

Alcoholism, A Reflection of Adaptive Failure

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Following my retirement from the Army in 1973, I began a second career, which primarily involved helping the alcohol dependent recover from their illness, alcoholism. Initially, my emphasis was essentially the same as AA (Alcoholics Anonymous). In addition, I emphasized the resolution of unresolved conflicts. However, in a short time, I noted that although some of my clients were in a recovered state, they felt "lousy". They were abstaining from alcohol one day at a time. Some would abstain for two to three months, only to succumb to their compulsive need for alcohol. One client expressed his dilemma by stating, "I have insights on my insights, but I still drink". I was not satisfied with the concept that the alcohol dependent were powerless over their illness. A referral to a medical doctor started me in the direction of the root cause of alcoholism.

I referred a woman to her medical doctor for mood swings, which were manifested by extreme hyperirritability and destructive behavior, followed by suicidal depression. Such episodes were commonly associated with excruciating headaches. She reported back, with a great deal of enthusiasm, that her doctor said she had a "severe case of hypoglycemia". I replied, "Hypoglycemia, what's that?" Subsequently, the biology of addiction became my emphasis. So-called psychological cues were to be a minor emphasis in the treatment process thereafter. Learning about hypoglycemia, its causes, prevention, and treatment opened the door to a bio-ecological solution to alcoholism. However, initially, my emphasis was upon a low carbohydrate, high protein diet, recommended supplementation of basic nutrients, such as a B Complex, a mineral combination, and Vitamin C. I also emphasized other areas, which are commonly neglected by the alcohol dependent, such as rest, exercise, and mental stimulation. I was encouraged by the

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changes and improvement observed, and by their reported gains. However, I still was not satisfied. The improvement was not sufficient to warrant an enthusiastic, "This is it!" William Philpott's (1979) reference to Theron Randolph's findings, concerning addictive adaptation, led me to the cornerstone. As early as 1950, Randolph, M.D., Allergist, declared that alcoholism was a food addiction problem. The 1968 edition of the *Rutgers University Dictionary of Words About Alcohol* (Keller, 1968) states,

...According to the theory of Alcoholics Anonymous, Alcoholism is 'an allergy of the body', implying a psychobiological sensitivity rendering alcohol especially noxious. H. W. Haggard (1944), pointed out that if the allergic reaction took the form of attraction to it, and resulted in uncontrolled drinking, alcohol would have to be considered an allergen different from any other. T.G. Randolph (1950, 1951, etc.), considering alcohol addiction in the context of a larger theory of food addiction', proposed that the substance from which an alcoholic beverage was derived might produce addictive drinking as an adaptive manifestation in certain susceptible individuals.

Guided by Randolph's principles of addictive process (1976a, b, d; 1977b and 1978), and a modified version of William Philpott's (1977) provocative food testing (1977), as described in the *Physician's Handbook On Orthomolecular Medicine*, I developed a procedure for identifying which substances, especially the grains, from which alcoholic beverages are derived, create a com-pulsiveness to self-medicate with an alcoholic beverage or other substance. I was satisfied, "This is it!" Philpott (1979) was right! We are indeed indebted to Randolph for his application of Specific Adaptation in a clinical setting. Widespread understanding, and application, would result in a treatment revolution for a myriad of illnesses, physical and mental.

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Rationale

Each addicted individual is uniquely different. Differences, to name a few, are: a. Biochemistry, influenced by genetics, and internal/external environment; b. Family constellation and personal relationship history; c. Cultural background, to include religious beliefs; d. Employment and associated stressors; e. Personal lifestyle, i.e., amount of exercise/rest, hobbies, and future plans; f. Personal trauma; g. Self image, and available support system/mechanisms. Consequently, an integrative (eclectic) approach (Thorne, 1973), which addresses the whole person, including an understanding of adaptive failure, as related to the stimulatory/withdrawal process observed in the alcohol dependent is required. The family constellation, social relationships, cultural traditions, and institutions are major, recognizable, impinging external factors, which influence the individual's maturation process across time. However, when physiological support processes are dysfunctional, because of genetic influence, or become weakened developmentally, the internal environment must be considered the major impinging factor in the behavior and the treatment of the alcoholic. Because alcoholism is a reflection of adaptive failure, the therapist must be able to apply an academic understanding of adaptation in a clinically useful process, to include diagnosis, treatment, and prevention. For example, Hans Selye's General Adaptation Syndrome (G.A.S.), is commonly presented in an academic environment concerning general features of adaptation as applied to groups of animals in an experimental environment. Conversely, Randolph's Specific Adaptation (1978) can readily be understood and applied by health service practitioners in the clinical treatment of a myriad of physical/mental illnesses and behavioral problems (Philpott, 1977).

