being brave with his eyes closed and his jaw clenched.

Phenomena that are emblematic of an accelerating/light one-sidedness in moving are that Tim cannot stop moving, which impacts all motor skills including speech, his slender, supple build, being optimally prepared to notice everything around him and respond to it, and his actions and reactions that lack reticence or restraint.

The **dynamic** that expresses in these phenomena has a centrifugal tendency and can be characterized as a fire consuming all around it.

5.4. Qualitative Principles in All Domains

In our descriptions of the principles of giving form, connecting, and moving, we have so far stated, for the sake of convenience, that the ability to give form is operative in the cognitive domain, the ability to connect in the affective domain, and the ability to move in the conative domain. The imbalance in the expression of these principles in children's development has been illustrated with six characteristic case studies. However, at closer consideration, the case studies confirm that these principles appear not necessarily just in one domain. When we look more precisely we become aware that they are also recognizable in the other developmental domains.

Mark's excess of form (3.3.1), for example, is primarily reflected in being stuck in his own thinking and in his recollecting the accident (*cognitive* domain). Nonetheless, he has likewise gotten stuck in the experience *emotionally*. And the excess form is also expressed in the conative domain: in his stressed behavior, his tense posture, his speech motor skills, or for example in how he handles his school supplies.

Malva (4.3.1.) shows her *affective* domain tendency to be blocked up and closed also in the conative domain. We described her as "... collides with objects, playing wildly, and unintentionally hurting other children and her dog." She also has difficulty expressing her anger, though, and her thinking appears to be trapped in anger (*cognitive* domain). The being blocked up and closed off is not just limited to the *affective* domain.

The description of Tim's case study (5.3.2.) indicates that the inability to stop moving (*conative* domain), also is present in his thinking (*cognitive* domain), as evidenced by the way he jumps from one subject to the next. The intensity and rapid changes of his emotions likewise indicate an over-mobility in the *affective* domain.

The three described qualitative principles are primarily active in their own domain, but can also be observed within the other two domains. Figure 5.3. is a schematic representation of how the three principles can be recognized in the different domains.



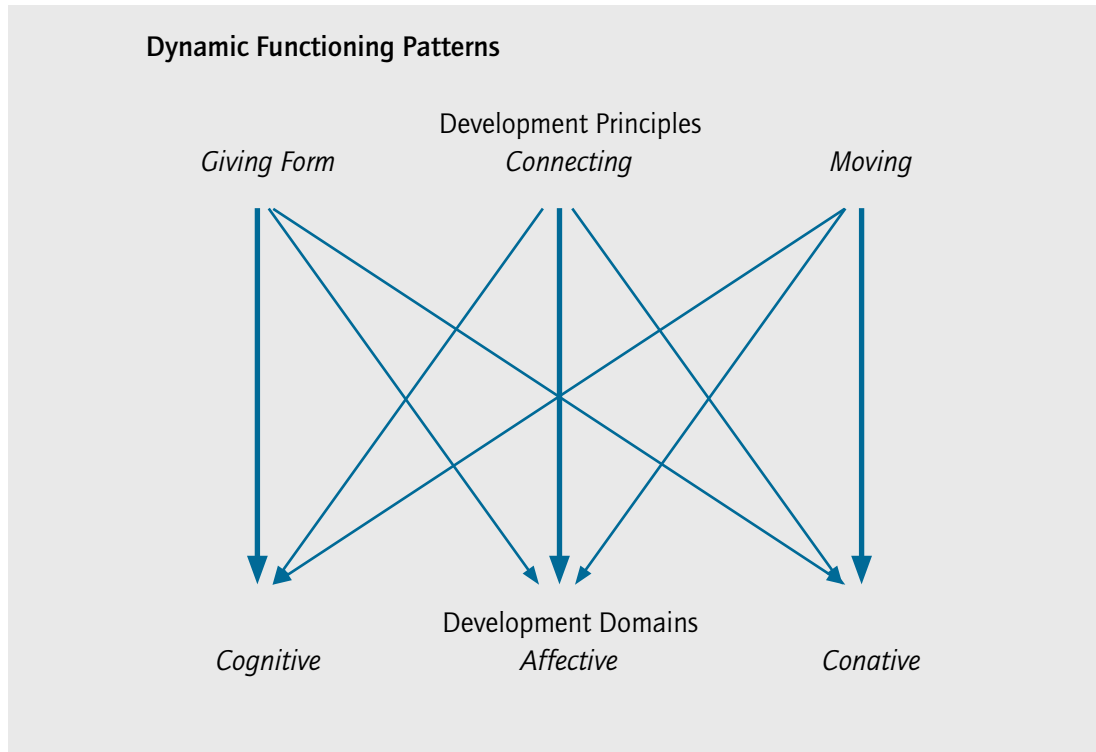


Figure 5.3. While the separate developmental principles (forming, connecting, and moving) each are primarily related to one of the domains (cognitive, affective, or conative), they are generally also recognizable in the other domains

Literature

Steiner, R. (2015). *Education for Special Needs - The Curative Education Course*. Chapter 5. Herndon: Steiner Books.

6. *Diagnosis and the 4-Step Approach*

6.1. Verifying the Individual Constitution Profile

In previous chapters we have explored the three domains of psychiatry and their essential principles: the ability to form, to connect, and to move. The six polar qualities that extend from these three principles may be utilized to depict the developmental potential of the child. We have subsequently presented several children with constitution profiles that more or less classically match these qualities.

In this chapter, we discuss a diagnostic approach that enables the assessment and careful characterization of an individual child's actual constitution profile. This characterization, the outcome of the *4-step* approach described in this chapter, may be combined with the result of the ICC, a procedure that will be explained in Chapter 9.

This approach may be employed by physicians and therapists as well as by other professionals involved in the care of children with a developmental disorder. We will describe the diagnostic process as it can be completed by an individual caregiver. The *4-step* approach may also be conducted in a multidisciplinary team.

The *4-step* approach, initially outlined for the work on the Bolk's Companions (Van der Bie, 2012), comprises four different strategies to describe the child. For each step we will define the required activity, the attitude one has to assume while engaging in this activity, and its results. The steps build upon each other. The outcome is a living picture of the child's developmental potential that points to its actual constitution profile and indicates a direction for developmental therapy and care.

6.2. The 4-Step Approach

6.2.1. Step 1: Observation: Collecting the Facts

The first step comprises collecting observations of the child. It starts as you greet him/her and observe the child's handshake and eye contact. Then you listen to the child's story, including its own and its parents' worries, complaints, and questions. You elicit information about the child's strengths and personal gifts, his or her likes and preferences, and inquire about wishes and expectations for the future. During the conversation, you also pay attention to the child's mannerisms and body language, how he or she sits, moves, and speaks. You observe his/her physique and build as well as his/her face, skin color, and facial expression. You pay particular attention to things that may be related to the child's complaints and questions. If you are able to observe the child in different settings, your observation may also include how the child relates to his/her surroundings, how he/she relates to other people, how he/she plays, and how he/she eats; it is also beneficial to learn about his/her sleep, digestion, and toilet training.

This first step will provide you with myriad disparate observations gleaned from your sensory impressions. Judgments and interpretations of a diagnostic nature as well as sympathy and antipathy may come up for you, as well as therapeutic impulses; however, it is important that you (consciously) refrain from conclusions. The **attitude** in this first step is of the interested spectator. This step yields a perceptual image of the child (Van der Bie, 2012, p. 27ff.).

Continued case history from Chapter 1

Josh is 8 years old as he enters the examining room for the first time behind his mother holding his father's hand. He has blond hair and blue eyes and stares into the distance. As I greet him, Josh puts his hand into my outstretched hand and stands right close next to me. When I release his hand, he remains very close to me.

Josh looks tall for his age. His face is somewhat elongated, with a narrow nose, slightly open mouth, and thin lips. When Josh sits down he slumps into the chair and supports his head with his hands. When asked a question, he looks at his parents waiting for their encouragement before giving a short answer. His voice sounds nasal.

Continued history

Josh's parents tell you about his angry moods that surface when he feels disadvantaged or when he thinks he is being teased. He becomes restless, turns red, and in his anger, starts screaming; sometimes, he also hits and kicks. After the outburst he starts to cry and crawls away; it is not easy to comfort him. Josh's parents also mention his love for animals. He has a rabbit that he is very sweet to and cares for tenderly. Josh is also fond of the cat, but the cat is afraid of his clutching hands. Josh nods in agreement when his parents recount this.

Physical examination

Josh's skin is ruddy and warm. In his elbow folds he has signs of a mild constitutional eczema. Josh breathes through his mouth due to moderate nasal congestion. Auscultation of his lungs reveals vesicular breathing with a prolonged exhalation and occasional wheezing. His breathing is superficial and fast. Heart sounds are normal, without murmurs. The abdomen is sensitive to the touch with active muscular resistance and normal peristalsis.

When standing, Josh cannot be still and wiggles from one foot to the other keeping his head a little slanted. He loses his balance a few times when walking along a line and when hopping. When he throws a ball he takes a little jump and when trying to catch, he misses the ball.

He needs help getting dressed.

6.2.2. Step 2: Pattern Recognition: Finding the Patterns in the Observations

In the next step, you first bring the array of observations of step 1 into memory. If you have missed something you may want to see the child again.

In this step you start to look for patterns in the perceptions you have collected. You can recognize patterns if you take a "transverse look" at your observations. This may start during the first step and may give some direction to your observation; but in order to obtain as complete a perception of the child as possible, you do not let it limit your observations in the first step. In this second step we intentionally try to order the observations by finding pertinent patterns

The **attitude** you have here is of open-minded *participation* in the development and life story of the child, which requires you to live in and move along with it to find the patterns. To begin, you may search in your memory for striking phenomena and characteristic features from which two, three, or four patterns then unfold. For instance, you may recognize vulnerability as a pattern when a child has evasive eye contact and startles at being touched; at the same time, you may find a pattern of heaviness in his/her mood and movements as well as in his/her speech. Patterns are verifiable on the basis of the phenomena you derived them from (Van der Bie, 2012, p. 36ff.).

Continued case history

The most striking phenomena in the meeting with Josh were:

- *his uncertainty and focus on the environment and seeking guidance from adults;*
- *the buoyancy and unrest in his movements;*
- *his nasal speech and open mouth with emphasis on exhalation and eczema, which all point to an atopic constitution;*
- *the way he deals with animals;*
- *his not being able to adequately deal with situations that do not match his expectations.*

These phenomena reveal a pattern of being overly sensitive and vulnerable both in his uncertainty and the allergic constitution. Josh seems too open to the environment to the point of merging with it, as became visible in the way he kept standing (too) close to me after the greeting. There is also a pattern of unrestrained tension when his expectations and those of the environment do not match, both in unexpected situations and in his dealings with animals. When something butts up against his personhood, he becomes agitated, which may result in an outburst; this may also be underlying his motor unrest.

6.2.3. Step 3: Comparing Patterns

In this next step it is important to first call to mind the observations and patterns you have found and reflect on them by putting them side by side and comparing them. Then you may find

that they have a connection for instance in that they occurred consecutively, or perhaps rather simultaneously, or seem to have the same origin. You may try to describe and recreate what happened with the child as the different patterns unfolded in time and search for insights into what may have happened in between.

The **attitude** in this phase is one of *empathy* (Van der Bie, 2012, p. 46ff.). This step usually follows when you have watched the child for an adequately long time and possibly as you speak to a colleague about him or her or write a report on your visit(s) with the child. It is a phase of seeming chaos, because in a sense, it requires you to "forget" the specific memories of the child and the patterns that you have found, and subject yourself to what presents itself, to what comes to mind as a comparison: "it is just as if... ." This can take the form of a mood that you ascribe to the child; and/or when you are familiar with constitutional typology, you may also come up with one or more developmental unilaterality in the constitutional profile of the child.

To support and verify your notion regarding constitutional typology you may also fill out the ICC (see Chapter 9).

