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HYPER SEXUALITY AND PSYCHOSIS AMONG MANIA WITH PSYCHOTIC SYMPTOMS

PSYCHIATRY

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ABSTRACT

Aims and Objective— The current study compared psychotic symptoms as measured by BPRS among patients of mania across groups with hyper sexuality and without hyper sexuality.

Method—One hundred male only patients being diagnosed as either manic episode or bipolar affective disorder current episode mania with psychotic symptoms were grouped as per symptoms of hyper sexuality were present or not and assessed with BPRS.

Results— A total of 100 male manic consisted of 55 patients with normal libido and another 45 patients with hyper sexuality with mean age of 29.67 ± 8.39 years and 27.73 ± 8.98 years respectively (t value = -1.113, df= 98 and p value= 0.268). The mean BPRS score for normal libido group was 31.53 ± 4.12 and for the group of increased libido it was 29.54 ± 5.16 (t value = 2.09, df= 98 and p value= 0.039). There was significant higher subscale score among increased libido group for excitement (t value = 3.99, df= 98 and p value= .000) and for grandiosity (t value = 2.434, df= 93.38 and p value= .017) all other subscale means were similar for both groups.

Conclusions— This study reveals that higher "excitement" and "grandiosity" are the differentiating psychotic symptoms for increased libido or hypersexuality in male manic patients.

KEYWORDS

Mania; Hyper-sexuality; Psychosis.

INTRODUCTION

There are many manic symptoms that includes long periods of euphoria, reduced sleep, irritability, racing thoughts, aggression, hyperactivity and hypersexuality [1]. Earlier studies reported Hypersexuality among approximately 57% of manic patients, however other studies reported in range of 25 to 80% prevalence of hypersexuality during mania[2-8]. In 1973, Carlson and Goodwin suggested three stages of a manic episode, starting as heightened sexual thoughts and activity in the first stage and then progressing to sexual preoccupation and ending in sexual delusions [3].

However the aetiology of hypersexuality is considered as multi-factorial which can include psychiatric disorders (e.g. mania) itself, substance-induced disorders or abuse specially cannabies, alcohol or amphetamine abuse. Other possibilities includes neuropathological lesions, e.g. frontal lobe syndrome or disinhibition, and adverse effects of medications. Numerous neurotransmitters are implicated in its pathogenesis, with dopamine and noradrenaline playing a crucial role in the neural reward pathways and emotionally- regulated limbic system neural circuits.

Methodology

This was a cross-sectional ie did not include data collected at follow-up time points, hospital-based study conducted at Dept Of Psychiatry, HTMC & Hospital, Rourkela, Odhisa, India. The study was approved by the institutional review board. Study sample consisted of patients fulfilling ICD-10 DCR for manic episode or bipolar manic episode without any comorbid major psychiatric or medical disorder and giving written informed consent. Each patient undertook an extensive clinical, diagnostic and psychopathological assessment. Information on patient demographics, past history, premorbid personality was obtained from interviews with patients and family members, as well as reviewing current and past medical records. Combining all available information, a consensus best lifetime ICD-10 DCR diagnosis was established for each patient. A detailed physical and neurological examination was done to exclude organic conditions that might account for the psychiatric manifestation.

Participants were patients of between the ages of 18 and 60 years being treated on OPD basis in two years between January 2017 and December 2018, a total of 100 patients consented to participate in this study. All consenting patients with their guardians were provided with self reporting personal and socio demographic details. Further they were assessed with YMRS and BPRS. YMRS was used for qualifying as manic state in moderate severity (score 26 – 37) for inclusion in the study. Patients and guardians were assessed for any alteration in sexual behavior and also BPRS was applied. The total sample was subdivided into two groups, first group was consisted with patients who had alteration in sexual behavior and another group was consisted with patients who were not reported for any alteration in sexual behavior. The exclusion criteria included patients with unstable or uncooperative patient's conditions.

Tools

Socio-demographic Data Sheet: The socio demographic data sheet included age, religion, education and socio economic class of the patients. It also recorded provisional medical diagnosis.

BPRS : The 24-item BPRS (version 4.0) assesses 24 psychiatric symptoms [9]. The presence and severity of psychiatric symptoms were rated on a Likert scale ranging from 1 (not present) to 7 (extremely severe). Thus, possible scores vary from 24 to 168 with lower scores indicating less severe psychopathology. The 24-item BPRS interviews and ratings were assessed following the 24-item BPRS administration manual.

Statistical Analyses

The collected data of all patients was statistically analyzed, using Statistical Package for Social Sciences (SPSS, Inc., Chicago, Illinois) version 10.0.

Data analysis included means and standard deviations for each group, and clinical subgroup of the sample. The parametric t-test was used for continuous variable and chi square test for categorical variables to determine if differences existed between the groups. Statistically significant levels are reported for p values less than or equal to 0.05. Highly significant levels are p values less than .001.

