

EDITORIAL

Depressive Morbidity in an Egyptian Population

The prevalence of depressive symptoms as screened by the G.H.Q. in an Egyptian sample shows a striking observation which deserves mention, that is the depressive symptoms are more common in rural than in urban population (39% compared to 23%, $P < 0.001$).

The overall estimates of depressive symptoms using the G.H.Q. is 31% which seems to be not much higher than in other third world countries (Master and Zung, 1977).

The Sociodemographic Variables

a) Age: The prevalence of depressive symptoms is higher in the age group (below 35 years) in the urban area due to the increased ambition, rising expectation and aspirations with inability of fulfilling these wishes. On the other hand, in the rural community the rates of depressive symptomatology are more frequent in the age group above 35 years. Ruralites feel loneliness due to immigration of their young generation to big cities; to the decrease of the intrafamily attachments and to the decline of the extended families.

b) Sex: The overall prevalence of depressive morbidity in women is higher than men (59% compared to 41%). Our culture generally accepts a greater expression of the feelings among females than among males; cultural norms restrict men in the affective behaviour and make it less socially desirable for men than women. Rural females expressed less depressive symptoms than urban women (52% & 66% respectively) who have to face multiple duties, different role functions and problems arising from the pseudo-emancipation of women and the dominance of the oriental man.

c) Marital Status: There is little agreement on the relationship of marital status to depression (Silverman, 1963).

In this study, we found that marriage was associated with markedly increased levels of depression. 66% of married compared to 32% of single subjects had depressive symptoms. Depression rates were found to be high in the single urban and in the married rural individuals. Findings let one wonder to what extent this difference among the study communities might be accounted for by the stresses afforded by marriage.

d) Educational and Occupational Status: A number of studies have found a greater frequency of depression among the well-to-do (Silverman, 1968), but this is not universally true (Pederson *et al.* 1972). The major population based studies have been unanimous in finding that symptoms related to depression are least common among the upper socio-economic group (Srole *et al.* 1962).

A notable, but not surprising, finding is the high frequency of depressed persons among the illiterates especially in the rural community. The educated professionals and semi-professionals in the urban community show high rates of depressive symptoms, this is because of the recent social changes in Egypt. There is no social or economical incentive to achieve higher education or a higher professional occupation, the discrepancy, may be, of course a major source of frustration.

Prevalence of Depressive Disorders According to DSM-III (1980)

Although several studies all over the world in varying populations have been carried out to estimate the prevalence of depression, but they are still far from being truly repre-

sentative because of nosological and diagnostic controversies (Kielholz *et al.* 1982).

By 1974 the World Health Organization (WHO) estimated that around 100 million people in the world were depressed (Sartorius, 1975), but by 1983, that figure had risen to 200 million (Gulbinat, 1983).

The prevalence of depression varies from one country to another, the estimated life time prevalence in Europe ranged from 14-27% and in North America is 26.6% (Weissman and Myers, 1978). In Argentina, the point prevalence is 12.8%, Chile 15.3%, Cuba 14.3%, Peru 12.6%, Mexico 19%, Colombia 10.8%, (Garcia, 1986) in India 22.5% (Sethi and Gupta, 1970; and Shah *et al.* 1980).

The overall estimates of depressive disorders in Egypt is 15.3%, the prevalence seems to be not much higher than in other third world countries. Blazer *et al.* (1985) and O'Hara *et al.* (1985), in Europe and North America, and Dubey (1964) in India, could clearly show that rural areas have a lower frequency in depressive disorders than urban. However, in our study a striking observation deserves mention, that is the depressive disorders are commoner in rural than in urban population (19.7% and 11.4% respectively).

Results indicate that a major change has taken place in our rural community. The current socio-economic situations, the immigration of the young population to cities, the changing social values, the tendency for individualization and the rapid civilization of the rural areas, may be important determinants of this high rate.

Category of Depression and Clinical Profile

1.9% of the urban population were labelled with the diagnosis of major affective disorder according to the DSM-III criteria compared to 3.3% of the rurals. The total prevalence is 2.5%.

