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Research report

Quality of life and mood disorder episodes: Community sample

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ABSTRACT

Objective: To assess quality of life among Brazilian young adults who are 18–24 years old and who experience depressive, manic/hypomanic, and mixed episodes.
Method: This is a cross-sectional population-based study. The sample was selected in clusters. Mood disorders were assessed using a short, structured diagnostic interview—the Mini International Neuropsychiatric Interview (MINI) for DSM-IV and ICD-10 psychiatric disorders. Quality of life was assessed by the MOS 36-item Short-form General Health Survey (SF-36).
Results: The sample comprised 1560 young adults. The prevalence ratio of mood disorder episodes were as follows: 10.0% depressive episode, 2.3% manic/hypomanic episode, and 2.4% mixed episode. Lower scores were found in all domains of quality of life among young adults who experience mood disorder episodes when compared to the general population ($p < 0.001$ in the eight domains of the SF-36). Moreover, the impact on quality of life was higher among young adults with mixed episodes, followed by depressive episodes.
Conclusion: Young adults with mood disorders, even without a previous diagnosis of bipolar disorder, have an impaired quality of life in comparison to the general population.

1. Introduction

Quality of life (QL) is a broad-ranging concept affected in a complex way by a person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment (TheWHOQOL Group, 1994).

The concept of QL has seen changes during the course of history; therefore, its definition depends on the tool used for evaluation (Pais-Ribeiro, 2004). In this study, QL was evaluated by the SF-36 General Health Survey, an instrument that addresses limitations in daily life due to physical and/or emotional health problems (Ware and Sherbourne, 1992).

In an attempt to measure the functional impact of mental disorders, different measures have been used, one of which refers to the perception of QL. In the literature, studies have focused on the evaluation of differences in quality of life between mood disorders and other psychiatric disorders in cross-sectional or case-control studies with convenience samples. These studies indicate that the loss in quality of life is higher in bipolar disorder than in unipolar depression (Yatham et al., 2004; Berlim et al., 2004), anxiety disorders (Ten Have et al., 2002), substance abuse (Ten Have et al., 2002) and chronic pain (Arnold et al., 2000).

Furthermore, bipolar disorder (BD) causes a reduction in quality of life on the same scale as a schizophrenic disorder (Brissos et al., 2008). Additionally, of five studies that compared QL among patients with BD and the general population, three of these used individuals with bipolar disorders who were recruited from health care services (Ten Have et al., 2002; Sierra et al., 2005; Gutiérrez-Rojas et al., 2008), while the other two have a similar population design (Kebede et al., 2006; Cramer et al., 2010). All of these studies have observed a functional QL loss among individuals with mood disorders.

Mood disorders, such as depression and BD, affect approximately 16% of the Brazilian population (Moreno and Andrade, 2005). According to the Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV), an episode of depression is characterised by the presence of a persistent depressed mood, a loss of interest, or a decreased pleasure in usual activities, with a minimum duration of two weeks. On the other hand, BD is characterised by the presence of at least one manic episode, an alternating depressive episode or at least one overlapped manic/hypomanic episode (American Psychiatric Association (APA), 1994). The manic and hypomanic episodes are characterised by abnormal, persistently high, expansive or irritable moods and increased activity or energy, lasting at least one week in cases of

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mania and four days in hypomanic episodes (American Psychiatric Association (APA), 1994).

According to the proposed of DSM-V, episodes of depression, mania and hypomania have the same diagnostic criteria. However, the term 'mixed episode' will be applied in the present study to the manic, hypomanic or depressive episodes by including the phrase "with mixed characteristics" in cases where the presence of manic or hypomanic episodes occur simultaneously with subthreshold or waxing-and-waning depressive symptoms (APA, 2012). To meet the criteria for the presence of mood disorder episodes, the symptoms must cause clinically significant distress or be harmful to social or occupational functioning.

In addition to adding to the population studies on this topic, which are scarce, this study breaks new ground by exploring the impact of mood disorder episodes on young people with no previous diagnosis of bipolar disorder. The young people evaluated in this study were not using an outpatient clinic or any other type of mental health service, and most had a study and/or work routine. However, at the time of the interview, the patients met the DSM-IV criteria for depressive, manic/hypomanic or mixed episodes independent of any prior diagnosis of BD, making it possible to evaluate these mood disorders in young people who have not yet received this diagnosis.

