

Ecologic and Biochemical Observations in the Schizophrenia Syndrome

1977 Status of Deficiency-Addiction-Diabetes Mellitus-Infectious Disease Process
and the Schizophrenic Syndrome Variable

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Introduction

In the mid-1970's, while engaged in a psychiatric practice heavily involved in the treatment of schizophrenia, I saw in their fluctuating symptoms what appeared to me as evidence of organicity (soft neurological signs) in my schizophrenic patients. Since that time I have been engaged in a classic medical model process of differential diagnosis endeavoring to sort out this organicity. To date my conclusions are that schizophrenia can be characterized as a separate disease only by virtue of its characteristic symptoms, but that in a more comprehensive sense it is a variant of a chronic disease process which produces many chronic disease variant syndromes involving varied tissues and superimposed infections. These diseases are named in accordance with the tissues involved, the superimposed infections, the autoimmune reactions evoked, or the endocrine glands disordered by the

process. These specific chronic physical and chronic mental deteriorating diseases stem from a common disease process.

Viewed at the level of clinical demonstration, this chronic disease process is observed to be an addiction. The deteriorating qualities of narcotic and alcohol addiction have been understood for a long time. What has not been appreciated until recently is that addictive adaptations to frequently used foods and commonly met chemicals can be as deteriorating to metabolism and tissues as narcotic and alcohol addiction. Also methods by which the process of addiction can be demonstrated have not been common medical knowledge.

Addiction and Maladaptive Reactions

Addiction is characterized as having: 1. relief or partial relief on contact with the addictant, and 2. the emergence of withdrawal phase symptoms on avoidance of the addictant. The emergency of withdrawal symptoms can range from one hour (often four hours) after exposure to up to three days after exposure.

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Foods and chemicals can be observed to be as addictive as are alcohol and narcotics. The conclusion can be drawn that addiction is dependent on the state of the person's metabolism. It is more correct to talk of an addictive state of metabolism than an addictive substance since the addictive state will spread to and encompass many substances. Pure air, pure water, and pure salt are nonaddictive, but there likely exists no food with its compounded chemistry that is nonaddictive.

Four to six days of avoidance is a sufficient period for the metabolic process to recover from its adaptive addiction. There then exists for a period of several days an acute hypersensitivity reactive state which can be used as a single substance exposure period to determine the reactive substances. The acute reaction begins to diminish in about 20 days, and within 45 days many minor reactive substances no longer produce symptoms. Within 90 days 95 percent of incriminated substances will not evoke symptoms on a single exposure if these exposures are spaced as much as four days apart. Induction testing using exposure to single substances takes advantage of the acute reactive phase, while a four-day diversified rotation of foods utilizes the refractive phase.

The chemistry of the adaptive addictive withdrawal phase and the acute reactive phase is observed to be identical. It consists of 1. an acute metabolic acidosis due to lack of completion of carbohydrate and lipid metabolism, and 2. if sufficiently chronic, is also reflected in disordered insulin metabolism and hyperglycemia. The insulin disorder during the adaptive addictive state is that of hyperinsulinism with resultant hypoglycemia, whereas when the adaptive addictive state fails to metabolically be maintained there emerges hypoinsulinism with the result being hyperglycemia. At this state some will be producing antibodies to insulin. Four to six days of avoidance characteristically reverts the hypoglycemia to hyperglycemia. The acute metabolic

acidosis is characteristic of early state and mild reactions as well as the severe and late stage process. On the other hand, the carbohydrate disorder is characteristic of only late and severe stage reactions. Acute edema which is usually localized and tissue specific is characteristic of acute maladaptive reactions as well as the addictive withdrawal state.

Relief of symptoms either of the addictive avoidance phase or the acute maladaptive phase can be reduced by: 1. Oxidation of toxins by O₂ or CO₂ plus O₂ or flash oxidation of intravenous vitamin C. 2. Detoxification by glucuronic acid. 3. Neutralization of the acid state by sodium bicarbonate given intravenously or orally. 4. By intravenous B5. Experience tells me that B6 intravenously in the range dose of 1,000 mg is the best relieving agent and that it can be favorably improved by the added support of vitamin C, magnesium, and glucuronic acid. The fact that B6 is the optimum relieving agent implies that a basic problem in these reactions is enzymatic deficiencies.

A formula with logic would be on the order of a marginal nutritional deficiency which when stressed by specific foods making specific enzymatic demands produces local edema in the most deficient tissues. Nutritional deficiency can develop in several ways such as: 1. Metabolic errors making demands for specific nutrients, especially B6. 2. Frequent use of a food making heavy demands for specific enzymes for metabolism of that food. 3. Malabsorption of foods. 4. Infections making demands for specific nutrients. 5. Poor eating habits.

