JAMES SCHALLER, M.D., M.A.R.

A.D.D. IRRITABILITY AND OPPOSITIONAL DISORDERS

CUTTING-EDGE SOLUTIONS
SINCERE THERAPISTS AND DOCTORS MISS

SCHALLER

A.D.D. IRRITABILITY AND OPPOSITIONAL DISORDERS

A.D.D., Irritability and Oppositional Disorders

by

James Schaller, MD, MAR

www.personalconsult.com

CONTENTS

Acknowledgements

My thanks to Randy Blackwell, a brilliant library and research assistant.

Many of the wise and practical school and educational solutions in this book are from the creative school psychologist and problem solver, Marisa Morelli. She has found stunningly effective answers to educational problems when everyone had lost hope.

I have received many helpful edits, lessons, and advice from Richard and Anne Swartley, Scott Kriefels, Louise Morelli, Bruce Kennedy, Robert Krupp, Dr. Thomas Whiteman, Dr. Ritchie Shoemaker, Ericka Basile, Helen Ercolino, Judge Thomas Pitt, Maureen Schaller, Michele Walton, Marianne Schaller, Dr. James A. Schaller and Barb Tury.

My thanks to Lisa Camp for her excellent front cover design, Phil Chow for tuning up my back cover, and to Ronald Gombach for superior web design and book production.

To my children, whose many unusual illnesses have kept me hopping to find new answers, when all the old clichéd ones failed.

Finally, I thank my colorful companion and wife, Joyce, for her friendship and love. She encouraged me to write this book because she cares for parents struggling with children.

Your personal physician(s) and mental health worker(s) should evaluate all medical and therapeutic suggestions. Nothing in this book is meant to replace their treatment and advice.

While each child and situation is unique, you should discover valuable insights that can solve your problems. These are solutions based on many years of in-depth study and practical research. May the Creator bless your love and pursuit of a happier and healthier child.

My Best,

James L. Schaller, MD, MAR

Preface

There is no job more difficult in the world than raising a child. Handling a youth who is out of control can feel quite impossible. I have been working with some of the best tornado tamers in the world, individuals who have rescued thousands of children. Let us save you time, money and emotional energy, and help pull your child back to safety, health and solid functioning. ***Some of the very best physicians and therapists routinely miss serious causes and treatments for inappropriate behavior. I am drawing on very advanced medicine, currently known by only a handful of clinical experts in the USA. These routinely missed causes for out-of-control behavior are only found together in this book.***

The time for this book is now! Why?

- I am finding too many errors by sincere therapists and physicians offering routine child and adolescent treatment.
- I also refuse to accept treatment failure, and this has led to solutions and publications in over sixteen areas of medicine, psychology, and healing. This information is helping youth who did not improve with the care of expert medical "specialists."

The days of knowing ***only*** psychology, pediatrics, neurology, family medicine or child psychiatry are gone. Today, ***the very best*** diagnostic care and treatment requires a very broad approach by clinicians who have a passion for cure. Child behavior problems need to be examined from more than one medical specialty or school of psychology. As you

will see, the causes of acting-out are more than simple labels like: "bipolar," "manic-depressive," "oppositional-defiant," "ADHD," "spoiled," "conduct disordered," "depressed," "hyperactive" or "addicted."

Some caring parents see three youth experts and are given five different diagnosis and three different treatment plans. This is unacceptable.

You have no time to waste. Your child needs clear intervention, and your stamina is finite. Like some parents, you may be worn out. The months or years of trying to help your child have been too long.

Most books on "troubled youth" are too exhausting to read and too theoretical. Internet options also do not discuss some of the material here. It would take thousands of hours of reading to find what is in this one book. Furthermore, consider the quality of Internet material. Having broad credentials and experience in a wide range of causes and solutions has equipped me to find what you need.

When you are drowning, you need solutions fast.

This book is a solutions book.

Some youth recover and are helped by one intervention. If this does not happen with your child, try not to lose hope. Solid tables stand on four wooden legs. You may indeed need to use four tools for a solid solution.

Keep in mind that you are not supposed to die for your child. If you feel you are "losing it" and burning out, get help!

My average out of control youth patient has seen 5-30 people before me. This does not mean all are completely wild. It means some causes have been missed. We will show you what is routinely missed, and then I will offer solutions to help and empower you.

A Broad Overview

1) How Out of Control is Your Child?
2) Commonly Missed Medical and Neurological Illnesses
3) Counseling Options and Solutions
4) School Problems and Helpful Options
5) Hidden Environmental Problems and Nutrition
6) Helping Parents: YOU Deserve a Break Today!
7) Medication Errors and Correct Use
8) Your Child's "Bad" Friends
9) Severe Aggression—Unable to Stay in Home
10) Self-Harm
11) Sexual Victimization or Offending
12) The Legal System and Substance Abuse

Introduction

How Out of Control is Your Child?

Let us just get a rough sense of severity so we talk the same language and use the right solutions:

1) **The Whiner:** the child who raises his voice, is easily annoyed, or only obeys after 5 requests.

2) **The Dramatic and Verbally Hostile Youth:** the child who curses, threats and insults.

3) **Mild Damage and Dangerous Verbal Comments:** the child who throws a book or bike but not directly at somebody. They might also threaten to hurt themselves, you or animals.

4) **Active Gestures and Serious Property Damage:** the child who holds objects in an aggressive manner but makes no contact. They put holes in walls or smash windows.

5) **Minor Harm:** the child who pushes, slaps, or hits with no major injury.

6) **Serious Violence:** youths who have serious intent and do serious harm, e.g., hitting with a bat or punching someone in the face repeatedly.

As you can see, there are many levels of out of control behavior. Intervene early to stop any progression. These broad categories do not fit every child. However, before we find the cause of your child's problems, let us get grounded in two key emotions before we talk about common stealth medical problems. You may value these two emotions as much as me, but fatigue can make great parents in need of a reminder.

A Child Must See Love, Not Bitterness and Hate

I will assume that the troubled youth we are planning to heal is exposed to love and not to constant hate. If you are reading this, you are most likely doing so out of love for a child. Before I offer some causes and solutions, I want to start with a basic assumption. For a child to function normally, they must be loved deeply by at least one reliable person. They cannot be exposed to constant bitterness and hate.

I have personally experienced the darkness of humans and have been treated savagely by some of them. They showed their anger with ***relentless*** hate and rage. Thankfully, I have also experienced real love.

In *Les Miserables,* a man steals some bread to help his family live. He is caught, thrown in jail, and cruelly treated. After he escapes, a priest provides refuge for him, but at night the man covertly repays the hospitality by stealing precious items from the priest's home. The man was caught and dragged before the priest. But the priest looks deep into the thief's wounded soul. He tells the police the stolen items were a gift, and that his guest had forgotten the silver candlesticks. The stunned thief is one word away from jail as he stands in the hands of the police. The priest gives him the precious candlesticks and his freedom. This story exemplifies how **the priest showed deep love and forgiveness.** As a result, the bitter man was restored.

In *The Count of Monte Cristo,* a man is unjustly thrown into prison, and his fiancé marries the man who framed him. While on a horrible exile, a fellow inmate tells him a location of secret treasure. After escaping, the Count finds it and returns with power and wealth. He then destroys those who had sent him to prison. Consequently, his beloved would not receive him, because ***his massive hate had transformed his soul.*** Long-term hate hinders a child's maturity and behavior.

"I Know the Cause!" Please be Open

Sometimes I am stunned at the absolute certainty of some parents. They come for my help, but when I find a cause they did not expect, they suddenly reason to the contrary. They came seeking confirmation not education. In the end, the only one who gets hurt is the child. Do not let narrow worldviews prevent good insight. We must all keep learning!

Please be open to new information. The youth in your life hang in the balance.

Commonly Missed Medical and Neurological Illness

Hormones or Excuses?

Michele is intermittently verbally abusive to her parents and binges on food in a manner that makes her folks wonder if she has an eating disorder. She is also impulsive at times and her parents are not sure of the reason(s).

When I asked if this abusiveness was tied to Michele's menstrual cycle, both mother and Michele told me it was not. Yet when I asked Michele to record her bleeding on a daily chart, it became clear that her cycle was closely connected to her cycle. She was having symptoms both before and during her period.

Behavioral changes are linked to hormonal changes:

1) The most common change is due to excess estrogen, which causes fluid retention in the brain. Natural progesterone removes this excess fluid. Progesterone receptors work better in the presence of sweets, which also help a girl make extra thyroid hormones to feel energized.

2) The second type of PMS is only seen in very thin women with low body fat, and therefore low fat estrogen. When their ovary estrogen falls, they are so thin that they do not have buffering fat estrogen to maintain proper levels. Estrogen levels can fall so low that some adolescent girls can lose bone and feel very irritable.

My father, a retired OB/Gyn physician with decades of experience, as well as thousands of other physicians and nurse practitioners, have successfully prescribed natural bio-identical progesterone for PMS *before* bleeding. In addition, a tiny natural estrogen patch for PMS in very thin women has been prescribed *during* bleeding.

Michele was treated with both as described above and has had no major outbursts in six months.

The Forgotten Critical Youth Hormone: MSH

If your child has a low MSH blood level, they could regress and have almost any problem behavior. Your local physicians and therapists will be clueless as to the cause. MSH or alpha Melanocyte Stimulating Hormone is one of the most serious blind spots in current medical practice. This hormone has a massive role in the body and brain. It is a major controlling hormone involved in possibly twenty functions. If it is low, a child could have any one of fifty different problems.

In my practice, MSH is not an optional lab. In fact, I feel it should be part of an average medical work-up for all Americans. Any child with problems in school or home, or that has mood or behavior troubles should be tested. Youth with addictions routinely have low MSH.

The most common cause of a very low MSH is exposure to mold toxins. But chronic inflammation, special staph infections in the nose, Lyme, some algae, certain spiders, and other biotoxin makers can significantly lower MSH as well. If it is below 35 according to LabCorp ranges, it is low. Many youth with mold exposure can have less then 20.

You might recall from high school biology that this hormone is involved in skin color. Now we know it has *many serious roles* in the body. In fact, many pharmaceutical companies around the world see the many roles for MSH. They are scrambling to make it because they expect to make a fortune.

So what do all these drug companies know? What roles does MSH have besides tanning and skin color?

Below are some possible effects of a low MSH in youth.

Memory and Learning: If your son or daughter has a low MSH, remembering information will be more difficult. A child with a low MSH will seem forgetful and appear to be only a fair student.

I wonder how many children across America receive special education because of a reduced MSH? Since this is still not normative medicine, we do not know the answer. It does appear quite common in our patients with mold or Lyme exposure.

Attention will fall in children or adults as MSH drops. I have repeatedly had patients called "ADHD" or "ADD," but this problem often started *after* they were ten years old. ADHD and ADD do not suddenly start in adolescence!

While true ADD or ADHD exists, most child experts are not aware indoor mold creates behaviors that look like these disorders. Many young children lose this problem when their moldy home or school is fixed. In this case, these children had "secondary" ADD or ADHD. The parent, teacher, or pediatrician did not hallucinate. The child was more than just "being a boy." This was more than just "ants in the pants." Their impulsivity and inattention was from a mold toxin—not from genetics, an intra-uterine exposure, or injury as in primary ADD or ADHD.

Obesity (or Too Thin): Typically children and adults with a low MSH gain weight. Often they gain a significant amount of weight. Perhaps some people try to feel better by eating. Others gain weight with only slight eating. Commonly, people with low MSH have their weight drift higher and higher. Diets may have some effect, but not to the extent that was desired. They lose five pounds instead of fifteen.

A small minority struggles to maintain their body fat and look waif-like. Some of these seem to have a lean body type with long arms. It might also be that they exercise massive amounts, perhaps to create natural opioids to feel better.

Pain Relief: MSH encourages production of your natural opioids. If your MSH is low, you will feel aches and pains more often. Some youth complain of headaches. Others report joint pain, which is often called "growth pains." Some just seem chronically irritated. They may yell, scream, pick fights or react in extreme ways. Typically, this is due to being excessively bothered by routine irritants which MSH-created endorphins block. Further, a youth may be more inclined to do addictive, impulsive, or pleasurable behaviors in an effort to feel "normal" or "right" again. These addictive behaviors are very diverse. Low MSH promotes alcoholism, illegal drug use, binge eating, sexual experimentation, impulsive exercise, intense schoolwork, speed driving, thrill seeking actions, pornography addiction, and rage. When on a binge, a person does not want to stop working or studying. Once they stop, they do not feel "right." Impulsive activity, even if it is constructive, may create a small amount of natural pain killing chemicals. Likewise, patients with rage may briefly feel "better" after a "blow-up" for a similar reason.

Flat or Bored Mood: Having an MSH deficiency can reduce your joy. A person can be left with a malaise that is often different than a typical depression.

Increased Body Inflammation: MSH has strong effects on your body's inflammation chemicals. If MSH drops, it will allow inflammation chemicals to increase. Inflammation causes increased pain, a depressed or irritable mood, increased agitation, and increased blood clots that may increase heart attacks and strokes. Low MSH is associated with inflammation that causes swelling and an increase in asthma and inflamed intestinal disorders.

Decreased Coping Ability: Low MSH makes it hard for body organs and the brain to handle stresses, e.g., personal stresses or toxin exposures.

Energy Changes: In our experience, some patients with low MSH have increased fatigue and are listless. Some are both agitated and have fatigue.

Nerve Repair: The average person experiences many events that can hurt neurons, such as falls, car accidents, sports accidents, and simple aging. It appears low MSH may slow nerve repair.

Appetite Changes: Low MSH can cause both extremes in eating. People can eat a great deal or lose their appetite. And this can change. They can also have appetite swings from season to season.

Sleep Changes: Either extreme is possible with low MSH. One can have very fragmented and poor sleep, with only 4-6 hours of sleep total each night. Others want to sleep all the time.

Eccentric Urination: While this is often seen as a sign of diabetes, few physicians realize a low MSH can also cause this annoying symptom. Children dislike standing out by having to urinate more often than their friends. Also, their unique urination removes salt from the body.

Body Temperature: Some children or adults have sensory flashes of hot or cold.

Testing MSH

Please do not go to just any laboratory for MSH testing. Dr. R. Shoemaker has found that LabCorp offers the most meaningful clinical results. I have also found this to be true. *We are not affiliated with LabCorp; we just feel they offer the best MSH testing.* If you want a doctor to order a test for you, you will need to have all the material in this chapter in hand. You will particularly need the material below. It lists the test code and the name of the special lab blood tube kit. LabCorp patient locations can be found on the Internet by searching, "Labcorp Patient locations."

The special MSH LabCorp test name & code is: alphaMSH 012542

Please make sure the lab has a special test kit in stock before you go—the "Trasylol kit."

Your doctor will need to write down a diagnosis code. One code Dr. R. Shoemaker commonly uses is 253.2, but your doctor can use any code they prefer.

Most physicians do not have the training to do this test in their office. So if an office clerk says they can do the testing, I would ask if they have any "Trasylol kits" in stock to be sent to LabCorp. After this blows them away, perhaps they might realize they are not equipped and send you to a local LabCorp.

Any MSH under 15 is an emergency and should be addressed promptly. The 15 could easily become <8 which means it is too low to measure. One concern is if the MSH stays at <8 for a long time, it might never return to normal. Also, the source of the inflammation(s) and/or biotoxin(s) needs to be found in a few weeks. A trusted prescription medication, "cholestyramine," with decades of use, can be started at a child child dose of one packet a day and an adolescent dose of two per day in divided doses. Cholestyramine binds biotoxins in the intestinal track so they are excreted and not re-absorbed. If your child experiences constipation or nausea, one might try magnesium oxide twice a day for constipation. If this fails, consider magnesium citrate at 1/3 to 1/2 of a teaspoon (once or twice a day). Nausea is often helped with an acid blocker like Pepsid or a stomach coating prescription like Carafate.

For further information, contact me at www.personalconsult.com for an email or phone consult.

Indoor Toxic Mold is Common

One of the largest blind spots in modern medicine is the frequency and effects of indoor mold. These biological chemicals cause more than a runny nose and asthma. Inhaling mold chemicals found in schools and many homes, causes hundreds of medical effects and typically effect behavior and mood.

The EPA and other experts believe that 30% of American structures have indoor mold. Some feel that perhaps the majority of schools have indoor mold. Why? Most school buildings are constructed by the lowest bid. These cheap buildings have very low quality and junky AC or HVAC systems that are too costly to maintain or run. As a result, their filters get filled with dust and mold spores or drip water. In addition, the AC is likely to be turned off during summer months, allowing the schools to become mold greenhouses with humidity levels over 70%.

When school reopens after a summer break, many youth enter their school happy, but are moody within a few days. This can be caused by mold. Since the brain is the most sensitive organ in the body, it is often the most sensitive to mold chemicals.

How can this happen? If your school or home had a leak, condensation, or some other type of water intrusion, and it was not dried and fixed within 48 hours, it is quite possible there is indoor mold present in the structure. Does it smell musty? Are their leak marks on the ceiling tiles or wall? Do you see visible mold? Is the carpet or flooring moist in any place? If your reply is "yes," you should assume you have an indoor mold toxin problem. This does not mean you have to burn down the structure. It does mean someone who is well trained needs to clean up the problem.

As a certified mold inspector and a certified mold remediator, one thing is clear to me—most of the folks testing and cleaning are clueless. Workers carry out dirty filters, dirty carpeting, or moldy dry wall through a

school or home, dispersing mold spores by the billions. The filters are junk, only MERV 8 rated, having large holes that will grab large spores but not dust. I highly suggest disposable MERV 11 rated filters, which grab all dust and the mold chemicals attached to them. These filters are available in any size from the Internet at Filters-now.com and Home Depot.

For more information on diagnosis and treatment, consider reading my co-authored new books on mold's effects:

1) *Stop Mold From Destroying Your Life*

2) *When Traditional Medicine Fails: The Mysterious Effects of Hidden Mold on Youth Health, Behavior & Learning*

3) *Mold Warriors: Fighting America's hidden health threat*

These books mention some important special labs a progressive open-minded doctor can order for your child. If your doctor says something grossly simplistic like "mold is everywhere," consider finding a new physician. Indoor mold must be removed immediately and very carefully according to most world health organizations publishing on this topic. Indoor mold is never acceptable for human living spaces. Period.

One essential first treatment is to get the youth away from any indoor moist and moldy areas. Any mold or dust with mold toxins must be HEPA vacuumed or removed in a manner that does not stir up the mold and disperse billions of spores. Any "mold remediator" that simply carries moldy material around without completely sealing it, does not use a full mask, or fails to seal off visible or smelly mold, is profoundly incompetent.

I offer over a hundred mold toxin articles at www.personalconsult.com or www.usmoldphysician.com.

Hidden Lyme Disease: A New "Great Imposter" that Loves the Brain

Angela was a pleasant young woman until she reached the age of sixteen. She then seemed to become nastier and have trouble concentrating. Her grades declined and she slept a lot. She had missed six days of school this month. Angela has several interests but little energy to act on them. If you mentioned homework or easy Saturday chores, she became verbally abusive. A school psychologist and an adolescent psychiatrist said she had ADHD and Major Depression.

Angela met with her local Family doctor, a smart and caring physician, who performed the routine tests. Since her dog had Lyme disease the previous year, her doctor also did a screen test, or antibody titer. It was negative.

When she was referred to me she had been put on Doxycycline for thirty days (due to her local deer exposure) and then sent for lab testing by a Lyme expert who had over twenty relatives with Lyme disease or other tick infections.

I am writing a book on pediatric Lyme disease which includes new tests performed by superior tick specialty labs, that are much more accurate than those routinely used by most physicians. Routine Lyme testing is prone to give "false-negatives" because the test strains are not common and the Lyme proteins they use are too limited--like trying to tackle someone using only three fingers. Lyme also has over twenty ways to hide from the immune system. Lyme disease is not considered as a diagnosis because many physicians ignorantly believe most patients have arthritis symptoms. Lyme disease is in the brain within ten days and the most common symptoms are emotional and cognitive. Also, many physicians assume Lyme will cause an eccentric bulls-eye rash, but Lyme creates over ten marks on the skin and most are tiny and often trivial. According to Dr. Charles Ray Jones, a pediatrician with 9,000 child patients with tick borne illness, only 7% of his Lyme patients have any

bulls-eye rash. The photo images he has given me show that the bulls-eye rash has twenty different presentations, and many are easy to miss.

Probably only 1 in 15 patients with Lyme disease is diagnosed. Most are never reported. In one study, only 1 in 40 physicians reported Lyme infections to local health departments. This is perhaps because the state medical boards often follow political agendas that minimize the Lyme disease problem. This policy can generate "witch-hunts" against experienced Lyme experts who know Lyme is not a trivial easy-to-kill organism.

