

SYMPTOMATOLOGY, SYMPTOM RESOLUTION AND SHORT TERM COURSE IN MANIA

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SUMMARY

In a prospective study, 40 patients satisfying DSM-III criteria for the diagnosis of a manic episode were identified and followed up for a period of 90 days. The patients were assessed on the Present State Examination Schedule and the Bech Rafaelsen Mania Scale. The severity of manic illness in the patients was observed to be same as in patients from the West. Symptoms of mania followed a variable pattern of symptom resolution. Majority of patients had recovered by the end of 90 days and were functioning normally.

The manifest psychopathology in manic disorder has been described by many workers (Carlson and Goodwin, 1973 ; Taylor and Abrams, 1973; Winokur, 1975; Leff et al., 1976). Many investigators such as Carlson and Goodwin (1973), Taylor and Abrams (1973) and Young et al. (1983) have also described short term course and the pattern of symptoms resolution in mania. The availability of reliable rating scales for mania viz. Beigel et al. (1971), Bech et al. (1975), Blackburn et al. (1977), Patterson et al. (1973), not only make the task of measurement of severity of symptomatology in this disorder more accurate but also facilitate comparability of various studies.

From our country, no study pertaining to short term course, symptom resolution and symptomatology in mania is available. Moreover, since there is evidence to suggest that the phenomenology of depression and schizophrenia in Indian patients is somewhat different from that seen in the West (Kulhara and Varma, 1985; World Health Organization, 1973; Kulhara, 1988; Kulhara, 1989), it may be worthwhile to pursue the subject of mania from a cross-cultural perspective to investigate whether differences among manics from the West and India exist or not. Because of this, we conducted the present investigation.

The study has a prospective design in which manic patients were repeatedly assessed over a short period of time. The present work also endeavours to describe the short term course and pattern of symptom resolution in manic illness from a transcultural perspective.

MATERIAL AND METHODS

Patients attending the out-patient clinic or admitted to the in-patient facility of the psychiatric unit of the institute were screened. Patients satisfying DSM-III criteria for the diagnosis of a manic episode were identified and taken up for further evaluation. The diagnosis was independently reached by both investigators.

For the assessment of manic psychopathology, Bech-Rafaelsen Mania Scale-BRMS (Bech et al., 1978) was employed. This scale consists of 11 items and the scoring is done on a 5 point scale ranging from 0 to 4. For clinical assessment, the Present State Examination-PSE (Wing et al., 1974) was employed. Delusions of grandiosity were subdivided according to the description of Harris (1977).

After initial assessments, the patients were again assessed on BRMS on the 3rd, 7th, 14th, 28th and 90th day. Assessments on

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PSE were done on 28th and 90th day. In addition, at the initial visit, detailed history was also recorded to gather information about certain socio-demographic and clinical variables. Assessments on BRMS were done by one of us (S. C.) and SPE assessments were done by P. K.

The data were analysed by paired 't' test and X² test. All 't' tests are one tailed because of unidirectional hypothesis of improvement.

RESULTS

The study sample consists of 40 consecutive cases of mania satisfying DSM-III (American Psychiatric Association, 1980) criteria for the diagnosis of manic episode. Mean age of the sample was 32.76 (SD = 12.80) years. For 14 patients, the current episode was their first episode of mania. 26 patients had been treated for manic disorder earlier (mean frequency of manic episode 4.26 episodes/patients). The drug treatment of the patients was not controlled and all patients received either phenothiazines or butarophenones. In terms of chlorpromazines equivalence, the patients received 300-900 mg chlorpromazine/day. 20 patients were hospitalized at the time of initial evaluations. At the end of the study, 16 patients were placed on Lithium prophylaxis. Certain socio-demographic and clinical characteristics of the patients are shown in Table 1.

