

**RETROSPECTIVE STUDY ON THE EFFECTIVENESS OF HOMOEOPATHIC
MEDICINE IN BIPOLAR AFFECTIVE DISORDER, MANIC TYPE****¹Dr. S. Karunakara Moorthi M. D. (HOM), ²Dr. Jaseel Ahammed N. P., ³Dr. Radhika P. and ⁴Ms. Resmy R.**Research Officer (H)/Scientist-2, ²2nd Year M.D. Scholar, ³2nd year M.D. Scholar, ⁴Statistician,
National Homoeopathy Research Institute in Mental Health, Sachivthamapuram P.O Kottayam Kerala.***Corresponding Author: Dr. S. Karunakara Moorthi M. D. (HOM)**

Research Officer (H)/Scientist-2, National Homoeopathy Research Institute in Mental Health, Sachivthamapuram P.O Kottayam Kerala.

Article Received on 11/12/2019

Article Revised on 31/12/2019

Article Accepted on 21/01/2020

ABSTRACT

Introduction: Mania can be defined as an abnormally elevated mood characterized by symptoms such as inappropriate elation, increased irritability, insomnia, increased speed and/or volume of speech, disconnected and racing thoughts, markedly increased energy and activity level, poor judgment, and inappropriate social behaviour. There are a number of medicines cited in homoeopathic literature which can be used for treatment of mania. A retrospective study was undertaken to explore usefulness of homeopathic medicines in the treatment of mania. **Methodology:** Case records of 30 patients were studied retrospectively to assess the symptoms of mania. Young's Mania Rating Scale was used to assess the response to treatment after 4 weeks of intervention. **Results:** A Friedman's test showed that the YMRS total score has significantly reduced from 37.87 ± 3.58 to 22.30 ± 12.35 . ($\chi^2=71.64$, $p<0.001$) over 4 weeks. Post Hoc analysis was done by applying Wilcoxon Signed rank test. Wilcoxon Signed rank test showed that there is significant reduction in the YMRS total score from first week onwards ($z=-2.443$, $p=0.015$). **Conclusion:** The findings are encouraging to open avenues for further studies on mania.

KEYWORDS: BPAD-Mania, Retrospective, Homoeopathy, YMRS.**INTRODUCTION**

Bipolar affective disorder (BPAD) is a multicomponent illness involving episodes of severe mood disturbance, neuropsychological deficits, immunological and physiological changes, and disturbances in functioning.^[1] Bipolar I disorder is defined as having a clinical course of one or more manic episodes and, sometimes, major depressive episodes. A variant of bipolar disorder characterized by episodes of major depression and hypomania rather than mania is known as Bipolar II disorder.^[2]

Mania is defined by a euphoric, expansive, or irritable mood that is accompanied by a marked increase in energy. Defining symptoms which must be present to make a diagnosis of mania are listed in table 1. They serve as the basis for the two most widely used criteria sets, namely DSM-5 and ICD-10.^[3,4] However, mania is diagnosed when these symptoms cause significant impairment in interpersonal, social, or work function.

Symptoms of mania

- Euphoric, expansive, or irritable mood
- Excessive energy
- Decreased need for sleep
- Racing thoughts/flight of ideas
- Rapid speech

- Grandiosity
- Impulsive pleasure seeking
- Distractibility
- Mood lability
- Hyper sexuality
- Hallucinations
- Delusions
- Severe thought disorder
- Aggressive impulsivity
- Hyper religiosity
- Extravagance

Most theories of mania view manic episodes as a defence against an underlying depression. Manic episodes may reflect an inability to tolerate a developmental tragedy, such as the loss of a parent. The manic state may also result from a tyrannical superego, which produces intolerable self-criticism which is then replaced by euphoric self-satisfaction. A manic patient's ego can be regarded as overwhelmed by pleasurable impulses, such as sex, or by feared impulses, such as aggression. Mania can also be viewed as a defensive reaction to depression, using manic defences such as omnipotence in which the person develops delusions of grandeur.^[2]

Recent studies demonstrate that bipolar disorder is the sixth leading cause of disability worldwide and is

associated with high rates of both morbidity and mortality; for example, death by suicide affects up to 5% of people with bipolar disorder.^[5,6] Manic episode can increase the risk of suicide, especially if the patient dominates by productive symptoms in the form of delusions.^[7] Although bipolar disorder represents a major public health problem, its causes remain incompletely understood. It is now clear that genetic factors play a significant role in the onset of bipolar disorder, as recent studies suggest a heritability risk of 85%.^[8] A study found that the median duration of untreated mania was four to six months.^[9]

