Part III

SPECIAL ATTENTION FOR SPECIAL PEOPLE

Time is a great teacher.
Who can live without hope?
In the darkness with a great
bundle of grief the
people march.

—Carl Sandburg,
"The People Will Live On"

Depression is most often overlooked in people under twenty and over sixty-five years old, though it seems obvious that your eight-year-old son and your seventy-year-old mother can become depressed from the hazards we've examined. Both the young and the elderly have so many crises, losses and health changes that we become diverted and miss the depression that may underlie their other problems.

The truth is that in our country depression is a national hazard of youth and old age. Once we learn to recognize its symptoms, this safe, nutritional program works for these people as it does for others.

13 The Young: Special Attention for Special People

It is hard to accept that young children, sweet, sheltered newcomers to life, are victims of mood disorder. After all, isn't childhood supposed to be a time of innocence and bliss?

Depression in childhood has also been difficult for psychiatrists to accept. When a few daring doctors first documented cases of depressed children forty-five years ago, their observations were promptly rejected. And as late as the 1960's, many psychoanalysts adamantly stated that depression did not and could not exist in children because they believed there must be a certain level of cognitive and emotional development before an individual can experience depression. It seems to me that one might as well say that a person must be full grown before she can sustain a physical injury. Children do not need a fully developed conscience to feel badly about themselves and life. All they need is the kind of disturbed chemistry which gives a "negative set" to perceptions and experiences.

Since the 1970's, psychiatrists have been specifically measuring, clarifying and defining depression in children and adolescents. Denial is—or should be—impossible by now, but since actual depression re-

mains difficult to define, children's "low moods" may be barely noticed, though they can take a devastating toll by interfering with emotional, intellectual and social development.

HOW CAN YOU KNOW A CHILD IS DEPRESSED?

The symptoms in youth may be the same as the ones listed for adult depression in Chapter 2, or they may be masked.

Just as hidden depression in adults often shows itself in physical symptoms, so, too, will the young have their own masks for depression, usually a behavior problem of some sort. Fifteen to twenty-five percent of children treated for behavior disorders are discovered to be depressed. The behavior may range from irritability and hyperactivity to listlessness and underactivity.

Sleep brain wave studies done on certain hyperactive children reveal a subgroup with an abnormal brain wave pattern similar to that in depressed adults.

Other behavioral symptoms of depression in children can include:

Social withdrawal
Learning difficulties, especially when there is a decline from previous functioning
School phobia
Anxiety upon separation from the parents
General anxiety
Habitual misbehavior
Excessive dependency
Chronic anger
Excess reactivity to loss
Eating disorders, either overeating, or anorexia

Obviously, any one of these behavior patterns can arise from other causes. A child with learning difficulties may have poor eyesight; a child who refuses to go to school may be right—perhaps the school is awful; there may also be other physical or psychosocial causes for these symptoms. But a child with problems of this type should be evaluated for depression. If you ask a child if she is sad and she says "no," this does not totally rule out depression. Other questions, such as the following, can yield additional useful information:

1. How much do you like yourself?
2. Do you feel things work out for you?
3. Do you have fun very often?
4. Do you think or worry about bad things happening to you?
5. Do you do most things okay or do you do a lot that is wrong?
6. How often do you feel like crying?
7. Do you like being with people?
8. Are you able to make up your mind about things pretty easily?
9. Do you like how you look?
10. Do you have to push yourself to do your school work?
11. Do you have any trouble sleeping?
12. Are you tired a lot?
13. Do you many times feel alone?
14. Do you have plenty of friends?
15. Do you get along with people?
16. Does somebody love you?
17. Do you worry about aches and pains?
18. Do you sometimes wish you were dead?

Of course such questions should not be fired at children in a rat-a-tat-tat fashion, but can be casually brought up over a period of time.

These are adapted from some of the questions in a special scale for measuring depression in children, the Child Depression Inventory, developed by doctors Aaron Beck and Maria Kovacs. It is used in eight- to thirteen-year-old children, and your physician can obtain this scale on request, sending $2.50 to:

Maria Kovacs, Ph.D.
Associate Professor of Psychiatry
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213

If you suspect your child is depressed, seek professional help before implementing the nutrient program.

WHICH CHILDREN BECOME DEPRESSED?

If you are reading this book because you are depressed or have recurrent low moods, the odds of your child having the same problem are increased. If your low moods have been overt, obvious and long-term, your child may not only be affected genetically, but by association as well. This is certainly nothing to feel guilty about, but it will help you to work with the situation if you are aware of it.