Angela's Lyme test came back negative from a local lab processing thousands of blood tests per week, but a Western Blot came back profoundly positive when it was sent to IGeneX, a leading Medicare approved, high quality tick disease testing facility with exceptional quality control performance. Many physicians do not understand Lyme tests are not very accurate. Even people with very severe advanced Lyme disease or a clear bulls-eye rash are called "negative" by most laboratories.

Angela's treatment was not what most infectious disease physicians would offer. She was given twenty weeks of Doryx, an enteric-coated form of the antibiotic doxycycline which is less annoying to the stomach, at a dose of 100 mg in the am and 200 mg at night. She also was given a second antibiotic Biaxin at 250 mg in the am and 500 mg in the evening for twenty weeks. Finally, she was given Flagyl for sixteen weeks to kill the protective seed-like Lyme cysts. Her physician felt these three antibiotics killed her Lyme infection by three different mechanisms.

Angela was also placed on some immune stimulators to help her body fight the infection. I tested her natural killer cells—cells involved in killing the cancer cells we make daily—and they were low. Her immune system was functioning poorly.

Finally, because Lyme has toxins on its outer shell that disperse when the Lyme is killed, Angela was also placed on the toxin binder cholestyramine. ***Some patients have an inability to remove these Lyme toxins. They circle the body, making the child sicker*** and more psychiatrically troubled. Only a few USA physicians use a special blood test to determine if your child has the inability to remove Lyme toxins from their body. The test is done by LabCorp and is called a HLA DRB, DBQ Disease Evaluation. This is discussed more fully below in "Stealth Behavior Effects."

Because Lyme tics also carry other infections, Angela was also tested for Ehrlichia, Bartonella, and the milder form of American Babesia (by IGeneX labs). Further, she was tested for mycoplasma fermentes by Medical Diagnostic Laboratory in New Jersey. All four came back negative.

She is doing very well now. And based on my training and research with Dr. Charles Ray Jones, Angela's experience is not unusual. Nevertheless, it would surprise most psychiatrists and other doctors to learn her ADHD and Major Depression disappeared with her Lyme antibiotic treatment.

For further information go to: www.personalconsult.com and you will find over 150 articles on Lyme disease.

Inflammation Chemicals are Like Flames in the Brain

Seth became hostile over the course of two years. He was treated with a number of psychiatric medications, and while they helped, his parent's questioned the "underlying problem." While sometimes a genetic or other primary psychiatric problem is the cause, Seth seemed to have had trouble due to multiple micro-abscesses in his mouth, and a chronic fungal sinus infection. When these were both treated over four months, he became suddenly sedated on his psychiatric medications. He was weaned off them over two weeks. It appears the inflammatory chemicals in his body were agitating and stimulating him.

Inflammation takes many forms. If you hit your finger or get a sunburn, the red, hot swollen skin is obvious. Some inflammation is very clear and some is entirely hidden. Let me just mention some sources of inflammation.

* A joint injury from a fall or twist
* Skin or scalp irritation or rashes
* Inhaling irritating chemicals—synthetic or biological
* Intestinal irritation from bad bacteria replacing the good ones, digesting irritating chemicals, allergies to food like wheat products, and autoimmunity.
* Foreign material like very old deep splinters
* Infections in various recesses of the body—teeth, gums, bladder, vagina, gallbladder, sinuses, nose, lungs, nails, appendices, and stomach.

In adults, chronic inflammation can lead to a heart attack or stroke. In youth, chronic inflammation can lead to behavioral change—a principle poorly appreciated by most physicians.

Here are some sample labs you can have done which might show evidence of inflammation:

Homocysteine

Some toxins and stresses eat up a child's B-Vitamins, and this causes a rise in homocysteine. A high homocysteine triggers inflammation. This lab test is well known to physicians. But you often have to ask for it to be done.

IgE

If a child or adult has asthma or allergies to a mold, the IgE level will be high.

Epstein Barr Panel

We all have been exposed to this virus. It is assumed everyone will have results showing it is present in the blood. Some physicians feel a very high number means your immune system is not able to keep down this infection, due to inflammation, toxins, or some other infection.

C-Reactive Protein

This inflammation lab has two types, the joint option and the cardiac test. The joint option measures larger amounts of C-reactive protein generated by arthritis. The cardiac result is more subtle and sensitive.

Other optional inflammation labs include: IL-1, TNF-a, C3a, fibrinogen, and lipoprotien (a).

Bouncy Labile Bartonella

John always went camping in New Jersey in the summer. He loved the time with his camp counselors and the other kids. He said they were "great friends" and loved seeing them each year. After a week at camp last year, he was "ill" for a week and did not participate in the usual activities. He was tested by routine labs for Lyme and was found to be negative. His joints were fine and he had no rash. He was very moody and hostile. He was sent to a child psychologist and a child psychiatrist. After five months, he was worse.

As a reminder, most labs are useless when testing for Lyme. Samples of clear positives have been sent to dozens of labs which called them "negatives"--these samples almost had Lyme crawling out of the test tube! Patients with clear Bulls Eye rashes, which always mean one has Lyme or a related spirochete, have routinely come back negative. So I had him retested by IGeneX testing for both Lyme and Bartonella. This lab is the premier Tick disease laboratory in the US and has *exceptionally accurate* results on both negative and positive blinded samples. I also had him tested ***only*** for Bartonella and Mycoplasma at Medical Diagnostics

Laboratory in New Jersey. He was positive for Lyme and **Bartonella.**

He was treated for three months with Ceftin to primarily treat his Bartonella. This infection is also called "cat scratch fever" and has over twenty types. He probably did not get it from a cat or a flea, but from a tiny poppy-seed sized tick. His mother and two sisters commented that he was weird and "abusive" prior to antibiotic treatment. After three weeks on Ceftin, he was clearly a different youth. All of a sudden he was talking to them "sweetly," according to his mother.

Bartonella is the cause of ***many psychiatric problems,*** but especially depression, agitation, panic, mania, bipolar, irritability, ADD, oppositional-defiance, fighting, substance abuse, autism-like problems and severe anxiety.

John is doing very well now.

Stealth Biotoxins in Rivers, Lakes or Ponds

Andy was spending the summer on Lake Griffin. It was a lake that his family had enjoyed for years. He went with his father to his grandparent's home. He arrived in June, and by August, Andy and his father were about ready to fight. The father read my article on toxic lake algae. They called, and I met with both of them.

The lake had lost most of its safe algae, perhaps with insecticides, pesticides, and copper. Now toxic blue-green algae had taken over. With each passing week, Andy and his father were getting increasingly agitated from breathing these toxins off the lake. It was ruining their mood and personality.

I did a special HLA test which shows unique outside materials coating their cells. These markings tell us how well a person can remove biological toxins. It turned out that the son and father shared an HLA pattern indicating both had the inability to remove algae biotoxins.

I told them to avoid any boating for two weeks and to take five packets per day of cholestyramine, a biotoxin binder. They were getting along much better after two weeks with this treatment and education about the lake.

They had almost reached the point of a fist fight. I wonder how many local lawyers or doctors would think that biotoxins from algae were the cause of an assault for their clients in jail?

If you want to know how well you or your child remove biotoxins, an open-minded physician can order the test. It is called an HLA DRB, DBQ Disease Evaluation.

Do not be overwhelmed by this confusing name. Let me make it simple. As you know, you cannot give one of your organs, e.g., a kidney, to just anyone. Why? Just as you wear clothing, and do not run around naked, human cells also have a type of clothing. On the outside of your cells are unique markers, which do not fit most other people.

After we were matching organ transplants for a while, some scientists noticed that some cell markers seemed to be found in certain diseases. So these cell markers or cell "clothing" were expanded into disease testing. If a person had a certain pattern, they were at higher risk to develop a certain disease. Using our clothing analogy, a person wearing black leather is rarely a kindergarten teacher. The clothes "make" or give us insight into the man, and the cell's outer markers or "clothing" give us insight into the cell.

Dr. R. Shoemaker used this testing in thousands of patients and found very clear patterns regarding mold toxin removal, Lyme toxin removal and algae toxin removal. He found that about twenty-five percent of the USA is poor at removing biologically active mold toxins. If exposed, mold toxins collect in their body and are very aggressive. Over time these individuals become ill. The same thing happens with those

playing or living on a lake with toxic algae—some youth do not remove these toxins and get agitated.

I also found the HLA patterns Dr. Shoemaker described, and they fit exactly many people's medical troubles. I have done a very large number of these HLA tests, and find that Dr. Shoemaker's patterns fit exactly what happens to many children. This is very progressive medicine. Only a small number of physicians are currently doing this type of analysis, even though the test can be done at many labs around the USA.

In the book *Mold Warriors: Fighting American's hidden health threat,* there are some tools for interpreting the HLA patterns. But some folks want clear coaching in reading their results.

We are very pleased to offer a reading of your results, which will be done by both Dr. Schaller and Dr. Shoemaker. The latter has done thousands of readings. For $35.00, you will have *two* prolific creative research physicians read your HLA pattern and send back a chart with your pattern circled clearly. (Of course, if one is indisposed, you will get one reading). The money will be used to fund further health care publications by the Shoemaker and Schaller team.

Simply send your results to Dr. Schaller.
Fax: 239 304 1987
Mailing Address: Professional Medical Services of Naples
Community Bank Towers
Suite 305
5150 Tamiami Trail North
Naples, Florida 34103

Enclose check payable to: James Schaller, MD

Or go to www.personalconsult.com home page and pay $35.00 by credit card where it reads, "Make a payment." Since either doctor may be away at conferences, allow fourteen days for processing.

The test name and LabCorp code is: HLA DRB, DBQ Disease Evaluation 012542. Some physicians use these diagnostic codes: 279.10, 377.34, 279.8. If the test is done at other labs like Quest, you will only get 20-40% of the results we need.

Please provide a fax, email, or mailing address to send your result.

Neurological or Genetic Illness—Lorenzo's Oil

Charlie was adopted at two weeks of age. His biological parents were "healthy," with no reported illnesses. His mother had "standard prenatal care." Charlie was aggressive and impulsive from the age of three. At five years old, he was treated with different medications with 50% success.

I met Charlie when he was 13 years old, and he was very aggressive but had a kind heart. I sent him to a research pediatric pulmonologist due to an unusual cough. It had been called a tic, but his parents remarked that the cough occasionally woke him from sleep—tics are not present during sleep.

The pulmonologist diagnosed him with a rare congenital disorder. She said it was only the second case she had seen. She offered some treatment that helped him partly.

I also had Charlie get full Neuropsychological testing. This is more advanced than IQ and achievement testing. It is able to look at very specific brain functions like memory and speech with extensive detail. Charlie showed modest deficits consistent with possible fetal exposure to alcohol.

Options:

1) If possible, ask for updated records from the biological parents. Any clue might help you with the genetics.

2) Go to Internet and search with the word, "Pubmed." Click on the main NIH site with about eleven million references. In the Pubmed search bar, look up the **exact disease name** the physician gave you. If you cannot navigate this, hire a senior medical student, a graduate student, a "smart computer person," or have the local research librarian show you how to do it. I have been hired by many people to do such research. Indeed, I was paid by a patient to research his rare blood cancer and found a treatment that radically stops the cancer in its tracks. It is now the standard treatment in the world. The point? I am a psychiatrist who published the first functional "cure" for a very rare blood cancer—my weakest area. Possibly, you can become an expert at the unknown if you keep at it.

3) Order copies of the best-looking articles for their clients in jail? In this day of HMO's, PPO's, massive overhead, huge medical school debt, and profound malpractice insurance, your doctor is not going to have time to research your child's illnessintensely. And no reference text is going to have the newest details of the child's illness. If you do not want to get the articles, print off the summary abstracts, and give these to your doctors. They may only read or skim fifteen abstracts. Do not hand them a pile.

   Unfortunately, it is unrealistic to expect your doctor to be a mother. Anger at physicians for not being "compassionate" with long sessions, misses the reality of horrible overbearing HMO medicine and will not help your child. Physicians who take your insurance will rarely be available for 1/2 hour appointments or do extensive unpaid study not covered by your insurance. Yet, if you hand them focused academic material, they may take a very serious look at it.

4) Since Charlie has neurological limits from a modest exposure, he should be considered for medications and special nutrients which improve injured brain function. This would include medications like selegiline and Alzheimer's medications at low doses. I am currently working on a book called *Autism to Alzheimer's: Tools for Aggressive Neuron Repair. For now, consider Smart Drugs II, The Physician's Guide to Life Extension Drugs* (800 841-5433) and Dr. David Perlmutter's short and very basic book, Brainrecovery.com. My position is that some medications have FDA approval for use in frail elderly with strokes, Alzheimer's, or Parkinson's disease, may also help some youth. In rare cases, the best drugs may not be available in the USA due to FDA application costs, marketing costs, and other medications that treat the same illness.

SAD: Your Bear Does Not Hibernate in the Winter

Phillip was arguing with the teacher. In his private school, that was equal to murder. His mother was called in, and both she and the teacher had no idea why he was so reactive and moody. He was fine the previous month.

Sun light controls some brain functions. In the northern states a drop in lux has significant effects on mood. So what is a lux? One lux equals the light from one candle.

When I lived in the Northeast United States, I had a sunlamp that was 10,000 lux. On a bright August day, if I turned it on, it was as bright as an ordinary desk lamp. No big deal. But on a "bright" November day, the lit 10,000-lux lamp displayed an appearance reminiscent of ET. It was so bright, it seemed as if an alien had landed.

Phillip had a form of depression that gets worse with low lux. Since the winter lux in the Northeast US is a mere fraction of spring and summer amounts, that is when the irritable depression showed up.

He was given two treatments that fit his mother's wishes.

* He was slowly raised up to 800 mg of SAMe, a natural anti-depressant. This is a substance already made in the body. I offer it at full wholesale for $21.00 (30 tablets/400 mg each). I am not aware of a cheaper price at any discount store. You can find these at www.personalconsult.com, and then click the "Wholesale Nutrients" button.

* He was also treated with a 10,000-lux box. It went off with a timer 30 minutes before he was to wake up in the morning. He again used it as soon as he came home for thirty minutes. But if used after 6 PM, he had insomnia.

Hidden Seizures

Mike was an energetic boy. At sixteen he seemed to have periods of eccentric behavior and hostility, with no apparent cause. These behaviors were getting him in trouble at both home and school. Indeed, he had been put on the dreaded, "Behavioral Probation."

His parents were frustrated since they had met with three counselors and two pediatricians. No one seemed to help. The teacher at their private school felt spanking was the only solution. But his parents thought something was being missed.

The second time I met Mike, he had difficulty interacting with me. He was not shy, he just had trouble staying on topic. He was tired with a headache. He mentioned being up late most evenings, and that he had tried a "couple beers" and hated them.

In past years, I evaluated many post seizure patients. Mike reminded me of them, but I was not sure. I referred him to a neurologist who ordered a regular EEG, and it was normal— not surprising. They miss over 50% of patients with epilepsy. I referred him to another neurologist, a friend, and told him he had "a post-seizure feel to me" and so he ordered

a repeat EEG that was "borderline" normal, and then a 24-hour EEG was done that showed clear abnormal findings. Mike was finally placed on a combination EEG with a video monitor that confirmed he was having small short seizures. Mike was then placed on a medication that stopped his abnormal findings, and his behavior normalized completely. He was having the type of seizure in which you do ***not*** jerk you limbs.

Mike was warned about triggers that stress the brain and promote seizures: poor sleep, alcohol, stress, flickering lights, extreme exercise, intense emotional feelings, some medications, head banging, high fever, anxiety, nutrition trouble, dehydration or binge fluid intake.

Another seizure issue is the magnesium levels inside brain cells. In my research, I have found that the cells scraped from under the tongue show most Americans have low magnesium inside these particular cells. I believe these cells are good indicators of low magnesium in brain cells. Many studies show a brain with high magnesium inside the neurons is less likely to spark and have seizures. High magnesium inside cells also allows the brain to handle injuries better, e.g., trauma or low oxygen. Since most Americans have far more calcium in their diet than magnesium, the calcium enters a cell and removes the magnesium, leaving us more vulnerable. Not good.

Here are some basic ways to get magnesium into a child:

1) Sublingual 50 mg lozenges that are absorbed into the blood directly under the tongue. One per day can be taken unless the child feels dizzy. It can lower blood pressure, but we have not had any trouble with one per day.

2) Magnesium glycinate or magnesium aspartate are options in which magnesium is connected to amino acids which allow for very good absorption through the gut wall into your blood. I would suggest taking about 500 mg per day.

3) "E-Lyte" magnesium drops are clear and can be added to any drink at a rate of 8 drops per drink. Since this is a low dose you really need the youth to use it regularly and have it easily accessible.

4) In autistic and severely retarded children, we use transdermal nutrients that include magnesium, many B-vitamins, and zinc. It is applied under 6 x 6 inches of saran wrap held with hypoallergenic tape and applied to the back just before sleep.

I have other options for seizure prevention, but this is a start.

Anorexia

Michelle was a 15 year old brought in by her mother to see if her medical condition was dangerous. Michelle wanted to go to a soccer camp, but her mother was unsure if Michelle was healthy enough. Michelle was required by her family doctor to gain 3 lbs. in the next three weeks in order to be allowed to go to the soccer camp. Her mother was concerned that Michelle might die due to poor medical care.

1) Michelle will probably be in need of treatment for 2 years. She will need a team that includes various specialists. The frequency of meetings will depend upon many factors unique to each child.

    * She will need a family doctor or internist familiar with eating disorders.

    * She will need a child or adolescent psychiatrist with interest in eating disorders that does both therapy and medication. If they are only doing medication, Michelle will need a separate therapist with 5 years experience in eating disorders.

* Michelle will also need a nutritionist. Many are quite familiar with anorexia. I would ask if they have had at least 20 anorexia clients for ongoing long-term care.

* Parents also often benefit from a coach. Therapists differ on whether your child's therapist can also be your coach.

2) Here are some signs that your daughter is in danger and needs more intense anorexia treatment. If she stops menstruating, has basic blood tests in the abnormal range, is 20% below her recommended weight, or is suicidal or cutting, then having a full treatment team is not an option. If the pace of weight gain is minimal, and certainly if the youth is 30% below their expected weight, they should be hospitalized. Generally, anorexic patients can learn some tricks from other patients. However, the outcome from hospitalizations is usually improvement.

3) Some medical testing results show your daughter needs needs very prompt medical care. These include an abnormal potassium blood level or an abnormal ECG. The ECG is a routine and painless heart test that measures the rhythm and function of the heart. A physical exam may also be seriously abnormal. One or more of these types of tests may show a youth requires brief medical hospitalization, admission to a residential treatment facility, or a combination of both. Many youth need prolonged residential care to survive. Some controversy exists as to the death rate of anorexia. Yet for the parent of a dead child, percentages are meaningless.

4) Typically, the child should consider ***food*** as the treatment of choice. The starved brain can sometimes increase "delusions" about the "badness of food" and the "fatness" of

a skinny patient. Surprisingly, it seems that nutritional deprivation does not always increase a longing for food, but increases false beliefs that undermine eating. This is very dangerous and serious.

5) An adolescent with anorexia should have minimal exercise. Her internist, family physician or pediatrician should set safe weight goals. This will assist in making decisions to allow or prohibit sports activities. For example, is your child needs to be 105 pounds to join a sports team, and is 98 pounds, they cannot play. An anorexia youth will often deny the importance of this "safe weight" and will resent any conditions for physical activity. To help with this denial, the physician should consider putting the weight and other reasons down oin a page so it is very clear. A doctor should never fudge the truth and medically "clear" a youth for any sport if they are too thin to be safe. Never put pressure on a physician to compromise their best judgment, unless you want to attend your child's funeral.

6) Generally, everyone involved should be caring, supportive and firm.

7) Eating disordered youth think in extremes of all kinds. They think doctors, parents, or nutritionists are good and caring, or bad and thoughtless. Arrogant therapists can be deceived into thinking past therapists were incompetent, when in fact the patient is seducing the therapist into thinking that way. Next year, *they* will be the ones described in negative terms. All team members need to have good and easy ways to communicate concerns. Assume the patient will try to split and divide team members.

8) If you feel hopeless, you are feeling the internal world of the child—they are deeply frustrated and hopeless. When they act and interact with you, it allows you to taste the feelings they have. I doubt this is something they notice. But understanding it can help you.

9) The clarity of medication use in anorexia is pitiful. Rather than list my favorites, since treatment will be so variable, just be sure the prescribing doctor is a specialist in child pharmacology and has read up on medications for anorexia. If you are unsure, go to the Internet and use the search word "Pubmed." Click on the Pubmed main home page to access the massive database containing millions of articles. In the search bar that appears on the Pubmed home page, put in "anorexia medication psychiatry."

