DOI: 10.14744/DAJPNS.2026.00324
Dusunen Adam J Psychiatr Neurol Sci
2026;39:112-123

RESEARCH ARTICLE

Unipolar mania as a distinct clinical presentation: Differences in illness course and psychosocial functioning compared with bipolar I disorder

Elcin Izmir Soygenc[1], Ozge Sahmelikoglu Onur[2]

[1]Gumushane State Hospital, Department of Psychiatry, Gumushane, Turkiye
[2]Tekirdag Namik Kemal University, Department of Psychiatry, Tekirdag, Turkiye

ABSTRACT

Objective: Growing evidence suggests that unipolar mania (UM) may represent a distinct clinical condition rather than a subtype of bipolar disorder (BD). The present study aimed to compare the sociodemographic characteristics, clinical features, and psychosocial functioning of euthymic patients with UM or bipolar I disorder (BD-I) and healthy control subjects.

Method: This cross-sectional study included euthymic patients with UM (n=58), BD-I (n=58), and healthy control subjects (n=58). Diagnoses were established according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, and euthymia was confirmed using the Young Mania Rating Scale, Beck Depression Inventory, and Positive and Negative Syndrome Scale. Psychosocial functioning was assessed using the Functioning Assessment Short Test (FAST) in all groups and the Bipolar Disorder Functioning Scale (BDFS) in the UM and BD-I groups. Sociodemographic and clinical data were collected using a structured form. Group comparisons were conducted using appropriate parametric and nonparametric statistical analyses.

Results: Both patient groups demonstrated significantly impaired psychosocial functioning compared with healthy controls across all FAST subdomains ($p<0.05$). On the BDFS, patients with UM showed better emotional functioning and less social withdrawal than patients with BD-I ($p<0.05$); however, total functioning scores did not differ significantly between groups ($p>0.05$). Clinically, UM was characterized by manic-predominant onset, higher rates of mood-congruent psychotic symptoms, longer episode duration, and more frequent hospitalizations. Suicidal behavior and total number of mood episodes were higher among patients with BD-I ($p<0.05$). In the final logistic regression model, mood-congruent psychotic symptoms during the first episode were independently associated with UM relative to BD-I, whereas a history of suicide attempts was associated with lower odds of UM ($p<0.05$).

Conclusion: Although both groups exhibited functional impairment, patients with UM demonstrated relatively better emotional and social functioning than those with BD-I. These findings suggest that UM may be associated with a distinct functional profile, with potential implications for prognosis and treatment planning. Incorporating functional outcomes into the clinical assessment of UM may help optimize therapeutic strategies and improve long-term psychosocial outcomes.

Keywords: Bipolar disorder, euthymia, functional outcome, psychosocial functioning, unipolar mania

How to cite this article: Izmir Soygenc E, Sahmelikoglu Onur O. Unipolar mania as a distinct clinical presentation: Differences in illness course and psychosocial functioning compared with bipolar I disorder. Dusunen Adam J Psychiatr Neurol Sci 2026;39:112-123.

Correspondence: Ozge Sahmelikoglu Onur, Tekirdag Namik Kemal University, Department of Psychiatry, Tekirdag, Turkiye
E-mail: ozge_sahmelikoglu@hotmail.com

Received: February 02, 2026; **Revised:** May 12, 2026; **Accepted:** May 13, 2026

INTRODUCTION

Bipolar disorder (BD) is a chronic psychiatric illness associated with substantial impairments in psychosocial functioning and quality of life. Despite periods of euthymia, only approximately 40% of patients with BD return to their premorbid level of functioning following a mood episode (1). Functional outcomes in BD are influenced by multiple factors, including age, illness-course characteristics (e.g., number of episodes, mixed features, and chronicity), insight, residual depressive symptoms, substance use, and psychiatric or medical comorbidities (2). Most studies examining psychosocial functioning in BD have focused on comparisons between depressive and manic episodes, consistently showing that depressive episodes exert a more detrimental effect on functioning than manic episodes (2).

Growing evidence suggests that unipolar mania (UM) may constitute a distinct clinical profile rather than simply a subtype of BD. UM and BD differ across epidemiological, biochemical, clinical, and treatment-related domains (3). Clinically, patients with UM have been reported to exhibit a higher prevalence of psychotic symptoms than patients with BD (4). Notably, the first episode in UM is more likely to be psychotic and characterized predominantly by mood-congruent symptoms. In addition, hyperthymic temperament appears to be more prevalent in UM (5). Conversely, rapid cycling, suicide risk, and comorbid anxiety disorders have been reported less frequently in UM than in BD (5).

Beyond its diagnostic implications, distinguishing UM from BD is clinically important because differences in illness course, suicidality, and treatment response may translate into distinct functional outcomes and management strategies. A clearer understanding of psychosocial functioning in UM may therefore contribute to more individualized treatment planning and improved long-term outcomes. Nevertheless, studies employing comprehensive diagnostic criteria to compare UM and BD while simultaneously examining the relationship between clinical characteristics and functional outcomes are limited. Therefore, the present study aimed to compare the sociodemographic characteristics, clinical features, and psychosocial functioning of euthymic patients with UM or bipolar I disorder (BD-I) and healthy control subjects, thereby contributing to the limited literature on this underexplored topic. Based on previously reported distinctions, we hypothesized that euthymic patients with UM and BD-I would differ in psychosocial functioning, with patients with UM exhibiting distinct profiles, particularly in occupational, emotional, and social domains.

METHODS

This study was approved by the Ethics Committee of Bakirkoy Prof. Dr. Mazhar Osman Research & Training Hospital for Psychiatry, Neurology and Neurosurgery in 06.09.2022 (Protocol No. 345), with additional approval obtained from the Clinical Research Ethics Committee of Bakirkoy Dr. Sadi Konuk Research & Training Hospital on January 9, 2023 (Decision No. 2023-01-22; Protocol No. 2023/21). All procedures were conducted in accordance with the Declaration of Helsinki, and written and verbal informed consent was obtained from all participants prior to enrollment. The study sample consisted of euthymic patients with BD-I who were followed in outpatient clinics and Community Mental Health Centers affiliated with Bakirkoy Prof. Dr. Mazhar Osman Research & Training Hospital, euthymic patients with UM, and healthy control subjects. Due to coronavirus disease 2019 (COVID-19) restrictions, the local ethics committee was not convening; therefore, ethical approval was obtained from an alternative institutional ethics committee, consistent with procedures used in other studies conducted during the same period. Participants who met the inclusion criteria and provided informed consent were included in the study. Psychiatric diagnoses were established through comprehensive clinical interviews conducted by experienced psychiatrists, as the Structured Clinical Interview for DSM-5 Clinical Version (SCID-5-CV) does not include UM. Patients in the BD-I group met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnostic criteria for BD-I, had a documented history of at least one manic episode and one depressive episode, and were euthymic at the time of assessment. Euthymia was defined as a Young Mania Rating Scale (YMRS) score <8 and a Beck Depression Inventory (BDI) score <10. The UM group was defined according to previously proposed criteria, including the absence of any lifetime depressive episode, a minimum illness duration of four years, a history of at least four manic or hypomanic episodes (including at least one manic episode), and a euthymic period of at least six months prior to assessment (3). Healthy control participants had no current or lifetime psychiatric diagnoses according to DSM-5 criteria. Exclusion criteria for all

