Patterns of Recurrence in Mood Disorders. A Clinical Study in Upper Egypt

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Mood disorders tend to be recurrent and the onset of the individual episodes is often related to stressful events. 50 Upper Egyptian patients were studied using a semistuctured psychiatric interview to characterize their patterns of recurrence. Both sexes were equally represented, their ages ranged between 18-46 years, most of them were unemployed and illiterate. 48% had Biplor Affective Disorder (more common in males), and 52% had Unipolar Affective Disorder (more common in females). BAD had a younger age of onset than UAD, 26% had a definite seasonal pattern of recurrence, mostly in winter time. In 58% of patients, precipitating factors played a role in their earlier episodes, then both the presence of and severity of stressful events diminishes with progress of illness. Prodromal symptoms were reported by 46% of patients. The mean duration of affective episodes was nearly constant (about one month) along the course of the affective disorder, and 76% of patients displayed constant clinical picture. The duration of emission gradually diminishes with repeated recurrences. 36% of patients reported residual symptoms in the inter-episode periods. Compliance to treatment was found to affect greatly the rate of relapses.

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Introduction

In mood disorders, the fundamental disturbance is a change in mood or affect, usually to depression or to elation. Most of these disorders tend to be recurrent and the onset of the individual episodes is often related to stressful events (ICD-10, 1992).

In unipolar depression, the prevalence in women is about two folds greater than in men, the onset ranges between ages 20 and 50. In bipolar disorder, the prevalence is equal for men and women, it begins from childhood to 50 years (Kaplan and Sadock, 1991).

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Silverstone et al. (1989) describe that the majority of patients with bipolar affective disorder relapse at least once during their lifetime, most several times. Factors which appear to play a facilitatory, and in some cases a causal, role in determining a relapse, include the season of the year, change in endocrine status, treatment with drugs affecting central monoamine neurotransmission and untoward life events.

Recurrent affective episodes are not infrequently preceded by prodromal symptoms. Giovanni, et al (1991) defined prodrom as as the early symptoms and signs that differ from, and are usually milder than those of the acute clinical phase. Molnar, et al (1987) discussed that there are three kinds of symptoms that may confound the study of pro-

dromes. One involves premorbid personality traits that may become more prominent at times of stress. A second area of overlap involves subclinical fluctuations in chronic affective conditions, e.g. patients with bipolar disorders who are clinically stable when treated with lithium usually display mood swings when followed up on a biweekly basis. Finally, after an acute episode of affective illness, despite apparent recovery, residual symptoms may persist.

The aim of the present study was to define the most important correlates of recurrence of mood disorders in a sample of Upper Egyptian patients. This would help in more understanding of the heterogeneity of mood disorders and broadening the scope of prevention and early management of relapses of affective episodes.

Subjects and Method

Fifty patients suffering from mood disorders were selected from the outpatient and inpatient psychiatric facilities in Assiut University Hospital, during the period from first of September 1992 Till the end of May 1993, according to the following inclusion criteria: (1) Primary mood disorder; (2) Recovery stage of an affective episode (hypomanic, manic, depressive or mixed); (3) At least one previous affective episode; and (4) Both males and females at different ages were included.

ICD-10 (WHO, 1992) was used for diagnosis and classification of mood disorders.

A semistructured psychiatric interview with the patient and a reliable informant including the following items: age at onset, duration since the first episode, duration of each episode, duration of each remission, seasonality of recurrence, the presence of precipitating factors, the mode of onset, the presence of prodromal symptoms, the presence of residual symtpoms, consistency of the clinical picture across the episodes, and the treatment status of the patient.

Results

This study was carried out on 50 patients with recurrent (more than one episode) mood disorder. Their sociodemographic data are shown in table (1). 24 patients (48%) were males and 26 patients (52%) were females; their ages ranged between 18 to 46 years (mean+ S.D. 29+10.7 years). 52% of the sample were unemployed, specially females (80.7%, $p<0.001$). 64% were illiterate or had only elementary education, with no significant differences between males and females. 75.8% of males were single compared to 50% of females ($p<0.01$).

Table (2) demonstrates the diagnostic breakdown and mode of onset of the current affective episodes (according to ICD-10). 48% of patients had bipolar affective disorder (BAD), and 52% had unipolar affective disorder (UAD). 17 males (70.8%) had recurrent BAD, current episode was mania in 15 patients (62.5%); more than half of them (37.5%) had rapid onset of the episodes. On the other hand, the majority of female patients (73.1%) had recurrent UAD, about two-thirds of them (50%) had gradual onset of depressive episodes.