Continued case history

In revisiting the observations of Josh and the patterns we described, it may seem that his openness (physically exemplified in his eczema and perpetually open mouth) combined with his vulnerability make it hard for him to stay focused. This may lead to a feeling of rising tension and unrest in his physical body. If this is not dealt with adequately by the environment, it may lead to an angry outburst or hurting others. His mood has the potential to disrupt others when Josh threatens to lose control of himself. You observe that he tries to maintain control of his emotional body by holding on to the adults around him. If this fails, it may result in physical or emotional harm, which initiates another (violent) reaction to be followed by remorse later on and the cycle repeats itself.

If we compare our observations and patterns to the three constitutional principles, we can see how the ability to connect is a struggle for Josh. Josh cannot breathe to the rhythm of his surroundings; the boundary between inside and outside is too

permeable. This can be described as an open, out-flowing dynamic: Josh cannot close himself off at the appropriate moment. Section 4.3.2. expounds on the characteristics of this constitutional dynamic. In the ability to form, Josh lacks structure, which manifests as outbreaks of eczema or his tendency to slump in his chair (section 3.3.2.). And as for the ability to move, this is overdeveloped in Josh's situation since he has a hard time sitting still (section 5.3.2.).

The unilateral directions in his development not only make it hard for Josh to function, but he also seems unable to escape them.

The ICC (Chapter 9) showed a centrifugal dynamic in all three developmental principles.

6.2.4. Step 4: Giving Meaning: Planning Therapy

In this step we try to find meaning in what we have described so far. We first reflect on what we did in the third step: how we used our empathy to recreate the experience of the child as we tried to order the patterns we found in the second step. This reflection leads to an appraisal of the situation. The fourth step is the one in which we assign a judgement.

The **attitude** in this step is one of *intuitive listening*.

The new insight in this step may be that the child's seemingly difficult and frustrating conduct is in fact a way to keep himself from harm, such as ward off overwhelming sensory impressions or other external influences. The child's conduct may also direct his/her caregivers to where his/her needs are. These insights give *meaning* to the observations of the child and may very well present themselves as an image, for example, from nature. The image frequently provides meaningful additional understanding of the developmental needs and demands of the child.

The meaning that is given them through the image brings the observations together to form a *coherent whole*, an image that does justice to the actual developmental potential of the child, as much as possible (Van der Bie, 2012, p. 48ff.).

The image also may aid us in determining the essential elements of the child's constitutional profile and where to start with a therapeutic approach: the image can specify a direction for treatment and care.

You may relate the image you have obtained to the child and/or his parents. They will often immediately recognize the diagnostic description and the direction of treatment and care. The treatment plan can then be worked out with them and your colleagues.

Continued case history

Several days after Josh's visit, as the practitioner reflects on the meeting and Josh's tendency to lose himself, leading to rising tension and holding on to his environment for fear of getting hurt. The provider comes up with the image of an octopus, his tentacles full of suction cups getting stuck on everything around him. At a later moment his reflection yields the image of a cat scraping along his legs, walking in the way until it finally gets hurt when he accidentally falls over it.

These images point to the need for Josh to find his own footing and self-confidence. Josh could be helped by learning to let go and breathe better physically as well as in his relationships to other people. And he would benefit by finding his own boundaries, rather than those being set by his surroundings, which may be difficult for Josh to bump up against.

Josh's ICC disclosed that his developmental problems were most pronounced in association with the principle of being able to connect, as will be outlined further in Chapter 9. The openness and outflowing dynamic in the ability to connect and his losing himself in the environment showed up in Josh's vulnerability and fears, as well as in his fast and superficial breathing and strong emotional outbursts.

In a conversation with Josh's parents, the practitioner discussed with them the results of the 4-step approach and together they looked at the images that emerged in step 4. Josh's one-sidedness was described as being hurt and lonely as a result of the great openness with which he conducts himself, which often leads to disrupting the contacts with people in his sphere, frustrating himself, and causing conflicts with

other children and adults. This seemed plausible to Josh's parents and they could well understand the need to try and aid Josh in being able to deal differently with his openness and resulting fears.

*The **direction of therapy** was defined as providing exercises to find strength and self-confidence in himself, learning to breathe differently, and experience and set boundaries.*

Later in the conversation, Josh joined in and was explained in words that were comprehensible to him how his further development could be supported by his parents and himself. At first, Josh seemed annoyed and angry, but the image of the octopus appeared to rouse his interest and improve his mood. With nods of his head, he indicated that anger and arguments with other children were not fun for him. Josh's mom put an arm around him and together they listened to the therapeutic suggestions of the practitioner. These suggestions will be further elaborated upon in Chapter 7.

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7. *Therapeutic Options*

7.1. Introduction

In previous chapters we have seen how we can chart a child's developmental process in different ways. In order to do this effectively, we may choose to define the categorical diagnosis and then add the descriptive diagnosis (see 1.4.). To further individualize the diagnostic process and establish the *developmental potential* of children, we have complemented the categorical and descriptive diagnosis with the constitution profile.

The questions that remain after establishing the developmental potential are: how can the child realize his/her full developmental potential and how can the child become competent in the world? We also might ask what support - or treatment does the child and his/her parents²⁴ or caretakers need to achieve a competent independent existence? How can we ascertain that the right approach and treatment come about at the right time? How can we bolster the health and development of the particular child?

We often begin with the questions that the child and his/her parents have as well as *their* concerns and expectations. Our goal is to aid the child in finding self-confidence, experiencing optimal well-being, feeling competent, and developing his/her full individual potential. The constitution profile is our aid and the context for making choices in available therapeutic options.

We have elaborated on the abilities to form, connect, and move as three distinct developmental principles of the constitution profile using processes we encounter in nature and in the arts. We have seen how a unilateral development of these principles may offset the child's development and trigger his/her feelings of stasis and limited possibilities (see 6.2.).

In this chapter, we will describe the therapeutic options that serve to balance out the unilateral component of the child's constitution. Theoretically, constitutional treatment could modify the lateralization by either:

24 As we mention "parents" in this Companion, this will refer to all of the child's responsible caregiver(s).

- Strengthening the “healthy center;”
- Diminishing the predominant one-sidedness, and/or employing the energy and lateralized ability to serve the child’s development;
- Strengthening the weaker polar opposite side.

The **healthy center** is primarily strengthened by creating a *lifestyle* that is adapted to the child. This includes a safe and loving environment with regularity and rhythm in sleep, eating, and inspiring activities interspersed with rest. Regularity contributes to the predictability of events, and thus reinforces the child’s feelings of safety.

To even out **unilaterality**, the *arts*²⁵ offer ample opportunities for supportive, creative, artistic, and therapeutic work. In these various therapies, the arts can offer a new outlet for a child who previously felt impeded in his/her development and health.

The next logical question is how do we choose the type of therapeutic intervention for such individualized diagnoses? In this chapter we will explore the rationales for different therapies for these children.

In chapters 3, 4, and 5 we discussed various case studies and the constitutional profiles of the children described in those cases. In these descriptions, we mentioned which therapies were selected for them without substantiating these choices. It is very possible that when reading about the therapies mentioned in these chapters, readers with practical experience in working with these children felt the choices of therapy were self-evident. Many of the qualitative aspects of constitution typology live more or less semiconsciously or unconsciously in our awareness.²⁶

For example, it seems obvious that an external therapy providing enveloping physical warmth enhances a child’s experience of safety and can therefore have a beneficial effect in a fearful or confused child.

Can we use constitution typology to make a rational choice from available therapies? Or to put

²⁵ We use the term arts here to indicate both different art and body-oriented therapies.

²⁶ These aspects may be recognized in certain metaphors such as “*he is hard-headed*,” “*she became a puddle when she heard him cry*,” “*he flies in all directions*.”

the question differently: what kind of artistic, physical, or movement therapy fits in with which constitution type?

We will discuss two aspects of the therapeutic options that we often employ. Before choosing a therapy, it is helpful to know the different *organizational levels* in the organism that are engaged by various therapies. This is elaborated in sections 7.2. and 7.3. Subsequently in section 7.4., following from what we learned from the case history of Josh, we will address the options that the various forms of therapy hold for harmonizing the unilaterality in constitution typology. This will be further explained by the short case studies from Chapters 3, 4, and 5, which we will revisit from this perspective in the first appendix.

7.2. Three Organizational Levels

We can distinguish three successive levels in child development when we implement a therapeutic plan. These levels will have to be addressed in sequence (from the most basic upwards) to achieve our goal of supporting child development. We have visualized the sequence of these levels in figure 7.1. on the basis of the "hierarchy of needs pyramid" by Maslow, which we simplified to fit our need.

- At a **first most basic level** the integrity of the child is at stake. Physical needs must be fulfilled and *safety and security* must be experienced on a physical level when children are to develop and grow in a healthy manner.
- At the **second level** the child sows seeds for the development of social-emotional skills by playing, learning, and socializing. From this, the child acquires a sense of being *recognized and appreciated*.
- At the **third level** the child develops its individuality and motivation, which in turn enables the child to realize self-development.

These sequential levels or echelons deserve attention and consideration when initializing therapy and need to be taken into account. In general, we begin therapy by first addressing the lowest, most basic of the three levels in a given child. When there is a relapse during treatment, it may be necessary to (re)focus therapy on a previous, lower level.

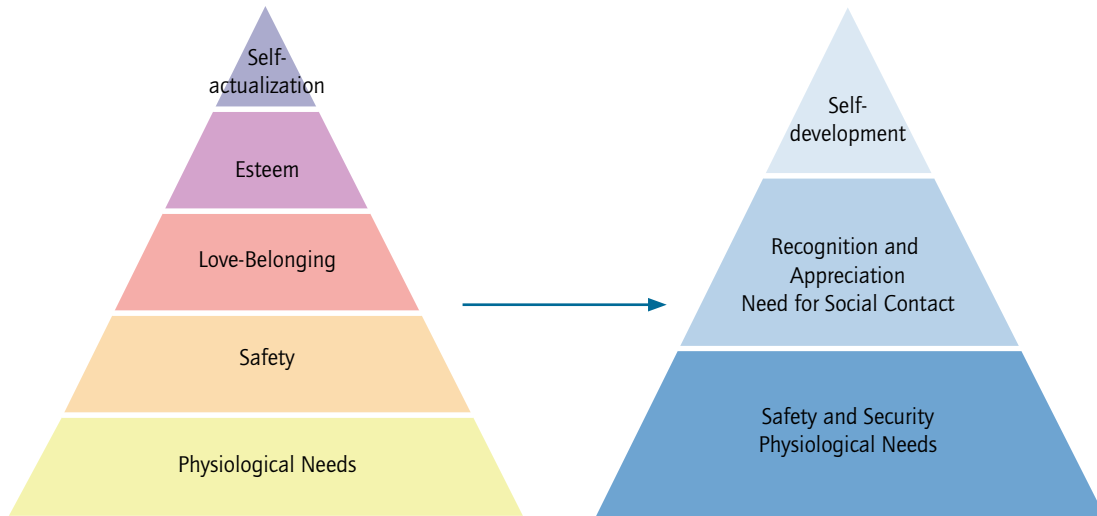


Figure 7 .1. On the left Maslow's original hierarchy of needs pyramid (Maslow, 1943) and on the right the simplified version

Note: The need for *social contact* has not been repeated for each different level but is of course essential on all three levels.

7.3. Choice of Therapy

Before discussing the choice of therapy for various forms of lateralization, an overview of therapies that can be used to strengthen the three echelons when working with constitution typology is necessary. Only a few examples are mentioned for each level.

7.3.1. Therapy Primarily Aimed at Promoting Safety and Security

Children thrive in a familiar and structured environment where physical needs such as nutrition, care, warmth, and affection are provided and in which attention is given to rhythm and regularity, to resting and sleeping, to food, and to kindness.

Safety and security also refer to feeling at home in one's body and to experiencing **well-being**. The confidence that the child can experience in physical exercise, in feeling healthy and energetic, and in motor and verbal skills are essential elements of safety and security (Price, 2005; Röhrich, 2009; Mehling, et al., 2011; Salvatore, Tschacher, Gelo, & Koch, 2015).

