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REAL-LIFE FUNCTIONING DOMAINS IN PATIENTS WITH AFFECTIVE DISORDERS

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SUMMARY

Background: *This study investigates impairments in real-life functioning domains among patients with affective disorders (depression and mania), addressing gaps in understanding the relationship between symptom severity and functional outcomes. The research aims to assess real-life functioning domains in clinical populations exhibiting varying degrees of affective disorder severity.*

Subjects and methods: *A cross-sectional study was conducted with 23 outpatients (16 with depression, 7 with mania) and 44 healthy controls. Participants were assessed using the Hamilton Depression Rating Scale (HDRS), Young Mania Rating Scale (YMRS), and Specific Levels of Functioning Scale (SLOF). Statistical analyses included Chi-square tests for functional impairments and Pearson's correlations to examine associations between symptom severity and functioning.*

Results: *Key findings demonstrate significant functional deficits in depressive patients across all measured domains (physical functioning, personal care, interpersonal relationships, social acceptability, activities, and work skills), with particularly pronounced impairments in physical functioning ($\chi^2=12.25$, $p<0.001$) and personal care skills (universally low scores). Manic patients exhibited comparable domain-specific impairments, though with less pronounced severity differentiation. Notably, symptom severity (measured via HDRS/YMRS scales) showed minimal correlation with functional outcomes, with the exception of an inverse relationship between depression severity and social acceptability ($r=-0.56$, $p<0.03$). Limitations include modest sample sizes and cross-sectional design, warranting future longitudinal research with larger cohorts.*

Conclusions: *Affective disorders broadly impair real-life functioning irrespective of symptom severity, except for depression's inverse relationship with social acceptability. This finding suggests that functional impairments in affective disorders may represent independent disease dimensions rather than simple byproducts of symptom intensity, emphasizing the need for targeted psychosocial interventions alongside symptom management.*

Key words: *affective disorders – depression – mania - real-life functioning - symptom severity - functional rehabilitation*

Abbreviations: *AD – affective disorders; RLF – real-life functioning; HDRS - Hamilton Rating Scale for Depression; YMRS – Young Mania Rating Scale; SLOF – Specific Level of Functioning Scale*

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INTRODUCTION

The quality of life for individuals with affective (depressive and bipolar) disorders encompasses multiple dimensions that must be considered when assessing and enhancing their well-being. These include psychiatric manifestations (emotional and cognitive symptoms of the disorder), somatic complaints, social well-being, and functional capacity in performing daily activities (Maj et al. 2020).

Research indicates that functional deficits associated with bipolar disorder significantly compromise quality of life by impairing social and occupational functioning over the longitudinal course of the illness (Rosa et al., 2006). Consequently, these impairments adversely affect independent daily functioning, often necessitating intervention by specialized mental health professionals.

Existing literature predominantly examines cognitive and psychosocial dysfunction in individuals with affective disorders (AD), yet research investigating functional impairments in their daily lives remains limited (Varghese et al. 2022). Notably, few published studies have systematically explored this issue or proposed interventions to enhance quality of life for this population (van der Voort et al. 2015). Consequently, a significant gap persists in understanding real-world functional capacities among those with AD. Investigating these difficulties could enhance our understanding of their lived experiences and inform the development of targeted support services and resources to improve their quality of life. Moreover, existing research has not established a clear correlation between symptom severity in AD and real-life functional impairments. As such, functional assessments should be conducted independently of symptom severity evaluations to ensure accurate characterization of patients' daily functioning.

The research aims to assess real-life functioning domains in clinical populations exhibiting varying degrees of affective disorder severity.

SUBJECTS AND METHODS

This clinical investigation was conducted over a nine-month period from March to December 2024, at the Outpatient Department of Psychiatric Hospital no. 1 Named after N.A. Alexeev (Moscow, Russia). The study

utilized a naturalistic, cross-sectional design and complied with the Declaration of Helsinki. Ethical approval was granted by the hospital's local ethics committee, and all participants provided informed voluntary consent.

The study included 23 outpatients diagnosed with mood disorders (MD) according to ICD-10 criteria (F30–F39).

