

Epidemiology of Depressive Disorders in a Household Rural Population in Egypt

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Abstract

Point prevalence of depressive disorders and the associated risk factors for households of an Egyptian rural community were carried out. In this study, the Arabic version of GHQ for Goldberg was used as a screening tool. This followed by a clinical psychiatric assessment based on DSM-III-R criteria for those scored at least 7 points on GHQ. Inclusion criteria were being at least 18 years of age, and being inhabitant of this rural community for at least 6 months before the start of the study. The overall prevalence of depressive disorders was 6.95%. The prevalence of individual depressive disorders were as follows: 1.37% for major depression (first episode), 1.28% for depressive episode (recurrent), 3.38% for dysthymia, 0.45% for bipolar affective disorders (depression), 0.27% for cyclothymia, and lastly 0.18% for depression (NOS). Depressive disorders were more prevalent among, 26-45 age group (53.95%), females (65.8%), singles (46.5%), mid-level and basic level of education (52.63%) and jobless persons including housewives (43.4%). The most prevalent depressive symptoms were easy fatigability (93.4%), intermittent insomnia (80.3%), irritability (81.6%), and depressed mood (78.9%).

Introduction

Depressive disorders are among the most prevalent psychiatric disorders worldwide. It has lots of physical, psychological, family and social disabling effects. Stoudimire (1987), found that the direct and indirect costs of these disorders worldwide is about 16 billion US\$ annually. Furthermore, Canino (1987) mentioned that most of patients suffering from depressive disorders were not diagnosed and treated properly. More than two thirds of these patients were not treated by psychiatrists.

The word depression refers to different meanings in the context of different fields such as psychology, psychiatry, pharmacology, and neurophysiology. The word depression also, may indicate a daily mood swings or natural reaction to events. Hence, we have to identify properly the prevalence of depression as a disorder as it is an initial and important step to know the

actual size of the problem, so that a proper planning for health services can be carried out. It will result also in better screening, proper referral and suitable management. This will cut down the direct and indirect costs of depressive disorders which result from abusing of health system, absenteeism from work and the needed health education.

The followings are a number of local and foreign epidemiological studies for depressive disorders. Okasha, et al., (1977), found that life time prevalence of depressive disorders among university stages students in Egypt was 24.5%, which was distributed as follows: 10.7% was reactive depression, 6.8% was manic depressive disorder and 5.2% was melancholic depression. In another study in Egypt, the lifetime prevalence was 22.8% in the rural regions compared to 39.5% in the urban regions (Abdel-Hakim, 1992). In the Epidemiological Catchment

Area study (ECA) which was conducted in USA, the life time prevalence of depressive disorders were as follows: 3.5-5.9% for major depression, 2.1%-3.8% for dysthymia, and life time prevalence for bipolar affective disorder was 0.8%-1.7%.

In the ECA study, females were more affected in all types of depression more than males and the prevalence was high in age group 30-44 for both major depression and bipolar affective disorder (Robin, 1991). Weissman (1994), found in a study conducted in different countries; namely, USA, Canada, Portrico, France, Western Germany, Italy, Lebanon, Taiwan, Korea, and Newseland; that life time prevalence for major depression range was 1.5% to 19.5%, whereas for bipolar affective disorder was 0.3% to 1.5%. Age at first time the patient suffered from depressive disorders was 24.8-34.8, and 18.8-28.8 years (ys) for major depression and bipolar affective disorders respectively. A relative increase of major depressive episodes among divorced and separated compared to married persons were also reported.

To the best of my knowledge, as regard to the Egyptian society, the epidemiological surveys for psychiatric disorders in general and depressive disorders in particular are scarce and are suffering from either small size of the sample, as in El-Akabawi et al., (1983), concentrated on specific age group as in Hammouda et al., (1990), or did not imply a clinical psychiatric assessment as in Abdel-Hakim study (1992) or focused only on university student population as in Okasha et al., (1977). Hence, there is a need for household epidemiological studies including different age groups in Egypt to fill the gap and to collect more comprehensive data to be used in planning and evaluation of the health care needed.