Randolph (1976c and 1980) enlarged upon the concept of Selye's G.A.S. to demonstrate, in a practical way, the phenomenon of individual susceptibility to various environmental substances. For example, he has repeatedly demonstrated individual susceptibility to substance addiction and associated stimulatory/withdrawal responses to alcohol, other drugs, chemical pollutants and frequently eaten foods, to include the source foods of alcoholic beverages. The interplay

between such specific environmental exposures and chronic/acute responses of reacting individuals, is expressed as Specific Adaptation (Randolph, 1978). He defined adaptation as "The ability of an organism to adjust to gradually changing sustained circumstances of its existence" (1978). The term, *gradually*, is highly significant when the reader considers that Scandinavians, Native Americans, and Native Alaskans, have a relatively short genetic history with grains, from which alcoholic beverages are commonly derived. I hypothesize they are highly susceptible to alcoholism for that reason and that is the genetic component of alcoholism; i.e., genetic incompatibility with one or more grains. However, it should be noted that frequency of contact is considered to be the primary cause of adaptive failure and consequently, addiction.

Tragically, although Randolph's work has been confirmed by others (Philpott 1977, 1979, 1980 and 1983), as has the practicality of applying the concept of adaptive failure to degenerative diseases, such as alcoholism, it is not commonly understood or applied among alcoholics, or by alcoholism therapists. Further, with understanding, application of Specific Adaptation to illnesses, which have not responded to current therapeutic modalities, is also readily discernible. For example, I have applied it successfully to anorexia and bulimia.

Randolph (1976a) defined the stage of resistance, or the adapted stage, as the addicted stage, and further subdivided it into phase Ha, adapted, and phase IIb, maladapted, reference Figure 1 below.

Specific Adaptation

Phase I	Phase II	Phase III
Preadaptive (Nonadapted)	Addicted	Postadaptive (Nonadaptive)
IIa Adapted	IIb Maladapted	
		Onset of the Present Illness

In other words, adaptation to specific substances (alcohol), by susceptible individuals refers to an addictive (adaptive) stage, with an initial phase of an increased

tolerance (adapted Ha), to a stressor substance such as alcohol. But, across a variable time period, depending on the individual's susceptibility, an adapted response is followed by withdrawal (Iib maladaptive phase).

During the adaptive Iia phase, the susceptible person is stimulated and tries to maintain that altered state of consciousness by repeated exposure to the substance (alcohol, peanut butter, broccoli, caffeine, nicotine, wheat, dairy products, or other substance), and may, or may not be, aware of their addiction at that stage. However, the postexposure stimulatory phase gradually diminishes, in both time and effectiveness, as withdrawal increases commensurably. Obviously, some readers will take exception to the word stimulatory, because alcohol is commonly referred to as a depressant. The experienced phenomenon of stimulation is declared to be a release of inhibitions because of the depressant effect of alcohol upon cerebral inhibitory processes. That alcohol is a *food/drug* combination, is overlooked (Randolph, 1976c). The food fraction often results in a stimulatory effect in the susceptible person, as will be illustrated later.

Addiction is characterized as having: 1. relief, or partial relief, of some level of discomfort on contact with the addictant, and 2. emergence of withdrawal phase symptoms on avoidance of the addictant. Randolph (1980), Philpott (1980), Mandell (1977, 1979 and 1983), myself, and others, have repeatedly demonstrated addictive withdrawal from commonly consumed foods. Avoidance for approximately four days, followed by exposure to a given substance, such as consuming a grain, from which an alcoholic beverage is derived, results in convincing evidence of adaptive failure, i.e., inability to metabolize the substance without an ecological disturbance manifested in physical, emotional, and/or behavioral changes from an acceptable norm, i.e., even keel (0), Table 1 (Randolph 1976 and 1978).

The emergence of these symptoms can range from seven seconds, in the case of an inhalant, to possibly three days after exposure to a specific food. However, most commonly, within fifteen to twenty minutes of exposure to a food, such as a grain, from which an alcoholic beverage is

derived, a stimulatory or withdrawal symptom is experienced.

Withdrawal may be delayed for long periods by consuming alcohol as often as necessary, and in amounts sufficient to maintain an adapted stimulatory response. Initially, reference Table 1, this adapted phase of addiction to alcohol tends to be present as stimulatory levels + or + + . Although more advanced stimulatory levels + + + or + + + + may develop, the more common process is a decrease in post-exposure stimulatory symptom free periods, in both time and effectiveness, despite increases in the frequency and/or amounts of alcohol consumed. When verbally expressing these levels, the phraseology is "plus one (+), minus three (-)", etc. Inevitably, without intervention, a given stimulatory level will merge with and then be superseded by approximately the same withdrawal level. As withdrawal symptoms become more prevalent, a change from a specifically adapted and relatively symptom-free state (Stage Iia) merges with a specifically maladapted state (Stage Iib) and will be characterized by any of the withdrawal levels of reaction shown on the lower half of Table 1. Of course, a person experiencing symptoms at + , can experience one or more symptoms at — or + . Further, a susceptible individual might, initially, be stimulated to + + , after consuming corn, followed by one or more symptoms experienced at + , or possibly + + . That is, a + + , or + + + , stimulatory level does not necessarily result in a commensurate withdrawal level.

