Chronic Fatigue Unmasked, Gerald E Poesnecker

Foreword
Second Edition
To all our respected readers: The diagnosis and treatment of chronic fatigue syndrome (adrenal syndrome) must be based on a complete interrelationship and rapport between doctor and patient. It is not possible to accurately diagnose or treat this condition from reading this book or any book. However, included in the following pages is the work of over thirty-five years clinical experience of a doctor who devotes a major part of his private practice to this often ignored condition. Nothing in this book should be necessarily taken as a consensus of present medical opinion. In general there is no such consensus on chronic fatigue syndrome. We do not claim that the herein described procedures cure chronic fatigue syndrome, but it is amazing how many patients seem to improve "spontaneously" while they are engaged in these therapies,
Since Dr. G. E. Poesnecker first described the Adrenal Syndrome in his 1975 book, It's Only Natural, what he then called "the disease no doctor wants to treat" has finally "come out of the closet" under the name Chronic Fatigue Syndrome. But little else has changed. Perhaps today we should call it, "the disease no doctor knows how to treat."
Those who are susceptible to the Adrenal Syndrome seem to have inherited a certain body make up that is frequently the governing factor as to whether the vicissitudes of life led to this condition or to some other that is better understood. Dr. Poesnecker estimates that approximately seventy-five percent of individuals react to common stresses mainly by the constriction of blood vessels, causing higher blood pressure and increased body tension.
The remaining twenty-five percent often respond by dilation of the vessels, experiencing a drop in blood pressure, confusion (due to lack of oxygen to the brain) and exhaustion. The latter are those susceptible to the Adrenal Syndrome.
In the past, the resources of Government and medical science have been concentrated on the needs of the seventy-five percent majority, which is understandable. The other twenty-five percent have not only been ignored and neglected but, frequently, denigrated as well. Too often they have been accused of malingering, both by physicians and family, simply because the methods of diagnosis designed to detect and monitor the majority, were, and are, woefully inadequate to address the needs of this large and, seemingly, growing minority.
We do not desire to appear to condemn the past actions of the medical establishment or the Government in this matter. They have used their resources and authority to confront the needs of the majority. This is right and proper. We only desire to bring to the attention of both medical and governmental powers that approximately twenty-five percent of our citizens are not being included in the main stream thinking and who, we feel, also have a right to a voice. Some of the most creative, inventive, sensitive and potentially productive members of our society are in this misunderstood and neglected group.

Before real progress can be made to help Adrenal Syndrome patients, a new view of the nature of medical investigation and treatment needs to be considered. The previous concept of regarding disease as the consequence of a single factor needs to be reassessed, especially as far as the Adrenal Syndrome patient is concerned.
For those of you who are among the twenty-five percent susceptible to Adrenal Syndrome, let me leave you with a few words of hope and good cheer. At last, your condition has been given a name by the medical establishment and you are no longer automatically considered to be a malingering second class citizen. This recognition should continue to grow and expand with each passing year, especially now that a new test called the ASI (Adrenal Stress Index™) has been introduced. This test, the details of which are included within as an addendum, allows doctors, for the first time, to monitor the tissue levels of adrenal gland secretions throughout an entire day.
Because your stresses produce exhaustion which forces you to rest (one of the most important factors in your recovery), the Adrenal Syndrome tends to protect you from the consequences of your stress. This fact combined with the lowered blood pressure that usually accompanies the Adrenal Syndrome makes for a long life and a lowered incidence of the most commonly caused fatalities of the majority, i.e., high blood pressure, heart attack and stroke. Or, as Dr. Poesnecker often says to his patients with the Adrenal Syndrome, "You're probably going to live forever, it just feels like you're going to die every day."
One more important factor that helps Adrenal Syndrome patients to live a long life is the fact that they must live carefully. They cannot dissipate without rapidly deteriorating. This forced life style of moderation keeps them free of many indiscretions that tempt and afflict those of the hypertensive-inclined majority.
So if you are a member of this select minority, rejoice. You are a very special person; you are a butterfly in the chrysalis just awaiting the proper attention to be able to spread your wings and fly to the heavens. Let this book help you make that metamorphosis.
David Roderick
President and CEO, Enzyme Process, Inc.

Introduction

Second Edition
For some thirty-five years, I have been successfully treating the Adrenal Syndrome, now frequently called Chronic Fatigue Syndrome by many physicians in our country, and ME (myalgic encephalomyelitis) by physicians in Britain and on the Continent. In the mid 1970's, when I first wrote of my work with this condition in my book It's Only Natural, most sufferers were thought to be either depressed, lazy or malingering. As the number of those afflicted increased to a point that they could not be ignored, orthodox medicine was forced to reevaluate its view of their complaints. Begrudgingly, even the most conservative practitioners had to admit that "something" was ailing these persons.
Several of these physicians were given my book, Adrenal Syndrome, by patients of theirs whom I also was treating. Others encountered it at various national and international seminars. As word of the book spread, its first edition was rapidly exhausted, thereby necessitating this second. Few changes have been required in this edition, attesting, to the soundness of the original concept.
Since the publication of Adrenal Syndrome, I have continued the search for the cause of this condition. This new research leads me to conclude that the terms Chronic Fatigue Syndrome, Chronic Fatigue Immune Dysfunction Syndrome and Adrenal Syndrome should not be used interchangeably. While to the patient there is little difference, to the physician there are nuances that must be considered. I feel that Chronic Fatigue Syndrome, as usually diagnosed, is usually identical with Adrenal Syndrome, and that these two conditions are caused by a gradual accumulation of small, but potent stresses that eventually create an overload of the immune system that the traditional prescription of time and rest is inadequate to correct. The onset of symptoms in these patients is slow and insidious. Usually they report past "spells" where they were exhausted beyond their expectations but from which they returned to "normal" in time. These were warnings of a weakening of the neuro-glandular systems of the body. Had they heeded these warnings and had they been able to find a physician trained in the diagnosing and treating of the Adrenal Syndrome, their final breakdown could have been avoided.
On the other hand, I view Chronic Fatigue Immune Dysfunction Syndrome as Adrenal Syndrome brought on by a sudden infection of some sort. It is usually caused by viruses that produce symptoms similar to that of influenza, though they may be of some unrelated origin. The question then is, "Does the influenza-like disease trigger an immune system already compromised by other stresses and thereby become the final assault that allows the Adrenal Syndrome to manifest, or is there a separate virus that produces symptoms similar to influenza, that is able to cause the ongoing condition we know as Chronic Fatigue Immune Dysfunction Syndrome?" At this time I have no definitive answer to this question but am inclined to favour the first explanation over the second.
The only difference between my treatment of Chronic Fatigue Immune Dysfunction Syndrome and the Adrenal Syndrome is that in the former

patient, special attention must be given to supporting the virus controlling components of the immune system.

My philosophy of clinical treatment for all of these conditions is based upon these three premises:
(1) Individuals who manifest Adrenal Syndrome have a body economy that differs from the majority and responds uniquely to stress. Any treatment must take into consideration the specific needs of these special patients, no matter how much these needs may differ from society's expectations. Frequently, their life styles need to be changed dramatically to allow them to develop their inherent potentials. Most of our society's working environment has been constructed for the seventy-five percent majority. To survive, many Adrenal Syndrome patients will have to create their own working environment.
(2) The basic underlying cause of the Adrenal Syndrome is the in ability of the body's immune system to manage the plethora of stress producing assaults upon it at any one time. When these accumulating stresses become greater than the immune system can control, the symptoms of the Adrenal Syndrome will begin to manifest in the susceptible individual. Effective treatment must be directed at reducing as many of these stresses as possible so that the level of stress in these patients is within the range that their immune system
can contain without producing symptoms. You can never eliminate all stress; nor would it be well to do so. Efforts to remove stress must take into consideration all forms of stress including, but not limited to, chemical, environmental, inimical organisms (bacteria and viruses), physical, emotional and even spiritual stresses.
(3) Lastly, we must concern ourselves with efforts to support and build the integrity of the immune system. If we think of the immune system as a glass tumbler, stresses in our lives as water dripping into that tumbler and symptoms of the Adrenal Syndrome able to occur only when the glass overflows, we can readily surmise that there are two main ways we can prevent this overflow:
We can slow the progress of the water dripping into the glass by reducing stress factors in our life style.
We can provide a larger tumbler. Our efforts to build and support the immune system of these patients is, in essence, a way to provide them with this larger tumbler. It is in this area that the practices of the orthodox practitioner and the Natural Physician deviate the most.
The immune system can be supported by a variety of procedures that are addressed in this book. These can be divided into two main groups, those supportive substances taken into the body, by mouth or injection, selected to give the immune system the elements it needs to better accomplish its task and those specific physical treatments given to the patient designed to assist the body in regenerating the components of the immune system.

The various methods used to support the immune system have been a part of the clinical practice of the Natural Physician for more than two centuries. Even so it is not to be expected that they will be readily accepted by the medical establishment in the near future. However, as the immune systems of our citizens continue to weaken, due to the innumerable man-made assaults placed upon them, eventually, all physicians will be forced to change their thinking and accept-and use-immune system regeneration procedures or fall by the wayside.
While I have been actively working with the Adrenal Syndrome for over thirty-five years, none of this work could have been possible without the pioneering research of Drs. Charles E. de M. Sajous, Henry R. Harrower, John W. Tintera, Royal Lee and John B. Bastyr. These men laid the foundation upon which I was able to build. Only Dr. Bastyr, now in his nineties, has lived to see the efforts of all of them accepted, at least in part, by the medical establishment.
Dr. G. E. Poesnecker October, 1993

CHAPTER 1

The Nature of the Disease

Adrenal Syndrome is a condition of the neuroglandular mechanism of the body which produces a weakening in the body's ability to respond to stress. The most common symptoms produced by this condition are unexplained exhaustion, a tendency to be oversensitive and/ or allergic to certain substances or environments, a lessening of the ability to reason rationally and to make decisions readily, a tendency toward low blood pressure, sensitivity to cold, poor circulation (cold hands and/or feet), and mental aberrations which can mimic a large variety of mental diseases. Most patients with Adrenal Syndrome have at least one of these symptoms, and some have all and many others besides.
This condition, to a lesser or greater degree, affects one-third to one-half of the American population. Luckily, most of those affected are not severely afflicted, but vast numbers of our people function at less than half their true potential because of Adrenal Syndrome. Since it is the nature of the Adrenal Syndrome patient to be a responsible, creative, and productive citizen, the loss to America created by Adrenal Syndrome is significant.