Aim of the work:

The purpose of the current study was to:

1. delineate the prevalence of depressive disorders in an Egyptian village.
2. define the most common clinical presentations for the depressive disorders in these regions.
3. identify the associated risk factors.
4. study the relation between these disorders and socio-demographic and cultural variables.

Method

During January 1996, the investigators of the current study choose a model village in Ismailia Governorate. Abu-Khalifa, a village about 30 Km away from the city of Ismailia and about 150 Km away from Cairo, the capital. The population of that village as counted by the investigators was 3009 persons. The village is representative in many respects of current rural Egyptian communities as the majority were either governmental employee, farmers, unskilled laborers children and adolescents in different educational levels. There are water supply and electricity. State-run services are the Local Administrative Assembly (LAA), a police station, 5 primary schools and 2 preparatory schools and 2 secondary schools (one general, and one technical). There are also a rural health center, an urban health center, 2 centers for family planning. The Suez Canal Faculty of Medicine did a collaborative effort with (LAA), in making this village feasible for research by enumerating the houses with illustrated maps for it. A preparatory stage was done including visiting the village. The key persons gave their oral consent about the study, demographic and other important information about the village.

Sampling

The current study is cross-sectional multi-stage type. The inclusion criteria were being living in the village for at least 6 months, before the start of the study. Second; only those 18 years and above were involved in the study. The total sample of the study was 1092 persons* (52.2% females, and 47.8% males).

All participants were subjected to:

1. Administration of the Arabic version of General Health Questionnaire (GHQ) for Goldberg
2. Administration of Psychiatric Assessment Schedule (PAS) of El-Akabawi to those scoring above 7 points on GHQ (See Al-Akabawi et al., 1983).
3. Semi-structured clinical psychiatric interview guided by the diagnostic criteria of the Diagnostic and Statistical Manual, 3, revised (DSM-III-R), to depressive disorders patients with general and neurological medical examination.

The validity and reliability of GHQ, and PAS were observed as they were used in similar populations, validity and reliability were high (See El-Akabawi 1983, Abdel-Aal, 1994). There were 215 non-responders. They either responded to GHQ improperly or refused to participate in the study from the start. Most of the second group were of high educational level, who exposed before to similar surveys, and whose opinion were the uselessness of such surveys to overcome their health problem. The investigators excluded them from the study from the first stage.

Results and Discussion

Current rates of different psychiatric

disorders according to -DSMIII-R were: the point prevalence for depressive disorders is 6.95%, which constituted the following varieties:

1.37% for major depression (first episode), 1.28% for depressive (recurrent), 3.38% for dysthymia, 0.45% for bipolar affective disorders (depression), 0.18% for depression not otherwise specified, and lastly, 0.27% for cyclothymia (see table 1.). The results of major depression, dysthymia, and bipolar depression are in accordance with ECA study, and Weissman (1994).

As in table (1), the overall points prevalence was 6.9%. This result is in accordance with Hammouda et al., (1990), Idris et al., (1989), Weissman and Klerman (1978), Romaniski and Merchant (1992). The sample study in Hammouda et al., was drawn randomly from household adolescents; 15-19 years of age, from six villages in Sharkia Governorate in lower Egypt. The point prevalence for depressive disorders using Beck Inventory for depression (first stage) was 7.7%. However in the second stage where a clinical based diagnosis was used a drop in the prevalence to become 6.7% was reported. In Idris et al., study (1989) in a random household sample in Sudan and where "DSM-III" which used as a reference for diagnosis and the point prevalence of depressive disorders was 8.8%. In Weissman and Klerman study (1978), the lifetime prevalence was 6.8%, where in the study of Romanoski and Merchant (1992), the lifetime prevalence was 5.9%. On the other hand, the point prevalence of the depressive disorders of the current study differed with many local and foreign studies. The following studies are examples: Okasha et al., (1977), El-Akabawi et al., (1983), Abdel-