Therapies that can contribute to a feeling of safety and security are therefore **body-oriented therapies**:

- External body-oriented therapy such as rhythmic embrocation and massage, ointment and oil compresses, as well as bath therapy;
- nutrition/diet therapy;
- physiotherapy/exercise therapy and psychomotor therapy.

7.3.2. Therapy Primarily Focused on Promoting Feeling Recognized and Appreciated

Child development is like a discovery hunt in which the child acquires qualities and skills with the help of others. Children develop aided by imitation and activity, free play, and broad social and cultural interest. These various experiences aid them in acquiring creative faculties to express personal emotions, thoughts, and skills and in developing **self-confidence**.

Therapies that can contribute to this are:

- Play therapy
- Modeling -, drawing -, and painting therapy
- Music therapy
- Movement -, dance -, and eurythmy therapy
- Speech therapy

7.3.3. Therapy Primarily Aimed at Supporting and Promoting Self-Development

Self-actualization is linked to the ability to take responsibility for self-development and implement one's own choices. At the same time people become aware of their qualities and potential and discover what fascinates them and what they want to focus on.

The therapies in question are primarily focused on developing a personal **identity** and discovering and realizing one's own intentions.

Therapies that can contribute to this are:

- Eurhythmy therapy
- Psychotherapy
- Biographical conversations
- Family/system therapy

7.4. Choice of Therapy: Josh's Case Study Continued

In the section below, we will revisit the case history of Josh in which we will search for different qualities that we could offer him and how these can be translated into a targeted therapy. Further examples directed specifically to each unilaterality can be found in Appendix 1.

Continued case history: therapy for josh (continuation of chapter 6)

In Chapter 6, we conclude that Josh's problems were first and foremost his difficulties with the ability to connect, and we described Josh as being hurt and lonely as a result of his great openness which disrupted his contacts with other children and adults, frustrating himself and causing conflicts with those around him. Josh and his parents recognized the need to try and aid Josh in being able to deal differently with his openness and resulting fears (6.2.4.).

The direction of therapy for Josh was to find strength and self-confidence, learning to breathe differently, and experience and set boundaries.

To initiate treatment to strengthen Josh's developmental potential we proposed the following therapies:

- ***Child-oriented therapy:***

Level 1:

- *Starting off with body-oriented therapy: full body embrocation with a warming oil, to help him experience his physical body and feel its limits. Then comes a period of rhythmic massage to further become aware and comfortable with his physical limits and through this a feeling of safety and security.*

Level 2:

- *This is to be followed by a period of artistic therapy in which observing and drawing helps Josh to further orientate himself to the reality around him. Painting with colors can help him develop his inner life.*
- *At a later stage, movement therapy (eurythmy therapy) can aid Josh in finding a relationship to the experience of distance/proximity and restraint/surrender in connections. Music therapy can subsequently help him hold his own rhythm and melody and at the same time play together and tune into another person.*

These therapies lay the basis for a healthy social life.

Level 3:

- *Psychomotor therapy is an option in puberty/adolescence when he needs help to deal with conflicts and frustrations in contact with peers and adults.*
- ***System - oriented therapy:***
 - *Parental guidance to support and help Josh's parents formulate questions about everyday parenting situations and problems.*
 - *School advice and guidance, in consultation with the parents, informing the teacher and the school about the findings of inquiries and give advice.*

- *Towards adolescence it may be helpful to institute coaching of parents, teachers, and care-givers in finding and realizing a personal perspective for Josh in terms of living, finding an appropriate residence, and work.*

The case history of Josh is continued in **Chapter 8 on Coaching and Support**.

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8. *Coaching and Support*

8.1. Introduction

What happens to us when we experience an unexpected, taxing, and painful event, like a traffic accident, or the diagnosis of a disease in a loved one or in ourselves? We understandably feel shock, confusion, or maybe even panic. Often, we are confronted with several different feelings all at once. The impending chaos makes it hard for us to grasp the larger picture, which in turn makes it difficult to assess the situation or envision what the future holds.

As we consider these feelings and emotions, can we extrapolate to inquire what it might require from children and their families when it becomes clear that a child has a developmental disorder? What insights help them deal with this new reality and realize a fresh perspective? Which processes do they go through?

These are important questions to be aware of for those of us following children with developmental problems and their families. When coping stages are not recognized and identified or addressed appropriately, it may, sometimes unconsciously, hamper a child's development and the progression of a healthy family life.

In Chapter 1 we indicated that diagnostic efforts should not only lead to classification and treatment options, but could also be the start of realizing new developmental potential. The growing insight in recent years into how people deal with life-changing events has been an important contribution to this. Dealing with the challenge of having a developmental disorder either oneself or a loved one, calls upon the same coping strategies. Adequate support in dealing with coping questions related to having a developmental disorder is a prerequisite for successful developmental therapy. We will discuss a few relevant insights into these questions in this chapter.

Elisabeth Kübler-Ross described **five stages of grieving**, which reflect how people cope with painful and traumatic events (Kübler-Ross & Kessler, 2014). In the concept of salutogenesis, Aaron Antonovsky took an important step in demonstrating how people integrate life-changing events

into their biography/life (Antonovsky, 1979). Creating a **life story** in the narrative approach can help develop a coherent image of one's life, in which the (developmental) disorder takes in its rightful place (Hewitt, 2003; Brantlinger, Jimenez, Klingner, Pugach, & Richardson, 2005).

The concept of "wholeness," both maintaining and recovering it, has a central place in each of these approaches. Whichever approach we take in dealing with the initial confusion, the end result should be that we eventually become "whole" again—in spite of our limitations. This wholeness becomes apparent when we can articulate the life-changing event for ourselves and for others. This gives the painful episode a place in our lives that we may recall, think about, and have feelings about.

8 .2. The Grieving Process: Kübler-Ross

Staging

The diagnosis of a developmental disorder will be a profound and sad experience for those involved. It triggers a type of grieving. Kübler-Ross described a progression of five emotional states in grieving based on her experience in counseling people around death and dying (Kübler-Ross 2014). The five stages Kübler-Ross distinguishes are **denial, anger, bargaining, depression, and acceptance**. However, bereavement is not a linear process for her, in which one stage follows the next. People sometimes skip stages, remain in one stage for a longer time period or fall back into earlier stages. When you support a family that has a child with a developmental disorder, it is crucial to be aware of these stages of the grieving process.

Stage 1

Denial is like retreating from or refusing to face reality. It entails that we deny those facts that are painful to us, which means we pretend that the loss is not there or has not happened. However, this will not heal the wound caused by the loss. Denial is a form of *self-protection*, a stage in which we do not open the door to more than we can handle. It may be a helpful means to gauge the rate at which we admit to the pain.

Stage 2

In the following stages of the grieving process emotions come to the foreground. In addition to sadness we often feel **anger or rage**: 'why did it happen to me/him/her; how could this occur?' We look for someone to blame: am I to blame, or is the doctor, the hospital, or the family? 'If things had been done differently, then all would have been well.'

Analogous to what occurs in other stages, this stage can become repetitive.

Stage 3

During the bargaining stage we negotiate present and future perspectives. 'If she can get different medication and therapies, things will be better,' 'If we change things from now on, he will surely be able to go to a normal school,' or 'she will certainly be able to learn a profession and be able to live independently if we start treatment now.'

Stage 4

This is often followed by a period of **depression**, of surrendering to helplessness: things will not get better and there is no one who can change it or help it. This can lead to the experience of desolation and loneliness, for ourselves and in our family circle.

Stage 5

It takes confidence and courage to take the step to **acceptance**. That means the child's disorder and the grief that comes with it can be acknowledged, and a new confidence emerges that the child's life can be good in spite of the disorder. This is the stage in which courage can be found to "go for it" and to realize a (developmental) perspective for and with the child.

Then the disorder and the grief about it have found a place in one's life and can be spoken about without the emotions, anger, guilt, blame, and sadness overwhelming everything else. At this point, one moves forward with the confidence to know that the wounds will heal, and one's focus can be directed toward the present and the future.

Blaming

In discussing the grieving process, the theme of "blaming" was mentioned. A blaming dialogue might sound like the following: 'At birth, the midwife had insufficient expertise, the ambulance waited too long; it would have been different if a wrong diagnosis had not been made. Should I

have been told at an earlier time that things were not going well?' The question of who carries the blame actually appeals to the "I": 'I have done something wrong. I should have acted differently or sooner. Is it my fault?' These may be inescapable questions, which are important to think about, but not good to ruminate on because they can block the coping process and our ability to find a new "wholeness" within the sadness we are experiencing.

Dealing with feelings of guilt, their own as well as accusations to partner, family, and others is a challenge for parents and for the individual who suffers from a disorder, but also for care givers. Sometimes it requires additional attention.

8.3. Salutogenesis

The wholeness mentioned in the previous paragraphs has been studied by Antonovsky (1979) and described as a "*sense of coherence*." The process of (re) inducing this wholeness is called "salutogenesis²⁷". The *sense of coherence* ideally means that our life and biography form a coherent whole in which all past events - both joyful and painful - have a place. There are no inaccessible, hidden incidents or open wounds that are denied or repressed. We do not develop the experience of coherence automatically when we have an illness or are suffering. The presence of resilience (Almedom, 2005) (Masten, 2001) (Masten, 2014) is a necessary basis for being able to experience coherence.

According to Antonovsky, the sense of coherence has three components. Events contribute to the experience of coherence when they are **comprehensible**, **manageable**, and **meaningful**:

- Events are **comprehensible** when we are able to understand and grasp what is happening, such as when a disease or (developmental) disorder is diagnosed;
- Events are **manageable** when we can handle the situation we are in, deal with it, and feel able to influence it - or acquire the skills for this if needed;

²⁷ Salutogenesis: the origin of health

Wikipedia: The word "salutogenesis" comes from the Latin *salus* = health and the Greek *genesis* = origin. Antonovsky developed the term from his studies of "how people manage stress and stay well" (unlike pathogenesis which studies the causes of diseases).

- Events have **meaning** when it makes sense to us that they have occurred and we can give and derive significance from the fact that they are in our lives, whether they were joyful, painful, or sad. Events have meaning when we can see them as worthwhile challenges.

The responsible care for children asks of us to remain aware of these conditions enabling children to develop a *sense of coherence* (wholeness). This opens the way for parents and children to work on accepting the disorder and possible painful experiences connected to it and give these an intentional place in their lives.

8.4. Narrative Approach

Children and adults with a developmental disorder may, due to confrontation with the diagnosis of a disorder, have had traumatic experiences with associated illnesses, hospital admissions, stressful treatments, and various admissions to institutions, and consequently, lose perspective of their life story. A natural sequelae is to acquire a blind spot for traumatic events of the past by repressing them and refusing to process their impact. Reconstructing one's life story can help to develop a coherent picture of one's life in which the developmental disorder and all that is associated with it also have a place (Van Beek & Schuurman, 2007). Our identity largely depends on the images we have of ourselves and those we get mirrored from our environment. The "*Lifebook for Youth*²⁸" is a tool that allows us to become aware of all of these images. They may be collected, ordered, and put together to form our biography - our life story - which can be an aid in processing past events.

In the *narrative approach* (White, 2005; White, 2007), people with impaired development can be guided to organize their traumatic experiences and painful memories and give them a place in their lives. We may help them reconstruct their life story by giving words to experiences or asking them to write about them, or by making a drawing or a painting. We can also access this process by making a collage of pictures and other attributes in a book or by putting them in a box. All of these activities can contribute significantly to the growing and developing child's awareness of his/her own identity. An empathic and supportive approach and help from the environment are

needed to put the story together. Working with life stories helps to restore wholeness and a sense of coherence as we are coaching these children and their parents.