Yet, even with no family history, one in every four children needing outpatient psychiatric care is depressed. More and more, it seems to me that nutrition is involved. Prenatal nourishment is the child's "preparation," a balanced nutritional arsenal against all kinds of disorders, including depression. Once born, the child needs to be guided to good nutrition and away from the common addiction to sugar fostered by sweetened infant formulas, Twinkies, sodas and sweetened cereals.

WHAT HAVE WE DISCOVERED ABOUT DEPRESSED YOUTH?

Dr. Kim Puig-Antich and other investigators have presented research indicating that the biological abnormalities in depressed children are similar to those in depressed adults. There are changes in sleep brain wave measures, brain amines, nervous system and hormonal function, brain cell receptor function and other biochemical alterations. All of this suggests that if the causes are the same, the treatment should also be the same.

Prompt treatment is urgently important because, when depression manifests at an early age, it is more likely to be a severe, recurring or even chronic variety.

SUICIDE IN CHILDREN

Younger and younger children are killing themselves—some of them as young as five. They overdose on household pills or poisons, jump from high places, run in front of cars, cut themselves with razor blades and bang their heads against walls. Fortunately they aren't very good at it. There are a great many unsuccessful attempts for every self-inflicted death.

Prior to my fellowship in child psychiatry at UCLA, I had not been exposed to such children, and it was a shock to me when I was assigned a seven-year-old girl who had tried to kill herself by jumping out of a second-story window. She verbalized clear and explicit wishes to die.

Depression can be horrendous enough for mature functional people with developed coping mechanisms. The immature child has to deal with the same

oppression and despair, but with far less understanding, less power to cope and a lot less information about possible treatment and relief.

Depression in Teenagers

"I'm irritated by the sounds of people eating and loud noises. Little things can send me off into very black moods. Most of the time I feel totally drained and exhausted. This is interspersed with violent anger and destructive rage. I feel 'spaced,' not human, a machine wrapped in gray glass and filled with helium. I have no ambition. I'm very confused."

Sometimes depression in teenagers is clearly articulated, as it was in the sixteen-year-old who told me this story. She was brilliant and wanted to get herself together before starting college in two months. When we talked, I learned that she'd developed a craving for sugar and bread, and had been eating a lot of junk food.

The day after our first meeting Anne started her daily program: L-tyrosine, 3200 mg in the morning, a multivitamin mineral, vitamin B complex 200 mg, 2000 mg of vitamin C, an extra 400 mg of vitamin B_1, 2000 mcg of sublingual vitamin B_{12}, and 150 mg of vitamin B_{15}. She also totally eliminated all sugar and bread.

When I saw her again, six weeks later, there had been a dramatic change. She told me she had no complaints and described her ambition: "To learn and to have fun, to write wild books and play good music; to be outrageous, infamous, and a legend in my own time"—and she may well be.

Her mother, a psychotherapist, said her daughter had improved "one hundred percent. She's totally different. Her moods are so even and she's not emo-

tionally reacting to everything. She's so reasonable and a pleasure to be with."

Though the existence of depression in adolescence has long been acknowledged, the diagnoses of specific cases are often missed. As with children, the symptoms vary widely with the individual. To be safe, any teenager with emotional or behavior problems should be evaluated for depression. The Carroll Test in Chapter 2 is also useful with this age group.

Some teenagers draw attention to themselves by being difficult to manage. Acting-out behavior such as rebellious or antisocial acts, truancy, and alcohol and drug abuse may be the primary signs of adolescent depression. Parents may get caught up in a power struggle with these teenagers and fail to look further for the cause of their misbehavior.

Thirteen-year-old Vance was referred to me because he was about to be rejected from the community group home where he was living. He had been shuffled from home to home because of his extreme restlessness, his agitated provocative behavior and insomnia accompanied by a night-time hyperactivity that totally disrupted everyone in the home. The foster parents were irritated and exhausted, and on the verge of sending Vance to yet another placement. He was intellectually gifted but doing poorly in school and refusing to attend. The strong tranquilizers he had been previously treated with had done nothing but create unpleasant side effects.

During our first interview Vance was very chatty, smiling, and making wisecracks. One would never guess he was depressed—and no one had. When I found out his mother died from an "accidental" barbiturate overdose when he was two years old, I decided to test him for depression. His score revealed severe depression.

He was treated for this and became a different

person. He slept well and was no longer disruptive. He went to school, finished his finals and was allowed to continue living at the group home.