Participants were assigned to three groups:

- **Group 1 (n=16):** individuals presenting with depressive episodes of different severity levels, either as part of recurrent depressive disorder or bipolar affective disorder;
- **Group 2 (n=7):** individuals with current manic episodes with or psychotic features as part of bipolar affective disorder;
- **Group 3 (n=44):** individuals without any current or past history of mental disorders.

Exclusion criteria comprised intellectual disability, substance abuse during evaluation, and declining participation.

The following psychometric tools were used:

- *The Hamilton Depression Rating Scale (HDRS)* - an 17-item clinician-administered instrument to measure the severity of depressive symptoms in individuals with mood disorders (Hamilton 1960)
- *The Young Mania Rating Scale (YMRS)* - an 11-item clinician-rated scale assessing manic symptoms (Young et al. 1978)
- *Specific Levels of Functioning Scale (SLOF)* evaluation of levels of real-life functioning for both clinical and non-clinical population (Schneider & Struening 1983, Mucci et al. 2014). The instrument comprises 43 behavioral items, each evaluated on a 5-point Likert scale (ranging from 1 = minimal functional capacity to 5 = optimal functional performance), with descriptive anchors indicating behavioral frequency and/or degree of autonomy. Total scores follow a positive directional relationship, whereby elevated values reflect superior functional performance within the specified life domain. These items are systematically organized into six functional domains: (1) physical functioning (5 items), (2) personal care skills (7 items), (3) interpersonal relationships (7 items), (4) social acceptability (7 items), (5) activities of community living (11 items), and (6) work skills (6 items). Key advantages of this tool include: high inter-rater reliability, sensitivity to changes in functional status over time, and comprehensive evaluation of real-world adaptive functioning (Mucci et al. 2014) The manuscript validating the SLOF scale for Russian-language populations is currently in preparation for publication.

Statistical analyses were performed using IBM SPSS (version 29.0.1.1) and Microsoft Excel. Functional impairments across various life domains in patients with depression (Group 1) or mania (Group 2) were evaluated via the Chi-square test. The relationship between symptom severity (depression/mania) and real-life functioning was examined using Pearson's correlation coefficient.

RESULTS

Sociodemographic characteristics

Age distribution reveals significant intergroup variability (see table 1). Group 2 demonstrates the highest mean age (41.29 ± 19.22 years), substantially exceeding Group 1 (28.06 ± 9.23) and Group 3 (33.82 ± 7.78). This age disparity corresponds with disease duration patterns, where Group 2 shows markedly longer illness chronicity (11.67 ± 8.55 years) compared to Group 1 (2.02 ± 0.64 years).

Educational attainment patterns differ substantially between groups. While Group 2 shows the highest undergraduate education rate (71.4%), it completely lacks postgraduate representation (0%). Conversely, Group 1 contains almost half postgraduate-educated participants (43.8%), and Group 3 demonstrates the most balanced educational distribution. Marital status distribution follows distinct group patterns, with Group 2 containing the highest proportion of married participants (57.1%) compared to Group 1 (18.8%) and Group 3 (38.6%).

Economic indicators also reveal important intergroup differences. Group 1 shows the highest dependency rate (37.5% supported by relatives), while Group 3 contains the most economically independent population with the highest proportion of above-average income earners (15.9%). Hospitalization frequency differs markedly between Groups 1 and 2, with Group 2 demonstrating substantially higher hospitalization rates (2.14 ± 1.46 vs. 1.31 ± 0.48 times).

The first cohort (Group 1) is characterized by younger individuals with higher educational attainment but greater economic dependency, exhibiting a more recent disease onset. In contrast, the second cohort (Group 2) consists of older participants with lower educational levels yet greater economic stability and a longer disease duration. The clinically healthy individuals (Group 3) demonstrates intermediate characteristics across most variables, while distinguishing itself with notable advantages in both educational and economic indicators.

Functional impairments measured using SLOF

Functional impairments were assessed utilizing the Specific Levels of Functioning (SLOF) scale.