A brief explanation follows for ease of understanding how to apply the ecological disturbance chart, Table 1, in a clinical setting. Tobacco and alcohol will be used as the sample substances; however, any substance, chemical, carbohydrate, or protein, for which individual susceptibility exists, could be used as an example. This specific fact emphasizes the importance of breaking all addictions and identifying all substances common to the addictive individual's environment, and for which incompatibility can be demonstrated.

Begin at 0, a preadaptive state (Table 1), commonly referred to as even keel, which is the baseline, from which stimulatory and withdrawal levels are measured. For example,

Table 1. Principal Clinical Features of Various Stimulatory and Withdrawal Levels of Ecological Disturbances.

Directions: Start at zero (0). Read up for predominantly Stimulatory Levels; read down for predominantly Withdrawal Levels.

Maladapted Advanced Stimulatory Responses	+ + + +	Manic With or Without Convulsions	Distraught, excited, agitated, enraged and panicky. Circuitous or one-track thoughts, muscle twitching and jerking of extremities, convulsive seizures and altered consciousness may develop.
	+ + +	Hypomanic, Toxic, Aggressive, loquacious, clumsy (ataxic), anxious, fear-Anxious, And Egocentric	ful and apprehensive; alternating chills and flushing, ravenous hunger, excessive thirst. Giggling or pathological laughter may occur.
	+ +	Hyperactive, Irritable, Tense, jittery, hopped up, talkative, argumentative, sen-Hungry And Thirsty	sitive, overly responsive, self-centered, hungry and thirsty; flushing, sweating and chilling may occur as well as insomnia, alcoholism and obesity.
Adapted Responses	+	Stimulated But Relatively Symptom Free	Active, alert, lively, responsive and enthusiastic with unimpaired ambition, energy, initiative and wit. Considerate of the views and actions of others. This usually comes to be regarded as "normal" behavior.
Maladapted Maladapted Localized Systemic Responses	0	Behavior on an Even Homeostasis	Children expect this from their parents and teachers. Keel as in Parents expect this from their children. We all expect this from our associates.
	—	Localized Allergic Manifestations	Running or stuffy nose, clearing throat, coughing, wheezing (asthma), itching (eczema and hives), gas, diarrhea, constipation (colitis), urgency and frequency of urination and various eye and ear syndromes.
	— —	Systemic Allergic Manifestations	Tired, dopey, somnolent, mildly depressed, edematous with painful syndromes (headache, neckache, backache, neuralgia, myalgia, myositis, arthralgia, arthritis, arteritis, chest pain) and cardiovascular effects.*
Maladapted Cerebral and Behavioral Responses	— — —	Brain-Fag, Mild Depression And Disturbed Thinking	Confused, indecisive, moody, sad, sullen, withdrawn or apathetic. Emotional instability and impaired attention, concentration, comprehension and thought processes (aphasia, mental lapse and blackouts).
	— — — —	Severe Depression With or Without Altered Consciousness	Nonresponsive, lethargic, stuporous, disoriented, melancholic, incontinent, regressive orientation, delusions, hallucinations, sometimes amnesia and coma.

* Cardiovascular manifestations, including rapid or irregular pulse, hypertension, phlebitis, anemia and bleeding and bruising tendencies may occur at any level.

my first and only attempt to inhale tobacco was identical to the experience of most would be smokers in a pre-adaptive state. Following inhalation, I began to cough and wheeze, reference —. My immediate thought was, "Get to the doctor!" As I panicked and threw the cigarette down, a friend, who was an addicted smoker, encouraged me to, "Keep trying, your body will get used to it. It will make you feel better". Essentially, what he said was, physiologically, you will adapt; you will be stimulated and relatively symptom free, i.e., +. However, the experience was so uncomfortable, I never tried to smoke again; but, had I done so, my friend would have been correct. I would have adapted, and upon exposure, assuming that I was otherwise adapting to my environment, I would have gone to +. However, the tragedy of +, is that, across time, to maintain stimulation, exposure to the substance typically increases in frequency and amount. At some point, in time, the user no longer goes to +, but many, on exposure, go to + or higher, followed by or greater levels. One, or more, of the symptoms listed at ++, are then experienced. At this level, Randolph identifies that alcoholism is established, reference ++, Table 1. Instead of the word alcoholism, I commonly refer to addiction. Addiction occurs, because, without exposure to tobacco or alcohol, the individual goes to at least , and for relief of symptoms, consumption (exposure) is required. Thus, the individual begins to self-medicate. An early stage of adaptive failure is established with the most common symptom being fatigue, . The autonomic nervous system begins to dysfunction, with the first line of defense, the pancreas, becoming inhibited in the face of the stressor substance (Philpott 1979). The addicted are now in "manual override", and must consume substances at frequencies, and in amounts, necessary to ameliorate their discomfort. Sequentially, across time, the individual may begin to react at the +++ level and experience one or more symptoms listed at that level. For example, upon exposure, a drinker may become aggressive and assaultive. Bartenders soon recognize such individuals and refuse to serve them. If the individual goes to + + +, a withdrawal, or greater, will be experienced, with one or more symptoms identifiable. For example, a blackout (no memory, of part, or all, of a

drinking period) is commonly experienced by those who consume alcoholic beverages. Fortunately, few in adaptive failure go to + + + +. However, when one does, the wife commonly is beaten, children abused, doors kicked in, holes punched in the wall, and a seizure may occur. As stated previously, it is not necessary to go to + + + +, to go to . However, if one does go to + + + +, a trip to is inevitable, with one or more symptoms experienced at that level or lesser levels. Minus four equates to the delirium tremens, which is sometimes experienced by the late stage alcoholic.