8.5. Josh' Story Continued: Coaching and Support

Developmental disorders and associated events may find a place in life and become integrated when we reconstruct a life story. This is an integral part of coaching and support of the person and their families. How did coaching of Josh and his family occur?

In Chapter 1 we introduced Josh's case history, including the concerns and questions of his parents. In Chapter 6, the *4-step* approach gave us further insight into his constitution typology and on this basis a further diagnosis was discussed and what that meant for Josh and his parents. In Chapter 7 we described the treatment options that were discussed with Josh and his parents.

Josh and his parents were coached by the attending physician as they went through the grief-processing stages of Kübler-Ross. In particular, the question of who was to blame for Josh's disability was difficult for the parents to let go. It resurfaced again and again because they had many questions about the events surrounding his illness as a young child: should they have sought help before? Should his mother's blood pressure have been regulated better during her pregnancy? Should they have been alarmed when Josh so easily startled as a baby? Allowing the parents to talk about this, as well as about Josh's behavior and his development, aided them in slowly ordering the events and giving them a place in their lives.

Explaining the images from the 4-step approach and the physician's pedagogical advice made Josh's incomprehensible behavior not only more understandable to them, but also more manageable. It aided them in accepting Josh as he is. It also made the advice for the therapies understandable, which contributed to their confidence. Only much later could the parents, and also Josh's sister and brother, see his situation as something that also had meaning for themselves.

Working on Josh's life story was also of great help, especially for Josh himself. Because of the coaching, Josh's mother could write the story about her pregnancy, the birth, and first few years of Josh's life. With support, Josh wrote something about the memories of the events in his youth, illustrating them with collages and drawings. This was brought together with photos from those years in Josh's book of life. Josh's father helped him put together a box for the book of his life, his old teddy bear, and other things that were valuable to Josh when he was a child. Josh took it with him when he was 20 years old and left home. Along with the therapies that were prescribed for his constitution, it enabled him to live in a guided-living situation and take up vocational training.

Over the years, Josh learned to deal with his sensitivity better and it became easier for him to describe his emotions so that he gradually had fewer emotional eruptions.

8.6. People with Developmental Disorders Who Found New Perspectives

Josh's story illustrates how one's perspective on life can evolve. Many people stand as an example for having to deal with an illness or disability and finding a new perspective in life for themselves. Books and films have been made about them.

Writers like Oliver Sacks (1995) and Andrew Solomon (Solomon, 2013) have recorded such stories about children and their parents. Biographies have been published by people who wrote about their child or themselves (Momma, 2014; Brown, 2014). The life of Temple Grandin, who suffers from autism and became world famous as an animal behaviorist, is a prime example of how a woman realized a strong and special developmental perspective that included her disorder (Wood, 2016).

These stories illustrate how experiencing a disorder can evolve from negative, strange, and disturbing to becoming part of life, and even becoming instrumental in realizing one's life goal. Once this happens, the disorder becomes accepted and integrated into one's life. And, just as in everyone else's life, there may at times be new and unforeseen setbacks as well as new opportunities and possibilities with a novel perspective.

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9. *ICC, a Tool to Assess Childhood Constitution*

9.1. Introduction

In addition to the conventional diagnostics, healthcare institutions inspired by the work of Rudolf Steiner among others utilize insights based on the concept of constitution typology in every day practice. A tool called the "Instrument for assessing Children's Constitution" (ICC) was developed in response to the need for a common language and an approach that would enable inter-subjectivity and repeatability of the assessments based on constitution typology (Niemeijer, Baars, & Hoekman, 2008). Findings from research on the development and implementation of the ICC have been published (Niemeijer M., Baars, Hoekman, & Ruijsenaars, 2018) in addition to its psychometric applications.

The ICC *supports* the assessment of the child's constitution in the diagnostic process. It is available via www.bolkscompanions.com/constitution-pictures. The text of the ICC can also be found as an attachment to this chapter (appendix II).

9.2. Structure of the ICC

The ICC consists of two parts: the first assessment component (part I) uses a seven-point scale; and the second (part II) a visual analog scale. The design employs the polarities characteristic of constitution typology. The tool also includes an explanation to facilitate its use. The person responsible for the treatment of the child is also responsible for completing and implementing the ICC. Responses to the ICC items should be based on the child's functioning within the *previous month*.

9.2.1. Part I: Seven Point Scale

Part I consists of 36 items within which each of the three developmental principles is evaluated

using 12 questions. This section is completed on the basis of observations in step 1 of the *4-step* approach (6.2.1.).

The data for filling it out are provided by care givers who are directly involved in the care of the child. In practice, this is usually done by the responsible physician or care giver, who can, if needed, consult with others who are directly involved in the child's daily care. However, everyone who knows the child intimately and who is moreover familiar with the methodology of the ICC can fill out this component.

The 36 items to be assessed are formulated using a seven point Likert Scale (Figure 9 .1.). The scale allows for quantifying equilibrium or disequilibrium (unilaterality), to a greater or lesser degree, in each of the formulated items. The score "0" (neutral) indicates balance, all other scores indicate greater or lesser degrees of one-sidedness. The assessment is applied to individual symptoms that may be observed in the child; it has an *analytic character*.

Item #	– Items (<i>Connecting</i>)	Score Josh							+ Items (<i>Connecting</i>)	Score
01	Does not let go of own plans in the interaction with others	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Easily abandons own plans in the interaction with others	
02	Has an even mood	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has abrupt mood changes	
03	Is closed in contact	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is open in making contact	
04	Gets stuck in own choice of conversation topic	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Wanders away from own choice of conversation topic	
05	Tendency to constipation	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Tendency to diarrhea	
06	Quickly falls asleep at night	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Falls asleep late at night	

Figure 9.1. Fragment of part I van het ICC: assessment of items on the seven-point scale

9.2.2. Part II: Visual Analog Scale (VAS)

Part II consists of three visual analog scales (VAS), one for each of the three developmental principles. Part II should also be filled out by the physician or care taker responsible for the diagnosis. This person interprets the characteristic impressions found in the third step of the *4-step*

approach and compares them to the characteristic descriptions of each of the six constitution typologies (reiterated in the explanation at the start of the ICC). These can then be applied to the three VAS, which have values ranging from -10 to +10 per scale.

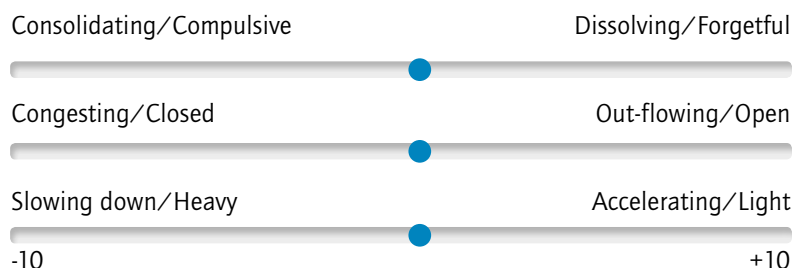


Figure 9.2. Part II of the Constitution Instrument (ICC): three Visual Analogue Scales (VAS)

These scales allow the responsible physician or care giver to give a *clinical judgment* on the degree of balance or one-sidedness of each of the three pairs of polar constitutional descriptions. The scales have two polar qualities each at one end. The investigator designates the point that seems to reflect the child's functioning vis-à-vis the applicable developmental principal most accurately (see figure 9.2.).

The VAS assessment appeals to pattern recognition or "*Gestalt*"²⁹ (Daston & Galison, 2007) (Stolper, et al., 2011). This assessment addresses *different abilities* in the investigator than just sense perception, which we applied to fill out part I of the ICC; it is *synthetic holistic* in character (Bortoft, 2012).

Completion of the three VAS in Part II of the ICC requires observation of and empathy with the child on the one hand and adherence to the three pairs of polar constitution descriptions of the scales on the other. By putting a mark on the scale we may indicate the extent to which the characteristic impressions that we found in step 3 of the *4-step* approach (6.2.3.) match the dynamics of the VAS. When we do not find one-sidedness, we place the mark in the middle. When we find that the dynamic fully corresponds to one of the extremes, we place the mark on the extreme right or left. In all other cases we weigh as accurately as possible where to place the mark between the two extremes.

²⁹ Gestalt: German terminology for a psychological concept that stands for the "overall picture," in which the whole is more than the sum of the parts

9.2.3. Determining the Child's Constitution Profile

The outcome of the two parts of the ICC is shown as the child's *constitution profile*. The profile shows the scores of parts I and II both on a ten point scale for comparability. For part II this is easy since the results on the VAS are shown in scores from -10 to +10.

Part I presents more of a challenge. Part I has 12 items for each of the three developmental principles, with scores on a seven point scale ranging from -3 to +3. This means that for each developmental principle the total score may range from -36 (12 x -3) to +36 (12 x +3). Therefore we have to divide the total score by 3.6, to be able to display them on the ten point scale of the constitution profile.

In addition to the total scores for part I and II, the *spread of the results* of part I is also shown in the profile. To this end, the results of all scores (< 0 and > 0) for each constitution type are added and then divided by 3.6 to fit the 10-point scale.

9.3. The ICC in Practice: Josh's Scores in Part I

In the next sections we continue Josh's case history. The results of his ICC is elaborated on as an example for how the ICC is used.

Part I of the ICC is filled out on the basis of observations found in step 1 of the *4-step* approach. Most of the scores were obtained by the physician's own observations and some scores are based on observations of other care givers involved in the study in the past month.

9.3.1. Part I – Giving Form

The 12 items filled out for Josh in Part I that relate to the developmental principle *giving form* as discussed in chapter 3, resulting in the polar qualities consolidating/compulsive (abbreviated in the scale to CC) versus dissolving/forgetful (abbreviated to DF) are listed below in the table. Since

the items that relate to this pair are randomized in the scale, the relevant item number is shown in the first column. In the second column the (-) items regarding the ability to give form are described, in the third column Josh's scores (from -3 to +3), and in the fourth column the (+) items (see below).

Note that the items relating to the different development principles have been randomized in the ICC list.

Item #	- Items (<i>Giving Form</i>)	Score Josh							+ Items (<i>Giving Form</i>)	Score
01	Does not let go of own plans in the interaction with others	○	○	●	○	○	○	○	Easily abandons own plans in the interaction with others	-1
04	Gets stuck in own choice of conversation topic	○	○	●	○	○	○	○	Wanders away from own choice of conversation topic	-1
09	Has fixed predictable style of interacting	○	○	●	○	○	○	○	Is unpredictable in interaction	-1
10	Has exact memories of events	○	○	○	○	●	○	○	Has none or vague memories of events	+1
11	Tends to tight control of own actions	○	○	○	○	○	●	○	Acts without thinking about it first	+2
13	Has dark brown or black hair	○	○	○	○	●	○	○	Has blond to red hair	+1
14	Has fixed thinking patterns	○	○	○	○	●	○	○	Thinks chaotically	+1
23	Has a strongly formed physique	○	○	○	●	○	○	○	Has an unformed physique	0
25	Is a perfectionist	○	○	○	○	●	○	○	Is untidy	+1
29	Shuts down when angry	○	○	○	○	○	●	○	Has unfocused explosive outbursts of anger	+2
31	Keeps appointments	○	○	●	○	○	○	○	Forgets appointments	-1
32	Has set habits	○	○	○	●	○	○	○	Does not (easily) make habits his/her own	0



The number of times the different scores were given to one of the items is:

	Scores < 0 (centripetal tendency)	Neutral	Scores > 0 (centrifugal tendency)
	0 x -3		0 x +3
	0 x -2	2 x 0	2 x +2
	4 x -1		4 x +1
Total	-4	0	+8

The sum total of the 36 scores on the seven-point scale for the developmental principle *giving form* is: -4 + 0 + 8 = 4.