Regarding the age at onset of the first affective episode (Table 3) it was found that recurrent BAD begins at a younger age (mean: 21.3 $\pm$8.2 years) than recurrent UAD (27.5$\pm$16.2 years). Affective disorders (unipolar or bipolar) started about 5 years earlier in females than in males. All differences were statistically insignificant.

13 patients (26% of the sample) showed definite seasonal pattern of recurrence of their affective disorders (Table 4). 9 patients (69.2%) had BAD ($p<0.01$).

Recurrence were limited to winter in 9 patients (69.2%) and summer in 4 patients (30.8), ($p<0.01$). 9 patients (69.2%) showed rapid recurrences (one or more episodes / year) ($p<0.01$).

Studying the role of precipitating factors in the initiation of affective episodes (table 5) showed that 58% of patients had suffered stressful events before the onset of their first episode; stress was rated as severe in 52% of them. With progress of the disorder, the number of patients suffering stress as well as the severity of stress gradually diminishes, so that preceding their third episode, only 24% of patients reported stress which was rated as mild/moderate in 22% of them ($p<0.05$). Neither the type of the disorder (UAD) nor the sex of the patient was found to be related to the presence or severity of stress.

Prodromal symptoms were reported by 23 patients (46%). The most frequent symptoms were anxiety (46%); mood changes, sleep disturbances (40% each), excessive dreams (30%), changed motive for life (28%), changed energy and vitality (26%), depersonalization and derealization (22% each). There was no significant differences in the type or frequency of prodromal symptoms between BAD and UAD or between male and female patients. These prodromal symptoms were found to begin 2 to 10 days before the onset of the affective episode, tend to last for a shorter period in depressive than in manic episodes, and to diminish gradually over successive episodes, but differences were statistically insignificant (Table 6).

The mean duration of the afective episode (mania or depression) is nearly constant (about one month) along the course of the illness (Table 7), with no significant differences between males or females.

Although the mean duration of remission (Table 8) does not vary between mania and depression at corresponding stages along the course of the illness, yet there is a significant reduction in the duration of remission with progress of the disorder and more frequent relapses, so that the duration of remission was 26 months following the first episode, 12-15 months following the second episode, and 8 to 10 months following the third episode. Differences were highly significant ($p<0.001$). No significant correlations were found between duration of episode and duration of remission in mania or depression.

During the periods of remission, 18 patients (36%) reported residual symptoms (Fig. 2) Lowering of mood, insomnia and anorexia were the commonest residual symptoms. There were no significant differences in these symptoms between BAD and UAD, or between male and female patients.

Looking for consistency of the clinical picture along the course of the affective disorder (i.e. exclusively recurrent manic or exclusively depressive episodes) (Table 9), it was found that 76% of patients ($p<0.01$) had constant clinical picture. 92.3% of these patients were females ($p<0.001$), suffering mainly depressive episodes (73.1%, $p<0.001$). Changeable clinical picture was more evident in male than in female patients (41.7% vs. 7.7&, $p<0.01$).

Table (10) illustraties the effect of compliance to treatment on the rate of recurrence of the affective disorders. All of the 50 patients had received treatment for the acute episodes, out of them 16 patients (32%) were compliant to maintenance treatment for at least 6 months, and only 10 patients (20%) continued prophylactic treatment for at least two years ($p<0.05$). Patients who were uncompliant to maintenance treatment developed the greatest number of relapses

Table 1
Sociodemographic Characteristics of Patients with Recurrent Affective Disorders

Parameter	Total (n=50)		Males (n=24)		Females (n=26)		p-value
Age (mean±SD)	29.3±10.7		28.4±10.4		30.1±10.9		N.S.
	No	%	No	%	No	%	
State of Employment							
Employed	15	30.0	13	54.2	2	7.8	
Student	9	18.0	6	25.0	3	11.5	<0.001
Unemployed	26	52.0	5	20.8	21	80.7	
Level of Education							
Illiterate	16	32.0	5	20.8	11	42.3	
Elementary	15	32.0	7	29.2	9	34.6	N.S.
Secondary	14	28.0	9	37.5	5	19.2	
University	4	8.0	3	12.5	1	3.9	
Marital Status							
Single	26	52.0	18	75.8	8	30.8	
Married	19	38.0	6	25.5	13	50.0	<0.01
Divorced	5	10.0	0	0.0	5	19.2	

