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UNIPOLAR MANIA – A SEPARATE ENTITY?

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SUMMARY

Twelve unipolar manics satisfying the inclusion criteria of having had three episodes of mania without a depressive episode were compared against bipolar manics on clinical psychopathology, demographic variables and family history of psychiatric morbidity. We found no differences between the two groups on any of the variables studied and concluded that unipolar mania is clinically homogenous with bipolar manic depressive illness.

Of late, there are reports of patients who seem to suffer only from recurrent manic episodes (Winokur et al 1969, Abrams and Taylor 1974, Abrams et al 1979). However, according to Perris (1982) this type is rare, having occured only in seventeen cases (1.1%) in a total of 1539 patients. Venkoba Rao et al (1982) noted that three (2.7%) out of 108 lithium clinic patients had recurrent manic episodes. Similar observations have been recorded by other investigators in India (Tandon et al 1981, Kuruvilla et al 1983).

Abrams and Taylor (1974) in their study of fifty manic probands observed that fourteen patients (28%) never suffered a depressive episode. In their study, unipolars typically had a later age of onset than bipolar manics. Nurnberger et al (1979) reported that thirty eight (15.7%) out of 241 lithium clinic patients never had an attack of depression. The unipolar manics had a significantly lower incidence of rapid cycling and suicidal attempts. Unipolar manics were no different from the bipolar group as regards the risk of illness among first degree relatives and responses to Lithium. Abrams et al (1979) replicated their earlier study which was methodologically more refined. Patients were classified as unipolar manics if they had 2 episodes of mania without any depressive episode. They reported an excess of males among the unipolar manics and also increased morbid risk of unipolar depression in their relatives. It is apparent from the above review that a small group of patients exist who have recurrent mania without having any depressive episode.

In the present study we examined the phenomenologic, demographic and family history of psychiatric morbidity for a group of unipolar as against bipolar manics.

Material and Methods

This study was conducted at the National Institute of Mental Health and Neuro Sciences, Bangalore. The sample included patients admitted to the inpatient psychiatric services of our unit from December 1982-December 1983. A diagnosis of MDP-Manic was arrived at using the DSM III criteria. Patients with history of organic brain disease or substance abuse were excluded. A case was diagnosed as unipolar mania when the patient had 3 episodes of mania with no depressive episodes. Our inclusion criteria was more restrictive than those used by Abrams et al (1979) and Nurnberger et al (1979). Information regarding family history and socio-demographic details were gathered from the case sheet and key informant as part of the clinical case work up (By K. S.). A detailed mental status examination was done at the time of admission (By K.S.).

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Results

During the study period there were twelve patients who satisfied the criteria for a diagnosis of unipolar mania. These unipolars were compared against bipolar manics admitted during the study period on demographic variables and family history of psychiatric morbidity. No significant differences emerged between the two groups on any of these variables (Table 1). As regards phenomenology again, no significant differences were found between the two groups on any of the variables (Table 2).

Table 1
Demographic and Family characteristics

	Unipolar (n = 12)	Bipolar (N = 17)
Mean Index Age (Year)	33.75 (SD = 12.08)	35.71 (SD = 13.55)
* Mean onset Age (Year)	21.83 (SD = 5.32)	29.76 (SD = 10.64)
Mean no. of episodes	5	4.05
Male/Female	9/3	9/8
Family History** of Psychiatric morbidity	2	7

* X^2 Computed using median test. NS

** includes one case of bipolar affective illness in the case of Unipolar mania. Four cases of bipolar affective illness in the case of bipolar group.

Discussion

We found no significant differences between unipolar and bipolar manic probands on phenomenologic, demographic variables and family history of psychiatric morbidity. Though a later age of onset for unipolars as compared to bipolar manics was noted no significant differences emerged between the two groups. When early onset bipolars were excluded from the analysis, Abrams and Taylor (1974) noted that most of such patients are likely to develop depression eventually and unipolar mania is not a distinct clinical entity. Venkoba Rao and Madhavan (1983) reported a prepondenance of recurrent manic episodes with no depression in seven out of 58

Table 2
Frequency of Symptoms in Unipolar and Bipolar

Symptoms	Unipolar (N = 12)	Bipolar (N = 17)	X^2
Euphoric Mood	9(75%)	14(82.35%)	ns
Irritable Mood	3(25%)	3(17.65%)	ns
Increased motor activity	12(100%)	17(100%)	ns
Rapid speech/ Flight of ideas	12(100%)	17(100%)	ns
Grandiose ideas/ delusions	12(100%)	17(100%)	ns
Distractibility	12(100%)	17(100%)	ns
Auditory Hallucination	1(8.3%)	2(11.76%)	ns
Visual Hallucination	1(8.3%)	0	ns
Olfactory Hallucination	1(8.3%)	0	ns
Persecutory delusion	1(8.3%)	4(23.52%)	ns
Formal thought Disorder	0	1(5.8%)	ns

cases (12%) when the onset was after the 60th year. Abrams et al (1979) in a methodologically more rigorous replicative study did find an excess of males among the unipolar manics as well as an increased risk of unipolar depression in their relatives. Their data could also suggest a deficit of females among their bipolar (Pfohl et al 1981) rather than a true difference.