The applicability of Specific Adaptation to illnesses, which have not responded to current therapeutic modalities, is readily discernible. For example, the anorexic would be classified as + + + to-----, and the bulimic would be classified as + + + to

Procedure

Randolph, Philpott, Mandell, and others, myself included, have repeatedly shown that the Specific Adaptation can be demonstrated by establishing a preadaptive state, (even keel), reference level 0, Table 1. This is accomplished by avoiding (clearing from) specific foods, and chemicals, including their alcohols, sugars, and source materials, for a period of four to six days. I refer to this process as "clearing". I have found four days of clearing to be adequate for an estimated 99% of clients. Exceptions happen, e.g., an anorexic took 7 days to lose her headache. Total abstinence from grains and commonly consumed foods is necessary, because alcohol carries with it the activity of the food from which it is derived. Because these food fractions are in liquid form, they are absorbed much more rapidly than the food source itself (Randolph, 1976c and 1978). Consequently, the person who is sensitive to the substances, from which alcohol is derived, would, in the adaptive addictive stage, obtain acute and rapid relief from maladaptive, Phase lib symptom(s), i.e., withdrawal. Because residuals are not uncommon, this adaptive failure may include incompatibility with the insecticides used on plant sources (Randolph, 1978).

Following the four day clearing process,

there is a period of time, estimated at twelve to seventeen days, when an acute reaction (demonstrated incompatibility), is observed/experienced following exposure (consumption). If incompatibility is genetic, instead of developmental, a maladaptive reaction occurs on reexposure despite the length of abstention. Four single food stress testing exposures are commonly made daily to determine which foods, or other tested substances, such as toothpaste, chlorinated water, deodorant, soaps, perfume, etc., are tested 1 1/2 hours after compatible food testings. Known addictants, such as alcohol, are not used for obvious reasons. Any substance not normally found in the human body, or, which is predictably stressful, such as, colorings, flavorings, additives, preservatives, sugars, etc., is not tested. These substances are considered stressors, which must be avoided. I sometimes refer to the human body as being similar to a diesel engine, which is unable to use a high octane fuel, such as sugar.

Test ingestion of previously avoided specific foods, such as a grain, from which a given alcoholic beverage is derived, results in

a convincing reaction, now experienced acutely, and so rapidly, that the relationship to the ingested substance is known and remembered. Experiencing the reaction motivates the individual to abstain from the incompatible grain, or other substance. Of course, those with a known history of seizures, asthma, or any reaction at ++ ++ or , Table 1, would only be tested in an inpatient facility under medical supervision.

When testing, and the client is at an adaptive level, + to ++, and relatively symptom-free, withdrawal effects are typically experienced at the same or slightly greater level, reference Table 1, levels -----, and ----- . That is, if reacting prior to testing at levels —, -----, and -----, slightly more advanced withdrawals usually manifest temporarily before ascending through lesser withdrawal levels during recovery.

Stimulatory and withdrawal courses of acute test reactions, shown in Table 1, as developed by Randolph, are also depicted in the chart below. The various courses of acute reactions may be followed, beginning on the left and reading the inscribed arcs clockwise (Randolph, 1978).