The assessment of BPAD may cover history of number of previous episodes, type of first episode in lifetime, predominant polarity of illness, duration and severity of episodes, inter-episodic recovery, presence or absence of suicidal behaviour, violence and agitation, seasonal variation in onset of symptoms, presence of rapid cycling and features of ultra-rapid cycling. Assessment of current episode may also focus on the issues of severity of symptoms, suicidality and agitation. Understanding the role of various psychosocial stressors and biological rhythms in onset of illness, precipitation of relapse and continuation of symptoms need to be understood thoroughly.^[10]

There is a paucity of prevalence studies of mental disorders in children and adolescents. There are some community studies who have reported prevalence rates of 9.4% in children aged 8–12 years, 12.5% in children aged 0–16 years, and 1.81% in adolescents aged 12–16 years. Bipolar affective disorder (BPAD) has been recognized in children since 1990; however, there is active controversy whether it could occur before the age of 12 years. Some robust Indian studies have reported 3%–4% prevalence of mood disorders in children and adolescents. Lifetime prevalence rates of BPADs in this age group have been calculated 2.1% equal in males and females.^[11] The current prevalence of (BPAD) is 0.4%–0.5%, 1-year prevalence is 0.5%–1.4% and lifetime prevalence is 2.6%–7.8%. In India, the prevalence of affective disorder ranges from 0.51 per thousand population to 20.78 per thousand population.^[12]

These disorders are often associated with comorbid disorders such as anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorders (CDs). Some authors feel that bipolar disorders often start in adolescents with an episode of major depression, chronic fluctuating abnormalities of mood over activity, cognition, and conduct disturbances. In the early stage, presenting symptoms are nonspecific and not limited to mood spectrum.

This study aims at retrospectively analysing the effectiveness of Homeopathy medicines in BPAD, manic type.

Homoeopathy in Bipolar Mania

A search of the Pub Med, Medline and Google Scholar databases using the words Homoeopathy, bipolar mania was conducted. Though homoeopathy is very effective and safe in the management of psychiatric ailments, there only few literature depicting the same. Management of acute psychotic episodes has been mentioned by Dr M D Phalnikar. He mentions the importance of causative factors and concomitants in successful prescription.^[13] St. John's Worts (*Hypericum*) have been found to be successful in mood disorders.^[14] *Melilotus* was also successfully used in the treatment of mania.^[15]

METHODS

Case records of patients diagnosed as bipolar affective disorder, current episode manic, during a period of June 2013 to September 2018 were collected. The total of around 60 case records were collected which had symptoms of mania Out of which, 30 cases were diagnosed as mania according to ICD 10 Diagnostic Criteria for Research by Consultant Psychiatrist of our institution. Those 30 cases were selected for the study. 20 cases were from the IPD and 10 cases were from OPD. Those with symptoms of hypomania (12), those who have not completed 6 months follow up (8 cases) and those who needed the intervention of Psychiatrist (10 cases) were excluded from the study. Consecutive consultations over a period of 6 months were reviewed by retrospective analysis of case records. Demographic data obtained from the charts included sex, age, marital status, educational status, and history of habitual moderate to heavy alcohol use.

This study evaluated the effectiveness of homoeopathy in the management of already diagnosed bipolar affective disorder- manic type. Medicines were prescribed in 30, 200 potency. Repetition was done every 4 hourly. If symptom were persisting, even after 1 week, next higher potency of same medicine was prescribed 4 hourly. Upon amelioration of symptoms, patient was kept on placebo.

We also tried to find out the precipitating factors, if any. The most commonly used drugs; its dosage and potency were also studied. The outcome of the treatment was determined using Youngs Mania Rating Scale. Assessment of the YMRS scale was done weekly for the first 4 weeks and then monthly once for the next 5 months.

Inclusion Criteria

- Persons of age group 12 – 70 years of age, who were diagnosed with BPAD, current episode manic with or without psychotic features.
- Those who have completed 6 months follow up.

Exclusion Criteria

- Episode due to psychoactive substance abuse
- Organic mental disorders
- Patients with life threatening co morbidities

- Pregnant and lactating females

Area of Study

The patients who have presented at the OPDs & IPDs of NHRIMH, Kottayam were selected for the study.

