Depression and the Gay Person

An Orthomolecular Exploration and Treatment Approach

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Introduction

Having become so common in our time, depression has been called by one psychiatrist (Cammer, 1981) a "perfectly normal" reaction so long as it does not "interfere in our daily tasks." Alexander Lowen (1981) believes there are to be found in depression "Energy Dynamics." He views the depressive condition as a reaction which "immobilizes a person." Lowen (1981) views depression as the "suppression of the feeling" which often can lead to "suicide and negativity" and believes that the "lack of energy" is a marked symptom of depression (while this is true, it could also be a yeast-mold allergy response). The present writer agrees with Lowen, but believes these states are interspaced with some emotional highs followed by a return to depression; which is not necessarily a manic depressive state. This author views the patient as adapting to his depression over a long period of time, until it is both chronic and viewed by the patient himself as "normal." Being near San Francisco, 15% of his practice is gay. His most common diagnosis is: 301.12 Chronic Depressive Personality Disorder, wherein often the patient will challenge the practitioner saying: "I am not depressed" or "I don't feel depressed" but they are in the therapist's office because psychologically they are not functioning. At this point the therapist turns to symptoms and several short psychological tests to demonstrate to the patient - you are depressed! In this practitioner's experience, the depressed state is often found in the gay person, who, like most of us, tends to deny his depression.

While it is true that Chronic Depression and the Affective Disorders are perhaps the most common mental disorders seen in a general medical practice, it is also true that symptoms often seem to mimic an array of somatic illnesses. Patients often present themselves first to a Primary Care Physician rather than to a Mental Health Specialist, with the patient often being sent home with a tranquilizer, placebo or told he is neurotic with no clinical reasons for his symptoms. One lesbian patient whom the author treated had been referred by her Pastor. Midway into treatment she stated: "Doctor, I am so happy to learn I am not crazy." She had been seen by five physicians in six months. Two of these physicians took her lover aside and told her the patient was neurotic and she would have to baby her. The patient was hypoglycemic and had some 32 allergies - many attacking her brain, causing psychiatric-like behavior. Most patients suffering Affective Disorders experience only depression. A few patients do experience severe mood swings between the two poles of Affective Disorder; that is Mania - extreme high - and Depression. These are referred to as Bipolar. Patients who experience only depression are often referred to as Unipolar. The present writer believes Unipolar depression is common whereas Unipolar Mania is rare. Andreasen (1978),

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too, believes the depressive syndrome is an extremely common one. The physician or family therapist identifying a set of symptoms leading to the diagnosis of depression must assess whether he is seeing a treatable "illness" or a "normal" response to life stresses. Men and women who identify themselves with the Gay or Lesbian Community *do not necessarily experience more stress or depression* than other members of general society. However, by the very nature of many of their life styles, they often experience depression whose etiology may be different from that of the heterosexual or members of society in general.

Symptoms/Diagnosis

Turning our attention to Orthodox Medicine and Psychiatry for a better understanding of symptoms, it will be noted the depressive syndrome is characterized by a dysphoric mood, typical despondency with occasional anxiety, in association with three or four other characteristic symptoms: decreased appetite, weight loss, insomnia, loss of energy, impaired concentration, guilt feelings, loss of interest or pleasure with changes in mood throughout the day, with the morning being the worst (Andreasen, 1978). Brown and MacDougall (1982) adhere to the position that depression is the major illness of the world and it is their belief that it is self-inflicted through physical inactivity and emotional reticence. If this belief is true, it would hold true for the depressed gay or lesbian person also.

Psychiatrists, in their attempt for classification of Affective Disorders, often delineate those depressions more likely to respond to Somatic (Pharmacotherapy) treatment into at least four subtypes: 1) *Endogenous* (one without apparent causes) vs. *Reactive* (responds to some stress or event — could be reactive hypoglycemia); 2) *Psychotic* (severe, incapacitating without a clear onset) vs. *Neurotic Depression* (milder, not incapacitating and typically chronic); 3) *Primary* (no prior medical mental illness) vs. *Secondary Depression* (prior mental illness, alcoholism, hysteria or antisocial personality); and 4) *Pure Depression* (non-mental history or family history) vs. *Depressive Spectrum Disease* (family history of disease other than depression). Andreason (1978) adheres to the practice — in endogenous, psychotic, primary or "pure" depression — that all are likely to respond to tricyclic anti-depressant medications. While all this may be well and good, does it truly fit the gay or lesbian patient? This writer believes it does! But not in the orthodox sense; that is, the depression is real, but the source is different.

