

The Hypoglycemic Association

NEWSLETTER

Correspondence: THE HYPOGLYCEMIC ASSOCIATION, P.O. BOX 8, SYLVANIA SOUTHGATE, N.S.W. 2224

Telephone: (02) 588-5290

PATRON: Dr George Samra

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PRESIDENT:	Dr Peter Dobie	Steering Committee	Ted Grant
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Sub-Editor:	Sue Litchfield		Susan Choc

The **NEWSLETTER** of the Hypoglycemic Association is distributed to members of the Association and to Health Professionals with an interest in nutritional medicine and clinical ecology.

memo:

FEES: Yes we have come to the end of the year and for most members of the Association their membership and subscription to this Newsletter expires on the 31 December, 1990. If your membership expires at the end of this month as shown on the top right corner of the address label you should receive a separate reminder to send in the annual fees. Doctors and practitioners who receive this Newsletter free of charge are of course exempted, however if the latter would like to forward donations to the Association, they will be publicly acknowledged. The fees have not changed but may be changed at the next General Annual Meeting to be held on the 2 March, 1991. These are \$15 per family or \$10 for pensioners.

MERRY CHRISTMAS AND HAPPY NEW YEAR

APOLOGY

Because of illness which incapacitated me I have been unable to get the Newsletter out before the 1 December, 1990, when a meeting was held in the YWCA in Sydney.

There is a lesson to be learnt from this. Please make a note of the meeting dates for the year 1991, which are shown on page 10 at the bottom. They commence at 2 PM in the YWCA at 2 Wentworth Ave, SYDNEY. A change of venue is not anticipated. The next Annual General Meeting is on 2 March, 1991 and details of the speaker will be announced. Sorry that this issue could not reach you earlier.

THE EDITOR

ATTENTION TRAVELLERS FROM THE COUNTRY

Members wishing to arrive early at our next public meeting can look forward to receive a hot cup of tea or coffee with their own self-provided lunches. Sue Litchfield will be there at 1 o'clock to help the starving long-distance patrons! Afternoon

!!tea or coffee will be provided during the break as usual.

Steve Duff telephone advisory service

Our life member Steve Duff is willing to talk to any person by phone on any problems relating to hypoglycemia, allergies and diet. This voluntary advice is based on his personal experiences with hypoglycemia and allergies and any problems of a more complex nature will be referred to nutritional practitioners. If you would like to have a talk with Steve, please ring him at his home on 529-8040. (Please note Steve's article in this Newsletter on page 2)

Books for sale at the meeting

Dr George Samra: **THE HYPOGLYCEMIC CONNECTION.**

Jur Plesman: **GETTING OFF THE HOOK**

Sue Litchfield: **SUE'S COOKBOOK**

Sue Litchfield will bring sugar-free cakes to the next meeting.

Contributions of articles by members and by practitioners are very welcome. If you would like to contribute an article to this Newsletter, please contact the Editor.

The Newcastle branch of the Association are still meeting

under the leadership of Bev Cook. They meet on the last Saturday of each month beginning 1.30 PM to 3.30 PM at the Hillsborough Primary School. Enter the school from the Waratah Avenue. For further information ring Mrs Bev Cook at 049-59-4369.

If any member would like to organise meetings in their local area or meet other members, we can help by advertising your name and phone number in this Newsletter.

MY STORY

by Steve Duff

When I began writing my story it started in 1984 when George Samra first diagnosed hypoglycemia. But upon reflection my story starts from when I was a toddler. I was fed on formula milk and cow's milk became my dietary basis as I grew older. I remember being a sick child from the age of 3 1/2. I was diagnosed as having a long term terminal chest disease called bronchiectasis and the doctors began an immediate course of antibiotics and it nearly killed me.

I was always a sick but happy-go-lucky child. My mother still had me in nappies until I was 5 years and I remember the embarrassment being forced to run around in public or at my sister's party. This bedwetting continued until my mother found another doctor who decided to try an electric machine that gave shocks to the body when water passed through the genital area. I remember the terrible fear - even now writing this down - and the tears come to my eyes. Of course, I stopped wetting the bed immediately! However a deep seated fear remained ever with me.

My mother stayed with this doctor for many years, although when he was not available there were others. I remember some mentioning allergies to milk and dust etc. and they would advise my mother to take her son to the mountains or reduce the cow's milk, but basically nothing changed.

Nevertheless, I was a happy child, full of energy, sometimes I could not be stopped. I always had silly fears about things, as though my perception was interfered with in some way. Mum always fed me on glucose when I was sick and there was always sweet drink around the house.

I was ill every 2 or 3 months for 2 weeks during which time I was given antibiotics. Then I got well until the next time.

I was always a little hyperactive or very quiet, never could find that balance in between, that peace of mind. I lacked drive and motivation and only glimpsed a small number of times what I felt was my real self throughout these years.

At the age of 17 I began drinking alcohol and smoke grass and cigs. This was the way to cope and have fun in life, as I perceived it. But nothing changed. Slowly my health deteriorated and so did my logic and rational thoughts. This went on until I was 33. I was no longer happy-go-lucky! Life was now more hell than heaven. I had become down and cynical. My skin was pale and greyish. I was hyperactive or down and anti-social, just as when I was a child but now grossly exaggerated. I did not want to die, but felt like it. I smoked a pound of marijuana whilst I locked myself in my room for a month. I punched the doors and walls and injured my hand. I knew I couldn't go on like this.

I went to St George Hospital with my injured hand, but as there was a strike on they told me that I had to go to my own doctor. But I had none.