   Print off the most useful abstracts and mail the resulting information to the prescribing physician. Unless they are academic psychopharmacologists, they probably have not done such a search in recent months or years. This insures your child is getting the best up-to-date options.

10) Get an MSH blood level from LabCorp. It seems a population of anorexia patients have abnormal eating from an abnormal MSH. See the section on MSH for more details.

Neurofeedback—Credible or Speculative?

Amy was very upset when her son was diagnosed with ADHD by her pediatrician. Stimulant medication was suggested. Although her nephew, also diagnosed with ADHD, had made some modest improvement with the use of stimulants, Amy wanted another option for her son. After some research, she enrolled her son in a research study that used Neurofeedback to treat agitation, poor focus, and impulsivity. She understood Neurofeedback is not an FDA approved treatment or one accepted by ADHD authorities.

During the fourth treatment, Amy's son developed mania and could not sleep; he was bizarrely agitated and wired. I gave the youth some anti-mania medication, and in a week, he was back to his baseline behavior.

Another "adjusted" series of Neurofeedback treatments were performed. After 45 treatments, Amy felt her son had improved 60-70%.

Neurofeedback is not as simple as biofeedback in which you learn how to control your pulse or blood pressure. It involves placing standard scalp electrodes on the child's head and teaching them by computer games and other techniques to increase certain brain waves. Some brain waves are believed to be associated with better behavior and concentration.

What is the "truth" on this treatment?

Sometimes there is no expert on a treatment or an illness. When I started my career in counseling and medicine, I thought there were experts, but soon found all were limited by their ideologies, mentors, data streams, and creativity. Some conservative practitioners are OK saying they have reached the end of available options. I hate to say I have no more solutions. So what does this have to do with Amy and Neurofeedback?

Physicians and basic scientists like to feel that their recommendations are based on reliable research studies, but some treatment options have less research available than others. For example, there are thousands of studies on ADHD stimulants and common antidepressants. In contrast, Neurofeedback has less research to support its utility. Although it usually requires significant expense and is not a standard of care in child and adolescent psychiatry, many parents feel this is a useful treatment. They also accept that it is a time intensive treatment. Further, if a child reaches their goals, they may need booster sessions to maintain benefits.

Some parents have used both medication and Neurofeedback. They will start with medication and transition to Neurofeedback. But again, this is not the standard of care of any government agency or the larger ADHD organizations.

Just remember, *you are the boss.* As the parent, you have to weigh the options and what fits your philosophy. In my case above, you will note that I report a manic episode induced by neurofeedback. I personally doubt it is a placebo treatment if it can induce mania in a family without a manic relative.

All medications and useful treatments have the potential for side effects. But perhaps more importantly, ignoring a problem and not helping a child often has more dangerous side effects.

Pain and Behavior Problems

Thomas had a successful career in football until injuring his wrist, hip joint, and right knee. He missed sports and began playing informal pick up games that injured his joints further. He also engaged in very aggressive weight training, lifting too frequently and too strenuously for his joints.

Over time, Thomas developed weekly headaches that became increasingly frequent. Routine treatment failed.

Thomas then began to verbally abuse his mother. He was also unable to function in school.

Pain decreases a youth's ability to cope. It can increase lability, moodiness, reactivity, and aggression. Therefore, it needs to be addressed with a wide range of serious and moderate treatments.

1) Thomas should have a toxicology screen in case he is using some other person's pain medications—available in many schools and neighborhoods.

2) He should consider systemic joint treatments that include IV nutrients to cool down inflamed joints that are deep under tissue, e.g., a hip.

   Other systemic nutrients can be taken daily by mouth to heal joints. Examples include:

   * At least 1000 mg of glucosamine sulfate.

   * At least 1000 mg of chondriotin sulfate.

   * At least 1500 mg of exclusively Omega 3 fatty acids per day to decrease inflammation. (Metagenics has a very concentrated enteric coated form that has no fishy taste—it opens below the stomach).

   * SAMe 1200 –2000 mg orally or 400-500 mg given transdermally has been very successful for us and in other studies for joint pain all over the body. The best price I know of for SAMe, which has been tested for quality, is from my wholesale web site: www.personal-consult.com.

   * A potent multivitamin with dosing far above the minimal RDA doses. Consider Arthripower, another wholesale product from my website, which includes many of these treatments in one bottle.

3) For most joints, I have designed a powerful, non-addictive cream that can be obtained by your physician from a compounding pharmacy. It combines multiple medications for delivery through the skin into one joint. It contains ketamine, ketoprofen, amitriptyline, gabapentin, and clonidine. This cream helped remove Thomas's wrist

and knee pain. It can be ordered by your doctor from (877) 363-7474, a compounding pharmacy that helped me develop the formula.

4) Steroids are only temporary Band-Aids for those with clear joint degeneration.

5) Thomas had been taking Motrin and Advil almost daily. He had been taking them for his joint pain and headaches. Unfortunately, if you take an abortive medication for headaches more than two days a week, you will induce a rebound migraine—very painful. Merely switching to a different medication in the same class will not solve the problem. For example, using Tylenol, then Vioxx, and then Motrin is really like using almost the same medication. We used some oral prednisone for a week and weaned Thomas from his over the counter medicine abuse, which seriously worsened his headaches and made him raw, nasty and reactive.

6) Many medications can be used on a regular basis to prevent pain. Common sample medication options that do not cause rebound migraines include Gabatril, Neurontin, Depakote, Elavil and Pamelor.

7) We also use sublingual magnesium that delivers spikes of magnesium into the blood to relieve muscle and inflammation pain.

8) Pain often causes depression. Inflammation chemicals from joint injury can inflame the brain and cause biological depression, which increases pain. (Inflammation increases depression, and depression increases pain). Thomas had further relief starting on Lexapro 2.5 mg per day, and raising it by 2.5 mg every ten days.

9) Some individuals are also helped by physical therapy, acupuncture, burning painful spinal nerves, or even surgery.

10) If a child needs routine narcotics for pain relief of a headache, they must have two labs done. They must have their MSH measured at LabCorp and a Lyme blood test shipped to IGeneX or Bowen Research Training center in Florida. A low MSH or Lyme can cause massive headache pain and these sources of pain are routinely missed. If the Lyme testing is positive or "indeterminate" or "borderline" (from IGeneX Labs) he is still quite possibly positive for Lyme if Lyme specific bands are positive. How? If a child has a + at an 18, 23, 31, 34, 37, 38, 83 or 93, then they have made antibodies to Lyme. You only make antibodies to bacteria you have been exposed to. So a single 18 + means a child probably has Lyme (or Master's disease -- a related spirochete bacteria). Further, a child with Lyme or possible Lyme needs to be tested for all the co - infections that deer ticks and other ticks can carry. Why? Because all common tick-borne infections cause severe headaches. Specifically, babesia, ehrlichia, bartonella and mycoplasma all are found in American ticks and all cause severe headaches.

Counseling Options & Solutions

Being a Friend or a Parent?

Andrea noticed her daughter Jennifer starting to pull away from her over the course of a year. She blamed it on her former husband Ted, but even when he was away on business, they still did not talk intimately. Andrea did not want to be intense like her own elderly parents. After the divorce, Andrea generally let her daughter do as she wanted, because she did not want to fight with Jennifer. She had done enough fighting with her past husband.

If parents are divorced, separated, or alienated, then their adolescent children may create some distance from one or both divorced parents to avoid playing the role of the missing parent. If your child became your emotional spouse, it would eventually crush them.

Jennifer needed time and help to grieve the loss of her parent's marriage, in the same way her parents needed to grieve the change.

1) It is hard to separate normal adolescent development from situations such as divorce. For example, when Jennifer began to connect with peers and talked less with Andrea, her mother wondered if this was normal or due to the divorce. No single series of one-liners is going to clarify this difference. Consider talking with friends, relatives, ministers, priests, neighbors, or a therapist who might help you discern if this is age appropriate separation.

2) Kids do not always have to be rebellious to be mature and separate from a parent. Nevertheless, staying connected to your children as you give them freedom is a very hard dance.

3) You are the parent. And a sincere parent has more power than a friend. For years, we have considered parents marginalized once a youth reaches middle adolescence. However, the facts appear to show that parents do matter until the day they die, and certainly through the entire teenage years.

4) Do not assume that just because Jennifer is frustrated with a rule, the rule is wrong. A physician may be annoying when they suggest you lose inches from your belly, but they may be right. One way all youth grow up is with *graduated frustration.* We learn to take on more responsibility and work harder as we grow up.

5) Ideally, one builds rapport before a child reaches thirteen. One can build rapport in later years, but it may not be as easy. Good rapport is essential to set limits and correct.

6) I am a big believer in the 4:1 rule; offer at least four positive comments for every negative comment. Did you tell your son his room is a mess? Where were the four positive things spoken today? Some parents do not buy the merits of regular encouragement. They oppose "fake praise." They are partly right. If fake, do not offer it. The youth will notice you are insincere. Incidentally, why do you have to pretend to be encouraging? If you cannot encourage a child for anything, then you believe your child is a serial killer. Or perhaps some stern parents think their children are simply doing what they "should do," and do not deserve praise for correct behavior? But if you are only critical, they will look elsewhere for connection. **They can get praise from their friends just for listening to a certain CD and wearing a hip shirt.**

Finally, Andrea learned to watch her tone when setting limits. Discipline with authority, but not like a raging lunatic who shows no control. Your tone and delivery influence the intensity of agitation from your child.

Some parents might say, "Joe, you are home an hour late, I am totally fed up with you! You are not using my car for the next two weeks!"

Or you can say with a regretful tone, "Joe, I am very sorry. You have left me no choice but to remove your car privileges for two weeks. I am sorry and perhaps I am making a mistake. But I really need you home on time, since the longer kids are out, the more likely they are to make mistakes."

The result is the exact same consequence—no car for two weeks.

Nothing is gained by power plays in disagreements. If Joe does not get the car for two weeks, you have won. Period. If you acknowledge his feelings and that it is hard to leave a "fun party" you are merely speaking the truth. If you mention your punishment might be "wrong," it makes things less polar. But do not give in to whining if you are confident in the punishment. You are just delivering the strong medicine with some honey. This type of delivery helps reduce reactions when the youth feels like the punishment is a disaster.

The issue with impulsive adolescents is not the present, but what is best for their future. If you want to be a parent, and not merely a chum, you need to keep their future in mind when setting limits.

Reactive Youth and Blow Ups

Barry is a 15 year old with a lower than normal IQ. He blows up and yells at his siblings, parents, and teachers weekly. A few times he has thrown objects at his siblings.

Children realize when they are on the outside. They feel much more than they can tell you. A child with cognitive limitations has even more trouble speaking about his or her feelings. And what is not spoken is often acted out. So instead of Barry saying, "I am mad at you for taking away my TV time," he curses at you.

Solutions:

1) Since Barry can be teased violently by peers, due to his cognitive limitations, he should not be allowed to store up even mild resentments. If a child is upset about one thing a day, they will explode over a mere sneeze after a week of collected offenses. Provide Barry an opportunity to talk about problems on a ***daily basis*** to prevent sudden blowouts.

2) The child should then be trained to discuss situations or people they think *will bother them in the future.* What do they expect will annoy them this coming week? In other words, if Barry often gets annoyed at Uncle John and is going to see him in two days, address the ways Uncle John is annoying to Barry ahead of time. Perhaps add some light humor since humor is a good way to cope.

3) Role-plays that are both fun and organized can be helpful. Utilize realistic present and future scenarios that may annoy Barry.

4) Look at his school workload. Is it appropriate for his abilities, or is he struggling too much? Of course, if Barry is emotionally overwhelmed from teasing, he will not be able to think clearly.

5) Consider a different school or location of classes to reduce teasing.

6) Other sections in this book discuss handling teasing, medication for impulsivity, and medication and nutrients for neuron enhancement.

The Protective Girlfriend

16 year old Ryan is very oppositional at home and has also started to refuse going to school or obeying a curfew. His mother has taken away his car keys, since he came home intoxicated at 3 am two nights in a row. He has become abusive to the family's two dogs and hit his eleven year old little sister in the head— "because she got on my nerves." He has recently met Melanie, a friendly and kind girl with no interest in abusing substances. She is a "B" student and plays soccer for her school's traveling team.

Research into conduct disordered young men show that, at times, a girlfriend has a very powerful influence.

A girl (or woman) can function as a form of "treatment," drawing the unruly and unsocial male into more empathic relating.

Of course, the young woman could be objectified and treated poorly by Ryan. And what parent would allow their daughter to date him.

On investigation, both Melanie and Ryan are pleased with the relationship. Ryan has treated her OK so far, though he routinely lets her pay for their meals out.

If she is willing to relate to you, a parent, in any way, befriend her. Take interest in her. Talk with her. She may be an advocate for some of your positions and support your concerns. If Ryan speaks against you to Melanie, she may try to settle down his extreme views of you. She may also gradually talk him into settling down his extreme behavior, which may bother her as well as you.

The primary risk in this type of relationship is an unplanned pregnancy. I would raise this issue with Melanie directly without being judgemental. Discuss the "high" of being in love as a "legal drug." She will not really hear you, but letting her know the feeling goes away in time might help her. Further, while adolescents are too immature for sex, a youth like Ryan is not going to follow your guidelines. So Melanie should be reminded and protected. She should be told that no form of birth control is 100% successful and many forms do not prevent sexually transmitted diseases. If they are determined to act out against your wishes, the use of anything less than two forms of birth control is a risk for a pregnancy. If Melanie is romanticizing motherhood, tell her the realities of being pregnant, breast feeding at 3 am, and suggest she help out any mother with an actual small infant. She should help out as many days as possible each week, and not just an easy two hour visit.

Anger and Social Sophistication

Laura is regularly mad at multiple peers in school and girls in her neighborhood. Her mother is confused about why this keeps happening. Laura has received private psychological testing which put her IQ at 95, just under the average of 100. Laura is young for her grade. She has one local friend and does not get invited to many social functions.

Teachers are trained to look for weaknesses in math, reading, writing, and other academic areas. If Laura is a year behind in reading, she can be given tutoring or tailored classes. However, social skills are hard to learn and do not come "naturally" for some.

If you look at what is needed for social success, it is amazing any of us have friends. Socializing involves knowing the nuances of facial expressions, subtle intonations and awareness of what turns off peers. Social skills also involves learning what is funny or boring to potential friends. So how was Laura helped?

1) We first gathered details of the specific social problems Laura was having. Details are critical to correct her mistakes. General principles are useless.

2) We used Dr. Novotni's inexpensive list of highly specific social skills, which helped her mother, teachers, and me focus on the exact objectives and not useless generalities. We all tended to agree that Laura had three serious social problems: meeting new kids, one-on-one talking with boys, and handling insults.

3) We started the social tutoring with role-playing, so that she was more confident and *ready for the next time* these problems occurred. Role-playing can work better at times if one uses *imaginary scenes,* with the *exact* people and places that are socially challenging.

4) Laura was also having trouble reading facial clues, so we watched TV without the sound and discussed the character's feelings.

Divide and Conquer Parents

Jean was making her parents very angry. They became angry at each other, rather than at her. Jean would raise an issue by her behavior or requests, and her parents would end up on different sides. They would often fight over the best course of action, and Jean would appear to get away with what she wanted.

Over three years her parents fought over boyfriends, school, religion, curfew, parties, and driving. One feared they were being too lenient, while the other felt they were being overbearing.

Children are your walking heart. They can make you feel incredibly vulnerable. Unfortunately oneness in parenting does not just happen

"naturally." Some parents perceive the other as a threat. They may even find themselves merely reacting as a parent, instead of providing calm security for their child. Here are some options to lower parental tensions:

1) Unless a court would declare your spouse or former spouse fully "unfit," he or she probably can offer a contribution. Share your concerns with each other without insults. Communicate the intentions behind your parenting position, in a clear focused way with a low voice.

2) Both parents fear what will happen if they comply with the other parent's position. Each should be able to express their fear without a power struggle. Make "I" statements, e.g., "I am afraid of making our son hate us." "I fear our daughter will close off if we are that strict." "Our son might get drunk at that party and get in a car accident." Mentioning your fears is less aggressive to your partner. They might also come up with solutions that respect your fears.

3) Allow time to discuss important issues. Talking at dinner on a Friday night before your child leaves is a disaster.

4) If you are divorced, follow the rule of saying at least four positive comments for every critical one when speaking of your past spouse. Some call this the 4 to 1 rule. Of course if your child's other parent is in jail, this is a challenge. But remember, what you say affects your child's identity. Avoid being overly negative even when a parent does not act responsibly. For example, "John, your father loves you, but if he is intoxicated, call me, and I will pick you up. I am sorry he has this problem." The goal is not to call John's father "trash," but to keep the youth safe.

5) Occasionally, couples can find support from other couples or therapists to think through complicated parenting issues with them. If you expect magical cures from a few sessions, you are being unreasonable.

The Move Solution

Paula's parents saw their daughter do everything they feared. She often skipped school and ran away to be with her friends, smoking pot and cigarettes daily. She had been sent to an alternative school for oppositional and troubled youth, but failed to apply herself adequately. Paula had also been to four therapists and two psychiatrists employed by her family's insurance plan. No real progress was made, and now she refused to continue therapy.

Paula's father, Tom, and wife Claire, had developed many friendships and felt nestled in their community. They thought they would stay in their home for decades. But when Tom was offered a new job in another state, they realized it might help their daughter.

They moved four months later.

Paula's life was her friends, and she was very upset. Her acting out increased in the months before the move. In the first weeks at her new home she threw a few items in the house, and put a hole in her bedroom wall.

However, she eventually made new friends and decreased her illegal and worrisome behaviors over a year. The transition to a new location with no contacts has drawn all the members of the family moderately closer.

Disasters with a Step Parent

Angela's parents divorced when she was 9 years old. She knew they were fighting but never believed they would actually divorce. After two years of modest conflict, Angela's home was sold. She moved into a smaller home with her sister and mother.

Angela sees her father Ed weekly. Her parents have been interacting civilly, and this has encouraged her. Sometimes she fantasizes that her folks will remarry and be a family again ...

But Angela's dream was not realistic. Tom started dating Ann after meeting at a work party. They shared a lot, and Ann felt she was talking to a male version of herself. She liked his ex-marine rugged good looks. He seemed very dedicated. They married eight months later.

Angela began defying her mother and stepfather soon after the wedding. She refused to perform her basic responsibilities and began yelling routinely.

Every child has two parents. A divorce does not change a child's mother and father. Any intrusion of another new spouse into the parental role is provocative.

Tom believes he is "helping" his new wife by helping her with childcare, and especially with "handling" Angela. He is no longer in the marines. Tom may transiently control her, but she will come to hate him. This hostility will leak out fifty ways.

Tom received some counseling and read some *brief* chapters about Angela's view of "family." He finally settled down. He became quietly supportive of his wife's interventions and let Angela's blood parent(s) take the leadership role.

He stopped trying to rescue his wife so much and supported her in other non-parenting ways. Eventually, after a few seasons, Angela and Tom respected each other's world.

Angela partly accepted Tom as her mother's new husband. Tom understood he was not Angela's father or boss. Thus Angela released the dream of her parents remarrying, and her defiance dissolved into normal age appropriate behaviors.

Social Anxiety and Destructive Solutions

Andy was not popular growing up. Talking in groups was unsettling, and contact with kids he did not know intimidated him. He did OK in school until the 6th grade when he began to have trouble getting to school. He was unusually sleepy in the morning. His parents found two bottles of whiskey in his dresser and a few small bags of marijuana.

Andy has had an anxiety disorder most of his life. He woke up with anxiety and as he thought about the day, he felt terribly restless. When he had to answer questions in class, Andy was overwhelmed with fear, which he hid from his peers. He could not articulate his feelings to his parents, and so they had no idea how uncomfortable he felt.

Andy found that alcohol and pot decreased his feelings of anxiety. His drug experimentation became common use.

Anxiety disorders are more than a dash of nerves before a final exam. They are the most common psychiatric disorders and are significantly painful.

Solutions:

1) Different types of counseling can treat anxiety:

    a. Making special custom relaxation tapes used twice a day for 15 minutes;

    b. Going over exact scary situations in immense detail and looking at thinking errors that are unreal and increase fear;

    c. Slow exposure to the feared events for a prolonged time, so that the fear turns to boredom; and

d. Serving and befriending "outcast" or younger youth, which makes shy youth feel more confident.