Hakim (1992), Blazer et al., (1994), Katz et al., (1995). The lifetime prevalence in Okasha et al., study (1977) was 24.5%, where the sample was drawn from university stages students in Egypt. The point prevalence in El-Akabawi et al., (1983), in an Egyptian village in lower Egypt was 16.1% for Dysthymic disorder, and 1.84% for major depression. The time factor as well as the smaller size of the samples in case of El-Akabawi et al., study may be the cause of the difference in prevalence. The prevalence in Abdel-Hakim study (1992) was 22.8% in the rural households in Menufeya, Egypt. Abdel Hakim used Beck Inventory for depression for those scored 5 points and above on GHQ screening. He did not use clinical psychiatric interview or a classificatory system as a reference for diagnosis as was done in the current study. This may account for the difference between the two studies. In the study of Blazer (1994), in a household in 48 different locations in the United States where the life time prevalence of major depression was 17.1%. However, in the study conducted by Katz 1995 in a households in Canada the point prevalence was 4% which is lower compared to the current study.

There was a significant sex difference in the results of the current study, where prevalence of depression in females was 8.8% compared to 5% in males. The results of individual depressive disorders also went in the same direction, except with bipolar depressive disorder. This sex difference is in accordance with Okasha et al., (1977), Abdel-Hakim (1992), ECA study (Robins, 1991), Weissman, (1977 and 1994), and Hammouda et al., (1990). The sex difference may be related to hormonal difference between males and females and/or psychosocial factors, such as learned

helplessness in case of females, their social status, their liability to accept the sick role, their expressive nature and dramatization of females compared to males (Weissman, 1977). As regard bipolar affective disorder, Kaplan and Sadock (1996) pointed out that most studies reported that there is no big sex difference. The relation of age group, marital status, educational level, and occupation with prevalence of depressive disorders are shown in tables 3, 4, 5, and 6, respectively. As regard age group as shown in table (2), the highest prevalence was among age group 36-45 which constituted 27.6% followed by age group 26-35, which constituted 26.3%. As regard the individual depressive disorders and age group (Table 3), the major depressive disorder and dysthymia were more prevalent in middle age and above (36 years old and above) than younger ages, compared to bipolar affective disorder, cyclothymia, and depression NOS, which were more among younger people (18-35 years old). These results were in accordance with Salokangas, et al (1996).

As regards marital status, as shown in table (2), the depressive disorders were more prevalent among singles (46.1%), and married (43.4%). For individual depressive disorders as shown in Table (4) major depressive disorder (1st episode) were more among singles (46.7%), then married 40%, whereas major depressive disorder (recurrent) was more prevalent among the married (78.6%). Dysthymia was more prevalent among singles (54.1%). Bipolar affective disorder, was more prevalent among singles 60% then married 40%. Both cyclothymia and depressive disorder (NOS) were more prevalent among singles, 66.7% and 100%, respectively. In general, there is relatively higher prevalence of depressive disorders among the single compared to the

married except in the recurrent type of major depression. This is supported by Lehtinen et al., (1994), Romaniski and Merchant (1992), Wisman (1994) and Salokangas et al., (1996). This result may be explained by lack of social support for single people, compared to the other groups.

As regards, the level of education, depressive disorders were more prevalent among those having middle (secondary, or technical) education 30.3%, and primary education 22.4%, followed by illiterate and those with read and write level of education 17.1%, and finally, university level of education. For individual depressive disorders as shown in Table (5), major depressive disorder, 1st episode was more prevalent among primary level of education (46.7%), whereas the recurrent type was more prevalent among illiterate 42.9%. Dysthymia was more prevalent among primary school level (35.1%). Bipolar affective disorder was more prevalent among middle level (40%). As we noticed there were more depressive disorders among middle and primary levels of education compared to other levels, except for major depressive disorders and recurrent which was more among illiterates. This was supported by Blazer et al. (1994), and Noh et al., (1994), who found that depressive disorders were more prevalent among lower levels of education, and illiterates. On the other hand Romanoski and Merchant (1992), that educational level did not have great effect on prevalence of depressive disorders.