For analyzing the BRMS (Bech et al., 1978) data, the mean scores of all items of BRMS at index and subsequent evaluations were considered. These are shown in the Table 2. Sleep disturbance was the most severe disturbance at index visit followed by abnormalities in the areas of activity (both verbal and physical), mood/well being, contact and self esteem. The resolution of symptoms followed a variable pattern with some symptoms resolving rapidly whilst others persisting. On the 3rd day, improvement in all the symptoms was observed which was more marked in items like sleep distur-

TABLE 1. *Socio-demographic and clinical characteristics of the sample (N = 40)*

Variable	Males (N=33)	Females (N=7)
Age (in years)		
Mean	32.3	34.42
S. D.	12.75	13.57
Marital Status		
Single	12	1
Ever married	21	6
Formal Education		
More than 10 yrs.	7	2
Upto 10 yrs.	23	4
Nil	3	1
Residence		
Urban	17	5
Rural	16	2
Age at onset (in years)		
Mean	27.81	27.14
S. D.	11.86	8.5
Duration of current episode (in days)*		
Mean	63.66	15.14
S. D.	74.33	8.47
Type of affective disorder		
1st onset mania	12	2
Recurrent mania	6	1
Bipolar illness	15	4

*t = 3.64, d.f. = 38; p < 0.01

bance, hostility/destructiveness, and self esteem; symptoms such as mood/well being and disturbance in activity did not show much improvement. From the 7th day, marked improvement was also seen in symptoms like flight of ideas and voice/noise level. On 14th day, continuation of improvement in most items of BRMS was noted though on items like motor and verbal activity and mood/well being, the improvement was not much pronounced. This trend was maintained on the 28th day. On 90th day, improvement in all the symptoms was apparent but the mean values for ratings on items like mood/well being, verbal and physical activity and contact were high in comparison with other items.

TABLE 2. Mean scores of BRMS items at index and subsequent evaluations

BRMS Item	Mean Scores for all patients at day					
	0	3rd	7th	14th	28th	90th
1. Activity (motor)	3.15	2.87	2.1	1.73	1.57	0.55
2. Activity (verbal)	3.17	2.87	2.1	1.53	1.27	0.56
3. Flight of Thoughts	2.7	2.48	1.65	1.43	1.05	0.35
4. Voice/Noise Level	2.42	2.15	1.43	1.13	0.78	0.35
5. Hostility/Destructiveness	2.37	1.87	1.55	1.05	0.87	0.25
6. Mood/Well Being	3.15	2.87	2.22	1.72	1.4	0.62
7. Self-Esteem	3.02	2.55	2.0	1.37	1.12	0.35
8. Contact	3.12	2.75	2.17	1.67	1.3	0.52
9. Sleep	3.48	2.73	1.87	1.43	0.92	0.35
10. Sexual Interest	1.1	0.95	0.52	0.35	0.17	0.12

To assess the short term course and the level of symptomatic improvement, the mean total BRMS score of patients as a group were analysed. The comparisons using paired 't' test are between the index evaluation and evaluation on 3rd day, between 3rd and 7th day and so on. These results are graphically displayed in Figure-1. It can be seen from

Figure-1, that the trend of significant improvement has continued till the 90th day.

Manic symptomatology was clinically assessed by employing PSE (Wing et al., 1974). Irreverent behaviour was present in all cases at index evaluation. Distractibility and pressure of speech were also present in almost all of the patients at the initial visit.