As common as this condition is, it is only indistinctly recognized and rarely treated by most professionals of the orthodox medical persuasion. For this reason, I call this condition the most ignored disease in the country today. Personally, I think this apathy has been produced by the general vagueness of this disease's character, by the neurotic-like symptoms of its victims, and by the slow and tortuous path of its correction even with the best and most advanced therapies. In our Clinic, I always meet the newly diagnosed hypo-adrenal patient with mixed feelings. I am, on one hand, pleased to know that the patient has started on the road to becoming useful and productive again instead of languishing in a low-functioning state; on the other hand, I always groan a bit inside when I think of the amount of care, time, and constant loving support that will be necessary to carry this patient through the seemingly unproductive early stages of treatment. With perseverance, however, all patients respond and, in the end, they prove to be among our most appreciative patients. This thought—at times, this thought alone— gives us the ability and the strength to carry on with the Adrenal Syndrome patient.
There seems to be a quirk in many doctors which, perhaps more than anything else, may explain their ostensibly conspiratorial refusal to recognize Adrenal Syndrome. Most physicians, in order to function as stable human beings, require a certain amount of personal ego satisfaction when they treat a patient. Even though there are vast fields of disease which are complete mysteries to modern medicine, the average day-to-day working physician often feels he must, at least in some manner, examine all the symptoms and problems that confront him. If he cannot rationally explain them, he must make up explanations and, if he cannot cure his patients, he must find some way to place the blame for his lack of understanding, knowledge, and ability on the patient or on the circumstances. In the early days of medicine, physicians had ready explanations for causes of symptoms and ailments which were presented to them. The fact that today we realize that most of these early explanations were ridiculous has not prevented the medical profession from continuing this practice. To witch doctors, all diseases are caused by demons which inhabit their patients. Their job, of course, is to extirpate these demons. The "scientific" physician, when confronted with a patient who displays the symptoms of Adrenal Syndrome, has a ready answer: "The patient is neurotic, mildly psychotic, unmotivated, or just bored with life." With that self-satisfied stance, that can be a "badge of our tribe," the patient is given a tranquilizer, antidepressant, or both and, with the fatherly advice to stop worrying and to go to work, he is sent home. It is just as impractical to tell a tubercular patient to go and play football as it is to tell an Adrenal Syndrome patient to stop worrying. Am I exaggerating? One has only to remember that a short time ago patients were literally bled to death in an effort to satisfy this medical ego.

There is, however, a specific cause that produces these wrecks of human society, and there are ways of returning these people to active, productive lives. This book defines this disease, lists the various symptoms produced by this condition, assesses the various stresses which trigger and aggravate this ailment, and outlines a comprehensive plan of treatment to overcome this insidious disorder.

The Adrenal Gland
Before proceeding with our discussion of Adrenal Syndrome, its causes and its treatment, let us consider the gland itself. The adrenals sit like a

bishop's cap on top of each kidney; each weighs about a nickel. The adrenal gland is recognized as one of the body's most important endocrine or ductless glands, that is, glands that produce hormonal or hormone-like substances and discharge them directly into the bloodstream. Each of the endocrine glands is subject to a chain of command. The pituitary gland, so-called master gland of the body, sends out stimulatory or trophic hormones which regulate each of the target endocrine glands, such as the adrenals, the thyroid, or the reproductive glands. The pituitary in turn is regulated or controlled by the hypothalamus, which produces specific releasing factors for each of the pituitary trophic hormones. The adrenal glands are composed of two parts—the medulla (inner portion) and the cortex (outer surrounding portion). The medulla fits inside the cortex like a walnut inside its shell. The medulla and cortex produce many substances, the most important of which are epinephrine (formerly called adrenalin), which is produced by the medulla, and various sterols, such as cortisone and aldosterone, produced by the cortex.

When the body is called upon to respond to stress, the adrenal gland is its primary agent. Stress on the body stimulates (probably by way of the sympathetic nervous system) the adrenal medulla to increase epinephrine production. This hormone increases the secretion of adrenocorticotrophin (ACTH) by the pituitary gland, which in turn activates the adrenal cortex to greater production of corticoids such as cortisone.

Diseases of the Adrenal Gland. Of primary concern in the discussion of Adrenal Syndrome is its differentiation from Addison's disease (organic adrenal insufficiency) and from adrenal insufficiency secondary to hypopituitarism. The term "Adrenal Syndrome," as used here, refers to a state of depletion of the adrenal glands in the absence of atrophy or destruction. In other words, it is a state of functional depletion or exhaustion. This is in contrast to Addison's disease in which there is physical atrophy or destruction of the adrenal glands, or to hypopituitarism in which there is some form and some degree of destruction of the pituitary gland. Both Addison's disease and hypopituitarism are relatively rare whereas Adrenal Syndrome, as herein described, is extremely common.

Diagnosis. At present, standard diagnosis of Adrenal Syndrome is a matter of exclusion; that is, such diagnosis is justified only after other causes of chronic fatigue, exhaustion, weakness, and lassitude have been ruled out. Unfortunately, the biological and biochemical changes which underlie this syndrome are poorly understood, and inasmuch as specific tests are not yet available, diagnosis depends on clinical features described elsewhere in this book.

Adrenal function may be assessed by standard laboratory tests which include serum Cortisol levels and urinary corticosteroids. In Addison's disease, even in advanced adrenal destruction or atrophy, the resting or basal levels of these tests may be within the lower levels of normal. For this reason, a diagnosis of Addison's disease may depend on results of a pituitary stimulation test in which corticotropin (ACTH) is injected into the patient. In normal persons a significant rise in serum Cortisols follows ACTH injection, but in Addison's disease there is minimal or no response. In cases in which pituitary insufficiency is suspected, the metyrapone stimulation test is utilized. These tests are described in detail in standard medical texts.

Standard medical texts state that clinical adrenal insufficiency (Addison's disease) usually does not occur unless at least 90 percent of the adrenal cortex has been destroyed by idiopathic atrophy, granulomatous destruction, or some other form of destructive process. By the same token, currently available tests, including the ACTH stimulation test, may not show abnormal results except in the case of advanced disease or depletion. On the basis of present information, it would appear that these tests lack the sensitivity to detect or diagnose lesser degrees of adrenocortical depletion, as in Adrenal Syndrome. Therefore, the condition of Adrenal Syndrome is largely undetected by orthodox measures.

History of the Disease

Early Recognition. In the past as in the present, there have been physicians who were not afraid to investigate the true nature of Adrenal Syndrome. The first truly clear-thinking researcher in this field was Charles E. de M. Sajous, M.D., LL.D., Sc.D. A Fellow of the American College of Physicians and of the American Philosophical Society, professor of therapeutics at Temple University in Philadelphia, professor at the Medico-Chirurgical College, and clinical lecturer at Jefferson Medical College, he produced a text in 1903 entitled The Internal Secretions and the Practice of Medicine (I). In his book, he credited the physician, Brown-Sequard, as first bringing attention to the importance of the adrenal glands, in 1856. It was, however, through the experimental research work of Dr. Sajous himself, in our own town of Philadelphia, that the full significance of the adrenal mechanism, and particularly that part concerning the Adrenal Syndrome, was brought into full realization. In his book, he devoted an entire chapter to functional hypoadrenia much of which I include here, not with the assumption that all of its conclusions are accurate eighty years later, but to show the amount of knowledge accepted as standard medical information and procedure at that time.

According to Dr. Sajous, The adrenals playing so important a role in the maintenance of the life process itself, it is obvious that, apart from any organic lesion in these organs, any marked depression of their functional activity should manifest itself by symptoms corresponding with this depression. To the symptom-complex of this condition I have given the name of "functional hypoadrenia" to distinguish it from the forms due to destructive disorders of the adrenals, which constitute Addison's Disease and offer, of course, a far graver prognosis. As a definition of this condition, I would submit that "functional hypoadrenia" is the symptom-complex of deficient activity of the adrenals due to inadequate development, exhaustion by fatigue, senile degeneration, or any other factor which, without provoking organic lesions in the organs or their nerve-paths, is capable of reducing their secretory activity. Asthenia, sensitiveness to cold and cold extremities, hypotension, weak cardiac action and pulse, anorexia, anemia, slow metabolism, constipation, and psychasthenia are the main symptoms of this condition.

The field covered by "functional hypoadrenia" is necessarily a vast one, since it includes the asthenias so often met within the four main stages of life: infancy, childhood, adulthood, and old age, usually attributed to a "weakness" or "exhaustion," and often "neurasthenia," which have been traced to no tangible cause. All I can submit herein, therefore, is a cursory analysis of the subject.

Hypoadrenia in Infancy and Childhood. In discussing functional hypoadrenia of infancy and childhood, Dr. Sajous pointed out that, although the adrenals at birth are one-third the size of the kidney and, therefore, relatively large, their functions are limited to the carrying on of the vital process, at least during the first year of life. During this time the mother's milk supplies the antitoxic products capable of protecting the infant against the destructive action of poisons. Dr. Sajous stressed the protective influence of mother's milk:

> It is an important function of the mother to transfer to the suckling, through her milk, immunizing bodies, and the infant's stomach has the capacity, which is afterwards lost, of absorbing these substances in active state. The relative richness of the suckling's blood in protective antibodies as contrasted with the artificially fed infant explains the greater freedom of the former from infectious disease.

He cited as striking proof of this immunizing function J.E. Winters' statement regarding the siege of Paris in 1870-1871 during the Franco-Prussian War: "While the general mortality was doubled, that of infants was lowered 40 percent, owing to mothers being driven to suckle their infants."

Children have a predilection to certain infectious diseases not only during infancy but through at least their first ten years. Dr. Sajous stated that mother's milk helps provide protection to the suckling against such diseases; vulnerability in older children is overcome as the adrenals, with other organs, acquire the power to supplant the mother in contributing antitoxic bodies to the blood.These facts, Dr. Sajous stressed, point to the adrenals and other prominent organs whose inadequate development explain the special vulnerability of children to certain infections. He believed that degrees of this hypoadrenia cause a child to be more or less liable to infection. He continued:

> That degrees of hypoadrenia exist in children is in reality a familiar fact to every physician when the signs of this condition are placed before him. The ruddy, warm, hard-muscled, heavy, out-of-door, romping child with keen appetite

and normal functions, is one in whom the adrenals are as active as the development commensurate with its age will permit. He is ruddy and warm because oxidation and metabolism are perfect and the blood pressure sufficiently high to keep the peripheral tissues well filled with blood; his muscular, skeletal, cardiac, and vascular systems are strong because, in addition to being well-nourished, they are exercised and well-supplied with the adrenal secretion, which.. . sustains muscular tone. As normal outcome of this state, we have constant stimulation of the functional activity of the adrenals. The muscular exercise and maximum food intake involve a demand for increased metabolism and oxidation, and the resulting greater output of wastes imposes upon the adrenals, as participants in the oxidation and auto-protective processes, greater work, more active growth and development, with increase of defensive efficiency as normal result.

The pale, emaciated, or pasty child with cold hands and feet, flabby muscles, whose appetite is capricious or deficient —the pampered house plant so often met among the rich—represents the converse of the healthful child described, just as does the ill-fed, perhaps overworked child of the slums. The emaciation, the cold extremities, indicate deficient oxidation, metabolism, and nutrition owing to the torpor of the adrenal functions; the pallor is mainly due to a deficiency of the adrenal principle in the blood and to the resulting low blood pressure, which entails retrocession of the blood from the surface. This child is not ill, but the hypoadrenia which prevails normally, owing to the undeveloped state of its adrenals, is abnormally low, and it is vulnerable to infection.

Sajous believed that all conditions which in the adult tend to produce functional hypoadrenia affect the child at least to the same extent.

Hypoadrenia in the Adult. Adults in whom adrenals may be inherently weak do not, as in hypothyroidia, show signs of myxedema; but their circulation and heart action are feeble, they tend to adiposis, and show other signs of hypoadrenia. I have witnessed suggestive bronze spots in such cases. As a rule, however, the development of the adrenals in adults is an accomplished fact—as also that of their co-workers in the immunizing process, the thyroid and pituitary.