Sample Size

A total of 30 cases were considered for analysis out of which 15(50.0%) were male and 15(50.0%) were female. Subjects were all patients of NHRIMH who fulfilled the following inclusion criteria diagnosis of bipolar mania, established on the basis of semi structured psychiatric interviews, review of all available medical records, and confirmation by the Consultant psychiatrist. The cases were between 14 to 68 years of age. Out of the 30 cases 18 (60.0%) have family history of BPAD. The duration of disease varies from 15 days to 40 years.

Statistical Analysis

The statistical analysis of all the baseline components such as elevated mood, increased energy, sexual interest,

sleep, irritability, speech, language – thought disorder, disruptive – aggressive behaviour, appearance and insight were compared at the end of treatment by Friedman test and the baseline score values and all the mean values were compared by using Wilcoxon Signed Rank Test, by using the IBM SPSS Version 20.0. $P < 0.05$ was considered as significant.

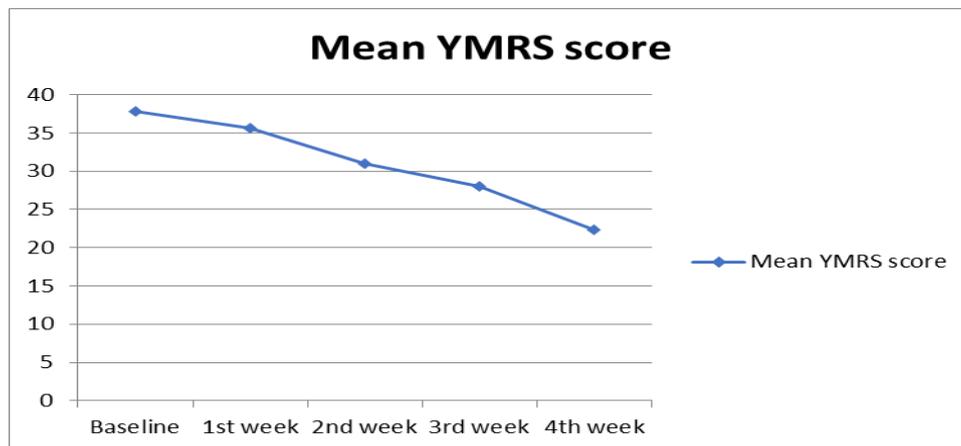
RESULTS

The symptoms were assessed using the Young Mania Rating Scale (YMRS). The YMRS total score significantly deviated from Normality. Hence Non-parametric tests were applied for comparison. The study period was 4 weeks. A Friedmann's test showed that the YMRS total score has significantly reduced from 37.87 ± 3.58 to 22.30 ± 12.35 . ($\chi^2 = 71.64$, $p < 0.001$) over 4 weeks. Post Hoc analysis was done by applying Wilcoxon Signed rank test. Wilcoxon Signed rank test showed that there is significant reduction in the YMRS total score from first week onwards ($z = -2.443$, $p = 0.015$).

Table 1: Comparison of YMRS total Score.

Variable	Baseline	Week 1	Week 2	Week 3	Week 4	Test Statistic	P value
YMRS	37.87 ± 3.58	35.60 ± 5.0	31.0 ± 8.80	27.97 ± 8.92	22.3 ± 12.35	71.64*	<0.001

*Friedmann χ^2 , $p < 0.05$, statistically significant



Graph 1: Trend Line of Mean YMRS total Score.

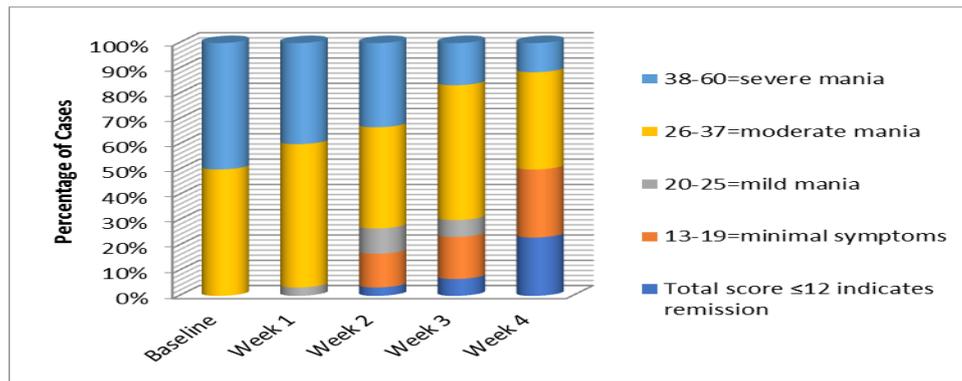
The severity of the disease were classified as Total score ≤ 12 indicates remission, 13-19=minimal symptoms; 20-25=mild mania, 26-37=moderate mania, 38-60=severe mania. At baseline 15 patients had score with moderate mania and 15 cases were of severe mania. There was a