RESULTS:

A total of 100 male patients were included for the study, the whole sample was grouped on the basis of patients showing normal libido and another group with increased libido. The first group of patients with normal libido consisted of 55 patients and another group was patients who had increased libido, that consisted of 45 patients. The mean age

of normal libido manic patient was 29.67 ± 8.39 years, whereas for increased libido manic group, the mean age was 27.73 ± 8.98 years) (t value = -1.113, df= 98 and p value= 0.268). There was total 30 unemployed and 70 employed patients 65 married and 35 unmarried, 81 belonging to low socioeconomic class and 19 belonging to middle socio economic class, respectively for groups of normal and increased libido group patients, on chi square test it is non significant difference. Most of the patients were educated upto primary (n=44), mostly hindu by religion (n= 88) who were distributed across both group. Clinically the onset of illness was acute in 31 and 28 patients respectively for normal and increased libido group. similarly "insidious" onset of illness was in 19 and 12 patients, and "abrupt" onset was in 5 respectively for normal and increased libido group. (Table -1)

The main result was the mean BPRS score for normal libido group was 31.53 ± 4.12 and for the group of increased libido it was 29.54 ± 5.16 (t value = 2.09, df= 98 and p value= 0.039). We compared means of all items of BPRS individually across these two groups (Table-2). All subscale means were similar, except for Excitement subscale which was significantly higher for increased libido group (t value = 3.99, df= 98 and p value= .000). There was also significant difference on subscale of grandiosity which was significantly higher for increased libido group (t value = 2.434, df= 93.38 and p value= .017).

DISCUSSION

In this study we studied the male manic patients grouping them as normal and increased libido group. We studied these two groups against psychotic symptoms items of BPRS, to find if any psychotic factors play any role in inflated libido. We evaluated a total of 100 male patients of either manic episode or bipolar affective disorder, current episode mania which were 17 and 83 respectively. Inflated sexual desire is a well known symptoms of mania, but it may not be always present, hyper sexuality has been reported in over 50% of patients in a manic attack, and it was reported higher in female patients [10]. Hence it should be interesting to investigate that its presence or absence are actually or not associated with any psychotic symptoms. But we could not found positive association in this study.

A manic symptom includes hyper sexuality with many other symptoms and depression includes hypo sexuality [11]. If we consider hyper sexuality an essential manic symptom then finding almost equal manic patients without hyper sexuality is difficult to explain. However one hypothetical reason could be mixed episodes misdiagnosed as manic episodes. Some of the cognitive deficits that can be found in manic patients are working memory, vigilance, inhibitory control, decision-making under risk, and processing speed, [12,13] and these cognitive deficits actually may be contributing to hyper sexuality.

The moderate size of the sample is strengths of this study. However, a number of methodological issues need to be considered. The study is cross-sectional so the direction of causality cannot be determined, male only sampling helped to collect larger number of the patients, but the results can not be generalized across gender.

CONCLUSION:

This study reveals that higher "excitement" and "grandiosity" are the differentiating psychotic symptoms as measured by BPRS for increased libido or hyper sexual group of male manic patients.

Table : 1 Sociodemographic variables of the study sample

		libido			t / chi-Square	df	Asymp. Sig. (2-sided)
		Normal	Increased	total			
Age		29.67 ± 8.39	27.73 ± 8.98		-1.113	98	.268
occupation	un employed	12	18	30	3.896	1	.048
	employed	43	27	70			
marital status	married	39	26	65	1.976	1	.171
	un married	16	19	35			
family income	LSES (1000-5000)	46	35	81	.552	1	.628
	MSES(5000-25000)	9	10	19			
education	illeterate	8	8	16	2.701	3	.440
	primary	28	16	44			
	secondery	13	16	29			
	graduate	6	5	11			
religion	hindu	49	39	88	.138	1	.711
	others	6	6	12			
mode of onset	abrupt	5	5	10	.714	2	.691
	acute	31	28	59			
	insidious	19	12	31			
substance use	absent	26	20	46	.80	1	.778
	present	29	25	54			
diagonosis	manic episode	7	10	17	1.581	1	.322
	BPAD	48	35	83			

Table 2. Comparison of mean BPRS scores across altered and unaffected libido in male manic patients.

	Mean ± SD HADS Score		t	DF	Sig.(2-tailed) p value
	normal libido n = 55	increased libido n = 45			
somatic concern	1.36 ± .75	1.15 ± .56	-1.579	97.220	.118
anxiety	.89 ± .89	.77 ± 1.02	-.590	98	.556
emotional withdrawal	.98 ± .13	.93 ± .25	-1.228	98	.222
conceptual disorganisation	.98 ± .13	1.11 ± .57	1.481	47.99	.145
guilt	.29 ± .45	.26 ± .49	-.254	98	.800
tension	2.60 ± .95	2.68 ± .99	.452	92.44	.652
mannerism and posturing	1.07 ± .37	1.04 ± .36	-.377	98	.707
grandiosity	4.05 ± 1.2	4.57 ± .83	2.434	93.38	.017
depressed mood	.52 ± .66	.53 ± .75	.043	98	.966
aggression	3.41 ± 1.11	3.60 ± .98	.853	98	.396
paranoia	3.09 ± 1.60	3.31 ± 1.71	.662	98	.509
hallucinatory behavior	1.16 ± .66	1.24 ± .85	.533	98	.596
motor retardation	1.00 ± .19	1.00 ± .00	.000	98	1.000
uncooperativeness	1.23 ± .57	1.20 ± .58	-.311	98	.756
unusual thought content	1.32 ± .81	1.66 ± 1.10	1.709	79.15	.091
blunted affect	1.01 ± .23	1.00 ± .00	-.574	54.00	.568
excitement	3.5 ± 1.03	4.42 ± 1.15	3.999	98	.000
disorientation	.98 ± .13	1.00 ± .00	.904	98	.368
Total	29.54± 5.16	31.53 ± 4.12	2.09	98	0.039

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