The purpose of this study was to evaluate the QL in young people aged 18–24 years, without a prior diagnosis of BD, whose depressive, manic/hypomanic or mixed episodes were diagnosed through an interview used in a population study of a community sample. The hypothesis of the present study is that the presence of any mood disorder in young people is associated with a decline in quality of life when compared with the general population.

2. Methods

This report is on a cross-sectional population-based study of 18–24 year-old individuals living in the urban area of Pelotas, RS (Brazil). The sample was selected in clusters, between August 2007 and December 2008, from a population of 39,667 in the desired age range, along the divisions used by the current census of 448 sectors in the city (IBGE, 2008).

To assure the necessary sample size, 89 census sectors were systematically selected by drawing, with an interval of four sectors, from a list of sectors by ordered by income per capita. Homes were selected within the sectors using a systematic sampling; the first house being the one at the corner designated by the IBGE as the beginning of the sector; every third house was selected. Full details on the study have been published elsewhere (Jansen et al., 2011).

After identifying the subjects, well-trained interviewers explained the purpose of the study. The youths who agreed to participate provided signed informed consent. The participants answered a questionnaire that collected socio-demographic data and an evaluation instrument of quality of life, as well as participated in a structured interview for the identification of Axis I Disorders in the DSM-IV.

The socio-demographic questionnaire asked the participant's age, gender, self-reported skin colour or ethnicity, study and work status. Socio-economic evaluation of the participants was performed using their classification according to the Brazilian Association of Research Companies (ABEP, 2003) method, which is based on the total accumulated wealth and the educational level of the head of household. In this classification, "A" refers to the highest socio-economic class, and "E" refers to the lowest one.

The levels of QL were measured by the SF-36 (Medical Outcomes Survey 36-item Short-form General Health Survey) (Ware et al., 2005). The survey consists of 36 items that address limitations in daily life due to health problems, giving a subjective estimate of the functional state of the individual. The SF-36 produces a scaled score that ranges from 0 to 100–100 being the highest score for QL—among eight domains: role physical health, physical functioning, general health, vitality, role emotional, mental health, social functioning and bodily pain. Validation for the Brazilian population showed that the reliability coefficients for the eight domains ranged from 0.77 to 0.94 and the validity ranged between 0.51 and 0.85 (Ciconelli et al., 1999).

A structured interview was carried out using the Mini International Neuropsychiatric Interview 5.0 (MINI) (Sheehan et al., 1998). This interview is designed to be used in clinical practice and research to diagnose interviewees according to the DSM-IV and the ICD-10 criteria. Psychometric characteristics for each disorder compared to a Structured Clinical Interview for DSM (SCID) may vary (Amorim, 2000). This study used the modules that investigate current depressive and manic/hypomanic episodes, while mixed episodes were evaluated by the simultaneous presence of depressive and manic/hypomanic symptoms.

After the instruments were codified, data processing was performed using double-entry in Epi-Info 6.04d (Dean et al., 1994) with immediate verification of data entry and tests of consistency of the two data inputs. STATA 9.0 software (StataCorp, 2009) was used for data analysis, in which the initial analysis aimed at obtaining the frequencies of mood disorder episodes and characterising the sample (STATA, 1996–2009).

The chi-square test was applied in the bivariate data analysis to describe the association between the occurrence of mood disorder episodes and the independent variables. ANOVA and Bonferroni tests were used to compare the means of the eight

Table 1
Socio-demographic and psychopathological sample characteristics.

Socio-demographic and psychopathological characteristics	Sample distribution	
	Mean (*N*)	SD (%)
Age	20.50	2.09
Gender		
Female	880	56.4
Male	680	43.6
Skin colour		
White	1144	73.3
Black	237	15.2
Mulatto, yellow or indigenous	179	11.5
Socioeconomic		
High (A+B)	583	37.4
Intermediate (C)	751	48.1
Low (D+E)	226	14.5
Studying		
No	843	54.0
Yes	717	46.0
Working		
No	530	34.0
Yes	1030	66.0
Depression episode	155	9.9
Mania/hypomania episode	36	2.3
Mixed episode	37	2.4
Role physical health	92.24	12.75
Physical functioning	85.66	27.55
General health	76.96	19.77
Vitality	60.50	18.37
Role emotional	79.19	34.00
Mental health	73.99	20.42
Social functioning	83.78	22.24
Bodily pain	75.01	21.17