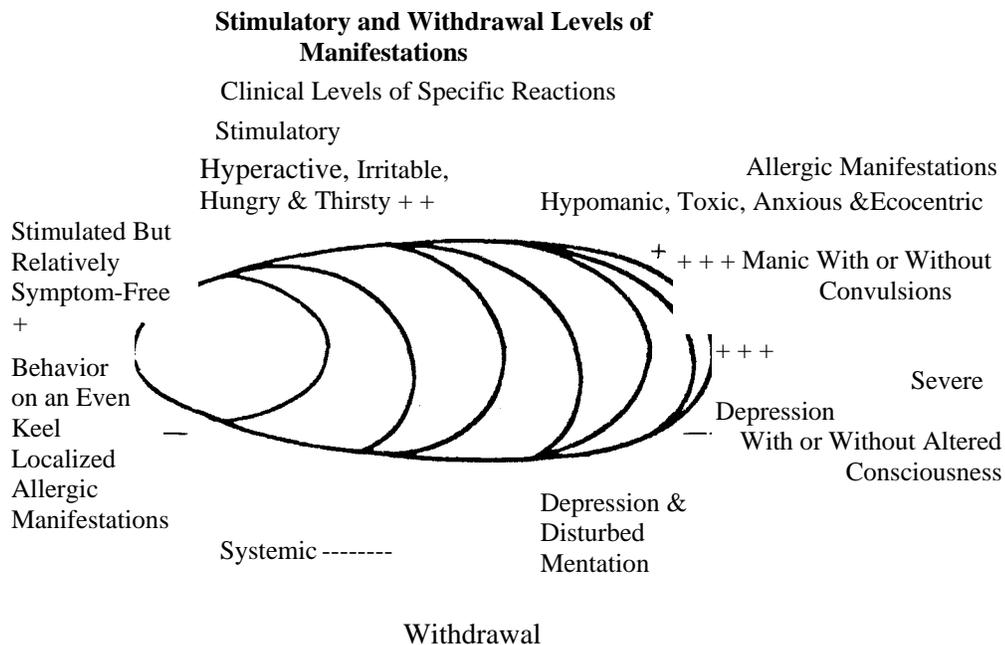


Chart 1: Test reactions, characterized by an initial stimulatory phase, may reach any stage of development (+, ++, + + + or + + + +) before merging with and then being superseded by the corresponding or slightly more advanced withdrawal phase (—, -----, -----, or -----).

The overall course of such test reactions inscribe any of the listed curves before receding. Start at center left, follow clockwise, induced reactions may reach any stimulatory level before merging with the approximately corresponding withdrawal level before receding.

The relative length of the stimulatory response in test provoked reactions is approximately 1/10th to 1/5th duration of the withdrawal phase (Randolph 1978). Across a variable time, the tobacco addict, and the alcohol dependent, are no longer able to maintain their relatively symptom free stimulatory levels, +, and ++, and may have possible transient increases to +++ or ++++, and sequentially, corresponding withdrawals become increasingly long and progressively worse. Nevertheless, they continue to smoke and drink, savoring their relative immediate, but short relief.

My procedure is to conduct an extensive interview and to use test instruments, such as the Experiential World Inventory (EWI)*, to establish base lines and to insure that medical or other referral is not necessary prior to beginning the clearing process. A thorough history of foods commonly consumed is made to insure that such foods are scheduled for testing. The client is given a choice of at least ten foods, which are rarely or never eaten, to consume during the four day clearing; that is, while establishing a preadaptive state (even keel). For example, honeydew, cantaloupe, apple, turnip, rutabagas, kohlrabi, papaya, squash, cod, and lamb are commonly listed. If a food is consumed any more frequently than once every fourth day, as apples commonly are, it is removed from the list of clearing foods. Apples are always peeled, prior to eating, because of the antioxidants commonly used and the possibility of insecticide residue. Initially, each clearing food is tested by itself, primarily by using a pulse test. The criterion used is to exclude the food from the diet if the pulse increases by eight or more, or decreases with an accompanying sudden onset of adverse symptoms. Pulse testing during the clearing process is primary, because the individual commonly begins the clearing process at-----or-----,

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and the symptoms gradually increase in magnitude and number, as abstention continues.

After four or more clearing foods are tested and considered compatible, the foods can then be eaten alone, together, or any time desired. Typically, withdrawal symptoms peak on the second or third day, followed by a sense of weakness, dizziness, sometimes expressed as faintness or fatigue. However, there is a clarity of mind, as the "fogbank" (brain fog) lifts. The fifth day is actually an additional day of clearing, as four new foods, also rarely or never eaten, are tested.

A diary is provided the client to record pulse, energy level, physical status, and emotional status before and after single food testings. Physical and emotional status indicators are usually expressed in terms of stimulatory or withdrawal symptoms. The pulse is taken for a full sixty seconds prior to test food consumption, and each fifteen minutes thereafter, over a period of one hour. The pulse is taken for a full sixty seconds, because, commonly, during the initial phase, the pulse may be somewhat irregular and inconsistent. Therefore, any errors would be multiplied. After consumption, energy, physical, and emotional recordings are summarized at the end of the one hour period. In this phase, the pulse is secondary, because, commonly, the individual is at 0, a preadaptive state, and readily recognizes any change from even keel. If not testing toothpaste, chlorinated water, shampoo, herbal teas, or other substances, common to the client's environment, clients are allowed to consume one or more of their clearing foods as snacks between testings. The client is encouraged not to go hungry, because the procedure is not a diet. However, everyone commonly loses weight, despite eating as often as they desire, especially the obese, because obesity is a food addiction problem (Randolph, 1976b and Mandell, 1983). The only restriction is that they limit themselves to the foods being tested, as scheduled, and to their compatible clearing foods, which can be consumed, as a snack, between testings.

