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Original Research

Mood disorders among adults

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ABSTRACT:

Background: The burden of mood disorders has become increasingly relevant as this causes a high degree of individual and social suffering. The present study to determine mood disorders among adults. **Materials & Methods:** 110 adults with mood disorders of both genders were subjected to Mood Disorder Questionnaire (MDQ) was used for screening bipolar spectrum disorders. The total MDQ score was obtained by summing the "yes" answers in the symptom checklist part. **Results:** Out of 110 patients, males were 50 and females were 60. Mood disorders were depressive disorders in 44, bipolar disorders in 40 and substance induced in 26 patients. The difference was significant (P< 0.05). MDQ score below 7 value was seen in 65 and 7 or more in 45 patients. The difference was significant (P< 0.05). **Condusion:** Depressive disorder and bipolar disorders were most commonly occurring mood disorder among adults.

Key words: Bipolar disorder, Mood Disorder Questionnaire, depression

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INTRODUCTION

Aging of the population is a significant public health challenge. It is estimated that by 2050, 80% of residents in middle- and low-income countries will be people over 60 years of age. In 2020, over 1 million Poles will be 90 years old, and in 2035 over 25% will be 65 and over. The progressive phenomenon of an aging population around the world, and particularly on the European continent, carries a number of risks, including the mental health of seniors, such as mood disorders.[1]

Existing studies on mood disorders in the ED have one or more significant limitations, including reliance on a single site, small sample sizes, use of screening measures lacking established psychometrics or exclusive focus on depressive symptoms rather than examining both depression and mania. Also, existing studies have not determined whether patients actually desire help for their mood disorder to be initiated in the ED, the proportion who are already in active treatment or the kinds of interventions that are preferred.[2]

Mental health is a fundamental and inseparable component of health and is directly related to the individual, family, and community well-being.[3] The burden of mood disorders has become increasingly relevant as this causes a high degree of individual and social suffering. It has been estimated that 15.4% of adults had a mood or anxiety disorder in the last 12 months. It has been also estimated that mental disorders, including anxiety and mood disorders, accounts for about 6% of all disability-adjusted life-years lost worldwide, representing more than all neurological and substance use disorders combined.[4]

The primary health care strategy involves the organization of health systems in three levels of care with progressive complexity (i.e., the primary, secondary, and tertiary levels). The aim of the primary health care strategy is maximizing the health in a community through an efficient use of local resources and following equity and solidarity principles. By maximizing the overall level of health in the community, the primary health care strategy can contribute to promote the economic and social development of low- and middle-income countries. Healthcare services utilization is high among individuals with mood disorders.[5] The present study to determine mood disorders among adults.

MATERIALS & METHODS

The present study comprised of 110 adults with mood disorders of both genders. All were informed regarding the study included after obtaining their written consent.

Demographic data such as name, age, gender etc. was recorded. All enrolled subjects were subjected to Mood Disorder Questionnaire (MDQ) was used for screening bipolar spectrum disorders. MDQ is a one-page self-assessment questionnaire and the duration of the questionnaire was estimated to be 5–10 min. The total MDQ score was obtained by summing the "yes" answers in the symptom checklist part. Results thus obtained were subjected to statistical analysis. P value less than 0.05 was considered significant.

RESULTS

Table I Distribution of subjects

Total- 110		
Gender	**Males**	**Females**
Number	50	60

Table I shows that out of 110 patients, males were 50 and females were 60.

Table II Assessment of mood disorders

Mood disorders	Number	P value
Depressive disorders	44	0.05
Bipolar disorders	40	
Substance induced	26	

Table II, graph I shows that mood disorders were depressive disorders in 44, bipolar disorders in 40 and substance induced in 26 patients. The difference was significant (P< 0.05).

