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PREVALENCE OF PERSISTENT DEPRESSIVE DISORDER AMONG PSYCHIATRIC OUTPATIENTS IN AL-AZHAR UNIVERSITY HOSPITALS

By

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ABSTRACT

Background: Persistent Depressive Disorder (PDD) has higher comorbidity rates and negative impact on different aspects of patient's life than episodic, non-chronic, Major Depressive Disorder. To our knowledge, no recent studies about PDD held in Egypt.

Objective: To estimate the prevalence and comorbidities of PDD and its subtypes among a sample of psychiatric outpatients.

Patients and methods: This was an observational, cross-sectional, non-randomized study. It was conducted in Al-Azhar University hospitals over the period from October 2109 till July 2020. Sample of 111 adult patients, aging (18 - 65) years old from both genders, who are visiting the psychiatric outpatient for whatever complaint are collected consecutively. Prior to applying the tests, patients with the diagnosis of bipolar I and II disorders, psychotic disorders, acute suicidality, intellectual disabilities, organic mental disorders, or history of brain surgery were excluded from the study. Those patients underwent detailed clinical examination, patient health questionnaire and persistent depression screener.

Results: Prevalence of PDD among our sample was 36.9% (n=41) with late onset in 55% (n=22). The subtype "intermittent major depressive episodes with current episode" was the most prevalent subtype in 61% (n=25). post-traumatic stress disorder and specific phobia were significantly more common in PDD cases (P= 0.001, P=0.41 respectively), while panic disorder was significantly less common (P=0.013). All other comorbidities were equally distributed among PDD and non-PDD cases.

Conclusion: PDD was a highly prevalent psychiatric disorder and may be masked by comorbid psychiatric disorders even MDD. These findings might promote psychiatrists to give more attention to PDD because of its impact on prognosis of other disorders and patient's quality of life.

Keywords: persistent depressive, dysthymia, chronic depression, psychiatric comorbidity.

INTRODUCTION

Depression is the most prevalent mental disorder affecting over three hundred twenty-two million people worldwide. It is ranked by World Health Organization (WHO) as the single largest contributor to global disability (7.5% of all years lived with disability in 2015). It is also the major contributor to suicide deaths, which number close to 800000 cases annually. It is more common among females than males (5.1%, 3.6% respectively). It is the fifth cause of disability on Egypt in 2017 *(WHO, 2017).*

If depressive symptoms persist for 2 years or longer, depression is considered to be chronic or, according to Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5): Persistent Depressive Disorder (PDD) or Dysthymia, representing a consolidation of the DSM-IV definitions of chronic major depression and dysthymic disorder. PDD incorporates four different clinical subtypes: (1) pure dysthymic syndrome; (2) persistent major depressive episode (MDE); (3) intermittent MDE with current episode; (4) intermittent MDE without current episode *(APA, 2013)*.

Patients with PDD have an earlier onset and higher comorbidity rates than patients with non-chronic depression, and are less responsive to traditional pharmacological or psychological treatments *(Guhn et al., 2019)*. It is a major public health problem regarding to its frequency and its impact. In the general population, it has an estimated lifetime prevalence of 4.6% in modern study *(Murphy and Byrne, 2012)*, or up to 6.4% in old studies depending on the diagnostic criteria employed, while in psychiatric population may reach 36% *(Schramm et al., 2020)*. In comparison to individuals with nonchronic -episodic- major depressive disorder, those with persistent depressive disorder are at higher risk for psychiatric comorbidities in general *(Wiersma et al., 2011* and *APA, 2013)*, and for anxiety disorders, substance use disorders and personality disorders. They are more liable for greater social impairment and lower quality of life, more impaired physical health, and more frequent suicide attempts and hospitalizations *(Klein et al., 2015)*.

Also patients with PDD have difficulties in their personal relationships, work, education, financial, sexual, and leisure activities *(Schramm et al., 2020)*.

Despite this high prevalence, there are several studies showing that patients with dysthymia are not diagnosed and consequently not treated appropriately. This difficulty in establishing a diagnosis of dysthymia is related to the presence of an underlying depression or its association with another disorder, often being the reason for the main complaint. However, despite the high levels of comorbidity, dysthymia is frequently the main underlying disorder *(Ventriglio et al., 2020)*.

