

Dysthymic Disorder in an Egyptian Sample

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Background: This study determined the 6 month prevalence of dysthymic disorder in Ismailia governorate, Egypt, and the clinical profile and risk factors associated with dysthymic disorder. **Methods:** A community sample of 922 residents was screened using the General Health Questionnaire and the Psychiatric Assessment Schedule. Those with depressive disorders based on the WHO Standardized Assessment of Depressive Disorders (Arabic version) were interviewed to determine sociodemographic information and risk factors for dysthymic disorders described in DSM-IV. **Results:** Dysthymia was the most common depressive disorder in the sample (9.87%), and constituted 52.92% of all depressive disorders. **Conclusions:** Dysthymic disorder is common in Ismailia governorate. Based on the sociodemographic and risk factors identified, we recommend a broadened role for general practitioners in the detection, management, and follow-up of dysthymic patients. Improved patient function and reduced costs of health services are likely to result from such action.

(Egypt.J.Psychiat., 1998, 21 :193 - 199).

INTRODUCTION

Dysthymia is a depressive disorder in which some symptoms of depression are present most of the time for at least 2 years with periods of no more than 2 months without symptoms (American Psychiatric Association 1994). One year prevalence rates for dysthymia have ranged between 4.5% and 10.5% (Bell,

1992). Diagnosis is often difficult due to the unclear boundary between dysthymia and major depressive episode (Bonder, 1995). Dysthymia may precede a major depressive episode and lead to so-called double depression, which has a poor prognosis (Keller *et al.* 1983). Dysthymia is more common in women than in men, but no differences in the prevalence of dysthymia have been identified among various socioeconomic groups (Breslin, 1996). Dysthymia has apparent biological origins, as there are changes in rapid eye movement (REM) sleep, thyroid function, and electroencephalogram (EEG) readings, which differ from those found during major depressive episodes (Howland & Thase, 1991). Function is generally impaired to a mild or moderate degree; and patients typically hold their jobs, continue social relationships and maintain some interests. However, these activities are not maintained at optimal levels because of the lethargy and lack of interest displayed by dysthymic patients (Bonder,

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1995). The purpose of this epidemiological study was to assess prevalence in an Egyptian community, clarify further distinguishing diagnostic features, and risk factors associated with dysthymia.

SUBJECTS AND METHODS

A randomized community sample of 922 persons out of 600,000 persons between the age of 17 and 70 years was studied during a 6 months period. Schizophrenic persons and other persons from whom valid information could not be obtained due to communication problems (e.g., mental retardation, deafness) were excluded. A multi-stage random sample was done. The first stage, two areas were chosen randomly out of 32 areas. The second stage, two subareas were chosen randomly from each area. The third stage, 145 families were chosen randomly from all the families of these areas. Twenty two persons were excluded and 21 persons refused to participate in the study. All members of the selected families were surveyed with the Arabic version of the General Health Questionnaire (GHQ-30) to determine those likely to have psychiatric disorders (Goldberg, 1972). The (GHQ-30) was used in several studies in Egypt in different populations and was proved to be valid and reliable. Rafrens (El-Akabawy, 1983) Persons with scores of 7 or greater were considered likely to have psychiatric disorders described in DSM-IV (American Psychiatric Association, 1994). The socioeconomic status of all subjects was rated as low, moderate, or high according to household income, education, occupation, social position and the home condition as assessed by the interviewer. Subjects were classified occupationally as unemployed, unskilled, semiskilled, skilled, and professional (Sartorius *et al.* 1983). All GHQ+persons were sur-

veyed by the Psychiatric Assessment Schedule (PAS) to determine psychiatric disorders according to the DSM-IV PAS was translated into Arabic by El-Akabawy and used many times in Egypt. Its validity and reliability was high, ranged from 0.83 to 0.89 (El-Akabawy, 1983).

All persons with a DSM-IV diagnosis of depressive disorder were then interviewed using the Standardized Assessment of Depressive Disorders (Arabic version) (SADD) to determine their clinical characteristics (Sartorius *et al.* 1983). Arabic version of SADD was used in other arabic community and was found to have high validity (0.83). Severity of symptoms was rated by the researchers on frequency, intensity, effect of the person on others, and the person's subjective well being. Information for this assessment was obtained from patients, family and relatives. Severity of the depressive disorder was rated as mild (the patient is able to cope with the demands of daily life, though with difficulty), moderate (the state interferes seriously with the patient's daily routine, without full incapacitation), or severe (social functioning of the patient is seriously disturbed or essentially arrested). For descriptive purpose depressive disorders were classified as dysthymia (DD), other depressive disorders (ODD), and depressive disorders in general (TDD). All the tools of this study were applied by a psychiatrist since most of the persons under the study were illiterates, the researcher applied the test as to read the question and record the answer.