To examine the domains of functional deterioration in patients with depressive and manic episodes, real-life functioning was assessed using standardized measures. The performance levels of clinically healthy individuals served as a normative reference for comparative analysis.

Table 1. Comparative Analysis of Sociodemographic Characteristics Across Groups

Variables	Group 1 (n=16)	Group 2 (n=7)	Group 3 (n=44)
Age (years)	28.06±9.23	41.29±19.22	33.82±7.78
Disease duration (years)	2.02±0.64	11.67±8.55	-
N of hospitalizations (times)	1.31±0.48	2.14±1.46	-
Education			
General secondary education	18.8% (n=3)	28.6% (n=2)	29.5% (n=13)
Undergraduate	31.3% (n=5)	71.4% (n=5)	29.5% (n=13)
Postgraduate	43.8% (n=8)	0% (n=0)	41.0% (n=28)
Marital status			
Single	56.3% (n=9)	42.9% (n=3)	52.3% (n=23)
Living with partner	25.0% (n=4)	0.0% (n=0)	9.1% (n=4)
Married	18.8% (n=3)	57.1% (n=4)	38.6% (n=17)
Income			
Supported by relatives	37.5% (n=6)	14.3% (n=1)	9.0% (n=4)
Low level	6.3% (n=1)	14.3% (n=1)	25.0% (n=11)
Average level	43.8% (n=7)	57.1% (n=4)	38.7% (n=17)
Above average level	6.3% (n=1)	0% (n=0)	15.9% (n=7)
High level	6 .3% (n=1)	14.3% (n=1)	11.4% (n=5)

Table 2. Real-world functioning in clinically healthy individuals (Group 3)

SLOF scales	Decriptive statistics									Tests of normality (Kolmogorov-Smirnov)	
	M	Me	Mo	SD	A	E	Q_1	Q_2	Q_3	Statistic	p
Physical functioning	24.48	25.00	25.00	1.11	2.45	6.06	24.25	25.00	25.00	0.43	0.00
Personal care skills	34.77	35.00	35.00	0.71	4.12	19.19	35.00	35.00	35.00	0.49	0.00
Interpersonal relationships	28.86	31.00	35.00	5.85	0.49	-1.22	23.25	31.00	35.00	0.20	0.00
Social acceptability	30.45	31.00	31.00	3.14	0.26	0.70	28.00	31.00	33.00	0.11	0.18
Activities	53.98	55.00	55.00	1.89	2.12	4.21	54.00	55.00	55.00	0.37	0.00
Work skills	27.00	28.00	30.00	3.47	1.34	1.38	26.00	28.00	30.00	0.19	0.00

Note: Measures of Central Tendency (M - mean, Me - median, Mo - mode), Measures of Dispersion (SD - standard deviation, Q_1–Q_3 - quartiles), Shape of Distribution (A - skewness, E - kurtosis). P-values provided.

Table 2 presents descriptive statistics and normality test results for the Specific Levels of Functioning (SLOF) scales in clinically healthy individuals (Group 3). The SLOF assesses various domains of real-world functioning, including physical functioning, personal care skills, interpersonal relationships, social acceptability, activities, and work skills.

Physical Functioning & Personal Care Skills

High median scores (Me = 25.00 & 35.00, respectively) suggest optimal functioning in these areas. However, strong negative skewness (A = -2.45 & -4.12*) and high kurtosis indicate a ceiling effect - most participants scored near maximum.

Interpersonal Relationships: A wider spread (SD = 5.85 and moderate skewness (A = -0.49)) suggest variability in social interactions, with some individuals scoring significantly lower.

Social Acceptability: Near-normal distribution (A = -0.26, E = 0.70), with the Kolmogorov-Smirnov test (p = 0.18) indicating normality.

Work Skills: Negative skewness (A = -1.34) hints that most participants scored towards higher competency.