It is possible that many psychiatrists consider major depression and panic to represent the major focus of treatment presenting clinically, and thereby may miss the opportunity to treat the underlying PDD. There is a risk in paying attention predominantly to somatic or anxiety complaints of the patients, considering the depressive symptoms as a secondary reaction, instead of the main disorder, which may lead to treatment error *(Klein and Black, 2013)*.

Patients with chronic depression seem to respond better to specific forms of therapy, e.g. the cognitive behavioral analysis system of psychotherapy (CBASP) than to unspecified forms of therapy. So it is necessary to identify chronic courses of depression since treatment of chronically depressed patients seems to be more successful when their particular needs and deficits, such as interpersonal problems and comorbidity with personality disorders, are directly addressed *(Brinkmann et al., 2019)*.

Psychiatrists with a horizontal perspective are more likely to diagnose Major Depressive Disorder, while those with a vertical perspective are more likely to identify chronic depression (i.e. PDD) in the majority of depressive patients. The incorporation of both perspectives into DSM-5 in a complementary way will possibly enhance the insight into depressive disorders and improve treatment results *(Ildirli et al, 2015)*.

A knowledge gap remains regarding the lifetime characteristics and correlates of chronic depression and the reliability of the PDD concept itself *(Nübel et al., 2020)*.

In Egypt, few studies discussed dysthymia, to our knowledge there are no recent studies on the new concept of PDD.

The present work aimed to estimate the prevalence and comorbidities of Persistent Depressive Disorder (Dysthymia) and its subtypes among psychiatric outpatients in Al-Azhar University Hospitals.

PATIENTS AND METHODS

This study was designed as an observational, cross-sectional, non-randomized study. It was conducted in Al-Azhar University Hospitals (Al-Hussein and Sayed Galal Hospitals) over the period from October 2109 till July 2020.

This study was approved by the Ethics Board of Al-Azhar University.

Sample of 111 patients was collected by consecutive sampling, from psychiatric outpatient clinics satisfying all the inclusion criteria: Psychiatric Outpatient and their ages ranging between 18 - 65 years. Patients are free from exclusion criteria: Cognitive Impairment, Bipolar Affective Disorder, Organic mental disease, history of neurosurgery and Psychotic Disorders. Those patients underwent:

1. Detailed clinical examination by well-trained senior psychiatrist including mental state examination (MSE) regarding DSM-5 criteria. The psychiatric interview will be based on the Structured Clinical Interview for DSM *(Brinkmann et al., 2019)*.
2. Patient Health Questionnaire-9: A Self-report questionnaire can provide an accurate diagnosis that is equally valid when compared to the structured clinical interview. PHQ-9 is one of the most widely used clinical diagnostic instruments. It is valid and reliable in detecting depression. In many studies, the Arabic version was used, and its validity and reliability were assured *(Alhadi et al., 2017)*.
3. Persistent depression screener: A paper-and-pencil screening composed of one question. It is to be administered following a self-rating instrument for depressive symptoms (e.g. PHQ-9). The PDS is based on the DSM-5 criteria for PDD and focusses on criterion for chronicity of the symptoms *(Brinkmann et al., 2019)*.

The screening question read:

“The previous questions covered various symptoms of depression. Now, please consider: When was the last period of two months or longer that you were not impaired by these symptoms?”

The following response options were given:

a. Less than a year ago.
b. More than a year but less than 2 years ago.
c. More than 2 years but less than 5 years ago.
d. More than 5 years but less than 10 years ago.
e. More than 10 years ago.

Answer Keys:

(a) and (b) indicate a likely absence of PDD ("PDS negative").

(c), (d) and (e) indicate a likely presence of PDD ("PDS positive").

Statistical Analysis:

The collected data were revised, coded, tabulated and introduced to a PC using Statistical package for Social Science (IBM Corp., Version 20.0. Armonk, NY: IBM Corp). Data was presented and suitable analysis was done according to the type of data obtained for each parameter.

- Description of quantitative variables as mean and SD.
- Description of qualitative variables as number and percentage.
- Chi-square test was used to compare qualitative variables.
- $P \leq 0.05$ was considered significant.

RESULTS

Age of the included patients was 32.23±9.22 years (mean±SD) ranging from 19 to 65 years. Male patients were 55 (49.5%) while females were 56 (50.5%). Majority of patients were singles 57 (51.4%). Offspring ranged between 0-3 with majority of 2 offspring in 24 (52.2%) of non-single cases. Most (66.7%) of sample had university education and 73 (65.8%) were jobless. Urban residents were 75 (67.6%) and nonsmokers were the majority 85 (76.6%) **(Table 1)**.