The validity of the concept of unipolar mania might be questioned in the absence of long-term follow up studies of these patients. It is well documented that bipolar illness occurs at a younger age than the unipolar depression (Prien et al 1974, Angst and Perris 1982). It is also reported that in bipolar probands the onset occured earlier if the disorder started with manic episode instead of a depressive episode (Perris 1968). Mania occurs in over half of the initial attacks in bipolar patients (Coryell and Winokur 1982). Perris (1982) in his study found that in majority of the cases changes in polarity from mania to depression had occured by the 3rd episode after the onset of illness but

10 out of his 45 cases had their first episode of depression after the third episode, rarely it may occur even after the 8th episode. In other words many of our patients may have got classified as unipolar manics simply because they have not had an occasion to have depressive episode as yet even though mean number of episodes in our samples was 5 and our more definition of mania (3 consequetive episodes of mania) was more strict. Another well known contaminating factor could be mild depression going unreported and patients may get falsely classified as unipolar manics. Nurnberger et al (1979) in their study on unipolar mania found that on detailed enquiry patients originally classified as unipolar mania had suffered from depressive episodes. Both these methodological problems could be overcome to some extent by a careful longitudinal study of a large sample of patients presenting with recurrent mania.

There are some limitations in our study. Firstly, the number of patients studied were small. Secondly, the study was limited to inpatient hospital population. Fieve and Dunner (1975) had subclassified bipolar disorder into bipolar I and II depending upon whether the episode was mania or hypomania. Bipolar I is likely to have milder episode of depression. Thus, our sample was biased towards bipolar I subtype with a consequent risk of missing a mild depressive episode. Thirdly, to study the psychopathology of an index episode no structured interview schedule was used with an attendant risk of overlooking some subtle differences between unipolar and bipolar manics. A careful longitudinal study of a large sample of patients is necessary to overcome some of the methodological problems raised in this article.

In the present study we did not find any difference between unipolar and bipolar mania on phenomenology, demographic variables and family history of psychiatric morbidity. These preliminary findings suggest that unipolar mania is not a clinically distinct entity and is homogenous with bipolar manic depressive illness.

References

ABRAMS, R. & TAYLOR, M. A. (1974), Unipolar Mania, *Archives of General Psychiatry*, 30, 441-447.

ABRAMS, R., TAYLOR, M. A., HAYMAN, M. A. & KRISHNA, R. N. (1979), Unipolar Mania Revisited. *Journal of Affective Disorder*, 1, 59-68.

ANGST, J. & PERRIS, C. (1982), The distinction between bipolar and unipolar affective disorders. Quoted by C. Perris In : Handbook of affective disorders, 45 (Ed.) E. S. Paykel, Churchill Livingstone, London, 45-68.

CORYELL, W. & WINOKUR, G. (1982), Course and outcome. In Handbook of affective disorder, Ed. E. S. Paykel, Churchill Livingston, London, 93-106.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS III Edition, (DSM-III) 1980, Washington, D. C. American Psychiatric Association.

FIEVE, R. R. & DUNNER, D. L. (1975), Unipolar and Bipolar Affective States, In : The nature and treatment of depression (Ed) F.F. Lach and S. C. Draghi, Newyork : John Wiley.

KURUVILLA, K., KARUNANIDHI, A., KANAGASABAPATHY, A. S. (1983), Effects of long term lithium carbonate treatment on thyroid function in psychiatric patients, *Indian Journal of Psychiatry*, 25, 98-101.

NURNBERGER, J., ROOSE, S. P., DUNNER, D. L. & FIEVE, R. R. (1979), Unipolar mania : A distinct clinical entity ? *American Journal of Psychiatry*, 146, 1420-1423.

PERRIS, C. (1968), The course of depressive psychoses. *Acta Psychiatrica scandinavia*, 44, 238-248.

PERRIS, C. (1982), The Distinction between bipolar and unipolar affective disorders. In : Handbook of affective disorders (Ed) E. S. Paykel, Churchill Livingstone, London, 45-68.

PFOHL, B. VASQUEZ, N. & NASRULLAH, H. (1981), The mathematical case against unipolar mania, *Journal of Psychiatric research*, 16, 259-265.

PRIEN, R. F., KLETT, J. & CAFFEY, E. M. (1974), Lithium prophylaxis in recurrent affective illness, *American Journal of Psychiatry*, 131, 198-203.

TANDON, A. K., ASARE, R., SAXENA, V. C. (1981), Lithium treatment in affective disorders, *Indian Journal of Psychiatry*, 23 58-61.

VENKOBA RAO, A., HARARA SUBRAMANIAM, N., PRAVATHI DEVI, S., SUGUMAR, A. & SRINIVASAN, V. (1982), Lithium prophylaxis in affective disorders, *Indian Journal of Psychiatry*, 23, 22-30.

VENKOBA RAO, A. & MADHAVAN, T. (1983), Depression and suicide behaviour in the aged, *Indian Journal of Psychiatry*, 25, 251-259.

WINOKUR, G., CLAYTON, P. J. & REICH, T. (1969), Manic depression illness C. V. Mosby & Co., St. Louis, U.S.A.