It was 1984 and I checked the phonebook where I found Dr George Samra's name. I wandered into the surgery after nearly running into a on-coming bus

"Sorry, we're booked out", said the receptionist but after MY

PROFESSIONAL FINANCIAL SUPPORT

THE HYPOGLYCEMIC ASSOCIATION would like to express its appreciation to the following doctors and health practitioners who have shown support and generosity by making a financial contribution to the Association.

Name	Firstname	City	Zip
BALGI,	DR DAS V	WEST WOL'GONG	2500
BASSAL,	DR N	SURRY HILLS	2010
DONOVA,	DESMOND J	MAROUBRA	2035
GUZOWSKA,	DR JANINA	SPRINGWOOD	2777
MARSHALL,	DR JOHN	MEREWETHER	2291
PETTIT	DR	CAREY BAY	2283
PILLAY	DR VIC	COFFS HARBOUR	2450
RYAN,	DR JOHN A	ALBANY CREEK	4035

This Society welcomes the moral and financial support shown to us over the years by all health practitioners receiving this Newsletter.

NEW ADDRESS

Dr George Samra, M.B., B.S. (Sydney)

Room 8 St. George Medical Centre
32-38 Montgomery Street
KOGARAH NSW 2217

Phone:588 5290 or 588 2111
Fax:588 2520

looking me over she added, "But I'm sure Dr Samra will make the time to see you".

"Dr Samra, I know that name!" I said.

I remember that day with joy. I knew deep down that was the beginning of a new life for me, a second chance, a second birth.

George seem to understand and know me, perhaps through his other diagnoses. I spoke and bumbled on and he explained the diet, the allergies as best he could in the little time we had. He asked me to read his book. I read the chapters of his book and cried with relief and joy. At last there was someone who was enlightened enough in the medical sense. Disturbed as I was I began on the diet and stuck to it rigidly for 2 years.

However, my deep scarred fears and psychological insecurities were still with me. Years of depressed perceptions and mood swings had left me confused and neurotic, although I did notice that I began slowly to think more rationally and logically.

I continued to smoke grass and cigarettes and drank Scotch over the weekends. This reinforced my old ways. It was a hard battle to give these up. Every few steps forward came a step back. My old friends and society reinforced my old negative self and I tended towards more rigid and obsessive behaviour as a defence mechanism. My new friends found it difficult to handle me. I abhorred my old self and was frightened of people who seem to have it altogether in life.

You see our ways of thinking don't go away just with dietary

(Continued on Page 6)

THE RELATIONSHIP BETWEEN HYPOGLYCEMIA AND PSYCHOLOGY

By Donna L Reams (Psychologist)*

AS PSYCHOLOGISTS in independent practice in Wollongong we see people with a multitude of problems, ranging from Parkinson sufferers which need to reduce the severity of their tremors to parents with difficult children or children with difficult parents.

Being people rather than disease oriented one of our primary goals is to treat the person rather than just a presenting problem and so our approach is holistic and eclectic. Our goal in essence is to get to the basis of the difficulty whether this be due to a physical, mental or emotional source, or any combination of these three.

Being in private practice we see people for a wide and varied range of concerns and problems. This is a prerequisite to financial survival in a small town like Wollongong where exclusive specialisation is out of the question. From this variety we have gained knowledge and experience that is quite comprehensive.

Regardless of the type of problem or assistance we are requested to give, we have found an across the board commonality in a large proportion of our clientele. These people are diagnosed as having an underlying physical problem such as hypoglycemia or hypothyroidism in addition to some psychological or emotional problem. However, usually both the client and other people, such as the referring doctor and family, believe the problem to be exclusively psychologically based. The most common descriptor or label applied to these clients would be that of neuroticism. Common symptomatology would include high levels of nervousness, depression, irritability, anger, relationship and/or sexual difficulties, and a general inability to cope with life.

These are not unusual symptoms given the right environment in which to flourish. Many people at times find themselves in desperate circumstances or have had a bad trot throughout life and therefore have more valid reasons for exhibiting these symptoms. What we find is that the groups with an underlying physical disorder have these symptoms for no valid accountable reason. There is a distinct magnification of symptoms in these clients.

Most of these clients do not report life circumstances that can be labelled as crises. They experience the moderate ups and downs that life offers but feel are beyond their ability to cope. They are reasonably intelligent and informed but are unable to use their common sense and intellect to calmly problem solve their way back to stability as most people do.

We acknowledge that we are seeing a biased portion of the population in this client group. These are people that can attribute a significant amount of their difficulties to a physical disorder but unfortunately these clients are slipping through the medical net and ending up on our doorstep. One of the key questions one asks at this point is 'why are they slipping through the medical network?'

The reasons we are catching these people is twofold. Firstly, the psychological markers to hypoglycemia emerge most of the time before the physical symptoms. Secondly, our criteria for diagnosis differs from that of the medical model.

Based on our clinical experience we have found that treatment of only the physical underlying disorder through diet or medication generally results in a high rate of recidivism. What one must question is what caused the disease in the first place. Granted, we do see some clients whose etiology may be traced to a car accident, being thrown from a horse or frequently to surgical procedures using anaesthesia. However, the majority of clients report a long-term history of gradually worsening symptoms over many years but with no specific incidence to cite. Insecurity or feelings of inadequacy when dealings with life's normal demands takes its toll. And the price the toll collects is stress on the body.

Ignoring any psychological or emotional dynamics, i.e. poor self esteem, lack of confidence, etc. leads to a continuation of stress on the body which frequently causes further deterioration on whatever is the weakest part of the body. In the case of hypoglycemia this would be the pancreas.

