

DEPRESSION (“WHAT IF THIS IS AS GOOD AS IT GETS?”)

by Ronald L. Myers, CNC

Depression—possibly the elusive condition in modern America. We deal with any number of patients with a diagnosis of “clinical depression”. Many of these people have been to more doctors and health care practitioners than they can remember, looking for the answer to their condition. If they had found it we would not be dealing with them. All of this would make you think this is a very difficult condition to treat! And so it is if you are using the wrong paradigm.

A colleague and good friend of mine would always say, “incorrect diagnosis leads to incorrect treatment which leads to—no results”. We want to get results for our depressed patients. To do this we must start off with the correct diagnosis of what is causing the depression.

The pharmacological paradigm for the treatment of depression helps many patients. But in the last decade, much research has proven the overwhelming effect a correct, individualized nutrition program can have on depression in all its forms. Depression is a sign of an imbalance in body chemistry—nutrition gives us the power to Balance Body Chemistry. As we accomplish this goal—things change. The patient feels better and actually IS better!

THE RESEARCH (A small sampling)

A Chinese study shows high folate levels enhanced the anti-depressive effects of lithium.¹ (Lithium is now available in vegetable, non-pharmacologic form from BRC as **Li-Zyme, Li-Zyme Forte**).

Thirty-five patients suffering from depression were compared to 35 controls. Plasma cobalt levels were lower in the depressed patients and significantly higher in the recovered patients.² According to the Merck Index, the best nutritional source of cobalt is probably vitamin B12.

A double-blind trial evaluated 80 elderly patients for six weeks while being supplemented with 10mg.daily of thiamine. Compared to controls, the supplemented females showed increased appetite, energy, body weight, general well being and less fatigue. The authors suggest that vague conditions in the elderly such as weight loss, fatigue, depression, etc be evaluated for vitamin B1 need.³

In comparing 10 depressed patients and 14 healthy, matched controls, there was significant reduction of RBC membrane omega-3 fatty acids in the depressed patients that was not due to reduced caloric intake.⁴

Depressive symptoms are the most common neuropsychiatric manifestation of folate deficiency. Borderline low or deficient red cell folate levels have been detected in 15% to 38% of adults diagnosed with depressive disorders.⁵

¹ Journal of Affective Disorders, 1992;24:265-270.

² Trace Elements in Medicine, 1992;9(1):43-44.

³ Journal of Gerontology, 1991;46(1):M16-M22.

⁴ Journal of Affective Disorders, 1998;48:149-155.

⁵ Nutrition Reviews, May, 1997;55(5):145-149.

The research is piling up revealing the link between nutrients (or lack there of) and depression. As with many of the non-pathological conditions we see on the increase today, nutritional therapy give us the ability to Balance Body Chemistry, which is the principle "find the cause, fix it and then everyone can move on" in practice. As I said above, depression is a sign of an imbalance in body chemistry. Many depressed patients have been told their depression is "due to a chemical imbalance", which one or ones are usually not defined.

Using clinical data, we can determine need for various nutrients in our depressed patients. Allow me to beat what should be a dead horse by now but I find it still alive and well. As we consider nutritional means of treatment for depression, let's remember to always, *ALWAYS, ALWAYS*, start with evaluation and *treatment* of the G.I. system if needed. In reviewing clinical data, I find the need for G.I. support more than 90% of the time.

CLINICAL DATA EVALUATION--

Lithium need--Hair Analysis

Cobalt or Vitamin B12 need--serum or urinary methylmalonic acid increased. Serum uric acid decreased < 3.0, in conjunction with MCV increased > 89.9; MCH increased > 31.9 can be used to extrapolate a vitamin B12 need if methylmalonic acid study is financially prohibitive.

Thiamin need--Anion Gap increased >12, CO2 decreased <24. Although the test is expensive, Red Blood Cell transketolase is an excellent test for determining thiamine deficiency.

Omega 3 fatty acid need--Essential fatty acid test. Serum cholesterol increased > 220, triglycerides increased > 110, HDL decreased < 50.

Folic acid need--Neutrophil Hypersegmentation Index increased >3 confirms functional folic acid need. This is a very inexpensive test. In my opinion, all female patients of childbearing age considering becoming pregnant should have this test *before* conception. Folic acid deficiency in pregnant females is known to cause a neural tube defect in the child. This simple, inexpensive test can identify those deficient patients and allow for correction of the deficiency before conception.

SUPPLEMENTATION--

Lithium need--**Li-Zyme Forte** up to 2 tablets t.i.d.

Cobalt or Vitamin B12 need--**B12 2000** 1 - 3 lozenges daily dissolved in mouth.

Thiamine need--**Bio 3B-G** 3 - 5 tablets t.i.d.

Omega 3 fatty acid need--**Biomega 3** 3 - 6 capsules t.i.d.

Folic acid need--**Folic Acid 800** 2 - 5 tablets t.i.d.

**Available from Viotron International, Ltd.
(800) 437-1298**