As regards occupation, as shown in table (2), the highest prevalence for depression was among those without work (43.4%), then employee (25%), then hard workers, and students, with the least prevalence was found among farmers (3.9%). Depressive disorders were more prevalent among employees in the current study, may be due to the economic

factors, as they have low income not sufficient for living standards. As regard to individual depressive disorders as in Table 6., major depressive disorder (1st episode) was more prevalent among employee (46.7%), however, major depressive disorder (recurrent) was more among those jobless persons (46.7%). Dystymia was found more among Laborers (40.5%), and students (50%). Bipolar affective disorder was more among students as well as laborers (either was 40%). These findings are in accordance with Abdel-Hakim (1992, and Romanoski and Merchant (1992).

As regards the frequency of the different depressive symptoms and signs, as shown in Table (7) the most prevalent symptoms were easy fatigability (93.4%), intermittent insomnia (80.3%), irritability (81.6%), and depressed mood (78.9%), whereas melancholic symptoms, suicidal attempts, psychotic symptoms, and guilt feeling were the least prevalent symptoms. These results are in accordance with Weissman, (1994).

Other findings

It was found that 72.4% of those having one of the depressive disorders have a family size of 4 members or more which is statistically significant. There is no statistically significant relation between presence of depressive disorders and the associated psychosocial stresses.

As regards family history of persons having any of the depressive disorders, 22.3% of persons having major depression, reported positive consanguinity between there parents. Also, there is a family history of one of the affective disorders in 22.4% which divided as follows: 9.3 having major depression, 7.9% of those having dysthymia, and the rest for other types of depressive disorders.

*As regards past history of persons suffering from depressive disorders, 39.5% gave history of similar condition in the past, 9.2% gave past history of other psychiatric disorders. As regards Axis II psychiatric diagnosis was found where there was no personality disorder.

However, there were histrionic, dependent, obsessive, and avoidant personality traits. The personality traits were more prevalent in patients with Dysthymic disorder

Table (1): Point Prevalence of Different Depressive Disorders in Abou-Khalifa Village, Ismailia Governorate, According to DSMIII-R.

Diagnosis	No. cases	% (n=1092)	%(n=76)
*M. D.,1 st	15	1.37	19.7
M. D. Recurrent	14	1.28	18.4
Dysthymia	37	3.38	48.7
Bipolar,**dep.	5	0.45	6.6
Dep. NOS	2	0.18	2.6
Cyclothymia	3	0.27	3.9
Total	76	6.95	

* N.B. mean:2.66, SD:1:18, * Major Depression, ** Depression

Table(2): General Characteristics of 18 Years and Older in Abou-Khalifa, Ismailia, Egypt.

Items		Depressed		Non-depressed		Total	Chi square	P value
		No.	%	No.	%	N=109		
Sex	Male	26	34	496	48.8	522		
	Female	50	65.8	520	51.2	570	6.05	0.001
	Total	76	100	1016	100	1092		
Age Groups	18-25	10	13.1	295	29.0	305		
	26-35	20	26.3	368	36.2	388		
	36-45	21	27.6	183	18	204		
	46-55	16	21.0	102	10	118		
	56+	9	11.8	068	0.7	77	22.4	0.0001
Marital Status	Single	35	46.1	457	44.9	492		
	Married	33	43.4	492	48.4	525		
	Widow	5	0.1	43	4	48		
	Divorced	3	0.4	24	2	27	1.99	0.58
Education	Illiterate	13	17.1	274	26.9	287		
	R and W	13	17.1	223	21.9	236		
	Primary	17	22.4	176	17.3	193		
	Middle	23	30.3	236	23.2	259		
	High	10	13	107	10.5	117	6.33	0.18

* The value is significant when P is 0.05 or less.