Our treatment strategy is based on the circular effect encountered in the Stress-Organic Syndrome Model or mind-body interaction wherein both the physical and psychological problems are addressed simultaneously.

The model shown in **Figure 1** helps to conceptualise how disease develops. Organic dysfunction is the actual disease regardless of its cause. At this level would be the diagnosis of a peptic ulcer or heart condition.

The medical model basically starts with the organic dysfunction which leads to distress. Distress is a physical symptom like pain, fatigue. Distress is something you can feel. The feeling ill causes stress which are defined as psychological symptoms such as nervousness, depression, agitation, lack of concentration, or the overall feeling of not coping.

The medical model has an upward movement on the model and until a measurable physical problem erupts patients frequently are diagnosed as neurotic due to a plethora of psychological symptoms but the absence of a recognisable physical condition.

The psychological model has a downward pattern. It says the

* Donna and her husband Carl Reams have a private practice at 51 Rowland Ave, Wollongong NSW 2500,(042) 28 7435

STRESS-ORGANIC SYNDROME MODEL

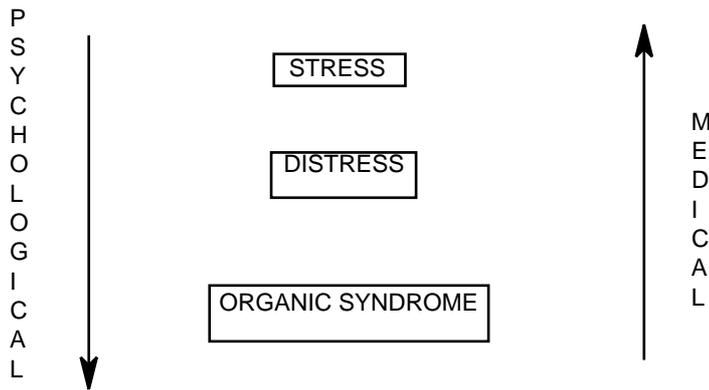


FIGURE 1

development of a condition starts with stress, i.e. Nervousness, depression, not coping. The long effects of trauma or stress causes distress such as pain, headaches, poor memory, etc. Stress induced hypertension is a good example of the long term effects of stress and distress can cause the organic condition where the body actually deteriorates in some manner.

We do not propose that every physical condition comes from a psychological condition. We accept that the medical model is also an accurate model. But what we do insist on is that there is a circular relationship in the model.

We do propose that an interaction occurs wherein stress, both chronic and acute, interact at the physical and mental levels. The reciprocity of the two levels contribute to the exacerbation of the other causing a steadily worsening effect in a circular fashion. Initially, acute stress causes a deterioration in the body. At some point symptoms of an acute nature commence, i.e. depression, confused thinking, coping difficulties which obstruct further an individual's already existing inadequate ego structure. This process places further stress on the body causing further deterioration and an increase in the frequency and severity of symptoms until the acute condition becomes chronic.

We endeavour to impress upon our clients the need to address both issues, however, they frequently feel so fantastic after a couple of months on the diet they discontinue counselling only to represent a couple of years later to start up where they left off. Yes, the diet stabilised the hypoglycemic symptoms but the emotional difficulties, left untreated, continued to stress the body leading to a return of symptoms.

TREATMENT STRATEGIES

The primary focus is on the identification of the problem - with conscious avoidance of simply doing symptom removal. Temperament and psychological assessments are administered to determine specific areas of emotional difficulty as well as appropriate medical tests when necessary to diagnose any physical difficulty. Psychological reassessment at approximately the three month mark is recommended to distinguish the initial exacerbation of emotional symptomatology due to an underlying physical disorder from valid problems.

We work on the perception of the events causing stress for the client, build confidence, self-esteem, assertiveness skills, social skills, relating skills.

If there has been a deterioration within the family structure

due to long term presence of some disorder family therapy may be necessary. A natural part of this process is identifying other family members who may have a physical underlying problem as well. More often than not, whenever a parent is diagnosed as hypoglycemic, at least one of the children is found to be hyperactive. If the child has reached puberty then a history of hyperactivity is reported but the child now displays hypoglycemic symptoms.

In addition to the standard dietary treatment we delay the treatment of mild to moderate allergies until necessary which may be any time from a couple of months to a couple of years. Dietary treatment of just the hypoglycemia serves to stabilise the client sufficiently without creating such a drastic change of eating habits that the client cannot adhere to the treatment plan. If the dietary regimen is too restrictive or disruptive to the family routine then the chance of failure is increased. We prefer a more gradual change in lifestyle management, encouraging clients to alter their normal eating habits permanently rather than for just a few months. For this reason, removal of allergy foods are introduced at a later date.

Again, to increase the chance of long term adherence to the diet allowances are made for weekly 'cheats' where the client can splurge (within limits) without feeling guilty. We do not find that these weekly cheats significantly affect the amount of time it takes to stabilise the hypoglycemia. Pavlova is out, but perhaps one beer, or a piece of apple pie. If one cheats every day then the hypoglycemia will not stabilise. Once a week does not have a serious deleterious effect. This strategy works especially well with children by increasing adherence and cooperation. Usually the client ends up eliminating the cheat naturally when they realise how it affects them.

If the client reports high caffeine consumption then often the first week or two is devoted to a gradual decline in the level of caffeine addiction so as to minimise withdrawal symptoms.

SUMMARY

Initial identification and effective treatment of any underlying physical disorder is paramount to helping our clients regain control of their lives. The disorder significantly reduces a person's ability to address any emotional or personality factors because of the confused thinking, poor memory, impulsiveness, lack of concentration, lethargy or mood swings commonly noted.

