Clinical correlates of acute bipolar depressive episode with psychosis

Marco Antonio Caldieraro\textsuperscript{a,b,}\textsuperscript{,}, Louisa G. Sylvia\textsuperscript{b,c}, Steven Dufour\textsuperscript{b}, Samantha Walsh\textsuperscript{b}, Jessica Janos\textsuperscript{b}, Dustin J. Rabideau\textsuperscript{d}, Masoud Kamali\textsuperscript{b,c}, Melvin G. McInnis\textsuperscript{b}, William V. Bobo\textsuperscript{f}, Edward S. Friedman\textsuperscript{g}, Keming Gao\textsuperscript{h}, Mauricio Tohen\textsuperscript{b,c}, Noreen A. Reilly-Harrington\textsuperscript{b,c}, Terence A. Ketter\textsuperscript{j}, Joseph R. Calabrese\textsuperscript{h}, Susan L. McElroy\textsuperscript{k,l}, Michael E. Thase\textsuperscript{m}, Richard C. Shelton\textsuperscript{b}, Charles L. Bowden\textsuperscript{n}, James H. Kocsis\textsuperscript{g}, Thilo Deckersbach\textsuperscript{b,c}, Andrew A. Nierenberg\textsuperscript{b,c}

\textsuperscript{a} Serviço de Psiquiatria, Hospital de Clínicas de Porto Alegre, Porto Alegre, RS, Brazil
\textsuperscript{b} Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA
\textsuperscript{c} Harvard Medical School, Boston, MA, USA
\textsuperscript{d} Biostatistics Center, Massachusetts General Hospital, Boston, MA, USA
\textsuperscript{e} Department of Psychiatry, University of Michigan, Ann Arbor, MI, USA
\textsuperscript{f} Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN, USA
\textsuperscript{g} University of Pittsburgh School of Medicine, Pittsburgh, PA, USA
\textsuperscript{h} Mood Disorders Program, University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, OH, USA
\textsuperscript{i} Department of Psychiatry & Behavioral Sciences, University of New Mexico Health Sciences Center, Albuquerque, NM, USA
\textsuperscript{j} Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine, Stanford, CA, USA
\textsuperscript{k} Lindner Center of HOPE, Mason, OH, USA
\textsuperscript{l} Department of Psychiatry, University of Cincinnati College of Medicine, Cincinnati, OH, USA
\textsuperscript{m} Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, PA, USA
\textsuperscript{n} Department of Psychiatry, University of Texas Health Science Center, San Antonio, TX, USA

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ABSTRACT

Background: Psychotic bipolar depressive episodes remain remarkably understudied despite being common and having a significant impact on bipolar disorder. The aim of this study is to identify the characteristics of depressed bipolar patients with current psychosis compared to those without psychosis.

Methods: We used baseline data of a comparative effectiveness study of lithium and quetiapine for bipolar disorder (the Bipolar CHOICE study) to compare demographic, clinical, and functioning variables between those with and without psychotic symptoms. Of the 482 participants, 303 (62.9\%) were eligible for the present study by meeting DSM-IV criteria for an acute bipolar depressive episode. Univariate analyses were conducted first, and then included in a model controlling for symptom severity.

Results: The sample was composed mostly of women (60.7\%) and the mean age was 39.5 ± 12.1 years. Psychosis was present in 10.6\% (n=32) of the depressed patients. Psychotic patients had less education, lower income, and were more frequently single and unemployed. Psychosis was also associated with a more severe depressive episode, higher suicidality, more comorbid conditions and worse functioning. Most group differences disappeared when controlling for depression severity.

Limitations: Only outpatients were included and the presence of psychosis in previous episodes was not assessed.

Conclusion: Psychosis during bipolar depressive episodes is present even in an outpatient sample. Psychotic, depressed patients have worse illness outcomes, but future research is necessary to confirm if these outcomes are only associated with the severity of the disorder or if some of them are independent of it.

1. Introduction

Psychosis is a frequent feature in bipolar disorder (BD) (Goghi and Harrow, 2016; Ostergaard et al., 2013) and is associated with worse prognosis, lower rates of recovery (Goghi and Harrow, 2016; Solomon et al., 2010) and shorter time to first recurrence (Pallaskorpi

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2.1. Participants

ClinicalTrials.gov (identif

2.2. Assessments

Clinical interviewers obtained demographic information (e.g., employment and disability status, household income, educational back-

2.2.1. Diagnosis and symptom severity

Lifetime and current diagnoses according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), including bipolar disorder and other psychiatric comorbidities, were established at the screening visit with the electronic Mini-International Neuropsychiatric Interview (eMINI-PLUS) (Sheehan et al., 1998). The eMINI-PLUS was also used to assess current suicidality. Symptom severity was assessed by the CGI-BP and the Bipolar Inventory of Symptoms Scale (BISS) (Bowden et al., 2007; Gonzalez et al., 2008), a structured interview that yields an overall severity score with subscales specific to mania and depression. The BISS also identifies five domains of behavioral psychopathology (i.e., depression, mania, psychosis, irritability and anxiety) (Thompson et al., 2010).

Items of the psychotic domain of the BISS were used to define the presence of psychotic symptoms (i.e., items 41-Persecutory Ideas; 42- Delusions; 43-Hallucinations; and 44-Impaired Insight). Patients were considered psychotic if a delusion or hallucination was definitely present; that is, there was a score of 4 on item 41 (persecutory ideas), a score greater than or equal to 2 on items 42 (delusions) or 43 (hallucinations), or a score of 3 or 4 on item 44 (impaired insight).

2.2.2. Functioning

Overall functioning was measured with the Longitudinal Interval Follow-up Evaluation-Range of Impaired Functioning Tool (LIFE-RIFT) (Leon et al., 2000). The LIFE-RIFT comprises an overall score as well as four subscales characterizing the extent to which current psychopathology impacts: (1) work (i.e., employment, household, student); (2) relationships (i.e., spouse, children, other relatives, friends); (3) overall life satisfaction; and (4) recreation. Higher LIFE-RIFT scores indicate greater functional impairment.

2.3. Statistical analysis

Data were analyzed using SPSS 20.0. Univariate analyses were performed using student t-tests for continuous variables with a normal distribution and Mann-Whitney U-tests for continuous variables with non-normal distribution. Categorical variables were compared using the chi-square (χ²) test or Fisher’s Exact test when indicated. To adjust observed associations for depression severity, a multivariate analysis was performed using a logistic regression model with psychosis being the dependent variable. All variables for which a statistically significant difference was observed in the univariate analyses were included as predicting variables. The severity variable used in this model was the depression subscale of the BISS. This subscale was selected because it does not include the BISS items that were used to define psychosis. All tests were two-tailed and a p-value < 0.05 was considered statistically significant, with no adjustment for multiple comparisons, given the exploratory nature of these analyses.

3. Results

Three hundred and three patients (62.9%) out of the 482 total sample presented with a major depressive episode at the time of enrollment. There were more women (60.7%; n=184) than men and the mean age was 39.45 ± 12.1 years. BD I was more frequent (64.7%; n=196) than BD II (35.3%; n=107). Among the depressed patients, 32 (10.6%) also presented with psychotic symptoms. Paranoid delusion was present in 2 patients (0.7%), any delusion in 17 patients (5.6%),
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