statistically significant difference in severity of the disease over a period of 4 weeks, $\chi^2(2) = 54.6$, $p < 0.001$. There is significant difference in the severity from the second week onwards ($z = -2.623$, $p = 0.009$).

Table 2: Severity of Disease based on YMRS total score.

Severity	Baseline	Week 1	Week 2	Week 3	Week 4	Test Statistic	P value
Total score ≤ 12 indicates remission	0(0.0)	0(0.0)	1(3.3)	2(6.7)	6(20.0)	54.6*	<0.001
13-19=minimal symptoms	0(0.0)	0(0.0)	4(13.3)	5(16.7)	7(23.3)		
20-25=mild mania	0(0.0)	1(3.3)	3(10.0)	2(6.7)	4(13.3)		
26-37=moderate mania	15(50.0)	17(56.7)	12(40.0)	16(53.3)	10(33.3)		
38-60=severe mania	15(50.0)	12(40.0)	10(33.3)	5(16.7)	3(10.0)		

*Friedmann χ^2 , $p < 0.05$, statistically significant.



Graph 2: Severity of disease based on YMRS total score.

There were 6 cases with >75% improvement from baseline out of which 2 cases showed 100% improvement. 6 cases were in 50 to <75% improvement range. 5 cases were in 25 to <50% improvement range. 10 cases showed <25% improvement. One case was status quo. 2 cases worsened.

The individual symptoms in YMRS were compared using Wilcoxon Signed rank test. There is significant difference in the symptoms Elevated mood, Increased motor activity, Sleep, Irritability, Speech, Language

thought disorder, content, Disruptive aggressive behavior and insight. (Values are given in table 3). The symptoms which showed no significant difference from baseline were sexual interest and appearance. The sexual interest was normal in 29 cases at baseline out of which 28 remained normal after treatment. Appearance was "Appropriate dress and grooming" in 29 cases at baseline which became 30 cases after 4 weeks of treatment. Thus in the case of these two symptoms significant difference from baseline is not preferable.

Table 3: Comparison of symptoms at Baseline and End.

	At Baseline n (%)	At End n (%)	Test statistic [#]	P value
Elevated Mood				
0 Absent	0(0.0)	3(10.0)	-4.164	<0.001
1 Mildly or possibly increased on questioning	0(0.0)	3(10.0)		
2 Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content	0(0.0)	10(33.3)		
3 Elevated; inappropriate to content; humorous	0(0.0)	6(20.0)		
4 Euphoric; inappropriate laughter; singing	30(100.0)	8(26.7)		

Increased Motor Activity-Energy				
0 Absent	0(0.0)	3(10.0)	-4.002	<0.001
1 Subjectively increased	0(0.0)	3(10.0)		
2 Animated; gestures increased	0(0.0)	11(36.7)		
3 Excessive energy; hyperactive at times; restless (can be calmed)	0(0.0)	3(10.0)		
4 Motor excitement; continuous hyperactivity (cannot be calmed)	30(100.0)	10(33.3)		

Sexual Interest				
0 Normal; not increased	29(96.7)	28(93.3)	-4.447	0.655
1 Mildly or possibly increased	0(0.0)	0(0.0)		
2 Definite subjective increase on questioning	0(0.0)	1(3.3)		
3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report	0(0.0)	0(0.0)		
4 Overt sexual acts (toward patients, staff, or interviewer)	1(3.3)	1(3.3)		

Sleep				
0 Reports no decrease in sleep	4(13.3)	12(40.0)	-3.563	<0.001
1 Sleeping less than normal amount by up to one hour	0(0.0)	1(3.3)		
2 Sleeping less than normal by more than one hour	0(0.0)	5(16.7)		
3 Reports decreased need for sleep	2(6.7)	3(10.0)		
4 Denies need for sleep	24(80.0)	9(30.0)		