Table (1): Baseline characteristics of the sample

Variables		**whole sample**		**PDD**	
Age (mean±SD)		32.23	9.22	34	10
		N	**%**	**N**	**%**
Sex	Male	55	49.5%	15	36.6%
	Female	56	50.5%	26	63.4%
Marital state	Single	57	51.4%	25	61.0%
	Married	37	33.3%	9	22.0%
	Divorced	8	7.2%	5	12.2%
	Widow	1	0.9%	1	2.4%
	Separated	0	0.0%	0	0.0%
	Engaged	8	7.2%	1	2.4%
Offspring	0	6	13.0%	3	20.0%
	1	6	13.0%	2	13.3%
	2	24	52.2%	5	33.3%
	3	10	21.7%	5	33.3%
Educational level	Illiterate	0	0.0%	0	0.0%
	Low	3	2.7%	1	2.4%
	Moderate	34	30.6%	14	34.1%
	High	74	66.7%	26	63.4%
Job	Employed	38	34.2%	15	36.6%
	Unemployed	73	65.8%	26	63.4%
Residency	Rural	36	32.4%	13	31.7%
	Urban	75	67.6%	28	68.3%
Smoking	Nonsmoker	85	76.6%	32	78.0%
	Smoker	26	23.4%	9	22.0%

Among the study sample of 111 psychiatric outpatients, PDD was found in 41 cases (36.9%) **(Table 2)**.

Table (2): Prevalence of PDD

Diagnosis		Number	Percentage
PDD	**No**	70	63.1%
	Yes	41	36.9%

The onset was early in 19 (46.3%) and late in 22 (53.7%). The subtype "intermittent major depressive episodes, with current episode" was the most prevalent in the sample (61%) followed by the "pure dysthymic syndrome, 17.1%" then "intermittent major depressive episodes, without current episode, 14.6%" **(Table 3)**.

Table (3): PDD onset and subtypes

Onset - Subtypes		N	%
Onset	Early, before age 21 years	19	46.3%
	Late, at age 21 years or older	22	53.7%
Subtypes	pure dysthymic syndrome	7	17.1%
	persistent major depressive episode	3	7.3%
	intermittent major depressive episodes, with current episode	25	61.0%
	intermittent major depressive episodes, without current episode	6	14.6%

Post-traumatic stress disorder (PTSD) and specific phobia were significantly more common in PDD cases (P= 0.001, P=0.41 respectively) while panic disorder was significantly less common (P=0.013). All other comorbidities were equally distributed among PDD and non PDD cases. Generalized anxiety disorder (GAD), (PTSD) and Obsessive-Compulsive Personality Disorder (OCPD) the most prevalent comorbidities **(Table 4)**.

Table (4): PDD relation with other comorbidities

Groups / Comorbid disorders	Non-PDD (N=70)		PDD (N=41)		P
	N	%	N	%	
Generalized Anxiety Disorder	28	40.0%	18	43.9%	0.687
Post-Traumatic Stress Disorder	2	2.9%	9	22.0%	**0.001**
Obsessive compulsive PD	8	11.4%	5	12.2%	0.904
Obsessive Compulsive Disorder	11	15.7%	4	9.8%	0.376
Social Anxiety Disorder	6	8.6%	4	9.8%	0.833
Specific Phobia	1	1.4%	4	9.8%	**0.041**
Avoidant Personality Disorder	3	4.3%	4	9.8%	0.252
Borderline Personality Disorder	4	5.7%	4	9.8%	0.427
Substance Use Disorder	11	15.7%	3	7.3%	0.198
Somatic Symptom Disorder	3	4.3%	3	7.3%	0.507
Dependent Personality Disorder	2	2.9%	2	4.9%	0.581
Panic Disorder	13	18.6%	1	2.4%	**0.013**
Paranoid Personality Disorder	2	2.9%	1	2.4%	0.896
Histrionic Personality Disorder	5	7.1%	1	2.4%	0.290
Alcohol Use Disorder	2	2.9%	0	0.0%	0.275
Agoraphobia	5	7.1%	0	0.0%	0.080
Illness Anxiety Disorder	4	5.7%	0	0.0%	0.119
Conversion Disorder	1	1.4%	0	0.0%	0.442
Adult ADHD	2	3.8%	0	0.0%	0.298
Trichotillomania	1	1.4%	0	0.0%	0.442
Schizoid Personality Disorder	2	2.9%	0	0.0%	0.275
Narcissistic PD	5	7.1%	0	0.0%	0.080
Antisocial Personality Disorder	2	2.9%	0	0.0%	0.275
Unspecified PD	1	1.4%	0	0.0%	0.442