Teenage depression can be obscure or combined with all sorts of diversionary actions, but it can also be blatant. I asked a seventeen-year-old boy why he came to see me. He said, "For my depression." I asked, "How long have you been depressed?" And he answered, "Since I was nine years old." Then he proceeded to tell me about his multiple suicide attempts through the years, twice by hanging, several times by overdose, once by wrist slashing. He recounted the details of his hanging attempts—how once the rope had slipped, saving him, how the next time it hurt his neck so much he scrambled back onto the chair from which he had jumped with his neck in a noose.

Two years before seeing me, he had started receiving various psychotherapies and was continuing with this. Occasionally someone would mention antidepressant medication, but no one followed through. As soon as we pursued a biochemical treatment plan, his symptoms cleared and he has continued to do well.

SUICIDE IN ADOLESCENTS

Steel yourself for this: the suicide rate in fifteen- to nineteen-year-olds has doubled in the past twenty years, to become the third leading cause of death in that age group. We read about it in the newspapers, we see television dramas featuring the true stories of such self-inflicted deaths. And still, we resist the idea of profound depression in our young people!

We have been trying to understand why this is happening. All kinds of reasons are proposed: the

violence in America, lack of affection in families, family mobility, rootlessness and social disintegration, parental absence and media exposure. Certainly all of these may contribute to the final disregard for life and loss of connectedness in the one who suicides. But the bottom line is still depression. The nondepressed youth will see light at the end of a temporary dark tunnel, while the depressed one sees endless darkness.

Depression is the core activator of suicide, and where suicide is increasing, depression must also be increasing. And could it be that the escalating alcohol abuse, drug abuse and junk food excesses help to produce this condition? Absolutely. All of these tilt the brain's chemistry in the wrong direction.

If you add to these substances poor coping abilities and decreasing social and family support systems, you have a dangerous mix. Romeo and Juliet killed themselves in frustration. Their situation and deaths were entirely romanticized. So it is with many of the sufferings of adolescents. Their suggestibility can lead them to follow suit even in fatal acts. Adolescent suicide is "contagious." It often occurs in clusters where one such act will trigger several more suicides in friends and siblings.

The media adds to this contagion, as do other manufactured elements in the adolescents' environment. Lyrics in punk and heavy-metal music propound nihilism, disillusionment, despondency and anger. Rock groups like the one named "Suicidal Tendencies" don't help the situation, when they sing about mutilated bodies, mass starvation and contaminated water, and then contemplate solving the issue of a threatening future by suicide.

Death is glamorized and presented as a desirable alternative to life. And some surveys show that about 55 percent of college students have considered sui-

cide specifically enough to have decided how they would do it.

Approximately six thousand documented adolescent suicides occurred in the United States in 1984. Professionals who specialize in this area say the real number is closer to twenty-five thousand. But even the six thousand number indicates that every hour and a half a young person somewhere in the United States is choosing and creating his own death.

Treatment Considerations

Even though we are beginning to recognize depression in children and adolescents, we are not yet adequately treating them. In fact, the treatment of childhood depression has received little research attention of any kind.

Just as there is limited experience in treating children with the standard antidepressant medications, the same limitations apply with the nutrient treatment detailed in this book. Barring any contraindications, it does seem reasonable and preferable, to use this program rather than medication, following the adjustments and modifications listed for the young.

The treatment for children should begin at one quarter the listed vitamin, mineral and amino acid dosages for adults. The vitamin E in the multivitamin mineral should not exceed thirty IU daily. All prepubertal children should be placed on a full spectrum free from amino acid supplement if they are taking separate amino acids. The dosage is one to two capsules with meals, two to three times daily. Children should not be placed on the amino acids without evaluation and monitoring by a physician, preferably with pretreatment blood and urine amino acid analysis by chromatography.

There is far more antidepressant drug experience with adolescents and also more experience with the nutritional program. Past puberty, the nutritional treatment can be the same as for adults, as listed in Chapter 4.

All of the other sections in the book relating to conditions predisposing to nutrient deficiencies, effects of food allergies, illnesses and unhealthy habits would apply to children and adolescents, as well as to adults.

The Old: Special Attention for Special People

In our country there are about thirty million people over sixty-five, and the number of the elderly increases yearly. Though they comprise 10 percent of our population, old people commit 25 percent of all suicides. A North Carolina study indicated that 14.7 percent of a cross section of the elderly suffered from some form of depressive illness. If we add the number of people with low moods to those with depressive illness, I wouldn't be surprised if 40 to 50 percent of those over sixty-five are feeling "down" at this moment.

Depression is the most widespread and expensive psychiatric illness, and the cost is multiplied in the elderly, whose depression tends to be more chronic, more severe and treatment-resistant.

The tone I'd like to strike is one of *preparation,* because many instances of low mood and depression can be modulated or even avoided if the person begins to prepare psychologically and physically in advance for the possible unpleasant changes that can accompany old age.