The adrenals, fully capable of sustaining oxidation and metabolism up to highest standard in all organs, also preserve the efficiency of all other defensive resources, including phagocytosis, with which the body is endowed to their highest level. On the whole, the normal adult whose adrenals functionate normally is relatively resistant to infection. The infrequency with which the physician is infected, notwithstanding daily exposure in his professional work, attests to this fact.

Dr. Sajous explained that functional hypoadrenia appears when, irrespective of any disease, as the result of the vicissitudes of life, the adrenals are exhausted by excessive secretory activity that exaggerated labor or exercise—fatigue—imposes upon them. He cited a striking difference between patients with Addison's disease and those with other kinds of illness whose muscles are organically normal; signs of fatigue appear quickly and muscular impotence asserts itself in functional hypoadrenia patients but, for example, in an advanced case of tuberculosis the patient may be able to show appreciable muscular strength. He used other illustrations of the influence of adrenal secretion over muscular tone to show the close relationship between fatigue and the functions of the adrenals:

The unusual prevalence of disease among soldiers in the field is, of course, partly due to the defective sanitation that a campaign entails; but fatigue—particularly that due to heavy marching, carrying heavy accoutrements—is, in my opinion, an important predisposing cause, through its influence upon the adrenals. Not only are these organs called upon to sustain general oxidation and metabolism at a rate exceeding by far that which amply suffices for normal avocations, but the fact that. . .they also serve to destroy the toxic products of muscular activity constitutes another cause of drain upon their secretory resources.

From studies of other investigators into the influence of fatigue on adrenal function in animals he noted that debility from any source—starvation, loss of blood, or other factors—makes the body vulnerable to disease. In a healthy animal, an injection of combined toxin and antitoxin resulted in no harm, but in an animal weakened by starvation or slight bleeding, death usually followed such an injection, with all the signs of poisoning by the toxin, including congested adrenals.

He pointed out the relationship between the adrenal gland and infection, adding that hypoadrenia from any source weakens the body so that it becomes vulnerable to disease. Among humans, he pointed to deficient food and excessive work as causes of the disease.

Other important morbid factors in this condition, according to Sajous, include masturbation and excessive venery. He wrote:

The pallor and asthenia witnessed in these cases, so far unexplained, can readily be accounted for if, as I believe, the liquid portion of the semen is rich in adrenal principle. This is suggested by the fact that spermin, the purest of testicular preparations, given the same tests, acts precisely as does the adrenal principle. The latter is an oxidizing body acting catalytically; it resists all temperatures up to, and even, boiling; it is insoluble in ether and practically insoluble in absolute alcohol, and gives the guaiac, Florence, and other heamin tests. Now spermin not only raises the blood pressure, slows the heart and produces all other physicological effects peculiar to the adrenal principles, but its solubilities are the same; it gives the same tests; it resists boiling. Moreover, it is regarded in Europe as a powerful "oxidizing tonic" and has been found equally useful in disorders in which adrenal preparations had given good results. The inference that spermin consists mainly of the adrenal product suggests that it is not specific to the testes, but instead, a constituent of the blood at large; not only did this prove to be the case, but it was found in the blood of females as well as in that of males.

Hypoadrenia in the Aged. To Dr. Sajous, the ductless glands greatly influence old age. He wrote;

all living organic matter is subjected, after more or less precarious periods of growth and adult existence, to one of decline and final disintegration. This applies particularly to the adrenals, if their functions are, as I hold, to sustain oxidation and metabolism, the fundamental process of the living state. Indeed, the senile state may be said to be as evident in these organs as it is in the features of the aged.

He quoted from investigators who had found that fat occurred in increasing quantities in the adrenal fibrous tissue between the cortex and medulla in very old animals and in the medulla of aged individuals. A marked—occasionally very great—reduction was found in the size of adrenals in the aged. In a study in which adrenals of three young men were compared with those of aged individuals, the adrenals in the young were well developed and in "full bloom," while in the aged they were shrunken and deficient, showing lowered activity, implying a lessening of the vital process the adrenal glands sustain.

"The asthenia of old age," he continued, "thus finds a normal explanation in the defective supply of adrenal secretion—precisely as it does in Addison's Disease. In fact. . .atrophy of the glands in the young may produce this disease." To Dr. Sajous, old age was caused by degeneration of the ductless glands. He believed that a condition of autointoxication existed in old age "quite in keeping with a decline in the antitoxic power shown by the adrenals." He also found a functional relationship between the adrenals and the thyroid in the genesis of old age.

Regarding the causation of old age, Sajous quoted an earlier researcher, Lorand: "It is evident.. .that all hygienic errors of diet or any kind of excess will bring about their own punishment, and that premature old age, or a shortened life, will be the result. In fact, it is mainly our fault if we become senile at 60 or 70, and die before 90 or 100." As Seneca said, "Man does not die, he kills himself."

Summary of Sajous' Work. Sajous, then, believed that the lesions to which the adrenals are subjected during infections and autointoxication, from birth to the last day of life, greatly shorten life by limiting the functional area of the organs through the local fibrosis they entail. "It is quite probable," he wrote, "that centenarians owe their prolonged longevity mainly to integrity of their adrenals." To this end he saw hygiene, particularly its influence on the prevention of infectious disease, "as one of the most useful of sciences" because it helps prevent even seemingly benign diseases (diseases from which people recover), which "in the end shorten our existence by compromising the integrity of the organs which sustain the vital process itself."

Sajous discussed also the prophylaxis and treatment of the hypoadrenal condition. While much of the prophylaxis he discussed is not germane to the present day, he made several pertinent comments. In discussing prevention of hypoadrenia in infants, for example, he said:

In infants, we should by every possible means prevent infection or intoxication to preserve the integrity of their adrenals and other autoprotective organs. The key of the whole situation lies in the fact that. . .nearly all the cases and nearly all the deaths are in bottle-fed babies. Physicians are, as a rule, entirely too ready to yield to the demands of social and other claims put forth by mothers who do not wish to nurse their offsprings. The responsibility assumed by both mother and physician under these circumstances is overlooked. I cannot but hope that if this continues, and the sacrifice of countless infants proceeds, laws may be enacted to prevent it by imposing upon the physician the duty of submitting to the State authorities a certificate in which sound reasons shall alone account for his consent to a departure from Nature's methods which entails deaths untold... .The death rate among foundlings in New York City reached almost 100 percent until wet nurses were provided. . . .Many. . .authorities have written forcibly upon this subject, but seemingly to no avail. The holocaust continues.

Dr. Sajous devoted several pages to proving that mother's milk contains antitoxic substances that are not present in the bottled variety. Surprisingly, only in the last few years has so-called modern medical science caught up with Dr. Sajous.

In referring to the prophylaxis and treatment of the adult patient, Sajous discussed the importance of rest, and of what physical stress with inadequate rest can do to the Adrenal Syndrome. This factor has changed little to this day.

The influence of excessive fatigue on the adrenals, we have seen, is such as to weaken greatly their functional activity and, therefore, their oxygenizing and immunizing functions of the blood. The main harmful feature in this connection is the relative deficiency of rest, which means, from my viewpoint, inadequate opportunity afforded the adrenals to recuperate. This, of course, should be proportionate to the amount of strain imposed upon these organs, and the resistance of which they are capable. It is probably owing to lack of this that apparently strong men are often the first to "give out" in forced marches. The physical examination being

based mainly upon the status praesens, and the adrenals being necessarily (for we are now dealing with a new line of thought) [Apparently still new today! — Author] overlooked as factors, there is marked inequality in the resistance of the men to strain. This applies as well to the pathogenesis of chronic disorders. In a personal analysis of 40 cases of hay fever, for instance, the severity of the disease corresponded to a considerable degree with the number of children's diseases the patient had had, the worst cases having had six of these diseases in comparatively quick succession.

To Dr. Sajous, this suggested the need of ascertaining the number and severity of children's and other diseases to which a recruit in the armed forces had been subjected and to add this factor to others in deciding upon his admission to the service or the arm to which he is to be assigned. He continued,

The mounted man suffers less from actual fatigue than the infantry man who must carry his accoutrements, arms, cartridge, etc., aggregating in some armies as much as 70 pounds. When, besides, defective or poor food, impure water, exposure, etc., and other frequent accompaniments of a campaign are taken into account, one need not wonder that disease is a far greater factor as a cause of debility and death than wounds. Briefly, fatigue should be considered, owing to its inhibiting influence on the adrenals and the immunizing process in which I hey take part, as an important predisposing cause of disease. The periods of rest should be so adjusted, therefore, as to counteract this by far the most destructive factor of active warfare. In civil life, such hardships are seldom endured, but here likewise much could be done to prevent infection by means calculated to insure the functional integrity of the adrenals.

To stimulate the adrenal functions when marked fatigue prevails would, of course, only aggravate the hypoadrenia after perhaps a period of temporary betterment. The powdered adrenal substance should, on the other hand, judging from the effects of injections of adrenal extracts in experimentally fatigued animals, serve a useful purpose.

In this last paragraph Dr. Sajous recommended taking powdered adrenal substance. To show that there is nothing necessarily new Under the sun, this substance, properly prepared so as not to lose any Of its natural factors, still remains the backbone of treatment of Adrenal Syndrome today. The work of this pioneering endocrinologist can never be sufficiently appreciated. We can only thank God for Ins great insight and candor, and attempt to carry forth the work he began.

Expanding Understanding of the Disease. A few years after Dr. Sajous' initial work, Henry R. Harrower, M.D., F.R.S.M. (London), in his book, Practical Organic Therapy, The Internal Secretions and the General Practice, asserted (2):

Since the adrenals are so extremely susceptible to so many outside influences, it is likely that they would be easily worn out, and as a matter of fact, "functional hypoadrenia" is as common a condition as any endocrine manifestation. From a practical standpoint, this is an extremely important symptom complex.

This was written a short time after World War I! Dr. Harrower continued: It is quite some years since Sajous began to emphasize the importance of this condition, and while his opinions were scouted, and some of his ideas declared visionary, it must be admitted that our present knowledge of this subject is very much in harmony with the following quotation from Sajous' monumental work: "Functional hypoadrenia is the symptom-complex of deficient activity of the adrenals due to inadequate development, exhaustion by fatigue, senile degeneration, or any other factor which without provoking of organic lesions in the organs or their nerve paths, is capable of reducing their secretory activity. Asthenia, sensitiveness to cold and cold extremities, hypotension, weak cardiac action and pulse and anorexia, anemia, slow metabolism, constipation, psychoasthenia are the main symptoms of this condition."

Harrower went on to say:

Asthenia is the rule and muscular tone (both striped and unstriped muscles) is poor. Exertion is impossible and the fatigue syndrome is prominent. The intestinal musculature is inactive and stasis, a common cause of hypoadrenalism, is also a usual result of it. Mental exertion, even the simplest exertion, often causes so much weariness and exhaustion as to be prohibitive. Mental elasticity is lost, and there is both mental and physical depression with the fear that the individuals now cannot accomplish their accustomed good mental work; and the story that they "have lost their nerve." With this, one frequently notes a fearfulness of making wrong decisions and vacillating and indecisive frame of mind. This is the most usual form of adrenal insufficiency. It is chronic both in origin and in its course.