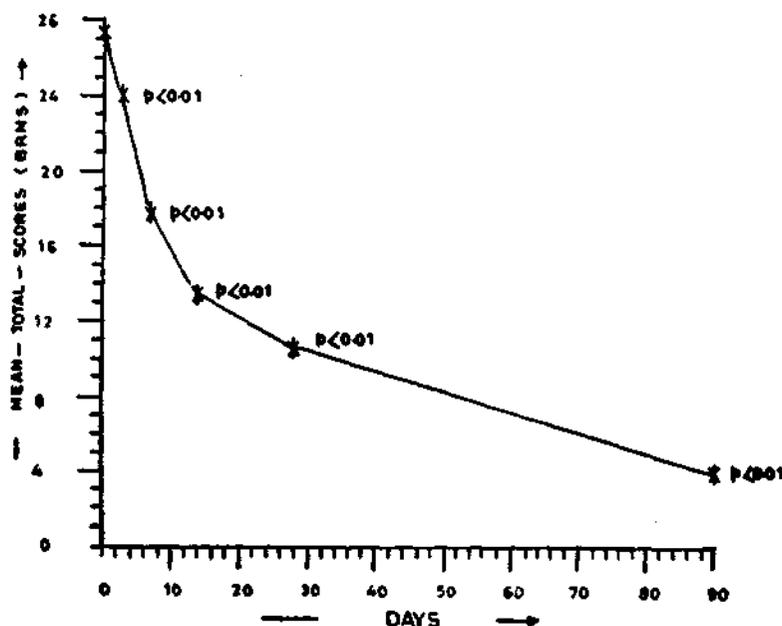


Fig. 1. Comparisons of mean total mania score.

Self neglect was evident in 62.5% of patients and 60% of the patients displayed gross excitement and violence. At the time of intake, the predominant affect was one of hostile irritability (82.5% of patients) followed by hypomanic affect which about 60% of the patients had at the time of index evaluation. Flight of ideas, incoherence and embarrassing behaviour were seen in about 30% of patients at the time of first contact. Significant improvement in all the symptoms was observed and by the 90th day and only few patients were rated to have disturbances of behaviour, affect and speech. Embarrassing behaviour was the only symptom in which significant improvement was not observed. These results are displayed in Table 3.

TABLE 3. Disturbances of behaviour, affect and speech at index and subsequent visits ($N=40$; percentage in parenthesis)

PSE Item	Present		
	at index visit	at 28th day	at 90th day
Behaviour* :			
Irreverent*	40(100)	27(67.5)	7(17.5)
Distractibility*	39(97.5)	8(20.0)	3(7.5)
Self Neglect*	25(62.5)	11(27.5)	4(10.0)
Gross excitement & violence*	24(60.0)	9(22.5)	5(12.5)
Embarrassing	12(30.0)	6(15.0)	5(12.5)
Bizarre Appearance*	10(25.0)	4(10.0)	1(2.5)
Affect :			
Hostile Irritability*	33(82.5)	13(32.5)	5(12.5)
Hypomanic*	24(60.0)	16(40.0)	9(22.5)
Suspicious	3(7.5)	0(0)	0(0)
Lability of Mood	2(5.0)	0(0)	0(0)
Speech :			
Pressure of speech*	39(97.5)	21(52.5)	4(10.0)
Flight of ideas*	12(30.0)	5(12.5)	2(5.0)
Incoherence	12(30.0)	2(5.0)	0(0)

*On applying χ^2 test, significant change in symptomatology is seen ($p < 0.05$).

Table 4 shows the occurrence of various types of delusions and hallucinations. Multiple delusions were seen in 27(67.5%) of the patients. Delusion of grandiose ability was the commonest delusion which 42.5% patients had followed by delusion of grandiose role (37.5%), religious delusion (27.5%), delusion of wealth (22.5%) and grandiose identity (5%). Significant reduction in the occurrence of delusional phenomena was seen over the follow-up period. Hallucinatory phenomena were uncommon and only 12.5% patients had them at the point of entry into the study. Only one patient had both auditory and visual hallucinations.

TABLE 4. Various types of hallucinations & delusions at index and subsequent evaluations** ($N=40$; percentage in parenthesis)

	At index visit 28th day 90th day		
Delusions :			
Grandiose ability*	17(42.5)	4(10.0)	0(0)
Grandiose role*	15(37.5)	4(5.0)	1(2.5)
Religious delusions*	11(27.5)	3(7.5)	1(2.5)
Delusions of Wealth	9(22.5)	0(0)	0(0)
Grandiose identity	2(5.0)	1(2.5)	1(2.5)
Hallucinations :			
Verbal hallucinations based on affect	5(12.5)	0(0)	0(0)
Verbal hallucinations			
Visual hallucinations*	1(2.5)	0(0)	0(0)

*Significant change (χ^2 test; $p < 0.05$).

**27 patients had delusions; 10 patients had single delusion and 17 had multiple delusions.

The outcome at the 90th day was as follows: 17(42.5%) patients were totally asymptomatic and had resumed normal working. 11 (27.5%) patients had achieved almost total clinical recovery but their working capacity was reduced. 6(15%) patients were still hospitalized but were participating in occupation and diversional therapies and the rest 6 (15%) were in the community but "sick listed".