Table(3): Point Prevalence of Depressive Disorders in Abou-Khalifa, Ismailia, Egypt, According to Age Group in Years.

Diagnosis (%)	18-25	26-35	36-45	46-55	+ 56	Total (n =100%)
M. D. 1 st episode	13.3	33.3	40	13.3		15
M.D. recurrent			21.4	33.7	42.9	14
Dysthymia	10.8	27	32.4	21.6	8.1	5
Bipolar	40	40		20		
Cyclothymia	33.3	66.7				3
Depression NOS	50	50				2

Chi: 2.085, P-value: 0.149

Table(4): Point Prevalence of Depressive Disorders in Abou-Khalifa, Ismailia, Egypt, According to Marital Status.

Diagnosis	Single		Married		Widow		Divorced		Total n=100 %
	n	%	n	%	n	%	n	%	
*M. D., 1 st episode	7	46.7	6	40	1	6.7	1	6.7	15
M. D. recurrent	1	7.1	11	78.6			2	14.3	14
Dysthymia	20	54.1	13	35.1	4	10.8			37
Bipolar, depression	3	60	2	6.6					5
Depression NOS	2	100							2
Cyclothymia	2	66.7	1	33.3					3
Total	35	46.1	33	3.4	5	0.9	3	6.6	76

Chi: 2.529, P value: 0.001, *M.D.: major depression

Table(5): Point Prevalence of Depressive Disorders in Abou-Khalifa, Ismailia, Egypt, According to Educational Level.

Diagnosis (%)	*Illiterate	**R and W	Primary	Middle	University	Total n=100 %
M. D. 1 st episode	13.3		46.7	20	20	15
M. D. recurrent	42.9	35.7		21.4		14
Dysthymia	10.8	18.9	35.1	21.6	13.5	37
Bipolar, depression	20	20	20	40		5
Dep. NOS			100			2
Cyclothymia				33.3	66.7	3

Chi: 1.153, P-value: 0.283, *illiterate, **R and W: read and write

Table(6): Point Prevalence of Depressive Disorder in Abou-Khalifa, Ismailia, Egypt, According to Occupation.

Diagnosis (%)	Witho ut	Labore r	Student	Employee	Farme r	Total n=100%
M. D. 1 st episode	26.7	13.3	13.3	46.7		15
M. D., recurrent	71.4	14.3			14.3	14
Dysthymia	40.5	18.9	13.5	24.3	2.7	37
Bipolar	40		40	20		5
Cyclothymia	33.3		10	66.7		3
Depression NOS	50		50			2
Total	43.4	14.5	14	25	0.95	76

Chi: 0.105, P-value: 0.07

Table(7): Frequencies of Depressive Symptoms and Signs in Patients Suffering from Depressive Disorders, In Abou-Khalifa, Ismaili, Egypt

Symptom or sign	n	%	Symptom or sign	n	%
Lack of energy	71	93	Hypersomnia	17	22.4
Easy irritability	62	81.6	Decreased libido	15	19.7
Intermittent insomnia	61	80.3	Death thoughts	14	18.4
Depressed mood	60	78.9	Hyperphagia	13	17.1
Lack of appetite	60	78.9	Guilt feeling	10	13.2
Lack of interest	53	69.7	Psychotic symptoms	8	10.5
Somatic complaints	44	57.9	Suicidal attempts	7	9.2
Lack of concentration	41	53.9	Melancholic symptoms	6	7.9
Slow thinking	37	48.7	Decreased body weight	4	5.3
Impairment in social functions	35	46.1	Increased body weight	2	2.6
Occupational impairment	34	44.7			

Future Directions for Research and Other Implications

*There is a need to replicate this clinico-epidemiological household study in urban Egyptian communities, as well as in similar and different rural communities before we can draw general conclusions to Egyptian society. *It is recommended that a research team on a national level, e.g. National Center for Social and criminological Research in Cairo (NCSCR), to carry out such national projects, so that other mental disorders can

be investigated simultaneously. Another alternative is a coordination between the NCSCR and different universities in Egypt to carry out only a research on a problem of interest, so that a whole picture can be drawn with avoidance to unnecessary research work.