Statistical analysis: Statistical analyses were conducted by the X² test, the difference of means test, and ANOVA. A P-value less than 0.05 was required for all tests of statistical significance.

RESULTS

The prevalence of dysthymic disorder (DD) during a 6-month period from September, 1995 to February, 1996 was (9.9%). DD was the most common depressive disorder in this community based sample, accounting for just over half of all depressive disorders (Table 1).

Socio-demographic pattern: Table 2 shows that DD was more frequent in the illiterate group (47.2%) than the other depressive disorders (ODD) ($P=0.003$). DD was also found to be common among unskilled, and semiskilled workers, and among the currently married individuals. There was no significant relationship with residence, gender, age groups or socio-economic status.

Clinical profile of DD: When present almost all symptoms were much more likely to be mild in severity than severe. These symptoms were sadness or depressed mood (100.0%), lack of appetite (86.8%), desire to be alone (81.3%), joylessness and inability to enjoy (80.2%), aggression (79.1%), social functioning disturbance (70.3%), hopelessness, anxiety or tension (64.8%), subjective experience of thought retardation (51.7%), indecisiveness (50.6%),

Table 1
Prevalence of DD and ODD in Ismailia governorate:

DSM-IV Diagnosis	Total	
	NO.	%
Major depressive disorders	28	2.8
Dysthymia	91	9.9
Other mood disorders	56	6.1
No depressive disorder	749	81.2
Total	922	100.0

Table 2
Socio - demographic pattern

Socio - demographic		DD N=91	ODD N=82
Residence	Urban, %	50.5	61.0
Gender	Male, %	47.3	57.3
Age groups	17-25 (N=61), %	6.6	14.7
	25-60 (N=99), %	86.8	76.8
	60-70 (N=13), %	6.6	8.5
	Age, Mean $\pm$ SD	41 $\pm$ 12	34 $\pm$ 11**
Marital status			
Never married (N=50), %		17.6	41.5*
Married, re-married, multi-married (N=100), %		65.9*	48.8
Divorced, separated, (N=23), %		16.5	9.7
Educational level Illiterate, %		47.2*	23.2
Occupation	< 12 years Education, %	37.4	48.8
	$\geq$ 12 years Education, %	15.4	28.0
	Unemployed, %	18.7	17.1
	Unskilled & Semiskilled, %	54.9*	32.9
	Skilled & Professional, %	26.4	50.0*
Socio-economic status Low, %		47.2	40.2
Moderate, %		44.0	51.2
High, %		8.8	8.6

*Significant as $P < 0.05$ in comparing DD with ODD.

** ANOVAP = 0.000, ODD < DD (Bonferroni $P = 0.000$,)

Fisher pairwise comparison $P < 0.02$

Table-3
Prevalence of risk factors of mood disorders described in DSM-IVig DD:

DSM-IV Diagnosis	DD% N=91
Inadequate discipline	8.8
illiteracy	33.0
Inadequate health insurance	64.0
Exposure to war & immigration	72.5
Role restriction	1.1

onstipation (48.4%), loss of interest (39.6%), lack of self-confidence (31.9%), worse mood in the morning (30.8%), change of body weight (28.6%), and inability to fall asleep (27.5%). The exceptions were lack of energy in 93.4%, of patients and decreased libido in 33.0%, which were usually severe when present.

Treatment during the present episode: Although 22.0% were receiving antidepressants, and 18.7% were receiving minor tranquilizers, 67.0% of patients received no treatment at all, a rate of no treatment significantly greater than in ODD ($P < 0.05$).

Risk factors for DD: Inadequate discipline, illiteracy, inadequate health insurance, exposure to war and immigration, and role restriction were significantly associated with DD more than other depressive disorders.

DISCUSSION

This study found DD to be significantly higher in illiterate subjects and, similarly, in unskilled and semiskilled persons. By contrast, DD was significantly less common in skilled and professional groups than were ODD. These results are generally consistent with other studies (Brown et al. 1985; Okasha, 1990; Shelton, et al. 1997). The association between DD and low educational and occupational status is likely linked to the early onset, and long course of dysthymia and its apparent undertreatment (Brown et al. 1985; Okasha, 1990; Shelton, et al. 1997). This protracted symptomatology may reduce productivity and negatively impact educational and occupational attainment.