DISCUSSION

Our sample of manic patients has few striking features. Firstly, there is a preponderance of male subjects in our study which is contrary to the finding of Winokur et al. (1969). This could be either because of socio-cultural factors or differential rate of incidence of mania in the two sexes in our country. For the former, it can be argued that because ours is a male dominated society, treatment is more frequently sought for males as the disorder has deleterious effect on the earning capacity of the afflicted ones. To support the latter, we do not have epidemiological figures from our country. The second striking feature is higher mean age at onset of our patients. This is higher than what has been reported in the literature (Taylor and Abrams, 1973; Winokur et al., 1969). We have no explanation for this observation. The third salient feature is that mean duration of current episode of illness is significantly less in females as compared to males. In the context of Indian culture it would appear that disorganized behaviour of females is perhaps less tolerated and therefore treatment is sought early. It may also mean that males are able to resist or evade treatment more effectively.

In many respects, the symptomatology as displayed by our patients in the areas of affect, behaviour and speech is similar to the observations of other workers (Carlson and Goodwin, 1973; Taylor and Abrams, 1973; Leff et al., 1976; Loudon et al., 1977). However, in our patients, distractibility as a symptom was more pronounced and embarrassing behaviour though present in only a minority of patients persisted for a longer period of time (Table 3). Our finding that hostile irritability was the dominant affect with which patients presented is in agreement with the observations of Taylor and Abrams (1973) and Carlson and Goodwin (1973) but not with the findings of Young et al. (1983) and Winokur et al. (1969).

In the present study only 27(62.5%) patients had one or the other delusions. This rate of occurrence of delusions in our sample compares favourably with the results of Leff et al. (1976) but some other workers (Young et al., 1983 and Loudon et al., 1977) have reported lower frequencies for delusional phenomena in manic patients. Grandiose ability was the commonest delusion seen in our patients which is in keeping with the trend reported in the literature. As compared with the findings of Leff et al. (1976) and Winokur et al. (1969), our patients had more delusions of wealth. In our socio-economic context, where people are less affluent, this may simply serve as a wish fulfillment.

Delusions and hallucinations with which our patients presented lasted only for a short time and by the 28th day, the number of deluded and hallucinated patients had significantly declined. This confirms the observation of Winokur et al. (1969) who have commented that delusions are the symptoms which disappear early.

Comparison of our results on the mania rating scale employed by us with the work of other authors is fraught with difficulties because of two reasons. Firstly, the tools of assessment are different and secondly, our's is a mixed sample whereas most studies have been conducted on hospitalized patients only. Notwithstanding these limitations, comparison with the work of Young et al. (1983) is possible because of close resemblance between Mania Rating Scale of Young et al. and BRMS (Bech et al., 1978). The mean total mania score of our patients at index evaluation compares very favourably with the mean total mania score of patients of Young et al. in the first week. This suggests that at intake, at least, our patients are as disturbed as the patients of Young et al. (1983). However, subsequent assessments indicate that in our patients perhaps, the symptom resolution is more rapid. This is indicated by a sharper reduction in mean

total mania score at 2nd and 3rd assessment as compared with the patients of Young et al. (1983).

In the present study, the pattern of symptom resolution i.e. change in symptom scores has been variable with some symptoms resolving quickly and some persisting for a longer period of time (cf. improvement in sleep disturbance and mood/well being). In this respect, our findings are consistent with other investigators.

It is difficult to compare the short term course of our manic patients with manic patients from the western world as comparable contemporary studies are not available. It would appear that the short term outcome in our patients is good with only 15 percent of patients still hospitalized at the end of 90 days. In our country where hospital beds for mental illness are a scarce commodity, the presence of a patient 90 days after admission suggests that the patient must really be ill to be still hospitalized.

In the context of trans-cultural psychiatry, more research is needed to clearly establish whether the short term outcome in our patients is better and also whether symptom resolution in Indian manics is more rapid.

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