Another section in Harrower's book is entitled "Neurasthenia as an Adrenal Syndrome." The word "neurasthenia" is not used as much today as it once was, nor is it as well understood by the general

public as it was at one time. Neurasthenia means weak nerves. Although they may not have heard of neurasthenia, people frequently speak of their weak or sensitive nerves and upset nervous system. I personally still find neurasthenia an acceptable term and an exact description of many patients I see daily.

Again, Harrower's report was so lucid that I include here the entire section on "Neurasthenia as an Adrenal Syndrome":

The minor form of "functional hypoadrenia" is more common than some have appreciated, and the fact that there is a psychic origin as well as the other physicologic causes already considered, allies it to the fashionable neurasthenia of today. In fact, some have stated that what is improperly called "neurasthenia" is not a disease per se, but really a symptom-complex of ductless glandular origin and that the adrenals are probably the most important factors in its causation. Campbell, Smith, Osborne, Williams, and others, including the writer, have directed attention to the importance of the adrenal origin of neurasthenia (though a pluriglandular dyscrasia is practically always discoverable), but so far this is not understood as well as its frequency and importance warrant.

A few quotations from the literature will firmly establish the importance of this angle from which to study this common and annoying symptom-complex. Quoting from the Journal of the A.M.A. (Dec. 18, 1915): "The typical neurotic generally has, if not always, disturbance of the supradrenal

glands on the side of insufficiency. The blood pressure in these neurasthenic patients is almost always low for the individuals and their circulation is poor. A vasomotor paralysis, often present, allows chillings, flushings, cold, or burning hands and feet, drowsiness when the patient is up, wakefulness on lying down and hence insomnia. There may be more or less tingling or numbness of the extremities."
. . .Kinnier Wilson in. . ."The Clinical Importance of the Sympthetic Nervous System" makes the following pertinent remarks: "Many of the common symptoms of neurasthenia and hysteria are patiently of sympathetic origin. Who of us has not seen the typical irregular blotches appear on the skin of the neck and face as the neurasthenic patient works himself up into a state? The clammy hand, flushed or pallid features, dilated pupils, the innumerable paresthesias (tinglings), the unwonted sensations in head or body, are surely of sympathetic parentage. In not a few cases of neurasthenia, symptoms of this class are the chief or only manifestations of the disease. Here, then, is a condition of defective sympatheticotonus; may it not have been caused by impairment of function of the chromophil system [adrenal system]?. . .There does not appear to me any tenable distinction

between the asthenia of Addison's Disease and the asthenia of neurasthenia. Cases of the former are not infrequently diagnosed as ordinary neurasthenia at first. It is difficult to avoid the conclusion that defect of glandular function is responsible for much of the clinical picture of neurasthenia. . . .[Wilson] makes the following apothegm: "Sympathetic tone is dependent on adrenal support, and until the glandular equilibrium is once more attained, sympathetic symptoms are likely to occur."
Interestingly, the 1915 quotation from the Journal of the American Medical Association postulated a relationship between neurasthenia and low adrenal function. Yet to this day, such a relationship is rarely considered in medical treatment. At the Clymer Health Clinic, we consider such cause and effect to be very common, and we treat it accordingly. Undoubtedly, because of this, we have become internationally known for our treatment of the weakened nervous system.

The most important advances in endocrinology made by Dr. Harrower were in connection with what he called the plural glandular treatment. In this form of treatment, he found it far more efficacious to use a variety of glandular substances than to use a single one in attempting to correct this or any of the glandular imbalances. In preparations he himself made and marketed, he, for instance, combined thyroid, pituitary, and sex-hormone substances along with what he called "remineralization" techniques; that is, the use of certain mineral elements plus his adrenal-gland substance to treat Adrenal Syndrome. Such plural glandular technique is used to this day. With modern methods of tissue-nutrition analysis, however, we are able to individualize the therapy for the specific case at hand to a far greater degree than was possible in Dr. Harrower's day.

While Dr. Sajous brought the condition of functional hypo-adrenalism to light, described its symptoms, and some of its causes, and suggested certain types of therapy, the further development of this therapy was in the hands of Dr. Henry Harrower. Dr. Harrower's work, however, was little appreciated by his contemporaries and, although he was able to help thousands of individuals during his lifetime, he was never able to convince more than a handful of his medical colleagues of the value of the plural-glandular substance therapy. Since this therapy was based upon supporting nutritionally the glandular components of the body, the results, though definite and long-lasting, were slow in developing. This fact probably led the medical profession to disregard them in favour of the quicker-acting, but noncurative, single-hormone preparations and synthetic compounds.

It is important to make a distinction between the use of endocrine hormones and endocrine substances. Even these early investigators realized that if the body is given a hormone which is produced by an endocrine gland, the gland, due to the natural functioning of the body's homeostatic mechanism, will stop producing its own hormone us long as the external hormone is being supplied. If this process is carried out long enough, the gland involved will actually atrophy— eventually it stops producing hormones. If, on the other hand, a patient is given glandular substance which is free from hormones but contains the other nutrient elements of the gland intact, the substance acts as a food to build and regenerate the gland, so that it may once again start proper functioning on its own. This is the basic difference in theory and practice between the medical practice of endocrinology and the natural or nonmedical practice of endocrinology. These early researchers realized that, except in emergencies, nutritional glandular therapy was the only practical, physiological way of re-establishing normal function among the endocrine glands. I a emergencies, it may be essential to give hormones in specific cases. Also, if the involved gland is destroyed, or there is no hope of regeneration, it may be necessary to give hormonal agents for life. However, in most chronic, glandular deficiencies, the use of glandular substance therapy is far more physiologically safe than the pure hormones.

Continuing Research. The work of Dr. Sajous and Dr. Harrower has been continued by a small group of medical practitioners, one cf the most dynamic of whom is John W. Tintera, M.D. In 1955 Tintera reported on the hypoadrenocortical state and its management, and in 1966 he advanced the hypothesis that reactive hypoglycemia may result more from hypoadrenocorticism with deficient counter-regulatory responses of the adrenal cortex than from insulin excess (3,4). (A later study on hypoglycemia in insulin-dependent diabetic patients acknowledged indeed that deficiency in counter-regulatory hormonal responses is important in hypoglycemia reactions).
Tintera described, in lay terms, the functional insufficiency of the adrenal glands in an article in Woman's Day in February 1959, entitled "What You Should Know about Your Glands and Allergies":
Think of your adrenal glands as the two central command posts, one perched above each kidney from which your body's chemical defences are mobilized and directed. Think of pollens, house dusts, and all other allergy-producing substances as attacking

invaders (which they are, of course). Now you're right up against the basic and real reason why many people suffer from allergies while some people hardly know what the word means.

What happens when the central command posts of allergic bodies fail to command the chemical defenders? Attacking invaders are on the ramparts, but the defences are enfeebled and disorganized. The invaders get in and bring about the damage which results in wheezes and sneezes, sniffles, hives, rashes, skin eruptions, and other miseries and also sets the body up, chemically, for endless repetition of the same.

This new knowledge discovered and proved by endocrinology, that branch of medical science devoted to the study of the body-regulating system of internally secreting glands, the endocrines, of which the adrenals are kings. Until endocrinology came up with the all-important knowledge, no one knew the basic cause of allergies.

Rightly, Dr. Tintera said that, until recently, there was no real, lasting cure for the allergies—only temporary relief which often required heroic measures. Usual treatments for allergies and infections were aimed at body chemistry disturbances at or near the surface.

Actually, many allergies are only the end results of processes that have their beginnings in adrenal gland failure. Most people stand up well against attacking invaders—so well that they do not know they're under attack. But 17,500,000 Americans [almost 10 percent of the population] succumb so readily to the same invaders they know only too well they are being attacked!

Endocrinology has now gotten deep down below the end results of allergy processes. In learning about the intricate and subtle chemistry of the adrenal glands, it discovered that the difference between the non-allergic majority was the difference between strong, alertly responsive adrenals which can and do marshal the body's defences in a flash, and weak, sluggish glands which are incapable of doing what they should.

I'm an endocrinologist. In more than 20 years of a busy practice with thousands of patients, I've yet to work with an allergic patient whose troubles weren't basically due to his poorly functioning adrenals, or who wasn't relieved of his allergic woes when his adrenals were put into proper working order. Included among these patients were sufferers of asthma as well as of hay fever, people "sensitive" to beef protein as well as those "sensitive" to house dust or to tomatoes or parsnips or whatever the so-called "sensitizing agent" happened to be.

To Tintera there are not "kinds" of allergies, only one "kind"—

impaired adrenal glands. For many years before this glandular basic cause was discovered, it was known that allergic persons were allergic to

many—not just one—substances. He found the identity of the "sensitizing agents" of little more than academic interest because the Controlling and only important matter is the state of the central command posts of bodily defences, the adrenals. He continued: In understanding why this is so, let's begin with the fact that body chemistry is exceedingly intolerant of all substances not strictly its own. Foreign substances, for the most part, are broken down and converted chemically; animal proteins into human proteins, vegetable carbohydrates into human carbohydrates, etc.

But there are many foreign substances which body chemistry can't handle by conversion. Some have to be neutralized chemically and so made harmless, and these are the "allergens" which cause allergies if neutralization doesn't come about. Others have to be killed or at least prevented from multiplying, and these are the living bacteria which cause infections if body chemistry fails to deal with them.

Ragweed pollen, for example, the pollen gets into the body through nostrils or mouth and burrows into nasal membranes. It cannot be dislodged by mucous flow or by sneezing, and it cannot be absorbed through conversion into a compatible chemical. If something isn't done, there will be inflammation and swelling of membranes of indefinite duration as more and more pollen gets in.

So there is an emergency. The alarm runs along nerve ways to the cores of the adrenals (the "medulla," in medical parlance). They respond by secreting a chemical or hormone. The blood carries it to heart, lungs, and other glands of the endocrine system, and back to the adrenal casings, the "cortex.".. .The medulla hormone stimulates lungs into providing added oxygen, heart into producing a faster blood flow, and the cortex into secreting a host Of hormones which first call forth the neutralizing chemicals from various body cells, then put them together in assorted ways, and finally command their assault on the attacking invaders. All this happens in a flash. The amounts of chemicals involved are so very tiny they're hardly measurable. The increases in heart and lung actions are not enough for the mind to be aware of them. Just the same, a highly successful defensive operation has taken place. Definitely the body in which it happened is not allergic.

In his defence, he asserted, takes place no matter where the attack incurs—in the membranes of the bronchial passages, the stomach lining, or the skin.

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The principal defensive weapon on the battlefront of surface membrane is the "antibody." For successful defences there must be antibodies for every variety of disease-causing bacteria or viruses; specific antibodies for pollen, for house dusts, tomatoes or parsnips, or whatever the foreign substance which is both inert and foreign and, therefore, is an "allergen."

The amazing thing is that the antibody for any given invader cannot exist until the invader actually attacks. Body chemistry takes the invader's chemical measurements, so to speak, and proceeds to tailor an antibody which fits the invader to a "T". This intricate, fast-moving chemistry takes place in the spaces between cells which are bathed in the body fluid called lymph. Lymph has chemical interchanges with the blood through the lymph channels and those channels have way stations or depots, the lymph nodes.

