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LONG-TERM EVOLUTION OF AFFECTIVE DISORDERS FROM THE POINT OF VIEW OF WORK CAPACITY

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The paper represents the analysis of 36 patients suffering from primary bipolar and monopolar recurrent affective psychosis who have been diagnosed on the basis of DSM-III criteria for the "episode" and according to C.Perris´s criteria for the disease.

The patients were divided into 2 groups: group A comprising 16 cases, having a good social evolution and who have not reached social functioning incapacity and group B, representing 20 cases who have reached social functioning incapacity.

The differences between the 2 groups were analysed regarding to the demographic characteristics as well as the clinical evolution before and after the index affective episode.

The research has allowed to state that the recurrent affective disorders may present an unfavourable long term evolution -- from a clinical point of view as well as from the point of view of its social functioning. The author suggests the perspective of continuing the study in order to establish the "prognostic factors" regarding the long term evolution in similitude with schizophrenia.

The work capacity of a human being is important not only because of his social existence or from the economic view of the person and his family. It is important, too, for the person´s self-esteem and dignity. This study was initiated taking into consideration this point of view.

The studies concerning the medium or long-term evolution of the recurrent affective disorders are less than those concerning schizophrenia. Although there are classical and recent researches concerning the evolution of these diseases at present does not exist an explicit preocupation regarding the specification of some "prognostic factors" and of some "predictors" as in schizophrenia studies. We must pay attention to this problem, because more frequent researches underline the posibility of an unfavourable evolution of the "recurrent affective disorders", despite the treatments

which exist, often reaching at "defective" states at maladive "chronicization" and at social handicap.

The hypothesis of this research project concerning the "recurrent affective disorders" is that there are cases whose course is directed from the beginning to a good or bad socio-clinical evolution. Certainly, the natural course of the disease may be influenced by therapeutic and social factors. On a first stage we have not granted a special importance to these factors, reducing them to a standardized level (the detailed analysis of these influences will be accomplished apart in another work). We have been interested in those cases which, because of the disease, get to social functioning incapacity, to professional handicap (pension) taking into consideration that this is an important indicator of evolutional gravity. We have compared these cases with a long-term studied group, which have not got to professional functioning incapacity (pension). Our studies refer to a reduced group of cases which does not represent an annual "cohort" or a prospective researched group, according to a case register.

After that, as concerns, it is a "pilot study" which can present only stage observations. The research proceeds on according to a lot of parameters and a complex methodology.

There have been selected confirmed cases with "primary recurrent affective disorders", bipolar and monopolar (according to DSM--III for episode and according to C.Perris for disorder), which presents a catamnesis for 4 years at least since the "affective episode" (I.E. = maniacal state, "psychotic" state included delirium - congruent with the affective state; or "major depression" included "melancholy" or "psychotic" - delirant depression, according to DSM-III). "Disphoric", "distimic" and "hypomaniacal" episodes have been registered separately. Especially in the monopolar depression cases, the "distimic episodes" which are previous to I.E. (major depression a.s.o.) could be considered as the expression of the progressive manifestation of the disease.

Cases which presented at least one schizo-affective episode (according to R.D.C. - Spitzer-Endicott criteria), cases of "schizophrenia" or "schizophrenic type of psychosis" have been excluded. Cases at which I.E. occured 10-20 years ago were reinterpreted when it was necessary according to the above mentioned criteria on the basis of medical documents and according to the "lists

of symptoms".

When a clinical episode (which required hospitalization) has occured less than 3 months from the discarge, it has been considered as a continuation of the preceding one. It was calculated only the "clinical episode" duration, i.e. the period which required the hospitalization. The real duration of the affective episode is, of course, longer by far. There have been studied only those cases which were integrated in the social-productive activity, having a good socio-professional efficiency before I.E.

For the study there have been kept 36 cases which were in the evidence of the Clinic Psychiatric Center Timisoara, during this research, which fulfilled the above mentioned criteria and for which we could obtain sufficient data. They have been continuously watched by controlling, every years after onset, for the whole catamnesis period.

By this "random checking", there are only few cases with good or very good evolution. However, because we have had into evidence all the pensioned cases from our zone, we could divide the lot into two groups:

1. Group (lot) A: cases with a good social evolution which did not get incapable of work. A part of these cases may advance unfavourable from the clinical point of view, namely some relapse and are rehospitalized. But they go on working at the same level, at a superior or at a slight lower one, in comparison with the I.E. period.