To get a total score on a ten-point scale this is divided by 3.6 = 1.111. This gives a rounded score on a ten-point scale of +1. The spread on the ten-point scale is -4 : 3.6 = -1 to +8 : 3.6 = +2 .^[30]

The scores of the seven-point scale set out on the ten-point scale for the principle "*giving form*" look like this:

Centripetal tendency
CC +10 _____ -1 ____ 0 ____ +1 ____ +2 _____ - 10 DF

Centrifugal tendency

9.3.2. Part II - Connecting

The 12 items in Part II that relate to the developmental principle *connecting* as discussed in Chapter 4 comprise the polar qualities congesting/closed (CCI), which are juxtaposed with the out-flowing/open constitutional tendency (OO) and are filled in as follows:

³⁰ The total score is calculated by adding all 12 item scores together : 4x - and 8x +. Dividing by 3.6 leads to a spread of -4 : 3.6 = a rounded figure of -1 and +8 : 3.6 = a rounded figure of +2.

Item #	– Items (<i>Connecting</i>)	Score Josh							+ Items (<i>Connecting</i>)	Score
03	Is closed in contact	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Is open in making contact	+2
16	Seems to not feel pain	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input checked="" type="radio"/> +3	Excessively sensitive to pain	+3
18	Has dry hands and skin	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has moist hands and skin	+1
19	Shows few to no emotions	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Shows vehement emotions	+2
20	Is mostly self-focused	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input checked="" type="radio"/> +3	Is especially focused on environment	+3
21	His/her skin feels thick	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	His/her skin feels thin	+1
22	Is not afraid to make mistakes	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Is afraid to make mistakes	+2
24	Is not sensitive to sense impressions	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Is very sensitive to sense impressions	+2
27	Has slow and deep breathing	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Has fast and superficial breathing	+2
30	Is not very aware of the environment	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is alert to the environment	+1
33	Does not (strongly) react to changes in the environment	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Reacts excessively to changes in the environment	+1
34	Sees and feels no danger	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input checked="" type="radio"/> +2	<input type="radio"/> +3	Is scared of everything	+2

The number of times the different scores were given to one of the items is:

	Scores < 0 (centripetal tendency)	Neutraal	Scores > 0 (centrifugal tendency)
	0 x -3		2x +3
	0 x -2		6x +2
	0 x -1		4x +1
Total	0	0	+22

This gives an overall score of $0 + 0 + 22 = 22$. On the ten-point scale this is $22 : 3.6 = 6.11$. The rounded score on the ten-point scale is **+6**. There are no negative scores and therefore there is *no spread*.

The scores of the seven-point scale set out on the ten-point scale for the principle "*connecting*" look like this:

Centripetal tendency Centrifugal tendency

CCI -10 _____ 0 _____ +6 _____ +10 **OO**

9.3.3. Part III - Movement

The 12 items of Part III which relate to the developmental principle of *movement* as discussed in Chapter 5 consists of the polar qualities slowing down/heavy (SH) versus accelerating/light (AL) and are filled out for Josh as follows:

Item #	– Items (<i>Movement</i>)	Score Josh							+ Items (<i>Movement</i>)	Score
02	Has an even mood	○ -3	○ -2	○ -1	○ 0	● +1	○ +2	○ +3	Has abrupt mood changes	+1
05	Tendency to constipation	○ -3	○ -2	○ -1	● 0	○ +1	○ +2	○ +3	Tendency to diarrhea	0
06	Quickly falls asleep at night	○ -3	○ -2	○ -1	○ 0	● +1	○ +2	○ +3	Falls asleep late at night	+1
07	Moves little	○ -3	○ -2	○ -1	○ 0	○ +1	● +2	○ +3	Is hyperactive	+2
08	Is not alert	○ -3	○ -2	○ -1	○ 0	● +1	○ +2	○ +3	Is alert and sees everything	+1
12	Has low muscle tone, is relaxed	○ -3	○ -2	○ -1	● 0	○ +1	○ +2	○ +3	Has high muscle tone, is tense	0
15	Has a heavy gait	○ -3	○ -2	○ -1	○ 0	● +1	○ +2	○ +3	Has a light step when walking	+1

17	Shows little initiative	<input type="radio"/> -3	<input type="radio"/> -2	<input checked="" type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Many and varying initiatives	-1
26	Heavy physique	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Petite light physique	+1
28	Shows little reaction to stimuli	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Reacts vehemently to stimuli	+1
35	Has to be woken up in the morning	<input type="radio"/> -3	<input type="radio"/> -2	<input checked="" type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Wakes up early in the morning	-1
36	Does not react to questions right away	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input checked="" type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Does not wait for a question, acts immediately	+1

The number of times the different scores were given to one of the items:

	Scores < 0 (centripetal)	Neutral	Scores > 0 (centrifugal)
	0 x -3		0 x +3
	0 x -2	2x 0	1 x +2
	2 x -1		7 x +1
Total	-2	0	+9

This gives a total score of $-2 + 0 + 9 = 7$. For the ten-point scale this will be a score of $7 : 3.6 = 1.94$. The rounded score on the ten-point scale is **+2**, with a *spread* of -1 (= $-2 : 3.6$) to +3 (= $+9 : 3.6$).

The scores of the seven-point scale set out on the ten-point scale for the principle "**movement**" look like this:

Centripetal tendency
SH -10 _____ -1 ____ 0 ____ +2 ____ +3 _____ +10 **AL** Centrifugal tendency

9.4. Part II of Josh's ICC

9.4.1. Completing the VAS

Part II of Josh's ICC with the three VAS has been completed by the responsible physician using the characteristic impressions that were formulated in step 3 of the *4-step* (6.2.3.):

Centripetal		Centrifugal
CC	0 + 1	DF
CCI	0 + 5	OO
SH	0 + 3	AL

9.4.2. Josh's Constitution Profile

When we want to determine Josh's constitution profile with the help of the ICC, we have the following scales available:

Constitution profile scales:

Consolidating/Compulsive	Dissolving/Forgetful
I _____ - 1 _____ 0 _____ + 1 _____ + 2 _____	
II _____ 0 _____ + 1 _____	
Congesting/Closed	Out-flowing/Open
I _____ 0 _____ + 6 _____	
II _____ 0 _____ + 5 _____	

Slowing down/Heavy

Accelerating/Light

I	_____	- 1	_____	0	_____	+ 2	_____	+ 3	_____
II	_____		0	_____		+ 3	_____		_____

Assessment of Josh's ICC

Each of the three developmental principles in Josh's constitution profile indicate a *centrifugal tendency*. This tendency is most pronounced in the principle of being able to connect, in the sense of an out-flowing openness. The centrifugal tendency is present to a lesser extent in the developmental principles of the ability to form and to move. The scores of the 36 items of part I show a similar picture to the scores on the VAS of part II.

This assessment is in line with what we have found in section 6.2.3. in which we formulated a characteristic impression of Josh's situation. In order to better compare the two outcomes, the result of step 3 of the 4-step is below:

Josh's case history continued – Step 3 of the 4-step Approach

In revisiting the observations of Josh and the patterns we described, it may seem that his openness (physically exemplified in his eczema and perpetually open mouth) combined with his vulnerability make it hard for him to stay focused. This may lead to a feeling of rising tension and unrest in his physical body. If this is not dealt with adequately by the environment, it may lead to an angry outburst or hurting others. His mood has the potential to disrupt others when Josh threatens to lose control of himself. He may be trying to maintain control of his emotional body by holding on to the adults around him. If this fails, it may result in physical or emotional harm, which initiates another (violent) reaction to be followed by remorse later on and the cycle repeats itself.

*If we compare our observations and patterns to the three **constitutional principles**, we can see how the ability to connect is a struggle for Josh. Josh cannot breathe to the rhythm of his surroundings; the boundary between inside and outside is too permeable. This can be described as an open, out-flowing dynamic: Josh cannot close himself off at the appropriate moment. Section 4.3.2. expounds on the characteristics*

of this constitutional dynamic. In the ability to form, Josh lacks structure, which manifests as outbreaks of eczema or his tendency to slump in his chair (section 3.3.2.). And as for the ability to move, this is overdeveloped in Josh's situation since he has a hard time sitting still (section 5.3.2.).
The unilateral directions in his development not only make it hard for Josh to function, but he also seems unable to escape them.

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10. *Epilogue*

10.1. Review

In this Companion, we have presented and discussed an additional approach for the diagnosis and treatment of children with developmental disorders. In our work with children and adults with disabilities, we have seen how the diagnostic criteria of the DSM-5, although helpful in defining and classifying the diagnosis, are principally *disorder-based*. In practice, they provide insufficient guidelines to the practitioner on how to support the individual child's development. The additional descriptive diagnosis offers more possibilities, but not the tools to optimize the **development potential** of these children.

The *4-step* approach we use to establish an additional *constitutional diagnosis* is a *development-oriented approach*, which gives direction to therapeutic options and lifestyle advice we can give to families (chapter 6). This approach may be complemented and supported with the individual assessment tool for children's **constitution profile** (ICC, Chapter 9). This way of working has been in use in practices and institutions around the world for many years. Discerning between **six qualities in the child's constitution** is at the center of this approach. These qualities were extensively described in chapters 3, 4, and 5.

On the basis of examples characterizing these qualities and their pronounced one-sidedness, we have further explained the six constitutional types in order that the reader could form a vivid picture of them.

The use of pictorial language to describe children's constitutional make-up appears to be a useful way to understand children with disabilities in their development potential and support them with therapeutic agents. Actually, this is often helpful for so-called "normal" children, too. In fact, who among us did not have moments of recognition of our own peculiarities when reading about the six constitution types?

We do not want to close this Companion without telling you how Josh, whom we have been able to follow throughout this text, fared in later life.

10.2. Case History of Josh – Review and Epilogue

In chapter 1 we started telling the story of Josh; at that time, he was 8 years old.

*At the age of 6 Josh was given an ambiguous **classification** by a child psychiatrist. Different classifications were considered: ADHD because of his hyperactivity; a developmental psychosis because of his strange behavior with fantasy stories; and an autism spectrum disorder on the basis of his communication difficulties, stereotyped behavior, fixed pursuits, and hyper-reactivity. The preliminary diagnosis of a developmental disorder not described in detail, in a boy with a presumably mild intellectual disability, was made.*

*The **descriptive diagnosis** mentioned his general developmental delay, the delay in speech and language development and self-reliance, and his communication challenges. Attention was also drawn to indications of a mild intellectual disability. Josh was admittedly small for his age, but had no physical features that pointed to a possible congenital disorder. This also applied to the one-time febrile seizure that was described as well as to Josh's airway problems. Josh grew up in a complete family that was always positively involved with Josh.*

*At the age of eight Josh was further examined and his **constitution profile** was established.*

*In Chapter 6, the examination on the basis of the 4-step approach was described, and in Chapter 9, the result of his ICC were analyzed. Both showed a **peripheral, centrifugal tendency** in all three developmental principles – giving form/connecting/moving. The one-sidedness in the connecting principle towards an out-flowing/open dynamic is the most glaring, but the centrifugal tendency is present in form giving and moving principles to a lesser degree. The ICC presents a consistent picture in the scores of the 36 items of part I as well as in the VAS of part II. Josh's constitution profile confirms the picture of oversensitivity and vulnerability found in the 4-step approach; Josh was not well anchored in himself and his self-confidence appeared to be limited.*

In Chapter 7, we described the three levels of therapeutic action in developmental issues:³¹

- *creating safety and security*
- *giving recognition and appreciation*
- *promoting self-development, –*
- *and the therapies that we recommended on this basis to Josh and his parents.*

We suggested a first-level therapy for Josh, since we deemed it important that he be able to experience physical safety, security, and trust. Subsequently, second level therapies helped him to develop self-confidence. They enabled him to acquire skills to remain more balanced in his relationships and contact with other people. In Chapter 8, we described how Josh and his family were supported in processing and eventually accepting Josh's situation, which aided in creating a safe place for Josh within the family.

Today, Josh is 21 year old. He lives and works at a care farm, a farm that provides work opportunities and sometimes living for people with special care needs, where he has his own apartment. He receives support in daily activities such as meal preparation and cleaning. In a learning/work trajectory he is developing skills in livestock farming, in milking and milk processing, and in horticulture.