The second stage of treatment is the identification and treatment of any underlying emotional or psychological difficulties, i.e. irrational thoughts about self and others, poor self-esteem, lack of confidence, or inadequate relating skills. Anything that effectively reduces a person's ability to lead a calm, relaxed and fulfilled life. If in the course of one's daily life public speaking is a must, and public speaking is a stressor, then appropriate treatment is instituted.

A combined treatment strategy addressing both the physical and emotional issues ensures a greater degree of efficacy.

Sir Robert Hutchinson remarked:

"Vegetarianism is harmless enough, though it is apt to fill a man with wind and righteousness."

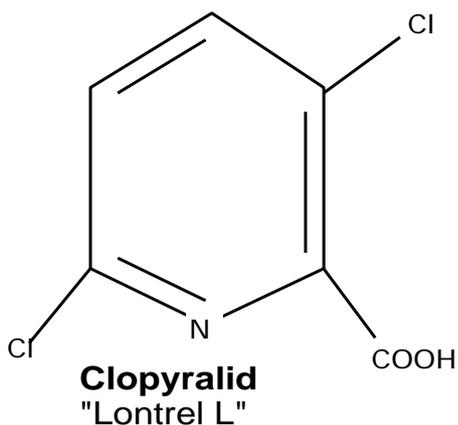
THE ORGANO CHLORINE DEBATE

By Don Pemberton, A.S.T.C. (Chem) B.Sc.

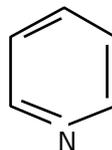
THERE ARE number of organochlorine compounds used as insecticides and herbicides which are not classified as organochlorines. Myself and others like me have been trying to get at the bottom of this problem for sometime. I don't know who is responsible for refusing to recognise the organochlorine nature of these materials and classify them as such. I suspect it may start with the chemical companies who manufacture and market these materials on a commercial basis. I suspect too that these same chemical companies then influence government sub-committees and others to recognise the classification.

Organic compounds can often be classified in more than one way. This is because the same compound may be capable of displaying a number of different chemical functions. That is to say the same compound may react in a number of different possible ways. Which particular way it reacts will depend upon the circumstances at the time. To take an example. We can have a compound which has both Alcohol and Aldehyde groups as integral parts of its structure. As a consequence this compound will be capable of acting either as an Alcohol or as an Aldehyde. If we are particularly interested in its Alcohol properties then we classify it as an Alcohol. If on the other hand we are particularly interested in its Aldehyde properties then we classify it as an Aldehyde.

When we examine the structure of *Clopyralid* (a herbicide), the active ingredient in *Lontrel L*, we can easily see that it can display three possible chemical functions.



- i) It can act as a carboxylic acid, since it contains the $-COOH$ or the carboxylic acid grouping
- ii) It can act as a pyridal or pyridine type compound, since it contains the



Pyridal
Structure

the pyridal or pyridine structure

- iii) It can act as a chlorine compound, since it contains two (Cl) chloro or chlorine groups.

Because these chloro or chlorine groups are integral parts of this organic compound, we are justified in calling it an organochlorine. In fact almost 40 percent of the weight of this organic compound consists of chlorine.

The name **Clopyralid** clearly recognises these three possibilities.

- i) *Clo* indicates that it is an organochlorine type compound.
- ii) *Pyral* indicates that it is a pyridal or pyridine type compound.
- iii) *Id* indicates that it is an acid type compound.

How is it then that we have resistance to the classification of this and other chlorine containing pesticides. In order to understand one such possibility I would suggest that it is necessary to go back and look at the history of pesticide development. The early pesticides to be produced on a large scale were materials such as DDT, Lindane, Heptachlor, Chlordane etc. These were all organochlorines or to be more precise chlorohydrocarbons. They had no functional groups associated with them other than organically bound chlorine. They were organochlorine pure and simple. They were very persistent and difficult to break down in the environment. At first this was a very important selling point. Their persistence meant that they held their killing power for a long period of time, so the frequency of application to control insects was less. However this very persistence was also their undoing. Because they took such a long time to break down, this together with their fat soluble nature caused them to bioaccumulate at the top of the food chain, so that not only were insects being poisoned other animal species were as well. When finally these pesticides started to appear in significant quantities in human beings the hazardous nature of these materials could no longer be ignored. Government agencies throughout the world became alarmed. These agencies either banned these materials completely or else their use was severely restricted. The publicity associated with these bans gave the organochlorines a particularly bad name. Realising this, chemical companies have tried to distance themselves from the organochlorines over the

past few years. Many have switched to the manufacture of organophosphates, compounds based on phosphoric acid or carbamates, compounds based on carbamic acid. Other compounds based on such things as pyridine are also being produced. Herbicides such as *Diquat* (Dipyridal) and *Clopyralid* fall into this last category.

Despite their efforts to eliminate the organochlorine grouping from their products, pesticide manufacturers have only had partial success in reaching this goal. To understand why this is so, it is necessary to take a closer look at the role the organochlorine group plays. The organochlorine group is particularly useful from several points of view. It provides a convenient way of controlling the vapour pressure or the volatility of the pesticide, allowing it to stay in contact with the target organism for long enough to be absorbed. In many cases the presence of organochlorine group assists in the transfer of the material through specific cell membranes within the target organism, thus increasing its ability to kill that organism. Many organisms also find it especially difficult to break down the organochlorine grouping as the grouping is alien to their evolutionary process. As a result their biochemical detoxification mechanisms are ill equipped to handle this grouping. Again this adds to the effectiveness of the material. It is not surprising then that pesticide manufacturers have found it necessary to maintain an organochlorine component in some of their products. The maintaining of this organochlorine component presents a problem in classification. How the material should be classified depends very much on your point of view. Pesticide manufacturers and entomologists tend to classify a compound according to the grouping which will be most active against the target organism. The ecologist tends to classify the compound in term of groupings that is most likely to cause harm to the environment. Physicians, particularly those interested in chronic illness, tend to look at the compound in terms of the groupings that is likely to cause long term harm or chronic illness in human beings. This is the crux of the problem with classification.