Table 2
Diagnostic Breakdown and Mode of Onset of Current Affective Episode (According to ICD-10)

Diagnosis and mode of onset	Total (n=50)		Males (n=24)		Females (n=26)	
	No	%	No	%	No	%
I- Current B.A.D.	24	48.0	17	70.8	7	26.9
1- Mania	20	40.0	15	62.5	5	19.2
a-Rapid onset	13	26.0	9	37.5	4	15.4
b-Gradual onset	7	14.0	6	25.0	1	3.8
2-Depression	4	8.0	2	8.3	2	7.7
a- Rapid onset	1	2.0	1	4.2	0	0.0
b- Gradual onset	3	6.0	1	4.2	2	7.7
II- Current U.A.D. Depression	26	52.0	7	29.2	19	73.1
a-Rapid	10	20.0	4	16.6	6	23.1
b- Gradual onset	16	32.0	3	16.6	13	50.0

All differences are not statistically significant

(8.2+6.8, $p<0.05$). On the other hand, patients who were kept on maintenance and prophylactic treatment developed the fewest number of relapses (3.7+2.8, $p<0.05$). Those patients who were compliant to maintenance but not to prophylactic treatment had an intermediate rate of relapses (6.4+5.2).

Table 3
Age (in years) at Onset of the First Episode of Recurrent Affective Disorder

Parameter		Recurrent BAD	Recurrent UAD
Total:	Range	14-39	13-48
(n=50)	Mean±SD	21.3±8.2	27.5±16.2
Males:	Range	14-30	13--47
(n=24)	Mean±SD	24.6±6.5	29.3±15.5
Females:	Range	13-39	17-48
(n=26)	Mean±SD	18.6±12.6	25.7±12.4

All differences are statistically non-significant

Table 4
Seasonal Pattern of Recurrent Affective Disorder

Parameter	Patients with seasonal pattern of recurrence	
	No.	%
Number:	13/50	26.0
Sex		
Males	6	46.0
Females	7	53.8
Season of recurrence:		
Winter	9	69.2*
Spring	0	0.0
Summer	4	30.8
Autumn	0	0.0
Diagnosis:		
Current BAD	9	69.2*
Current UAD	4	30.8
Frequency:		
Every year:	9	69.2*
Every 2 years:	1	7.7
More than 2 years	3	23.1

Table 5
Role of Precipitating Factors in Recurrent Affective Disorder

Presence of precipitating factors	Severity of Precipitating Factor: Mild/moderate		Severe		Total	
	No	%	No	%	No	%
Before 1st episode	3	10.3	26	52.0	29	58.0
Before 2nd episode	8	66.7	4	8.0	12	24.0
Before 3rd episode	11	22.0	1	2.0	12	24.0
p (1st vs. 2nd)	<0.001		N.S.		<0.05	
p (1st vs. 3rd)	<0.01		<0.01		<0.05	
p (2nd vs. 3rd)	<0.001		N.S.			

Table 6
Duration (in days) of Prodromal Symptoms (mean ±SD)

Affective episode	Mania	Depression
First	5.5±1.8	4.8±3.8
Second	7.6±2.9	4.4±5.0
Third	4.5±2.5	3.8±2.3

All differences are statistically non-significant

Table 7
Duration (in months) of Recurrent Affective Episode (mean±SD)

Episode	Depression	Mania
First	1.0±0.78	1.0±0.8
Second	1.2±0.8	1.0±0.8
Third	1.2±0.8	1.1±0.8

All differences are not statisticaslly significant

Table 8
Duration (in months of Remission (mean±SD)

Remission after	Mania	Depression
First	26.7±80.1	26.1±40.1
Second	15.2±13.3	12.3±10.9
Third	8.0±14.7	10.6±6.3
p (1st vs. 2nd)	<0.005	<0.005
P (1 st vs. 3rd)	<0.001	<0.001
P (2nd vs. 3rd)	<0.001	<0.001

Table 9
Constancy of Clinical Picture Along the Course of Recurrent Affective Episodes

Clinical picture	Total		Males		Females	
	No	%	No	%	No	%
I- Constant	38	76.0*	14	58.3	24	92.3**
a- Depression	26	52.0	7	29.2	19	73.1
b- Mania	12	24.0	7	41.7	5	19.2
II- Changed	12	24.0	10		2	7.7***