groups included intellectual disability, neurological disorders, history of brain injury or head trauma, alcohol or substance use disorder, pregnancy, and significant medical comorbidities (e.g., autoimmune diseases, acute infections, malignancies, dementia, neurodegenerative disorders, or cerebrovascular diseases). Additional exclusion criteria for the patient groups included a history of mixed episodes, bipolar II disorder, electroconvulsive therapy within the previous six months, and comorbid psychiatric disorders other than specific phobia. Participants in the UM group were further excluded if they had a lifetime history of major depressive episodes or any history of antidepressant use. Participants who did not meet remission criteria based on the YMRS, BDI, and Positive and Negative Syndrome Scale (PANSS; all subscale scores ≤3) were also excluded. A total of 180 individuals who had read the study information form, provided written informed consent, and agreed to participate were initially interviewed. In the BD group, one patient was excluded because of largely incomplete scale data, and another was excluded because of communication difficulties related to language barriers. In the UM group, two patients were excluded due to alcohol/substance use disorder. In the healthy control group, two participants were excluded because they failed to complete a substantial portion of the scales. Consequently, the final sample consisted of 174 participants: 58 patients with BD, 58 patients with UM, and 58 healthy controls. Psychosocial functioning in both patient groups and healthy controls was assessed using the Functioning Assessment Short Test (FAST). In addition, functional differences between the UM and BD-I groups were further evaluated using the Bipolar Disorder Functioning Scale (BDFS).

Instruments

Sociodemographic Data Form

A structured form developed by the researchers was used to assess eligibility criteria and collect sociodemographic and clinical data, including age, sex, education level, marital status, occupation, socioeconomic status, age at illness onset, number of manic and depressive episodes, total number of episodes, illness duration, number of hospitalizations, history of suicide attempts, alcohol and substance use, family history of BD, comorbid medical conditions, and current medications and dosages. In the UM group, "manic onset" specifically referred to a first episode of full mania, excluding hypomanic episodes.

Young Mania Rating Scale (YMRS)

The YMRS is an 11-item clinician-administered scale developed by Young et al. (6) in 1978 to assess the severity of manic symptoms. The scale evaluates elevated mood, increased motor activity and energy, sexual interest, sleep, irritability, rate and amount of speech, thought disorder, thought content, disruptive or aggressive behavior, appearance, and insight. The validity and reliability study of the Turkish version was conducted by Karadağ et al. (7).

Beck Depression Inventory (BDI)

The BDI is a 21-item self-report scale developed by Beck et al. (8) in 1961 to assess somatic, emotional, and cognitive symptoms of depression. Higher total scores indicate greater severity of depressive symptoms. The validity and reliability study of the Turkish version was conducted by Hisli (9).

Positive and Negative Syndrome Scale (PANSS)

The PANSS is a 30-item clinician-rated scale developed by Kay et al. (10) in 1987 and consists of positive, negative, and general psychopathology subscales. The validity and reliability study of the Turkish version was conducted by Kostakoğlu et al. (11). The PANSS was administered to assess and exclude residual psychotic symptoms, given that psychotic negative symptoms may occur in BD even outside acute episodes.

Beck Anxiety Inventory (BAI)

The BAI is a 21-item self-report scale developed by Beck et al. (12) to assess anxiety symptoms, with higher scores indicating greater anxiety severity. The validity and reliability study of the Turkish version was conducted by Ulusoy et al. (13).

Bipolar Disorder Functioning Scale (BDFS)

The BDFS was developed by the Scientific Working Group on Mood Disorders of the Turkish Psychiatric Association (14). It consists of 52 items across 11 subscales assessing emotional, cognitive, sexual, and social functioning domains. Higher scores indicate better functioning.

Functioning Assessment Short Test (FAST)

The FAST was developed by Rosa et al. (15) in 2007, and the Turkish version was validated by Aydemir and Uykur in 2012 (16). It consists of 24 items assessing functioning over the previous 15 days across six domains: autonomy, occupational functioning, cognitive functioning, financial issues, interpersonal relationships, and leisure activities. Higher scores indicate worse functioning.

Statistical Analysis

All analyses were performed using Stata version 19.0 (StataCorp, College Station, TX, USA). Normality of continuous variables was assessed using graphical methods, skewness and kurtosis values, and formal normality tests. Descriptive statistics were presented as median (Q1–Q3) for continuous variables and frequency (%) for categorical variables. Continuous variables were compared using the Mann–Whitney U test or Kruskal–Wallis test, whereas categorical variables were compared using the chi-square test or Fisher's exact test, as appropriate. For PANSS scores, distributions were interpreted in relation to the theoretical minimum values and the presence of floor effects. As a sensitivity analysis, PANSS comparisons were additionally reassessed using one-way analysis of variance (ANOVA). When overall three-group comparisons were significant, post hoc pairwise comparisons were conducted using Bonferroni correction.

Multivariable linear regression models were used to examine psychosocial functioning (FAST total and subscale scores) across groups, with healthy controls serving as the reference category. Covariates included age, sex, education, employment status (employed vs. unemployed), and BDI score. Heteroskedasticity-robust standard errors were applied. Omnibus tests were used to assess overall group effects, and Šidák adjustments were applied to account for multiple comparisons. Additional regression models restricted to the UM and BD-I groups evaluated BDFS total score, emotional functioning, and social withdrawal while controlling for age, sex, education, employment status, BDI score, and treatment-related variables (current valproate or lamotrigine use and treatment duration).