Graph I Assessment of mood disorders

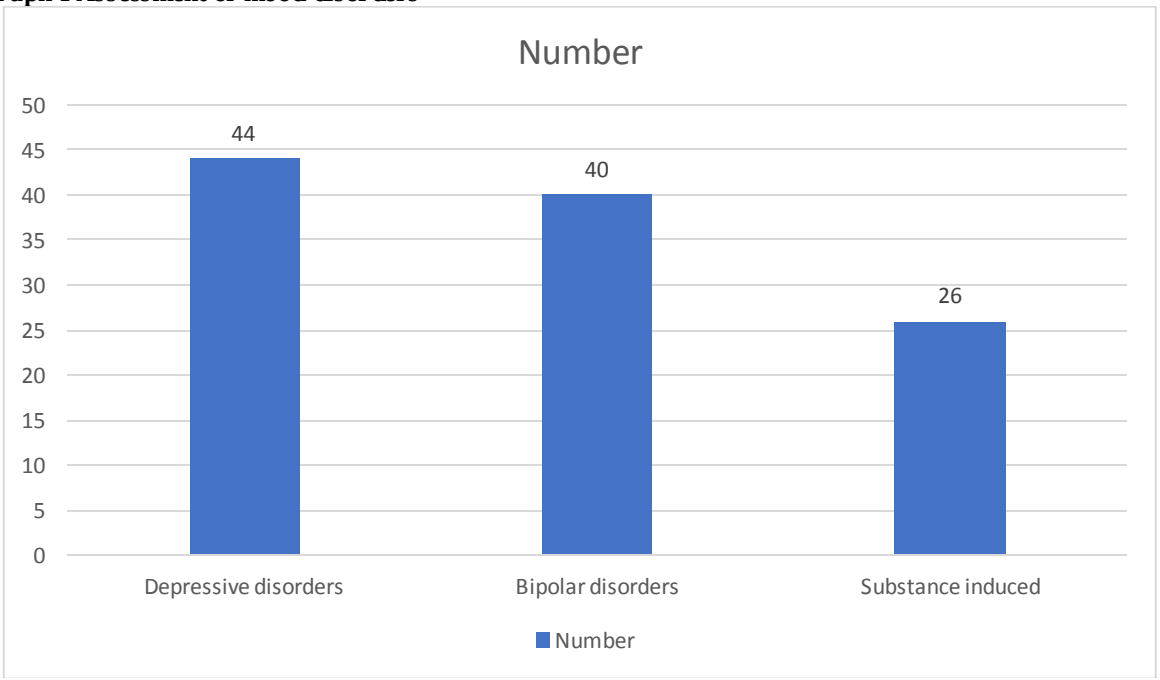
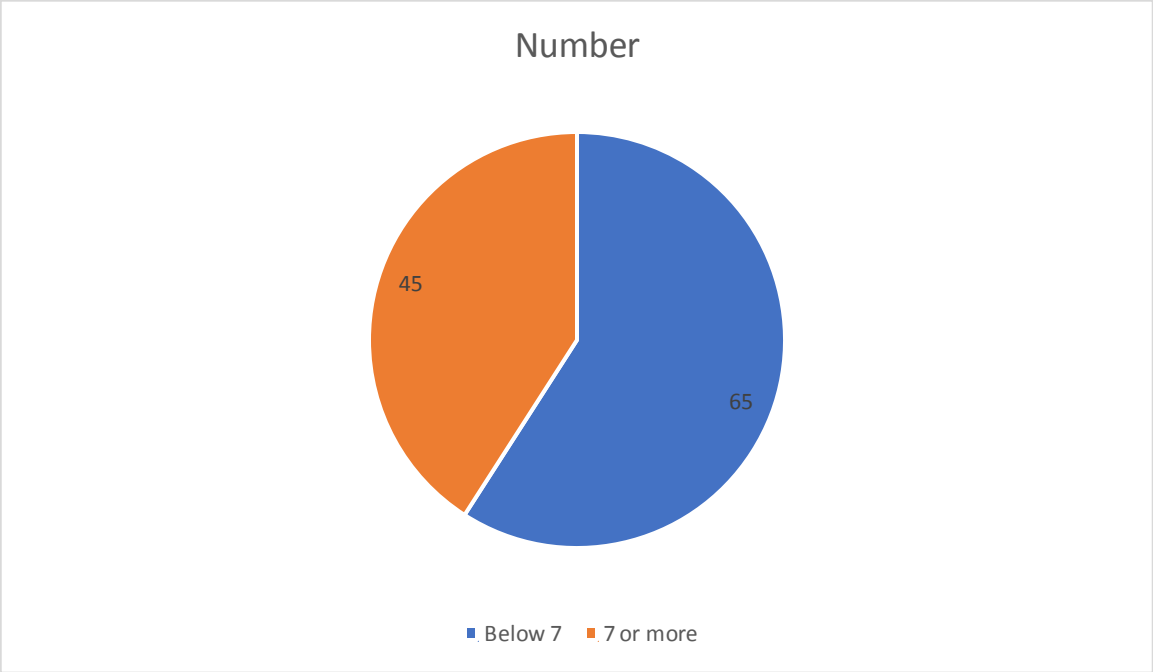


Table III Assessment of Mood Disorder Questionnaire

Point value	Number	P value
Below 7	65	0.02
7 or more	45	

Table III, graph II shows that MDQ score below 7 value was seen in 65 and 7 or more in 45 patients. The difference was significant (P< 0.05).