In the nodes, from materials fetched through the channels, are manufactured floating cells, lymphocytes, which first collect the newly-formed antibodies and then carry them to the membranes where the invaders, having caused the antibodies to be formed in the first place, are digging in. Now, we are at the key point. Antibodies cannot be formed and the lymphocytes cannot discharge their burdens of antibodies without the assistance of the hormones of the adrenal cortex. If the adrenal cortices are under-functioning, if they are semi-exhausted and unable to respond fully to stimulation, these essential hormones are either insufficient in amounts or they are chemically out of balance. Here then, is the basic cause of allergies and infections.

Dr. Tintera explained that the cortex of the adrenal secretes no fewer than thirty-two hormones when functioning healthily. They and the hormones of the medulla are so vital in body chemistry that without them life is impossible.

Routinely they regulate the chemical conversion of our food into both fuel and building materials; they regulate the transport of the fuel throughout the body for "burning" with oxygen in each and every tissue, and the transport of the building materials and its uses in repairing and replacing old cells and tissues. On the emergency level, adrenal hormones prepare the body to withstand stress of whatever kind and degree.

Regarding stress, he wrote, "Walking is stress because it burns more body fuel. Running is a greater stress and so are heated arguments, tearful, and other powerful emotions, and thousands of other things which require changes in blood flow rate, in the diameters of arteries and veins, in the tensions of muscles."

All these stresses are perfectly normal and it is no less normal for our bodies to be under constant attack by "foreign" invaders since everything outside ourselves is foreign. But this constant attack is constant stress. Add everything together and you get the idea of how much work our adrenals are required to do. They are uncomplaining strong organs when all is well with them, but some people are born with undersized or weak adrenals, due to the accidents of heredity. (Emphasis added.) Under the stress and strains of living, the question for any individual is how much his adrenals can take; how much reserve strength. . .they have.

A person with very poor adrenals may never be affected by it if he lives a completely sheltered life, free of extraordinary stress. But that kind of life is neither desirable nor possible. Stress is the essence of living; from it comes pleasure and happiness. But if the adrenals are not thoroughly competent, each stressful incident cuts into their reserves. The day must come when those reserves are exhausted and the whole body is in trouble.

That explains why some people are allergic and susceptible to infections from birth while others are adults before those calamities befall them. One had poor adrenals from birth and the other had adrenals without enough reserves to last. And you can almost be positive that in any of these cases, the built-in weakness has been compounded many times by the common American diet which is bad enough to pull down even the strongest adrenals.

He explained that the adrenals in all his allergic patients are weak and semi-exhausted, secreting their hormones in insufficient and ii ii balanced amounts. His treatment, to cure them of their allergies, is nil injection of an extract of beef adrenals which contains the whole assortment of adrenal hormones in the balance drawn up by Nature. I his permits the beaten-down glands of the patient to rest by adding hormones to body chemistry that take over the work. He does not use cortisone or its derivatives, except in emergencies, because, to be successful, the drug must be given in amounts that would upset the balances between the different groups mentioned and would cause renal atrophy if given over a protracted period. His patients were required to follow a high-protein, medium-fat, and low-carbohydrate diet. It permits all meats and fish, all dairy products, all fruits, and all vegetables, except the very starchy ones. It forbids all stimulating (i i inks, especially alcoholic ones. It is the kind of diet that puts the least stress on the adrenals by permitting them to function with lop efficiency, the kind of diet that does not exhaust but builds adrenal reserves. Fortunately, our adrenal glands have recuperative power; they will come back if given the chance.

We can see from Dr. Tintera's work that not only is the Adrenal

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Syndrome problem flourishing at a later day, but it is actually much more pronounced than it was in the times of Sajous and Harrower. Why? Simple. Its causes are becoming more and more pronounced on all levels of our daily life with the continued assaults to our body by more and more sophisticated drugs and medicines and continued assaults from the outside due to increasing forms of pollution, contamination, and toxicity. The wonder is not that there are people who are affected by what I call Adrenal Syndrome; the real wonder is that there is anyone in the country who does not have this condition. It is amazing that any of us is able to function in an adequate manner and adapt to the great number of stresses and general assaults to the body that abound today. Dr. Tintera's work also reveals new aspects of the adrenal gland, particularly its control of allergies. Most patients who have allergies are victims of Adrenal Syndrome even though they do not as yet have the other classic symptoms. Dr. Tintera's comment on inherited adrenal weakness is also interesting. My work has consistently verified this point, and I now refer to these patients as having "Chronic Adrenal Syndrome."

Current Concepts. In more recent years relatively little has been done to explore and clarify the biochemical alterations in the body which cause Adrenal Syndrome. One research study, which reviewed the relationships between adrenocortical functions and infectious illness, stressed the presence of depressed adrenocortical secretion during chronic infection, although most information was based on studies of tuberculosis. Perhaps the most exciting and promising advance toward understanding clinical disorders and illnesses brought about by early, delicate hormonal imbalances has been in the realm of thyroid physiology. This research has been concerned with relationships between hormonal secretions and depression. In studies of depressed patients testing with the hormones was the only early method of detecting hypothyroidism, as results of usual laboratory tests remained in the normal range. This research is exciting because revelations in this area may provide clues which will lead to better understanding of Adrenal Syndrome—not only its causes but the disease process as well.

Meanwhile, Dr. Hans Selye, the Canadian physiologist, in his long-term study of stress and its effect on the human body developed a theory which he called "General Adaptive Syndrome" (GAS). According to Dr. Selye, the body contains a complex mechanism designed to permit it to adapt continually to the various stresses and pressures which assault it from all sides, inwardly and outwardly. As

long as this system is capable of functioning in a more or less normal fashion, the human body and mind are able to adapt successfully to a wide range of stresses and assaults, whatever their nature—chemical, physical, bacteriological, viral, mental, or emotional.

Actually, this ability to adapt is common to all forms of life. When a life form can no longer adapt, it becomes extinct. In other words, this ability to adapt is the very essence of life itself. The mechanisms in the human body which produce this adaptation are, admittedly, complex and, as yet, not fully understood, but one of the most important entities in this adaptation is the adrenal gland. Without this small but mighty gland sitting like a bishop's cap on the top of the kidney, we would not be capable of adaptation. With a strong and vital adrenal gland, we are capable of adapting to almost everything Nature and life can throw at us. With a weakened or poorly functioning adrenal gland, the ability to adapt becomes more and more difficult until a point is reached at which it is difficult for an individual to function productively in our stress-filled, high-adaptability-requiring society.

Because of the central position of this gland in general adaptive syndrome, I call the condition, which basically is a poorly functioning ability to adapt, the Adrenal Syndrome. The name is short and descriptive, though certainly not all-inclusive. It should not be confused with other presently known conditions, except possibly Addison's disease; but, since this condition is caused by distinct pathology of the adrenal gland, differentiation should be easy. Henceforth, in this book, when I speak of Adrenal Syndrome, I refer to that condition of the neuroglandular system which produces a weakening or breakdown in the body's general adaptive mechanism.

The whole theory behind the Adrenal Syndrome can be stated simply if we take into consideration the previous discussion. There is within the body a mechanism which controls: 1) tissue repair and regeneration, 2) one's ability to fend off substances which might cause allergic or similar reactions in the body, 3) one's ability to withstand stress and to be capable of meeting the needs of the environment at any specific time, and 4) the mechanism to prevent or overcome all forms of disease. It is this system which animates and vitalizes us to become vibrant, useful members of society. As long as this system functions normally, there are few problems of life, be they physical, mental, or emotional, which we cannot overcome. It is the great productive center of all strength and vitality in the body. No matter what difficulties the body may encounter, as long as this adaptive mechanism is functioning well, we have every opportunity

to overcome these problems. If there is a weakening or a breakdown in this system, everything else in life falters. Every molehill which the average person would leap with ease becomes an insurmountable mountain to the individual with Adrenal Syndrome. The simplest of life's tasks becomes complicated and monumental when the general adaptive mechanism is not up to par. At first the mind still functions and ambition is alive, but the body is not capable of carrying out the directions of these motivators. Eventually, frustration develops which causes depression, further exhaustion occurs due to stress and worry, and finally even ambition and mental capabilities themselves come under the influence of this weakened system. In extreme cases, suicide is not unknown among the victims of this disorder.

Causes of the Condition

What causes this system breakdown? Why are some people affected and others not? There are two common causes of this condition. They are often mixed in the sufferer to the point that it is difficult to say which actually caused the disorder in any specific case. The two causes are hereditary weakness and overwhelming stress. After twenty-five years of working with this condition, I feel that inherent hereditary weakness of the system is probably the most consistent cause of the difficulty. The glandular weakness seems to be passed down from one generation to another, the most common relationship being from mother to daughter, although any genetic combination is possible. Without adequate treatment, each succeeding generation becomes worse than the previous generation. Therefore, in most Adrenal Syndrome cases, the sufferer has inherited a lessened ability to adapt to the stresses of life. To make this more readily understandable to the patient, I usually refer to this situation as the inheritance of a weakened or poorly vascularized adrenal gland. While this is not entirely scientifically correct, there being other factors in a deficient general adaptive system, this is easy for the patient to comprehend and is not far from the truth.

Some persons' adaptive mechanisms are so weak that no matter how they govern their lives, they are destined to have a problem with this system. Such a problem usually begins at puberty from the stresses of the glandular changes which occur at this time. These patients come to us and say, "I've been tired as long as I can remember, Doctor. I never have had the energy or the ability to do what other people do with ease." The majority of hereditary adrenal cases, however, have sufficient adrenal functioning to live a relatively stable, normal life until a truly overwhelming continuing stress

presents itself which exhausts the adaptive mechanism and finally throws these patients into full Adrenal Syndrome. These patients show the working of the two basic causes of Adrenal Syndrome: First, a hereditary weakness of the basic system itself; and, second, stresses of various types which are able to exhaust the functioning of the mechanism. The combination of these factors, however, varies tremendously in any specific case. For instance, as previously mentioned, it is possible for an individual to be born with such a weakened adaptive system that almost any of the normal adaptive needs of life can throw that person deeply into Adrenal Syndrome. Patients with this weakness are to be greatly pitied for, until they receive proper treatment, they never are able to experience the real pleasures and satisfactions of life. Then there are patients who have some weakness of the adrenal system but who can live fairly normally until the stresses in their lives start piling up, forcing them into the symptomatology of Adrenal Syndrome. Next, there are individuals who are blessed with a fairly normal adrenal mechanism, but who are unfortunate enough in life, as Shakespeare put it, "To suffer the slings and arrows of outrageous fortune," and to have stresses and pressures so enormous and so unresolved that the normal-functioning adrenal system with which they are blessed is no longer capable of sustaining their needs. It eventually weakens and plunges them into some variety of Adrenal Syndrome. Last, there are the fortunate persons whose adrenal or general adaptive mechanism is so strong that almost nothing in life can affect it. They are capable of going through all possible stresses and, therefore, they do not fall into Adrenal Syndrome, no matter what occurs.

Most of us fall somewhere in between the extremes of the last category of individuals who possess a strong general adaptive mechanism and the first-mentioned case of the unfortunate patients with serious hereditary inadequacy.

