Epidemiology and Control of Depressive disorders

Mood can be defined as a pervasive and sustained emotion or feeling tone that influences a person's behavior and colors his or her perception of being in the worldhange programs might limit transmission.

Patients with only major depressive episodes are said to have *major depressive disorder* or *unipolar depression.* Patients with both manic and depressive episodes or patients with manic episodes alone are said to have *bipolar disorder.* The terms "unipolar mania" and "pure mania" are sometimes used for patients who are bipolar but who do not have depressive episodes

Three additional categories of mood disorders are hypomania, cyclothymia, and dysthymia. Hypomania is an episode of manic symptoms that does not meet the criteria for manic episode. Cyclothymia and dysthymia as disorders that represent less severe forms of bipolar disorder and major depression, respectively.

A major depressive disorder occurs without a history of a manic, mixed, or hypomanic episode. A major depressive episode must last at least 2 weeks, and typically a person with a diagnosis of a major depressive episode also experiences at least four symptoms from a list that includes changes in appetite and weight, changes in sleep and activity, lack of energy, feelings of guilt, problems thinking and making decisions, and recurring thoughts of death or suicide.

Epidemiology

Mood disorders are common. In the most recent surveys, major depressive disorder has the highest lifetime prevalence (almost 17 percent) of any psychiatric disorder.

The lifetime prevalence rate for major depression is 5 to 17 percent. The annual incidence of bipolar illness is considered generally to be less than 1 percent, but it is difficult to estimate because milder forms of bipolar disorder are often missed.

<u>Sex:</u>

An almost universal observation, independent of country or culture, is the twofold greater prevalence of major depressive disorder in women than in men. The reasons for the difference are hypothesized to involve hormonal differences, the effects of childbirth, differing psychosocial stressors for women and for men, and behavioral models of learned helplessness. In contrast to major depressive disorder, bipolar I disorder has an equal prevalence among men and women. Manic episodes are more common in men, and depressive episodes are more common in women. When manic episodes occur in women, they are more likely than men to present a mixed picture (e.g., mania and depression). Women also have a higher rate of being rapid cyclers, defined as having four or more manic episodes in a 1-year period.

Age:

The onset of bipolar I disorder is earlier than that of major depressive disorder. The age of onset for bipolar I disorder ranges from childhood (as early as age 5 or 6 years) to 50 years or even older in rare cases, with a mean age of 30 years. The mean age of onset for major depressive disorder is about 40 years, with 50 percent of all patients having an onset between the ages of 20 and 50 years. Major depressive disorder can also begin in childhood or in old age. Recent epidemiological data suggest that the incidence of major depressive disorder may be increasing among people younger than 20 years of age. This may be related to the increased use of alcohol and drugs of abuse in this age group.

Marital status:
Major depressive disorder occurs most often in persons without close interpersonal relationships and in those who are divorced or separated. Bipolar I disorder is more common in divorced and single persons than among married persons, but this difference may reflect the early onset and the resulting marital discord characteristic of the disorder.

Single women have lower rates of depression than married women , but the opposite is true for men.

The presence of MDD or bipolar disorder is a strong predictor for future separation or divorce.

Unemployment:

MDD is 3 times more common among those without a workplace than those with one.

Mood disorders can easily lead to unemployment & low income(Social regression)

Race & Ethnicity:

The prevalence of unipolar major depressive episode and bipolar I disorders did not show significant variation based on race and ethnicity.

Socio-economic status:

Most studies found only a weak or no correlation between major depressive disorder or bipolar I illness and socioeconomic status

Because hypomania is not as disruptive as mania, in terms of academic and social carrier, the educational level of bipolar II patients is above the average and, in contrast to unipolar major depression and bipolar I disorder, bipolar II patients tend to belong to higher social classes

Urban vs Rural residence

As urban communities are more stressful than rural ones, most studies concluded that major depression was more frequent in urban residents than in their rural counterparts.

Seasonal factors:

spring and fall are the peak times for depression. summer is peak time for mania.

seasonal affective disorders occur in approximately 20 to 25 percent of the patients with recurrent major mood disorders.

Geographic factors:

There is a general, but weak, trend for lower prevalence of depression and higher rate of mania in regions located closer to the Equator. At least in the Northern Hemisphere, winter depression seems to be more frequent in countries situated farther from it.

Family history

Family studies address the question of whether a disorder is familial. More specifically, is the rate of illness in the family members of someone with the disorder greater than that of the general population? Family data indicate that if one parent has a mood disorder, a child will have a risk of between 10 and 25 percent for mood disorder. If both parents are affected, this risk roughly doubles. The more members of the family who are affected, the greater the risk is to a child. The risk is greater if the affected family members are first-degree relatives rather than more distant relatives. A family history of bipolar disorder conveys a greater risk for mood disorders in general and, specifically, a much greater risk for bipolar disorder. Unipolar disorder is typically the most common form of mood disorder in families of bipolar probands. This familial overlap suggests some degree of common genetic underpinnings between these two forms of mood disorder. The presence of more severe illness in the family also conveys a greater risk.
Patients(MDD & bipolar disoredrs) with family history of mood disoreders are significantly younger at the beginning of illness & need less stressors to precipitate illness

Life events & Environmental stress

A long-standing clinical observation is that stressful life events more often precede first, rather than subsequent, episodes of mood disorders. This association has been reported for both patients with major depressive disorder and patients with bipolar I disorder.
Some clinicians believe that life events play the primary or principal role in depression; others suggest that life events have only a limited role in the onset and timing of depression. The most compelling data indicate that the life event most often associated with development of depression is losing a parent before age 11 years. The environmental stressor most often associated with the onset of an episode of depression is the loss of a spouse. Another risk factor is unemployment; persons out of work are three times more likely to report symptoms of an episode of major depression than those who are employed. Guilt may also play a role.

Social support:
Weak or lacking social support (including social network, social interaction) can be considered a major risk factor.
Regarding social interactions, the frequency of the interactions is more important than the amount.

Dietary factors:
Folate deficiency is a risk factor for MDD.Omeg-3 Fatty acid deficit in both unipolar and bipolar disorders.

Comorbidity

Individuals with major mood disorders are at an increased risk of having one or more additional comorbid disorders. The most frequent disorders are alcohol abuse or dependence, panic disorder, obsessive-compulsive disorder (OCD), and social anxiety disorder. Conversely, individuals with substance use disorders and anxiety disorders also have an elevated risk of lifetime or current comorbid mood disorder. In both unipolar and bipolar disorder, whereas men more frequently present with substance use disorders, women more frequently present with comorbid anxiety and eating disorders. In general, patients who are bipolar more frequently show comorbidity of substance use and anxiety disorders than do patients with unipolar major depression.

Preventive measures:

Early detection and treatment of mood disorders ,decrease suicide cases & overall mortality. As the majority of patients with mood disorders are first seen by primary care physicians, diagnosis and appropriate management in primary care level is important.