To identify clinical correlates of UM relative to BD-I, univariable logistic regression analyses were first conducted within the patient groups. Variables associated with UM at $p<0.20$ in the univariable analyses were entered into the multivariable logistic regression model. Current treatment variables and functioning subscale scores were not included in the primary logistic regression model because they may reflect treatment decisions or consequences of illness course rather than independent baseline or illness-course correlates. Multicollinearity was assessed using variance inflation factors (VIFs), with VIF values <4 considered indicative of no substantial multicollinearity. Results are reported as regression coefficients or odds ratios (ORs) with 95% confidence intervals (CIs). All statistical tests were two-tailed, and $p<0.05$ was considered statistically significant.

RESULTS

Sociodemographic characteristics of the UM, BD-I, and healthy control groups are presented in Table 1. No significant differences were observed among the groups with respect to sex ($p>0.05$). Marital status also did not differ significantly across the groups ($p=0.085$ and $p=0.164$, respectively). In contrast, years of education differed significantly between groups ($p<0.001$), with the control group demonstrating higher educational attainment than both the UM group ($p<0.001$) and the BD-I group ($p<0.001$), whereas no significant difference was found between the UM and BD-I groups ($p=0.231$). Employment status also differed significantly among the groups. The proportion of participants who were actively employed was significantly higher in the control group than in both the UM and BD-I groups (both $p<0.001$), whereas no significant difference was observed between the two patient groups ($p=0.990$). Similarly, the overall five-category employment distribution differed significantly across groups ($p<0.001$). Post hoc analyses indicated that this difference was driven by comparisons between each patient group and the control group (both $p<0.001$), with no significant difference between the UM and BD-I groups ($p=0.507$).

Clinical characteristics of the UM and BD groups are summarized in Table 2. The type of first mood episode differed significantly between groups: euphoric mania predominated in the UM group, whereas depressive episodes were more common at illness onset in the BD group ($p<0.05$). Psychotic symptoms during the first episode were significantly more frequent in the UM group than in the BD group ($p<0.05$). Valproate use was significantly more common in the UM group, whereas lamotrigine use was more frequent in the BD group ($p<0.05$). The use of lithium and carbamazepine did not differ between the patient groups. The BD group had a higher total number of mood episodes, whereas manic episodes were more frequent in the UM group ($p<0.05$). Mean episode duration and number of hospitalizations were both significantly greater in the UM group ($p<0.05$). A history of suicide attempts was significantly more common in the BD group ($p<0.05$).

Symptom severity and psychosocial functioning scores are presented in Table 3. No significant differences were observed among the groups in YMRS, BDI, PANSS positive, PANSS negative, PANSS general psychopathology, PANSS total, or BAI scores

Table 1: Comparison of sociodemographic characteristics among the UM, BD-I, and healthy control groups

	UM (n=58)	BD-I (n=58)	Control (n=58)	p	UM vs. BD-I*	UM vs. control*	BD-I vs. control*
Age, years (median [Q1–Q3])	40.50 (35.00–49.00)	45.50 (40.00–52.00)	41.50 (35.00–48.00)	**0.027**[K]	0.077	1.000	**0.047**
Sex, n (%)							
Female	28 (48.3)	37 (63.8)	39 (67.2)	0.085[χ^2]	–	–	–
Male	30 (51.7)	21 (36.2)	19 (32.8)				
Education duration, years (median [Q1–Q3])	12.00 (5.00–12.00)	8.00 (5.00–12.00)	14.00 (12.00–16.00)	**<0.001**[K]	0.231	**<0.001**	**<0.001**
Employment: Currently employed	23 (39.7)	16 (27.6)	47 (81.0)	**<0.001**[a]	0.990[a]	**<0.001**[a]	**<0.001**[a]
Employment: Not currently employed, n (%)							
Unemployed	18 (31.0)	21 (36.2)	0 (0.0)	**<0.001**[b]	0.507[b]	**<0.001**[b]	**<0.001**[b]
Retired	5 (8.6)	5 (8.62)	4 (6.9)				
Housewife	10 (17.2)	16 (27.59)	5 (8.6)				
Student	2 (3.5)	0 (0.0)	2 (3.5)				
Marital status, n (%)							
Married	30 (51.7)	35 (60.3)	39 (67.2)	0.164[χ^2]	–	–	–
Single	20 (34.5)	10 (17.2)	15 (25.9)				
Widowed	0 (0.0)	2 (3.4)	0 (0.0)				
Divorced	7 (12.1)	10 (17.2)	4 (6.9)				
Separated	1 (1.7)	1 (1.7)	0 (0.0)				

K: Kruskal–Wallis (Mann–Whitney U test); *: Bonferroni-adjusted p-values for pairwise comparisons; a: p values for "working status" were calculated using a dichotomized employment variable (currently employed vs. not currently employed). The overall p value was obtained using Pearson's chi-square test, and pairwise p values represent Bonferroni-adjusted comparisons between UM vs. BD-I, UM vs. Controls, and BD-I vs. Controls; b: p values for "employment status" were calculated using the full five-category employment variable (employed, unemployed, retired, housewife, and student). The overall p value was calculated using Pearson's chi-square test, whereas pairwise comparisons were conducted using Fisher's exact test with Bonferroni adjustment for multiple comparisons (UM vs. BD-I, UM vs. Control, and BD-I vs. Control). UM: Unipolar mania; BD-I: Bipolar I disorder; C: Healthy control group. Bold p-values indicate statistical significance.

(all p>0.05), indicating that the patient groups were assessed during euthymia. In contrast, all FAST subscale scores and the FAST total score differed significantly across the three groups (all overall p<0.001). Post hoc pairwise comparisons demonstrated that both the UM and BD-I groups exhibited significantly greater impairment than healthy controls in autonomy, occupational functioning, cognitive functioning, financial issues, interpersonal relationships, leisure activities, and total FAST score (all p<0.001 for both UM vs. controls and BD-I vs. controls). However, no statistically significant differences were found between the UM and BD-I groups in any FAST domain after Bonferroni correction. Although the BD-I group demonstrated numerically greater impairment in occupational functioning than the UM group, this difference did not reach statistical significance (p=0.057). Similarly, no significant differences were observed between the two patient groups in autonomy (p=1.000), cognitive functioning (p=0.566), financial issues (p=1.000), interpersonal relationships (p=0.473), leisure activities (p=0.605), or FAST total score (p=0.266).

Comparisons based on the BDFS are presented in Table 4. The UM group demonstrated significantly higher scores on the emotional functioning and social withdrawal subscales than the BD group (p<0.05). No other subscale or total score differences were observed between the groups (p>0.05).