DISCUSSION

In our sample, the female to male ratio (2:1 while being 1:1 in the whole sample) correspond to a well-established information obtained from many previous studies which state that the rate of chronic depression is almost twice as great in women than in men *(Schramm et al., 2020)*.

Regarding employment status, our findings are in line with other studies which demonstrated that patients with chronic depression have a higher risk of employment problems, including decreased productivity and increased unemployment. A study found that at 6 months follow up, 14% of patients with dysthymia were newly unemployed, compared with 2% new unemployment in the control group and 3% new unemployment in a group with rheumatoid arthritis. It is observed that there is an inverse relationship between the prevalence of mental disorders and functionality of the patients *(Hellerstein et al., 2017)*.

Prevalence of PDD among psychiatric outpatients in this study (36.9%) is close to some previous studies, particularly those found rates of dysthymia at around 36% among DSM III psychiatric patients, but higher than some other studies those fount it to vary from 26 to 36% in psychiatric populations *(Murphy & Byrne, 2012* and *Markkula et al., 2015)*. These differences may be due to an evolution and expansion of the concept of PDD.

The chronic characteristic of dysthymia is associated with higher rates of prevalence mainly because it is well established that any factor that elevates the duration of a disorder raises its prevalence and, consequently, the chances of identification of a case.

The majority of our PDD patients had a late onset of the disorder (55%), a finding which was in conflicts with other studies *(Schramm et al., 2020)*.

This discrepancy could be explained by the difference in the study sample by changing and expanding the concept of PDD and because these symptoms have become a part of the individual's day-to-day experience, particularly in the case of early onset. They may not be reported unless the individual is directly prompted *(APA, 2013)*.

The most prevalent subtype of PDD was intermittent major depressive episodes, with current episode by about 61%, which was in line with the assumption that the leading cause of patients to seek psychiatric help was acute moderate to severe complaints rather than chronic mild ones. In a previous study it is estimated that 75% of people with dysthymia meet criteria for at least 1 major depressive episode, referred to as double depression *(Wenzel, 2017)*. To our knowledge, no studies examined prevalence of PDD subtypes.

PDD patients had high comorbidity rates with generalized anxiety disorder, post-traumatic stress disorder and obsessive-compulsive personality disorder. In comparison to Non-PDD cases post-traumatic stress disorder and specific phobia were significantly more common in PDD cases, while panic disorder was significantly less common. All other comorbidities were equally distributed among PDD and non PDD cases.

Regarding comorbid PDs, cluster C PDs was the most prevalent by 11 diagnoses, then cluster B by 6 diagnoses. The most prevalent PD was OCPD then avoidant and borderline. This finding showed a minor difference with other previous studies which count avoidant PD as the most prevalent PD *(Erkens et al., 2018)*. This minor discrepancy may be due to small sample size and sociocultural factors.

In a previous epidemiological studies, common psychiatric comorbidities include major depression (up to 75%, which is counted in our study as a subtype of PDD regarding the diagnostic entity introduced into DSM-5), anxiety disorders (up to 50%), personality disorders (20–40% or more among those with early-onset PDD), somatoform disorders (2.8%–45.2%), and substance abuse (up to 50%) *(Erkens et al., 2018* and *Köhler et al., 2019)*. In our study, the comorbidity rate of Substance Use Disorder is less than western studies, this discrepancy may be due to socio-cultural factors.

The presence of another disorder leading to the under recognition of dysthymia is a source of treatment error. There is a risk in paying attention predominantly to somatic or anxiety complaints of the patients, considering the depressive symptoms as a secondary reaction, instead of the main disorder *(Vandeleur et al., 2017)*.

Even though, this findings are not new in scientific literature, this is the first description of such a new diagnostic entity in an Egyptian psychiatric population.

