Functional recovery is limited in people with bipolar disorder


METHODS

Design: Prospective cohort study, part of the larger decade long McLean-Harvard First-Episode Project.

Setting: Inpatient units at McLean Division of Massachusetts General Hospital; 1989 to 1996.

Population: 173 people (mean age 33 years, 55% male) were consecutively recruited within 72 hours of psychiatric hospitalisation for manic (75%) or mixed (25%) episode bipolar disorder (DSM-IV criteria). Exclusions: current substance withdrawal, delirium, previous psychiatric hospitalisation unless for detoxification only, documented IQ < 70, ill for > 1 year, previous treatment with a mood stabiliser or antipsychotic for > 3 months in total.

Prognostic factors: Participants were assessed weekly until discharge. Semi-structured telephone interviews were conducted at 6, 12, 24, 26, and 48 months by experienced assessors. Information obtained included symptoms, occupational status, residential status, current treatment, and determination of syndromal, symptomatic, and functional recovery.

Outcomes: Likelihood of syndromal, symptomatic, and functional recovery (according to occupational and residential status); risks of first relapse or recurrence.

Follow up period: Average 4.86 years, 87% followed for > 2 years.

MAIN RESULTS

Syndromal recovery: 98% experienced syndromal recovery at 2 years. Predictors of earlier syndromal recovery were shorter initial hospitalisations (HR 1.99, 95% CI 1.36 to 2.93, p < 0.001), female sex (HR 1.72, 95% CI 1.16 to 2.56, p = 0.008), and below median initial depression ratings (HR 1.65, 95% CI 1.14 to 2.39, p = 0.008).

Symptomatic recovery: 72% had symptomatic recovery at 2 years. Functional recovery: at 2 years, 43% had functional recovery. Predictors of functional recovery were age > 30 years (OR 3.28, 95% CI 1.58 to 6.82, p = 0.006) and shorter initial hospitalisations (OR 2.82, 95% CI 1.36 to 5.88, p = 0.006). First relapse or recurrence: 20% had new episodes of mania, 20% new episodes of depression and 19% switched phases without recovery within 2 years (see http://www.ebmentalhealth.com/supplemental for table). Predictors of mania were initial mood-congruent psychotic features (HR 2.79, 95% CI 1.31 to 5.91, p = 0.05); low premorbid occupational status (HR 2.53, 95% CI 1.15 to 5.35, p = 0.02), and initial manic versus mixed state (HR 3.38, 95% CI 1.00 to 11.5, p = 0.05). Predictors of depression were higher premorbid occupational status (HR 5.08, 95% CI 2.16 to 11.90, p < 0.0001); initial mixed presentation (HR 4.52, 95% CI 2.23 to 9.16, p < 0.0001); and any comorbidity (HR 2.60, 95% CI 1.20 to 5.66, p = 0.02).

CONCLUSIONS

Among people with bipolar disorder who require hospitalisation, many have relapses, switches, and limited functional recovery.

Q What is the prognosis for people hospitalised with first episode bipolar disorder?

A The classical description of affective disorders as episodic illnesses with full symptomatic and functional recovery between episodes is no longer valid. Kraepelin’s conceptualisation of functional decline as being pathognomonic of schizophrenia, and not affective disorders, no longer holds true. Many people with mood disorders, whether their symptoms persist or not, never return to their premorbid level of functioning after becoming ill. Even with adequate care, the long term course of bipolar I disorder appears to be one of chronicity, with recurrent or subsyndromal symptoms of mania or depression frequently present.

KEY POINTS

- Functional recovery is limited in people with bipolar disorder.
- Many people with mood disorders, whether their symptoms persist or not, never return to their premorbid level of functioning after becoming ill.
- The long term course of bipolar I disorder appears to be one of chronicity, with recurrent or subsyndromal symptoms of mania or depression frequently present.

Follow up period: Average 4.86 years, 87% follow-up for > 2 years.