2) Youth respond to many medications for excess anxiety. If Andy's parents have genetic anxiety disorders, medication might be worth considering. They can use antidepressants like Celexa or Lexapro (1/4 of the smallest tablet in the first week), or anti-anxiety agents like Klonopin, Buspar or Gabatril. Gabatril, for example, prevents the removal of the brain's natural anti-anxiety chemical. Starting at 1 mg at night is often effective, and it can be increased by 1 mg increments up to 50 mg per day. Theanine is a Japanese nutritional food extract that is reported to help with adult anxiety in some initial studies. Discuss these options with a specialist in child medication.

3) Parents can calmly share their childhood fears. The result? The child will connect better with their parent, learn that their parents survived their fears, and know that everyone has some anxiety.

No Bargaining Power So No Compliance

Charlie was an 11 year old boy who was moderately defiant. Nothing the parents did worked, and they came to me wondering if he was a candidate for medication treatment. When he acted defiantly, he was sent to his room for 1-4 hours. But this failed, and his parents had run out of ideas.

When I asked them to describe Charlie's room, the response was quite informative. Charlie was not adjusting his behavior because his room was like a 5 star hotel. He had Cable TV and a collection of recorded TV shows he liked. He had computer games and music CD's that he played on his computer and boom box. He had filtered Internet access, which allowed him to instant message and email his friends.

Amusingly, he had his own "snack bar" fully stocked with different types of drinks, crackers, cookies, and chocolates. He had everything but a mint on his pillow.

So what did we do?

His cable was removed. His computer games and CD's were removed. His computer was put on a password that only his parents knew, so that he could not receive or send instant messages or email. And finally, his grocery store and "concierge service" were removed.

Surprise, surprise, surprise. Suddenly, Charlie was very upset at the idea of not having access to these things. Now when he was sent to his room, all he could do was read. He never read for fun.

Over 3-5 months, his behavior improved 75%. He would still have battles with his parents, but at least now they had tools to adjust his behavior.

For a small child, bargaining power might be big fat nickels. For an adolescent, it might be some of the privileges described above. For young adults, it might be larger financial support.

Never agree to the child's perspective that you owe them anything more than basic food, reasonable shelter, clothing, a high school education, civil conversation, love, and health care. Anything else is sheer gravy. Do not give in to entitlement that makes your sacrificial actions, gifts and privileges unappreciated.

A sign this is occurring is the child or youth that does not say, "Thank you." This is taught and does not come naturally.

If your child acts like a martyr when they protest your limits, respond *playfully* in a similar manner. You can play the role of an abused parent with an abusive unappreciative child. Two can play the whiney game.

Routine Parental Drinking & Adolescent Behavior

Ricky was 15 years old and increasingly hostile. His grades were declining since entering Junior High School. He yelled at his mother and refused to obey his parents and teachers. Ricky was fairly well behaved for years and did well in school. He had looked up to his father Russell until 2-3 years ago when friends became Rick's functional god.

His parents demanded he go to therapy. When asked to state five wishes, Ricky mentioned he wanted his father to stop drinking. When discussing the topic he seemed angry.

Adults are more accountable than children or adolescents. Blaming parents has little appeal with judges when someone is twenty-five and trying to justify crimes. However, an adolescent's ability to connect and attach to parents is influenced by parental behavior. That does not mean we have to be perfect parents, just "good enough" parents.

Unfortunately, children are the fragile links in the family chain. When our "major" problems are not addressed, barriers are created that prevent healthy connections with children. Russell worked long hours and drank to numb the weariness. He cursed and occasionally broke things on the floor, showing his frustration with family members.

Russell was told his drinking *might* be giving his son a "justification" or a model for yelling at his parents and disrespecting his teachers. Further, Russell learned that 4 drinks a day causes clear brain atrophy. But Russel only cared about his "beer belly"—the one that increases diabetes and prostate cancer. So Russell stopped drinking to preserve his "figure."

Over the course of a year, Ricky and his father spent more time together doing things that *Ricky enjoyed*, and his father often pretended he enjoyed. Nevertheless, Russell was glad he no longer felt so guilty about his behavior. Ricky gradually settled down over a year and his anger and grades markedly improved. He continued counseling for 1 1/2 years.

No one could point to a single session or a single event that seemed to improve Ricky's anger, disrespect and falling grades, but Russell and his son's counselor believe the father's growth helped his son's growth.

Let's think back to our own youth. Many of us have made serious errors in judgment while drinking alcohol. Why model this for our children now?

All We Do Is Yell

When I call up Joan, she is often in yelling matches with her children. Every few minutes there is a shriek between child and mother. The children do not respect her directions, and she tests their eardrums. Joan tells them not to disturb her, yet they nag her repeatedly every few minutes.

She feels very guilty and says, "I know I am not a very good mom. I just see no way to control my kids. They fight me on everything! And I am fed up with it. I just feel so bad about all the yelling I do."

1) Raise the bar of behavior expectations. If your child feels that you are only going to enforce screamed commands, they will never obey until you scream. From now on Joan must expect obedience immediately after each command.

2) Do not sit in guilt for yelling at your children. Simply, make a clear apology for it and move on. An apology for yelling offers an example to youth of what they will have to do in the future — be accountable for their behavior.

3) Explain to them your new expectations for obedience, or they will feel you have changed the rules of the game without warning. Tell them you will expect them to do what you tell them the first time. Give at least two examples: "If I call you to come in from playing, I expect you to come in when I tell you. Also, if I tell you to go to bed, go to bed."

4) Be sensitive to your child's times of hyper focus, such as the end of a sports game, video game, or movie. At such times, it may be very frustrating to be pulled away on command. So transition them if you see this by comments such as, "After the next goal you have to come in." Of course, your child will find 500 reasons why they should not obey. But lets just make it easy—especially at first.

   The younger and the more impulsive a child is, the more they need eye-to-eye directions and time to transition from one activity to your directed activity, e.g., an 8 year old with ADHD needs more forewarning than a mellow 13 year old.

5) Reward prompt obedience with praise, appreciation, affection, or something concrete, e.g., a special note or snack.

6) You will be tested. Tell them you understand that they may be tempted to test you, and that you will follow through with any consequences you have calmly explained. The consequences should be frustrating but not massive.

Where Is the Fun and Lightness in My Folks?

Lilli wanted to avoid her parents. Her mother had muscle and joint pain; her father was mildly depressed and irritable. Her mother's physicians were "worthless." Lilli was annoyed that her mother was "always ill and complaining" and "no fun." She also avoided her father, since he was "nothing but a crabby downer who just finds fault with everything I do."

Solutions:

1) Lilli's mother is likely in serious pain. Unfortunately, we live in a time where the ability and creativity of physicians is limited due to lawsuits and massive payment cuts. Therefore, her mother will have to do some of her own research to find creative doctors that pursue solutions. The days of a single medical Pope who is an expert in an entire field of medicine are long gone. She will have to see different types of doctors until she gets better.

2) Lilli's mother may want to try some of the following options for joint and muscle pain

    a. SAMe—increased by 200 mg increments and not for people with true mania or high homocysteine blood levels. A Vitamin B-complex usually keeps homocysteine low.
    b. Lidocaine patches for the 2-3 worst areas.
    c. Neurontin
    d. Gabatril
    e. Pamelor—which needs an EKG and blood levels to be in a safe range.
    f. "Schaller cream," a special joint cream that puts 5-6 medicines into a specific joint; available by calling (877) 363 7474. It does require a prescription.
    g. Very low dose hydrocortisone taken orally at about 5 mg morning and afternoon, may help augment poor adrenal output of this anti-inflammatory hormone. Prednisone 1 mg is equal to the entire cortisone output of the adrenal during a day. I am talking about much lower doses of cortisone than is commonly used. This small cortisol dose will still allow your adrenal to work and not hurt your bones. Some doctors like to check your 24-hour urine cor-

tisol level, to see how much your adrenal is making. Under pain and stress cortisol is used up at a faster rate.

h. Test for Lyme disease with a Western Blot from IGeneX and read *Mold Warriors* or my other mold books if exposed to earthy moldy smells or visible mold

3) Lilli's father sounds depressed and over worked. Those who are "less informed" do not believe in biological depression. By their titanic ignorance, they assist in the suffering of biological relatives. They also promote the epidemic of suicides. This cause of death has always been present but rarely put on death certificates in the past. Depression decreases work and relational success. It increases divorces and addictions. Depression should be treated to 100% recovery. Clinicians who can only offer useful antidepressants, often miss stealth medical causes and struggle to get *every patient* 100% relief.

   In Lilli's case we see that her father's depression makes her want to avoid him.

   Depression isolates. Over time, people enjoy you less. Lilli is this way with her father. Her life is challenging enough without feeling her folks have a marriage founded on misery.

4) Lilli is going to leave home as soon as possible unless some joy is restored in the home. Perhaps in this situation, starting with aggressive medical care may help to provide some temporary relief while also helping to find the cause and solutions of joint/muscle pain and depression. (The medical section of this book mentions some commonly missed mood, joint and pain causes).

The Child-Parent Finally Revolts

Jane is the oldest of three children. Her mother Patricia has been divorced for four years. Patricia works hard as a paralegal, but Jane's father, an alcoholic, is not able to keep a job. Hence, Patricia cannot depend on child support payments to raise Jane.

Recently, Jane's grades have fallen from a B's to D's. She has also become very insulting and hostile toward her mother.

Solutions:

1) Learn what is happening in the child's life. I simply asked Jane to write down what she did for two days. She was rewarded with a music CD for this annoying and boring homework assignment.

   Jane's daily routine was largely acting as the second parent in the family. She did hours of housecleaning, laundry, and babysitting, with little time for her own interests and activities.

   Further, Jane did not realize she resented this parental role.

2) If you think you have a reasonable hunch as to a contributing cause, explore it directly. When Jane's mother asked her if she felt like a parent, Jane denied it. But the next day, Jane told her mother this was exactly how she felt. Later, Jane told me that just saying this to her mom took the edge off.

3) Do not trivialize the power of empathy. Patricia quickly realized that Jane felt overwhelmed. Just knowing her mother was thinking about her made Jane feel less alone.

4) Modify the excess responsibility on your child. Patricia felt bad that Jane had to sacrifice some of her favorite activities for the household. So Jane's mother arranged for two neighbors, her sister, and a mature babysitter to come in four afternoons a week to "cover" for her daughter. It was not easy coordinating this extra care, but the effort was not lost on Jane. After five weeks, she was much more affectionate to her mother.

5) Patricia also asked her sister Judy and her friend Lindsey to check in with her daughter periodically. Jane had always looked up to Judy and Lindsey as real or figurative aunts. Jane needed this additional support and encouragement from other women who are good listeners. Some youth really connect with older relatives and family friends. This should be encouraged if the adult is a positive force.

6) Further, Patricia began teaching Jane's two younger siblings to do more of their own care, and to be more responsible with household chores appropriate for their age.

7) Patricia made it a point to ask Jane each day how she was doing. She supported Jane if her siblings were hostile to Jane's reasonable requests, e.g., to bring their dishes to the sink or to pick up toys.

8) Patricia was also very generous with her praise and affection for Jane, being careful not to smother her, but simply pampering Jane in ways she liked, such as a back rub before bed. The first time Patricia did this Jane seemed stunned and surprised. She hugged her mother after the third time. And while busy Patricia could not do it more than twice a week, she felt like a great mother when she showed this type of affection.

9) Patricia eventually discussed this issue with Jane's father. He slowly learned to be more sensitive of his daughter's stress. Though he did not talk about feelings much, just asking "How's it going?" or "Is being the oldest getting to be too much?" was appreciated. This also surprised her at first, and she wondered if an alien had possessed her father's body.

In a year's time Jane's behavior calmed down. Her grades also improved. She still wished her mother could be more helpful but understood that every good parent has limits.

The Danger of Emotional Illiteracy and Dissociation

Michael is an accomplished athlete with many awards in football. He enjoys the aggression on the field. He has a couple of girlfriends and is sexually active. He binge drinks about twice a month, but is rarely caught. His grades are average. His mother asked me for a consult.

When I asked about their talks over the years, it seemed that despite the clear love of Michael's parents, there was little emotional connection or emotional dialogue. Michael might get angry at times and even say, "I feel angry," but this level of "male" communication is minimal emotional maturity.

Often when youth are emotionally illiterate or unable to talk about their emotions, we say they are "dissociated" or "disconnected" from their emotions. They certainly have feelings, but they cannot label them or discuss them.

Why address this limitation? If someone is disconnected from emotional awareness, they may be more prone to act out in destructive ways. Their acting out could be penalties on the football field for unsportsman-like conduct, sexual impulsivity, fighting, impulsive vandalism or substance abuse.

1) The first step is to identify the signs of dissociation. These include: slowness in answering, flat feelings, staring, memory lapses, daydreaming, over-activity to avoid feelings, twitching or other physical gestures done repeatedly like foot tapping.

2) Get a full list of *emotional* vocabulary words. But start using four in your conversations with your child. The most important four are: anger, sadness, fear, and happiness. A six year old should be able to use these easily, but I have met 60 year old men who struggle to use them. You ask them how they are feeling, and they have no real reply. No one trained them.

3) Michael's parents should start to model emotional labeling. What does this mean? Simply, they should mention instances in their own lives in which they zone out and dissociate, and perhaps then list the feeling they buried. So a parent can mention an event, explain they walled off their feelings, and label their feeling. For example, Michael's mother had not received an email reply from her best friend for three weeks (the event). She mentioned very briefly that she was "pretending it did not bother her" that Jenny had not returned the email (the walled off feeling). And finally, that it actually did hurt her and make her both sad and mad" (the labeled emotion).

4) Michaels parents should start guessing at his feelings. For example, if he has a poor performance in a game, he might be asked, "You seem mad and sad about losing the game?" If he acknowledges either feeling, ask him to explain or "tell us." If he can go into details, let him talk completely.

5) Avoid family interactions that cut off a child's feelings.

   a. For example, some parent's are working hard during the day. When they finally get home, they shut off any intense discussions or "complaining" from their children that last over two minutes. They simply cannot handle it. If possible, try to save a little energy for "therapy time" at least a couple days a week. So you have the energy to ask each of your children, "How are you doing?" If they give you a simple, "fine," simply ask specific questions about personal aspects of their life — a friend who insulted them, a teacher who is moody or a subject that is hard.

   b. Some younger siblings are overwhelmed by the verbal "debating power" of their older siblings. They avoid arguing over problems, because they always get refuted and verbally crushed. And so they merely leave or blow up if conflicts occur. The blowing up is not what you want. Therefore, make sure they are able to be "heard" and that any imbalance in power is moderated, so they can make their point. You are not taking sides, but you are making sure each has the chance to express their thoughts. This also helps the intense sibling or friend who do not listen well. Why? They will be disliked and do poorly with teachers or bosses and even romantic relationships later in life, if they do not learn to listen and turn down their intensity.

Empathic Failure: Refuting a Child's Feelings

After ten minutes with Melissa, her father was tired of listening to her. I did not have a sense that she was anything other than a normal 14- year old girl with an illness. Her father was a "bottom line" type, a computer technologist who was really sick of "listening to whining" from his daughter.

Two years later, Melissa became very secretive and withdrawn. Her father thought she was on drugs; her mother thought she was depressed. She did not really "talk" to either parent.

When her father requested a consult, he suggested he come in and give me an update on his daughter. I asked him how he was doing. He mentioned his company had a huge downsize and merger, and that he almost lost his job—I sensed it had made him very fearful. I explained to him that such serious and unfortunate stress from a job often has negative impacts on our children. They may feel a parent is unavailable. If we are reactive, we are obviously going to be avoided. He agreed that he was stressed and reactive with Melissa. He agreed to discuss this with her. He also learned that apologies to our children are good acts of modeling, since we expect our children to apologize for their errors.

Her father did talk to his daughter in a letter, apologizing for his specific past errors. Three days later, Melissa mentioned to her mother how a boy at a party had forcefully grabbed her and touched her aggressively and sexually, and it upset her greatly. He was a very "popular" youth, and she did not feel he would accept responsibility. It continued to bother and depress her.

After talking to her mother and doing some modest counseling, Melissa returned to herself. She seemed to gradually relate to her father better over the next year. Melissa's mother felt that her husband's humility and apology made it easier for Melissa to approach her parents and share something she felt shame about, which was someone else's criminal act.

Transitioning From Child to Adolescent Parenting

Lynn was an obedient and pleasant child until she reached middle school. Then, with each passing year, the fights with her parents increased. She yelled about cleaning her room, when to do homework, and attendance at parties and school dances. "Everything is an argument," her mother said. "If I asked her to breathe, she would refuse." Recently, Lynn stayed up until midnight on the phone with a friend, when 9 pm is the latest she can use the phone on a school night.

Young children must have predictability, structure, firm discipline and regularity to believe the world is safe and secure. Lynn's parents did an excellent job with this first stage of parenting, but they forgot parenting changes as a child reaches adolescence. The structure is not released, but it does start to slowly decrease.

Freedoms and privileges are *linked* to fulfilling reasonable age-appropriate responsibilities. If a child wants to go to a movie, they cannot go if they came in 2 hours late the day before. If a child's grades are falling due to avoidance of homework, they should not be allowed liberal contact with friends. Simply put, adolescents get what they earn.

There is no set pattern for this process. It strains both youth and parents and is fully tailored to each child. It is a dance of accountability and freedom. Your "gut feeling" is not always correct. You may be doing the right thing when you feel bad about a decision, and the wrong thing when you do what comes naturally. And it can be wise to admit you are unsure of your rules or limits to your child, even as you hold to your position.

So what worked for Lynn? We had Lynn and her parents each write down their wish list — Lynn wrote down her desired privileges and her parents wrote down the behaviors they expected. Since school came fairly easy for her, Lynn agreed that if she was not getting a B- average, she would only be allowed to socialize one weekend night a week. If she got an A-, her parents agreed to two nights out per weekend. But she had to be reachable by cell phone and could not turn it off for any rea-

son. She also had to leave her destination with an exact street address and the landline. She also could not be in a home with boys without a parental presence. As far as her "sloppy disorganized room," I asked the parents to ignore it and just close the door.

It is generally inappropriate for me to tell a parent the norms for their own parenting. Yet, I told them what they already knew—they were in a battle and in war you pick your priorities. You do not get your ideal fantasy experience of parenting. I also did not tell Lynn her parents were controlling jerks. I explained that this was "business," and she would get more freedoms as she was responsible. Also, she needed to learn to make her appeals and positions very clear and reasonable. Yelling and whining would be ineffective.

In about nine sessions over four months, there was some improved affection between Lynn and her parents. It was scary for her parents to allow her certain privileges. It should be. The world does have dangers and it is wise for parents to mention them to their children.

Lynn is going to leave for college in a very short time. Her parents should carefully allow her earned freedoms with appropriate safeguards. As a result when Lynn leaves home, she won't be clueless about how to use her new freedom and how to make her own decisions.

Meaningless Chaos vs. Spirituality

Michael is a highly intelligent 13 year old. He is indifferent to his family, friends and school. This attitude started after his father died 2 years ago. He reads books with dark themes and is very withdrawn. He has stolen from family members to buy video and computer games and is more cynical than other youth in school or the neighborhood.

Margie, Michael's mother, fears he is going down a bad path. She doubts biological depression because it does not run in the family. She worries something is incurably wrong. She found Michael with some cigarettes, but when she told him to stop, he replied, "What else is there to live for?"

Michael's belief about the world has been destroyed since his father died.

In his child world, you have a father to play with and safe. Your mother is not exhausted from work and running a home by herself. The bills are paid, and there is no talk of moving to a smaller, more affordable home, not to mention a different school.

One of Michael's deepest core beliefs included, "Fathers do not die when you are a child." Unfortunately, in his experience, his belief was wrong.

Solutions:

Margie went to a seminar called "Fresh Start" at a local church and found other single adults, some with children. She found two mothers with boys Michael's age, and with much "cheerleading," she was able to get him to join her in some family visits. He eventually became very close to a boy named Paul and his mother Christine.

Margie had been raised in a Christian tradition but dropped it while in high school. Now, she decided to give it another try. The second church she visited had an appealing youth ministry, and over six weeks, she found a few folks she liked.

One day, she was talking with Michael on a long car ride alone. She asked him how he was doing.

"Better, I think. Different."

"How so?" she asked.

"I don't know. I'm not so hopeless, I guess."

"Why is that?"

"I believe in God... I think He hears me... I guess I feel less alone."

After further discussion, Michael's mother learned he was quite involved in exploring his spirituality. He said he was talking to God and felt "good" after he prayed. Michael also found some of the church people "nice." He stopped stealing, since he felt "bad if he did it."

The bottom line: if a youth's life is empty and meaningless, a personal relationship with God can be greater than suffering, and connection with nice people of faith is very powerful.

