2025 Italia St., Ocean Park, San Juan, P.R. 00911
Tels. 787-726-5021/Fax.787-728-4687
Email: eramirezmd@gmail.com
Web site: www.addapr.info

# THE CARIBBEAN MODEL OF THERAPEUTIC COMMUNITIES SINCE ITS BEGINNINGS IN 1961 TO THE PRESENT AND ITS FUTURE PROJECTIONS

WFTC Genoa Institute 2010
THE FUTURE OF TC IN THE CHANGING WORLD
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Presented by Efrén Ramirez, MD
Director, Ocean Park Ambulatory TC,
President ADDA
(Adults with Attention Deficit Disorders) Foundation,
Co-coordinator, (with Ron Williams)
of the WFTC Caribbean Region Initiative

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# Efrén Ramírez, MD

## Profile

Dr. Efrén Ramirez graduated *Alpha Omega Alpha* in the Founding Class of the University of Puerto Rico School of Medicine in 1954. His first clinical research project as a psychiatrist was the establishment, between 1962 and 1966, of the prototype of the drug-free therapeutic community system for heroin addicts (*The Ramirez Concept*). In 1966 he brought his *Concept* to New York City where as Commissioner of Addiction Services he founded Phoenix House. He has been an international therapeutic community program consultant to various USA programs, to the Vatican, to Latin American governments, to Hogar CREA International, to ASPIRA of America, and to the Foundation for Community Development in Puerto Rico. He headed the Puerto Rico Mental Health Program from 1985 to 1990. Since 1993 he has directed the Ambulatory Therapeutic Community of Ocean Park, an outpatient therapeutic community for ADD children and adults in San Juan. Since 1999 is president of the Adults with Attention Deficit Foundation of Puerto Rico. He is co-coordinator, with Ron Williams, of the Caribbean Basin Region of the World Federation of Therapeutic Communities.

A more detailed curriculum vitae can be found at www.efrenramirezmd.com. His e-mail address is eramirezmd@gmail.com.

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This coming spring, it will be **fifty years** since I started my involvement in the design, organization, management and supervision of drug-free therapeutic communities with professional mental health support in hospitals, prison settings, schools, and free-standing community residential programs. I summarized my activities during the period between 1960 to 1990 in a magisterial speech delivered in Salamanca University, Spain, in 1990 titled "**The Therapeutic Community Systems of Puerto Rico: Past, Present and Future".** [1]

**Today I wish to concentrate on my work related to the Therapeutic Community Concept (Caribbean model) during the last 20 years.** My purpose with this presentation is to share with you what I have learned during this time for the benefit of your program development, to help in the improvement of evaluation, diagnosis and follow-up techniques, to stimulate independent clinical research, and to give you the opportunity to test and replicate my findings.[2]

During the last 20 years I have **confirmed and validated 8 basic principles** of the successful design and management of a community based therapeutic community with professional drug free mental health support, which became apparent is my 1960-1990 practice.

Since 1990 I have modified and expanded several of the original programmatic principles in the light of my additional experience as an international advisor, and I have also been able to incorporate new developments in the neurosciences, especially the theory of the biogenetic roots of addictive behaviors, and to formulate my own epigenetic hypothesis of the etiology of addictions and its corrective treatment in primary, secondary and tertiary levels.

During the last two decades, I have also **discovered and successfully tested several techniques, methods and protocols in my clinical research unit** ("CISLA II" - **Centro de Investigaciones Sobre la Atención** - Attention Spectrum Disorders Research Unit-ASDRU) of the Ocean Park Ambulatory Therapeutic Community that I have run from my home in San Juan. These new techniques have proven to make the Therapeutic Community work easier, more efficient and cheaper than before. I present these recent findings in the hope that they will be copied and validated independently by many of you, so that they can become "mainstream" procedures.

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1 See www.addapr.org. An inventory of the activities and presentations during the 50 year period is listed on line: www.comunidadterapeuticacaribena.com.