After adjustment for years of education, employment status, age, sex, and BDI score, the overall group effect remained significant for the FAST total score (p<0.001). Both the UM group (B=11.52, 95% CI: 8.52–14.52; adjusted p<0.001) and the BD-I group (B=14.00, 95% CI: 10.03–17.96; adjusted p<0.001) showed greater impairment than healthy controls, whereas no significant difference was

Table 2: Comparison of clinical characteristics between the UM and BD-I groups

	UM		BD-I		p
	n	%	n	%	
Type of first episode					
Mania	53	91.4	27	46.6	**<0.001**$^{X^2}$
Hypomania	5	8.6	0	0.0	**0.022**$^{X^2}$
Depression	0	0.0	31	53.4	**<0.001**$^{X^2}$
Psychotic symptoms during first episode					
Absent	6	10.3	20	34.5	**0.002**$^{X^2}$
Present	52	89.7	38	65.5	
Current mood stabilizer treatment					
Valproate	38	65.5	18	31.0	**0.003**$^{X^2}$
Lithium	24	41.4	29	50.0	0.062$^{X^2}$
Carbamazepine	1	1.7	2	3.4	0.591$^{X^2}$
Lamotrigine	0	0.0	6	10.3	**0.006**$^{X^2}$
Seasonality					
Absent	16	28.6	26	44.8	0.072$^{X^2}$
Present	40	71.4	32	55.2	
Unknown	2	3.5	0	0.0	
History of suicide attempts					
Present	5	8.6	17	29.3	**0.004**$^{X^2}$
Absent	53	91.4	41	70.7	
Number of suicide attempts					
0	53	91.4	41	70.7	**0.013**$^{X^2}$
1	5	8.6	13	22.4	
2	0	0.0	2	3.4	
≥3	0	0.0	2	3.4	
Family history of psychiatric disorders					
Present	27	46.6	29	50.0	0.710$^{X^2}$
Absent	31	53.4	29	50.0	
Age at onset of first episode, median (Q1–Q3)	23.50 (20.00–27.00)		23.50 (20.00–32.00)		0.778^{m}
Age at initiation of psychiatric treatment, median (Q1–Q3)	23.50 (20.00–28.00)		24.00 (20.00–32.00)		0.680^{m}
Total number of episodes, median (Q1–Q3)	6.00 (5.00–9.00)		9.00 (5.00–13.00)		**0.036**^{m}
Number of manic episodes, median (Q1–Q3)	5.00 (4.00–7.00)		3.00 (2.00–5.00)		**<0.001**^{m}
Number of hypomanic episodes, median (Q1–Q3)	0.00 (0.00–3.00)		2.00 (0.00–3.00)		0.365^{m}
Number of depressive episodes, median (Q1–Q3)	0.00 (0.00–0.00)		3.00 (2.00–5.00)		**<0.001**^{m}
Mean duration of episodes, median (Q1–Q3)	30.00 (20.00–30.00)		22.00 (20.00–30.00)		**0.003**^{m}
Total number of psychiatric hospitalizations, median (Q1–Q3)	4.00 (3.00–6.00)		3.00 (2.00–5.00)		**0.002**^{m}

m: Mann–Whitney U test; X^2: Chi-square test (Fisher's exact test). UM: Unipolar mania; BD-I: Bipolar I disorder. Bold p-values indicate statistical significance.

observed between the two patient groups (B=2.48, 95% CI: -1.88–6.84; adjusted p=0.997). A similar pattern was observed across FAST subdomains, including autonomy, occupational functioning, cognitive functioning, interpersonal relationships, and leisure activities: both patient groups demonstrated significantly greater impairment than healthy controls, whereas no differences emerged between the UM and BD-I groups. In contrast, the financial issues domain was not significant in the adjusted model (p=0.091) (Table 5).

In treatment-adjusted analyses restricted to the patient groups, no significant difference was observed between UM and BD-I in BDFS total score (B=-3.62,

Table 3: Comparison of YMRS, BDI, PANSS, BAI, and FAST scores among the study groups

	UM median (Q1–Q3)	BD-I median (Q1–Q3)	Controls median (Q1–Q3)	p^K	UM vs. BD-I*	UM vs. controls*	BD-I vs. controls*
Young Mania Rating Scale	2.00 (1.00–3.00)	1.00 (1.00–2.00)	1.00 (1.00–1.00)	0.057	–	–	–
Beck Depression Inventory	3.00 (2.00–4.00)	3.00 (2.00–5.00)	3.00 (3.00–5.00)	0.146	–	–	–
PANSS Positive Symptoms[1]	7.00 (7.00–7.00)	7.00 (7.00–7.00)	7.00 (7.00–7.00)	0.231	–	–	–
PANSS Negative Symptoms[1]	7.00 (7.00–7.00)	7.00 (7.00–8.00)	7.00 (7.00–7.00)	0.312	–	–	–
PANSS General Psychopathology[1]	16.00 (16.00–16.00)	16.00 (16.00–17.00)	16.00 (16.00–16.00)	0.325	–	–	–
PANSS Total Score[1]	30.00 (30.00–31.00)	30.00 (30.00–31.00)	30.00 (30.00–31.00)	0.237	–	–	–
Beck Anxiety Inventory (BAI)	3.00 (2.00–3.00)	3.00 (2.00–5.00)	3.00 (1.00–4.00)	0.078	–	–	–
Functioning Assessment Short Test (FAST)							
Autonomy	2.00 (0.00–3.00)	1.00 (0.00–4.00)	0.00 (0.00–1.00)	**<0.001**	1.000	**<0.001**	**<0.001**
Occupational functioning	8.00 (2.00–11.00)	11.00 (6.00–14.00)	0.00 (0.00–0.00)	**<0.001**	0.057	**<0.001**	**<0.001**
Cognitive functioning	1.00 (0.00–4.00)	2.00 (1.00–4.00)	0.00 (0.00–0.00)	**<0.001**	0.566	**<0.001**	**<0.001**
Financial issues	0.00 (0.00–1.00)	0.00 (0.00–2.00)	0.00 (0.00–0.00)	**<0.001**	1.000	**<0.001**	**<0.001**
Interpersonal relationships	4.00 (3.00–7.00)	6.00 (3.00–8.00)	3.00 (2.00–4.00)	**<0.001**	0.473	**<0.001**	**<0.001**
Leisure activities	5.00 (4.00–6.00)	4.00 (3.00–6.00)	2.00 (1.00–3.00)	**<0.001**	0.605	**<0.001**	**<0.001**
FAST total score	22.00 (14.00–27.00)	25.00 (14.00–34.00)	6.00 (4.00–8.00)	**<0.001**	0.266	**<0.001**	**<0.001**

K: Kruskal–Wallis test for overall p-values; 1: PANSS scores were additionally reassessed using one-way analysis of variance (ANOVA) because of clustering near the theoretical minimum values. The pattern of statistical significance was consistent with the Kruskal–Wallis analyses (all p>0.05 with one-way ANOVA). *: Bonferroni-adjusted p values for pairwise comparisons. PANSS: Positive and Negative Syndrome Scale; FAST: Functioning Assessment Short Test; YMRS: Young Mania Rating Scale; BDI: Beck Depression Inventory; BAI: Beck Anxiety Inventory; UM: Unipolar mania; BD-I: Bipolar I disorder; C: Healthy control group. Bold p-values indicate statistical significance.