The uninformed physician or psychotherapist can look to traditional and old established reasons for the gay or lesbian patient's depression: Guilt over his or her sexual orientation, rejection, social isolation, religious conflict, ad infinitum and in so doing often misses the primary cause of the gay person's depression — life style. *For many,* the gay or lesbian life style includes heavy drinking and, in this writer's opinion, a high rate of alcoholism. Late hours often lead to improper rest and sleep patterns. Additionally, poor diets are seen in their attempts to control weight. This often leads to irregular meals and being hypocaloried, which brings about chemical imbalances, plus the added stress found in the sexual game; as well as the prevalent use of drugs. While many "take vitamins", their body chemistry and life style demand amounts far beyond that which are considered "average or normal".

This Therapist/Nutritionist views four major parts to depression which he believes are almost always present: 1) *Poor self image* caused by an actual or imagined failure; 2) *Guilt;* 3) *Internalized and unidentified anger* (often connected to parents or even caused by diet-induced disease); and 4) a *physical component* such as undiagnosed allergy, hypoglycemia, improper diet, chronic disease, and/or nutritional deficiency. Oftentimes these depression subparts (poor self-image, guilt, anger) are produced in part or whole by the physical component (allergy, etc.). The writer estimates 70% of his *individual patient's* depression is truly physical in nature and is caused by

allergy and other diet-induced disease. No honest and/or informed physician or psychotherapist can assess how much of the depression the patient is experiencing is based in psychological causes until the physical component has been assessed and satisfied. Once this is accomplished it has been the writer's experience that there is a residual symptomatology — about 30% — demonstrated by the patient which is truly psychological in nature. Approaching the diagnosis in this fashion and with the therapist serving as a teacher, there is given tangible hope to the patient, allowing him or her to realize they are not as "Psychiatric" as their symptoms may overtly suggest. It takes depression out of the "moral issue" and puts it where it often belongs — in biochemistry.

Case History/Treatment

Treatment is best illustrated by a case history. Let's call the patient John. He was a 27 year old white gay patient of second generation Greek heritage; tall, fairly good looking, bright and completing an M.B.A. degree. He was under treatment with a dermatologist for six months while he was having his "face redone." This physician had the patient on Vibramycin daily for the six months, which had caused skin eruptions over his back. He was referred to the writer by his former lover, who "couldn't stand him, but wanted to help him", for a drinking problem. The patient was very depressed, flippant in his verbal response - almost caustic at times, had a poor self image (related to having his "face redone"?), angry, had great feelings of guilt, and was always looking down on people. They were never good enough. He was in social isolation, a target for other Greek family members, experiencing fatigue, poor concentration and moderate to heavy drinking at gay bars. There was some sexual dysfunction, for alcohol abuse increases estrogen in men. He was later diagnosed as 301.81 Narcissistic Personality Disorder in addition to his chronic depression.

Serving as a teacher, the author explained, over several sessions, how somatic-based mental conditions often were produced by chemical imbalances. The patient was not overly trusting but did believe this was a novel approach because he felt abused by his former doctors; gaining little relief. A 5-hour glucose tolerance test was ordered, producing a positive diagnosis of hypoglycemia, and he was placed on a high protein and complex carbohydrate diet. This was followed by a mega vitamin program, which demonstrated lessened depression changes in 72 hours and M.M.P.I, changes in six weeks. Hypnosis was used on one of his twice weekly sessions, where he was taught relaxation techniques. Next, he was referred to an allergist who used the interdermal method. This testing demonstrated 27 allergies for which treatment was begun. His alcohol ingestion with the hypnosis and nutritional approach was down to "one drink a night" which he felt was most "satisfying". His response to lamb, a national Greek dish, upon injection was an immediate stiff neck, which remained until it was neutralized by 5 other injections to "cancel" the lamb. His behavior was over 50% changed. However, the therapist was not able to move him beyond this point so began to investigate what he, as a therapist, was missing. In conference with his physician, the decision was made to place the patient on Lithium Carbonate — a small dose of 600 mg daily — which produced even more change. It was also found that his Amino Acids were unbalanced and Amino Acid therapy was started. The Lithium, within a matter of weeks, produced weight gain and thirst which is one of the side effects. This was controlled by salt tablets (5 gr.) and having the patient rotate his Lithium two days on and two days off. This produced good results, halting the weight gain and thirst.

The patient was seen for 26 out-patient visits, was hypnotized for 14 sessions, was placed on a hypoglycemia diet, had his allergies tested and brought under treatment, his amino acids were balanced with supplementation, he was placed on Lithium and was discharged with a good prognosis and excellent progress within four months from the start of "psychotherapy". His drinking was almost

non-existent, he was dating again, being less caustic, and was about to take his M.B.A. orals. He began to return to Church. He was encouraged to begin a group which the author would start in 90 days — to help stimulate his continued growth. This approach, especially for the gay or lesbian patients, has been found to be more economical, less time consuming, and to produce effective results because it considers their life-style.

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