2 The articles and teaching materials relevant to the period **1990-2010** are available online at www.addapr.info in English and in Spanish: www.addapr.org. Related links are: on the therapeutic effects of nutritional (chelated lithium): www.litionutrienteesencial.com; and on the basic information on nutrigenomics: www.club120.net.

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They include new developments in the areas of diagnostic, prognosis, nutrigenomic treatment of the epigenetic roots and new developments in primary, secondary and tertiary prevention.

Finally I will conclude my remarks with an **8-step view into the future of the world-wide Therapeutic Community movement.**

**I. Among the basic therapeutic community concepts reaffirmed and validated during the last 20 years are:**

1. The hypothesis that "**addictions can be cured until it is proven otherwise**" which I utilized in the early 60s as a motivational, hopeful slogan.
2. The **superiority of community based (NGO) programs** over governmental programs, as validated by the United Nations Office of Drug Addictions and Criminality 1998-2008 survey.
3. The identification of **personality disorder spectrum as a common** denominator of addictions in their several manifestations.
4. The hypothesis that Therapeutic Communities of the Caribbean model[3] are effective as treatment and prevention centers for mental, psychosomatic and psychosocial dysfunctions **beyond the addictions syndrome**.
5. The **stellar role of the ex-addict** in all the phases of the therapeutic community experience, noted by a British investigator in 1967.[4]
6. The essential role of **family participation in all aspects of treatment** in the therapeutic community and in the management and community support of the T.C. operation.
7. The **viability of the transcultural application** of the Therapeutic Community concept (Phoenix House, Hogar CREA International, and the World Federation of Therapeutic Communities experience).
8. The **superior cost-efficiency** of the (ONG) TC model over the professionally run programs.

**II. In terms of modification and improvement of basic TC concepts we have:**

1. The evolution of the essential TC model towards Ambulatory Therapeutic Communities such as the Ocean Park ("barrio") Ambulatory Therapeutic Community and the home-based family therapeutic communities that have "sprouted" from the "barrio" operation.[5]
2. The simplifications of the Self Diagnostic Octagonal Evaluation from the original multi disciplinary team effort developed for hospital and correctional institutions programs,

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3 Ramirez, E. 1966 *The Mental Health Program of the Commonwealth of Puerto Rico. Rehabilitating the Narcotics Addict.* Vocational Rehabilitation Administration, U.S. Department of Health. Fort Worth, Texas. Ramirez, E. 1968 Review of Existential Psychology & Psychiatry, Vol. VIII No. I, Page 43-53, Winter 1968.

4 Fiddick Peter, *Junkie cure Junkie*-Manchester Guardian Weekly, February 16, 1967. (www.addapr.info/testimonials)

5 Ramirez E., *Is Drug Rehabilitation Possible Through Out-Patient Services* ?, Pontificium Consilium Pro Familia, Citta del Vaticano, Anno III, No. 1, 1998

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into a four page self-evaluation form for the diagnosis of the underlying personality disorders behind the addiction syndrome and for the diagnosis of the psychosocial and psychosomatic genetically related co-morbidities (Ref. present day preadmission self evaluation kit at www.addapr.info), included in Appendice A.