Upon request, Josh is happy to look back on his life up till now and to tell about the coaching he has received and what this has meant for him.

Josh is quite happy with his home on the care farm. He says that his love for animals has brought him here, and that the work he does provides him with immense satisfaction. Dealing with the other people on the farm remains a challenge for him. Josh likes to be among people, but he knows that it is not easy for him to do this in a socially-acceptable way. He is often told that he should not be so pushy or be so

31 Based on the simplified version of Maslow's hierarchy of needs pyramid (section 7.2.)

quick to anger. He is working on this aspect of his personality, but continues to live removed from other people for his own as well as others' comfort.

Getting away from home, from his mom and dad, was difficult for him. However, when his younger brother Harry left the house, Josh accepted that it was also time for him to take this step.

Josh celebrates his birthday on the day I visit him--his first away from home. In the morning, his co-workers sing Happy Birthday to him and he serves a treat with the coffee. This is simultaneously scary and exciting for Josh. Josh's parents come in the afternoon with his older sister, Clara and his brother, Harry. Frits, his personal coach, also comes to celebrate.

Josh is proud to receive visitors in his own room. He has helped in the kitchen to bake a cake for them, which was no easy feat since the cake had to be exactly the way he had always done it at home with his mother. When he encountered a few hiccups in this process, he lost his temper, and Frits, his personal coach, had to come and help. Josh and his visitors recount to me how his life until now has progressed. These have been eventful years for Josh and his family. Josh's brother Harry tells that for years it seemed to him that everything revolved around Josh, that all attention was focused on him. Josh was ill or mom had to go to school for talks with the teachers about Josh; Josh always had to go to therapy, which took time away from the other children. Harry always felt he was to blame when Josh was angry or cried. Fortunately he now has a different perspective and realizes that he often could not help it that Josh behaved like he did. He himself has also benefited greatly from conversations with a coach, and realizes that he has learned to deal with similar situations in his life now thanks to these experiences.

Clara adds that they really had fun when they could draw and paint together at the large kitchen table as children. Josh smeared the paint all over himself rather than on the paper, but he would visibly enjoy it. And she remembers how dad was always on the road for his job and how she had to take care of her younger brothers when mom

had to leave. She admits that this was quite difficult as the dynamic between Harry and Josh was always somewhat explosive.



Josh's mother gets out a photo album. Right away, Clara finds the page with a picture of the family at a campsite in France. Josh is sitting between mom and herself and next to them are dad and Harry. It was taken when Josh was about 11 years old. At that time the many tests Josh had undergone had not really yielded any tangible results. Indeed, Josh had a developmental delay and was found to function at a somewhat lower intellectual level; he did have symptoms of an autistic disorder, but those were insufficient to make a formal diagnosis. No clear cause for the constellation of Josh's symptoms had been found. However, they had fortunately found a suitable

school for Josh where he learned to work with his hands. The conversations with the family physician helped mom and dad to better understand Josh. Josh had also been referred by their family doctor to artistic therapy, which taught him to declare his wants, needs, likes, and dislikes. Josh also tells how he learned to enjoy the massage he received. His mother says she felt she could really "see" Josh again after the massage sessions and that he became more himself through therapy. Josh also remembers his music therapy sessions fondly. They helped him to harmonize better with his family members, since it allowed him to play music together with them, which was really important to him.

His mother adds how, for her, the conversations with the whole family and the psychologist were helpful. All of them could tell their own story about feelings of

insecurity and sadness, about not being comfortable and being misunderstood, but also about nice things. In the few conversations with her she felt confirmation that each of them had their own special place in and contribution to the family.

Josh has made great strides in his development, which have led to him to being able to live semi-independently and find fulfillment in his life. The therapies in particular have been important for this. The diagnosis with the 4-step approach and checking this against the ICC made it possible to make a tailored choice of therapies for Josh that the rest of his family could understand and support. Due to various life circumstances, Josh's constitutional examination has not been repeated.

Josh and his parents, as well as his siblings, are happy with the developmental steps that Josh has made, and are grateful for having learned about his constitution profile. They each were able to use the outcome in their own way and better understand how they can deal with Josh in their family.

10.3. Discussion

Constitution profiles based on the six developmental qualities have been used in practice for years to the satisfaction of clients and their care givers, but this modality is still in its infancy as far as scientific validation and accountability is concerned. The use of pictorial language in healthcare practice, which is a necessity when working with constitutional typology, is on the rise, but is also in its initial stages. The publication of the tool to assess the child's actual constitution (ICC) provides a foothold to make diagnostic testing towards developmental progress verifiable for the first time (Baars & Niemeijer, 2004). Some further steps have been taken in published articles towards justifying the method and validation of the instrument (Niemeijer, Baars, & Hoekman, 2008; Niemeijer & Gastkemper, 2009; Niemeijer M., Baars, Hoekman, & Ruijsenaars, 2018; Niemeijer M., Baars, Hoekman, & Ruijsenaars, 2018). The next step will be to examine the outcome of this special way of working with children and families, and then to make it more widely available.

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Appendix One (to Chapter 7)

This appendix is an addendum to Chapter 7, which concerns therapeutic options. Here, we will discuss in more detail the specific approach and therapy options for lateralization in each of the six constitutional tendencies described in Chapters 3, 4, and 5.

A. Therapy Options for an Unbalanced Ability to Form

The consolidating/compulsive constitution: Mark

We presented Mark (11 years old) in section 3.3.1. as an example of someone with a consolidating/compulsive constitution. We concluded in 3.3.1.:

"**Phenomena** that point to a consolidating/compulsive tendency in Mark's constitution are Mark's attention to his appearance, the way he presents himself, and his tense posture. Also, the compelling, repetitive way he ruminates on the "accident theme" and the way he is stuck in his habits and routines, specifically, the way his coat is buttoned and how he positions his belongings on his desk. In addition, his characterization of the car accident and the person who caused it suggest a tendency toward inflexibility.

The **dynamic** of too much of the form giving principle shows itself as centripetal, inwardly directed tendencies, which lead to consolidation and stiffening."

We would opt for a treatment strategy that aims at strengthening the dissolving, centrifugal dynamic in Mark's constitution profile.

Level 1 External/physical therapies: Bath therapy and massage can help him to let go and relax.

Level 2 Artistic therapy: The specific practice of painting wet-on-wet with watercolors of light

hues can help to a child with Mark's constitution to experience and learn to accept the process of letting go. In music therapy it is the act of listening to music that appeals to the emotions which is helpful.

Level 3 The pedagogical approach: To support the "dissolving" tendency, distraction and movement are useful. It is also helpful to ignore the compelling and compulsive tendencies in someone like Mark and direct his attention to a subsequent activity.

The dissolving/forgetful constitution: Robert

Robert (13 years old) was our example in section 3.3.2. of a person with a dissolving/forgetful constitution. We concluded in section 3.3.2.:

"**Phenomena** that point towards a dissolving/forgetful dynamic of the form giving principle in Robert are a dreamy consciousness, his staring gaze, and lack of focus. Other behavioral examples are the effort he has to make to take care of himself and to articulate his speech and the fact that he needs to be reminded of his appointments and what to bring along. The expression of a centrifugal dissolving tendency may also be seen in his rounded, somewhat unformed physique, his curly hair and red blush on the cheeks, the perspiration, and his slouched posture.

The **dynamic** of too little of the form giving principle shows itself as centrifugally-directed tendencies that lead to dissolution and formlessness."

The treatment strategy for this constitution would be to present him with the form-giving principle.

Level 1 External/physical therapy: External therapy provides the form-giving principle in a more passive way. Rhythmic massage, for example, may be applied specifically to enhance form and structure. More active movement therapies such as eurythmy and speech therapy can also contribute to the form-giving, structuring inclination that is needed in a child like Robert.

Level 2 Artistic therapy: Particularly clay modeling where the child can bring shape to a lump of clay in free forms or with a model, presents the form-giving principle in a compelling way and helps to reinforce the important role of form.

Level 3 Pedagogical approach: This level may offer clarity and repetition, with secure daily rhythms and habits. Short, clear questions and announcements, verbally and, where possible, supported by other inputs like visual information (such as pictograms and sign language) further support the need for structure.

B. Therapy Options for an Unbalanced Ability to Connect

The congesting/closed constitution: Malva

We presented Malva (7 years old) in section 4.3.1. as an example of someone with a congesting/closed constitution. We concluded:

"Phenomena of Malva's mostly congesting/closed constitution when making connections are: her pent-up anger, her flushed face and fiery look, and her stomping feet. A congesting dynamic can also be seen when she collides with objects, playing wildly, and unintentionally hurting other children and her dog. She shows little restraint and does not adequately respect other people's boundaries, which indicates a lack of being able to connect in Malva's congesting/closed constitution.

A congesting/closed **dynamic** becomes visible as an inwardly directed (centripetal) energy that is contained by a solid and hard-to-penetrate boundary. The boundary may be broken down with increasing force/pressure from inside."

In therapy, we link up with this dynamic and try to harmonize with it. Key elements for this are giving Malva room to be, help her relax and calm down, trying to reach her in spite of the boundary she has made, and improving her ability to connect with the environment.

Level 1 Relaxing, calming activities, and softening of boundaries can be achieved physically with **body-oriented therapies** such as massage.

Level 2 Improving the child's ability to connect to the environment can be supported by doing observation exercises in **artistic therapy** by drawing, painting, and modeling. **Music therapy** may also be a tool, specifically making music together on stringed instruments, which requires tuning in to the other player(s) and at the same time listening and playing oneself.

Level 3 For **pedagogical purposes** relaxing means to refrain from challenging the child directly, allowing him/her his personal space without letting go of the subject in spite of any "fire-spitting."

The out-flowing/open constitution: Angelique

In section 4.3.2. we presented Angelique (9 years old) as an example of a person with an open/out-flowing constitution. Section 4.3.2. concludes with:

"**Phenomena** that point to Angelique's outflowing/open constitution are a strong focus on her environment, insufficient boundaries, and limited self-confidence, insufficient warmth and a thin skin, her eczema, her sensitivity to touch, seeking external support in the environment, her doll, the one she knows and trusts; and her fear of the new and unknown. All of these indicate an overabundance of connecting in Angelique's outflowing/open constitution. When she receives affirmation, she experiences self-confidence and can shine.

The outflowing/open **dynamic** becomes visible in an organism that has centrifugal tendency and a weak outer boundary, does not experience sufficient support in its own strength, nor offers sufficient resistance to the surroundings."

Therapies that harmonize on the out-flowing/open dynamics are characterized by setting boundaries with the child, providing selected content such as bolstering stories to the child, and warming practices such as adequate clothing.

Level 1 External/physical therapy: Warm compresses and embrocation can support the skin in its function as border to the outside world. An out-flowing/open dynamic leads to a physical loss of warmth because the ambient temperature is always lower than the body's temperature.

Level 2 In **artistic therapy** the use of painting with warm colors helps to create and furnish a sheltered interior space, a nest, a den, or a house.

Level 3 For the **pedagogical** approach this means that giving confidence and offering a stage is important. She could maybe learn to use an extra layer of protective clothing.

C. Therapy Options for an Unbalanced Ability to Move

The slowing down/heavy constitution: Carline

Carline (12 years old) was our example of a person with a slowing down/heavy centripetal constitution in section 5.3.1.

"Phenomena that refer to a one-sided balance in the ability to move, with a predominantly slowing down/heavy dynamic, are exemplified in Carline's posture and movement, the obesity that hinders her motor skills, her dreamy consciousness, her mood that resonates with her environment, becoming unhappy when faced with a challenge, and a subsequent change in mood with a friendly word and some encouragement.

The **dynamic** behind the manifestations of a slowing/heavy one-sidedness in moving manifests as a lack of moving impulse; and when an impulse does occur, it quickly extinguishes. This indicates a centripetal dynamic: each impetus to movement slows down and falls still into heaviness."