Let us take an example. The insecticide *Dichlorvos* is an organically substituted phosphoric acid with an organochlorine component (Vinyl Chloride). It is classified by manufacturers and entomologists as an organophosphate, because it is the phosphate grouping which is the most active against insects. I can see nothing wrong with this classification if it is active against insects alone. However, its toxic activity is not confined to insects. It is highly toxic to many other species. I have no doubt that again it is the phosphate grouping that is responsible for the acute toxic effects on these other species. However acute toxicity is only part of the story. What concerns me and clinical ecologists is the long term or chronic effects. It is not likely that these would be due to the phosphate group as we know that the phosphate group is rapidly broken down. It is the organochlorine component that is most likely to be implicated. It is now generally agreed that organochlorines can cause long term chronic effects. Similar considerations apply to other so called organophosphates such as *Chlorpyrifos* and of course the compound in which we are interested *Clopyralid*. By all means classify these materials as organophosphates, pyridals etc.; but let us recognise them too for their potential to cause long term harm to humans and the environment. Let us also classify them as organochlorines.

I can understand why chemical companies are reluctant to recognise the organochlorine nature of some of their products,

but it is now time to put that aside. For the sake of all of us it is important that we know the true nature of the materials that we are dealing with; so that we will be in a better position to rationally assess their potential for harm or otherwise. This refusal to recognise a compound for what it is and hide behind some arbitrary classification does little for intellectual honesty. It serves to add to the confusion of physicians and ecologically minded people many of whom have only a scant knowledge of chemistry and toxicology. I hesitate to say it - but perhaps this is the object of the exercise.

—O—

STORY

by Steve Duff

(Continued from page 2)

changes. It can be just as frightening and debilitating changing irrational thought processes, as changing the diet is. We want to get well so quickly through diet - eating every 3 hours, new foods in, favourite foods (easy foods) out - that we can hurt ourselves with anxiety here also.

I was noticing cycles of behaviour, strong positive at first, then down weak negative feelings next, mustering will power at some point on the downward arc, moving once again into a positive way of being again upward.

I wanted to accelerate this psychological change. I felt I could be stronger.

I started wit Jur Plesman's book "GETTING OFF THE HOOK" and his self-awareness classes. One year later I did another class which taught meditation, superlearning techniques and self analysis through the Rational Emotive Therapy technique.

But you know I still had problems. It was now 4 years into the diet in 1988. At times I felt exceptional, at other times I felt lost. I stuck to my diet and utilised the self awareness methods. It was that deep scarred fear suppressed and still partly suppressed to this day. I was still having the occasional Scotch binge by myself or with mates. Smoking cigarettes and grass more often. "Fear of what?" I seemed to have worked myself into a corner. Nevertheless, I grew stronger.

It's now 1990. I don't drink, smoke or eat things that I shouldn't. I have now through meditation added a spiritual way to my life.

You see I noticed as my body grew stronger with diet, my mind (my brain functions) progressed naturally toward more rational and positive thoughts. A more efficient functioning biologically with optimum nutrients opened the way upwards to a higher consciousness.

When I look back into my life and compare that with how I feel now I realise that life can indeed be beautiful.

Step by step, do not stop.

—O—

Rex Stout explains how the taste buds triumph:

"The fricassée with dumplings is made by Mrs Miller whose husband has left her four times on account of her disposition and returned four times on account of her cooking and is still there."

DIET CRIME AND DELINQUENCY

by
Dr George Samra M.B., B.S. (Sydney) *

THE SCIENCE of food reactivity is a very awkward area of medicine. Personal biases of doctors and patients often makes it impossible for the dietary therapist to develop a successful management programme for each individual patient.

The Chinese have a saying, "Food is medicine". The Chinese see some link between good health and what we eat, as well as ill health and food consumed. On the other hand, conventional Western medicine, even in these modern times, virtually denies the possibility of any food causing any symptoms or disease conditions. In his paper presented at the I.L.S.I. Australian Symposium on Diet and Behaviour in Sydney, New South Wales, on the 2nd December, 1985, Professor Dr Alfred Harper makes the following summation:

"Most of the widespread beliefs about diet and behaviour are based on subjective, anecdotal reports or misrepresentations of, and unjustifiable extrapolations from, scientific observations. Before attempting to assess the merit of some of the popular beliefs about diet and behaviour, it is nonetheless important to recognise that there is a substantial body of scientific evidence showing that mental performance and behaviour can be influenced by nutritional status and thus directly by diet."

Throughout the rest of this paper Professor Harper proceeds to quote numerous scientific nutritional data showing relationships between foods and disease, but with each example dismisses them on the strength that the material lack double blind scientific method. Professor Harper is Professor at the Department of Nutritional Sciences at the University of Wisconsin, Madison, USA. Like many a doctor before him, Professor Harper seems to walk around with blinkers on. He has an excellent knowledge base and is obviously intelligent, yet seems to claim that malnutrition can cause symptoms rather than specific components of any diet. The time is long overdue for the medical myopia to be corrected with intelligent consideration that certain foods may affect certain people, and that in the science of food reactivity no two people are exactly identical.