The Diabetes Mellitus Disease Process as Precursor to Chronic Degenerative Diseases

The chemistry of addiction and that of adult onset diabetes is observed to be the same process. Monitoring the chemistry of the addictive adaptation state reveals hypoglycemia to be due to the stress of the addictive withdrawal state and hyperglycemia to be present during the acute

reactive state produced by provocative tests of foods or chemicals after a four-day avoidance period. A chemical diabetes mellitus state exists during the adaptive addictive state. This chemical diabetes mellitus state does not have a fasting hyperglycemia, and its presence can only be demonstrated by provocative testing. The majority of the time the adaptive addictive and therefore the chemical diabetes state is maintained for years without proceeding to the next stage of the process. If and when metabolic circumstances are such that the adaptive addictive adjustment cannot be maintained, then fasting hyperglycemia emerges and the diagnosis of clinical diabetes mellitus is made.

The adaptive addictive (chemical diabetes mellitus) stage has been poorly understood until recently both as to diagnosis and significance. It is diagnosable by provocative testing after four days of avoidance of the addictants. The presence of hyperglycemia is determined by monitoring blood sugar before and one hour after the provocative test. The emergence of numerous physical and central nervous system symptoms reveals the evidence of the relationship of this adaptive addictive (chemical diabetes mellitus) state to chronic deteriorating physical and mental diseases. The diseases are named according to the tissues involved, the disordered endocrine glands, the autoimmune disorder evoked, or the secondary invading microbes. The diseases produced in this way encompass a long list of common degenerative diseases common to mankind. Hans Selye rightly recognized the role of various stresses in the disease process.

We now can go a step further by the observation that addiction to foods and chemicals is in general man's greatest stressor. In identifying the chemistry of addiction as being that of chemical diabetes mellitus, we understand how the adult onset diabetes mellitus process in its chemical diabetes mellitus stage is a precursor to many chronic degenerative diseases, both physical and mental, including also the classic

development of frank clinical diabetes mellitus. The reversibility of these diseases by avoidance of the symptom-incriminated substances (addictants) provides convincing evidence of the relationship. Further convincing evidence of the relationship emerges when the acute reactions evoked during provocative test exposure after a period of avoidance reveals these symptom reactions to be the diseases in miniature, i.e., acute reactions which are the same as the chronic reactions of the diseases.

The Role of Infections

Infections characteristically develop from opportunist organisms in malnutrition, diabetes mellitus, and edematous tissues. These factors are all characteristic of the chronic disease process leading to many chronic physical and chronic mental illnesses. The infections also further poison the metabolic processes and then become part and parcel of the continuing disease process. All possible efforts should be made to isolate and eradicate these infections. Virginia Livingston, M.D., and I have through dark field microscopic examination and cultures of urine and feces observed consistently the presence of the opportunist pleomorphic microbe Progenitor cryptocides in schizophrenia. This is a parallel to Virginia Livingston's observations of neoplastic disease. This agrees with James Papez, M.D., who cultured this microbe from the brains of schizophrenics and also observed it under dark field microscopic examination parasitizing red blood cells.

The Role of Learned Responses

Maladaptive responses repeatedly evoked lay down learning in which these responses later are evoked by associated stimuli which were initially present during the evoked responses. Generally these learned, responses are not as intense as the organically evoked responses. However, these learned responses can be quite severe even after the organically evoked responses are corrected.

Obsessive-compulsive responses are especially hard to manage due to their self-reinforcing mechanism and the reluctance of the patient to give up these particular types of defenses.

I have found that the most rapid method of training-out phobias is to give 1,000 mg B6 I.V., 12.5 g vitamin C I.V., magnesium sulfate 2 g I.V., Calphosan 10 cc. I.V., and if need be to obtain adequate inhibition, then add Preltron (sodium glucuronate) 10 cc. I.V., adrenal cortical extract 10-20 cc. I.V., and Dex-phanthanol 10 cc (2,500 mg) I.M. to the above. These patients then listen to a 30-minute tape of a discussion I have with them about their symptoms. Some desensitize at the rate of three minutes per symptom while a few require up to 15 minutes per symptom. Five to 10 hours total practice is usually adequate.

Obsessions and compulsions are best handled by the technique of stimulus interference in which a mild (below pain level) electrical stimulus is given immediately after a verbal cue representing the symptom. Symptoms such as affectual that cause suffering to the patient are usually handled well. However, those that deal with judgments of right and wrong and obsessional criticism of other people are often refused to be touched or even insightfully accepted as symptoms. These particular types of obsessive-compulsive symptoms remain the bane of all doctors no matter what the methodology of treatment may be.

Conclusions

Schizophrenia and indeed most psychotic states, many so-called psychosomatic reactions, and some neuroses can on induction testing of foods and chemicals be demonstrated to exist as reactions to frequently used foods and commonly met chemicals. The subject is observed to be in a state of adaptive addiction to these substances with frequent emergence of withdrawal phase symptoms which we term the symptoms of the illness.

Monitoring the chemistry of addiction reveals

this to be the state of chemical diabetes mellitus characterized by acute metabolic acidosis, disordered carbohydrate metabolism, and disordered lipid metabolism.