Years ago, I talked with a priest who spent twenty-four years in Russian POW camps—five years of which was in solitary. He survived due to an intimate relationship with God.

Perhaps Michael and this priest are onto something.

School Problems

Creative Homebound Instruction

Dean is a 12 year old with the diagnosis of Bipolar disorder. He is very wild. He is being referred for residential education and treatment, but his mother refuses this option. In his state, there are in-home counseling services, but these "set him off" and so have been discontinued. At school, he is threatening to other students and likes to break windows. If a teacher confronts him, Dean becomes threatening.

Dean seems hopeless. He does not fit into regular treatment options. If he continues to go without an education, he will find it harder to learn in the future.

1) One surprisingly effective option was giving him one hour of homebound instruction each weekday. This is effective for students who do not get in trouble at home. This treatment also does not require the police to take him somewhere. He seems to hate everyone associated with the school except one woman who teaches him.

2) Youth with severe neurological and psychiatric disorders like mania or psychosis can take longer to fully stabilize with medications than adults. Generally, if aggressive and persistent with medication, he may be able to return to a non-home education in the future. "Aggressive" means considering new generation antipsychotic medications, increasingly being used for mania. (Yet if your child is sedated over a week, the dose is excessive. "Aggressive" means effective and not making any child into a zombie).

Also, make sure you are using a child psychiatrist who has 2 years of full-time training in child and adolescent psychiatry to suggest medications. This special training is the least experience one should accept

from someone toying with brain chemistry in a child. Most of my important lessons came years after I completed this type of intense program.

When Your Child is Einstein

Jill is very intelligent for an eleven year old. She learned to read at an early age. She always scores high on standardized tests, even though she does "not try" and thinks they are "ridiculous." She seems to have the vocabulary of a 40 year old adult. Jill is very hostile toward her mother and considers her teachers to be "useless." She is starting to test all the family rules and has stopped doing her homework.

Jill has the mind of an older youth, but the coping ability of a child.

1) She needs a radical adjustment in her school program or she will come to hate school. A gifted child needs a fully appropriate and tailored educational experience. Gifted children deserve this as much as those with learning disabilities.

2) Some children do better skipping grades or taking classes that are very advanced around their interests. Some enjoy doing special independent study.

3) Consider getting ideas for your local school from a private school psychologist—such education consultants should know your child's school district well.

4) There are a number of books on gifted children at various ages. Log on to Amazon.com, and look over the many options. Some are very short and sweet.

5) As her parent, you will need some guidance on how to set boundaries which do not cause your daughter to be treated as an adult—she is not an adult. She is smart.

They are not the same thing. You might try getting help with this kind of guidance from a therapist who works with children and who can also act as your coach. Others find parent's support groups economical and useful.

6) If your daughter surpasses you at academics, it is a wonderful gift — unless you are insecure. Yet, you are still the boss, and you will still need to teach her lessons about life. Establishing fair rules and loving your child does not require a Ph.D. I have often worked with children that were far superior to me at traditional academics, yet they were still children that needed the guidance and care all children need.

All is Dandy-Forget the IEP

Trish is a very polite and friendly girl. Adults like her. Her peers are starting to warm up to her. She may have very mild Asperger's Syndrome, with eccentric interests and social limitations. Her IQ testing shows good verbal skills, but a low performance IQ. Since there is a 21-point difference between these IQ's, she would typically have a learning disability. Indeed, she has a math learning disability in two previous evaluations and trouble with reading comprehension and word retrieval.

At the year-end teachers meeting, the teachers express how much they like Trish. They also mention it would probably be good not to "label her" as "Learning Disabled." The idea of an individual education plan (IEP) is never mentioned.

I have great sympathy for teachers and have enjoyed working with them as patients and colleagues. Often, they are asked to do the impossible: to teach each unique child in a way they can learn.

Yet, as with all things, the child comes first in critical matters like education. Her teachers are getting caught up in the reality that Trish is

truly a good-hearted youth with an essentially good vocabulary. However, learning has *many* facets and subjects, and Trish will slowly fall behind unless she has a tailored IEP. Most IEP's are of a poor quality and often not sufficiently detailed to be useful. Teachers have to complete piles of them, and may lose heart in trying to follow them.

1) If you do not pursue the best education for your child, it is unlikely he or she will be given the tailored education needed. School resources are very limited. You have to get involved and learn the basics to get the ideal education for your child. Good tailored schooling does not just happen.

2) Get an advocate who can teach about the law, procedures, and options for your area. Occasionally, some school advocates are free.

3) Some localities have publications from state or legal advocacy groups that spell out the process of individualized education and the law in simple language. So if a school official gives you the runaround, you can make confident appeals.

4) Talk to other parents who are in your circumstance or have already addressed this situation.

5) If you have a school psychologist that did a free psychological evaluation, and you feel like the treatment suggestions are too thin and vague for a teacher to use, say so. Many of the actual suggestions to help kids are very boilerplate and useless. After reading a thousand of these, they all sound the same. So how does that help your child? It does not help anyone.

6) In a perfect world, you would have your own personal school psychologist carefully read your child's testing report, and then give you exact ideas for the IEP meeting. Some might even come to the IEP meeting. These meetings can be scary for parents, simply because it is not something they do regularly.

7) Be careful about burning yourself out supplying the services the school is legally obligated to provide. Some caring parents drive their children all over town for educational services. If a child needs occupational therapy to learn different pencil mechanics, or special help with visual processing of words, or any one of a hundred different required solutions, the child is eligible to receive this help. As a society, we have decided this training is money well spent. Society knows if your child learns they will eventually become a taxpayer.

The School Does Not Fit

Andy is seven and resists going to school. He complains daily that he "hates school." His mother has a home business, and he keeps asking relentlessly to stay home. She visits the school occasionally. One day she had a minor revelation.

"I went into the school, and at first it smelled bad. Then I sat and ate with him at lunch—the food was terrible! I also spoke to his miserable, moody burned-out teacher. On another day, I watched as he played in the cold, wet outdoor lawn for recess.

I started to think that my son is 'going to work' from early dawn till late in the afternoon (by the time his bus dropped him off). This sure is a crumby life for a 7 year old. My boy needs more than twenty minutes of recess each day, and it should be indoors when the weather is hellish. And he needs more than a brief lunch with junk food, before lining up and sitting still hour after hour."

I came to the conclusion that this school environment was poor. It was anti-child and pro-teacher. Some schools are just not possible to fix."

So she took her son out of the school and starting home schooling. It was tough at times to get him to do his work, and his mother did find an extra hour a day of intense teaching a challenge.

"But I also noticed he was much happier being with me. At night, when I would tuck him in and talk, he would connect with me in a deep and affectionate way. It is more work to have him miserable than to do the teaching. " Mother knows best with this child. While many parents do not have the option of home schooling, other parents do. Yet they never consider it. Why? Some parents think they will hurt their child's socialization. A major doctoral paper shows this is not true. Some youth do better in a home educational setting.

Academics Ignored due to Psychiatric Issues

Tamara's mother had a severe bout of Major Depression that was poorly treated and caused her to stay in bed for six months. The depression started a month after Tamara's father died in a car accident. After her father's death and mother's emotional collapse, Tamara was diagnosed by her school's psychologist as having Post-Traumatic Stress Disorder (PTSD). She was given some supportive counseling but continued to struggle for three years. Tamara was just tested by a different school psychologist, since her grades have continued to worsen. The tester was surprised to see Tamara had been given therapy, but no support for her learning disability in reading. Now she is three years behind her class with an IQ of 97, just below average! She did not have the intellect to lose three years of tutoring.

Tamara had a history of exploding which made her teachers very uncomfortable. They really did not like her in class. What would help her?

1) Tamara's instructors must first be informed of her recent loss and her mother's illness. Two teachers had no knowledge of either event, and the youth was not walking around with a badge that said, "My father just died, and my mother is not functional." Certainly, this does not allow her free reign, but it may help the instructors to be aware of her recent losses.

2) Her instructors need to be taught her *exact abilities,* so that she is set up for success and not asked to do tasks above her limits.

   These abilities will be less than her previous ones, because now she is thinking about her father and mother all day, zoning out due to the grieving process and her inability to handle her loss.

3) Tamara's caretaker's need to check-in weekly with her teachers, so that the teachers can share what is happening in the class. This can be by phone, email, or letter. What matters is ongoing contact between caretaker and teachers.

4) Tamara was so far behind her peers in reading, that she was given training with an "English as a second language" teacher. This had never been tried in her school, but it worked very well for her. This class and style did not overwhelm her. They started with phonics and consonants.

5) Tamara was given *profoundly aggressive* special education three hours per day.

6) She was "checked on" *daily* by the school counselor for five months. At times they talked, but often the school

counselor just said "hello." The regular contact with a functioning adult helped.

Emotional Problems or Junior Criminal?

Doug was an eighth grade student receiving learning disability assistance. He was involved in some small thefts and occasional drug use. It was unclear whether he was a bad child or a child making bad decisions.

A bench warrant was issued for Doug by a judge, because he did not show up for a scheduled court appearance. Doug's court hearing was for bringing a knife to school.

He was put in a youth detention center. Then he was placed on Ritalin for ADHD and Tenex for impulsivity. However, he became very agitated and got into a fight.

After a new fresh evaluation, Doug was found to have multiple emotional disorders. He did have ADHD, but also had panic attacks and severe fears of certain places—agoraphobia.

1) Doug was treated with Strattera, a non-stimulating and gentle ADHD medication at half the lowest dose and then raised to a regular dose.

2) He was placed on Gabatril, a modest anti-anxiety medication. He was started at 2 mg with food at bedtime to prevent nausea and headaches. After three months he took 8 mg in the morning and at night. (Gabatril is the first medication of its kind. It increases the body's own anti-anxiety chemical GABA by preventing its removal.)

3) I also showed Doug ways to decrease his fears by special "cognitive-behavioral techniques" used by child psychologists and some child psychiatrists (M.D. s).

After nine months, Doug reported no anxiety. He had no recent fights, and also, since his anxiety was less, he did not feel the absolute need to carry a weapon.

The Magic of a New School: Hidden Exposure?

Julia gradually became more irritable and hostile in class. During my interview, it was unclear what was bothering her. She was asked to leave her school and went to another local school. In two weeks, her behavior problems surprisingly stopped. What happened?

Some might think Julia had a better teacher or liked the children better. I do not think so. Others might feel the expulsion "knocked some sense into her." I doubt it. And why did she have slight circles under her eyes?

One possibility is an exposure in the previous school:

1) The school had poor ventilation, causing very high carbon dioxide.

2) The school had both new rugs and new pressed wood in locations within 50 feet of Julia. These can release unhealthy gases.

3) The school used a number of floor cleaning chemicals, disinfectants, and bug and lawn chemicals known to bother a small percentage of people.

4) The school had "no more mold than what was found outside." As a certified mold inspector and remediator, I told them that indoor air *should be well filtered*, causing the indoor air mold counts to be *far below* the outdoor mold counts. Her school was forty-seven years old. I doubt it had avoided excess moisture and water leaks in half a century. Both create indoor mold.

Class Size and Teacher Temperament

Carrie and her brother Glenn were 10 months apart and in the same eighth grade class. They both had learning disabilities. Specifically, they were reading at a sixth grade level. They just had a great school year. Why?

1) They were each in a special class with only 14 students and with one full time aid.

2) Carrie was very sensitive to criticism. Therefore, she was matched with a very pleasant, warm, nurturing teacher that would forgive almost anything except truancy.

3) Her brother, on the contrary, pushed teachers. Therefore, Glenn was placed with Mr. Davis, a very strict military style male teacher. Mr. Davis was not interested in being anyone's father figure. He had the attitude that you were the kid and he was the boss. He did not tolerate any disrespect or bad language. Glenn did well in his small class.

Home Bound Schooling is Not Horrible

April was very ill, and her physicians could not figure it out. She was tired and had low energy. For her to go to school was too difficult. Once she blurted some curses at her parents about going to school, saying they were "clueless." Of course, she happened to be right, but I was not going to add gas to that flame.

Finally, she refused to go to school. She had two options: be declared truant or receive medical homebound instruction. Since I had just found a clear new medical illness, I prescribed homebound. Curiously, some school staff did not believe she was as ill as her labs showed. In some people's minds, youth illness only exists if you break your arm, almost die in a car accident, or get cancer.

April became increasingly sick. She slept a full fifteen hours a day. Her illness was eventually fixed, and she returned to school eight months later.

When her parents finally understood she was ill, and stopped seeing "homebound" as a failure, April did much better. She focused on getting well and saw quite a few physicians that first year.

Because so many of her friends were not mature enough to know how to relate to her, she ended up becoming closer to her parents and brothers.

In later years, she stayed close to her entire family. This was because her family finally understood that she was not faking anything, and cared for her in her time of need.

Trapping a Youth and Explosions

Terry had a problem with attachment. He could not socially connect with people. He also had mental retardation, severe learning disabilities, and severe emotional problems. Since he was not functioning at school or at home, he was placed in a residential care facility. He was regularly "exploding" at the facility.

1) Terry has little ability to express feelings, so when he is upset or afraid, he "explodes." Therefore, his caretakers need to learn which triggers upset him, since he cannot identify or recall why he got mad.

2) The last time he exploded, the Gym teacher refused to allow him to leave the Gym. Terry had just been poked in the ribs repeatedly by another sneaky student and was very agitated. The Gym teacher had not noticed this provocative behavior. Terry was "trapped" by the command to stay.

3) Terry's initial "behavior treatment plan" was poor and vague. When it was revised, it included very specific examples of what "triggers" him, and then highly concrete and specific solutions. Any generalizations like, "we will try to identify stressful triggers in class" is useless. The point of these behavior plans is to write down very exact behavior triggers.

4) Terry was set up with "escapes" if he got mad and agitated. He could go to the special education teacher, the behavioral specialist, the emotional support center, or the school counselor. He could also take a "time out" from his work at any of these places.

5) Many youth like Terry perceive a touch as an assault or at least a push. Hence, most should not be touched.

6) Yelling does not work with these youth. If you yell at them, they feel they can yell back at you.

7) Children need to see that if they do "x," they will get a "y" consequence. They also need to understand that their "x" behavior causes others to feel uncomfortable. This will take very simple and repeated instruction.

Gifted Placement Error

Patty has an "A" average and is typically in the 90th percentile ranking on psychological testing. However, she is ranked in the 27th percentile in processing speed and 35th percentile in working memory. After she was placed in the gifted program for two years, her grades fell to C's, and she became more and more annoyed with her divorced parents. She was also bossy with her teachers. She actually skipped two days of class to go "shopping."

Giftedness does not mean smart. It means a child is functioning three years ahead of their age! This is not merely advanced learning but a massive step into more complex schooling. If a child is not appropriate for these classes, they will have trouble.

Parents need to be careful not to become obsessed with giftedness and treat it as an intellectual status symbol. This is especially true if their child is content with their current classes. A child has to want to be in a gifted program. It is like going on a diet. If you are not motivated, forget it.

If a child is not motivated or able to function at this precocious level, they can develop depression, anxiety, and become oppositional. They can stop doing schoolwork and occasionally become truant.

Patty has two huge flags that show she is not suited for a gifted program. She has a low processing speed and a fair working memory. In gifted classes, the material comes at the kids fast and furious. A low processing speed will feel like the material is coming out of a fire hose. Low retention, or "working memory," will make it difficult to recall the classwork.

A "high IQ" in young children can drop over time. IQ is not as stable as previously reported. Children often have IQ's that drop in five to ten years.

Hidden Environment Problems and Nutrition

Household Fumes and Personality Changes

Roger is a 14 year old youth with a decrease in mood and school functioning. He has become hostile, oppositional, and reactive. His main interest is skateboarding with his friends, who his parents feel are well mannered. He enjoys complex tricks and had a small sprain last month. He is otherwise in perfect health based on a routine physical exam and standard blood work. His toxicology drug screen is negative.

Roger had a slightly red face and slowed thinking. I asked him to spell "world" backwards and to subtract 7 from 40. He did both, but it took too long.

When I explored Roger's skateboard interest, it became clear that the youth rode and cleaned the board daily.

He cleaned the board with an aerosolized tan chemical that no one was able to identify. Typically, he cleaned the board about 30 minutes a day in his garage, and was very careful to be thorough.

He denied sniffing the substance.

Roger and his parents mentioned the garage door was closed during the cleaning, and that the rags were left out on the workbench. The poor ventilation in the garage and continued evaporation of the rags were obviously a cause for concern.

The cleaner was discontinued entirely, and the youth was acting normally within 5 weeks.

When Nutrition Brought A Child Home

Michelle was the child of two traditional healthcare providers— a pediatrician and a nurse practitioner. For 6 months, she was severely hitting her siblings in the back and occasionally smearing feces in her bedroom. Her grades fell from outstanding to borderline failures.

Her irritability was beyond controllable, and she cried regularly for hours with no apparent reason.

Michelle asked her mother, "Mommy, what is wrong with me?!"

A previous physician had diagnosed her as being Bipolar based on his interviews and knowing two relatives had the disorder. As seasons passed, this respected academic child psychiatrist, an expert on mood problems, felt his medications could offer nothing further. They had helped partly, but there was "nothing more to add," since she could not be sedated by any additional medications.

Michelle had become much less assaultive and 50% less irritable but was still failing school and was fully unmanageable at home.

Because of the child's eccentric eating habits, which included junk foods with processed grain, trash fats that undermine brain function, and poor baseline nutrition, I felt there was nothing to lose by adding:

* A very high quality nutritional shake (flavorful peach, raspberry, or chocolate)—twice daily.

* Liquid magnesium and lime sublingual magnesium—since magnesium is involved in about 300 different bodily chemical reactions and has many roles in the brain.

* Omega 3 fatty acids—a tiny strawberry gel form made for small children or an enteric-coated variety (Fisol or Metagenics brands). Both are available at published

wholesale prices from my web site. These structural fats have been found to help many brain disorders and functions.

* A wide variety of B-Vitamins in a transdermal prescription cream was applied to her back in the morning, under some hypo-allergenic tape, as she slept.

I was very pleased to see, that in a week, the child was making some mild but quantifiable improvement. In two months, Michelle was at full baseline after being continuously ill for over 15 months. Her grades eventually rose to A's, and her behavior was fully age appropriate.

Her family and I had not expected such obvious behavior change. However, we all noted when Michelle stopped her supplements, she became manic, aggressive, and assaultive within three weeks. Her parents replaced them, and she returned to normal. Since then, they have aggressively kept her on all these supplements for 2 years. She has had no more relapses.

The body has many essential required nutrients. Few are consumed at ideal levels for maximal functioning of the brain. Dozens of studies and my personal research into essential nutrient blood levels, show most youth have clear nutrient deficiencies. Most are not so severe that they have severe deficiency disease like scurvy, but their levels are unacceptable. No one can promise your child will have Michelle's recovery or any observable improvement. Usually, I see no clear benefit with supplements on the behavior trouble of youth, but what is there to lose?

The Red Sugar Baby

Danny was an eight year old with a sharp mind, and a sharp tongue, who acted like he owned the world. He was a good student, had many interests, and seemed to generally be in normal health. Yet once a month, he seemed to act bizarre and aggressive. He could not sit still, would make weird jokes about "poop" and "pee," and could not sleep well. He would also laugh without reason for extended periods.

One family friend and a teacher at Danny's school expressed concern that Danny looked "manic."

His mother was confused by these behaviors and could not recall anyone in Danny's bloodline who was manic, bipolar or had ADHD.

She asked her pediatrician about sugar and artificial agents in food. He replied that the "entire idea of a connection between food and behavior is nonsense." Some months later, Danny's mother noticed his bizarre behavior a few hours after eating colorful "holiday" candy brought home from school.

She tracked the days he was bizarre, and found most of these brief episodes were associated with caffeine from sodas, more than two bites of artificially colored corn-syrup based candy, and food with miscellaneous colorings.

While most ADD, ADHD, mania, and behavior problems are *not* due to diet or the consumption of synthetic substances, there are *occasional* youth with striking reactions to some substances. These children do much better with food that does not "glow." And if corn syrup products are bad for adults, causing them to produce fat in six minutes, why would we think corn syrup is okay for children?

When food colorings and high fructose corn syrup foods were removed from Danny's diet, his behavior clearly improved. However, since so many foods carry these ingredients, he was accidentally given some 3 to

6 times a year. When he ate these things he had an eccentric behavioral reaction about 60% of the time. Twice he became sleepy and assaultive.

I suspect that most children *do not* have severe behavioral problems from these substances. The idea that most ADHD or mania is due to diet is taking an insight to an extreme, and ignores the massive genetic and brain research showing unique abnormalities in ADHD youth.