The whole area of managing disease using food avoidance as therapy, is swamped with difficulty. Longstanding assumptions about food and food management need to be reassessed. Even if it were shown beyond any dispute that a certain food caused a certain symptom, e.g. for an individual patient's consumption of chocolate immediately causes a headache, then the success of treatment cannot merely be assumed. Success of treatment depends on many factors, particularly that of patient compliance. For patients to be compliant they need to be well motivated and see the success of dietary management in a short and finite time, and they also need to have some confidence in the precision of the diagnosis - nobody really wants to give up

chocolate. Unless you have a well motivated and compliant patient, the chances of success with dietary management are very limited. I have worked with patients who have criminal convictions in both Long Bay Gaol and Parklea Prison in Sydney, as well as through the Probation and Parole Service. I have also some years ago worked with the organisation WHO in Goulburn, New South Wales, on a drug and alcohol rehabilitation programme. My own impression in the work in these areas is that food and criminal behaviour have for most individuals a major relationship, however keeping a patient motivated and compliant on a restrictive diet is difficult with this type of patient.

"Anything absorbed into one's body may react in one of three ways. It may cause a good reaction, a neutral reaction, or a negative reaction".

Food eaten is absorbed. Conventionally trained doctors can only see the logic of food causing good or neutral reaction but cannot accept the obvious possibility of a negative reaction. If one was to stand behind a bus exhaust and inhale a large amount of diesel exhaust, then obviously this would cause a negative reaction. It is logical that anything absorbed may as a possibility cause negative reactions. Caffeine is a component of foods, particularly tea and coffee. Work done by Neims and von Borstol shows the effects of caffeine differs considerably from person to person. It is a stimulant which causes wakefulness, irritability and nervousness, especially in those not used to ingesting caffeine. No one challenges the validity of this work, yet the concept of food ingested causing a negative reaction is still strongly resisted.

A negative reaction to food may take various forms depending upon the target organ. In simplistic terms, if the target organ is the stomach or intestines, colic may occur, or if the reaction is on the skin, a rash may be produced; a reaction in the joints may cause joint pain, and when the brain is the target tissue, a headache may occur. There is enormous individual variability in the science of food reactivity. The area of medical treatment is made more difficult by the fact that often the likely offending foods are favourites for a particular patient. The whole spectrum of food reactivity for the individual patient is masked by many other factors. Sometimes there is the masking effect of consuming good quality food with the offending culprit food and a disguising or minimising of symptoms sometimes occurring. Other factors come into play. A true food allergy with antibodies by a patient to a particular food in general is regarded as being more severe than a food intolerance whereby negative symptoms can be shown to occur when a particular food is consumed. For some patients it requires repeated exposures to the offending food before a symptom is produced, and for some patients one exposure is enough. For individual patients also the quantity of the offending food may be of significance - some people can get away with eating just a small amount of a food they are allergic or intolerant to.

* Dr George Samra has his surgery at Room 8, 32-38 Montgomery St, KOGARAH NSW 2217 Ph: 588-5290

So far we have explored the 'No Man's Land' (and No Doctor's Land) of food causing firstly negative reaction and secondly hurting specific target organs. When the brain is the target organ, then the possibility of symptoms is enormous. In my book "**The Hypoglycemic Connection**" symptoms of hypoglycemia are listed on page 11-12 and include such things as nervousness, irritability, exhaustion, faintness, dizziness, tremors, sweats, mood swings, depression, headaches, migraines, sleep disturbances, forgetfulness, anxiety, antisocial feelings, antisocial behaviour, aggression, poor concentration, poor memory etc. Hypoglycemia is just one of the many ways that the brain may be the target organ of food ingestion. Hypoglycemia is a condition in which the patient mishandles sugar and other simple carbohydrates they consume. In most cases the blood glucose drops suddenly two or three hours after consuming a sugar load such as a soft drink or a piece of cake. When the blood sugar drops suddenly or goes very low, the brain is necessarily affected as under normal circumstances glucose is the only fuel the brain utilises. Most nutritionists agree that blood sugar levels below 3.6 $\mu\text{mol/l}$ are sufficient to cause symptoms and signs in patients.

Hypoglycemia is a major component of many a food reactivity model whereby abnormal behaviour is said to be triggered. Western countries consume massive amounts of sugar nowadays compared to say 100 years ago - at least 20 times as much per person. The vast majority of people have no problems handling this sugar load. However some people do mishandle sugar and this alone may at various times cause symptoms of brain starvation, including anxiety, weakness, tremors, lightheadedness and often even behavioural problems. A diabetic patient who has accidentally overdosed on insulin exhibits all of these features. Reactive hypoglycemia is said to occur as a result of pancreatic mishandling of ingested sugar, whereby the pancreas oversecretes insulin as a response to a carbohydrate load. The essential features of treating hypoglycemia are avoidance of simple carbohydrates, such as sugar, honey and glucose, as well as the consumption of frequent, small meals, either containing a complex carbohydrate or protein or both. Yudkin, in a paper on 'Patterns and Trends in Carbohydrates Consumption and their Relationship to Disease' in 1964 made the scientific observation that high sucrose consumption was associated with high incidence of diabetes, obesity, and other health problems. Further incriminating evidence on sugar in criminal behaviour was produced by Barbara Reed, a Probation Officer in Ohio, before the US Senate Select Committee on Nutrition and Human Needs. She was able to produce a large case load of probationers whose diets had been modified to be free of refined sugar, food additives, coffee, soft drinks, dried fruit and alcohol, with amazing rates of recovery and vast improvement in symptoms. Reed not only claims that probationers dramatically improved on her restrictive diet but further that their likelihood to commit further crimes was dramatically less. This aspect of abnormal behaviour takes exploration into food reactivity one step further. The fact that the brain may be the target organ of a negative food reaction may obviously now cause numerous symptomatology. A food causes headaches, migraines, dizziness, confusion, tiredness, mood swings and possibly even hyperactivity. When discussing food as a provoking factor in crime, there is the assumption that the brain has been a target organ; in order that abnormal behaviour resulting in crime has occurred.