3. The seamless adaptation of the classic TC phases (community outreach, induction, treatment, re-entry, and generative community action) to the ambulatory TC model.[6]
4. The identification in 15,000 consecutive admissions to the Ocean Park Ambulatory Therapeutic Community (OPATC) in the last 16 years, of attention deficit spectrum personality disorders as a consistent prodromal high risk factor in all addictive disorders.[7]
5. The development of an internet based social network (http://groups.google.com/group/individuantes) to expand the outreach, reentry, and community action programs beyond the physical neighborhood of the OPATC. As of now we have "friends" in 8 countries.
6. The introduction of TC techniques and protocols in the classroom, parishes and the workplace, through the voluntary participation ("generative social action program") of Individuantes (persons who have joined and participated successfully in a Caribbean-style therapeutic community) who are parishioners, teachers, school directors, school counselors, business managers and supervisors.[8]
7. The international exchange program of trained TC operators as the basic ingredient of the international expansion program (the Daytop Home, Phoenix House, Hogar CREA International, and the WFTC experience).
8. The recognition of the archetypal spiritual factor as an essential component of rehabilitation (after Dr. Carl G. Jung) using dream diary work, the use of chelated lithium; and assisted group meditation and individual mandala visualization techniques to gain insight into unconscious (archetypal) factors influencing awake attitudes and behavior.[9]

**III. In terms of the new developments in the past 20 years, from my perspective we have:**

1. **The discovery for the first time, of the corrective/mood stabilizing effect of dietary supplementation with low dose chelated lithium (non toxic, non addictive, over the counter product, available in most health food stores) on the attention deficit spectrum disorder underlying all addictive behavior**.[10]

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6 Ramirez, E. *The Treatment of Lithium-Deficient Attention Deficit Spectrum Disorders in an Ambulatory Therapeutic Community,* XIth. Latin-American Conference of Therapeutic Communities. Buenos Aires, Argentina, April, 12-14 2007. (www.addapr.info)

7 Ramirez, E. (ADD Addiction Connection), *Tratamiento Holístico de Déficit de Atención*. 2do. Congreso Latinoamericano del Déficit de Atención - Tropimar Convention Center, Isla Verde, P.R. 30 de mayo de 2001.

8 *Is Drug Rehabilitation Possible Through Out-Patient Services*?, Pontificium Consilium Pro Familia, Citta del Vaticano, Anno III, No. 1, 1998.

9 "Intermediate Treatment Manual" www.addapr.info).

10 Ramirez, E. *The Treatment of Lithium-Deficient Attention Deficit Spectrum Disorders in an Ambulatory Therapeutic Community,* XIth. Latin-American Conference of Therapeutic Communities. Buenos Aires, Argentina, April 12-14, 2007, (www.addapr.info)-(www.littionutrienteesencial.com).

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2. The introduction of Nutrigenomics as the preferred nutritional protocol of essential nutrient supplements (nutrients that are essential for the protection, repair and nourishment of the epigenome: the site of most of the genetic variations and interactions responsible for the attention deficit spectrum).[11]
3. The clinical confirmation in thousands of patients over the last 15 years that empirically determined individually adequate doses of chelated lithium can regulate temperamental outbursts in the clinically recognized temperament spectrum (aggressiveness, callousness, impulsivity, irritability, bipolarity, anxiety, sexuality and phobias).[12]
4. Confirmation that an ambulatory therapeutic community can achieve most of the benefits associated with the residential programs and can do so at less expense and effort (the OPATC experience 1993-2010).
5. Because of shared genetic tendencies, the family, not just the individual, is defined as the human unit of treatment, and its participation is required in all the phases of treatment, starting with an initial family evaluation.
6. The substitution of allopathic pharmacology (which is focused on symptoms palliation) with a drug and codependence-free alternative system to conventional practice, which I have called "The Practice of Naturist Healing for Psychiatrists, and Psychologists, counselors and former addicts".[13]
7. The substitution of traditional anamnesic (Freudian) psychological therapeutic practices by an existentially based therapeutic dialogue and "tertulias" (personal effort and mutual help assemblies with a proactive, not a retroactive approach based on Sufi traditions).[14]
8. The implementation of the "Plan 2018 y Más Allá" (Plan 2018 and Beyond) to provide parallel support to the United Nations Plan "Beyond 2008" designed to support NGOS in expanding their programs to reduce humankind's vulnerability to addictions.[15]

## IV. In conclusion, a look towards the future:

My 50 year experience in the field of addiction research has convinced me that **human vulnerability to addiction lies in the attention deficit global pandemia**.[16] My experience also shows that the **attention deficit spectrum disorders are epigenetic conditions, which therefore can**

11 www.club120.net

12 Clinical Research data base of the Ocean Park Ambulatory Therapeutic Community- OPATC, 1993-2000.

13 Text in preparation – publishing date will be announced when appropriate through our web links.

14 "Intermediate Treatment Manual",(www.addapr.info).