Table 3. Reference Values for SLOF Scale Measures in Clinically Healthy Subjects (Group 3)

SLOF scales	Levels of functioning (points)		
	low	medium	high
Physical functioning	≤24	25	≥26
Personal care skills	≤35	-	≥36
Interpersonal relationships	≤23	24-35	≥36
Social acceptability	≤28	29-32	≥33
Activities	≤54	55	≥56
Work skills	≤26	27-30	≥31

To categorize individuals' functioning levels (low, medium, high), the following analytical approaches were applied based on the distributional properties of the respective scale scores (see table 3):

1. Normally Distributed Scales (e.g., *Social Acceptability*)

- Thresholds were determined using mean (M) and standard deviation (SD):
- Low level: Scores ≤ M - (2/3) SD
- Medium level: Scores within (M - (2/3) SD; M + (2/3)SD)
- High level: Scores ≥ M + (2/3) SD

2. Non-Normally Distributed Scales (e.g., *Physical Functioning, Personal Care Skills, Interpersonal Relationships, Activities, Work Skills*)

- Quartile-based (Q) classification was applied:
- Low level: Scores ≤ Q_1 (first quartile)
- Medium level: Scores between Q_1 and Q_3 (third quartile)
- High level: Scores ≥ Q_3 (see table 3)

Subsequent analyses measured functioning levels in clinical populations (Group 1 and Group 2), with results compared against these normative benchmarks.

The study revealed significant impairments in the daily functioning of individuals with depression (Group 1) across multiple life domains (see figure 1). The most pronounced deficit was observed in *physical functioning*, where a low level was predominant (93.8%). *Personal care skills* were notably affected, with all depressed patients demonstrating low functioning in this domain. In the realm of *interpersonal relationships*, a medium level of functioning was most common (81.2%), suggesting some retained social capacity despite the illness. *Social acceptability* showed mixed results, with low and medium levels being equally prevalent (50.0% in each group), indicating variability in social adaptation. Additionally, patients frequently exhibited low functioning in *daily activities* and *work skills* (87.5% in each group), highlighting challenges in productivity and routine tasks. These findings underscore the pervasive impact of depression on multiple aspects of functioning, emphasizing the need for targeted therapeutic interventions.

Functioning levels in patients with manic episodes (Group 2) varied less distinctly (see figure 2). Low and medium levels were equally distributed in *physical functioning*, *activities,* and *work skills* (71.4% and 28.6%, respectively). All patients exhibited low functioning in *personal care skills*. For *interpersonal relationships*, nearly all patients (except one) had medium functioning, though this trend was not statistically significant (p>0.05). Similarly, *social acceptability* was predominantly low (except one case), but without significant difference (p>0.05).

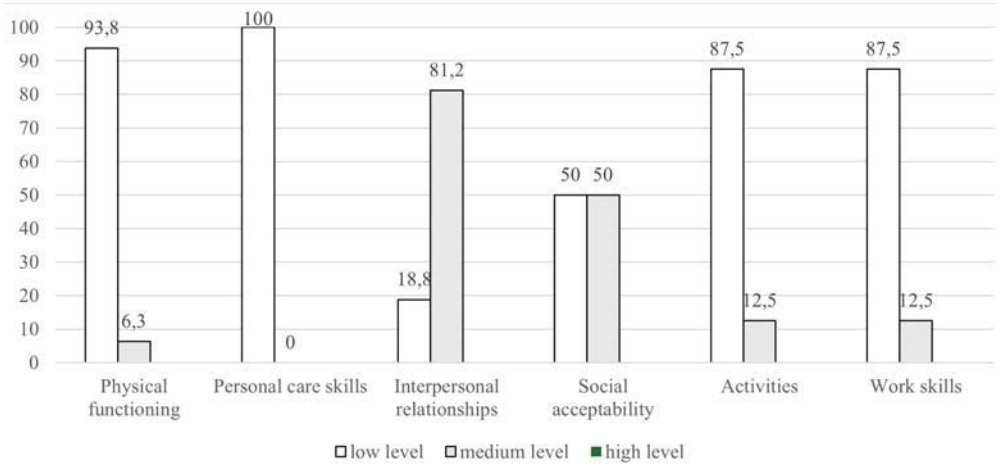

Figure 1. Significant impairments in the daily functioning of individuals with depression