* p<0.01 (total constant vs. total changed)
** p<0.001 (females constant vs. females changed)
*** p<0.01 (males changed vs. females changed)

Table 10
Effect of Compliance ot Treatment on the Rate of Recurrence of Affective Disorders

Stage of treatment	Compliant			Uncompliant		
	No	%	No. of attacks (mean+SD)	No	%	No. of attacks (mean+SD)
Acute	50	100.0	5.6±4.3	-	-	-
Maintenance	16	32.0	5.4±4.1	34	68.0	8.1±6.8*
Prophylactic	10	20.0	3.7±2.8**	40	80.0	6.4±5.2*

* p<0.05 (treated vs. untreated in the same stage)
** p <0.05 (treated vs. treated in different stages).

Discussion

The present study has declared some important correlates of recurrent affective (mood) disorder in a sample of Upper Egyptian patients.

Although the studied sample (50 patients) was relatively small, yet it reflected the frequently reported observation that bipolar affective disorder is more common in males (70.8%), while unipolar affective disorder is more common in females (73%); this is in accordance with many reports, e.g. Mollica (1986) and Kaplan & Sadock (1991).

Recurrent affective disorders were found to be more common in employed and unskilled males and unemployed (house-wives) females. This finding agrees with that of Okasha (1990) that mood disorders are more frequent among the semiprofessionals and unskilled males. Rodgers (1990) pointed out that depression is more common in females not having an employment outside the home.

There is a tendency for recurrent bipolar affective disorder to begin somewhat earlier in both sexes than recurrent unipolar affective disorder. This finding is similar to that of Goodwin et al. (1990).

50% of the female patients were married and 75% of the male patients were single. This difference in marital staus could partly be explained by the finding that most female patients (73%) had unipolar affective disorder with an age of onset around 25 years which gives females a better chance for marriage since the age of marriage for females in our subculture of Upper Egypt is usually below 20 years. On the other hand, males, because of socioeconomic factors, usually get married at a later age (25-30 years) which coincides with the disease onset in this study.

Another factor is that most male patients (70.8%) had a diagnosis of bipolar affective disorder which, because of the disturbing manic episodes, is more stigmatized in our culture than unipolar affective disorder. This diminishes the chance for marriage of male patients. Another view is that marriage, as a stress, increases the likelihood that women will be diagnosed as depression, but decreases the likelihood that men will be (Okasha, 1990) which partly accounts for the higher incidence of unipolar affective disorder in married women in this study.

The mode of onset of recurrent mania was more rapid than that of recurrent depression. This is consistent with the results of Winokur (1976).

Strictly seasonal pattern of recurrence was recorded by about one quarter of the studied patients, most of them (70%) had bipolar affective disorder with rapid frequency (one or more episodes per year); these findings are consistent with those of Wher, et al (1987). Recurrences were mainly in winter time (70%) and to a lesser extent (30%) in summer with no cases recorded in spring or autumn. This could probably be explained by the lack of definite demarcation between spring and summer times or autumn and winter times in the continental climate characteristic of Upper Egypt, so that the year is usually perceived as if it were two seasons only.

Hippocrates (1969) recognized that some individuals regularly experience depressive episodes on an annual basis, either recurrent winter depression or recurrent summer depression. In other seasons, the same individuals may be less severely depressed, euthymic, hypomanic or manic, Winter depression is usually accompanied by atypical symptoms including overeating, oversleeping, and carbohydrate graving, that is triggered by light deficiency and responds to phototherapy (Rosenthal, 1984). Patients with summer depression usually experience typical or endogenous symptoms such as insomnia and loss of appetite and weight (Boyce & Parker 1993).

The contrasting clinical pictures of summer and winter depressions are reminiscent of the contrasting pictures in dichotomous classifications of depression such as endogenous versus reactive, psychotic versus neurotic and typical versus typical (Davidson, et al 1982)

Precipitating factors were found to play a more significant role in the initiation of the first affective episode (in 58% of patients) than in sucbsequent episodes (24% of patients).