*The response rate can be improved through a good preparatory stage preceded

conduction of the community study by enough time. A good relation with key people can be built, and any emergent or expected problem can be dealt with through this preparatory stage. However, the Egyptian society need more education through different means of media about the importance of their collaboration in such kind of research.

Conclusion

The current study encourages undertaking more community surveys of depressive disorders as well as other psychiatric disorders on a coordinated national based scale and better design. Yet within its limitations it came with specific findings, which can be used in planning and implementation of health services needed for similar rural communities.

The multi-stage design of the current study as well as its containing of a clinical psychiatric assessment refine results which had been got from general screening, and add helpful data about the risk factors of depression compared to studies which did not include this clinical approach.

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وبائيات الاضطرابات الاكتئابية في مسح منزلي لمنطقة ريفية في مصر

لقد تمت دراسة معدل الانتشار المحدد لاضطرابات الاكتئاب وعوامل الخطر المتعلقة به . ولقد استخدمت الدراسة استطلاع الصحة العامة المعرب لجولد برج كاداه مسحية اوليه لسكان مجتمع ريفي تابع لمحافظة الاسماعليه -القاهره -مصر ولقد اتبعت بقباله اكلينيكيه طب نفسيه معتمده على التشخيص الامريكي الثالث المعدل لكل من حصل على سبع درجات فاكثر في استخبار الصحة العامة المشار اليه آنفا .

وقد شملت الدراسه كل من هو بالغ ١٨ عاما فاكثر من الجنسين وبشرط ان يكون من سكان القرية لمدته ٦ اشهر على الاقل قبل البدء في الدراسه .

وكانت النتائج كالآتي : معدل الانتشار المحدد لكل اضطرابات الاكتئاب هو ٦,٩٥ % . وبالنسبه لمعدلات الانتشار لاضطرابات الاكتئاب المختلفه فكانت كالتالي : ١,٣٧ % لنوبه الاكتئاب العظمى)

الاولى (١,٢٨ % لنوبه الاكتئاب العظمى (المتكرره) ، ٣,٣٨ % لاضطراب عسر المزاج ، ٠.٤٥ % لاضطراب ثنائى القطبيه (نوبه اكتئاب) ٠,٢٧ % للاكتئاب الدورى واخيرا ٠,١٨ % للاكتئاب غير المصنف، ولقد وجد ان اضطرابات الاكتئاب اكثر انتشارا بين الاشخاص فى المجموعه العمرية من ٢٦ - ٤٥ عاما (٥٢,٦٥ %) وبين الاناث (٦٥,٨ %) ، والعزاب (٤٦,٥ %) ، والمستويات التعليميه المتوسطه والأساسية (٥٢,٦١ %) ، والاشخاص الذين لا يعملون ، شاملة ربات البيوت (٤٣,٤ %) . ولقد وجد ان اكثر الاعراض الاكتئابيه ورودا هى سرعه الاجهاد (٦٢,٤ %) والارق اثناء النوم ٨٠,٣ % وسرعه الاسهاله (٨١,٦ %) ومزاج حزین (٧٨,٩ %) .

Service at the Institute of Psychiatry Abbasia, Cairo

24 hours emergency service.

Three daily outpatients clinics, four days a week.

Four specialized clinics in child psychiatry, addiction, psychosexual disorder, and sleep disorders.

An inpatient department with 100 beds, 25% of which are free .

A day hospital that provides rehabilitative, vocational and occupational therapies for patients with residual handicaps secondary to their mental disorders.

An electrophysiological unit embracing assessment through EEG, evoked potential, brain map and sleep laboratory.

A unit for psychological assessment.

A biochemical laboratory which carries out routine lab investigations in addition to substance detection in body fluids.