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Recurrent unipolar mania: A comparative, cross-sectional study

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Abstract

Introduction: A significant number of patients experience recurrent episodes of mania without depressive episodes. Evidence from the available literature suggests that these patients differ from typical "bipolar" or "manic–depressive" patients, but results have been inconsistent. The current study aims to add to this literature by comparing the demographic, clinical and risk factor profiles of patients with recurrent mania with and without depression.

Methods: 66 patients with a diagnosis of bipolar I disorder were divided into "unipolar mania" (recurrent mania alone, MA) and "bipolar" (both mania and depression, MD) sub-groups. Comorbid diagnoses were assessed using the Mini International Neuropsychiatric Interview (MINI), and genetic and environmental risk factors were explored using the Diagnostic Interview for Genetic Studies (DIGS), Childhood Trauma Questionnaire (CTQ), and an additional questionnaire designed for the purpose of the study. Differences between the MA and MD groups in terms of demographic variables, clinical profile, comorbidities and antecedent risk factors were explored.

Results: Patients with both mania and depression had higher frequencies of lifetime suicide attempts, antidepressant treatment, and catatonic symptoms. There was some evidence of an association between overcrowding in childhood and the presence of depressive episodes. No other differences in demographic, clinical or risk factor variables could be found between the two groups.

Discussion: Our results are consistent with the view that unipolar mania is not a distinctive disorder, or even a distinctive subtype of bipolar disorder. However, this conclusion is provisional as it is based only on clinical and demographic data.

1. Introduction

Bipolar disorder, by definition, is an affective or mood disorder which consists of distinct episodes of elevated mood (mania) and depressed mood (depression). However, a significant number of patients present with recurrent episodes of mania without experiencing depressive episodes. The nosological status of these patients is a matter of debate. According to both the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) and the World Health Organization (WHO)'s International Classification of Diseases (ICD), patients with recurrent mania still receive a diagnosis of bipolar disorder, as these patients do not differ substantially from those with mania and depression in terms of their clinical profile and prognosis [1,2]. Some authors have suggested that these patients should be placed in a separate category, which has been usually termed "unipolar mania" [3–5]. This form of mood disorder has been reported to occur in around 5%–28% of patients in Western countries, though higher rates have been reported in Asian and African countries [6–9].

In order to consider unipolar mania as a distinct diagnostic subtype, it should be possible to demonstrate significant differences between this group and patients with classical, "manic–depressive" bipolar disorder. Studies attempting to do this have yielded inconsistent results. Distinctive features reported for unipolar mania include a male preponderance [3,4,10], lower rates of rapid cycling and suicide [11–13], more psychotic symptoms [5], a poorer response to treatment with lithium [5,14], lower rates of comorbid anxiety disorders [10,15] and attention-deficit–hyperactivity disorder [10], a premorbid hyperthymic temperament [11,16], and more familial genetic loading for depression [4]. However, these findings have not been consistently replicated [9,17,18], and the existence of a unipolar group has been challenged on theoretical grounds [19]. Some authors have reported better outcomes for

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unipolar mania than for bipolar disorder [11,12], while others have found a worse outcome in patients with mania alone [15]. In longitudinal studies of patients with recurrent mania, a majority experienced sub-threshold depression at some point in time [10,20], and almost half developed major depressive episodes when followed up [20]. In the longest prospective study of unipolar mania, only 7 of 27 patients (25.9%) with this initial diagnosis remained free of depressive episodes when followed up for twenty years [21].

Given the above findings, some authors have concluded that while the term "unipolar mania" may be useful as a clinical descriptor because of its frequency, it is unlikely to represent a separate disorder or subtype within the bipolar spectrum [9,17]. However, others have still argued for a separate diagnostic status for this condition on clinical and genetic grounds [11,16]. These opinions, based largely on clinical data, must be viewed in the light of contemporary conceptual models of bipolar disorder, particularly those which view mania as the primary feature of the disorder [22]. Mania has been considered as arising from the effect of external factors upon a pre-existing hyperthymic temperament, while depression in bipolar patients may arise from an inherent affective instability [23,24]. Moreover, despite a wealth of neuroanatomical and neurophysiological studies, the exact neurobiological processes involved in the transition from mania to depression and vice versa remain unclear [25].