95% CI: -8.66 to 1.41; p=0.156). However, the BD-I group demonstrated lower emotional functioning than the UM group (B=-0.54, 95% CI: -0.90 to -0.18; p=0.004), whereas the difference in social withdrawal was attenuated and remained borderline significant (B=-0.38, 95% CI: -0.76 to -0.00; p=0.047). Among treatment-related variables, current lamotrigine use was associated with lower BDFS total scores (B=-12.57, 95% CI: -24.33 to -0.81; p=0.036), whereas valproate use and treatment duration were not significantly associated with functioning outcomes. BDI score was not independently associated with BDFS outcomes in the fully adjusted models (Table 6).

In the univariable logistic regression analyses, age (OR=0.96, 95% CI: 0.92–1.00; p=0.044), presence of psychotic symptoms during the first episode, history of suicide attempts (OR=0.23, 95% CI: 0.08–0.67; p=0.007), total number of episodes (OR=0.92, 95% CI: 0.86–0.99; p=0.023), and mean episode duration (OR=1.08, 95% CI: 1.03–1.14; p=0.003) were significantly associated with unipolar mania. Regarding characteristics of the first episode, both mood-congruent psychotic symptoms (OR=5.06, 95% CI: 1.79–14.29; p=0.002) and the coexistence of mood-congruent and mood-incongruent psychotic symptoms (OR=5.00, 95% CI: 1.25–19.96; p=0.023) were associated with higher odds of UM. Male sex, years of education, employment status, and seasonality met the predefined inclusion threshold (p<0.20) and were therefore entered into the multivariable model. The type of first episode could not be analyzed because of perfect separation. In the multivariable logistic regression model, mood-congruent psychotic symptoms during the first episode remained independently associated with higher odds of UM relative to BD-I (adjusted OR=4.72, 95% CI: 1.48–15.05; p=0.009). Conversely, a history of suicide attempts was independently associated with lower odds of UM (adjusted OR=0.27, 95% CI: 0.08–0.89; p=0.032). Mean episode duration showed a borderline association with UM (adjusted OR=1.06, 95% CI: 1.00–1.12; p=0.064). Age, sex, education, employment status, seasonality, total number of episodes, and other categories of psychotic symptoms were not significantly associated with UM (all p>0.05) (Table 7).

Table 4: Comparison of bipolar disorder functioning scale scores between the UM and BD-I groups

	UM median (Q1–Q3)	BD-I median (Q1–Q3)	p	
Emotional functioning	9.00 (9.00–9.00)	9.00 (8.00–9.00)	**0.001**	m
Intellectual functioning	12.00 (11.00–12.00)	12.00 (10.00–12.00)	0.304	m
Sexual functioning	10.00 (8.00–12.00)	8.00 (7.00–12.00)	0.058	m
Perceived stigma	10.00 (9.00–12.00)	10.00 (8.00–12.00)	0.869	m
Social withdrawal	9.00 (8.00–9.00)	8.00 (7.00–9.00)	**0.008**	m
Household relationships	16.00 (15.00–18.00)	16.00 (14.00–18.00)	0.472	m
Relationships with friends	13.00 (12.00–15.00)	12.50 (11.00–15.00)	0.708	m
Participation in social activities	13.00 (11.00–15.00)	12.00 (10.00–14.00)	0.291	m
Daily activities/hobbies	11.00 (10.00–13.00)	12.00 (10.00–13.00)	0.883	m
Ability to take initiative	6.00 (4.00–8.00)	5.00 (4.00–7.00)	0.655	m
Work functioning	11.00 (9.00–12.00)	11.00 (9.00–12.00)	0.742	m
Total Bipolar Disorder Functioning Score	118.00 (110.00–126.00)	116.00 (104.00–125.00)	0.115	t

t: t-test; m: Mann–Whitney U test; UM: Unipolar mania; BD-I: Bipolar I disorder.

DISCUSSION

In this study, we compared the sociodemographic, clinical, and functional characteristics of individuals with UM, BD-I, and healthy controls. Both patient groups demonstrated lower educational attainment and employment rates than healthy controls despite being comparable on other sociodemographic variables. Clinically, the UM group was characterized by manic and psychotic first episodes, whereas higher rates of suicide attempts were more prominent in the BD-I group, suggesting that early illness characteristics and suicidality may differentiate the clinical trajectories of the two conditions. Although symptom severity was comparable across groups during euthymia, both UM and BD-I patients exhibited significantly greater psychosocial impairment than healthy controls, with no overall functional differences between the patient groups. Nevertheless, patients with UM demonstrated better emotional functioning and less social withdrawal, suggesting selective areas of relative functional preservation. These findings remained significant after adjustment for potential confounders, supporting the view that UM and BD-I share a substantial functional burden while differing in specific clinical and functional domains. Overall, the final logistic regression model indicated that, relative to BD-I, UM was independently associated with mood-congruent psychotic symptoms during the first episode, whereas a history of suicide attempts was independently associated with lower odds of UM.

Sociodemographic findings indicated that healthy controls had higher educational attainment and employment rates than both patient groups, whereas no significant differences were observed between the UM and BD groups. Although data regarding educational and occupational outcomes in mood disorders are limited, previous studies have suggested better academic functioning among individuals with a manic-predominant course (17). This pattern was not observed in the present sample, which may be attributable to methodological factors such as the relatively small sample size, the cross-sectional design, or recruitment from a tertiary care setting, potentially limiting the detection of subtle group differences.