2. Group (lot) B: cases which got incapable from the professional point of view (pension), thus maintaining more than 2 years. Usually, these cases have an unfavourable evolution from the clinical point of view, and the seriousness of the disease is greater.

In order to evaluate the functioning of the socio-professional level we used the Carlson scale.

The results are summarized in 3 Tables. In Table 1 we present the general characteristics of the lot from the following points of view: demographic, the period of catamnesis, the changes which happened in the professional and marital statute.

In Table 2 we present data regarding the I.E. and the evolution of the disease.

In Table 3 we present some clinical characteristics of the lot. At the same time there were presented data characterizing

Table 1. General and professional characteristics of the group

	A good social functioning			B deteriorated social functioning (pension			Total
	U	B	Total	U	B	Total	
1. Number of cases	6	10	16	8	12	20	36
men	5	6	11	5	5	10	21
women	1	4	5	3	7	10	15
2. Average time of catamnesis (years)			11,8			8,6	10,02
catamnesis less than 7 years			1			7	
3. Marital statute at I.E.							
1. Married	4	5	9	7	9	16	25
2. Unmarried	1	4	5	1	1	2	7
3. Divorced-widower	1	1	2		2	2	4
4. Changes in the marital statute:							
1. Unmarried-married		3	3				3
2. Married-divorced					2	2	2
3. Multiple changes		1	1		1		2
5. Instructive professional statute at I.E.:							
1. graduated			6			7	13
2. medium skill			7			8	15
3. reduced skill			1			6	7
4. pupil-student			2				2
6. Changes in the socio-professional statute - in comparison with I.E.							
1. working at the same or at a superior level	4	7	11				11
2. working at an inferior level (reduced efficiency)	2	3	5				5
3. pensioners, house activities				8	12	20	20
4. hospitalized more than 75% of time (nr.3 included)				1	2	3	3
7. Average time (years) since I.E. until pension				2,2	2,8	2,6	

Table 2. The I.E. and the evolution of the disease aspects

	A			B			Total
	U	B	Total	U	B	Total	
Number of cases	6	10	16	8	12	20	36
8. Average age at I.E.:	35,5	30.3	32.9	45.5	40	42.7	
- men	34.8	33	39.4	48	48.2	48.1	
- women	39	29	24.4	41.3	34.1	37.7	
9. Average period of hospitalization (months)	2.5	3.3	2.9	4.8	4.6	4.7	3.8
10. Number of cases which presented psychiatric hospitalization until I.E.	4	1	5	6	5	11	16
11. Number of hospitalizations until I.E.	5	1	6	19	11	30	36
12. Average time (years) since the first psychiatric hospitalization until I.E.	6	3	5.6	8.3	4.4	6.5	5.5
13. The period elapsed since the I.E. until the first relapse with hospitalization	3.5	2.7	3.1	0.9	1.3	1.1	2.1
14. Number of hospitalizations for relapses/year of evolution	0.5	0.7	0.7	0.9	0.8	0.8	0.7
15. The average duration of the hospitalizations years	2.5	2.6	2.5	3.4	3.1	3.3	2.9

Table 3. Clinical characteristic features of the group

	A			B			Total
	M	B	Total	M	B	Total	
Number of cases	6	10	16	4	12	20	36
16. Monopolar mania		2					
17. Episodes of querulent mania "paranoid-Murphy"		5			3		8
Episodes of delirant mania "psychotic"		2			2		4
Episodes of delirant depression "psychotic"	3		2				5
18. Clinical type of I.E.:							
- depressive	6	5	11	8	8	16	27
- maniacal		5	5		4	4	9
19. Cases of subclinical episodes ambulatory treated			4			16	20

group A and B, for each of them being separately presented the characteristics of the monopolar patients (=M) in comparison with the bipolar ones, too (=B).

From Table 1 results that there are not significant diferences between the number of monopolar and bipolar patients, from the two groups both generally and concerning the sex - repartition. From all of these 36 cases, 21 were men and 15 women. Men preavail in the group A, while in the group B it is an equal sex - repartition. The medium time of catamnesis is more increased in the group A (11.8 years) in comparison with the group B (8.6 years).

In this respect there are significant differences between the two groups, after a longer period of catamnesis, the cases from the group A did not get incapable of social functioning. From Table 1 also results that the time elapsed since I.E. until the settlement of the social functioning incapacity is 2.6 years on the average. Therefore, for the cases from the lot B, this incapacity

is decided during the first three years since I.E., and it lasts; the patients unregaining it on the next years of evolution.