Level 1 Physical therapy options: For an organism with muscles that need help with tone

initiation, stimulating massages are a first step to incite more movement.

Movement therapies in physiotherapy such as sensorimotor physiotherapy, eurythmy therapy, and dance offer additional possibilities to activate movement and overcome the heaviness.

Level 2 Artistic therapy options: Music therapy can stimulate movement and action with modalities like percussion and wind instruments. Choosing appropriate music and rhythms for an instrument such as the djembe will further support the waking and activating effect.

Level 3 Pedagogical options: in working with Carline, stimulating her physical expression and enthusiasm is paramount. The teacher's own enthusiasm for an activity is shared with the child with the aim of igniting a spark of initiative. Immediately afterwards the teacher initiates the movement and the child is taken along in the activity.

The accelerating/light constitution: Tim

We presented Tim (10 years old) in section 5.3.2. as an example of someone with a accelerating/light constitution. We concluded:

"**Phenomena** that are emblematic of an accelerating/light one-sidedness in moving are that Tim cannot stop moving, which impacts all motor skills including speech, his slender, supple build, being optimally prepared to notice everything around him and respond to it, and his actions and reactions that lack reticence or restraint.

The **dynamic** that expresses in these phenomena has a centrifugal tendency and can be characterized as a fire consuming all around it."

Level 1 Here too, a first step in treatment can be taken with **body-oriented therapies** such as a warm bath with lavender oil or a relaxing massage that stimulate the muscles to relax.

Level 2 Art therapy in the form of music therapy can call on being quiet and listening, particularly music with descending/decelerating rhythms such as the trochee played on stringed instruments.

Movement therapy can contribute to learning to harmonize the child's own movement, to attune them to the other person and to the environment.

Level 3 The **pedagogical approach** is aimed at creating an environment with limited sensory stimuli. The pedagogical **attitude** is one of preserving inner peace as well as providing for moments of rest in which Tim is regularly asked to reflect on earlier events together with the teacher.

Appendix II (to Chapter 9)

The ICC – Part I

Estimates based on the overall impression of the child and whether and to what extent he or she has a one-sidedness with respect to the described polar phenomena may be recorded below. This ought to be based on the clinician's own observations and/or his/her experience in dealing with the child *during the past month*.

0 indicates a balance in the relevant polar statements

+ and – indicate a slight one-sidedness

++ and -- indicate a moderate one-sidedness

+++ and --- indicate a strong one-sidedness

PM: Do not tick more than one box for each question. Questions 5, 6, 23, and 35 are optional, however, please, answer them if you can; a non-response indicates that there are no findings pertaining to the given item.

Item #	– Items (<i>Connecting</i>)	Score								+ Items (<i>Connecting</i>)	Score
01	Does not let go of own plans in the interaction with others	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Easily abandons own plans in the interaction with others	
02	Has an even mood	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Has abrupt mood changes	
03	Is closed in contact	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Is open in making contact	
04	Gets stuck in own choice of conversation topic	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Wanders away from own choice of conversation topic	
05	Tendency to constipation	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Tendency to diarrhea	
06	Quickly falls asleep at night	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3		Falls asleep late at night	

07	Moves little	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is hyperactive	
08	Is not alert	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is alert and sees everything	
09	Has fixed predictable style of interacting	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is unpredictable in interaction	
10	Has exact memories of events	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has none or vague memories of events	
11	Tends to tight control of own actions	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Acts without thinking about it first	
12	Has low muscle tone, is relaxed	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has high muscle tone, is tense	
13	Has dark brown or black hair	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has blond to red hair	
14	Has fixed thinking patterns	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Thinks chaotically	
15	Has a heavy gait	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has a light step when walking	
16	Seems to not feel pain	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Excessively sensitive to pain	
17	Shows little initiative								Many and varying initiatives	
18	Has dry hands and skin								Has moist hands and skin	
19	Shows few to no emotions	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Shows vehement emotions	
20	Is mostly self-focused	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is especially focused on environment	
21	His/her skin feels thick	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	His/her skin feels thin	
22	Is not afraid to make mistakes	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is afraid to make mistakes	
23	Has a strongly formed physique	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has a strongly formed physique	
24	Is not sensitive to sense impressions	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is very sensitive to sense impressions	

25	Is a perfectionist	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is untidy	
26	Heavy physique	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Petite light physique	
27	Has slow and deep breathing	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has fast and superficial breathing	
28	Shows little reaction to stimuli	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Reacts vehemently to stimuli	
29	Shuts down when angry	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Has unfocused explosive outbursts of anger	
30	Is not very aware of the environment	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is alert to the environment	
31	Keeps appointments	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	IForgets appointments	
32	Has set habits	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Does not (easily) make habits his/her own	
33	Does not (strongly) react to changes in the environment	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Reacts excessively to changes in the environment	
34	ISees and feels no danger	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Is scared of everything	
35	Has to be woken up in the morning	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Wakes up early in the morning	
36	Does not react to questions right away	<input type="radio"/> -3	<input type="radio"/> -2	<input type="radio"/> -1	<input type="radio"/> 0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	Does not wait for a question, acts immediately	

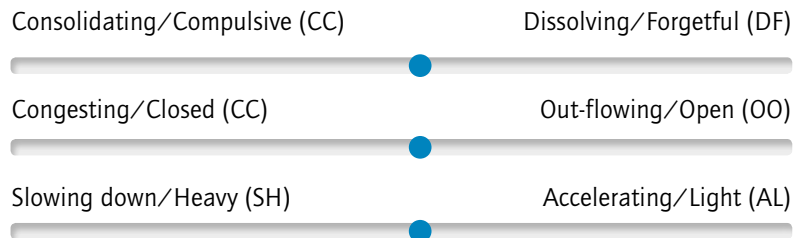
The ICC - Part II

Initials:

Date of birth:

Indicate on the following three lines (three Visual Analogue Scales) how your assessment of the child's constitutional dynamic corresponds to the dynamic of the six polar constitutional qualities. You will find an explanation of the constitution qualities used below, at [explanation.htm](#), and in Bolk's Companion *From Special Needs to Realizing Your Full Potential – Working with Constitution Pictures*, chapters 3, 4, and 5 (www.bolkscompanions.com).

A middle dash indicates no one-sidedness. A dot at either end of the scale indicates one of the polar qualities. In all other cases, estimate where the dash between the middle and one of the extremes should be set as precisely as possible.



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General remarks: If you have questions you may send a mail to: info@bolkscompanions.com.

Instructions for use: *The dynamic assessment of the six polar constitutional pictures*

The outcome of Part II is based on your ability to empathize with the child as well as on your knowledge of the six polar constitutional qualities and the dynamic between them. You can then compare your picture of the child with the dynamic of the polar constitutional pictures. This will allow you to assess to what extent the image you have of the child corresponds to the dynamic polar aspects of these pictures.

Stages in the assessment process

See also Chapter 6 of the Bolk's Companion *From Special Needs to Realizing Your Full Potential – Working with Constitution Pictures*

1. Establish what you think are the child's most striking phenomena (section 6.2.1. Bolk's Companion *From Special Needs to Realizing Your Full Potential*). You could also use the 36 items of part I of the questionnaire to aid you in this.
2. Departing from the phenomena that you have observed, imagine yourself in the child's shoes and create a mental image of the child (see also sections 6.2.2., and 6.2.3. Bolk's Companion *From Special Needs to Realizing Your Full Potential*). The aim is to find the coherent dynamic that expresses itself in the phenomena that you observed.
3. Carefully read through the description of the three polar constitutional principles described below. In reading, try to experience the range from one extreme quality to its opposite. Experiencing this range is comparable to submitting yourself to a dynamic assessment tool, along the span of which you may be able to find the position where the child fits in. See also the directive below about the dynamic assessment tool.
4. Compare the coherent dynamic you found at the second stage with the three visual analogue scales of the dynamic assessment tool and ascertain where your picture of the child fits in the range between the two extremes of the relevant developmental principle. Place a dash on the

Visual Analogue Scale in the spot that corresponds to your comparison.

The three polar constitution principles

I The consolidating/compulsive (CC) versus dissolving/forgetful (DF) principle

This polarity is primarily about the **ability to give form**; psychosocially, this manifests in the polarity of fixed thoughts and perseveration in juxtaposition to dreaminess, and limited concentration. See also Chapter 3 of the Bolk's Companion *From Special Needs to Realizing Your Full Potential*.

On the consolidating/compulsive (CC) side of this developmental principle, we may experience an inability to let go of certain memories, a lack of psychic relaxation, and a tendency toward physical rigidity. On the dissolving/forgetful (DF) side, we find the tendency to forget particular memories, an uncontrolled psychological tendency to become "loose," as well as a loss of physical contour. Subsequently, we may experience a continuum between consolidation and dissolution in the way the child remembers things, as well as psychologically, and in his/her physique. Health presupposes a balance between consolidating (giving more form) and dissolving (giving less form). The dynamic between the two extremes can be found more readily when one is aware of this middle position, where some but not all memories are remembered, where there is a psychological balance between tension and relaxation, and the physique is well-formed, without being stiff or loose. The middle position represents the healthy equilibrium between the extremes of consolidating and dissolving or between compulsiveness and forgetfulness. We may characterize the dynamic in this polarity from its middle position and find that with regard to the consolidating/compulsive (CC) tendency, we may speak of a **"centripetal, densifying, form-enhancing"** quality. And with regard to the dissolving/forgetful (DF) tendency we may speak of a **"centrifugal, form-dispersing"** quality.

II The congesting/closed (CCl) versus out-flowing/open (OO) principle

The polarity in the **ability to connect** concerns the boundary between the child's inner and outer world, as well as the rhythmic alternation between connecting to and releasing from the environment. When we consider the phenomena of this polarity in the same way we did in the previous polarity, we notice a continuum, this time between the introverted congesting/closed

(CCI) one-sidedness versus the extraverted out-flowing/open (OO) constitution. This is also reflected in both soul and physical phenomena. In the congested/closed constitution we find an excess of closure and blockage, as well as thick, dry skin; in the out-flowing/open (OO), we find a one-sidedness manifesting as unrestrained, out-streaming energy and losing oneself in the environment; physically, this manifests as the tendency to sweat.

Characterizing the *dynamic* of this polarity from the perspective of its middle-position, we can depict the congested/closed one-sidedness as a ***"centripetal closing off and getting clogged"***; the out-flowing/open one-sidedness as a ***"centrifugal releasing and losing oneself."***

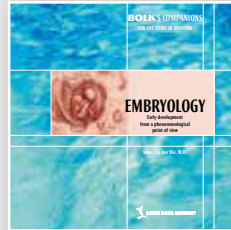
III Slowing down/heavy (SH) versus accelerating/light (AL) principle

Central in the polarity that concerns the ***ability to move*** are the heaviness or lightness with which a child moves. Phenomena of movement are rooted in metabolic processes. The various phenomena of the slowing down/heavy (SH) dynamic can manifest as a delay in movement and a lack of mobility psychologically and as excessive inertia and heaviness physically. The accelerating/light (AL) one-sidedness in the constitution reveals itself in quick movements and a lack of rest and relaxation, an uncontrolled will in moving and acting, and in fast metabolic processes.

In health, we find a balance between acceleration and deceleration, between lightness and heaviness. We may characterize the dynamic of these two extremes from the perspective of the mid-point stating that in the slowing down/heavy (SH) constitutional dynamic there is a ***"centripetal orientation that is impulse-less and delaying"***; versus a ***"centrifugally-oriented, brake-less acceleration"*** in the accelerating/light (AL) one-sidedness.

BOLK'S COMPANIONS FOR THE STUDY OF MEDICINE

Other publication in the series:



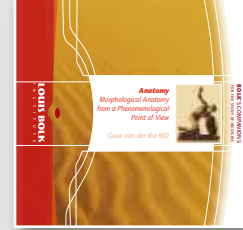
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Phenomenological Point of View

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Anatomy
Morphological Anatomy from a
Phenomenological Point-of View

Guus van der Bie MD
Publicationnummer GVO 03

Can we give a scientific basis to our feeling that humans have unique human features? Are the human mind and the human organism 'nothing but' another variation of animal life? Can we find answers for the questions that satisfy both head and heart?