15 "Plan 2018 y Más Allá" in Spanish www.addapr.org and "Beyond 2008" in English www.addapr.info).

16 Interview of Professor Niall Ferguson by Janet Tassel, published in the May-June 2007 issue of Harvard Magazine as "The global empire of Niall Ferguson: Doing history on a sweeping scale". Prof. Ferguson holds that our society is facing imminent collapse because of three factors: the unequal distribution of wealth, the poor utilization of human resources, and the pandemic level of attention deficit disorders, the third being the most important because it is the cause of the other two.

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**be reversed with basic nutrigenomics, using chelated lithium as a catalytic biogenetic regulator for every human being**.

Our long range mission, for the future of our children and their descendants, is to leave them **a legacy of the best opportunities for integral health**, humanitarian education, ecological awareness, non sectarian spiritual awareness, and harmonious family and community living.

In our Caribbean network of therapeutic communities we call that ideal "**Operación Serenidad", which is not an ideological utopia but a realistic extrapolation, to the whole of human society of the therapeutic community experience of the last 50 years**.

Our "Plan 2018 and Beyond" is a practical proposal identifying dozens of community action initiatives around the leadership of "Individuantes" (persons who have joined and participated actively in our therapeutic community) and their family, committed to sharing their individuation experience within their circles of influence: relatives, friends, neighbors, fellow workers, their congregations, clubs and civic and political groups. **The "Individuantes" (trained and supervised by their therapeutic community) carry with them their personal testimonies, their communication skills and their personal experience with the TC concept, the therapeutic dialogue techniques and their tertulia expertise plus their knowledge of nutrigenomic prevention and treatment**.

The future of the practice of natural healing by psychiatrists, psychologists, counselors and TC staff, Plan 2018, Operación Serenidad and the collaboration with the United Nations initiatives (WFTC, UNODC, and UNESCO) is in the hands of the rehabilitated "Individuantes" graduated from our TC system. In my 50 years of experience I have observed that between 10 and 15% of the TC alumni are naturally motivated to helping others - I call them "Indigo". They called themselves "The New Breed" back in the 60's -70's. I believe the New Breed of "Indigo Individuantes" is alive and well and thriving for the good of humanity.

The future of our effort is also in the hands of an enormous number of relatives, friends and professionals who have witnessed the amazing achievements of many of our recovered addicts. This growing population of witnesses, if well recognized, trained and supported by our TC network of operations and participants, will be instrumental in arousing a popular voice (**vox populi**) that will challenge conventional professionals, institutions and clients to familiarize themselves with our drug-free TC alternatives and will give our TC networks a chance to be recognized as viable options to deal with the global pandemia of attention deficit disorders and their mental, psychosomatic and psychological complications, starting with the addictions spectrum.

Our principal intentions, from my perspective, should be:

1. To achieve a **global understanding of the causal relationship** between the epigenetic dysfunction known as attention deficit spectrum disorders and virtually the totality of mental, psychosomatic and psychosocial dysfunctions that affect humanity.