REASONS FOR INCREASED DEPRESSION

One half of the depressed elderly experience their *first* episode after sixty, because older age is a stressful, vulnerable time emotionally and physically. The aging brain becomes increasingly sensitive to nutritional and other biochemical changes in the body, and the elderly have up to a 52 percent reduction in neurotransmitters. They also have generally lower blood protein levels and a decreased capacity for binding and utilizing protein. This affects the amino acid levels and contributes to the neurotransmitter shortage. There are innumerable internal physical changes, such as a 25 to 40 percent drop in the production of thyroid, a drop in growth hormones and a 50 percent drop in adrenal function. There is also a drop in the hormones handling glucose, so that older people have greater problems with diabetes, hypoglycemia, general glucose intolerance and disturbed brain functioning.

There are some conditions in older people that predispose them to the brain chemical changes leading to depression. Nutritional deficiencies are among the most important. Poor eating habits, poor food digestion and absorption, mouth and tooth problems—all lead to the kind of imbalance we've noted in people with low moods and low energy. Older people also have more physical illnesses, which can precipitate an associated depression. They use more medicines that can cause depression as a side effect. The amount of the brain enzyme called monoamine oxidase (MAO) increases and tends to destroy the "good mood" chemicals.

For various reasons, stress and its concomitant physiological changes may also increase as we get older. Our friends and loved ones die. We lose our

support systems. We may get less exercise—both of the physical and the mental variety.

But depression in the older person is probably more nutritionally connected than for any other age group except, perhaps, adolescence. Many scientific studies have shown the nutritional deficiencies in this age group. The risk is highest in those who live alone, although it often occurs among those living in institutions and receiving a so-called balanced and adequate diet under the supervision of a dietition. The B vitamins are especially deficient, and, of course, they are particularly implicated in depression.

As we've seen, aging decreases food absorption. For this reason it's important to take in larger than usual amounts of nutrients in order for some of them to get through. Yet older people usually eat less.

Of those over sixty-five years old in our country, 10 to 15 percent have a vitamin B_{12} deficiency, 10 to 15 percent have anemia, 15 to 20 percent have thyroid problems and 10 to 12 percent have a folic acid deficiency. All these conditions can be associated with depression.

ATTITUDE AND AGING

Though many of the declines in function that come with aging are related to nutritional deficiencies, others may be attitudinal. Both need attention. Old age becomes what you expect it to be. You gradually prepare yourself to fulfill your attitudes about aging. Whom do you choose to focus on when you take note of people older than you? Do you look at those who are limited, ill and suffering in various ways or do you pay more attention to those who are vitally alive, energetic and have an enthusiasm for life? Do you

pay attention to George Burns and Bob Hope? Do you look at the lives of Picasso, Georgia O'Keefe, Joán Miró? Or do you watch with dread the stooped figures who do their lonely painful shuffle down cold, unfriendly streets? Do you think of everlasting independence or are you planning for your convalescent home? Both options are there. Whichever you focus on subtly programs your own subconscious mind to create that later in your life. You are in control.

SENILITY OR DEPRESSION?

A dreaded disease of later years is senility or what is medically called dementia. Many have a deep-seated unconscious or even conscious fear of losing their minds and it is senility, not psychosis, which can truly bring this about. However, once the mind is "lost," it's lost. The key again is preparation, attention to the *process* of getting there.

Alzheimer's disease is a devastating, untreatable, progressively relentless and finally fatal form of brain deterioration. Five percent of those over sixty-five years old have Alzheimer's, and it causes 50 percent of all true senilities. Twenty percent of those over eighty years old have some degree of Alzheimer's. There are other equally disastrous causes of senility such as arteriosclerotic brain disease, multiple blood clots in the brain with destruction of brain tissue, and various degenerative neurological diseases.

Tragically, but understandably, the demented or senile person, who can be difficult to manage, may be separated from her overwhelmed family and carted off to custodial care to vegetate, a shell of her former self. There we only provide her with sedation, food, a bath and bed—and maybe TV. But all cases of

so-called senility don't have to be this disastrous. Proper treatment for depression may sometimes strikingly reverse the "senility" symptoms.

EVERY SENILE PERSON SHOULD BE EVALUATED FOR DEPRESSION

Depression often looks like senility in older people. Of those initially diagnosed as senile, approximately 15 percent turned out on later follow-up to have had depression. Even with extensive medical work-ups, the proper diagnosis for this 15 percent had been missed. An even greater number of "senile" people do not have such a thorough evaluation, so we can assume that depression is missed more than 15 percent of the time. Even more problematic and complicated is the fact that 25 to 30 percent of the truly senile also have a superimposed depression which makes their mental deficits seem much worse than they are. In my opinion, there is nothing to lose and possibly a restored mind to gain by treating a senility of unknown origin with antidepressant nutrients according to the recommendations on page 56.