In 1974 Feingold proposed the idea that hyperactivity in young children was caused by food colours, having observed that many Aspirin-sensitive individuals seem to react to various food dyes including tartrazine (yellow food colour, code 102). At the molecular level there is a resemblance of salicylates to many artificial food colours. It appears that somewhere between 1/2 to 1/3 of patients strictly adhering to the Feingold diet improve dramatically in their symptomatology. No two people are identical, and that even with this degree of response improves the non-drug alternative of food and dietary manipulation must necessarily be examined carefully.

Hyperactive children, apart from being overactive, often have poor concentration, are restless, often antisocial and are disruptive at school. It is claimed by many therapists that hyperactive children are on average of a higher intelligence. If it is accepted that food and food additives can cause hyperactivity, then surely it must be accepted that so may other abnormal behavioural manifestations including violence, criminal activity and juvenile delinquency. Work has been done by C K Commers and reported in the Medical Tribune, January 9, 1985. In his study of 45 normal children he compared three groups each having either a high protein, a high carbohydrate breakfast or no breakfast. Commers concluded that sugar in addition to a high carbohydrate breakfast increased deviant behaviour, whilst sugar in addition to a high protein breakfast had no significant effect. Commers concluded from his studies that it is not sugar itself but the absence of a well-balanced meal plus sugar that can lead to hyperactivity.

Other work has been done by Prinz, reported in the Journal of Behavioural Ecology, Volume 2, Number 1, 1981, in an experimental double blind study. Sugar consumption was tabulated for a group of hyperactive children and a control group, and trained observers, blind to the purpose of study, evaluated children's behaviour by categories, viewing a videotape made through a one-way mirror. Prinz claimed that sugar consumption was found to significantly correlate with observed restlessness and destructive-aggressive behaviour.

There are further fairly convincing studies on diet and behavioural modification. S J Schoenthaler has had published several articles in the International Journal of Biosocial Research, including one titled "Diet and Crime: An Empirical Examination of the Value of Nutrition in the Control and Treatment of Incarcerated Juvenile Offenders" and another article "The Northern Californian Diet-Behavior Programme: An Empirical Examination of 3000 Incarcerated Juveniles in Stanislaus County Juvenile Hall". From his own work he concluded that there is a high prevalence of reactive hypoglycemia as a cause of delinquent and criminal behaviour. He contends that a high proportion of prison inmates, up to 90 percent, are in fact hypoglycemic. Some of the work he did in 1982 compared the disciplinary actions recorded per day for a group of 34 boys before a change was made in the diet of the Institution, with boys who had not had the dietary change instituted. During the experiment the quantity of sugar in the food was dramatically reduced. Schoenthaler found that the experimental group experienced 45 percent fewer disciplinary actions than the control group.

The food model as a cause of violent, criminal or delinquent behaviour, requires several logical steps to be believed. Step one is that food ingested as with any absorbed material may cause good, neutral or negative reactions. The ridiculous assumption that food cannot cause negative reactions long held by Western-

trained doctors must be shed. Once it is accepted that food may in fact cause negative reactions, then the mechanism of reaction can be seen in terms of target tissues, i.e. different parts of the body may be affected by food reaction. Such manifestations may include a skin rash, or even heart palpitations. When the target organ is in fact the brain then the possibility of multiple symptoms exists. Food allergies, sugar reactions, oxygen deprivation and chemical toxicity may all target the brain and cause symptoms. When the brain is the target organ possibilities of reactions include violent behaviour, aggressiveness, criminal behaviour, hyperactivity and even delinquent behaviour.

Dietary Treatment of Criminal and Delinquent Behaviour

- 1) Hypoglycemic-type diet
- 2) Removal of Reacting Food (allergies)
- 3) Vitamin and Mineral Supplementation

Hypoglycemic Diet

The essential features of the hypoglycemic diet are that sugar, honey and glucose should be avoided, sweet fruit and fruit juices should be eliminated, including dried fruit, and frequent small meals approximately every 2 1/2 hours should be consumed, and these meals should be high in complex carbohydrates or protein or both. It is hard to argue against a hypoglycemic diet for any person. It is a drug-free treatment, it is quality food mostly farm-grown, and unlike drugs cannot possibly hurt anyone.

I have come to regard the hypoglycemic diet as a brain stabilising diet even in patients not suffering from hypoglycemia. It does this by maintaining blood sugars on a fairly even keel, preventing peaks and troughs of blood glucose. Glucose is the only brain fuel under normal circumstances and this helps keep the brain functioning normally. A Glucose Tolerance Test (GTT) may be useful in determining whether hypoglycemia (or glucose mishandling) is present in any particular patient.

Removal of Reacting Foods (allergies)

As stated before no two humans are exactly identical. I use allergy testing and dietary records to attempt to identify foods that may be reacting and causing symptoms in a patient. With violent, criminal and delinquent offenders, it is reasonable to remove caffeine from these people's diets and if there is little or no improvement, a diet avoiding milk products and yeasted foods including bread, yeast spreads, tasty cheeses, malt and vinegar, should be tried.

