Dysthymia in Young Adults: A Survey

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Abstract

Introduction: Dysthymia is a recurrent, prolonged depressive disorder, understudied, often undertreated and can lead to high rates of death by suicide. A descriptive survey was done to assess the prevalence and severity of Dysthymia among young adults living in selected residential areas of urban community of Delhi and to find out the relationship between Dysthymia and selected demographic variables, that is, age, gender, marital status. *Methodology:* A quantitative research approach (non- experimental) with descriptive survey design was used. 200 young adults were administered Cornell Dysthymia Rating scale (CDRS). *Findings:* Three fourth study subjects were found to have moderate dysthymia. 32 (16%) study subjects had mild dysthymia while 13 (6.5%) study subjects had severe dysthymia. Statistically significant relationship was found between dysthymia and age of the subjects. *Conclusion:* Dysthymia should be addressed through educational programs geared toward acknowledging and addressing dysthymia.

Keywords: Dysthymia; Young Adults; Residential Community.

Introduction

Dysthymia, or Dysthymic Disorder (DD), is a longstanding mood disorder that is characterized by fluctuating dysphoria that may be punctuated by brief periods of normal mood. Far less symptomatically dramatic than its cousin major depression, DD is fairly common in the community and in primary care and mental health settings. While no consistent biological findings are evident, DD appears to have a genetic predisposition. In both psychiatric and primary care settings, DD can be difficult to detect. Treatment may include both pharmacotherapy and psychotherapy, although responses to either may be modest and/or short-lived. The course of DD may be lengthy and a number of prognostic factors are associated with poor outcome [1].

At any point in time, 3% of the population may be affected by Dysthymia. Within a lifetime it appears to affect approximately 6%. Those with immediate relatives who have had major depressive disorder have a greater likelihood of developing Dysthymia. If a person develops Dysthymia, it usually happens early in their lives- from childhood to early adulthood. The symptoms of Dysthymia tend to be chronic, yet people often do not seek treatment unless they develop major depression. Having Dysthymic Disorder increases the risk of developing major depressive disorder. Of those with Dysthymia, approximately 10% will go on to develop major depression. The presence of both conditions is sometimes known as "double depression" [2].

While the cause of the disorder may not be clear, physiologic abnormalities have been associated with Dysthymia. For example, polysomnography or sleep studies have indicated irregularities such as shorter periods of dreamless sleep (nonrapid eye movement NREM sleep); taking a shorter period of time to enter rapid eye-movement REM sleep (latency); and increased frequency of rapid eye movements (density) during REM sleep. Interleukin-1, a group of 11 cytokines which plays a central role in the regulation of immune and inflammatory responses can be elevated. Further, serotonin, a neurotransmitter, can have a lower maximum rate of uptake. In females with Dysthymia, platelet monoamine oxidase activity,

which is needed for neurotransmissions, can be lower [3].

According to the 1988 Epidemiological Catchment Area Study, the prevalence of DD in the US general population is 3.1 percent [4] whereas data from the 1994 National Comorbidity Survey indicate a prevalence rate of 6.4 percent [5]. In a 2004 analysis of the literature, investigators determined a lifetime prevalence of DD in US communities of 3.6 percent [6]. These rates of DD appear comparable to those found in the Netherlands (4.6%) [7]. To summarize, the lifetime prevalence rate of DD in US communities appears to be between 3 and 6 percent.

In US primary care settings, the prevalence of DD is somewhat higher than in community samples. For example, Howland reported rates from 1.3 to 31.9 percent, with a pooled prevalence rate of seven percent [8]. Spitzer and colleagues found that most US primary care settings harboured rates of DD between 5 and 15 percent [9].

In comparison with US primary care settings, rates in international primary care settings seem to vary more. For example, Lecrubier and Weiller [10] reported that the point prevalence rate of DD in primary care settings of 14 countries was 2.1 percent. Baldwin [11] summarized the available international data and reported lifetime prevalence rates in foreign primary care settings between 3.7 and 20.6 percent. In a recent study among primary care patients in Spain, Aragones et al. [12] found a current prevalence rate of 4.8 percent. As one might expect, the rates for DD are higher in psychiatric settings as well as among women compared with men.

Globally Dysthymia occurs in about 105 million people a year (1.5% of the population). It is slightly more common in women (1.8%) than in men (1.3%) [13]. The lifetime prevalence rate of Dysthymia in community settings appears to range from 3 to 6% in India [14]. However, in primary care settings the rate is higher ranging from 5 to 15%. United States prevalence rates tend to be somewhat higher than rates in other countries [1].

Living with the unrelenting burden of Persistent Depressive Disorder (PDD) or dysthymia leaves those who are afflicted feeling despondent and hopeless most of their lives. PDD or Dysthymia is a recurrent, prolonged depressive disorder with no clearly demarcated episodes. Dysthymia, from the Greek "ill humour" or "bad state of mind" is understudied, often undertreated and can lead to high rates of death by suicide [3]. New researches and surveys are needed in order to provide more data related to disease condition so that taking care of it will be more easy and effective. Keeping this in mind, a descriptive survey was done to assess the prevalence and severity of Dysthymia among young adults living in selected residential areas of urban community of Delhi and to find out the relationship between Dysthymia and selected demographic variables, that is, age, gender, marital status.