Almost all of us feel the effects of lowered adrenal functioning at some time in our lives, usually following a bacterial or viral infection or after some particularly gruelling mental or emotional stress. At such a time, we often experience a temporary weakness and an inability to do our regular tasks as efficiently and as accurately as we would like. This is the result of adrenal exhaustion. If we are wise, at this time we will rest and not attempt to force ourselves to do more than our weakened ability readily allows. If we obtain sufficient sleep, stay on a healthful diet, and do not force ourselves to work until our strength returns, our adrenal system will shortly regenerate. The Adrenal Syndrome patient is constantly in a state

that the average human being experiences only occasionally. In Chapter II of
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this book, "The Nature of the Adrenal Patient," this state is discussed at great length.

As can be seen from the above discussion, Adrenal Syndrome is due to a malfunctioning of the neuroglandular system of the body. It is caused by a breakdown in a physical component of the human system. Unfortunately, most of the symptoms which are produced lead the person to feel, from their vagueness, that the main difficulty is one of a mental or an emotional nature. The symptoms of Adrenal Syndrome are almost identical to those caused by anxiety and various other mental conditions. When we are fearful or in a state of depression, these emotional states cause various glandular mechanisms of the general adaptive system to produce secretions which cause symptoms similar to mental problems. Cold sweating, dry throat, rapid and irregular heartbeat, dizziness, cloudiness of the mind, nausea, flushing of various parts of the body, and so on, can all be caused by various emotional effects on the general adaptive system. These symptoms are the body's attempt to prepare us for a possible threat which does not exist, except in our fears. For instance, if we were out in the woods hunting, the cry of a wildcat behind us would create a certain sense of fear. This fear would cause the body to prepare for what is known as the "fight or flight" mechanism—either to fight this danger or to run away from it as rapidly as possible. When, in our modern life, we develop an emotional fear or apprehension, the body mechanism is not always capable of distinguishing it from a true danger; therefore, through the glandular system, it prepares us in the same manner as if we were ready to elude a real danger. Since there is no real danger and subsequent action, we do not readily utilize the hormones which were pumped into our systems, and thus a variety of symptoms are produced as these hormones first register and then slowly dissipate.

Many modern psychologists and psychiatrists recommend physical activity, such as running or jogging, to help allay the symptoms of anxiety and similar difficulties. What is occurring, of course, is that the various anxiety-produced substances are being more naturally utilized by the physical activity and are not left lying around, as it were, to create more physical symptoms to aggravate the original anxieties further. This therapy has much merit although it is not an answer to the original anxiety. In Adrenal Syndrome this same admixture, which is produced by the anxious patient, is produced by the weakened glandular system itself in an effort to bring its body hormone levels up to the normal level. Thus, we have a situation in which a person is not necessarily anxious or emotionally distraught
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and yet the physical weakness (the Adrenal Syndrome) produces symptom patterns which are almost identical to those produced in the nervous, neurotic individual. Just imagine what can happen to I he patient suffering from this condition who goes to the average physician! Since there are no specific laboratory tests which identify Adrenal Syndrome in its earlier stages, the doctor finds no known disease process; and since the patient's symptoms mimic those of an emotional or mental difficulty, it is little wonder that the physician usually diagnoses the condition as mental anxiety. The patient is advised to stop worrying, told to go home and relax, given either a tranquilizer or antidepressant or both, and summarily dismissed. This is not meant as a criticism of the doctor who followed recommended medical therapy; in fact, almost any competent medical authority not conscious of or skilled in the diagnosis of Adrenal Syndrome would come to the same conclusion. Most Adrenal Syndrome patients are convinced by the time we see them that they are mental cases. They have been assured by their physicians, their friends, and even their loved ones that there is nothing wrong with them that a change of mind, a change of the way I hat they look at their lives, or a few tranquilizers won't help. This is not true. They are individuals with a true physical disorder as specific as if they had pneumonia or tuberculosis. You might as well tell the tubercular individual to stop coughing as to tell the Adrenal Syndrome patient to stop worrying or to stop feeling so tired and do mi honest day's work like any normal human being. Persons afflicted with Adrenal Syndrome simply are not normal human beings; they are individuals with a real problem who need real treatment and real understanding.

An Ominous Triad

Thus, Adrenal Syndrome may be viewed as a triad, all three parts Of which must be considered in every case: First, the heredity factor on which all prognosis or outcome is based. Second, the stress component which is composed of stresses that may cause the Adrenal Syndrome or be caused by it. Third, the group of symptoms which, due to the nature of the condition, are not only caused by the Condition, but can become stresses which further aggravate the condition.

We therefore can amplify our original definition by stating that Adrenal Syndrome is that condition of the neuroglandular system which can be produced in an hereditarily weakened structure by a multitude of possible stresses which, in turn, cause a variety of
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symptom patterns which can in themselves become stresses, thus creating a self-perpetuating disease.

The whole condition sounds ominous and almost hopeless of resolution, and so it must seem to the afflicted patient. For it is a condition that not only can be triggered in sensitive people by ordinary stresses of life, but which actually produces its own stresses via its symptomatology. We might say it is a condition which feeds upon its own excrement. As we come to understand more about the character of this disease, we see why it is so neglected and so prevalent.

To understand it more fully and to become knowledgeable in its treatment, we must comprehend the interplay and ramifications of its three sides: heredity, stresses, and symptoms.

Heredity. Little can be done about the inherited factor except to attempt to determine its extent since all treatment and prognosis (length of treatment and chance of complete recovery) depend on this fact. If inherited weakness is great, treatment must be extensive and great efforts must be made to reduce all patient stresses to a minimum. Conversely, if the heredity factor seems slight, treatment and stress reduction can be much less stringent and a quick recovery can be assured.

There is unfortunately no simple, exact way to determine the degree of hereditary weakness in any specific case. A clinician with much experience can usually make a true estimate from the case history. Three matters are of prime importance: the age at which the symptoms began, the severity of the symptoms, and the amount of stress necessary to produce the symptoms. If the symptoms began early, were severe, and seemed to set in with no appreciable external stress, the heredity factor is strong and such a case will require the best therapy we have.

As a general guide, we can say that the degree of inherited neuroglandular weakness is in direct proportion to the severity of the patient's symptoms and inversely proportional to the stresses involved and the age at which they began.

Stress. Much has been written here concerning stress, but little has been written to define the stress; to understand the stresses that affect Adrenal Syndrome—not only that cause it but also that exacerbate it—is to understand the syndrome itself.

A stress in this context can be defined as any factor which stimulates the general adaptive system. These stresses can be divided into several types: First, those stresses which would affect all human
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beings somewhat alike, i.e., cold, heat, physical exertion, infectious diseases, toxic substances, malnutrition, and such things as exposure to war, flood, earthquake, and fire. Second, stresses which are individual due to personal background and experience. For instance, you may have a relative to whom you owe a large sum of money which you are unable to pay. Word of his return from a long journey may gladden the hearts of the rest of his family, but it can strike fear and consternation in yours because of the debt. This example of personal duress is the type of unseen stress that is usually the most difficult to diagnose and correct. Third, stresses which develop from the condition itself. The Adrenal Syndrome usually causes a weakened digestive function which, in turn, has an effect on the pancreas to produce a hypoglycemic condition which in turn produces more stress. This weakened digestion also allows many foods to enter the blood stream incompletely broken down, thereby stimulating the body to

produce antibodies to attempt neutralization of the foreign substance. These antibodies, when they next contact this food substance, produce certain end products which may act as cerebral allergens, causing a variety of stress symptoms. These are only two of the stresses caused by this condition of the adaptive mechanism, but the list is long and readily shows the self-perpetuating nature of Adrenal Syndrome.

A full understanding of the stresses involved in Adrenal Syndrome is vital to recovery because all treatment is based on two simple principles on which the physician and the patient must work together. One, do all possible to build strength into the adaptive mechanism, and, two, remove as many stresses from this mechanism as possible. Unless the nature of the stresses are understood, they cannot be removed from a person's life. Some stress admittedly is useful, but long experience has taught me that no matter how hard a physician and a patient work, there will always be stresses left. It was Benjamin Franklin who said, "Those who have nothing to worry about will worry about nothing."

Symptomatology. Symptoms of Adrenal Syndrome are unique not so much because of their basic character, for these are symptoms common to other conditions, but because they themselves can have a profound effect on the course and progress of the disease. To understand this facet of Adrenal Syndrome, let us examine a typical patient. Let's take a working mother who is developing the condition and who of late has been experiencing unusual and unexplainable symptoms, such as strange tinglings, dizziness, mild nausea, the inability to concentrate, difficulty in remembering and in making
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decisions, being constantly and usually tired, digestive disturbances, apprehensions and anxieties which do not seem to have a basis in fact but which come sweeping over her for no apparent reason. Every little thing seems like a mountain to her, every cry of one of her children sounds like a screaming siren in her ear, every request of her husband seems like an unwarranted demand. Why would she not be anxious? Why would she not wonder if she is losing her sanity? Why would she not manifest all forms of worries and fears which, by their very nature, create further stresses which in turn worsen the Adrenal Syndrome, which creates more symptoms, and so on, ad infinitum.

Symptoms of Adrenal Syndrome produce a snowballing effect and, unless they are controlled, there is little hope of helping the patient. Once these symptoms begin, they are sufficient in themselves to continue the condition regardless of outside stresses.

Attempting to explain Adrenal Syndrome is like trying to explain the feelings of a new mother to a man. Words can only approximate the experience and perhaps only poorly at best. Just as mother love is not reducible to mere language, the sensations of Adrenal Syndrome cannot easily be described.

Summary

Adrenal Syndrome, a condition of the neuroglandular system, produces a weakening in the body's ability to respond to stress and, if not arrested, can lead to a breakdown of the body's ability to function. The condition is not easily diagnosed; in fact, diagnosis is usually a matter of exclusion. Although Adrenal Syndrome has been recognized for over eighty years, it has changed little in symptom pattern and in treatment required. At the turn of the century, Charles E. de M. Sajous, M.D., pioneered in the study and the treatment of adrenal gland malfunction, citing fatigue and other bodily abuses as major causative agents. He gave then the same or similar admonitions to patients as we do now in the Clymer Health Clinic. Although we may be able to refine his suggestions to make his admonitions more specific and sophisticated for a more rapid and complete recovery, the basis of treatment was outlined long ago by this intrepid pioneer. Henry H. Harrower, M.D., in the period following World War I made advances in treatment of adrenal malfunction, using what he called plural-glandular treatment—which is used to this very day at the Clymer Health Clinic. John W. Tintera, M.D., continued studying adrenal disease, especially the relationship of adrenal malfunction to allergens. Another doctor who made an important contribution to this subject is Hans Selye, Ph. D. He
identified the general adaptive syndrome theory, describing it as the mechanism by which the body adapts to various stresses and pressures by controlling tissue repair and regeneration, fending off substances which might cause allergic or similar reactions, withstanding stress, being capable of meeting the needs of the environment at any time, and preventing or overcoming all forms of disease. In what we call Adrenal Syndrome, the general adaptive mechanism is unable to perform these functions. In Adrenal Syndrome, the malfunction of the adrenal gland results from a negative interaction of heredity, stress, and a combination of individual symptoms.