However, diet is making our youth more obese and setting them up for health problems. If you wean these from your home, the very worst outcome is that your child will eat healthier. The best outcome is that it *might* help a child's behavior.

The Hidden Agitators All Around

Claire has had epilepsy since she was young. Over the last five years, she has been more prone to rashes and allergies. She has also suffered from impulsivity, eccentric moodiness, and oppositional defiance toward her parents. She plays field hockey and has been getting testy with her coach. Her neurologist prescribes both seizure medications and psychiatric medications for depression, but the latter seem to make her worse.

Medications taken daily for years can deplete the liver of substances it uses to remove drugs and toxins. Even when liver detoxification materials get really low, routine lab tests will still look normal.

A tell-tale sign noted by environmental toxin oriented physicians, is that even low doses of antidepressants, other medications or herbs have very unsettling effects that do not go away immediately.

Once the liver is depleted of breakdown, cleaning, and toxin removal agents, you are more vulnerable to all sorts of allergens, and the allergy immune system becomes more reactive.

1) Claire took multiple nutrients to refill the liver with detoxification substances, e.g., she was given *sublingual* glutathione made by a compounding pharmacist—since it is poorly absorbed orally, NAC, SAMe, Milk Thistle, Vitamin C, and alpha lipoic acid. NAC is used to treat victims of Tylenol overdose as well as toxic reactions from dry cleaning fluid.

2) She lived in a home with a measured humidity of 73%. At 56%, you have dust mites; at 66%, mold grows and loads the body with mold toxin dust. She used a disposable MERV 11 filter in her AC air handlers to scrub mold dust out of the air. She also used ozone when she was away for the weekend to kill mold and dust mites. When she returned, she flushed her home for 5 hours with fresh air, since ozone is profoundly toxic.

3) Her new car and new home both gave off miscellaneous fumes and gases. The air conditioning intakes were then fitted with a thin charcoal filter on top of their standard one. A special gas grabbing charcoal product was inserted into the air ducts. And finally, some of her HEPA filters had a VOC filter added to remove the gases.

4) Some physicians feel that cholestyramine can bind some toxins in the intestinal track. She was placed on two packets per day between meals.

After 3-4 months, she was calmer, happier, and more relaxed. She "felt better" and had less "brain fog." Simply put, she related better to everyone and could think more clearly.

Her family believes it was these interventions that calmed her moodiness and defiance.

Put the Pedal to the Metal: Missed Heavy Metals

Daniel was an 11 year old boy with new mood, behavior, and school performance problems. The previous year he was fine. His home water was tested annually for six years with a basic test that only tested for iron. After some new construction on their street, his parents noted a change in their well water sediment. The water was retested with a basic test, and except for an increase in iron, no major changes were noted.

Over 5-7 months, the youth's behavior changed. He showed an irritable and depressed mood, easily becoming argumentative and oppositional. He had trouble focusing for prolonged periods, cried inconsolably and broke things intentionally. His test scores and handwriting skills also declined.

Two pediatricians, a family physician, two child psychologists, and a child psychiatrist evaluated him. ***Basic*** *lab testing was normal. He was "medically cleared" by the pediatricians who felt the youth had a psychiatric disturbance. The child psychologists diagnosed him with ADHD, Major Depression, and Oppositional Defiant Disorder. The Child Psychiatrist agreed.*

Daniel was treated with a special reward program at home, under a psychologist's weekly direction, and treated with multiple medications by a psychiatrist. All medication trials made him worse. The behavioral reward treatments did not produce change despite weekly modifications. The child cried inconsolably for longer periods, occasionally lasting up to 45 minutes. The parent's terminated all medications and behavior treatment, and sought other opinions.

The mother purchased four hair test kits that test essential minerals and common heavy metals (Great Smokies Diagnostic Laboratory: College of American Pathologists #31722-01 and CLIA License #34D0655571).

These results came back in the "excessive or positive range" for three of the four people tested from the home. Specific metals found were mercury, arsenic, lead, and cadmium.

As a general principle, heavy metals are dynamic and often migrate to brain, liver, kidney, fat, or bone. Heavy metals do not sit in blood, so the hair tests were regarded as a mere screening. The only obvious metal exposure noted was from arsenic treated wood used in the family outdoor play area. Play in this area ceased, and the wood materials were removed.

I ordered a new ***comprehensive water analysis*** and ***blood testing for mercury, arsenic, lead and cadmium***. Daniel's blood tests showed levels of two metals in the high "normal range." The boy's mother, however, showed blood mercury over twice the upper normal range. Again, since heavy metals do not float in blood, we tested the home water. It was strongly positive for lead, mercury, cadmium, and arsenic (Doctor's Data: CLIA License #14D0646470).

The parents decided on a trial of "NDF" or "Nanocolloidal Detox Factors" (a non-prescription product). NDF is an oral liquid tincture containing pulverized plant components in alcohol. The liquid contains 2-3 micron diatoms of chlorella (red blood cells are about 7 microns). Chlorella is used in industry, mines, and water treatment to bind heavy metals.

After only two weeks, he was playing games he had abandoned. In three weeks, he was affectionate with family and relatives, and was considered "himself again" by his teacher, getting marks in the top 15% of the class.

Helping Parents

The Mandatory Role of Babysitters

Will and Deborah have four children aged 1, 2, 5, and 12 years old. Their marriage is OK, but things are wearing thin. Deborah knows that Will loves her. For example, he tries to provide by working 10-hour days under tremendous stress. By the time he comes home at night, he is exhausted. Deborah, after a full day of parenting, is drained as well.

Justin, their 12 year old, is suddenly becoming oppositional and defiant. He talks back to his parents and occasionally refuses to come home when called. He also slams doors regularly.

In a perfect world, every person has 2.36 children born five years apart. Five years allows them to get plenty of foundational attention. But more than attention, it is hard for parents to meet the basic needs of multiple children.

In some cultures, women have supported polygamy just for the child-care help provided by the other wives. The idea of continuing to raise their four children alone, with only the help of a distracted father, was insane to them.

Justin is demanding attention from parents who are too stretched to offer him the time he desires. From his perspective, negative attention was better than no attention.

Solutions:

Deborah invited her mother to spend more time with her during the day and hired two college girls to come help her three days a week from 3-8 pm.

After a few weeks, Deborah really noticed the help she was getting. She was able to take some time out with girlfriends, do some yoga, and fi-

nally found herself being drawn to Justin more. Her husband found that when he came home, the kids were more settled. He also came to realize how disconnected he felt from Justin. Over the next few months, he and his wife spent extra time with him playing chess and computer games, making unusual foods, and going out for small meals.

In four months, Justin's oppositional behavior was reduced two-thirds. In six months, it was virtually gone.

Be realistic about the demands of parenting and the limits of your time. Supportive trusted adults help you maintain a connection with your children at a critical time. "Babysitters" can be a gift to kids, offering play, attention, and lightness. Parents receive the gift of rest and refreshment that allow them to have more capacity to care for their children.

A Parenting Coach

Mike is a 15 year old youth who is becoming much more distant from his parents. His grades are now C's after being solid B's for years. Each day, he watches two hours of TV and spends one hour instant messaging his friends over the Internet. His longest sentence is, "I don't know."

Is Mike OK? Is his behavior normal? What boundaries should you set up for him? Sometimes good friends or relatives offer helpful advice with these challenging parenting issues.

But for many youth a parenting coach is needed who has the time to learn the *unique* problems you are having with your unique child. A parenting coach is a mature therapist or mentor who exists *only* for you, and not your child.

For example, if Mike knew he was confiding in a counselor and then learned it was your personal parenting coach, he would get silent fast.

The parenting coach is not someone who tells you what to do. They help you process different options that fit with your goals for your child.

A coach is useful to consult while parenting a child of any age, but one particular age span may require prolonged assistance. Specifically, a youth can seriously derail between the ages of 15 to 18. The bigger temptations have already started by age 15. If the youth can make it to age 19 without too many severe mistakes, the future looks very promising.

Runaways & the Police

Kim is a 16 year old who has become "impossible to manage." She hates her stepfather, who intervenes when she verbally abuses her mom. In the last month, she has thrown small books against walls. She now curses regularly and usually misses a day of school each week. Kim said she was going to a girlfriend's house one night, yet when her mother called at 9 pm, she was not there. When she finally came home at 2 am, her mother responded with minimal agitation, and yet she still left again the next night.

A child who is impossible to manage is in need of firm boundaries to prevent escalation. A youth who runs away may end up at a friend's home, but they may also end up drunk, using drugs, or acting out sexually.

In this culture, a youth at sixteen is not allowed to be out at 2 am. Call the police, and allow them to augment your authority.

Solutions begin one day at a time with the re-establishment of sanity.

Explain that you are not trying to upset her or ruin her "fun," but that you love her and she is out of control. Make it clear you regret having to call the police, but she left you with no other option. You did this because you love her and that she cannot be replaced. Further, your child should be reminded that bad consequences tend to increase the later someone is out at night.

Set the limits for a child who is wild, but make it clear you do not enjoy restraining them with police.

I Can't Get The Facts

Garrett is a 15 year old who seems normal one day and troubled the next. His parents just noticed their son has red eyes, but he explains he accidentally put caustic contact lens cleaner in his eyes when inserting them. He comes home very late and reports that his friend's car broke down. Calls to the friend's mother confirmed that the car was "having problems starting" but functions properly now.

Garrett's parents "feel like they are losing their mind" when they try to follow their gut and explore suspicious "mystery events."

Youth assume privacy. But if you suspect they are having serious problems with alcohol, drugs, illegal activity, sexual risk taking, or dangerous thrill-seeking behavior, you may want to monitor them.

"Monitoring" will violate boundaries that your children and their peers believe are rights. If you overdue your investigation into their personal side, they may briefly hate you. If you find something they are doing wrong, they will immediately balance their guilt by accusing you of violating their space. But these types of actions are sometimes necessary for long-term safety.

Match your investigations with your fears. If you are only worried about a child smoking cigarettes, do not hire twenty retired FBI agents.

Options:

1) A small voice activated recorder can be placed on you home phone which records all calls and is easily hidden. (Consult your family attorney to find out whom you cannot tape).

2) Computer monitoring software allows you to see all instant messages, emails, and web sites visited. Since the computer has replaced the phone for some youth, this

is an area in which there is no privacy—it is your computer. Many crimes are being solved by evidence from computers.

3) Some parents fear what goes on in their home while away. A home video recorder can survey outside or inside public areas, or you can place smaller concealed video devices in clocks, smoke detectors, and other common enclosures. Wireless versions exist but cost more. It is also possible to install a video camera in a car pointed at the speedometer and front view on a 24-hour recycling tape. Digital devices have better images than older devices.

4) Search their bedroom.

5) Search their book or gym bag.

6) Perform a clothing pocket search which looks for less obvious smells, drug residues, or spills associated with alcohol and/or drug use. Keep in mind that any article of clothing can be altered as well, e.g., hidden pockets within the lining of coats or baggy pants.

7) Search areas of "low traffic"—shed, attic, basement, crawl space, under outdoor rocks, and bushes. These all make good hiding places.

8) Hiring a licensed private investigator is often worth the money and not as expensive as you might think. They can covertly follow your adolescent child for two nights on the weekend for a modest fee. If your child is in trouble, they are not going to a church. Use an investigator with a good reputation with local law firms or one that has good references. Call the references. Finally, investigators can often locate the names and criminal background of any

person with a car who meets your child or drives them. Some of these people will be well known to local police, and many investigators have close relationships with local police. They share information. For example, the private investigator may easily learn from local police that the "friend" your child met is a known drug dealer.

Medication Errors and Correct Use

Aggressive Irritable Depression

Len is 14 years old and speaks to adults as if he is dying from boredom. He is distant, uncooperative, and annoyed. He sits low in his chair with a slouch that portrays a dismissive attitude. His grades have fallen from B's to F's. He is very hostile, argumentative, and yells back at you for trivial reasons. He seems to do little else but play computer games and "hang out" with a few local friends. His only recent stress is a move three years ago.

Biological Depression in children and adolescents is not easy to see. The signs or symptoms are not obvious. Depressed youth usually do *not* appear sad and often still enjoy some activities. Behaviorally, they commonly are hostile, irritable and moody. Many become more prone to verbal fights partly because depression thins a child's defenses. Any mild annoyance produces an excessive reaction—they seem to be dressed in rice paper during a hailstorm. They seem frustrated with everything and have increased boredom.

Many practitioners are satisfied with a 60% improvement in children like Len. But Major Depression has a death rate of 15% and must be taken seriously and treated completely.

Medications

Some oppositional youth will not take medication without a reward. Do not assume they will be "reasonable," since medication may make them feel flawed. Yet once they feel better, they will often be willing to take their medication without incentives.

Most anti-depressants are started at doses far too high. This sloppy care causes anxiety, restlessness, nausea, and headaches. This is especially true if a youth is already anxious. Likewise, youth that are already oppositional or inclined to reject medication, will not accept any side effects and will reject any medication that causes discomfort.

Solutions:

Use a pill cutter on caplets or tablets to make the first dose 1/4th of the recommended dose. If the medication is in a capsule you can open the capsule and approximate 1/2 the first dose. If you are very eager to speed treatment, you can always take another 1/4 dose in 6 hours if there are no side effects. You can always increase the medication fairly quickly, perhaps a half tablet a day if there are no side effects. Common signs you are taking too much medication too fast include *new* onset of vivid dreams, insomnia, headaches, sedation and nausea.

The starting dose has nothing to do with the final dose of a medication, which may need to be high.

For simplicity, let me only mention a *sample* of key medications and common errors in using them in an outpatient setting:

Lexapro—a pure medication with no useless metabolites. However, the first dose should be 1/4 of 10 mg. Most physicians start with 10 mg. If your child has no side effects, the dose can be increased to 5 mg after 2-3 days, and 10 mg after another few days. For convenience, a liquid form is available for youth who hate pills and for low starting doses (like 2.5 mg). If you feel the need to rush, you can increase your child 1/2 of a tablet every 24-48 hours. If you are going too fast, you will see or hear complaints of side effects.

Effexor—a useful medication for youth who do not respond to gentler anti-depressants like Lexapro. The starting dose of 37.5 mg is usually too high for the first few days, so open the capsule by pulling it apart. Please have the child's blood pressure and pulse checked with each dose increase. Battery powered automatic arm blood pressure machines are $40-$80.00 and are usually accurate. Consider buying one. Most physicians do not get blood levels, but peak blood levels are useful if doses over 375 mg are needed. The company markets the drug as a once a day medication, but

to prevent mild withdrawal symptoms in some, consider splitting the dose and giving some in the morning and most in the evening.

Wellbutrin SR—the starting dose should be 1/4 of a 100 mg slow release tablet. This fraction can be cut approximately with a pill cutter sold in any pharmacy. If the child has no side effects, the dose can be increased by 1/4 of a tablet every 12-48 hours depending on your goal — quickly stopping suicidal feelings or improving mood with no side effects. According to new research, *it can be cut but not crushed.* It is not useful for anxiety, unless the anxiety is purely a part of Major Depression. The dose can be raised quickly over days if there are no side effects. It helps some youth with ADD or ADHD, but this benefit can be overstated.

Zoloft—a medication with a long history of use in youth. A careful first day dose is 1/2 of a 25 mg tablet but it can be raised quickly thereafter. If the benefit is lost over months or seasons, it may need to be raised fairly often. In my research on Zoloft blood levels over the years, they seemed to fall commonly. This is not information known by most child psychiatrists.

The Most Effective Natural Treatment

SAMe—we use this natural liver substance in youth when the child or parent wants a natural treatment. Its main side effect is anxiety. If this occurs the dose is too high for your child or the child may have a vulnerability to mania. Like all anti-depressants, SAMe can induce mania in bipolar youth with as little as 300 mg. In youth who have manic relatives or possible mania, start with an oral dose of 200 mg. Increase by increments of 100 mg until reaching 600 mg. All doses should be taken in the morning. If there are no problems with 600 mg, it is doubtful mania is an issue.

A young child might only need 200-600 mg. A larger adolescent may need 1000-1600 mg.

If your child has belly cramping or other intestinal side effects, consider our patent pending transdermal SAMe cream. This special SAMe cream allows you to bypass sensitive intestines and the liver and deliver 400 mg through the skin (equivalent to approx. 1200-1400 mg by mouth). The cream form of SAMe probably costs less, and prevents the loss of SAMe due to limitations in intestinal absorption or liver removal. While we have a lot of research on SAMe use in adults, there is little research in dosing youth.

If you want the best price for oral SAMe, we have found that my wholesale price of thirty 400 mg tablets at $20.00 is perhaps the best in the country, and can be ordered from www.personalconsult.com.

What Are You Looking At? You're Always Against Me!

Tom and Michele are youth with four other well-behaved and functional siblings. Their parents flew in to see me from Wyoming and brought both kids. They explained that Tom and Michele were "different" and had some "eccentric behaviors."

Specifically, Tom had no history of trauma but talked as if traumatized. Tom believed others hated him based on a glance or a smile. He had a fight 7 years ago with another young man he perceived as staring at him. "I can't tell if he is insecure, paranoid, or both," his father says.

"Michele is always preparing for a lawsuit," her mother explains. She takes notes of disagreements and offenses, imagines great wrongs done by her siblings, and argues points that make no sense. She also has eccentric beliefs that her art is amazing when it is just okay."

In looking at the family's genetic history, we found that two Aunts had schizophrenia on the father's side. The mother's family had an uncle who displayed eccentric behavior with possible hallucinations. Two of the relatives were currently on psychiatric medications. If they stopped them, they did poorly. It may be possible that both youth have acquired

a *trace* of their relative's severe illness, which is manifested in paranoid perceptions and seeing the world as constantly threatening.

A Course of Action:

1) Get the exact details and symptoms of all relatives with psychiatric illness.

2) If you can get the exact medication experience of blood relatives, note what medication helped or failed. However, some medications that "failed" were probably started at doses that were too high or were not raised high enough.

3) Though they may refuse, the youth should be assessed for mild psychosis or personality disorders through brief psychological testing. Two possible tests psychologists use include the MACI and the MMPI-A. Some rare psychiatrists (M.D.'s) also get trained in them.

4) Have them meet with a psychiatrist. Provide a two-page terse summary of the family's genetic history and observed eccentric behavior. Allow the youth to react indifferently, perhaps even implying they are only doing this for your peace of mind. Your child may not be able to accept they have a problem at this time.

5) Low doses of anti-psychotic medicine often will slowly correct their distorted perceptions. It is important to start with very low doses since they may become paranoid about medication, especially if they feel any side effects. I am not aware of any herbal treatments that have good and clear studies to show they help paranoid feelings. A few Asian herbs are reported to help decrease psychosis,

but they have other active brain chemicals which might cause side effects.

6) As always, the medical causes of mental illness need to be ruled out, especially the ones in the first section of this book that are usually missed by most sincere physicians.

New Agitation With Medication

Eddie was moody for the last year and very hostile. When he started picking on his younger sister too aggressively, his parents took him to the family doctor. The physician felt he was depressed, reminding everyone that depression ran in the family. Eddie was started on Prozac 20 mg. Over the next 5 weeks, Eddie seemed to be worse and more agitated.

He was removed from the Prozac and started on Paxil CR 20 mg. The family doctor thought that Paxil would be useful, since it is advertised as good for anxiety. However, Eddie was again more restless, aggressive, and hostile. His parents were confused. They had always thought the doctor was quite smart and helpful.

Eddie could have one of five causes for this unusual worsening of his condition.

1) We have found that many youth can get akathisia from antidepressant medications. What is akathisia? It is a serious restlessness and agitation caused by some medications. This is a well-published side effect in leading psychiatry journals, though poorly known by busy physicians. Prozac, Zoloft, and Paxil have many studies showing this problem. Despite the fact Celexa and Lexapro have thousands of studies, it is very rare in them—perhaps due to the absence of dopamine stimulation.

2) Some youth can develop a hypo-manic or manic state from a medication. They become eccentrically irritable, loud, sleepless, impulsive, and *extremely* moody. Full detailed symptoms can be found on the Internet under "mania." Antidepressants can bring out mania in a bipolar person or cause a temporary "medication mania" that typically goes away when the medication is stopped.

3) Most starting doses are meant for "simple" dosing. However, simple often means too high, especially during the first few days. Generally starting with a whole tablet or capsule of any size, is too much for the first day. If you are not using a pill cutter, it is often too high a dose for the first day. If the medication is a capsule, pull it apart or cut it open. It is better to give 20-40% of the capsule contents than the entire capsule—if you want to avoid side effects. You can always increase the dose quickly if no side effects are present.