Irritability				
0 Absent	0(0.0)	5(16.7)	-4.618	<0.001
2 Subjectively increased	0(0.0)	10(33.3)		
4 Irritable at times during interview; recent episodes of anger or annoyance on ward	0(0.0)	12(40.0)		
6 Frequently irritable during interview; short, curt throughout	29(96.7)	3(10.0)		
8 Hostile, uncooperative; interview impossible	1(3.3)	0(0.0)		

Speech (Rate and Amount)				
0 No increase	1(3.3)	7(23.3)	3.874	<0.001
2 Feels talkative	0(0.0)	12(40.0)		
4 Increased rate or amount at times, verbose at times	29(96.7)	11(36.7)		
6 Push; consistently increased rate and amount; difficult to interrupt	0(0.0)	0(0.0)		
8 Pressured; uninterrupted, continuous speech	0(0.0)	0(0.0)		

Language-Thought Disorder				
0 Absent	0(0.0)	5(16.7)	-3.416	0.001
1 Circumstantial; mild distractibility; quick thoughts	0(0.0)	0(0.0)		
2 Distractible, loses goal of thought; changes topics frequently; racing thoughts	0(0.0)	9(30.0)		
3 Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia	30(100.0)	16(53.3)		
4 Incoherent; communication impossible	0(0.0)	0(0.0)		

Content				
0 Normal	13(43.3)	15(50.0)	-2.017	0.044
2 Questionable plans, new interests	0(0.0)	3(10.0)		
4 Special project(s); hyper-religious	0(0.0)	7(23.3)		
6 Grandiose or paranoid ideas; ideas of reference	17(56.7)	5(16.7)		
8 Delusions; hallucinations	0(0.0)	0(0.0)		

Disruptive-Aggressive Behaviour				
0 Absent, cooperative	0(0.0)	5(16.7)	-4.169	<0.001
2 Sarcastic; loud at times, guarded	0(0.0)	8(26.7)		
4 Demanding; threats on ward	1(3.3)	9(30.0)		
6 Threatens interviewer; shouting; interview difficult	27(90.0)	8(26.7)		
8 Assaultive; destructive; interview impossible	2(6.7)	0(0.0)		

Appearance				
0 Appropriate dress and grooming	29(96.7)	30(100.0)	-1.00	0.317
1 Minimally unkempt	0(0.0)	0(0.0)		
2 Poorly groomed; moderately dishevelled; overdressed	0(0.0)	0(0.0)		
3 Dishevelled; partly clothed; garish make-up	0(0.0)	0(0.0)		
4 Completely unkempt; decorated; bizarre garb	1(3.3)	0(0.0)		

Insight				
0 Present; admits illness; agrees with need for treatment	0(0.0)	8(26.7)	-.153	0.002
1 Possibly ill	0(0.0)	0(0.0)		
2 Admits behavior change, but denies illness	3(10.0)	6(20.0)		
3 Admits possible change in behavior, but denies illness	0(0.0)	0(0.0)		
4 Denies any behavior change	27(90.0)	16(53.3)		

#Wilcoxon Signed rank test- χ^2 statistic, $P < 0.05$, statistically significant.

Table 4: Medicines used at baseline.

Name of the Medicine	Potency	No. of cases (%)
Belladonna	200, 1M	9 (30.0)
Calcarea carb	200	1(3.3)
Ignatia	200	3(10.0)
Lachesis	30, 200	3(10.0)
Natrum Mur	200	1(3.3)
Nux Vomica	200	1(3.3)
Phosphorus	30, 200	2(6.67)
Pulsatilla	200	1(3.3)
Stramonium	30, 200	6(20.0)
Sulphur	200, 1M	3(10.0)

DISCUSSION

This was a retrospective study to explore the usefulness of homoeopathic medicine in BPAD, manic type. All the cases were diagnosed according to the diagnostic guidelines given in ICD -10 by Consultant psychiatrist of the institution. Medicines were prescribed on homoeopathic principles.

The goal of management in mania is to control the aggression, agitation and disruptiveness of patients at the earliest. There was significant reduction in the intensity of the symptoms after individualised homoeopathic treatment. After a period of 4 weeks, out of the 15 patients with moderate mania, 2 were in remission, 3 were of minimal symptoms, 3 were of mild mania, 6 were of moderate mania and 1 case became severe. Out of the 15 patients with severe mania, 4 were in remission, 4 were of minimal symptoms, 1 were of mild mania, 4 were of moderate mania and 2 cases remained severe. Significant changes were observed after 2 weeks of intervention.