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CHAPTER II

The Nature of the Patient

In my original work on the Adrenal Syndrome, I described the nature of the adrenal patient thusly:

Before discussing the treatment of hypoadrenalism used at our clinic, let's consider the nature of the person who is most likely to develop this disorder and the manner in which it is produced. If I could describe the hypoadrenal patient in one single word, that word would be "sensitive". He is cognizant of all that is going on around him, and he feels an overconscientious sense of responsibility about those near and dear to him and even about the whole world. This person's nervous and glandular systems are delicately balanced; yet he is willing to take the cares of the world on his own shoulders.

Such a nature is not sufficient alone to cause adrenal insufficiency. In my own estimation, a hereditary weakness of adrenal structure must be present. There are some persons who fit this description but who nevertheless have sufficient glandular vitality to avoid adrenal hypofunction. On the other hand, we do find persons who are by nature not perfectionists or inclined to drive themselves, yet suffer from this ailment. In these persons, it seems that the hereditary weakness is so strong that even a relatively normal amount of stress is sufficient to cause adrenal hypofunction.

Differences in Degree of Symptomatology

Not counting various external, physical, bacteriological, and chemical stresses, the two basic causes of Adrenal Syndrome are unremitting stress on an individual and the degree of hereditary weakness in the basic neuroglandular system on which the general adaptive mechanism depends. The Adrenal Syndrome patient is a combination of these two factors. These factors can be in any proportion and the variation in this proportion produces the different reactions shown by various Adrenal Syndrome patients. For instance, a patient may have only a mildly weakened general adaptive system, but be subjected to severe and unremitting stress in his life. If so, there is a good chance that eventually the general
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adaptive system will break down. This patient is an Adrenal Syndrome case and in need of treatment; however, the character and extent of his problem are different from that of the individual who has a severe hereditary or congenital weakness in his system and in whom seemingly insignificant stresses can produce severe Adrenal Syndrome difficulties. Both patients require treatment and much of the treatment is similar, but the emotional counselling and the general tenor of the psychological approaches to these two patients are entirely different.

The degree of symptomatology in a patient can often be calculated as a sum of these two factors. On a hypothetical scale of one to ten, taking one as normal and ten as severe, the first individual might have a two on the hereditary scale, but a nine on the stress scale. Together they total eleven. On the other hand, the second patient may have a two on the stress scale, but a nine on the hereditary scale. Together they also total eleven. The severity of symptoms in these two would be similar because of the eleven reading, but treatment would vary because of the different causes.

Obviously, the person who registers one on both scales has little problem. If a person rates a five on both scales, he approaches the area of symptoms. As patients display greater hereditary weakness and stress, say a seven on one scale and an eight on the other, they are going to have larger problems. In assessing the nature of the adrenal patient, these two interdependent factors which produce Adrenal Syndrome must be

considered.

All Adrenal Syndrome patients are scored on these two scales for degree of hereditary weakness and degree of stress, and the doctor who treats them must ascertain their score on each scale as accurately as possible in order to prescribe the proper treatment so they may return to normal.

Adrenal Syndrome patients should be divided into two separate groups. First, that group which I stressed in my earlier work which, although they have certain hereditary weaknesses, are basically normal human beings who have been subjected to various stresses which have caused a definite, demonstrable change in their general adaptive systems. Second, those patients, and unfortunately their number is large, who have such defective general adaptive systems that the ordinary and mundane stresses of life leave them exhausted and incapable of coping. The latter patients require the most understanding and the best treatment we can give. They require the full understanding and cooperation of their families and friends. They generally require life-long treatment of one sort or another to help keep the general adaptive system in a reasonable form of

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functioning activity. There are no factors in their lives which can be ignored. There are no thought processes in their minds which do not affect for good or ill their basic problem, and, yes, their entire existences. It is really for this group of individuals that this book was written. The first type of Adrenal Syndrome patients can gain adequate information for their needs from my original text, but for those sufferers whom I now call "Chronic Adrenal Syndrome" patients, the first work was only an introduction. For them, a complete commitment on the part of themselves, their families, their friends, and their doctors is absolutely necessary for a proper resolution of their problem.

It is true, stress is not what happens to us but how we react to what happens to us. This statement must be qualified, however. When an Adrenal Syndrome patient has advanced to a certain stage in his condition, his mind, due to a variety of difficulties the two most important of which are lack of oxygen to the brain and cerebral allergies, cannot properly evaluate the stresses under which he is placed. The patient's mind simply is not capable of reasoning to the extent necessary to prevent further damage to the general adaptive system. It is necessary that patients in this condition be placed in an environment which is as stress-free as is possible and given proper treatment until improved cerebral activity allows them once again to be able to regulate and evaluate the stresses of their own environment. These patients, usually those with strong heredity factors, are so overwhelmed by common stresses that life in an ordinary household becomes almost untenable until some improvement in their condition is made. The nature of emotional stress in the individual with a weakened adrenal system can be so complex and so incomprehensive to the average person, that he often may seem mentally disturbed. No other group of people more exemplifies the truth of Benjamin Franklin's statement, "Those who have nothing to bother them will be bothered by nothing," than do those with Adrenal Syndrome.

With a weakened adrenal mechanism, the tiniest molehill becomes a Mount Everest. The slightest misconstrued remark becomes condemnation of a major magnitude. The most sedentary physical task is an insurmountable obstacle.

Example of Hypoadrenalism

Hypoadrenalism commonly occurs in a person who has cared for a loved one through a long, extended illness. Take, for

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instance, a woman whose husband developed cancer and was operated on unsuccessfully. Physicians gave up all hope, but the man had a sturdy constitution and lived on for a year or so before he finally succumbed. The family, not wealthy, could not hire nurses and others to care for him, so his wife took care of him. She often was up day and night, watching out for his needs. The man she loved for many years gradually changed. Little by little he withered before her eyes. His emotional nature changed and he became a most difficult person with whom to live. There were times she wanted to scream at him, yet she knew that would not be kind or socially acceptable, so she held it in. She could not get her proper rest. She did not eat properly because she had lost her appetite. Instead she snacked on foods that did not supply her body with the vital elements she especially needed at the time. Her adrenal glands, the willing servants that they are, kept pouring out hormones to sustain her during the entire time. Unfortunately, they, like her, got little respite.

The unremitting and constant stress intensified. Although the glands can recuperate during sleep to some degree, her rest was less than normal and her glands had little time for their own regeneration. But they are valiant friends; they did not give in. They kept functioning and working well beyond their normal requirements.

Finally, death came to the husband. But stress was not over for the wife. She had to deal with the undertaker and then the lawyers. Then the government, inconsiderate relatives, and other people disturbed and even preyed on the recent widow.

During all this additional stress, her steadfast adrenal glands kept working their best to produce the substances she needed to keep going. Finally, she was able to rest. The undertaker, the relatives, the lawyers, and even the government were satisfied. At last she could relax. What about her adrenal glands? They were exhausted. They, too, demanded a well-earned rest. As soon as the stresses were removed and the adrenal glands were not needed to the extent they had been during heavy stress, their function slowed to enable regeneration for the preservation of the whole physical system. The widow suddenly felt tired and exhausted. Expectedly, she went into a period of depression and exhaustion.

Depending on the basic hereditary integrity of the adrenal glands, at this point she might or might not develop hypo-adrenalism. If the glands were basically strong and healthy, she would be able to recuperate and pick up her life in a reasonable time. If the glands were inherently weak, she might develop hypo-adrenalism. If the

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glands were weak, when they became so exhausted, even with the rest they were receiving, they might not be capable of regeneration to their normal state. They still were functioning, or the woman would die, but at a level far lower than before the prolonged period of stress, much lower than the level needed for normal daily existence.

We have just reproduced a classic case of functional hypo-adrenalism. Although there are many other ways of describing this syndrome, from this case history certain specifics can be derived about the nature of the stress most likely to produce this condition.

First, although the stress itself is not necessarily great, it is generally unremitting. Also, we sensitive humans are not able to overcome it—either because of a sense of responsibility or because of our emotional dependency. That is, even though it was exhausting her adrenal glands, the wife in the above example had no choice but to take care of her husband. For her own physical well-being, she could have abandoned him, turned him over to relatives, if such existed, or tried to get the state to take care of him. It would have prevented her from developing hypo-adrenalism, but her own sense of responsibility would not have allowed it. In my experience, I have found most stresses that produce hypo-adrenalism come from doing what a person believes to be his duty. If we are to prevent hypo-adrenalism in those who are susceptible, we must teach them to learn to control their response to the stress.

Our attitude—what I call acceptance of the stress—is often on par with or even more important than the stress itself in producing reaction. For example, had the woman whose husband was dying been able to rearrange her life, much of her later trouble could have been prevented. She could have eaten foods and nutrients that are best able to build up the adrenal glands, supporting the glands through this difficult period. With more knowledge she could have changed her basic attitude toward her husband at this time to a complete acceptance of his condition and of his unavoidable death.

From the foregoing, one can readily see how easy it is to develop Adrenal Syndrome. The situation described is all too common, but the patient should be capable of responding within a fairly short time if she is receptive and if adequate treatment is given. The problem with so many cases is that only rarely is treatment given toward rebuilding the general adaptive system. The patient is usually untreated and must live through the ensuing years as best she can. Much of her ability to improve depends on the stresses placed upon her and upon the basic integrity of her general adaptive system. If her future stresses are within reason,

and her adaptive system relatively normal, she may gradually return to a normal state of health and productivity, time and rest being a good doctor

in this instance. On the other hand, if her adaptive system is marginal and the stresses of widowhood difficult, without specific treatment she may never return to normal and may even continue to deteriorate with time. If such patients would seek the help of professionals trained to intervene in this condition, much misery and nonproductiveness could be prevented. It would be interesting to take a survey to find out how many on our ever growing state and federal welfare rolls are actually victims of this disorder. The normal mind and body is a productive mechanism. It is designed as such and likes to work as such. When it does not, one certainly has the right to wonder if it is functioning normally or whether it is in some unknown manner defective. Are the so-called poor really lazy and hereditarily unproductive or are they perhaps victims in many cases of a dysfunctioning adaptive system?

Chronic Adrenal Syndrome

How do individuals with Chronic Adrenal Syndrome differ from patients with the simpler type? How can you as a husband tell if your wife has this problem? How can you as a mother tell if your son or daughter is a Chronic Adrenal Syndrome sufferer? How can you as a lover tell if your future mate may have this difficulty? The answers are not easy, but there are answers.

Differences in Types of Adrenal Syndrome. When I first interview a patient, I look into his eyes. The Bible says that the eyes are the windows of the soul. That may be true, but they are also the windows of the general adaptive system. Persons with Chronic Adrenal Syndrome show to a lesser or greater degree an appearance in the eyes that is unmistakable to the trained observer. They have a certain vague staring, a vacantness which in my experience is without precedent in other disease conditions. It is nearly impossible to describe, but the person who has seen it once will never miss it again. A similar appearance is found in those who are taking street drugs and in some who imbibe too much alcohol, but, while similar, there is a distinct difference between the look of the Chronic Adrenal Syndrome patient and those who have been taking drugs or alcohol.