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2. To achieve a **worldwide confirmation and clinical validation** of the corrective effects of a nutrigenomic protocol of nutritional program enriched with chelated lithium in the context of Therapeutic Community environment especially for the undernourished third world countries and "third world" pockets in developed countries.
3. To achieve **wider recognition and support for the TC concept** in all of its known manifestations as a viable alternative for psychosocial reform.
4. To obtain a **World Health Organization recognition of chelated lithium as an essential nutrient for humans**, with a suggested daily minimum maintenance dose of 1,200 micrograms (regular food world-wide provides only around 500 micrograms per day).[17]
5. To make available, free of charge for the user, **internet access to the Self Evaluation of the Personality kit and a preliminary diagnosis of addicted vulnerability** and prevention advice (courtesy of the ADDAPR Foundation).
6. To make available through the UNESCO educational outlets and through the UNODC Training Programs, **training modules for families all over the world** (Home Therapeutic Communities) a house based life-long program for primary, secondary and tertiary prevention against addiction vulnerability.
7. To establish a **world wide interactive social network of home therapeutic community** leaders to share information, techniques and supervision for their programs. At the same time, to create a cybernetic civic society network with enough grass-roots power to affect national policies.
8. To carry our **message to conventional (conservative) leaders of the religious, academic, business, political, and NGO organizations**.

17 Ramírez, E. *The Treatment of Lithium-Deficient Attention Deficit Spectrum Disorders in an Ambulatory Therapeutic Community*, XIth. Latin-American Conference of Therapeutic Communities. Buenos Aires, Argentina, April, 12-14 2007, (www.addapr.info).

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# APPENDIX A

## COPY OF THE 5 PAGE PRE-ADMISION KIT FOR THE FADDA CYBERNETIC CLINIC PROGRAM

PERMISSION IS GRANTED TO ALL TC OPERATIONS
TO UTILIZE THIS MATERIAL FREE OF CHARGE WITH
THE ONLY PROVISION OF GIVING
CREDIT TO ITS SOURCES

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# Demographic information

Name:_____ Age: _____
*(Paternal last name) (Maternal Last name) (Name) (Initial)*
Date of birth: _____ /_____/_____ Place: Hour:
*Day Month Year*
Occupation: _____ Schooling:_____
Work Address: _____ Work Telephone #:_____
Religious affiliation:_____ Referred by: _____
Residential and/or Postal address: _____

Telephone #:_____Cellular #: _____ Fax. #:_____

Email:_____ Web Page: _____
In case of emergency notify: _____ Relationship:_____
Telephone #: _____ Cellular #: _____
Minors, name the father or guardian: _____ Cellular/Tel #:
Address:

Medical plan (__) Deprived (__) SSS (__) Medicare (__) IMC (__) MCS (__) Cosvi (__) Humana (__) Blue Cross (__) UTI (__) Cigna (__) Palic (__) Medical First (__)
Other plans, please specify: _____
Contract #: _____ Group: _____ Expiration Date: _____
Initial authorization #: _____ Follow-up #: _____

Have you have received treatment in the current year? Yes ___ No ___
Diagnosis: Date of last treatment: ___
Name of the psychiatrist: _____ Type of Treatment:
Signature of the Patient: _____ Date:____

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## DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT DISORDER

N=Not Measurable L=Light M=Moderate S=Severe C=Catastrophic (Incapacitating)