These results also provide useful information about the symptomatic features that are relatively specific to DD,

and thus could aid in differentiating it from MDD. The symptoms significantly associated with DD were low self-esteem, hopelessness, social withdrawal, irritability or excessive anger, decreased concentration and low energy. These results are strongly confirmatory of the reports of Gwirtsman et al. 1997 and Ravindran et al. 1996. We also found somatic symptoms to be significantly more prevalent in DD. This has been previously observed in other Egyptian and Eastern samples but not samples from Western countries (Okasha, 1990). Since somatic complaints in DD are generally taken to primary care physicians, it is likely that many of these patients are assessed now only outside the mental health system of care and that they add substantially to the cost of the general medical care (Ravindran et al. 1996).

We also identified four risk factors associated with DD: inadequate discipline, illiteracy, inadequate health insurance, and exposure to war and immigration. These risk factors tend to be chronic or recurring in their effect. By contrast recent major life events are the main risk factors for major depression (Ravindran et al. 1996). Recognition of these differences in the pattern of risk factors may further aid in differential diagnosis of the two conditions.

DD was equally prevalent in men and women. Although this is consistent with most studies (Kessler et al. 1992; and Brown et al. 1992), some studies have found dysthymia to be more common in women than men (Breslin, 1996). One factor that may contribute to the relatively low rates of DD in women in this study is that in Egypt, families often try to hide psychiatric problems in young women, in part out of concern that the stigma of mental illness will reduce the woman's desirability as a wife.

In this study DD occurred largely among married persons. Whereas other Egyptian studies (El-Akabawy, 1983 and Okasha, 1990) have reported similar findings, most western studies have reported that depression was more common among divorced and separated persons (Hirschfeld & Cross, 1982; Weissman et al. 1996). the strong social support provided by family and friends to divorced women in Egypt may contribute to this different pattern.

Despite the high prevalence of DD, it is infrequently diagnosed and even less commonly treated with drugs (Shelton et al. 1997). In the present study, when treatments were provided, antidepressants and minor tranquilizers were most often used. The undertreatment of DD is likely associated with underrecognition of mild, depressive disorders. Chronicity of symptoms may reduce the likelihood that patients and families will recognize the depression, since the think of DD as a personality disorder requiring lengthy psychotherapy rather than as a pharmacologically treatable condition.

this study, one of the few published that specifically dwells with DD, does have methodological limitations that limit its conclusions. Diagnoses were assigned as mutually exclusive, therefore we did not capture data on patients who may have had lifetime or comorbidity with other mood disorders, also, the strength of a randomized community sample is to some degree reduced by subtle underreporting of psychopathology in the family based setting of the evaluations. We endeavored to minimize this problem by establishing effective linkage with local persons who were already trusted by families based on their provision of minor health care needs. This contributed to the high rate of family participation.

Appropriate treatment of DD may re-

sult not only in disease remission, thus improving the quality of life of the individual, but also improved long-term prognosis. Because DD is a risk factor for the development of major depressive episodes, effective treatment of patients with DD may prevent the development of more severe affective conditions (Ravindran et al. 1996; Gwirtsman et al. 1997). We believe these results support the importance of primary care physicians discovering and treating DD, and enhanced educational efforts for these purposes are desirable.

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إضطراب عسر المزاج فى عينه مصريه

قام الباحثون بدراسه عسر المزاج فى عينه مصريه من مدينه الاسماعيليه توامها ٩٢٢ شخصاً بإسخدام مقياس الصحة العالمى وجدول التقييم الطبى النفسى بالاضافه إلى دراسه عوامل المخاطرة وتم عمل مقابله طبيفسية لهؤلاء الذين استوفوا السمات الاكلينيكيه المبينه على المحكات التشخيصيه لتقييم منظم الصحة العالميه للاضطرابات الإكتئابيه - لنقص العوامل النفسيه الاجتماعيه - وأظهرت النتائج أن حوالى ٩, ٨٧ ٪ من العينه لديهم إضطراب عسر المزاج والذى يشكل حوالى ٥٢, ٩٢ ٪ من كل الاضطرابات الاكتئابيه المشخصه فى العينه.

ويناقش الباحثون النتائج والدلالات والتوصيات التى تهدف إلى تحسن الأحوال الطبفسيه والتقليل من نفقات الخدمات الصحيه.