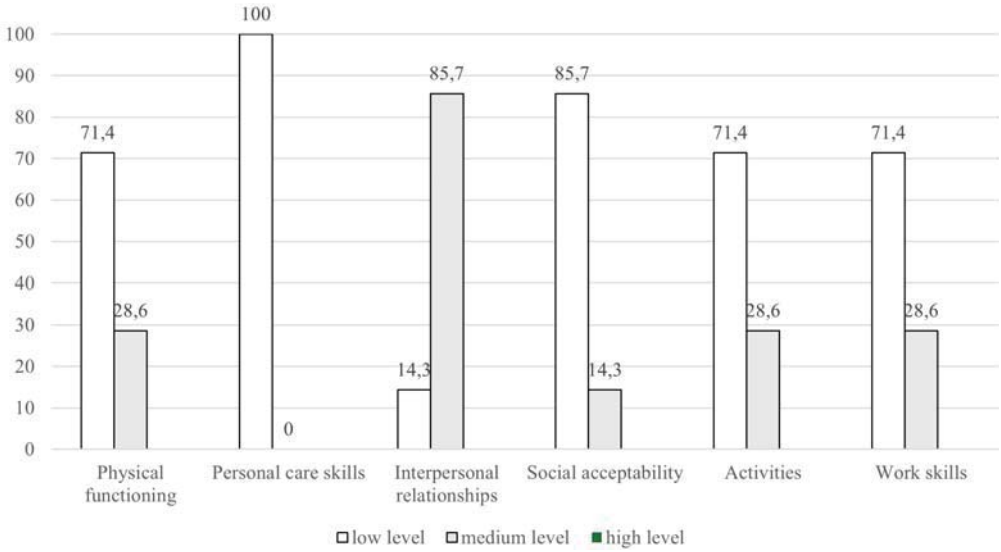

Figure 2. Razine funkcioniranja kod pacijenata s maničnim epizodama

Table 4. Relationship Between Symptom Severity and Real-Life Functioning Domains

SLOF scales	HRSD		YMRS	
	r_s	p	r_s	p
Physical functioning	0.30	0.26	0.32	0.48
Personal care skills	0.37	0.16	0.32	0.49
Interpersonal relationships	0.45	0.08	0.10	0.83
Social acceptability	-0.56*	0.03	0.45	0.31
Activities	0.12	0.65	0.15	0.75
Work skills	0.34	0.200	0.23	0.62

Note: HRSD - Hamilton Rating Scale for Depression; YMRS – Young Mania Rating Scale; SLOF – Specific Level of Functioning Scale, r_s - Pearson correlation coefficient, p - p-value

Depression (Group 1) showed more pronounced deficits, particularly in *physical functioning* and *daily tasks*. Mania (Group 2) presented milder but pervasive challenges, with less statistical differentiation between functioning levels. Both groups shared severe difficulties in *personal care skills*, highlighting a critical area for therapeutic focus.

Relationship Between Severity of Depression/Mania and Real-Life Functioning

This study examined potential relationships between symptom severity (depression and mania) and real-life functioning. Statistical analysis employed Pearson's correlation coefficient.

A statistically significant negative correlation was observed between the severity of depressive symptoms and real-life functioning assessed (see table 4). Positive correlations approaching significance were found between depression severity and *interpersonal relationships* ($r = 0.45$, $p = 0.08$), and *personal care skills* ($r = 0.37$, $p = 0.16$). This relationship suggests that individuals experiencing more pronounced depressive symptoms tend to exhibit greater impairments in daily functioning. Moderate effect sizes ($r = 0.30$-0.45) were observed for several depression-related correlations despite non-significant p-values, suggesting potential clinical relevance. Manic symptoms (YMRS) showed no significant correlations with any SLOF domain, though the strongest positive association was with *social acceptability* ($r = 0.45$, $p = 0.31$) This indicates that functional outcomes may be less directly influenced by manic symptoms in the examined population.

DISCUSSION

The research aims to assess real-life functioning domains in clinical populations exhibiting varying degrees of depression/mania severity.