Graph II Assessment of Mood Disorder Questionnaire



DISCUSSION

Mood disorders in older people are an increasingly serious health and social problem, and their prevalence increases with age.[3] The most common mood disorders are bipolar disorder, which is the occurrence of mania and hypomania, and depressive disorders.[6] Bipolar disorder (BD), also known as bipolar affective disorder or manic-depressive disorder. Individuals with BD experience episodes of an elevated or agitated mood known as mania/ hypomania alternating with episodes of depression.[7] Bipolar disorders have two main subtypes, bipolar I disorder (BD-I), bipolar II disorder (BD-II). The diagnosis of BD-I need one or more manic episodes. A depressive episode is not required for BDI diagnosis, but it frequently occurs. The diagnosis of BD-II need one or more hypomanic episodes and one or more major depressive episode.[7]Bipolar disorder not otherwise specified (BD-NOS) is a catchall category, diagnosed when the disorder does not fall within a specific subtype. Hypomanic episode do not go to the full extremes of mania (i.e., do not usually cause severe social or occupational impairment, and are without psychosis), and this can make BD-II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of high productivity and creativity.[8] The present study to determine mood disorders among general population.

In present study, out of 110 patients, males were 50 and females were 60. Yang et al[9] tested the ability of the Chinese version of the Mood Disorder Questionnaire (MDQ) to identify Bipolar Disorders (BD) in patients diagnosed with Major Depressive Disorder (MDD) or Unipolar Disorder (UD) in the clinical setting. 1,487 being treated for MDD or UD at 12 mental health centers across China, completed the MDQ and subsequently examined by the Mini International Neuropsychiatric Interview (MINI). Receiver Operating Characteristic (ROC) curves were used to determine the ability of the MDQ to differentiate between BD (BD, BD-I and BD-II) and MDD or UD and patients with BD-I from patients with BD-II. Of the 1,487 patients, 309 (20.8%) satisfied the DSM-IV criteria for BD: 118 (7.9%) for BD-I and 191 (12.8%) for BD-II. When only part one of the MDQ was used, the best cut off was 7 between BD and UD (sensitivity 0.66, specificity 0.88, positive predictive value 0.59, negative predictive value 0.91), 6 between BD-II and UD, and 10 between BD-I and BD-II. If all three parts of the MDQ were used, the MDQ could not distinguish between BD and UD at a cut off of 7 (or 6), and the sensitivity was only 0.22 (or 0.24).

We found that mood disorders were depressive disorders in 44, bipolar disorders in 40 and substance induced in 26 patients. It is suggested that using self-report may result in a substantial underestimation of the lifetime prevalence of mental disorders due to incomplete recall. Older people may be less likely to recall past mental disorder episodes, particularly those occurring in their youth, as compared with younger individuals.[10] This differential recall could contribute to explain why the lifetime prevalence of mental disorders did not increase with age in the current analysis. Given the potential limitation of the self-reported lifetime prevalence, the 12-month and 30-day prevalence should be preferred when studying the distribution of mental disorders in epidemiology research.[11]

In a study by Kroenke et al[12] women had a higher prevalence of anxiety disorders compared with men. However, the difference was numerically lower and

not statistically significant for the lifetime prevalence versus the 12-month and 30-day prevalence. The reasons behind this finding are unclear. A possible explanation for this finding is that women may have longer or more recurrent episodes of anxiety disorders than men. Also, incomplete recall of older episodes may have contributed to attenuate sex differences in the lifetime prevalence of anxiety disorders. The prevalence of mood disorders in the current study was not statistically significantly different between women and men. However, odds ratios for 12-month and 30-day prevalence were well above 1 and 95% CI were very wide, suggesting that the current study may be underpowered to detect a true difference between sex groups. Overall, results from the current study suggest that interventions aimed to integrate mental health services into the primary healthcare strategy may have a greater benefit for women versus men.

CONCLUSION

Authors found that depressive disorder and bipolar disorders were most commonly occurring mood disorder among adults.

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