Methodology

A quantitative research approach (non-experimental) with descriptive survey design was considered as a good fit for the present study. The study was conducted at the selected residential areas of urban community of Delhi. The reasons for selecting the setting were: feasibility of conducting the study, expectation of cooperation from subjects, familiarity with setting, economy of time and easy access. The population selected in the present study was young adults living in the selected residential areas of urban community. The population was selected on the basis of previously done researches in which high prevalence of Dysthymia was shown in the age group of young adults. Total sample size for the present study was 200 young adults between the age group of 20-40 years, both genders, able to read and understand English language, living in selected residential areas of urban community. The sampling technique adopted in this study was purposive sampling.

The data collection tool for this study had two sections. Section 1 consisted of questions related to demographic data of sample subjects such as age, gender, education, occupation, and marital status. Section 2 consisted of a standardized tool called Cornell Dysthymia Rating scale (CDRS). It was developed by Mason et al. in 1993 in NIMH. The CDRS includes 20 items. Each item is characterized by explanatory or illustrative description and rated from 0 (symptom absent) to 4 (severe symptoms). 11 items are rated by frequency of occurrence, 5 items were rated by severity of degree and 4 items are rated by both frequency and severity.

Content validity of CDRS was assessed by Mason et al. comparing means, standard deviations and frequency distributions of ratings on items of the CDRS and Hamilton Depression Rating Scale (HDRS). Symptom ratings on these two scales were compared with data from the DSM-IV Field Trial. In addition, the frequency of symptoms in the DSM-IV Field Trial was compared with the frequency of symptoms in the sample as measured by both scales using Spearman rank order correlations Excellent content validity was demonstrated, since CDRS assesses the primary and most common symptoms of Dysthymic Disorder.

Inter-rater reliability was calculated using a subsample of 10 patients. Five raters were paired up and each patient was rated by a pair of raters. Average interclass correlations (1,k) for the 10 pairs were 0.92 for the Cornell Dysthymia Rating Scale indicating the high reliability.

Based on the scores obtained, a range was created to divide the problems into 'mild dysthymia', 'moderate dysthymia' and 'severe dysthymia'. The possible range of scores to be obtained was from 0-80. The following categories were created for the interpretation of the dysthymia faced by study subjects. Hence, their scores were interpreted as:

Scoring from:(0-20): Mild dysthymia

(21-59): Moderate dysthymia

(More than 60): Severe dysthymia

Subjects who were present at the time of data collection and met the inclusion criteria were taken as study subjects after taking informed consent from each subject. Permission to conduct survey on the residents of selected areas of New Delhi was taken from President of Resident Welfare Associations (RWAs) of the selected urban residential colonies in Delhi. Purpose of the study was explained to the study subjects and the tools were administered. The responses and data thus collected were analysed using both descriptive and inferential statistics.

Findings of the study

Description of demographic characteristics of study subjects

Table 1: Frequency and percentage distribution of adolescents by their age, gender, educational qualification, occupation and marital status.

N= 200

S. No.	Demographic characteristics	Frequency	Percentage (%)
1.	Age (in years):		
	• 20-25	45	22.5
	• 26- 30	47	23.5
	• 31-35	58	29
	• 36-40	50	25
2.	Gender:		
	• Male	112	56
	• Female	88	44
3.	Educational Qualification:		
	• Illiterate	0	0
	• Primary school	0	0
	• Secondary school	65	32.5
	• Graduate	101	50.5
	• Post graduate and above	34	17
4.	Occupation:		
	• Government job	38	19
	• Private job	37	18.5
	• Self employed	57	28.5
	• House-wife	23	11.5
	• Student	45	22.5
	• Unemployed		
5.	Marital status:		
	• Single	70	35
	• Married	119	59.5
	• Widower/ widowed	11	5.5
	• Divorced	0	0
	• Separated	0	0

Findings on prevalence and severity of dysthymia among young adults

Table 2: Frequency and percentage distribution of the study subject by the severity of dysthymia and mean, median, mode, and standard deviation of dysthymia score.