In the prospect of the marital statute in the I.E. period prevail married people. This prevalence known in literature is more evident in the group B, this fact can be explained by the E.I. appearance at an advanced age. There are few changes in the patients marital statute; there are not significant differences between the two lots. This could be explained by the different average age as well as by the different evolution type of the disease.

Regarding the instructive-professional level, it is superior in both lots; for all that, in the group B there are more persons with a reduced skill. In the group A, from 16 cases 11 work at the same level or at a superior one, and 5 at a slight inferior level. For one year a case was pensioned, resuming then the activity and continuing it for 10 years. In the group B, all the 20 patients have lost their social work capacity (it was the selection criterion, otherwise). Only one case continues to be employed in an easy activity with reduced and protected work (the 3rd degree pensioned). After a pension for 5 years, one case has regained the activity for 2 years, then having been pensioned again for 4 years. From the 20 cases, were hospitalized more than 75%, from the catamnesis period.

Table 2 emphasizes series of differences between the two groups. Thus, the cases which lose the social functioning capacity (group B) present the following differences in comparison with those cases which do not lose this one (group A). There is a more advanced age at the beginning (I.E.) at the men from the group B, both at the monopolar and at the bipolar (the last ones have a later beginning in both groups). They have a longer period of I.E. (this fact was ascertained by all the research workers as an index of gravity).

In group B there is a greater number of cases which have been hospitalized with a "neurotic" symptomatology, before I.E., with a greater number of episodes (hospitalizations) in an approx.equal period of time since the first psychiatric hospitalization at I.E. This situation suggests that in this cases the major affective episode is announced by affective disorders which are initially manifested with a reduced intensity, but which are insistently repeated until the evident and major starting of the disease, and which leads rapidly to pensioning. It presents an approx. 3 times redu-

ced period since the I.E. remision until the first clinical relapse. During the subsequent evolution, it presents an increased number of clinical relapses on year, having a longer average duration in the group B.

From clinical point of view (Table 3) we found that group A presented two maniacal monopolar psychoses (which we included during the bipolar ones). We found 5 episodes of querulent mania in the group A and 3 ones in group B (paranoid-Murphy type), and in each lot we met two delirant maniac. We found 3 episodes of psychotic depression (delirant) in group A and 2 ones in group B. In conclusion, we do not ascertain significant differences regarding the clinical image.

It looked interesting to us that I.E. have been depressive in most cases for both groups, and bipolar cases included. We point out once more the presence of the alcoholism and of the addictive behaviour more frequently in group A than in group B, 5 cases from 16 in comparison with 3 cases from 20. The ambulatory treatments for border clinical episodes are more frequent in group B in comparison with the lot A. Other remarks which we do not present in detail are as follows: We did not find significant differences between the two groups regarding the type of premorbid personality. Also, for group B the genetic load is only slightly increased. But group A does not represent a lot with a good or a very good clinical evolution. The correlation between relapses and life events is significantly more increased in group A.

Reccurent affective disorders can have an unfavourable evolution on long term, both from the clinical point of view and from the social adaptation one. A series researches workers underlined the more unfavourable clinical evolution of the bipolars, but these researches refered only to the relapse rate.

In our casuistry we equally found monopolar and bipolar patients in the group those with unfavourable evolution, from the social adaptation point of view. This group clinically advances more unfavourable than those one of the patients which maintain the social functioning capacity concerning both the number of the clinical relapses and the period spent in the hospital.

The problem we were interested in - and which we want to study - is the following: if in the affective disorders the "prognostic factors" can be established concerning the long-term evolution

in similitude with those from schizophrenia. We are encouraged in this direction by the finding which we have done regarding the fact that the loss of the first 3 years since the I.E. (in our group). Finally we mention the main characteristics of the patients´group with an unfavourable evolution both from the socio-functioning point of view and from the clinical one (group B), which we have found during this pilot study.

Group B would be characterized as follows (in comparison with group A): - onset at a more advanced age, both for the monopolars and for the bipolars; - a lower instructiv-professional level; - - long duration of I.E.; - more psychiatric hospitalizations for the "disphoric" episodes with neurotic intensity; - short time since the I.E. until the first clinical relapse; - increased number of clinical relapse/year of evolution with a more increased average duration of the hospitalizations; - reduced conditioning of life events relapses; - multiple subclinical episodes between hospitalizations; - overadded ethylism (and drug addiction) is less frequent.

Our pilot study suggests that these elements which were evaluated in the first 4 years since the I.E., could make up "prognostic factors" or "predictors" on the long-term evolution. Systematic, prospective and retrospective researches are to clear up this ascertainment.

Literature at the author.

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