Dysthymic disorder was the most common diagnostic category in the urban population (4.1%), while adjustment disorder with depressed mood was more frequently encountered in rural population (6.7%).

The cross cultural comparison between western population and ours revealed startling differences as found previously in Egypt by Okasha (1977) and Gawad and Arafaa (1980).

The severity of depression, as estimated by Beck Depression Inventory (BDI) among high G.H.Q. scorers shows an interesting finding. It is noticed that about 38% of the high G.H.Q. scorers were classified according to Beck's scores as not depressed.

The inventory was able to discriminate those with severe depression (5%) from other groups. It seems likely that mild depression is the most prevailing type of depression as regards the severity of depressive symptoms.

CONCLUSION

The findings of our study indicate that various sociodemographic data have an important role in the genesis of depressive symptoms. Migration, urbanizations, changes in the structure of the family, disequilibrium in the economical and social life, the conflict between traditions and modernization, the vacillation of values, the despair of youth for a better future, the failure of identification with the political or religious leaders have influenced the psychiatric morbidity of all depressive symptoms and the occurrence of social morbidity of fundamentalism and drug dependence.

Epidemiological surveys can outline the national mental health policy; however, up to now, there are many methodological problems that face epidemiological study. It is suggested that improving the quality of future research in this area, is considered to be a ma-

or strategy of a mental health program so as to enlighten the priorities in financing health services.

It is worth mentioning that primary prevention and early treatment of depression can reduce mortality by 30%. As a matter of fact, the training of primary health care physicians and general practitioners is necessary if we want to reduce the pain of sufferers of depressive disorders, and if we want to minimize the irrelevant costs and the decreased productivity caused by depressive symptoms in our developing country.

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REFERENCES

- Blaser, D., George, L., Landerman, R., Pennebacher, M. *et al.* (1985) Psychiatric disorders: A rural / urban comparison. *Arch. Gen. Psychiat.*, **42**: 651-6.
- Dubey, K. (1964) Survey of mental morbidity in India at mental hospital Agra. *Indian J. Psychiat.*, **6**: 98.
- Garcia, R. (1977) Prevalencia de enfermedades mentales en Santo Domingo Reporte especial de la secretaria de salud publica Dominicana.
- Gawad, M.S. and Arafaa, M. (1980) Trans-cultural study of depressive symptomatology. *Egypt. J. Psychiat.*, **3**: 163-82.
- Gulbinat (1983) Quoted from Garcia, R. (1986) Epidemiology of depression in Latin America. *Psychopathology*, **19**: (Supp.) 22-5.
- Kielholtz, P., Poldinger, W. and Adams, C. (1982) Masked depression. Deutscher Arzte-Verlag.
- Master, R.S. and Zung, W.W.K. (1977) Depressive symptoms in patients and normal subjects in India. *Arch. Gen. Psychiat.*, **34**: 972-974.
- O'Hara, M., Kohout, F. and Wallace, R. (1985) Depression among the rural elderly. *J. Nerv. Ment. Dis.*, **173**: 582.
- Okasha, A., Khalil, A.H., El Fiky, M.R., Ghanem, M. and Abdel Hakeem, R. (1988) Prevalence of depressive disorders in a sample of rural and urban Egyptian communities. *Egypt. J. Psychiat.*, **11**: 167-181.
- Pederson, A., Barry, D. and Babigian, H. (1972) Epidemiologic considerations of psychotic depression. *Arch. Gen. Psychiat.*, **27**: 193.
- Sethi, B. and Gupta, S. (1970) An Epidemiological and cultural study of depression. *Indian. J. Psychiat.*, **12**: 13.
- Shah, A.V., Goswami, U.A., Maniar, R.G., Hajariwal, D.C. and Sinha, B.K. (1980) Prevalence of psychiatric disorders in Ahmedabad: An epidemiological study. *Indian. J. Psychiat.*, **22**: 376.
- Silverman, C. (1968) The epidemiology of depression: A review. *Am. J. Psychiat.*, **124**: 43-51.