When these patients are examined, a difference in their blood pressure levels between the reclining and the standing positions is

often registered. In general, the blood pressure is somewhat lower than normal in these patients and tends to drop or at least not to rise as it should in the normal individual when they stand up from a reclining position. For instance, if a normal blood pressure reading is 120 over 80, Chronic Adrenal Syndrome patients may have a blood pressure reading of 110 over 70 in the reclining position, but when they stand, it may drop to 100 over 70 or even to 90 over 70. The amount of the drop is usually indicative of the severity of the condition. There are many qualifications concerning this testing mechanism, however. If a patient with Chronic Adrenal Syndrome constantly attempts to force himself to activity, he may show the same rising of blood pressures when he stands up as do normal individuals. However, after waiting a minute or so, the blood pressures will gradually start to drop because his adrenals are simply not strong enough to hold the higher level for any length of time. In my earlier book, 1 stated that the amount of drop in the postural blood pressure is indicative of the condition of the adrenal patient. This is still true, but, as suggested here, must be interpreted with many reservations. One has to know how to read these pressures and equate them with the nature and the state of the patient at the time of the reading. Of recent years I have come to use the expression of the eyes as far more indicative of the state of these chronic adrenal individuals than the postural blood pressure readings, although the latter are still of great value, especially if they include the resting pressure, the pressure immediately upon standing, and the pressure at 20-second intervals for a minute to a minute and a half while the patient remains standing. The amount of drop and the speed of drop as time progresses gives a good indication of the state of adrenal functioning.

In regard to postural blood pressures, a patient may come in feeling exhausted and yet have a good blood pressure reading. On the other hand, a patient may come in feeling quite well with a poor blood pressure reading. This may be explained by the fact that there is always a certain time lag between the exhaustion of the glands and the symptoms produced; blood pressure usually predicts how patients are going to feel rather than how they are feeling at that time. For instance, if a patient who is feeling poorly has a good pressure reading, I can usually predict with confidence that he will improve within a day or two and feel much better. On the other hand, if a patient feels good but has a poor reading, I usually advise that patient to increase his medication and to take it easy for the next few days or he will go into a period of decline.

Further information necessary to diagnose the Chronic Adrenal Syndrome case must come from the patient history. This history usually shows that the adrenal patient has had spells of exhaustion, weakness, inability to concentrate, poor memory, allergic sensitivities, sensitiveness to many ordinary situations, and so on, as far back as he can remember. Most often these victims started to notice their difficulties at puberty, although many assure me that they had the symptoms even earlier. There is a group which did not notice difficulties at puberty, but did notice them in their late high school years or when they tried to keep up with the rest of the students in college. In this latter group, most went away to college, lived in a dormitory or apartment, did not get sufficient sleep, ate poorly—either insufficient amounts or junk foods or both, had stressful relationships with members of the opposite sex, may or may not have had financial difficulties, and were overconscientious in their studies, often attempting to obtain grades which were beyond their native abilities. These stresses are exactly the type to trigger a latent Chronic Adrenal Syndrome.

Other histories show that the first signs of this syndrome occurred shortly after marriage or after the births of children. All of these events have this in common: They are normal stresses of existence which occur at various times in our lives and which our adaptive mechanism should take in stride, but which are sufficiently stressful in individuals with a weak adaptive system to trigger the lull Chronic Adrenal Syndrome. This hereditary weakness must be compared to an internal bomb that only requires sufficient stress to act as the spark to light the fuse, and once it is set off, their systems, like Humpty-Dumpty, are difficult to put back together again.

The character and mechanism of a chronic adrenal case can generally be differentiated from the hyperstress-type case because the chronic patient shows symptoms at an earlier age, though not invariable so, but, more importantly, tends to be triggered by stresses which the average person should be able to handle without real difficulty. This last factor is the true dividing line between these two types of Adrenal Syndrome patients.

Symptoms Similar to Mental Illness. Most Chronic Adrenal Syndrome patients are considered by their friends, relatives, and health practitioners —the people from whom they seek aid—to be suffering from some form of mental or psychological disturbance. This is true to such an extent that during our first interview with them, the majority of these patients assert they are sure that they

have mental or psychological problems. One of the first and most important tasks of our therapy is to convince them that this is not true. Unless we accomplish this, treatment is difficult and sometimes nearly impossible. Many of these patients are called schizophrenic, some paranoiac, some manic-depressive, and most are called neurotic. This is not to say that all schizophrenic, manic-depressive, or paranoid patients are Chronic Adrenal Syndrome victims. There are true paranoids, true schizophrenic patients, and true manic-depressives, but Chronic Adrenal Syndrome can mimic the symptom patterns of all of these mental conditions. What I am saying is that any person, who has been diagnosed as having one of these conditions, should be examined to also determine whether, possibly, his condition is Chronic Adrenal Syndrome. Such patients are brought almost daily to our Clinic. Many are helped because, as it turns out, they are suffering from Chronic Adrenal Syndrome and, therefore, can be treated by specific physical means.

Determining Characteristics. Having treated these patients for over twenty-five years, I have found a variety of interesting characteristics which are of great help in understanding and diagnosing these patients. A history of these might be helpful to those who are, themselves, wondering whether they or one of their loved ones might have this ambiguous but disabling disorder.

"Don't Make Me Wait!" It is difficult for these people to wait calmly for any length of time. Usually either one of two things happens when they attempt to wait. Either they gradually become more and more exhausted until they simply have to lie down and rest, or they gradually grow irritable to the point that they become extremely disagreeable, ready to lash out at almost anybody about anything. In our Clinic, I specifically tell all chronic adrenal patients that when they have to wait and feel either of these symptoms starting to come upon them, they are to let the nurse know that they

can no longer wait and go to rest or enter some activity to relieve their anxiety. We then call them when a treatment room is available.

When an adrenal patient starts to feel this type of anxiety, he must take action, i.e., remove himself from the environment which is causing the anxiety, no matter where he may be. To sit and fight these sensations is to create more stress and tension, and, what is worse, this inaction can produce a destructive, martyred attitude. He might think: "Why does the doctor make ME wait?? If he is

truly concerned about me, he would not make me sit here; poor little me." This attitude is common and understandable in Adrenal Syndrome patients, but it is unproductive and generally unfounded. These patients need only the freedom and the good sense to excuse I themselves and to go somewhere to rest whenever this exhaustive irritation overcomes them.

Sometimes if I am not specifically sure of the diagnosis of a difficult case, I may let the patient sit in my waiting room for some time, observing him repeatedly out of the corner of my eye for signs and symptoms of either of these states. If either of these patterns occurs, I can be pretty sure that a diagnosis of Chronic Adrenal Syndrome is accurate.

"You Make Me Mad!" One somewhat common experience of these patients that had me befuddled for a while was finally clarified in my own mind by a clinic case. The patient, the wife of a judge in a southwestern state, was an obvious Chronic Adrenal Syndrome victim who had been placed on heavy doses of amphetamines for many years to keep her functioning. Even with these, however, she awakened in the morning feeling so exhausted and depressed that she had little desire to get up or to attempt any activity of the day. She had discovered, however, in some accidental way, that if she became angry, gradually she would start feeling better and eventually be able to get up and go about her daily duties. While she was staying at our Clinic, she vented her imaginary wrath on the first person she saw in the morning. This was usually a member of the kitchen staff bringing her breakfast. This anger was quite vehement, as extreme emotion was necessary to stimulate her poor, abused adrenals to even a modicum of activity. Of course, this daily occurrence was soon reported to me. Whenever I visited this patient a little later in the morning, she always was in a very pleasant and good humour as the wrath had dissipated as soon as the adrenals were stimulated. I could not understand about what the kitchen staff had complained. Only later, after the patient had left our Clinic, was I able to consider the situation calmly and understand the mechanism behind her early-morning tirades. In this particular instance, the taking of amphetamines for a long period of time had created such a constant stimulus to the adrenal system that even they were no longer adequate to get her glands started after a night's rest. It took the strong stimulus of rage to wake up her poor, weakened adrenal mechanism. The problem with this method of adrenal stimulation was that the degree of rage necessary to get her going

created severe stress on everyone around her. While this patient was at our Clinic, our staff absorbed the force of her conduct, but when she returned home, her husband was the sole recipient. Little wonder that he was anxious to have her remain with us!

While this was certainly the most extreme case we encountered of anger being used to activate the system of a chronic adrenal patient, this same action occurs to a lesser degree in many victims of this disorder. I have as patients many women with this problem who, when the stresses get too great, throw themselves into a state of severe hysteria and remain in this state until they have sufficiently stimulated their adrenal system and poured sufficient hormones into their bloodstream.

"But I Can't Forget It!" Another common characteristic of Chronic Adrenal Syndrome is the patient's inability to clear the memory of consciousness of personal problems so that treatment and cure can proceed. Probably because of poor circulation and, therefore, poor oxygenation that is common to the brain of these patients, the normal reasoning faculties, particularly those used to distinguish between that which is rational and that which is not, do not function as they should. Therefore, these patients have difficulty clearing their minds of certain thought processes which unfortunately remain imbedded, as it were, in the memory and constantly act as recurring stresses which make treatment most difficult. Possibly some specific form of chemical activity due to a failure of the general adaptive system allows this to occur in the brain. In the near future we may be able to ascertain this chemical activity and, by neutralizing it, hasten the patient's ability to free himself from these retained, unproductive thought patterns.

A few simple examples illustrate this point. In an unguarded moment, a husband may have said something to a wife that she misunderstood and he did not fully mean. The normal wife can rationalize after a while from his actions that he really did not mean what he said and then forget it. The Chronic Adrenal Syndrome patient often cannot free the incident from her consciousness. She constantly turns it over and over in her mind, building stress to the point that she cannot sleep, and at times may go into fits of uncontrolled anger and hysteria. Counselling, even by the best of physicians, often has little effect on these patients. About the only help at the present time for this patient is an active treatment of the general adaptive system to improve the oxygen-carrying power to the tissues of the brain so that it can again function in a more rational manner. This will usually work, although it takes time to clear some patients' minds and the unfortunate obsession can be very painful and trying to those who are near and dear to these patients.

Or, for example, because of a patient's gradual deterioration into Chronic Adrenal Syndrome her husband may no longer think of her as desirable. He wants a divorce. She is told that the only way of preventing this is to once again make herself desirable. The way that this must be done is to cure her Chronic Adrenal Syndrome. However, the fear of losing her husband becomes such a chronic stress that it makes therapy difficult. As rapidly as treatment strengthens her general adaptive mechanism, she tears it down by worry and concern over a situation which can only be corrected by the treatment which she is negating by her actions.

Both of these cases illustrate what I mean when I say that this condition is self-perpetuating and malignant in its nature. It produces emotional patterns which, by their nature, tend to worsen the condition itself. These states I have called the "dead-end canyons of emotions," in that while the emotion exists, it creates nothing productive. All it can do is to tear down and destroy the basic functioning of the body.

These patients have a condition which is basically a general adaptive system weakness. Their bodies cannot adapt to the stresses placed upon them. In one group of patients, the body may be basically normal, but the stresses placed upon it are of such a magnitude that it starts to malfunction, at least temporarily. Treatment usually corrects these cases fairly quickly, and as long as the patients are somewhat careful of future stresses, they can usually avoid returning to the Adrenal Syndrome.

For the vast number of people who have an inherent hereditary weakness of this adaptive mechanism, knowledgeable and extensive treatment is usually required over a long period of time, but they can be returned to life as functioning, productive members of society. To achieve this end takes true understanding on the part of their physicians, their families, and their friends, and, to some degree, from society as a whole.