Infections invariably invade the maladaptive tissues due to the low oxygen in the edematous tissues and due to malnutrition of tissues. There also exists an immunological defect in relationship to infectious agents.

Hans Selye was right when he observed chronic stress leads to chronic disease either physical or mental. However, what Hans Selye did not know was that mankind's greatest stressors are addictions to frequently used foods and commonly met chemicals.

The degree of physical and mental symptoms evoked during exposure to autogenous bacterial and fungal vaccines makes imperative a systematic examination for chronic infections in chronic degenerative physical and mental diseases. The most noble efforts using nutrients, food avoidance, and food rotation cannot render some of these patients symptom free, whereas the addition of autogenous vaccines and sometimes initially antibiotics can reverse the chronic physical and mental symptoms. Catatonia, paranoia, morbid depression, and obsessive-compulsive symptoms are especially prone to be bacterial or fungal in origin. It cannot safely be predicted in any given case what type of infection would produce specific symptoms. The common bacteria, *Staphylococcus aureus*, has been observed as a serious producer of paranoia and obsessive-compulsive symptoms. Some psychotic states thought to be irreversible chronic illness have been observed to clear of symptoms when their chronic infection of *Staphylococcus aureus* was successfully treated. It surprises and enlightens even the most experienced psychiatrist to see supposed irreversible obsessions and compulsions or morbid depression disappear when an isolatable infection is adequately treated with autogenous vaccines. Infectious agents are of equal importance as foods and chemicals in evoking mental symptoms.

It is imperative that a thoroughgoing ecologic examination includes infectious agents as symptom producers. The most effective treatment of chronic physical and chronic mental diseases needs to honor:

1. Nutritional needs. Basic nutrition in general, but especially B6, zinc, vitamin C, and pantothenic acid. Acute nutritional deficiency reactions occur when exposed to the biochemical stress of frequently eaten foods due to the demands that are being made for specific enzymes needed in the metabolic process of these foods.

2. Addictions should be discovered by a period of avoidance followed by a systematic single exposure induction testing. The re-establishment of addiction is avoided by a four-day diversified rotation diet.

3. Chronic infections are treated by autogenous vaccines and, if indicated, antibiotic treatment initially. Adequate nutrition is necessary also to build immunological defenses against infections.

4. When organic causes of symptoms are removed, there still remains learned residuals which can be improved by appropriate treatment such as de-sensitization of phobias, inhibition of obsessions and compulsions, conflict resolution, learning of social skills, and personality maturity.

Central lessons learned from this ecologic-metabolic differential diagnostic study are:

1. Generalizations from one food to another are demonstrated not to be valid. The generalization that a reaction to corn syrup (as glucose) can serve as evidence of across-the-board reaction to carbohydrates has led to inefficient treatment of diabetes mellitus and hypoglycemia. Optimum dietary management of carbohydrate interference can only be achieved by knowing, by test evidence, the assortment of substances that evoke the disorder. These may be carbohydrates, fats, proteins, and nonfood chemicals. Optimum dietary management is achieved by an initial avoidance of and later spacing of incriminated substances.

2. A four-day (or if preferred seven-day) diversified rotation diet keeping foods in family groups is likely the greatest protection humans have against developing addictions which lead to chronic physical and chronic mental diseases. There needs to be an initial three-months period of avoidance of incriminated substances. Ninety-five percent of the time all incriminated food can be successfully reintroduced into the diet. Even the diabetic who has been poorly controlled by the traditional diet and insulin may well find himself in good control without evidence of either symptoms or hyperglycemia and be able to reintroduce into his diet sugar, pie, cake, and ice cream after the initial three months' avoidance. The schizophrenic who on initial tests of wheat may have been depressed, paranoid, hallucinated, and delusional may return to wheat provided there are no symptoms on exposure to wheat on a once-in-four days' basis after three months' initial period of avoidance.

3. An optimum amount of vitamin C for metabolic function and defense against infectious agents is in the range of 10 to 20 g a day. This cannot possibly be obtained in food without supplementation. The optimum amount of B6 is about 1,500 mg a day. Again this amount of B6 cannot be obtained in food without supplementation. A lesson learned from this adventure into the differential diagnosis as to causes and treatment of physical and mental chronic diseases is that optimum health can only be achieved by supplementation and not by food alone.

Format for Research

Now that the significance of reactions to foods and chemicals is understood as evoking physical and mental symptoms, we are prepared to examine the chemistry of two dimensions, that of the symptom-free or relatively symptom-free state versus the symptom-evoked state. These two phases need to have parallel examinations in the areas of metabolic errors, metabolic shifts, organ reactions, toxins, endocrine shifts, and so forth.

Making such examinations I have found porphyria to be frequent in schizophrenia. Using this type of examination as applied to carbohydrate metabolism demonstrates this disorder to be the central metabolic malfunction in an assortment of chronic deteriorating physical and mental illnesses including schizophrenia.

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