A family history of psychiatric disorders was more common in both patient groups than in healthy controls, with no significant difference between the UM and BD groups. Previous studies investigating familial aggregation in UM have yielded inconsistent findings, with some reporting lower familial loading (18) and others reporting no differences relative to BD (19). In a Turkish sample, Yazıcı et al. (3) reported lower rates of major depression and suicide history among relatives of patients with UM, although these differences did not reach statistical significance. Variability in the diagnostic criteria used to define UM across studies may partly explain these inconsistencies and complicates direct comparisons.

Several differences in clinical characteristics were observed between the UM and BD groups. Patients with UM more frequently presented with euphoric manic onset and mood-congruent psychotic symptoms during the first episode, whereas depressive onset and a greater total number of mood episodes were more common in BD. These findings are consistent with previous report describing a manic-predominant and psychotic-onset profile in UM (18, 20). In line with most

Table 5: Multivariable linear regression models for FAST scores

Predictor	FAST Total score		FAST Autonomy		FAST Occupational functioning		FAST Cognitive functioning	
	Coeff. (95% CI)	p (adj. p*)	Coeff. (95% CI)	p (adj. p*)	Coeff. (95% CI)	p (adj. p*)	Coeff. (95% CI)	p (adj. p*)
Overall group effect		**<0.001**		**<0.001**		**<0.001**	—	**<0.001**
UM vs. Control	11.52 (8.52 to 14.52)	**<0.001 (<0.001)**	1.08 (0.46 to 1.70)	**0.001 (0.002)**	4.06 (2.78 to 5.33)	**<0.001 (<0.001)**	2.11 (1.13 to 3.08)	**<0.001 (<0.001)**
BD-I vs. Control	14.00 (10.03 to 17.96)	**<0.001 (<0.001)**	1.41 (0.57 to 2.25)	**0.001 (0.003)**	5.33 (3.80 to 6.85)	**<0.001 (<0.001)**	2.42 (1.27 to 3.58)	**<0.001 (<0.001)**
BD-I vs. UM	2.48 (-1.88 to 6.84)	0.172 (0.997)	0.33 (0.64 to 1.30)	0.413 (1.000)	1.27 (-0.43 to 2.97)	0.073 (0.514)	0.32 (-0.88 to 1.51)	0.520 (1.000)
Age	-0.12 (-0.27 to 0.02)	0.090	-0.05 (0.09 to -0.01)	**0.008**	-0.04 (-0.10 to 0.02)	0.200	0.02 (-0.02 to 0.06)	0.333
Male sex	0.96 (-1.75 to 3.66)	0.486	0.50 (-0.11 to 1.10)	0.106	0.45 (-0.60 to 1.50)	0.400	-0.81 (-1.57 to -0.04)	**0.038**
Education duration	-0.35 (-0.75 to 0.04)	0.081	-0.03 (-0.11 to 0.05)	0.436	-0.17 (-0.32 to -0.02)	**0.028**	-0.04 (-0.15 to 0.08)	0.529
Employment status	-6.45 (-9.23 to -3.67)	**<0.001**	-0.88 (-1.52 to -0.24)	**0.007**	-5.74 (-6.97 to -4.51)	**<0.001**	0.09 (-0.73 to 0.92)	0.824
Beck Depression Inventory score	1.44 (0.67 to 2.22)	**<0.001**	0.11 (-0.08 to 0.31)	0.253	0.30 (0.02 to 0.59)	**0.036**	0.35 (0.07 to 0.62)	**0.013**

Linear regression models were adjusted for age, sex, education duration, employment status, and Beck Depression Inventory score. *: Pairwise adjusted p values for group contrasts were corrected using the Šidák method within each outcome. FAST: Functioning Assessment Short Test; Coeff: Coefficient; CI: Confidence interval; UM: Unipolar mania; BD-I: Bipolar I disorder.

previous studies (21), age at illness onset did not differ between the patient groups, although some studies have reported an earlier onset mania in UM (22).

Evaluation of illness course indicated that manic episodes predominated in the UM group, whereas depressive episodes were more frequent in the BD group. Although some studies have reported shorter episode durations in UM, patients with UM in the present study exhibited longer mean episode durations and higher hospitalization rates (23). This finding may reflect characteristics of the study setting, as participants were recruited from a tertiary referral center where patients with more severe or treatment-resistant illness are more likely to receive treatment. Consistent with previous literature, suicidality was significantly more prevalent in BD, likely reflecting the greater burden of depressive episodes in this group (3, 24, 25).

Differences in pharmacological treatment profiles were also observed between the two patient groups. Valproate use was more frequent in the UM group, whereas lamotrigine use was more common in the BD group. In contrast, the use of lithium and carbamazepine did not differ between the groups. Previous studies have suggested a reduced prophylactic response to lithium in UM and comparable responses to valproate in UM and BD, which may partly account for these findings (3). However, given the inconsistencies in the literature and the cross-sectional design of the present study, treatment-related findings should be interpreted cautiously and require further investigation in prospective studies (26).

Psychosocial functioning was significantly impaired in both patient groups compared with healthy controls, even during euthymic periods, as assessed by the FAST. These findings are consistent with previous literature demonstrating that functional impairment often persists beyond symptomatic remission in BD (27). No significant differences were observed between the UM and BD groups across FAST subdomains. However, further evaluation using the BDFS revealed that patients with UM demonstrated better emotional

Table 6: Clinical and treatment-adjusted predictors of BDFS total score, emotional functioning, and social withdrawal

Predictor	BDFS Total score		BDFS Emotional functioning		BDFS Social withdrawal	
	Coeff. (95% CI)	p	Coeff. (95% CI)	p	Coeff. (95% CI)	p
BD-I vs. UM	-3.62 (-8.66–1.41)	0.156	-0.54 (-0.90– -0.18)	**0.004**	-0.38 (-0.76– -0.00)	**0.047**
Age	0.08 (-0.29–0.44)	0.685	0.01 (-0.01–0.04)	0.309	0.01 (-0.02–0.03)	0.589
Male sex	0.90 (-3.56–5.37)	0.689	0.05 (-0.30–0.40)	0.787	0.08 (-0.27–0.43)	0.647
Education duration	0.11 (-0.51–0.73)	0.728	-0.02 (-0.07–0.02)	0.343	-0.01 (-0.05–0.03)	0.548
Employment status	1.47 (-3.57–6.52)	0.563	-0.15 (-0.59–0.28)	0.492	0.17 (-0.20–0.55)	0.360
Beck Depression Inventory score	0.67 (-1.12–2.46)	0.457	-0.06 (-0.20–0.08)	0.375	-0.02 (-0.13–0.09)	0.687
Current valproate use	-3.38 (-8.34–1.58)	0.179	0.04 (-0.31–0.40)	0.811	-0.05 (-0.40–0.30)	0.764
Current lamotrigine use	-12.57 (-24.33– -0.81)	0.036	-0.12 (-1.24–1.00)	0.831	-0.65 (-1.47–0.17)	0.117
Treatment duration	0.00 (-0.33–0.33)	0.984	-0.00 (-0.03–0.02)	0.892	0.00 (-0.02–0.03)	0.683

Linear regression models were adjusted for age, sex, education duration, employment status, Beck Depression Inventory score, current valproate use, current lamotrigine use, and treatment duration. BDFS: Bipolar Disorder Functioning Scale; Coeff: Coefficient; CI: Confidence interval; UM: Unipolar mania; BD-I: Bipolar I disorder.

