

A “School Phobia” that Wasn’t

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Introduction

It is all too easy for conventional psychiatrists to make presumptions about the diagnosis and management of cases which they see. They have their biases and preconceptions, which, one way or another, we all have. The problems which can arise out of that can, in the case of psychiatry, be potentially devastating to the lives of patients. Even simple, medical conditions with psychiatric manifestations can fool a psychiatrist, who forgets that he or she is a doctor first, and a specialist second. One example I reported in 1988¹ was of an atypical case of hypothyroidism mimicking schizophrenia. I report here another example of a patient with a serious situation, who was misdiagnosed by a psychiatrist and whose condition was solved and easily managed once preconceptions were overcome.

Case Report

AF was a fourteen-year-old schoolboy in England in previously good health. Without any warning, one day he locked himself in his bedroom and could be heard crying. He refused to go to school where his performance had previously been very good. His family took him to their family doctor, who, in turn, arranged an urgent psychiatric referral. The psychiatrist diagnosed “School Phobia” and prescribed Anafranil (Clomipramine) in a low dose. Increasing the dose provided no improvement and AF continued to remain most of every day in his room. As a next step the psychiatrist recommended admission to a psychiatric hospital, something to which the family felt very reluctant to agree.

AF’s sister and he husband were living in our community, along with their two

sons. I already knew that she experienced reactive hyperinsulinism (hypoglycemia), likely secondary to food sensitivities. The younger of the two boys was prone to hyperactivity. They knew of my interest in orthomolecular psychiatry. The family decided that it might be best to bring AF to Canada to see if I could help him.

He presented as a clean, well-groomed young man with a pleasing manner. He was open with his feelings of depression and had no insight into any explanation of why he refused to go to school. He denied hallucinations and paranoid ideation. He experienced no racing of thoughts nor thought blocking.

I administered the Hoffer-Osmond Diagnostic (HOD) Test. This showed dysperceptive features but none of severity to indicate a schizophrenic process. Because of his family history, as noted above, I felt that food allergies/sensitivities were the most likely cause of his situation. I persuaded him to undertake a therapeutic fast, using the following advice (as modified from Cott:²)

1. Make up your mind that it is necessary, and that you need to stick with the fast through thick and thin, good and bad.
2. You take nothing at all by mouth except water.
3. No food.
4. No drinks but water.
5. No candies or chocolates.
6. Absolutely no cigarettes.
7. No toothpaste.
8. No cosmetics.
9. No flowers.
10. No consumable gifts.
11. Plenty of spring or mountain water (if not available, then bottled), at least three litres per day.
12. Plenty of physical and mental activity:
a) if fasting at home, continue normal routine and take extra walks of at least

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two miles per day; b) if fasting in a hospital, walk around as much as possible and make frequent use of the exercise equipment in the physiotherapy department.

13. Twice daily showers or baths.

14. Twice daily warm water enemas, especially if symptoms are severe. This may be omitted from home fasts, especially if symptoms are not severe.

15. Expect that the first 48 hours will be the worst, and increasingly severe before there is any improvement.

As expected AF did feel worse during the first two days but then began a rapid improvement. By the fourth day he felt entirely well. By his sister's report his moods had reverted to the state before he became ill. That left the issue of what had been the cause.

I described the process of Provocative Food Testing thus: The testing is carried out by exposing the patient to only one new food substance at a time, eating or drinking it, most conveniently mealtimes. If there is a reaction, this will be felt as a return of any, or all, or any combination of the patient's symptoms, or a rise in pulse rate, between 20-30 minutes after trying the food, of greater than ten beats per minute over the rate at the time the food was taken - where there is no other explanation of that rise.

No reaction will last for more than an hour or so. From these reactions (or lack of) two lists are built up. The first list consists of those foods to which a reaction took place, and which should be avoided whenever possible thereafter. The second list consists of those foods to which no reaction occurred, and which can be safely taken at any of all of the following meals. All mealtimes following a fast should be considered testing sessions.

AF's No-Reaction Food List

Milk	Cheeses	Coffee
Peanuts	Tomato	Cauliflower
Bread	Beef	Tea
Peas	Carrot	Zucchini

Corn	Chicken	Sugar
Rice	Celery	Apple
Eggs	Turkey	Salt
Potato	Broccoli	Pear
Bacon	Fish	Pepper
Lettuce	Cucumber	Orange
Apricots	Cherries	Pineapple
Peach	Raspberries	Strawberries

The days went past. AF experienced no reactions. All involved, myself included, became increasingly anxious because no answer was forthcoming. Abruptly, one afternoon well after lunchtime, AF had a strong reaction and burst into tears. What had he done? He admitted filching a red Smartie (a coloured, coated, chocolate candy) from one of his nephews. The reaction cleared up quickly and he became cheerful again. To confirm the reaction, at my advice, he was given a second red Smartie. The same thing happened again.

The Solution to the Mystery

At the time of the above events, in Britain, deep freezers were uncommon. The dealers, in their zeal to sell these appliances, would offer inducements to would-be customers. These included such things as pre-packaged meats, frozen fruit and vegetables, and treats, such as "ice lollies" (popsicles). AF's parents had bought a deep freezer a short while before he became ill. Included was a large bag of red ice lollies (coloured with red dye #A2 or amaranth, the same colouring as red Smarties), with which he had over-indulged. Many writers have implicated amaranth and other artificial colours as a cause of hyperactivity in children.

The Aftermath

AF avoided all artificial colouring agents thereafter. He became School Captain, the top academic student at the school and a schoolboy Rugby international player. He performed well at university and is now in a professional career.

Discussion

What guided me to the diagnosis? School phobia generally develops in someone who is performing poorly at school and/or is being bullied either by peers or teachers. Neither condition applied to AF. His illness began very rapidly. Clinically, an infection, such as meningitis or encephalitis, would have been obvious. A cerebral tumour would have presented more insidiously.

This left an environmental cause, but what? Then there was the family history. This was not proof that he shared the sensitivities of his sister and nephew. It did, however, raise the suspicion of a genetic predisposition to such sensitivities. None of us thought of the purchase of the deep freezer and what had come with it. So, empirically, I felt that the best way of trying to find the cause was a Therapeutic Fast followed by a Provocative Food

Test. But none of the foods included in the list was the cause of AF's illness. It was sheer serendipity, his consumption of the red Smartie, which actually provided the diagnosis and revealed the explanation. For that I can take no credit at all. It did help that I did not blindly accept the initial diagnosis of "School Phobia" and was open minded about there being other possibilities. The consequences of accepting that diagnosis would have been dire indeed. I shall deal with the whole issue of food sensitivities/allergies in a subsequent case report.

References

1. Paterson ET: A case of thyroid disease - a lesson in orthomolecular medicine, *J Orthomol Med*, 3, 141-144, 1988.
2. Cott A: Controlled fasting treatment for Schizophrenia, *J Orthomol Psychiat*, 1974; 3 (4), 301-311.

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