Hunt et al. (1992) found an excess of events during the month immediately preceding relapse of mania or depression. The major events were bereavement, divorce, personal injury or disease, loss of job and retirement. These stressors (or provoking agents) usually act on vulnerable subjects to precipitate a relapse (Brown, et al 1986). Vulnerability indicates predisposition to affective disorder characterized by greater sensitivity to stress but with no added risk in its absence (Rodgers, 1990). Also, the severity of stress required to precipitate the episode was found to diminish gradually as the disease progress. This observation is similar to many studies (Perris, 1984 and Cassano, et al 1989) which demonstrated that either more psychosocial stressors were involved in the initiation of first episode than in subsequent episodes of major affective disorder, or that psychosocial stressors appeared to have less impact on episodes occurring later in the course of illness, than on the initial episode (Kindling phenomenon).

Kindling model provides an interesting but non-homologous paradigm (i.e. kindled seizures do not clinically resemble affective illness) in which events that

are initially triggered begin to occur spontaneously (Post, et al 1986). These psychosocial stressors may be associated with neurobiological encoding of memory-like functions, thus providing a long-term vulnerability to subsequent recurrences and perhaps a mechanism for the retriggering of episodes with lesser degrees of psychosocial stress (Robert & Post 1992). So that with sufficient repetitions of episodes, specific triggers may no longer be required to induce a full-blown syndrome.

About half of the studied sample recorded prodromal symptoms in the form of anxiety, mood changes, sleep disturbances, excessive dreams or night terrors, changes in the motive for life, changes in the energy and vitality, depersonalization and derealization in the same order of frequency. These symptoms were similar in both sexes having either mania or depression. The most frequently reported depressive prodromal symptoms are depressed mood, loss of energy, and difficult concentrations.

As for manic episodes, increased activity, elevated mood and decreased need for sleep are the commonest prodromal symptoms (Hopkinson, 1985). Within each patient there is a striking consistency in the prodromal symptoms that proceed each episode (Molnar, et al 1987). The prodromal symptoms of relapse closely resemble those of the first episode (Fava, et al 1990). Also, these prodromal symptoms were nearly constant over time in each individual. This finding is similar to results of Paykel, et al (1976). The duration of prodromal symptoms diminishes while the course of recurrent affective disorder progresses. Patients with bipolar illness, despite their characteristic lack of insight, often are able to recognize prodromal symptoms (Court, 1989).

Since prodromal symptoms may proceed the full syndrome by weeks or months, if patients and their families are educated to recognize the patient's characteristic prodromal symptoms, recurrence of affective disorder could be treated earlier and perhaps more effectively by using lower doses of medication (Molnar, et al 1987; and Kupfer, 1989).

The mean duration of affective episodes (mania or depression) was nearly constant (about one month, ranged between one to three months) in both sexes and in different episodes along the course of illness. This finding is consistent with many reports since Kraeplin (1921) who stated that the duration of affective episodes varies considerably but is usually one to three months.

About one third of the studied cases had residual symptoms of depressive nature (lowering of mood, insomnia and anorexia) during the periods of remission. Similar symptoms were reported by Akiskal, et al (1993) who pointed out that these symptoms may be interpreted as a prodroma of a depressive relapse if they rapidly increased in intensity.

The inter-episode period (remission) did not differ between male or female patients having either unipolar or bipolar affective disorder; but it significantly varies inversely with the number of relapses (i.e. it is much shorter between recent episodes than between earlier ones) and it insignificantly varies inversely with the duration of the episode (i.e. the longer the episode the shorter will be the remission). This was more apparent in later episodes especially depressive ones. Coryell and Tsuang (1985) found that, when the affective episodes are too frequent, they will be too long-standing and the interval between episodes will be too short.

In a series of studies with large number of subjects, it has been described that unipolar and bipolar affective disorders

tend to be not only recurrent but also progressive in the sense that there are long intervals between early episodes, but with successive recurrences, there is progressive shortening of these intervals of remission (Goodwin, et al 1990).

In the majority of patients with recurrent affective disorder (76%) the clinical picture was constant (they had only recurrent manic or recurrent depressive episodes) throughout the course of their illness with no sex differences. On the other hand, in patients with changeable clinical picture (24%), male predominated (41.7% vs. 7.7%). These findings are in agreement with those of Paykel, et al (1976) who demonstrated consistency of the clinical picture over time in each individual in recurrent affective episodes.