| | N | L | M | S | C | Remarks : |
|---|---|---|---|---|---|---|
| 1.**Melancholic Pessimism** (Fearful, phobias) Being afraid of failure based on previous experience | | | | | | |
| **2. Disorganization** (Confused, muddle-headed) Having difficulty in planning | | | | | | |
| **3. Procrastination** (Photo-finish) Having difficulty in taking initiative | | | | | | |
| **4. Dispersion** (scattered, polyvalent) Getting involved in too many things at once. | | | | | | |
| **5. Careless Verbalization** (Inappropriate,blunt) Impulsive expression, in hacking tact. | | | | | | |
| **6. Risky Behavior** (Daredevil) Seeking challenge and danger for adrenaline rush. | | | | | | |
| **7. Boredom** (Apathy) Intolerance to idleness or to having nothing to do. | | | | | | |
| **8. Distraction** (Short attention span, absent minded ) Difficulty in focusing attention on uninteresting things or events | | | | | | |
| **9. Inventiveness** (Fantasy prone) Using creativity to find unsuspected alternatives, including lying. | | | | | | |
| **10. Rebelliousness** (Oppositional, stubborn) Tendency to resent boundaries and rules | | | | | | |
| **11. Irritability** (Short fuse) Intolerance to frustration. | | | | | | |
| **12. Impulsivity** (Impatient, hasty) Acting without fully considering consequences | | | | | | |
| **13. Preoccupation** (Anxious worrier) Excessive, unnecessary concern | | | | | | |
| **14. Insecurity** (Indecisive, ambivalent) | | | | | | |
| **15.Affective Bipolarity** (Moody, unpredictable) Fluctuating affective states. | | | | | | |
| **16.Restlessness** (Jumpy, wired) Could be internal (anxiety) or external (hyperactivity). | | | | | | |
| **17.Addictions** (Obsessive, dependent) Compulsive, repetitive, self destructive habits. | | | | | | |
| **18.Low Self Esteem** (Self deprecating, depressed) Tendency towards self punishment and feeling worthless | | | | | | |
| **19.Poor Insight** (Clueless,) Need to be coached. | | | | | | |
| **20.Family History** (Who do you take after?) Historical confirmation of genetic susceptibility. | | | | | | |
| TOTAL | | | | | | |

Legend: N=No symptoms
L=Mild tendency, under control
M=Annoying symptoms, no external functional impediment
S=Severe symptoms, functional impairment not incapacitating
C=Catastrophic symptoms, incapacitation

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**Inventory of Psycho-social Dysfunctions** Victim Aggressor

| | N | L | M | S | C | N | L | M | S | C |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Bullying | | | | | | | | | | |
| 2. Addictions (alcohol, drugs or other dependencies) | | | | | | | | | | |
| 3. Weak nutrition | | | | | | | | | | |
| 4. Makes fun of others | | | | | | | | | | |
| 5.Gutter language and conduct | | | | | | | | | | |
| 6. Codependence | | | | | | | | | | |
| 7. Compulsive buying | | | | | | | | | | |
| 8. Corruption | | | | | | | | | | |
| 9. Cruelty (animals, old people) | | | | | | | | | | |
| 10. Delinquency-criminal behavior | | | | | | | | | | |
| 11. Demagoguery-exploit tears | | | | | | | | | | |
| 12.Violent contact sports | | | | | | | | | | |
| 13. Quarreling in family | | | | | | | | | | |
| 14. Divorce | | | | | | | | | | |
| 15. Diseases of sexual transmission | | | | | | | | | | |
| 16.Tax evasion | | | | | | | | | | |
| 17. Religious Fanatism | | | | | | | | | | |
| 18. Pharmacodependency | | | | | | | | | | |
| 19. Favoritism in the family | | | | | | | | | | |
| 20. Fraud | | | | | | | | | | |
| 21. War | | | | | | | | | | |
| 22. Homicide | | | | | | | | | | |
| 23. Homophobia | | | | | | | | | | |
| 24. Sexual harassment | | | | | | | | | | |
| 25. Gambling | | | | | | | | | | |
| 26. Parasitism | | | | | | | | | | |
| 27. Child Abuse(violence) | | | | | | | | | | |
| 28. Misogyny (hatred of women) | | | | | | | | | | |
| 29. Dogmatic Partisanship | | | | | | | | | | |
| 30. Pedophilia | | | | | | | | | | |
| 31. Prejudice (any kind) | | | | | | | | | | |
| 32. Commercial propaganda | | | | | | | | | | |
| 33. Prostitution | | | | | | | | | | |
| 34 Suicide | | | | | | | | | | |
| 35. Illegal Arms and Drug Traffic | | | | | | | | | | |
| 36. Human traffic (slavery) | | | | | | | | | | |
| 37. Vandalism | | | | | | | | | | |
| 38. Violation | | | | | | | | | | |
| 39. Taking advantage of others/Con artistry | | | | | | | | | | |
| 40. Domestic violence | | | | | | | | | | |
| totals | | | | | | | | | | |