The sixth day of the program is commonly referred to as "Murder Day" because of the pronounced reactions to one or more of the grains. If the grain testing day falls on a work day, the client is told to bypass grains until they can be tested on a non-work day. This is necessary, because the reactions may

Food	Before		After			
Corn meal mush with dark Karo syrup, salted to taste; two or more bowls; if no reaction, one more bowl in an hour. If no reaction, then next meal of mature corn as with corn on the cob.	Pulse:	76	15: 80	30: 90	45: 96	60: 100
	Energy:	Good	Same	Same	Same	Down
	Physical:	Little tightness	Same	Achey	Nervous	Slight
	Emotional:	Good	Same	Good	Down	Down
	Pulse:		15:	30:	45:	60:
	Energy:					
Physical:						
Emotional:						

Handwritten notes: Achey in shoulders, Down Nervous Worse, Down, Down

Figure 2. Corn test results of twenty-eight year old abstaining alcoholic.

result in poor work performance. Notably, very few react to rice. The reactions to wheat and corn are commonly expressed in terms, such as, "Just like a hangover", and "Who needs to drink booze, just eat wheat". One individual wrote "Wow, it was just like I had three shots of whiskey. This is weird". Examples of maladaptive reactions are shown at Figures 2 through 5. Figure 2 shows the response of a twenty-eight year old recovered alcoholic, who had been referred by his medical doctor for headaches and depression, which were chronic following his abstention from alcohol.

He related to me, "I haven't had a drink of alcohol in eleven years, but I have had a headache for eleven years and I've been depressed for eleven years". As he said the words "depressed for eleven years", the tear? began to roll down his cheeks. Notably, his pulse increased 24 beats a minute and -----to ----- symptoms became evident at 30 and 45 minutes. Because of limited space on his

diary, he wrote the following on a separate piece of paper, "After I ate corn meal, my back began to ache and my pulse went way up. My eyes were watery and somewhat bloodshot. Tightness in the chest, but still no headache. My wife asked me if I was getting a headache, because she could see it in my face, dark circles and the whole works. I felt tired and sleepy, energy level down, and I was nervous...I broke out in a cold sweat, got real shaky, weak and slight headache...I developed an excruciating headache... Absolutely, no more corn"!!!

Notably, his symptoms, as reported, following the corn, have commonly been labeled as the dry drunk syndrome. Other substances, which he reacted to were: wheat, chicken, eggs and cantaloupe.

Figure 3 shows the response of a 34 year old alcoholic episodic (binge) drinker, who had already destroyed two marriages because of his irritability. He related that he could go

Figure 3. Corn test results of episodic drinker.

Food	Before		After				
Corn meal mush with dark Karo syrup, salted to taste; two or more bowls; if no reaction, one more bowl in an hour. If no reaction, then next meal of mature corn as with corn on the cob.	Pulse:	60	15: 69	20: 74	30: 67	45: 64	60: 63
	Energy:	MID	High	High	High	High	High
	Physical:	Good	Fuzzy	Fuzzy	Fuzzy	Fuzzy	Fuzzy
	Emotional:	Good	Spaced	Spaced	Spaced	Spaced	Spaced
	Pulse:		15:	20:	30:	45:	60:
	Energy:						
Physical:							
Emotional:							

Handwritten notes: TOOK REACT KIT 30 MIN. FUZZY, DRUNK, NO MOTOR SKILLS. HEART BEAT SPACED, IRRITATED

<u>Food</u>	<u>Before</u>	<u>After</u>
<i>Potatoes</i>	Pulse: 72 Energy: OK Physical: OK Emotional: OK	15: 76 30: 80 45: 91 60: 99 ^{on high!} Energy: what energy Physical: drained - lamy Emotional: wanted to cry <i>UPSET. nasty to EVERYONE</i> <i>IMAGINE 76 72 - HIGH - 100 HIGH</i>
<u>DAY TWO</u>		
<i>cracker wheat</i>	Pulse: 69 Energy: OK Physical: OK Emotional: OK	<i>Reaction</i> 15: 76 30: 83 45: 90 60: 97 ^{wouldn't count} Energy: none Physical: none Emotional: I'm helping hard want to cry - upset - obvious quick to argue - everyone 15: 30: 45: 60: ^{thinks I'm} HIGH on something Energy: <i>HELP!</i> Physical: <i>WHOPPER AS BOOZE</i> Emotional: <i>DORSET IT!</i>
Wheat: Start with Bulgor or Stonebuhr, salted to taste. Two or more bowls. If no reaction, one more bowl in an hour. If no reaction, consume for lunch. (Use reverse side for additional testings of wheat.) If no reaction, consume for evening meal; no reaction, consume for evening (8:30) meal. No reaction, consume for breakfast the following day. If no reaction, go on to corn.		

Figure 4. Potato and wheat reaction of young female alcoholic and tobacco/cocaine user.

six to seven months without drinking, but he felt rotten day after day. Further, he said, he could get relief from his symptoms by drinking and then feel good for a little while. His most common alcoholic beverage was beer. Most commonly, beer is made from barley, corn, hops, yeast and water. He identified his reaction to corn as a "Whopper". Twenty minutes following consumption of corn, he can be identified as having reached + + +. Other foods, which he reacted to, were: wheat, oats, soybeans, chicken, turkey, lamb, pork and cod.