A disadvantage of the literature reviewed above is that it includes few studies from countries such as India, where manic episodes are more frequent overall than depressive episodes in bipolar patients [26,27]. In this study, we compare the clinical, demographic, family history, comorbidity and risk factor profiles of South Indian patients with recurrent unipolar mania and bipolar I disorder.

2. Methodology

2.1. Study setting and sample characteristics

The current study is a cross-sectional descriptive study carried out at a general hospital psychiatry unit in South India. This unit has a follow-up clinic for patients with mood disorders, which treats around 150 to 200 patients every week, and around 95 patients are admitted every year at this unit with a diagnosis of bipolar affective disorder.

We screened 84 consecutive patients with bipolar I disorder in the period 2013–2014, whose diagnoses were confirmed using the Mini-International Neuropsychiatric Interview (MINI) [28]. The inclusion criteria were (a) diagnosis of bipolar I disorder as per DSM-IV criteria, (b) age 18–60 years, (c) at least two lifetime episodes, and (d) willingness and ability to provide written informed consent. Patients with mania secondary to medical or neurological conditions, or to the effects of substance use, were excluded. Of these patients, 18 had only a single episode of mania at the time of assessment, and were excluded from our analysis as their future outcome was uncertain, leaving us with a final sample of 66 patients. Compared to the final sample, these eighteen patients were younger at presentation (mean 23.8 vs 31.6 years; Mann–Whitney $U = 293.5$, $p < 0.01$), had a lower mean body mass index (mean 22.2 vs 24.4 kg/m^2; Mann–Whitney $U = 375.5$, $p = 0.036$), and were less likely to be receiving mood stabilizers at the time of assessment (9 of 18 vs 62 of 66; $p < 0.01$, Fisher's exact test); they were comparable on all other study variables. This study was approved by the institute's Scientific Advisory and Ethics Committees.

2.2. Patient assessment

Comorbid anxiety and substance use disorders were also identified using the MINI. Details on individual patients' demographic and clinical profiles, including the presence and nature of psychotic symptoms during affective episodes, were obtained by direct interviews with patients and their caregivers, and supplemented by consultation of patients' medical records. Environmental risk factors were assessed using a semi-structured interview schedule designed for the study, which covered obstetric complications, childhood living conditions, exposure to common infectious diseases in childhood, urbanicity, and prenatal exposure to toxins such as nicotine, alcohol and pesticides. Family histories of affective and other psychiatric disorders were assessed using the Diagnostic Interview for Genetic Studies [29]. Histories of childhood trauma were recorded using the Childhood Trauma Questionnaire (CTQ) [30].

Of the 66 patients included in our study, 38 had experienced at least two manic episodes without a depressive episode; the remaining 28 had experienced at least one depressive episode. Of these 38 patients, 21 fulfilled the most frequently used research definition of recurrent unipolar mania — namely, at least three lifetime manic episodes without a depressive episode [31].

2.3. Data analysis

We compared those patients with mania alone (MA) ($n = 38$) and those with both mania and depression (MD) ($n = 28$) on all demographic, clinical, treatment and risk factor variables. As a secondary analysis, we also compared those patients with more strictly defined unipolar mania ($n = 21$) and those with both mania and depression ($n = 28$). All statistical tests were two-tailed, and a value of $p < 0.05$ was considered statistically significant.

3. Results

Of 66 patients who had experienced at least two lifetime mood episodes, 38 (57.6%) had only manic episodes and constituted the MA group, while 28 (42.4%) had both manic and depressive episodes and formed the MD group. Patients in the MD group had a mean of 2.7 manic episodes (range 2 to 8) and 1.6 depressive episodes (range 1 to 7) over the course of their illness.