The current study's findings align with prior research demonstrating the association between depression and functional impairments. Depressed individuals frequently experience physical limitations that may stem from somatic symptoms commonly observed in this population (Trivedi 2004). Furthermore, the motivational deficits characteristic of depressive states often result in diminished self-care behaviors, manifesting as neglect of personal hygiene and disorganized living spaces. Existing literature suggests a bidirectional relationship between depression and social functioning, whereby depressive symptoms may both precede and follow reductions in social support networks throughout various life stages (Eberhart & Hammen 2006; Vanderhorst & McLaren 2005). Cognitive models of depression posit that affected individuals tend to interpret ambiguous social cues negatively, internalize these perceptions, and consequently withdraw from social interactions (Joiner & Coyne 1999). This cognitive bias may explain the observed tendency for depressed individuals to selectively attend to negative social stimuli while experiencing reduced feelings of social belonging (Steger & Kashdan 2009).

The observed impairments in real-life functioning domains among individuals experiencing manic episodes align with established symptom profiles and previous empirical findings. The noted limitations in physical functioning appear directly attributable to characteristic manic symptoms, given that manic states typically involve heightened energy levels and psychomotor agitation, potentially linked to dopaminergic dysregulation (Minassian et al. 2011). Regarding interpersonal functioning, the current findings corroborate existing literature demonstrating significant social impairments during manic episodes. Previous research has operationalized different forms of aggressive behaviors, including physical, verbal and relational aggression (manipulation of social bonds) (Crick et al. 2007; Kaye & Erdley 2011). These behavioral patterns may emerge reactively in response to perceived threats or proactively as part of the symptomatology (Poulin & Boivin 2000). The cumulative effect of these tendencies likely contributes to the social acceptability challenges observed in manic patients. The consistency between these findings and prior research reinforces the clinical understanding of mania as a condition with multidimensional functional consequences.

The current study further examined potential associations between symptom severity in depression

and mania with real-life functioning outcomes. Contrary to initial expectations, the analysis revealed no significant relationship between symptom severity and overall functional impairment across most domains. However, a noteworthy negative correlation emerged between depressive symptom severity and *social acceptability*, suggesting that individuals with more severe depression demonstrated greater adherence to social norms. This finding may be explained by characteristic features of depressive symptomatology. As a mood disorder depression often leads to heightened self-monitoring behaviors. The increased psychological distress associated with severe depression might consequently motivate individuals to maintain socially appropriate conduct, possibly as a compensatory mechanism to mitigate the interpersonal difficulties commonly associated with the disorder. The findings align with existing literature underscoring the debilitating impact of depression on psychosocial functioning, whereas the role of mania in functional impairment appears more variable and context-dependent. Further research with larger and more diverse samples is warranted to clarify these relationships. These results highlight the clinical importance of incorporating functional rehabilitation strategies into treatment programs, emphasizing the restoration of daily living skills alongside symptom management. The dissociation between symptom severity and functional outcomes suggests that comprehensive intervention approaches should address both clinical symptoms and real-world adaptive capacities independently.

Limitations

Limitations include classifying individuals with bipolar disorder and unipolar depression into the same category, modest sample sizes and cross-sectional design, warranting future longitudinal research with larger cohorts.

CONCLUSIONS

The findings demonstrate that individuals with depression and mania exhibit impairments across key domains of real-life functioning, including physical functioning, personal care, interpersonal relationships, social acceptability, daily activities, and occupational skills. Notably, however, symptom severity in depression and mania shows no significant association with overall functional impairment, with one exception: a negative correlation was observed between the severity of depressive symptoms and functioning in the domain of *social acceptability*.

These results suggest that affective disorders - regardless of symptom severity - may lead to broad functional deficits in multiple life domains.

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Conflict of interest: *None to declare.*

Contribution of individual authors:

Study design: Alexey Pavlichenko, Oksana Fisenko.
Literature review: Oksana Fisenko, Tatiana Popova.
Data collection: Oksana Fisenko, Alexey Pavlichenko.
Statistical analysis: Oksana Fisenko.
Manuscript writing: Oksana Fisenko, Alexey Pavlichenko.
All authors approved the final manuscript.

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