Figure 4 shows the reactions of a 21 year old, attractive female, who was addicted to alcohol, tobacco, and cocaine. She was a court directed case and had contacted various state approved agencies to determine which program she would enter. When advised that she would have to agree to give up all addictions to enter the program, she replied, in

words to the effect, that it was the first program that made sense to her, and she wanted to give up all her addictions. Her responses to potatoes and wheat are self explanatory. Other foods, which she reacted to, were: pineapple, zucchini, broccoli, cauliflower, dry beans, turkey, brussel sprouts, peanuts, yogurt, and onions. She is now free of all addictions and will soon marry. She enjoys living even keel and is highly motivated to maintain that status.

Figure 5 shows the test results of a thirty year old alcoholic, who was a daily maintenance drinker, and commonly consumed two six packs of beer daily. His wife told him he had to make a choice, alcohol or his family. He chose his family, and following contact with various agencies, he chose to give up all of his addictions, which he said, "made sense". Notably, as seldom happens, his pulse did not change significantly.

<u>Food</u>	<u>Before</u>	<u>After</u>
Corn meal mush with dark Karo syrup, salted to taste; two or more bowls; if no reaction, one more bowl in an hour. If no reaction, then next meal of mature corn as with corn on the cob.	Pulse: 58 Energy: O.K. Norm. Physical: O.K. Norm. Emotional: O.K. Norm. Pulse:	15: 61 30: 60 45: 58 60: 60 Energy: OK - OK - OK Low - Low - Physical: OK - OK - OK HEADACHE - LOUSY Emotional: (I, R, TABLE @ 10 min.) THEN O.K. - TERRIBLE Pulse: 15: 30: 45: 60: Energy: EXT - LOW Physical: TERRIBLE - Sick @ 2 hrs. Emotional: TERRIBLE - @ 2 hrs.
ALTER 2 HOURS BIRD HEADACHE FOR HOURS / 6 : LIKE HANGOVER -		

Figure 5. Thirty year old alcoholic's response to corn.

However, its effect was significant and he made the observation that he had a bad headache for hours, "like a hangover". Some months later, he wrote to advise that he was living even keel, actively employed, enjoying his family, and saving money. He was also exercising and enjoying a sense of energy that he had never experienced before.

The previous described cases are not exceptional. The responses described are typical of the alcoholics treated since 1981. Rarely has an individual been incompatible with only one food, such as a grain. Usually, multiple reactions throughout the testing process are experienced and commonly involve one or more of the grains. However, one individual, who had been classified as an alcoholic, because of the quantity and frequency of alcoholic beverages consumed, was compatible with all the grains, but incompatible with beef. Beef, which he ate daily, caused him to be lethargic and he would then self-medicate with alcohol.

Although the individual commonly reacts to wheat within fifteen minutes, if no reaction is experienced, it is tested all day long plus breakfast the next morning. If a reaction occurs any time during that period, testing of wheat is discontinued. Extended testing is necessary because wheat is absorbed slowly and no grains have been in the intestinal tract for five days (Philpott, 1977). In addition, wheat is a substance which may be eaten all day long; for example, toast or a wheat cereal for breakfast, followed by a midmorning cracker snack, followed by a sandwich for lunch, etc. Consequently, the individual's

susceptibility may be such that multiple feedings are necessary, before a reaction occurs. If there are no medical reasons to preclude such action, the individual clears from their reaction by consuming 1/4 tablet of Alka Seltzer Gold, combined with a level teaspoon of Buffered Vitamin C, which is derived from Sago Palm. A corn derived Buffered Vitamin C, might be allowable, but because it may carry the allergenicity of corn, it is not used. However, one can find literature, which indicates a corn induced reaction is not possible, because no corn proteins are left in the Vitamin C.

Following a return to even keel, after a reaction, testing proceeds. The individual now associates adverse symptoms with ingestion of specific foods, and is motivated to abstain from incompatible foods. When one young lady, who reacted adversely to wheat, was advised that she could retest wheat, after a period of ninety days abstention, she replied, "I don't care if I ever eat wheat again; I never want to feel that way again".

Abstaining results in no biological cue to self-medicate with alcohol or a substitute. Clients commonly state that when the biological compulsion (addiction) is absent, they can deal readily with the psychological cues. Of course, therein lies the necessity to stop all addictive substances used as substitute dependencies. Blood serum tests unfortunately, result in no such motivation because the individual does not experience identifiable adverse reactions associated with the food. Commonly, the individual's favorite food, which gives relief of symptoms, i.e., +, ++, or +++, versus -----, -----, or -----, is declared to make

them feel good, "I couldn't be incompatible, it makes me feel better!"

Supplementation is also encouraged, although the success of the program does not depend upon supplementation. That is, individuals, who have not been able to afford supplementation, have been successful in establishing and maintaining "Even Keel". Minimally, Alka Seltzer Gold is considered necessary for proper clearing, i.e., establishing a preadaptive state (Even Keel, 0) following a maladaptive reaction. However, for those who can afford supplementation, a B Complex (rice base) is recommended, as is Bronson's Pharmaceutical Mineral Insurance Formula, developed by Roger Williams. In addition, the amino acid, Glutamine, is recommended, per Roger Williams research findings (1959 and 1981). Further, Buffered Vitamin C is encouraged. However, after ninety days, supplementation is recommended at four day intervals to preclude sensitization to one, or more, of the substances included in the makeup of the vitamin/mineral. All vitamins, minerals and glutamine, are tested following a four day abstention, and of course, the client is warned that more does not mean better.