*Legend:*

*N: No Symptoms;*

*L: Slight,tendency under control*

*M:Annoying, no functional impediment*

*S: Severe; With function impediment but does not incapacitate.*

*C: Catastrophic; Symptoms cause Incapacity*

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# List of Psychosomatic Conditions

(Conditions recognized by a Health Professional, Naturist, Advisor or by the own patient).

| Conditions | N | L | M | S | C | Conditions | N | L | M | S | C |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 acne | | | | | | 31 pituitary disorders | | | | | |
| 02 allergies | | | | | | 32 hyperactivity | | | | | |
| 03 anemia | | | | | | 33 hysterectomy | | | | | |
| 04 anorexia/bulimia | | | | | | 34 hiv + | | | | | |
| 05 anxiety | | | | | | 35 frequent indigestion | | | | | |
| 06 arthritis | | | | | | 36 frequent urinary infections | | | | | |
| 07 asthma | | | | | | 37 insomnia | | | | | |
| 08 high sugar (diabetes) | | | | | | 38 digestive problems | | | | | |
| 09 low sugar (hypoglycemia) | | | | | | 39 problems of memory, concentration | | | | | |
| 10 bipolarity | | | | | | 40 menopause | | | | | |
| 11 cramps (nocturnal) | | | | | | 41 irregular menstruation | | | | | |
| 12 cancer | | | | | | 42 migraines | | | | | |
| 13 chronic fatigue (fibromyalgia) | | | | | | 43 obesity | | | | | |
| 14 dandruff/eczema | | | | | | 44 urinary track infections | | | | | |
| 15 frequent colds | | | | | | 45 osteoporosis | | | | | |
| 16 cardiovascular problems | | | | | | 46 parched skin | | | | | |
| 17 cellulites | | | | | | 47 high blood pressure (__/__) | | | | | |
| 18 cholesterol high___low__ | | | | | | 48 problems of the prostate | | | | | |
| 19 colitis | | | | | | 49 frequent pneumonia | | | | | |
| 20 compulsive eating | | | | | | 50 problems of the kidneys | | | | | |
| 21 Crohn' s (regional ileitis) | | | | | | 51 reflux | | | | | |
| 22 attention disorders (ADD) | | | | | | 52 premenstrual syndrome (PMS) | | | | | |
| 23 macular degeneration | | | | | | 53 sinusitis | | | | | |
| 24 depression chronic (dysthimia) | | | | | | 54 stress | | | | | |
| 25 diabetes (type I___; type II __) | | | | | | 55 problems of the thyroid | | | | | |
| 26 diarrhea | | | | | | 56 high level triglycerides | | | | | |
| 27 backaches | | | | | | 57 ulcers | | | | | |
| 28 constipation | | | | | | 58 | | | | | |
| 29 Pharmacodependency | | | | | | 59 | | | | | |
| 30 liver problems | | | | | | 60 | | | | | |

ADDITIONAL COMMENTARIES / OTHER CONDITIONS NOT LISTED:

_____

_____

_____

_____

Did you know that Attention Deficit Disorder is basically a nutritional deficiency of chelated (amino acid-bond) lithium?

Did you know that Attention Deficit Disorders are high - risk indicators for Axis I (DSM-IV) psychiatric disorders?

Did you know that correcting the lithium deficiency in a therapeutic? community environment - residential or ambulatory - can prevent serious and catastrophic ADD complications and co-morbilities?

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Please, tell me your story (What you want me to know about you)

Since when do you have this condition?

Have you undergone any kind of treatment?

Have you relapsed?

Which are your reasons to look for aid at these precise moments?

What are your expectations from the treatment?

**Did you read my articles: www.addapr.info? Do you have any questions?**