USANA Technical Bulletin

Bipolar Disorder/Manic Depression

Description

- Bipolar disorder, also known as manic-depression, is a mood disorder in which the person experiences severe pathologic swings from hyperactivity and euphoria to sadness and depression.

Causes

- The cause of bipolar disorder is unclear, but biological, hereditary, and psychological factors may be involved.[1]

Types

- This disease may be dominated by manic or depressive episodes, or moods may be mixed.[1]

At Risk

- According to the American Psychiatric Association, approximately 0.4% to 1.6% of adults have bipolar disorder. This disorder is equally common in women and men, more common in higher socioeconomic groups, and associated with high levels of creativity. Thirty years is the average age for the onset of bipolar disorder.[2]

Prevention and Management

- Mania is treated with lithium. About 14 days are required before improvement is noted. When manic symptoms are severe, lithium is usually administered in combination with an antipsychotic such as haloperidol, until the acute symptoms abate, allowing tapering and discontinuation of the antipsychotic. Lithium is slightly more effective in preventing manic than depressive episodes. The depressive phase is treated the same as for any major depressive disorder.[3]
- Folic acid, vitamin B_{12} or vitamin C may be deficient, and supplementation may be beneficial.[3]
- Supplementation with omega-3 fatty acids may benefit some patients.[4]

Sources of Additional Information

- http://www.psych.org/
- http://www.mentalhealth.com

Abstracts

Fava M, Borus JS, Alpert JE, Nierenberg AA, Rosenbaum JF, Bottiglieri T. Folate, vitamin B12, and homocysteine in major depressive disorder. Am J Psychiatry 1997 Mar;154(3):426-8. OBJECTIVE: The authors examined the relationships between levels of three metabolites (folate, vitamin B12, and homocysteine) and both depressive subtype and response to fluoxetine treatment in depressed patients. METHOD: Fluoxetine, 20 mg/day for 8 weeks, was given to 213 outpatients with major depressive disorder. At baseline, depressive subtypes were assessed, and a blood sample was collected from each patient. Serum metabolite levels were assayed. Response to treatment was determined by percentage change in score on the 17-item Hamilton Depression Rating Scale. RESULTS: Subjects with low folate levels were more likely to have melancholic depression and were significantly less likely to respond to fluoxetine. Homocysteine and B12 levels were not associated with depressive subtype or treatment response. CONCLUSIONS: Overall, the results are consistent with findings linking low folate levels to poorer response to antidepressant treatment. Folate levels might be considered in the evaluation of depressed patients who do not respond to antidepressant treatment.

References

[1] Diseases. 2nd ed. Springhouse (PA):Springhouse Corporation;1997. p 46.
[2] Cecil Textbook of Medicine. 20th ed. Philadelphia:WB Saunders Company; 1996. p 2002.
[3] Werbach MR. Nutritional Influences on Mental Illness. Tarzana (CA):Third Line Press;1991. p 81-94.
[4] Rudin DO. The major psychoses and neuroses as omega-3 essential fatty acid deficiency syndrome: Substrate pellagra. Biol Psychiatry 1981;16(9):837-50.