4) If a youth has *any* anxiety symptoms, they usually cannot tolerate standard anti-depressants at common starting doses. Most should be treated for a week with no more than a 1/2 of the smallest size tablet. Many sincere physicians start at the FDA recommended dose or the pharmaceutical campaies' suggested starting dose. Since the FDA raids some of the best physicians in the US and opposes positive comments on the benefits of *essential* nutrients, their medical positions are often flawed, including their dosing advice for individual children. Pharmaceutical companies usually only test their medications on small numbers of patients and often their medications are not tested on children. So after five years, dose patterns often change as savvy clinicians notice that recommended starting doses need adjustment.

5) If a youth has an insufficient amount of detoxifying components inside their liver, they can have an eccentric restlessness and a poor response to the medication. If a doctor does not know what this means, they have not been exposed to environmental toxicology research. Unfortunately, most doctors have not studied this material. On my web site I have two articles that discuss the way the liver removes medication. I discuss the use of NAC and glutathione which are two common chemicals *required* by the liver to work optimally. A routine liver function test will *not* show if a child has low NAC or glutathione. For more information, go to www.personalconsult.com with the search with the word "liver."

One final concern I have is that all children have a wide array of toxins in their body, and some may be stuck in liver enzymes, like a baseball in a pitcher's glove. If you take a new medication, the medication might kick off the toxin from the liver enzyme. The toxin then goes around the body and makes your child feel ill.

Your Child's "Bad" Friends

Friends From Hell

Angel made a serious transition in the last two years with her friends. Now her mother Ann is very worried because Angel's friends are too casual about school, regularly drink alcohol, smoke pot at least weekly, smoke cigarettes daily, are sexually active, and all seem to be fairly non-compliant with their parent(s).

Angel feels she has a constitutional right to her current friends.

Certainly they have filled some void after her parent's divorce four years ago. However, as the song goes, her mother feels certain that Angel is on a "Highway to Hell."

"If I do not get her away from them, I feel there is no hope for her." Her mother said.

Since I am not one to argue with a reflective and concerned mother, here is what she did:

1) Her mother set up a six-month plan to wean her daughter away from this particular group of friends. She did not want a sudden intense reactive fight with her daughter which she thought would be imminent if she acted to terminate such profound attachments abruptly.

2) She coordinated a series of events with a *combined goal*—adding pro-social exposures with good kids while making it increasingly harder to see her friends.

3) The computer was moved to a desk in the family room, a very public area, and a new "parent only" password was put on the computer to control and limit Internet communication with her daughter's bad friends.

4) Phone calls to friends were not allowed after 9 pm.

5) She could not go out past 6 pm on weekdays and 10 pm on weekends.

6) Angel loved the theatre. So her mother took her to a play each week, even if it fell on a weeknight. In fact, she helped Angel meet a few directors. Four months later, Angel got a regular part in a play. Not everyone in the cast was a good influence, but most were better than Angel's current friends.

7) The family doctor, a long-term friend and "uncle" for Angel, was asked to discuss the use of a nicotine patch for smoking and birth control—specifically birth control options that would work in a "forgetful" girl and condoms. While he made it clear the best form of birth control and healthy romance was avoiding intercourse entirely, the physician was not a fool, and he knew pregnancy was possible since Angel was impulsive.

8) Angel had two cousins she enjoyed. Ann worked to increase their contact, inviting them to go shopping with her and Angel. They also had some movie nights together, some DVD movie rentals at home, and some at a local movie theater with occasional sleepovers. The cousins really liked Ann, so they enjoyed coming over to visit. As for Angel, she slowly went from tolerating these visits to generally appreciating them.

9) Ann explained that Angel would have to join her at a local church, which had a very active and lively youth group. Angel refused to go the first week but Ann explained that until Angel lived elsewhere and gave up her free board, she would have to attend. She ended up meeting 3-4

youth over a number of months that she liked. In order to promote these relationships, Ann relaxed some of her rules on phone calls and emails from "church friends." These youth were not perfect, but at least they did not aggressively get involved in routine illegal behavior.

Feeling Like a School Loser and Predatory Boys

Leslie was 14 years old and had a very tough defiant attitude. All her classes were in special education. She complained of "hating school," and that it was "boring." She said she was "not learning anything." Leslie also despised her homeroom teacher. Leslie had received eight days of school suspension over the last school year.

She has recently been spending a lot of time with her boyfriend Randy. Her mother is concerned about the relationship.

Solutions:

1) Leslie has to have a better experience at school. This will require some careful reflection on a tailored educational program. If she feels like a loser, she will stop going. This will require more than a few burned out school staff indifferently doing an "IEP." Please look over this book's "School Problems" section for options.

2) Biological age and body development have nothing to do with emotional maturity and insight. She has refused psychological testing for years. She must be required to take the testing and be rewarded profoundly and/or given strong consequences for not doing so.

3) Eventually, Leslie was allowed to get a dog from the local rescue shelter for doing the testing. The educational testing revealed that she was reading at a *kindergarten* level.

Her IQ was in the high mentally retarded range. Hence, her defiant toughness essentially was used to hide her inability to read.

4) Her boyfriend rarely spoke with Leslie's mother. He was relatively unknown. However, learning that Randy was "conduct disordered," prompted Leslie's mother to end the relationship. The risk of Leslie becoming pregnant was an immediate concern, since conduct disordered boys can easily take advantage of mentally retarded girls. Leslie's safety had to be considered as well. Randy had a history of thefts, fights, school suspensions, and had spent time in juvenile detention. Some conduct-disordered boys are not charming, have poor social skills, and can scare regular girls. They prefer relating to girls like Leslie, because they feel "safer."

Structured Clubs and Programs

Gil was taken to a psychologist at the age of 9 and diagnosed with ADHD and Oppositional Defiant Disorder. His parents went through six medication trials and read a number of books related to these diagnoses. They now felt that the ADHD was fairly well controlled—Gil had less impulsivity, hyperactivity, and distraction. They had hoped the constant arguing and defiance would decrease. It did some, but only about 1/3.

Solutions:

1) Structure can come from many places. For Gil, he improved with a Karate master and a mentoring neighbor.

   * Specifically, Gil wanted to be tough and strong like most boys. The Karate master had very strict rules, codes of conduct, and formalized respect. For example, respectful bows were given to the sensei (or teacher) at the start and end of each session. Testing

boundaries and pushing the teacher earned you extreme amounts of push-ups or cleaning duties. Quickly, Gil understood the message that if you wanted to learn how to fight well, you will act appropriately.

* Gil also loved cars. His mother noticed that Ron, a neighbor and close family friend, worked on his cars every Saturday. She asked her husband what he thought of having Gil spending some time with Ron. He agreed this was a good idea if Ron was receptive. They would also think of a way to return the favor.

  Ron was a former military man and understood the request before Gil's father finished his sentence. Ron said he would "try it out for 2 Saturdays. Then they would decide if it was a useful activity." Gil's father almost saluted and said, "Yes, Sir!"

  Ron told Gil to come to his garage at 10 am sharp. This would allow some extra sleep time for a growing child's body, yet with some structure. Incidentally, Gill arrived at 10:30 the second Saturday and was "kindly" sent home.

  "Sorry Gil, love your company and help, but the deal was 10:00," Ron explained. "I hope to see you next Saturday when I work on my transmission. I'll show you how to change one over."

  Both the Karate master and Ron promoted a positive structured environment that helped Gil be more compliant in other settings. Fusing mentors to your child's interests is a good thing. If your child has un-

usual interests, explore the Internet with them. There is bound to be some helpful information to get them started.

2) Depression from ADHD does not last long—typically less than an hour. Regular biological depression is present most days most of the time. The later should always be considered in youth with oppositional behavior or ADHD. (25% of ADD or ADHD children have depression).

3) A child therapist should assist you in setting up a behavioral plan that rewards obedience and results in lost privileges if disobedient. Expect the child to blow a gasket with any limitation in "freedoms." And expect the first three plans to fail as they become tailored to your child. A disobedient child wants you to give up and become demoralized in the power struggle.

4) Look for any alienations or underlying hurts (physical and/or emotional trauma) that may be bothering and discuss them, e.g., excess screaming or hitting, loss of a parent through divorce, death of a close friend or relative, problems at school, lost relationships, or a move. These can increase oppositional behavior and restlessness that looks like ADD or ADHD. If you are a good listener the child may oppose you less because of your attention and care.

Distracted Overworked Parents & Youth Rage

Mitchell was 28 years old when he came to see me, yet struggled with an issue from his youth. After a few months, he seemed to be increasingly angry in our sessions. That was good, because he was easily angry with others at home and work, and I felt it was better to get this anger "into my room" so we could work on it. We explored why he was angry and little seemed to be truly significant in the present. He was mad at his single mother for her unavailability while he was growing up.

"She actually volunteered for different church and community events and we had no father! What 'extra time' did she think she had? I would ask her for help with my homework, to do something fun with me, or to drive me somewhere—it always seemed a labor!!"

Solutions:

1) It is very hard to be a parent. Who does not make a parenting mistake every week? And being a single parent can be even more challenging than what couples handle. So if you have made a mistake, apologize fully, clearly, and soberly. If you have been distracted by something, admit it and express your love for your child.

2) If you are involved in a project or enterprise that is not required for your survival, consider dropping it if you have limited time with your children. If you are unsure, ask your trusted family and friends their opinion. Ask them if they sense possible alienation in your children toward you. If you do not ask, they may not mention their observations.

3) Once you get involved in a project or enterprise take a fresh look at your relationship with your children after a month, as well as each season. And *ask them directly* what they think about your time with this project.

Severe Aggression—Unable to Stay in Home

Oppositional Adolescents with a Connection to a Relative

Michael is a 17 year old junior in high school who rarely studies. He is constantly fighting with his parents and talks to them as if he was their president. He has no clear depression and has regular disrespect for his teachers and parents. He has tried alcohol and marijuana but does not regularly use either—"they are for idiots." He wants to stay out every night until 3 am and refuses curfews. He does not respect anyone but his Uncle Vincent, whose wife died in a car accident 2 years ago.

Michael has some struggles with standard authority. But some youth do respect some authorities. Sometimes these "authorities" are famous musicians, actors, or professional athletes. On occasion, it includes a family member or members who connect with the child in a *special* way and are also *trustworthy*.

Uncle Vincent was open to having Michael stay with him; so Michael lived with him his last year of high school. Uncle Vincent was even able to do some mentoring. Michael seemed to test boundaries much less and connected well with his uncle.

Michael graduated with a high school degree, worked at Uncle Vincent's company at an entry-level job for 9 months, got bored, and then went to college. He graduated in 3 1/2 years in the top 20% of his class.

No Chance of Control: The Dangerous Bull

Eric is a 16 year old in serious trouble. He has had arrests for distribution of drugs, has been in multiple assaults, has often missed school, and steals from his mother. He is having regular unprotected sex and seems to care little about this risk. Occasionally, he has fights in which he gets hurt or hurts someone else severely.

In many ways, Eric is easy to treat. Unless he has mania or suffers from hallucinations or delusions, he should immediately go to a residential treatment facility. He is out of control, and when he becomes 18 (in many states), your ability to influence his life will be minimal. He is like the gunshot wound victim who is losing blood. If you do not radically and immediately stop the bleeding, he will be lost.

He is showing signs of profound impairment, a lack of impulse control and a poor conscience. Eric needs a long-term treatment environment. These come in many forms.

1) Some are paid for by the juvenile court system, and involve having the family court take control of your child. They will send your child to a juvenile center that has structure. You might seek the help of a probation officer, or hire a lawyer familiar with juvenile law *in your area*. They must serve as *your* consultant, not your child's. Lawyers do not represent two people at the same time. If the attorney is working for your child, they will have to fight for your child's freedom—the last thing this youth needs!

2) Your school district is obligated to provide an *appropriate* educational experience. If your child is severely out of control, they may have to pay for residential treatment and education. Do not expect all schools to do this without pressure from a parent. You often will need educational or legal advocates to help you with this process, since such residential treatment facilities are very expensive and school districts have limited funds. Delaying such placements does save money. But any delay also allows your child to hang on the edge of a cliff—bureaucrats may be too slow to pull them away from a fall. Therefore be very aggressive. The youth needs a residential placement NOW.

3) Even a jail or a correctional facility is at times a useful short-term treatment.

4) Some youth are 18, yet emotionally have the maturity of a 14 year old. If you need to have your child remain in residential care, the state of Alabama allows for continued parental authority. This option requires you to get the youth to Alabama, and to find a program that fits your child with an opening.

5) Be careful about rescuing your child from a "bad" residential setting. Some abuse does occur rarely in some facilities, but many youth like Eric are skilled manipulators. If you help your child "get out" of residential treatment, you may be rescuing them from crucial help or from a place that curbs them from further criminal activities.

6) Some private residential programs will send "escorts" to take your child by plane to their residential facility if the child is under 18. This can work successfully with some youth.

Boot Camps

Lauri is 16 years old and refuses any curfew. Her mother and stepfather took her license. She still sneaks out and meets her friends at late hours or just does not come home. She is failing at school. She rejects her parents' plea for any outpatient treatment. Because she has missed so much school and is unwilling to comply with basic rules, her parents took a special step.

They decided to use the local family court to assist them in having her sent to a boot camp for 30 days.

Boot camps are highly variable, so you cannot assume any are beneficial or poor. Over time, local officials may get a sense of their quality. Ideally, they should offer you some information. Some may even let you visit and survey the program before your child is sent. However, this is not always functional. At least make sure they have a license and access to medical care.

My major concern with quality camps is that parents may simply expect too much. While change may occur, it is a type of "jump start" change, and not a magic place. As soon as the youth returns, they must have a solid and complete treatment plan at home, or any progress is often lost.

I am often stunned to see parents resist my treatment plan after a boot camp or a rehab. They are casual and think that it is OK to place this "return to home plan" low on their "to do" list. This is simply ignorance of how change is maintained after a mountain top experience. A "return home plan" must be in place with specific treatments and accountability to ensure any measure of success. Otherwise, expect a relapse to many of the old behaviors.

Your child's therapist and probation officer may have ideas on what should be included in your child's treatment plan when your child return's home.

Self-Harm

The Cutting Youth

Kelly is 15 and a "difficult" child. Last year, she mentioned to her aunt that her uncle repeatedly "touched" her sexually when she was younger. She is moody and irritable and it does not follow any particular pattern. She also has scars on her arms and stomach from cutting herself.

Cutting is not a coping method most of us use. However, it is common and functions in a number of ways, including helping people who feel they are "dissolving" pull themselves together.

Cutting is easily reinforced, because it usually gives the person some relief—it does *not* hurt like a paper cut. You likely do not have any understanding of this experience, and that is fine. It is better that parents assume they do not know how Kelly is feeling. Most parents have no desire to cut themselves or know the relief that it offers.

Solutions:

1) Part of treatment is identifying all the triggers that promote cutting and discussing these issues to get them out on the table, e.g., a harsh word from a boyfriend or a poor grade in a class. Counselors can offer other ways to handle these types of frustrations.

2) Watch anti-depressant starting doses. All serotonin anti-depressant medications can have akathisia (a special uncomfortable agitation which makes you want to move). Lexapro and Celexa seem to have less of this side effect, but start with 1/4 to 1/2 of a 10 mg Lexapro or 1/2 of a 10 mg Celexa.

3) Look at the triggers for cutting. There are many common ones:
    a. Feeling trapped
    b. Anger and resentment
    c. Overwhelming feelings
    d. Sadness
    e. Boredom
    f. Loneliness
    g. Stress
    h. Guilt
    i. Relief
    j. Zoning out
    k. Togetherness with other cutting youth
    l. The medical disorders in the first section of this book.

4) Medication can stabilize moodiness and reactivity to some extent. Although it is not as useful as in other disorders, it does help. Common medications are Lexapro, Celexa, Paxil, Neurontin, Lithium, and Depakote, though the latter has weight gain. Gabatril may have benefits starting with 1 mg at night and increasing by 1 mg every 5 days. If sedation or nausea occurs, simply take with food, or slow the dose increase.

5) Some patients feel relief from cutting. Some think cutting gives a narcotic-like experience and may respond to anti-narcotic medications, e.g., Naltrexone.

6) Contact with other aggressive cutting youth may need to be limited, since cutting can be a "contagious" coping method.

Suicidal Behavior

Nancy broke up with her boyfriend, and then had a really intense argument with her mother. A few hours later her sister walked into her room and found two bottles by her bed. Although it was unclear if she took anything from them, she was very hard to wake up and fell right back to sleep after 20 seconds of being awake. Her mother called 911. After being treated in the emergency room, Nancy was transferred to a psychiatric hospital.

Suicide is a leading cause of death in youth.

Here are crucial suicide basics, balanced solutions and preventive measures:

1) Do not trivialize suicidal talk or "gestures." A youth taking a small number of Benadryl or scratching a wrist is a form of "communication" that requires your "attention." They are at a higher risk of committing suicide and are "asking" you to help them. Any sadistic person who mocks a child like Nancy for wanting attention is ignorant of the reality that such youth are often successful at killing themselves. They need serious and complete treatment. It is not a time to use the cheapest psychiatrist and therapist in your HMO insurance plan.

2) Feel free to ask the youth if they are having thoughts or desires to hurt themselves. If they refuse to discuss it, call their therapist and/or psychiatrist. Avoidance can be a sign of suicidal thoughts.

3) Remove all guns, sharp knives, and any full bottles of prescription or over-the-counter medications from the home. For example, an overdose of Tylenol or aspirin is profoundly deadly and causes a horrible death if emergency care is not provided promptly.

4) Buy a bottle of activated pharmaceutical charcoal capsules. If your child takes an overdose and is awake, they can take some capsules while you wait for an ambulance or drive them to an emergency room. Activated charcoal capsules will absorb *some* of what they swallowed. The charcoal must be "activated" and it should be in a thin capsule that will dissolve in a minute — do not buy rock-hard tablets.

5) If a youth overdoses, bring any medicine bottle near the child, and do not delay transporting the child to the emergency room. Never assume just one type of medication was taken, since combinations are common. Emergency room physicians need to be reminded of this also. If you have a cell phone, call the ER to tell them you are coming and give them any data they request. If your child is *drowsy or* unconscious you cannot accept waiting in an ER waiting room—a significant overdose can be more dangerous than a heart attack.

6) Youth who abuse drugs are at a higher risk for suicide. Nothing can rule out drug abuse except regular toxicology screens.

7) Youth with relatives who have tried to commit suicide are at higher risk. Suicide is a genetic coping method. However, in my practice if an adolescent and their parents are well educated about depression, and if the youth is treated until they have absolutely no depression, the risk of suicide is low.

8) If a youth has trouble with suicidal tendencies, do not accept a prescription for psychiatric medication from a neurologist, internist, family doctor, or pediatrician. If they have not been suicidal for 9 months, and money

is tight, they can be referred back to these individuals for refills, but only after a child psychiatrist determines they are stable. Further, they must see a child or adolescent therapist weekly. The most common options for this would be a child psychiatrist (M.D. or D.O.), a child psychologist (M.A. or Ph.D.) or a licensed clinical social worker (M.S.W. or D.S.W.). Any practitioner should have at least five years experience working with youth.

9) Common triggers that increase the risk of suicide:

   a. Anxiety, panic, or agitation
   b. Hopeless feelings
   c. Loneliness and isolation
   d. Sudden loss of a loved one or loss of a boyfriend/girlfriend
   e. Sudden changes at home or school
   f. Feeling trapped or unsafe
   g. Alcohol or drug use

10) Two other suicide triggers deserve special focus:

   * *Medication blood levels fall to useless levels*

   Many medications stop working as the liver gets used to them. The liver does not make enzymes wastefully, but will keep making more to remove a medication when exposed to it. Meaning? Expect an effective medication to need at least two increases after a successful dose. If no one is monitoring the medication's effectiveness, a youth can become depressed and hopeless again. Most youth are not going to think they need an increase in their medication. They will feel it failed. This leads to suicidal hopelessness.

** Invasive probing therapy*

When a youth is actively suicidal and hopeless, it is not helpful to aggressively probe into the details of their sad feelings or past hurts. Having them talk about the death of their beloved mother two years ago will only undermine them now and remind them that all loved ones will die eventually. How is that useful? While it is wise to know their current feelings and suicidal status, the therapist should not try to "fix" triggers. They need to immediately address the threat.

11) Therapists and parents can make appeals to correct cognitive distortions. For example, a youth may think, "If my 'love' rejects me, I cannot live." Remember Romeo and Juliet were adolescents not adults. And adolescents think in "all or none" and "black and white" terms.

12) If your child is actively suicidal or has made a suicidal gesture, they may require *in-patient* hospitalization. If a youth is unstable and cannot be controlled or cannot be supervised 24 hours a day, this option may be inevitable. If they refuse, states have differing laws on your authority. Your local crisis center will be able to tell you what the law is for your state. Their number is in the blue pages of your local phone book. If you want your child hospitalized against their will, you will need to have the *exact facts* describing their suicidal status such as recent suicidal comments and actions.