Vitamins and Minerals in Therapy

I often prescribe a vitamin, Vitaglow Zinc Plus C, which incorporates in a fairly high dosage chelated zinc as well as vitamins B3, B5, B6 and vitamin C. In rare cases I may use vitamin B12 or B complex injections as an adjunct to treatment. Historically, vitamins have in times been shown to have a major role in psychiatric diagnoses; the early stages of scurvy (vitamin C deficiency) and pellagra (vitamin B3 deficiency), both may manifest with psychosis including delusions and hallucinations.

In the 1920's a high proportion of inmates of mental institutions in southern USA were found to be presenting with severe behavioural changes, were found to be suffering with pellagra and responded to niacin (B3) supplementation.

My view of mega vitamin therapy is as follows. When vitamins are being used in a very high dosage, particularly on

patients not shown to be deficient to the vitamin(s) being supplemented, then the vitamin therapy is in fact a drug therapy. However, vitamins are very safe drugs unlike the vast majority of drugs used in psychiatric medicine. I personally see mega vitamin therapy in the absence of dietary modification as a weak treatment. If someone is reacting to sugar or cow's milk in their diet, then no drug or vitamin for that matter alone can undo the reactions of these foods. Harsh critics of mega vitamin therapy criticize trials on psychiatric patients with treatments including nicotinic acid (B3) and ascorbic acid (C) for failing to cure large populations of patients in which they are used. Vitamins are very safe drugs and if they only help 10 or 20 percent of psychiatric patients then they are well worth trying and may be an excellent value for those particular patients. The role of vitamins in psychiatry is no different to the role of other psychiatric medications in so far as no one particular drug cures every single patient. However if a vitamin works, or even helps a patient, then it must be seen as a preferable mode of treatment. Dr Abraham Hoffer's work in the 1950's using large doses of nicotinic acid on schizophrenia was a landmark in mega vitamin therapy and the excellence of results reported by some patients has led to the obvious usefulness of mega vitamin therapy in psychiatric conditions. In the ranks of conventional medicine the opponents to dietary manipulation and dietary therapy for prisoners and for behavioural disordered patients is enormous. The strength of their criticism is ridiculous, especially the criticism of a treatment which is drug-free and particularly safe in its nature. Professor Harper concludes

"...therefore, public policy decisions to institute specific dietary modifications, including changes to the sugar intake, to affect changes in behaviour of incarcerated juvenile delinquents or adult criminals have no scientific justification".

Doctors Love and Pease, on the other hand, are more conciliatory in their conclusion and

"....the question of reducing behaviour problems through modification of the diet is that there is clearly no fact, nor is their evidence available to lay the concept to rest as fiction".

These doctors wish to research the matter more, using independent, interdisciplinary teams using standards of scientifically acceptable evidence to oversee the conduct of studies and results.

Conventional doctors for the most part continue to refuse to believe that any food can affect any patient in a negative way. Nutritionists on the other hand are seen as having a warped bias that all disease and conditions and abnormal behaviour are in fact caused by food. Sadly, however, patients and inmates must continue to suffer until these biases are resolved, and meaningful, reproducible, scientific work is done to solve these issues. In my experience there are some associations in many patients of food and abnormal behaviour. Experimentation with dietary management is such a harmless therapy that I see no reason to withhold this sort of treatment despite the absence of concrete established scientific basis for it.

Calvin Trillin:

Marriage, as I have often remarked, is not merely sharing one's fettucine but sharing the burden of finding the fettucine restaurant in the first place.

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BROWN RICE CAKE

by
Joy Sharp

2 1/4 cups brown rice flour.
1/4 cup soy flour.
5 ozs. margarine.
5 mls sugarine.
3 eggs.
1 tsp. vanilla.
1 2/3 cups milk. (Nut milk - 1/4 cup ground nuts blended with
1 tsp. baking powder 1 cup of milk I use pecan nuts
chopped pecan nuts. for this recipe)

Cream together the margarine sugarine a pinch of salt and vanilla.

Add the egg mixing until uniform. Add the sifted flours and baking powder alternatively with the milk. Pour into tow 8" pans and add chopped pecan nuts to the top mixing in a little.

Bake at 350 degrees for 40-50 mins.

Yoghurt Whip
by Catherine King

1 Pkt Lo Joule Jelly
2 cups of water
250 grams (1 carton) plain yoghurt.

Place jelly crystals in bowl. Pour in cup of the water boiled & dissolve crystals. Pour in 1 cup cold water. Let

stand till room temperature. Add yoghurt to jelly mixture & whip till mixed. Pour into jelly mould & refrigerate to set. Serve with cream or carbohydrate modified icecream or fruit & crushed nuts.

BROWN RICE COOKIES

by Joy Sharp

200 gms Becel margarine
10 gms Sesame Seeds
2 teaspoons Vanilla
5 mls sugarine or 2 tablespoons of Rice Syrup
2 eggs
2 cups of brown rice flour
3/4 cup arrowroot
50 mgs. Chopped nuts (cashews, pecan, almonds, peanuts, sunflower seeds etc.) vary the nuts to your own taste and dietary needs
10 gms. ground nuts. (I use hazelnuts)

Cream together the margarine, sesame seeds, vanilla, sugarine or rice syrup and the ground nuts. (The ground nuts seem to help to cream the margarine.) Add the eggs then flour and arrowroot and last the chopped nuts. Drop a teaspoon of the mixture on to a tray and flatten with a fork. Bake for 20-25 mins. at 350-375 degrees or until they get a little golden.

Oscar Wilde:
"After a good dinner, one can forgive anybody, even one's own relations"

1991 MEETING DATES

2nd MARCH - 1st JUNE - 7th SEPTEMBER - 7th DECEMBER