Table 7: Univariable and multivariable logistic regression analyses of baseline and illness-course clinical correlates of UM relative to BD-I

Predictor	Univariable model		Multivariable model*	
	OR (95% CI)	p	Adjusted OR (95% CI)	p
Age	0.96 (0.92–1.00)	**0.044**	0.98 (0.93–1.03)	0.433
Male sex	1.89 (0.90–3.98)	0.095	1.37 (0.52–3.61)	0.522
Education duration	1.08 (0.98–1.18)	0.109	0.99 (0.88–1.12)	0.902
Type of first episode	N/A**	–	–	–
Psychotic symptoms during the first episode (reference category: absent)				
Mood-congruent psychotic symptoms	5.06 (1.79–14.29)	**0.002**	4.72 (1.48–15.05)	**0.009**
Mood-incongruent psychotic symptoms	1.33 (0.20–8.78)	0.765	1.35 (0.17–10.51)	0.774
Both mood-congruent and mood-incongruent psychotic symptoms	5.00 (1.25–19.96)	**0.023**	2.20 (0.44–10.95)	0.336
Seasonality (present vs. absent)	2.03 (0.93–4.43)	0.075	2.22 (0.85–5.82)	0.105
History of suicide attempts (present vs. absent)	0.23 (0.08–0.67)	**0.007**	0.27 (0.08–0.89)	**0.032**
Total number of episodes	0.92 (0.86–0.99)	**0.023**	0.95 (0.87–1.05)	0.306
Mean duration of episodes	1.08 (1.03–1.14)	**0.003**	1.06 (1.00–1.12)	0.064
Total number of psychiatric hospitalizations	1.10 (0.95–1.27)	0.222	–	–
Employment status (currently employed vs. not employed)†	1.73 (0.79–3.78)	0.173	1.24 (0.48–3.16)	0.658

*: Variables with p<0.20 in the univariable analyses were considered for inclusion in the multivariable model; **: Not estimable because of perfect prediction;
†: Because of sparse employment subgroups, a binary employment variable was used as a parsimonious indicator in the logistic regression analyses. OR: Odds ratio; CI: Confidence interval; ref: Reference category.

functioning and lower social withdrawal than patients with BD, whereas total functioning scores did not differ between the groups. These findings may be explained by the absence of depressive episodes, fewer total mood episodes, and lower suicidality in UM. Previous studies have consistently shown that depressive symptom burden, including subthreshold symptoms, is strongly associated with functional impairment (28,

29), and that recurrent episodes and hospitalizations contribute to poorer long-term outcomes (30). In this context, the relatively better emotional and social functioning observed in UM may reflect a lower cumulative illness burden.

The present study is notable for its comprehensive assessment of sociodemographic, clinical, and functional characteristics using validated and reliable instruments. Nevertheless, several limitations should be acknowledged. First, the relatively small sample size and cross-sectional design limit causal inferences. In addition, no a priori power analysis was conducted to determine whether the sample size was sufficient to detect meaningful between-group differences, which may have reduced the statistical power of the study. An important limitation concerns the operational definition of UM. The use of a four-year depression-free period is not based on a universally accepted temporal criterion, and depressive episodes in BD-1 may emerge later in the illness course. Therefore, some patients classified as having UM may eventually transition to a BD-1 phenotype, and the findings should be interpreted cautiously. Furthermore, although psychosocial functioning was assessed using the FAST and BDFS, both instruments rely primarily on patient-reported outcomes. The inclusion of clinician-rated instruments, such as the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) or the Hamilton Depression Rating Scale (HAM-D) could have strengthened the methodological rigor of the study. Specific phobias were not excluded because they are generally circumscribed and unlikely to substantially influence study outcomes. Nevertheless, several potential confounding variables were not controlled for in the analyses. In addition, reliance on patient- and caregiver-reported information may have introduced recall bias. The inclusion of only patients with BD-I and recruitment from a tertiary care center treating relatively severe cases further limit the generalizability of the findings. Despite these limitations, the assessment of patients during euthymia and the comprehensive evaluation of both clinical and functional characteristics represent important strengths of the study. Future longitudinal studies with longer follow-up periods and more objective functional measures are needed to clarify the validity of UM as a distinct clinical entity.

CONCLUSION

The present study provides evidence that UM differs from BD-I not only in clinical course but also in specific domains of psychosocial functioning during euthymia. Although overall functional impairment was comparable between the groups, patients with UM demonstrated relatively better emotional functioning and less social withdrawal. These findings suggest that depressive episode burden may play a critical role in shaping functional outcomes across mood disorder subtypes.

Clinically, the findings support consideration of UM as a distinct and clinically meaningful presentation, with potential implications for functional assessment, rehabilitation strategies, and individualized treatment planning. Future longitudinal studies with larger and diagnostically well-characterized samples are needed to determine the persistence of these functional differences over time and their relevance for long-term prognosis and treatment response.

Ethical Approval: This study was approved by the Ethics Committee of Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatry, Neurology, and Neurosurgery Clinical Research (date: 06.09.2022, number: 345) with additional approval obtained from the Bakirkoy Dr. Sadi Konuk Training and Research Hospital Clinical Research (date: 09.01.2023, number: 2023-01-22).

Informed Consent: Written informed consent was obtained from all participants prior to participation in the study.

Conflict of Interest: The authors declare that there is no conflict of interest.

Financial Disclosure: The authors declared that this study has received no financial support.

Use of AI for Writing Assistance: Not declared.

Contribution Categories		Author Initials
Category 1	Concept/Design	O.S.O.
	Data acquisition	E.I.S.
	Data analysis/Interpretation	O.S.O., E.I.S.
Category 2	Drafting manuscript	E.I.S.
	Critical revision of manuscript	O.S.O.
Category 3	Final approval and accountability	O.S.O., E.I.S.
Other	Technical or material support	E.I.S., O.S.O.
	Supervision	O.S.O.