Study also identified the frequently indicated medicines for mania. Belladonna was used in 200 and 1M potencies in about 30% cases. Stramonium was used in 20% cases. Other medicines which were frequently indicated was Ignatia, Sulphur, Lachesis, Phosphorus etc.

There were no adverse events noticed during the course of the treatment. This reaffirms the importance of individualization approach of Homoeopathy in treating the manic patients. This study upholds the findings of Master Dr.Hahnemann mentioned aphorism §221 about the medicines used in manic diseases.^[16]

The management of BPAD cases consist of 2 aims: 1) selection and administration of the acute remedy and the selection and administration of deep acting constitutional remedy, after the acute episode is over. In this paper, we confined ourselves to the management of acute manic episodes.

CONCLUSION

We have found homoeopathic medicine is effective in the reduction of symptoms of mania within a short

period. So, this study will act as a paradigm for further research works on the symptom. More well-designed prospective studies are warranted to prove the effectiveness of Homoeopathy in mania.

ACKNOWLEDGEMENT

The study was undertaken under the guidance and support of Dr. K. C. Muraleedharan, Officer-in-Charge, National Homoeopathy Research Institute in Mental Health. We are extremely thankful to him. We also thank Dr. N.D. Mohan consultant psychiatrist, who helped us in diagnosing the cases.

CONFLICTS OF INTEREST

There are no conflicts of interest.

REFERENCES

1. Marwaha S, Durrani A, Singh S. Employment outcomes in people with bipolar disorder: Systematic review. *Acta Psychiatr Scand* 2013; 128: 179–193.
2. Benjamin James Sadock, Virginia Alcott Sadock, Pedro Ruiz, Kaplan & sadock's synopsis of psychiatry, Eleventh edition, Wolters Kluwer private limited New Delhi, 2018.
3. American Psychiatry Association. The Diagnostic and Statistical Manual of Mental Disorders (5th edition)-DSM-5, Arlington, DC: American Psychiatric association, 2013.
4. World Health Organization. ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization, 1992.
5. Goodwin FK, Jamison KR. *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression*. 2nd ed. New York: Oxford University Press, 2007.
6. Jamison KR. *Touched with Fire*. New York: Free Press, 1993.
7. Wierzbinski P, Zdanowicz A, Klekowska J, Broniarczyk-Czarniak M, Zboralski K. The epidemiology of suicide in bipolar disorder in the manic episode—preliminary reports. *PolMerkur Lekarski*, 2014 Apr; 36(214): 254-6.

8. Narrow WE, Rae DS, Robins LN, Regier DA. Revised prevalence estimates of mental disorders in the United States: using a clinical significance criterion to reconcile two survey's estimates. *Arch Gen Psychiatry*, 2002; 59: 115–123.
9. Wertham FI. A group of benign chronic psychoses: prolonged manic excitements with a statistical study of age, duration and frequency in 2000 manic attacks. *Am J Psychiatry*, 1929; 86: 17-78.
10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310104/>.
11. The Need for National Data on Epidemiology of Child and Adolescent Mental Disorders, *J. Indian Assoc. Child Adolesc. Ment. Health*, 2008; 4(2): 22-27.
12. RS Swaroopachary, Lokesh Kumar Kalasapati, Sarath Chandra Ivaturi, C M. Pavan Kumar Reddy. Disability in bipolar affective disorder patients in relation to the duration of illness and current affective state. *Archives of Mental Health*, 2018; 19(1): 37-41.
13. Acute psychotic episode, *British Homoeopathic journal*, April 1962; 51(2): 103-108.
14. Naseem Akhtar Qureshi, Abdullah Mohammed Al-Bedah; Mood disorders and complementary and alternative medicine: a literature review; *Neuropsychiatr Dis Treat*, 2013; 9: 639–658. online 2013 May 14. doi: 10.2147/NDT.S43419.
15. A.Saine; *Melilotus* in the treatment of mania. *British Homoeopathic journal*, 1994; 83: 3: 177.
16. Hahnemann S *Organon of medicine* 5th and 6th edition combined B.Jain Publishers (P) Ltd, New Delhi.