    The length of stay will vary depending on how rapidly your child seems to improve, how compliant they are with treatment, your insurance company and the availability of an intensive day program (when your child comes home to sleep).

Generally, in-patient facilities are stabilization units and do not cure. Staff may suggest discharge after only 3 days but each child is unique. Have your arguments ready if this would be unwise in your case.

If a child needs a medication because of severe depression, mania, or other mental illness, do not expect immediate results. Some youth respond slower to medications, while others improve quickly—perhaps due to a structured environment or being removed from a bad situation, e.g., substance abuse, parent-child relational problems or unhealthy peer relations.

Sexual Victimization or Offending Traumatic Secrets

Pam is a 19 year old with a seven year history of drug abuse. She moves every 3 months after trashing apartments financed by her mother and grandmother. She has been unable to work and is addicted to various drugs.

She has been put on methadone daily to make heroin ineffective. It has worked, but she appears too sedated.

She threw a brick at her mother today after having kicked her dog last week.

We only know the tip of Pam's reality. Her world has two large secrets that control her life. Why is she using drugs? Is it a genetic vulnerability, pleasure seeking or an attempt to escape? Secondly, why she is violent toward her mother and dog?

Pam was sexually assaulted as a 9 year old girl. As usual, her sociopath abuser told her it was her fault and that she would be hurt if she told anyone. She was too ashamed to tell her mother and denied it to many therapists who worked with for brief intervals.

Only when she found someone she trusted, a calm and warm therapist who made her feel safe, did Pam mention her sexual assault. Unfortunately, most people can only handle low levels of emotional intensity and emotional pain, and communicate in subtle ways, "Keep your emotional pain away from me."

After discussing her assault, Pam did not become magically cured. In fact, she became more aggressive and increased her substance use, likely due to the fresh memories and feelings that became more real after years of suppressing them.

One of the problems with treating PTSD (Post Traumatic Stress Disorder) and substance abuse is that the combination makes treatment four times as hard. Recovery is generally a two-year process of intense treatment.

Options:

1) Since Pam's fiancé and loved ones will be seen as abusers and then might be might be abused by Pam as she "defends herself." So they should be educated about this "transfer"—an abused person re-experiences current contacts as the past abuser.

2) If Pam is a danger to herself or others, she may need to be hospitalized.

3) After she is stable emotionally and is no suicide risk and is not assaultive, she might want to attend a 3-4 week residential treatment program. This would keep her away from drugs, by filling her time with constructive action and methods to beat drug cravings.

4) Expect relapses and some relapses are hidden. Therefore, routine toxicology urine screens are recommended—

weekly. Regular urine drug screens keep a person on track for both emotional health and addiction recovery. This testing is important because illegal drugs prevent the processing and working through of the abuse this is necessary for recovery.

5) She will need to see a safe therapist 4-7 times per month.

6) Once she is able to function, change methadone to Suboxone, which she can get from a regular doctor instead of going to a methadone clinic everyday. Special physicians with this specific Suboxone license can be found at: www.suboxone.com. Currently, I offer this service along with approximately 5,000 other US physicians.

7) Fresh memories and thoughts of abuse will make "drug anesthesia" more appealing. All concerned should understand that this will be a long and difficult process.

8) If any Major Depression is diagnosed, it *must* be treated or no progress will be made.

9) Any person with an inability to recover from an addiction needs to have an MSH level done (LabCorp) which is involved in making your our body's narcotics. Also, common infections which cause impulsivity, emotional trouble and fatigue must be carefully ruled out. Specifically, any smart physician treating an addict who is struggling with their recovery, needs to prove the addicted youth has no Lyme, Babesiosis, Master's Disease, Ehrlichiosis, Mycoplasma, Relapsing Fever or Bartonella by using IGeneX or a couple small specialty labs. Any physician that thinks these infections do not occur in your state is making a grave error. And if they only use tests from

massive national labs, then they have no clue about the junky test kits being used, and they are not up to date on this important clinical medicine.

The Excessively Flirty Daughter

Phil worries about his daughter Karen's sexual acting out. He is genuinely scared that she could get HIV, herpes, or pregnant. Currently, she dresses quite seductively and seems to be boy crazy. He thinks she is out of control and fears it will only increase.

Solutions:

1) A warm and affectionate father is good birth control. The kinder you are, the higher her standards for true love. No adolescent has true love. Such selfless love takes many years to develop and is not associated with romantic chemical highs.

2) She needs to have someone discuss the reality of youth sex and "romance." Some boys want a sexual relationship fairly quick. Girls, on the contrary, prefer kissing and cuddling, but are unaware they are lighting a fuse to dynamite—the body is not made to stop easily after 10 minutes of kissing or "petting."

3) Traditional one-on-one dating starts at 16. Group dates and activities are recommended as a general rule, particularly for younger teens, since they allow for making healthy connections and lessen the pressure to be fused to one person. Children can lose lonely feelings if they have a healthy peer group. A solid set of relatives and many friendships helps a youth avoid putting too many emotional eggs into one romantic relationship.

4) Teach her to stay in contact with her girlfriends and platonic boy friends while seriously about a boy. Why? If she drops these friends, she will create an immature obsessive "romance" that is more like religious worship which is unstable and unbalanced. If it ends, she will be alone and possibly devastated.

5) Limit phone calls, emails, and Instant Messaging to 30 minutes per day. Be mindful that any form of adolescent communication with a boyfriend can become intense, especially time alone. Slowing a run away train with some prevention is better than having to forgive a pregnancy.

6) Invite boys to your home and get to know them. Do not be a rude and embarrassing father or mother. Let them know (in subtle ways) how much you respect and treasure your daughter.

7) Let her know that it is natural for a teen to "fall in love." Yet this love she is feeling is more like a drug, in which chemicals cause her to feel immersed in a surreal environment. Love is perceived as real, but this drug effect makes them trivialize the faults of the other person. Just the thought of holding the other's hand has a drug-like effect. Real love requires loving an unattractive person or a person who is not popular. Anyone can love someone who makes them feel "high." Karen needs to understand that while these feelings are natural, relationships with merely the "love drug" usually fail. In fact, marriages with youth under 21 have a rough divorce rate of 85%. Hence, the "perfect" boyfriend often becomes the "imperfect" husband.

8) All of the comments thus far assume Karen has had no history of sexual abuse, is not manic, does not have mental retardation, does not have PTSD, and is not abusing drugs. These issues have further implications and need more specific interventions.

9) The loss of a parent or the death of a close loved one, can cause a youth to look to "love and romance" as a balm to heal the hurt. If the youth needs a balm, other forms of nurture exist besides romance. Increase her contacts with people and activities which are comforting.

10) Proms, spring breaks, and senior weeks are times of clearly increased alcohol, drug use, and sexual acting out. You will need to reflect long on a balanced position that allows some liberty and fun, but does not indulge the youth in a risky free for all. Mob thinking in adolescents is very dangerous. Consider some generous alternative options to drinking, drug use and sexual acting out. Reward a youth who avoids these activities. The reward would be highly tailored to your child's tastes and your budget.

The Legal System and Substance Abuse

Early Moderate Drug Abuse

Kevin is 14 years old. His involvement in baseball and track has decreased in the last year. He is still interested in spending time with his neighborhood friends who are polite and receptive toward adults, but his lack of motivation, mild moodiness, and restlessness are cause for concern.

Any youth over 13 with behavior problems should have an unplanned urine toxicology screen. You should have them tested on Monday so that weekend partying shows up positive. Note that some youth do more drugs before, during, or after school than on the weekends.

If you continue to find drug materials or suspect drug use has not stopped, do not depend on one testing. Youth that use drugs daily occasionally are "negative" for marijuana and other drugs in simple screen tests.

Repeat the laboratory testing and ask your physician to have *quantitative* metabolites done, not simple positive and negative results. Why does this matter?

A youth may have clear illegal drug metabolites that come up under the positive range or "cut off" tests. If we find metabolites it means the youth is using! They may have taken a brief break, used lower amounts, or been around heavy users. But these are all issues to address. Also, if you repeat quantitative levels, you can see whether positive drug metabolites are *going down.*

It is commonly known marijuana testing can stay "positive" in screen tests for 4 weeks. Once a youth is caught with a positive result, some youth are tempted to binge. They think, "Why not *really* party since I was already caught." If the quantitative levels are going down after 2 weeks, it means the youth is at least cutting back.

Solutions:

1) Schedule one-on-one time with a therapist they like. It is important for them to pick the therapist. A bond of trust improves success. However, they cannot shop forever and interview eight different people. If they refuse to see anyone, you will have to hold them accountable.

2) Some schools have special programs that mix academics and/or marketable skills training with modest group or individual counseling.

3) Treat the factors that are compelling the youth to use: trouble making friends, social anxiety, general anxiety, depression and feelings of failure. These are only a sample.

4) As with all addictive compulsions, you have to wean an addicted youth from people, places, and things that promote use. *Kevin's friends appeared polite and receptive but you cannot assume these are healthy relationships.*

5) Add satisfying pleasures to help replace the larger pleasure of the drug(s). They do not need to be massive joys.

6) If the youth depends on you for their livelihood, you have more control than you may think.

7) Make sure Kevin's MSH blood level is at least thirty-five, since MSH manufactures the body's natural narcotics (LabCorp only).

A Belief in Justice Increases Legal Behavior

Michael was sexually abused as a youth. The perpetrator, a male babysitter and "family friend," repeatedly fondled him over two years. Michael eventually told his mother who then reported the man to the police. He was sentenced to prison and released many years later.

Michael began to struggle in school and wondered if he was a "homo." He soon found himself using drugs and stealing regularly.

The family considered filing a civil lawsuit against the abuser for emotional damages, but the man had a very limited income. Two years passed after Michael's 18th birthday after which time a lawsuit could not be filed.

When Michael finally entered therapy, he was in many ways thinking like a 13 year old. He was furious about the "lack of justice" and felt that the perpetrator's jail time was not restitution to him personally—it only "briefly" removed the man from the street.

First, some attorneys will not file a sexual lawsuit for a person unless the victim is acting in a law abiding manner and not abusing drugs. Yet sexual assault, especially without treatment, makes many forms of self destructive acting out and drug use more common. Also, if the victimizer has minimal income, it is hard to gain restitution.

Some people hire former police, retired state troopers, or retired FBI agents to investigate the perpetrator. When followed, they might catch him starting to initiate a crime. For example, a convicted child abuser may not be allowed contact with children. If the investigator catches such contact on video this might be a parole or probation violation, and result in a return to jail. It might also help prosecutors to be given a search warrant of the perpetrator's house and computer. If child pornography is found they may end up back in jail. Most youth would see this as justice.

Out of Control Youth Incest

Ben is a 15 year old male with few friends. He has been severely teased by his older brothers and the neighborhood kids. They have even beaten him up a few times. His seven year old sister mentioned to their mother that Ben "hurt her in the leg." On follow up, it appeared that he had regularly fondled her sexually. His parents were very upset and concluded that Ben "was a pedophile and sociopath, and would spend the rest of his life abusing pre-adolescent girls."

I would not assume Ben is going to become a child abuser. But he does need a firm and aggressive intervention. Sexual abuse inside a family is very serious. It hurts its victims severely. However, some perpetrators, especially youth offenders, are not doomed to become lifelong child molesters if aggressive treatment is used, and if the youth is capable of feeling guilt.

1) Ben needs to be told clearly that little girls should not be touched in their private areas and that it is very hurtful to them to do so. Also, if he wants to live at home, he can never do this again.

2) Ben cannot be left alone with any young girl. Prevention is better than having to forgive.

3) He needs to take complete responsibility for the violation.

4) Ben is not allowed any form of pornography or movies containing sexually explicit scenes since they may stimulate him to act out. Some people would argue that masturbation with pornography is a release. I completely disagree. Pornography can increase acting out.

5) The law should be explained to Ben, specifically the criminal consequences if this is done again.

6) Ben may be stuck in an immature state from his social traumas. Treatment may help him to move toward establishing healthy peer relations and age appropriate fantasies. Youth are still evolving and some offenders, who are considered "losers" and abused themselves, do well with intense relational therapy with someone who wants to work with them. "Intense" therapy means at least 2x per week. Anything less sometimes fails.

7) Victim-Offender Mediation Programs are also available. In cases of boundary violations, e.g., sexual assault, offenders do not care about the feelings of the victim. These programs force them to face the facts, realize the pain they have caused and start the long process of developing empathy.

Pro-social Legal Thrills vs. Illegal Ones

Ron was bored with high school. He hated it. His grades were D's and he had three arrests for fighting. On the weekends he was eager to get out of the house and meet with friends. He drives very fast.

Some youth have a deep need for thrills. One option is to guide these youth into *pro-social legal thrills.*

Such thrills vary and should be limited to avoid obvious danger and illegality. There is no easy answer to finding the balance between risky and too risky.

Some people like scuba diving with "safe" reef sharks that eat fish. But they would never go near a tiger shark or other species known for aggression toward humans.

Other thrill seekers like flying, hang-gliding, skydiving, or Bunji cord jumping.

Ron liked riding horses fast—perhaps too fast.

Ultimately the youth has to find thrilling things that *they* enjoy. Parents just need to carefully negotiate when activities are dangerous and never cut corners on suggested safety. If the motorcycle or skateboard calls for a solid helmet, never compromise this minimal standard.

Some believe that thrill seekers have a deficit in the dopamine pleasure system in the brain. Some medications or special nutrients can be given orally or topically to *mildly* enhance this system.

Make School a Success or Make a Criminal

Les had major problems in school. He felt like a failure. He hated his special education classes and his dyslexia problem. He liked some of the other youth but disliked the teachers. Now he is fighting with his parents about going to school and has started throwing things when talking about school. Les had an older brother who had a similar progression. His folks are very afraid that Les will take after his brother, who is only successful at avoiding arrest.

Youth need to be successful. At times, this means lowering the bar of expectations for youth that take longer to learn things. But for Les it involved finding something that he could master. Most of us need to feel competent at something. While reading, writing, and arithmetic are important, some may never feel like masters of these skills.

We found that Les liked to use his hands. He liked to look at what he created and see something tangible. He already loved building different things—cars, toy houses, and even tiny bird houses. But this was something more than a hobby. It was something that gave Les a sense of accomplishment.

Some youth have serious interests in computers, music, art, drafting, and other areas that are not primary school classes.

1) Look for hobbies the youth is already engaged in.

2) Are there activities the youth has *seen* in relatives, friends, neighbors, or on TV that have caught their interest? If yes, help them explore as many interests as possible.

3) If they have no interests or seem unwilling to ponder on possible interests, consider therapy for depression, marijuana abuse, or demoralization.

4) If a youth is passive, it might be helpful for them to explore different hands-on options. For example, I have had youth visit mechanics, A/C technicians, boat captains, artists, and musicians. Most people only have one job at a time. He may only need to enjoy one craft to survive.

Fluffy, Immature, and Pleasure Seeking

Steve barely graduated from high school and then dropped out of college. He worked regular retail jobs and then spent a year simply seeking pleasure and fun. During that time, he bought a modest sports car with an outrageous stereo system and lived with different friends and girlfriends.

He was fired from three out of his last four jobs with questions about missing money—once it was a certainty. Steve also had chronic troubles with parking tickets, speeding tickets, car insurance, and inspections. He casually ignored them and eventually a warrant was issued for his arrest.

Steve seemed much calmer than his mother. She wanted to just pay his fines and bills. Yet she may be making an error.

1) Do not give away anything to an immature youth for free. Helping with bills or fines is based on a written agreement to get certain things in return that you want. Ideally get what you want first. If a youth has a drinking problem, require ten AA meetings before you pay for a fine. If they

took money from a local store, and you are being asked for restitution, have the youth do serious work to help someone. Perhaps they can shovel snow filled driveways of all your neighbors for free, or pull weeds for free for elderly home owners. But it should not be a place they can steal.

2) Steve needs a budget advisor to make a list of his mandatory expenses and to subtract these from his biweekly income. If possible, the advisor should be someone other than a parent.

3) This adolescent is a "here and now" foolish youth. He does not think about the future. But if he is not able to save, defer gratification, or think at least a week ahead, he will become unable to function.

4) If this young man has enjoyed *any aspect* of a job, try to find the satisfying parts. Perhaps he can be specifically mentored in those areas to improve or advance his marketability.

5) Steve has had trouble the past 10 years with organization skills, reflecting a long-term history of mild depression and ADD. He has shown a 45% improvement on medications but insists on a natural approach. "Natural" to him means no treatment of any kind and "just allow me to ignore my problems."

6) If you are able, get specific neuropsychological testing from a special Ph.D. psychologist that can test praxis defects. Praxis is the ability to go from ideas to action. Some youth have a praxis learning difficulty. They have trouble going from an idea or fantasy to carrying out a plan of action.

7) Consider not paying fines and letting the youth use a public defender. He may have to do structured probation and unpleasant community service. If he refuses to do his service, he will have to do more service. If he still refuses, he will have to do brief jail time. Jail may help him move from living in fantasy to living realistically. Specifically, he might become willing to look for solutions.

Pets are a Youth's Best Friend

Walt never seemed to care much about people's feelings. As a child he would wrestle with neighborhood children and at times bite them. As he grew he became very hostile with his mother, stepfather, siblings, and friends. Walt also broke home curfew rules, took money from his folks, and shoplifted. Furthermore, he skipped school quite often.

Attachment to people is very important for success. If a person regards people as no more important than a shrimp or a shrub, they are not going to be functional. If people are objectified and used, the person is functioning as a future criminal. All children and adolescents can be selfish, self-centered, and narcissistic. But they usually have connections with family and friends. In Walt's situation, although his family was reasonably caring, he could not attach to them.

His mother bought the family a German Shepherd. Much to everyone's surprise, Walt became very attached to the animal. She had feared he would treat the animal badly but he actually became annoyed if others did not attend to "his dog." The dog even sleeps next to his bed.

Walt has been doing better in his compliance at home and school. His mother is hopeful that perhaps this bond is a start. It is a clearly positive step.

Contacting Dr. Schaller

The treatment of child and adolescent youth behavior problems is constantly growing. The material published here is constantly being increased and modified. This book is only a basic introduction to the options for children and adolescents with behavior problems.

If you would like to have an email, phone, or face-to-face consult with Dr. Schaller, please go to www.personalconsult.com. On the home page are simple directions to serve you in any of these three ways. If you are unable to use a computer then call us. We will try to help you or find someone who can.

Dr. Schaller treats youth from all over the USA and would be willing to discuss your child with an email or phone consult. Further, if he visibly sees your child once a year, and you have other local physicians willing to do a physical exam, he can also treat them. If you would like to explore ways Dr. Schaller could help your son or daughter, please call his Tampa office at (813) 909 8009 or his Naples office at (239) 263-0133. He is also exploring opening an office in New England.

If you have read this far, you obviously care for your child. Dr. Schaller sincerely wishes you every success as a parent, especially if you feel challenged to do your best and if you feel very finite as a parent. It is a good that children do not need perfect TV parents, but merely ones that try to love them.

Your personal physician(s) and mental health worker(s) should evaluate all medical and therapeutic suggestions. Nothing in this book is meant to replace their treatment and advice. Also, please do not assume anything said in this book is the standard of care in any location, in any specialty, or is endorsed by any agency of the government.

This book and many others are available as an e-book directly from Dr. Schaller's primary web site, www.personalconsult.com. The price of

his e-books are significantly reduced because you supply the paper, it is not bound, and the cover will not be as attractive. However, it might allow some with tight finances to be able to afford this book and others.

JAMES SCHALLER, M.D., M.A.R.

Are you tired of treatment failure?

Are you ready to go beyond a 5 minute diagnosis?

Do you want broad treatment options tailored to you and your child's specific situation?

Here is a book with solid and real solutions.

Every week parents from all over the United States bring their children to Dr. Schaller. Most have spent a great deal of money and time on their child, and are desperate and hopeless.

These same loving parents routinely see their children restored to complete functioning after treatment. After years of failed visits to sincere therapists, family doctors, child psychiatrists, pediatricians and alternative practitioners, "Dr. J" consistently finds solutions for troubled youths.

"Dr. J" is the author of fourteen books and dozens of publications in some of the world's leading journals of child and adolescent psychiatry, neurology, pediatrics, and medicine. His writings are translated in multiple languages around the world.

Visit www.personalconsult.com where many have read from hundreds of Dr. J's progressive articles.

Dr. Schaller resides with his wife and children in Florida.

ISBN 0-9787473-5-6

9 780978 747350 59000