Peer-review: Externally peer-reviewed.

REFERENCES

1. Huxley N, Baldessarini RJ. Disability and its treatment in bipolar disorder patients. Bipolar Disord 2007; 9:183-196. [CrossRef]

2. Burdick KE, Millett CE, Yocum AK, Altimus CM, Andreassen OA, Aubin V, et al. Predictors of functional impairment in bipolar disorder: Results from 13 cohorts from seven countries by the global bipolar cohort collaborative. Bipolar Disord 2022; 24:709-719. [CrossRef]

3. Yazici O, Kora K, Uçok A, Saylan M, Ozdemir O, Kiziltan E, Ozpulat T. Unipolar mania: a distinct disorder? J Affect Disord 2002; 71:97-103. [CrossRef]
4. Angst J, Grobler C. Unipolar mania: a necessary diagnostic concept. European Archives of Psychiatry and Clinical Neuroscience 2015; 265:273-280.
5. Perugi G, Passino MC, Toni C, Maremmani I, Angst J. Is unipolar mania a distinct subtype? Compr Psychiatry 2007; 48:213-217. [CrossRef]
6. Young RC, Biggs JT, Ziegler VE, Meyer DA. A rating scale for mania: reliability, validity and sensitivity. Br J Psychiatry 1978; 133:429-435. [CrossRef]
7. Karadağ F, Oral T, Yalçin FA, Erten E. Reliability and validity of Turkish translation of Young Mania Rating Scale. Turk Psikiyatri Derg 2002; 13:107-114.
8. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. Arch Gen Psychiatry 1961; 4:561-571. [CrossRef]
9. Hisli N. Reliability and validity of the Beck Depression Inventory in a university student population. Turk Psikiyatri Derg 1988; 7:3-13.
10. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophr Bull 1987; 13:261-276. [CrossRef]
11. Kostakoglu A, Batur S, Tiryaki A, Gogus A. Reliability and validity of the Turkish version of the Positive and Negative Syndrome Scale (PANSS). Turk Psikiyatri Derg 1999; 14:23-32.
12. Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: psychometric properties. J Consult Clin Psychol 1988; 56:893-897. [CrossRef]
13. Ulusoy M, Sahin N, Erkmen H. Turkish version of the Beck Anxiety Inventory: psychometric properties. J Cogn Psychother 1998; 12:163-172.
14. Aydemir O, Eren I, Savas H, Oguzhanoglu NK, Kocal N, Ozguven HD, et al. Development of a questionnaire to assess inter-episode functioning in bipolar disorder. Turk Psikiyatri Derg 2007; 18:344-352. [Article in Turkish]
15. Rosa AR, Sánchez-Moreno J, Martínez-Aran A, Salamero M, Torrent C, Reinares M, et al. Validity and reliability of the Functioning Assessment Short Test (FAST) in bipolar disorder. Clin Pract Epidemiol Ment Health 2007; 3:5. [CrossRef]
16. Aydemir O, Uykur B. Reliability and validity study of the Turkish version of functioning assessment short test in bipolar disorder. Turk Psikiyatri Derg 2012; 23:193-200. [Article in Turkish]
17. Angst J, Gerber-Werder R, Zuberbühler HU, Gamma A. Is bipolar I disorder heterogeneous? Eur Arch Psychiatry Clin Neurosci 2004; 254:82-91. [CrossRef]
18. Manchia M, Miola A, Tondo L, Baldessarini RJ. Unipolar Mania: Prevalence and Patient Characteristics. Acta Psychiatr Scand 2025; 151:680-688. [CrossRef]
19. Aghanwa HS. Recurrent unipolar mania in a psychiatric hospital setting in the Fiji Islands. Psychopathology 2001; 34:312-317. [CrossRef]
20. Mehta S. Unipolar mania: recent updates and review of the literature. Psychiatry J 2014; 2014:261943. [CrossRef]
21. Andrade-Nascimento M, Miranda-Scippa Â, Nery-Fernandes F, Kapczinski F, Quarantini LC. The identification of unipolar mania subtype based on anxiety comorbidity. J Affect Disord 2011; 132:356-359. [CrossRef]
22. Baek JH, Eisner LR, Nierenberg AA. Epidemiology and course of unipolar mania: results from the national epidemiologic survey on alcohol and related conditions (NESARC). Depress Anxiety 2014; 31:746-755. [CrossRef]
23. Chang CE, Wang J, Lin YT, Chiu CC, Hsieh MH, Huang MC, et al. Characterization of clinical features and comorbidities between bipolar affective disorder with and without depressive episodes. Psychological Medicine 2023;53:4103-4113. [CrossRef]
24. Amamou B, Chebbi W, Allegue M, Mhalla A, Zaafrane F, Gaha L. Unipolar Mania: A Particular Aspect of Bipolar Disorder in Tunisia. Clin Psychopharmacol Neurosci 2018; 16:209-213. [CrossRef]
25. Grobler C, Roos JL, Bekker P. Unipolar mania reconsidered: evidence from a South African study. J Psychiatry 2014; 17:483-491. [CrossRef]
26. Stokes PRA, Yalin N, Mantingh T, Colasanti A, Patel R, Bellivier F, et al. Unipolar mania: Identification and characterisation of cases in France and the United Kingdom. J Affect Disord 2020; 263:228-235. [CrossRef]
27. Sengupta G, Jena S. Disability in patients with bipolar disorder in full or partial remission: a cross-sectional study. Prim Care Companion CNS Disord 2022; 24:21m03183. [CrossRef]
28. Rosa AR, Bonnín CM, Vázquez GH, Reinares M, Solé B, Tabarés-Seisdedos R, et al. Functional impairment in bipolar II disorder: is it as disabling as bipolar I? J Affect Disord. 2010; 127:71-76. [CrossRef]
29. Sanchez-Moreno J, Martinez-Aran A, Gadelrab HF, Cabello M, Torrent C, Bonnin Cdel M, et al. The role and impact of contextual factors on functioning in patients with bipolar disorder. Disabil Rehabil 2010; 32(Suppl 1):S94-S104. [CrossRef]
30. Murru A, Pacchiarotti I, Verdolini N, Reinares M, Torrent C, Geoffroy PA, et al. Modifiable and non-modifiable factors associated with functional impairment during the inter-episodic periods of bipolar disorder. Eur Arch Psychiatry Clin Neurosci 2018; 268:749-755. [CrossRef]