FATS

(PART 5)

WHAT ABOUT CHOLESTEROL?

by Ronald L. Myers, CNC

This issue will focus on the other side of the coin regarding the "cholesterol myth." You can hardly read a magazine, newspaper or watch the nightly news without hearing about the horrors of (increased) cholesterol. What about *decreased* cholesterol; are there any health related problems associated with this clinical finding?

Let's look at what current research has to say about the risks of low cholesterol and human psychology.

PSYCHOLOGICAL

LOW CHOLESTEROL AND DEPRESSION—
Results of a study conducted by Dutch researchers provide additional evidence for a link between low cholesterol levels and an increased risk of depression in men. Investigators measured serum cholesterol levels in some ***30,000 men***, as part of a large screening program. (Now that's a research project—Editors note.)

They compared the presence of depressive symptoms, anger, hostility, and impulsivity in these men, to men with cholesterol levels in the normal range. They found that men with chronically low cholesterol levels showed a consistently higher risk of having depressive symptoms.

Cholesterol may affect the metabolism of serotonin, a substance known to be involved in the regulation of mood as the researchers have previously shown that serotonin levels are also reduced in men with low levels of cholesterol. *Psychosomatic Medicine 2000;62*

LOW CHOLESTEROL AND AGGRESIVE BEHAVIOR—
Despite the fact that most people are worried about having cholesterol levels that are too high, yet another study has found that low cholesterol is actually associated with adverse behavioral effects such as aggression and depression.

While the medical establishment continues to push the suppression of cholesterol levels to abnormally low levels, it is not widely known that there is a *significant amount of evidence* linking low cholesterol to aggressive behavior and depression.

According to researchers from Yale University School of Medicine, "The well-documented negative association between serum cholesterol and aggressive behavior has led Kaplan (*Psychosom Med 1994 Nov-Dec;56:479-84*) to propose a cholesterol-serotonin hypothesis of aggression.

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According to this hypothesis, _low dietary cholesterol_ intake leads to depressed central serotonergic activity, which itself has been reported in numerous studies of violent individuals."

- Researchers studied 25 violent psychiatric patients
- For 7 days, the patients wore signaling devices that emitted an average of seven signals a day.
- Following each signal, patients filled out a mood questionnaire.

The authors found that "Total serum cholesterol (TSC) concentration was positively associated with measures of affect, cognitive efficiency, activation, and sociability, suggesting a link between low TSC and dysphoria."

"These findings are consistent with the cholesterol-serotonin hypothesis and with the substantive literature linking both *aggression* and *depression* to depressed central serotonergic activity," they conclude. _Journal of Behavioral Medicine, December 1, 2000; 23: 519-529_

LOW CHOLESTEROL AND VIOLENCE—
Lowering cholesterol could trigger changes in brain chemistry that encourage violent behavior, according to a report. Dozens of studies support a connection between low or lowered cholesterol levels and adverse violent outcomes in certain populations. Cholesterol levels directly affect the activity of serotonin, a brain neurotransmitter implicated in the control of violent behaviors. It is possible that lowered cholesterol levels may lead to lowered brain serotonin activity; this may, in turn, lead to increased violence.

Many studies seem to support the existence of a cholesterol-violence relationship. One 1992 analysis, published in the journal Circulation, looked at 18 different study groups and found 50% more violent deaths in men with cholesterol levels less than 160 milligrams per deciliter (mg/dL) than in the group with the highest cholesterol levels. A 1996 French study of nearly 6,400 men, published in the British Medical Journal, also found that a low average cholesterol was linked to subsequent death by suicide. Three separate neurological studies (in 1989, 1990, and 1994) agreed that in humans, low brain serotonin is linked to increased impulsive violence, including homicide, arson, and suicide. _Annals of Internal Medicine (1998;128(6):478-487); The Journal of the American Medical Association (1997;278:313-321)_

LOW CHOLESTEROL AND SUICIDE RISK—
Canadian investigators examined the relation between low serum total cholesterol and deaths from suicide. Adjusting for age and sex, they found that those in the lowest quarter of total cholesterol concentration had more than _six times the risk_ of committing suicide as did those in the highest quarter.

This effect persisted after the exclusion from the analysis of the first 5 years of follow-up and after the removal of those who were unemployed or who had been treated for depression. These data indicate that low serum total cholesterol level is associated with an increased risk of suicide. _Epidemiology 2001 Mar;12:168-72_

(Above citations obtained from Google search of mercola.com.)

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This is a very small sampling of the research regarding decreased serum cholesterol and related psychological conditions (not to mention steroid hormone problems, tissue repair problems, impaired synthesis of bile salts, etc, etc). How many patients suffering with one or more of these (psychological) conditions are being treated with one or more psychotropic medications instead of a nutritional program designed to balance their body chemistry and increase their serum cholesterol? That would be the principle of "*find the cause, fix it and then everyone can move on"* in action. Instead of the band-aid approach used most of the time by a high percentage of health care practitioners.

The reason the band-aid approach is used so often is probably that it is easier. To satisfy my curiosity, I asked a small number of doctors that I work with "which is more difficult clinically; to increase serum cholesterol that is too low or to decrease serum cholesterol that is too high?" I found UNANIMUS agreement that increasing low cholesterol is far more difficult than decreasing cholesterol that is too high.

I want to give you ways of increasing cholesterol that is too low using dietary and supplemental means so you can more effectively help your patients *suffering* with this condition. Because as you can see from the research cited above, these patients ARE suffering much more, on a daily basis than are the patients with increased cholesterol.

HOW TO INCREASE SERUM CHOLESTEROL

DIET—
The patient should NOT be following a ***low*** or ***no*** fat or ***low*** or ***no*** cholesterol or *vegetarian* diet!!

According to Dr. Mary Enig (*Know Your Fats: The Complete Primer for Understanding the Nutrition of Fats, Oils, and Cholesterol,* p.57, Bethesda Press, 2000), "The effect of natural fatty acids on serum cholesterol levels is dependent on the original serum cholesterol levels: high serum cholesterol *decreases* with consumption of most fatty acids, including all saturates; LOW SERUM CHOLESTEROL *INCREASES* with many of the fatty acids, including saturates, monounsaturates and sometimes the polyunsaturates." (Emphasis added.)

SUPPLEMENTATION—
MN-Zyme Forte 1 tablet with each meal; provides 25 mg. of manganese per tablet.
Clinical findings developed by the Balancing Body Chemistry group showed a consistent manganese need in patients presenting decreased serum cholesterol.

BioImmunozyme Forte 1 tablets with each meal, provides manganese synergists.

Flax Seed Oil 2 capsules with each meal, source of Omega 3, 6, and 9 unsaturated fatty acids.

Evaluate patient for (1) hypochlorhydria and (2) liver dysfunction. If positive treat with **Hydrozyme** (1) and **Livotrit Plus** (2). Most cholesterol is synthesized in the liver.

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