How these questions are answered depends on the scientific method we use: the current scientific method to learn about biological facts, the *4-step* approach to understand more about the meaning of these facts, or a combination.

Early embryological development can teach us about the unique and characteristic qualities of the human being.

The result is, for example, a possibility to understand the relation between consciousness, psychology, and behavior and the shape of the body.

Biochemistry offers insight into the continuous changes within the human organism. But can we maintain awareness of the coherence of the (changing) organism as we study the details? How can the many processes be understood as prototypical aspects of a unique organism?

The scope of the answers to these questions can be enhanced by using a combination of the current scientific method and the *4-step* approach developed specifically to research the coherence of processes within living organisms. The current scientific method is used to discover biological facts. The *4-step* approach helps us in finding the meaning of the facts.

What emerges is a new grasp of the interrelations between biological processes, consciousness, psychology, and behavior.

Can we give a scientific basis to our feeling that the human being has unique human features? Are the human mind and the human body 'nothing but' another variation of animal life? Can we find answers for these questions that satisfy both our head and our heart?

How these questions are answered depends on the scientific method we use. In this publication two methods are used: the current scientific method to learn about anatomical facts and the *4-step* approach to understand the meaning of these facts.

Human morphology can then be understood as an expression of the unique and characteristic qualities of the human being.

This results in new possibilities for understanding the relation between consciousness, psychology, behavior, and morphological aspects of the body.

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Physiology
Organophysiology from a
Phenomenological Point of View

Christina van Tellingen MD
Publicationnummer GVO 04

Can physiology give more insight into the living human organism than the mere facts reveal at first? Is the level of activity the same for all organs? Are the vital qualities at work in organs unique for organisms and limited to biological activity? Can we find a scientific basis to research the coherence between organ systems? By enhancing the current scientific method with the *4-step* approach, we can find meaning in the facts and understand them as an expression of life itself. The *4-step* approach makes the relationship between organs visible and comprehensible. It approaches scientific facts from the point of view of their coherence and can give totally new insights this way. What emerges is a grasp of the interrelations between biological processes, consciousness, and nature.



Immunology
Self and Non-self from a
Phenomenological Point of View

Guus van der Bie MD
Publicationnummer GVO 05

Why write this new booklet on immunology when there are already so many excellent texts on the subject? This Companion is about questions such as: why is it that the immune system functions as one organ? What coordinates the immunological functions? Here, an attempt is made to develop a viewpoint to answer these questions. By using the *4-step* approach, the factual knowledge obtained through reductionism is placed in a larger perspective. The concept that is presented in this Companion is derived from the functioning of organisms, observed in the way that was introduced by Goethe in his phenomenological method. This also includes the acquisition of insight into the holistic concept behind the immune system. Moreover, the organism as a whole can then be seen as an expression of the same concept.



Pharmacology
Selected Topics from a
Phenomenological Point of View

Christina van Tellingen MD
Publicationnummer GVO 06

Pharmacology gives us insight into the way organic processes change when foreign compounds are introduced into the organism. Pharmacology is a changeable subject, depending on the needs and knowledge of the time. Can we find an inner coherence in the manifold ways compounds influence organisms? What should such a framework be based on? How can we understand the effect on human consciousness that most compounds have? We can enhance the scope of the answers to these questions by using a combination of the current scientific method and the *4-step* approach. It illuminates the known facts about the activity of compounds in organisms, and provides the means to find their significance.



Dementie en ik

Marko van Gerven MD
Christina van Tellingen MD (red.)
Bestelnummer GVO 12

Een inspirerend boek voor de lezer die behoefte heeft aan meer dan één manier van kijken naar dementie. Prachtige verhalen die tot de kern doordringen worden afgewisseld met eerste stappen om dementie ontwikkelingsgericht te benaderen. *Tom van der Meulen, directeur Ideon, dementie-professionals*

Een bijzonder boek waarin beschreven wordt, dat ondanks beschadigingen in de hersenen zoals bij dementie, ontwikkelingsmogelijkheden blijven. *Mw. S. de Ruiter, familielid dementerende*

Dit boek draagt bij aan een integrale benadering van dementie en de dementerende mens, die niet de ogen sluit voor de verschrikkingen van de ziekte, maar desondanks nieuwe perspectieven biedt om het proces van het terugtrekken van het ik met moed en vertrouwen aan te gaan. *Wouter Endel, huisarts*

BOLK'S COMPANIONS

FOR THE PRACTICE OF MEDICINE

Other publication in the series:



The Healing Process Organ of Repair

Guus van der Bie MD
Tom Scheffers MD
Christina van Tellingén MD
Publicationnummer GVO 07



Respiratory System Disorders and Therapy

From a New, Dynamic Viewpoint

Christina van Tellingén MD
Guus van der Bie MD (Eds.)
Publicationnummer GVO 08



Depressive Disorders An Integral Psychiatric Approach

Marko van Gerven MD
Christina van Tellingén MD
Publicationnummer GVO 09



Depressieve stoornissen Een integraal psychiatrisch antwoord

Marko van Gerven MD
Christina van Tellingén MD
Bestelnummer GVO 11

After finalizing the series BOLK'S Companions for the Study of Medicine for the moment, this module on The Healing Process introduces a new series of BOLK'S Companions that studies the Practice of Medicine. In it, we research the healing process itself. There proved to be an enormous volume of scientific literature on the subject. It is easy to lose oneself in the countless details included in the descriptions of this process.

The 4-step approach in systems biology makes it possible to examine physiological and pathological processes in terms of the processes themselves. This results in a characterization of the various phases of the wound healing process. Out of this, new insights into the origin of health and disease emerge that also offer possible leads for medical practice.

In this Companion, the experience of three of our own patients with asthma and pneumonia is used as backdrop for the study of airway disorders. Nearly all of us have had some experience with respiratory disease, given that colds, flus, sinusitis, and bronchitis are so common. Most physicians and therapists know people with asthma and pneumonia from own experience and will readily recognize the descriptions we provide.

The experience with these patients leads us through a study of airway disease which opens up to a wider view with new insights and innovative avenues of individualized treatment for respiratory disorders in general. Our research has alerted us to the part rhythm plays in the healthy respiratory tract and in the treatment of its disease. Rhythmic processes, consequently, are the subject of the final paragraphs of this Companion.

The treatment of depressive disorders is increasingly under scrutiny. We classified the risk factors of depressive disorders according to the scientific method applied in systems biology and phenomenology. The ordering in four biological levels that resulted from this, helps clarify the causes of the disorder. Together with the developmental history, it can lead to an individualized treatment of the patient, tailored to his or her specific situation. The treatment aims at restoring the deficient forces of self-healing.

This Companion presents a working model based on this methodological approach, as well as a variety of case histories to illustrate how applying this model can aid diagnosis and treatment in practice. Tables are added ordering well-researched regular and integral treatment methods according to the four biological levels.

"Dit boek beschrijft op heldere wijze hoe een systematische aanpak de basis kan vormen voor een meer individuele benadering in de behandeling van depressie"

Prof.dr. Jan van der Greef, hoogleraar analytische biowetenschappen Universiteit Leiden en wetenschappelijk directeur systeembioïsche research bij TNO.

Deze uitgave richt zich op psychiaters, psychotherapeuten, psychologen, orthopedagogen, paramedici werkzaam in de geestelijke gezondheidszorg en studenten in deze richtingen.



Dementia and I

Marko van Gerven MD
Christina van Tellingena MD (Ed.)
Publicationnummer GVO 14

This Companion contributes to an integral approach of dementia. It does not close its eyes to the horrors of the disease, but rather provides new perspectives to meet the process of withdrawing of the mind with courage and confidence. *Wouter Endel MD, Amsterdam*

An inspiring book for the reader who searches for more than one way of looking at dementia, with an approach to dementia from a developmental perspective. The special attention to spiritual issues at the end of life is meritorious. The book combines the practice of working with the demented individual with theoretical concepts. *Tom van der Meulen, director Ideon, dementia professionals*

A special book which describes that despite brain damage, development opportunities continue to exist in dementia. *Mrs. S. de Ruiter, family member*



Endocrinology

Guus van der Bie MD, Ricardo Ghelman MD PhD, Loes van den Heuvel MD, Kore Luske MD, Majella van Maaren MD (Ed.)
Publicationnummer GVO 15

How can we conceptualize seemingly random psychological and physical symptoms of endocrine disease in a holistic way? How can we understand signs and symptoms of disease including the anatomical and physiological changes in the involved organs in relation to the bio-psycho-social functioning of the individual?

The authors of Endocrinology - A methodological approach towards integrative understanding strive to elucidate the methodology of the 4-step approach, which they have long employed in their own medical practices. It is the authors' hope that sharing this approach facilitates a deeper, more integrated understanding of common endocrine disease as well as offers tools for discovering the commonalities and coherence in seemingly unrelated bio-psycho-social phenomena. The ultimate goal of this exploration is to further individualize conventional medicine.

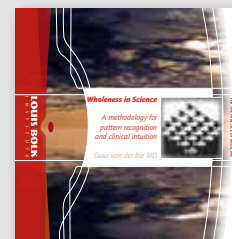


Van beperking naar ontwikkeling Werken met constitutiebeelden

Martin Niemeijer MD
Christina van Tellingena MD (red.)
Majella van Maaren MD (eindred.)
Publicationnummer GVO 16

Het leven van een kind met een ontwikkelingsstoornis is een bijzondere opgave voor het kind zelf, en voor de ouders en andere gezinsleden. Lag in het verleden veelal de nadruk op de stoornis zelf, nu wordt de vraag welke ontwikkelingsmogelijkheden een kind heeft steeds belangrijker. Kunnen we samenhang vinden in, en betekenis geven aan, waarnemingen aan uiterlijk en gedrag? Wat kan hiervan de meerwaarde zijn?

Deze Companion gaat in op een constitutietypologie, die al decennialang in instellingen over de hele wereld wordt gebruikt. Het kan als aanvullende methode dienen om naar een kind te kijken en zorgvragen te beantwoorden. Deze wijze van het beschrijven van een kind sluit aan bij de behoefte om handvatten te vinden hoe het ontwikkelingspotentieel van het kind optimaal te realiseren.



Wholeness in Science A methodology for pattern recognition and clinical intuition

Guus van der Bie MD
Publicationnummer GVO 10

How do you develop clinical intuition? How do physicians gain practical knowledge about disease? Diseases do not merely concern a partial defect, they recreate the life of the patient. The author shows that experienced physicians conceive of diseases as integrated concepts, which they can apply to the individual situation of the patient. Clinical intuition is a form

of pattern recognition that supports the ability to recognize an integrated 'whole.' This Companion presents practical exercises that allow readers to train and expand their ability of pattern recognition through Goethe's methodology. Questions and introspection aid to become aware of what you did. This makes obvious that clinical intuition, as experiential knowledge, can become a skill that is actively developed.

From Special Needs to Realizing Your Full Potential

Working with Constitution Pictures

The life of a child with a disability presents special challenges for the child, parents, and family members. Whereas health care in the past used to focus on the disabilities, nowadays questions regarding the development potential of these special children have become increasingly important.

The "constitution typology" described in this Companion has been used in institutions around the world for decades. The approach is an answer to the need in healthcare to understand how the developmental potential of the child can be optimally realized.

How can we look at children using "constitutional typology?" Can we find coherence in and give meaning to their appearance and behavioral characteristics? How can this contribute to happier individuals, families, and communities? This Companion addresses these questions with examples that are recognizable to many. Then it uses a stepwise approach to applying these principles in healthcare practice. The qualitative concepts from "constitution typology" combined with the *4-step* approach as well as an assessment tool developed for this purpose will give parents, doctors, and other care providers an additional angle with which to view the "whole child."

This points the way to new developmental perspectives.

