Quality of life in euthymic bipolar I patients: a prospective study

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Dear Editor,

According to the World Health Organization (WHO), Bipolar Disorder (BD) type I has a prevalence of between 1.0% and 1.6% in the general population and is one of the twenty major causes on the worldwide list of diseases that compromise an individual's total functioning[1-3]. Most of the quality of life (QOL) studies on BD emphasize the negative impact in the different QOL domains at all disease stages, but mainly the depressive episodes. Few studies have investigated QOL of bipolar patients during euthymia.

Thus, the present study aims to compare QOL scores in BD type I euthymic patients at two different times, with an interval of 2.5 years (only 38 from 84 could be compared due to absence of euthymia, refusal to participate, unknown location and death).

The Hamilton Rating Scale for Depression (HAM-D-17 ≤ 7)[4] as well as from the Young Mania Rating Scale (YMRS ≤ 7)[5] were used to evaluate if patients were euthymic. They answered a questionnaire to gather clinical and socio-demographic data. Afterwards, they were evaluated through the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, axis I (SCID-I)[6]. Once confirmed the BD type I diagnosis and the state of euthymia, the patient answered the World Health Organization Quality of Life-BRIEF (WHOQOL-BRIEF) instrument[7].

Observations regarding the analyzed patients are as follows: female (78.9%); average age 39.39 years (standard deviation, SD = 11.24); with no permanent partner (84.2%); with paid occupation (60.5%); having predominantly manic/hypomanic first episode (57.9%); no rapid cycling (97.4%); without suicide attempt (73.7%); without psychiatric comorbidities (78.4%); average age at first episode 24.5 years (SD = 11.31), without presence of psychosis during life (55.3%); and time of disease evolution of 14.91 years (SD = 9.9). In relation to the socio-demographic and clinical characteristics of the 38 subjects analyzed at both times, there were also no significant long-lasting differences ($p > 0.05$).

The physical, social and psychological health domains presented reductions, but these reductions were only significant in the psychological health domain ($p = 0.02$) (Table 1).

The psychological health domain refers to individuals' subjective experience regarding their state of psychic well-being related to their personal experience. Therefore, one assumes that BD, by inflicting intense psychic suffering, may cause unfavorable self-analysis in these subjects, regardless of the presence of mood symptoms, resulting in the low scores found in this work. On the other hand, our results confirm the idea that bipolar patients, even when they achieve full clinical remission, show difficulties in returning to their previous level of functioning[8-10]. These findings point to the need of greater care to these individuals, even when euthymic, since unfavorable self-analysis can contribute to more social isolation behaviors, more hopelessness and greater chances of new episodes of the disease.

The main limitation of this study was the small sample size. Additionally, other limitations should be highlighted: first, the retrospective data gathered, which increased the chance of memory bias; second, the selected sample of patients from a specific medical service prevented us from generalizing the results.

Table 1. Quality of life in two different moments (n = 38)

WHOQOL domains	Baseline	Follow-up	Test Z*; *p* value
Physical Health Md (Min-Max)	64.28 (35.71-89.29)	60.71 (32.14-78.57)	- 1.69**; 0.091
Psychological Health Md (Min-Max)	66.67 (33.33-100)	60.42 (29.17-79.17)	- 2.29**; 0.022
Social Relations Md (Min-Max)	66.67 (16.67-100)	58.33 (25-100)	- 0.045**; 0.964
Environment Md (Min-Max)	51.56 (31.25-90.63)	59.37 (18.75-87.50)	- .788***; 0.431

Md: median; Min: minimum; Max: maximum.* Wilcoxon Test. ** Based on positive ranks. *** Based on negative ranks.

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