When depression looks like dementia, there can be profound memory loss and intellectual deterioration, a short attention span, changed speech, a sloppy, disheveled appearance and even incontinence.

I once hospitalized a seventy-year-old woman who barely knew her name. She didn't know where she was or the date. She didn't know the name of the president of the United States or what she had eaten for her last meal. She felt her mind was a blank and complained, "I can't remember what any of my relatives look like." She said, "I give up, I surrender, there's no hope, I'm vile, destructive, evil, ruining everyone around me. And the other patients are play-

ing out a scenario against me." She was in anguish, suffering from imaginary guilt for having killed someone. She was exceedingly agitated, wringing her hands and repeating these imagined wrongdoings, over and over.

We put her on an antidepression nutrient program, and this patient was transformed into a charming, very intelligent, interesting, informed person, with no signs of her previous disordered condition.

TREATMENT CONSIDERATIONS

Treating the older senile or depressed person is much harder than it sounds, harder than for any other group. The elderly metabolize drugs differently and are more prone to side effects. Some of the usual antidepressant medications can complicate certain medical conditions, especially heart disease and heart rhythm problems, an enlarged prostate gland, glaucoma and constipation. Other, safer drugs may have to be used in selected severe cases.

Even with nutrients the situation is more complicated in older people because some patients with heart disease are on what is called beta-blocker medication. The phenylalanine and tyrosine supplements described in Chapters 4 and 5 may not mix well with that medicine, though the rest of the program would be satisfactory.

I have, however, not found this to be a problem. If you are taking medicine for your heart, ask if it is a beta-blocker. If it isn't, you should have no problems. If you are on a beta-blocker, add tyrosine to your daily nutrient plan if the vitamins and tryptophan have not worked after one month's administration. If you do use the tyrosine, start with only one capsule

daily and gradually proceed upwards in dosage as needed and tolerated.

Before an older, generally ill person starts the nutritional program, other chapters should be studied to rule out specific causes of the depression such as vitamin B_{12} deficiency or medication side effects. If you are in poor health and are under the care of a physician, it would be useful for your doctor to obtain blood and urine amino acid chromatography tests to determine your amino acid needs more precisely.

In the nutritional treatment program in Chapter 4, I do suggest the elderly start with reduced dosages of some of the nutrients. You can also begin with one new supplement every two to three days and gradually add to the program.

Add the nutrient supplements in this order:

1. Multivitamin mineral
2. Vitamin B complex—some older people may need to double or triple the vitamin B complex dosage if they have many of the symptoms of B vitamin deficiencies listed on the chart on page 56.
3. Vitamin C
4. Tryptophan
5. Tyrosine
6. Mixed amino acid compound

Please see Chapters 4 and 6 for further details on the treatment program. Be sure to follow the precautions on page 53 regarding taking tryptophan if you have a history of high blood pressure. If you are over sixty-five, Chapters 7 and 10 are also very important for you. Review them all and then proceed on your way to a happier mental outlook with each passing day.

THERE IS ALWAYS HOPE

A sixty-eight-year-old patient of mine had had four major depressions in her life. During the depressions she became tearful and agitated, feeling "deadened, unreal and strange, mean and possessed by evil spirits." She was full of guilt and despair, sure that God had totally forsaken her for her imagined wrongdoings and unable to be consoled.

She was in a fulfilling forty-four-year-long marriage when I first met her. During well times, she was involved in golf, gardening, poetry, church and family activities, and she had traveled extensively. Each of her depressions was precipitated by a bout of flu and an associated course of antibiotic treatment. Each required one to two months of psychiatric hospitalization. Part of her treatment clearly involved the nutritional support of her immune system plus doing whatever could be done to avoid catching the flu. We did this and she remained physically and mentally healthy until she became so busy taking care of her sick husband that she neglected herself and stopped following the program. At that point she had a relapse, which further clarified to her the necessity of taking care of herself. She resumed the nutrient program and has continued to remain well.

Old age does not have to be a time of withdrawal, lack of interest, depression and despair. We can always learn and grow by adding new interests and activities. This is especially possible if our brain chemistry is balanced. We are getting to live more years as the life span stretches. This is wonderful when the quality of life is good; it is just marking time with a "life sentence" when you are depressed. The lucky or prepared ones with properly working brain chemicals can enjoy life up to their dying breath. I believe that is how it is meant to be.