In summary, it can be said that susceptible individuals practice self treatment (self-medication) of their maladaptive responses to alcohol or a source material, e.g., a grain, by consuming alcohol as often as necessary, and in amounts, which will ameliorate or postpone their withdrawal. This self regulated process may satisfy their need for prolonged periods. However, when the individual can no longer maintain the relatively symptom-free stimulatory levels, higher stimulatory and comparable withdrawal levels, Table 1, and Chart 1, are experienced and characterized by chronic reactions. Despite this, the specifically maladaptive reacting person (alcoholic) tends to continue the established habit. This is especially true if they are addicted to other substances, such as tobacco, which provide psychological and biological cues to consume alcohol. Recovery to an even keel state is not possible without eliminating these additional stressors. Some individuals are susceptible to contaminated ambient or domiciliary air or contaminated water (Randolph, 1977a and 1980; Zamm, 1980) and may require treatment in an inpatient

ecological unit to properly clear and to identify all incompatibilities. If this is not done when necessary, the alcoholic will experience maladaptive (lib) reactions, which may trigger a return to alcohol for temporary and rapid relief of symptoms. Again, food fractions in liquid form are absorbed rapidly, with pronounced relief of adverse symptoms in the addictive stage (Randolph, 1976c).

Baselines are established through test protocols, such as the EWI, and of course, by self report. Except for those alcoholics, who have also had a pronounced history of drug use, such as amphetamines, LSD, marijuana, etc., elevated pretest scores on the EWI typically improve to T-score 50, or below, at post test. T-score 50 is the mean score of the psychiatric population upon which the instrument was normed. Also, post test, clients invariably, and enthusiastically, pronounce themselves at zero, or even keel. Typically, they are highly motivated to maintain even keel. If they depart from even keel, for other than a psychologically induced change in their autonomic nervous system, they act as detectives to find out what has adversely affected them.

Implications

The implications for prevention, diagnosis, and treatment of alcoholism, other addictions, and mental/physical illnesses, through application of Specific Adaptation, on an outpatient basis, are readily apparent. For example, anorexia and bulimia have been treated successfully through clinical application of Specific Adaptation principles. However, the following implications are specific for those specializing in the field of alcoholism:

1. Applying the principle of Specific Adaptation to the treatment of alcoholism will reduce the cost and length of treatment, recidivism, and the need for a lengthy participation in a self help support group.
2. Ignoring the need to stop all addictions when treating alcoholism, or any other addiction, should be considered malpractice. The day of brushing aside such a need, by reciting the worn out cliché, "One thing at a time", is a form of denial.
3. Therapists, who are addicted to tobacco and other substances, are acting unethically in treating alcoholism, i.e., therapists

are trying to take a twig out of someone's eye when they have a beam in their own eye. (Tobacco addiction is more difficult to treat than alcoholism) — (Randolph, 1980).

4. Recognizing adaptive failure early, and applying Randolph's principles of Specific Adaptation to a prevention/treatment program, is the solution to the widespread use of alcohol and drugs in our nation's schools.
5. Although single food stress testing results in the susceptible individual experiencing adverse effects, and thereby motivating abstention, biofeedback equipment may be readily used to identify those who are susceptible to addictive substance use. Such equipment can be used to identify incompatibility of environmental substances, to include foods (Laird, 1986), and chemicals.
6. AA participants, and their affiliated groups, to be in harmony with Bill W., a co-founder of AA, need to integrate the information found in this paper, and in referenced material. Bill W., in his latter days, wrote three letters to AA physicians in which he encouraged emphasis upon the biology of addiction. AA participants, and affiliated groups, can now declare that alcoholics do have power over their illness and they need to emphasize a healthy mind in a healthy body through application of Specific Adaptation principles. Of course, other health principles are applicable as well.
7. As insurance companies acknowledge the need to break all addictions, because of their biologically and psychologically conditioned relationship, alcoholism treatment insurance claims should not be paid, unless treating agencies incorporate the principles of Specific Adaptation. That is, all addictions are treated at the same time and substances, which are demonstrated to be incompatible, are avoided.

Summary

Alcoholism is seen primarily as a physiological adaptive failure process influenced by individual susceptibility, and is reflected in a stimulatory phase, which the alcoholic attempts to maintain, thereby avoiding the withdrawal phase. The root cause is most commonly an incompatibility with one or more of the grains,

from which alcoholic beverages are derived. Consumption of alcohol derivative sources, in any form, as well as other addictive substances, act as a biological/psychological cue to consume alcohol.

Adaptive failure, in the presence of individual susceptibility, is best understood and applied to the illness of alcoholism, by having a working knowledge of Theron Randolph's, Specific Adaptation.

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