Compliance to treatment following control of acute episodes was found to have a great impact on the rate of recurrence of affective disorder. So that, patients who were kept on maintenance treatment suffered fewer relapses (mean = 5.4) than those who neglected it (mean = 8.1). Also patients who were kept on prophylactic treatment had much less relapses (mean = 3.9) than those who discontinued it (mean = 6.3). This finding agrees with the frequently reported evidence from controlled studies (e.g. Kaplan & Sodack 1991) that remaining on treatment considerably reduces the relapse rate of affective disorder.

In conclusion this study has revealed some important features of the pattern of recurrence of mood disorders in Upper Egyptian patients. The onset of recurrent mania is more rapid than that of recurrent depression. The duration of the affective episode is nearly constant (about one month). Strict seasonal pattern of recurrence was observed in only 25% of patients, most of them had rapid cycling. Precipitating factors play a significant role in the initiation of the first episode than subsequent ones. Prodromal symptoms were reported by half of the sample, and residual symptoms by one third of the sample. The clinical picture was constant over the course of the illness in 75% of patients. The inter-episode period varies inversely with the number and duration of relapses. Compliance to treatment has a great impact on the course of illness.

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Le mode de reccurence des troubles de l'humeur. Une étude clinique en haute Egypte

50 patients de haute Egypte ont été étudiés à l'aide d'un entretien psychiatrique semi-structuré afin de caractériser leur mode de rechute. 48% souffraient de trouble affectif bipolaire (plus fréquent chez les hommes) et 52% souffraient de trouble affectif unipolaire (plus fréquent chez les femmes). Nous avons identifié quelques caractéristiques significatives tel que l'âge de début des épisodes, l'aspect saisonnier, le rôle des facteurs déclenchants, les symptômes avant-coureur, la variation du tableau clinique, les symptômes résiduels et le rôle de l'observance thérapeutique.

أنماط المعاودة فى الاضطرابات الوجدانية

دراسة إكلينيكية فى صعيد مصر

أجريت هذه الدراسة على خمسين من مرضى الاضطراب الوجدانى، وقد كانت تشخيصات العينة هى : اضطراب وجدانى أولى، كما كانت النوبة الحالية : إما هوس أو اكتئاب أو النوع المختلط من الإكتئاب والهوس، وكان يستلزم أن يكون المريض قد أصيب من قبل بنوبة اضطراب وجدانى واحدة على الأقل. وقد وجد أن متوسط عمر المريض عند حدوث أول نوبة واحد وعشرين عاما فى مرضى الاضطراب الوجدانى ثنائى القطبين وسبعة وعشرين عاما فى مرضى الإكتئاب المتناوب. وقد ظهر أن أربعة وعشرين (٤٨٪) من المرضى كانوا يشكون من اضطراب وجدانى ثنائى القطبين، و (٥٢٪) من المرضى كانوا يشكون من اكتئاب أحادى القطب، ستة عشر (٦٢٪) منهم كانت لديهم بداية بطيئة للمرض. وقد لاحظنا من هذه الدراسة أن متوسط مدة نوبة المرض حوالى شهر كما أن مدة هجوم المرض تقل كلما توالت نوبات المرض، وتظهر النتائج أن ثمانية وثلاثون (٧٦٪) مريضاً وجدت لديهم صورة إكلينيكية ثابته فى كل نوبات مرضهم. وأن ثلاثة عشر (٢٦٪) مريضاً وجد لديهم نمط ثابت فى معاودة المرض فى فصل بذاته.

وقد وجدنا فى هذه الدراسة أن تسعة وعشرين مريضا (٥٨٪) توجد لديهم أحداث بيئية أو اجتماعية شديدة سبقت النوبة الأولى، ولكن قل دور هذه الأحداث فى النوبات التالية للمرض، وفى أربعة وعشرون (٤٨٪) من مرضى هذه الدراسة وجد أنهم يشعرون بأعراض متقدمة للأعراض الفعلية للمرض ومن أكثر هذه الأعراض المتقدمة للمرض هو القلق والأرق وتقلبات المزاج وأن أثنان وعشرون (٤٤٪) من مرضى هذه الدراسة كان لديهم تاريخ إيجابى لوجود شخص أو أكثر فى العائلة مريض نفسيا بمرض مشابه.

وقد استخلصنا من هذه الدراسة أن التدخل العلاجى فى مرض الاضطراب الوجدانى ليس لعلاج الأعراض الحادة للمرض فقط ، ولكن لتقليل نسبه معاودة المرض، وذلك بمداومة العلاج لفترة طويلة وهو ما يسمى بالعلاج الوقائى.