N=200

Dysthymia categories	Frequency	Percentage (%)	Mean	Median	Mode	Standard deviation
Mild Dysthymia	32	16	29.71	31	29	7.325
Moderate Dysthymia	155	77.5				
Severe Dysthymia	13	6.5				

The data in Table 2 depicts that approximately three fourth study subjects, that is, 155 (77.5%) had moderate dysthymia. 32 (16%) study subjects had mild dysthymia while 13 (6.5%) study subjects had severe dysthymia (Figure 2). Mean dysthymia score was 29.71 and standard deviation obtained was 7.32.
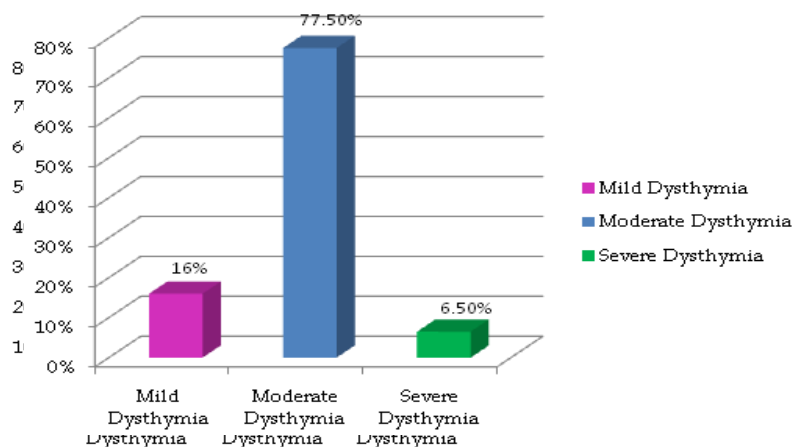

Fig. 2: Column diagram showing the frequency percentage distribution of study subjects by their severity of dysthymia.

Findings related to the association between severity of dysthymia and selected variables (age, gender and marital status).

The data were analyzed to find out the relationship between severity of dysthymia and selected demographic variables by computing the chi-square test values. The results of the chi-square calculations are given below in Table 3.

Table 3: The association between severity of dysthymia of study subjects and age.

N = 200

Category	Mild dysthymia	Moderate Dysthymia	Severe dysthymia	Test used	X^2 value
Age(in years)					
20-30	8	77	7	Chi-square test	6.847*
31-40	24	78	6		

$X^2 (2) = 5.991$ p< 0.05*, significant

With regard to the relationship between age and severity of dysthymia, the obtained chi square value of 5.991 is greater than the table value of 6.847 at df (2) at 0.05 level of significance. This indicates that there is statistically significant relationship between the severity of dysthymia and the age of the study subjects. Thus, age had significant influence on severity of dysthymia of study subjects.

Table 4: The association between severity of dysthymia of study subjects and gender.

N = 200

Category	Mild dysthymia	Moderate dysthymia	Severe dysthymia	Test used	X^2 value
Gender					
• Male	20	81	11		
• Female	12	74	2	Chi square test	5.74

$X^2 (2) = 5.991$ p> 0.05, not significant

The data depicts that the obtained chi-square value of 5.74 is lower than the table value of 5.991 at df (2) at 0.05 level of significance. This indicates that there is no significant relationship between the severity of dysthymia and the gender of the study subjects.

Table 5: The association between severity of dysthymia of study subjects and marital status.

N = 200

Category	Mild dysthymia	Moderate dysthymia	Severe dysthymia	Test used	X^2 value
Marital status					
• Single	13	55	2	Chi square test	
• Married	19	91	9		4.36
• Widower/Widowed	-	9	2		

$X^2 (4) = 9.488$ p> 0.05 , not significant

The data shows that the obtained chi-square value of 4.36 is lower than the table value of 9.488 at df (4) at 0.05 level of significance. This indicates that there is no significant relationship between the severity of dysthymia and the marital status of the study subjects.

Discussion

Dysthymia has become a subject of global concern. Although dysthymia is often considered as 'subsyndromal' depression, it can lead to significant morbidity and impairment of functioning, as well as, it can be a predictive of future episodes of major depressive disorder [20].

The present study concluded that more than three fourth of the study subjects had moderate dysthymia. Less than 1/4th of them had mild dysthymia and while 6.5% had severe dysthymia which is in agreement to a conference report by OMICS International which reports that the lifetime prevalence rate of dysthymia in community settings appears to range from 3 to 6% in India. However, in primary care settings the rate is higher ranging from 5 to 15% [21].

The present study concluded a significant relationship between the severity of dysthymia and the age of the study subjects indicating that age had significant influence on severity of dysthymia among study subjects. A similar result was observed in a survey of five U.S. communities which suggested that although the onset and highest risk periods of major depression and dysthymia are in the young adulthood, a residual state of dysthymia occurs in middle age and old age [22].

The present study revealed surprisingly that there

was no significant association between gender and severity of dysthymia which is not in agreement with previous studies and statistics which estimate that the lifetime prevalence of dysthymia tends to be 4.1% for women and approximately 2.2% for men [23].

Conclusion

Dysthymia should be addressed through educational programs geared toward acknowledging and addressing dysthymia. Nurses can educate the community about dysthymia and how to reduce the causative factors of dysthymia. In the context of the increased prevalence of dysthymia, the nurse administrators should arrange awareness campaigns on dysthymia for the community people and should also assess the effectiveness of such programmes thereafter. Findings of the study will act as catalyst to carry out more extensive research on a large population sample in various other communities. This will help to identify the various aspects of dysthymia. Based on the studies, effective preventive and curative actions can be planned. However, the future studies must be done with larger samples for generalization of the findings.

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