CONCLUSION

PDD was a highly prevalent psychiatric disorder rand may be masked by comorbid psychiatric disorders even MDD. These findings might promote psychiatrists to give more attention to PDD because of its impact on prognosis of other disorders and patients quality of life.

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معدل انتشار اضطراب الاكتئاب المستمر بين مرضى عيادات الطب النفسي في مستشفيات جامعة الأزهر

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خلفيــة البحــث: اضــطراب الاكتئــاب المســتمر هــو تشــخيص جديــد تــم إدخالــه فـــي الـــدليل التشخيصـــي والإحصـــائي للاضـــطرابات العقليـــة، الإصـــدار الخـــامس، وهـــو يمثـــل دمجًـــا لتعريفـــات الإصـــدار الرابـــع للاكتئـــاب المـــزمن واضـــطراب عســـر المـــزاج. وهـــو يختلـــف عـــن نوبـــات اضـــطراب الاكتئـــاب الجســـيم العرضـــية وغيـــر المزمنـــة فـــي ارتفـــاع معـــدلات الاعـــتلال المشـــترك والتـــأثير الســـلبي علـــى جوانـــب مختلفـــة مـــن حيـــاة المـــريض. علـــى حـــد علمنـــا، لا توجـــد دراســـات حديثـــة حـــول اضـــطراب الاكتئـــاب الجســـيم أجريـــت فـــي مصر.

الهـــدف مـــن البحـــث: دراســـة مـــدى انتشـــار اضـــطراب الاكتئـــاب المســـتمر وأنواعـــه الفرعيـــة والاعـــتلالات المصـــاحبة بـــين عينـــة مـــن مرضـــى العيـــادات الخارجية للأمراض النفسية بجامعة الأزهر.

المرضـــى وطـــرق البحـــث: اعتمـــدت هـــذه الدراســـة علـــى الملاحظـــة لقطـــاع مـــن مرضـــى عيـــادات الطـــب النفســـي بمستشـــفيات جامعـــة الأزهـــر والـــذين تتـــراوح أعمـــارهم بـــين 18 إلـــى 25 ســـنة ولا يعـــانون مـــن الاضـــطرابات الذهانيـــة، اضـــطراب ثنـــائي القطـــب أو الخلـــل المعرفـــي أو العضـــوي بـــالمخ. وقـــد تـــم جمـــع عينـــة مـــن 111 مريضـــا بطريقـــة التـــوالي مـــن العيـــادات الخارجيـــة للأمـــراض النفســـية فـــي الفتـــرة مـــن أكتـــوبر 2019 وحتـــى يوليـــو 2020. **وقـــد خضـــع هـــؤلاء المرضـــى إلـــى:** فحـــص عيـــادي مفصـــل، اســـتبيان صـــحة المريض-9 وفاحص الاكتئاب المستمر.

نتـــائج البحـــث: كـــان معـــدل انتشـــار اضـــطراب الاكتئـــاب المســـتمر بـــين عينـــة الدراســـة 36.9٪ (العـــدد = 41) مـــع ظهـــور متـــأخر فـــي 53.7٪ (العـــدد = 22). النـــوع الفرعـــي "نوبـــات الاكتئـــاب الجســـيم المتقطعـــة مـــع نوبـــة حاليـــة" هـــو النـــوع الفرعـــي الأكثـــر انتشـــارًا فـــي 61٪ (العـــدد = 25). وكـــان اضـــطراب مـــا بعـــد الصـــدمة والرهـــاب المحـــدد أكثـــر شـــيوعًا بشـــكل ملحـــوظ فـــي حـــالات اضـــطراب الاكتئـــاب المســـتمر، بينمـــا كـــان اضـــطراب الهلـــع أقـــل شيوعًا.

الاســـتنتاج: اضـــطراب الاكتئـــاب المســـتمر هـــو اضـــطراب نفســـي واســـع الانتشـــار وقـــد يكـــون مغطـــى بالاضـــطرابات النفســـية الأخـــرى بمـــا فيهـــا نوبـــات الاكتئـــاب الجســـيم. وقـــد تشـــجع هـــذه النتـــائج الأطبـــاء النفســـيين علـــى إعطـــاء المزيـــد مـــن الاهتمـــام لاضـــطراب الاكتئـــاب المســـتمر لمـــا لـــه مـــن تـــأثير على تشخيص الاضطرابات الأخرى وجودة حياة المرضى.