Brief report

Psychosocial impact of dysthymia: A study among married patients

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Abstract

Background: Unlike major depression, the psychosocial impact of dysthymia has received far less research attention. This study attempted to assess the psychosocial consequences of dysthymia.

Methods: The sample consisted of 30 married patients with DSM-IV dysthymic disorder and a matched control group of 30 married patients with recurrent major depressive disorder (RDD), diagnosed using structured interviews. Apart from ratings of severity of depression, assessments of psychosocial impact included quality of life (QOL), disability, perceived social support and marital adjustment. Psychosocial parameters were evaluated using vernacular versions of well-validated scales previously used in similar populations. Matched normal/medically ill controls were derived from Indian studies which had assessed the same parameters using the same instruments.

Results: Patients with dysthymia were significantly impaired on measures of QOL, disability, social support and marital adjustment compared to normal/medically ill controls. On the other hand, the two groups of dysthymia and RDD were comparable on these measures apart from significantly lower social support among patients with dysthymia. Duration of illness and severity of depression emerged as the most important correlates, particularly of impaired QOL and disability levels.

Limitations: Small hospital-based sample, normal/medically ill controls derived from other studies and cross-sectional assessments were the major limitations.

Conclusions: Dysthymia had considerable adverse psychosocial impact in terms of QOL, functioning (disability), social support and marital adjustment. Severity and chronicity appeared to be important mediators of this negative psychosocial impact. Increased awareness, improved recognition and adequate treatment might help negate some of the untoward social consequences of this condition.

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Keywords: Dysthymia; Disability; Quality of life; Social support; Marital adjustment

1. Introduction

Improved definitions and growing literature about dysthymia have revitalized the efforts to characterize, understand and treat this condition. Despite these advances, clinicians are relatively ill informed about this disorder and many might often fail to detect it.

This is unfortunate because a chronic psychiatric condition such as dysthymia has the potential to adversely affect several key areas of lives of patients and their significant others. Given the enduring nature of their complaints these patients report high degrees of morbidity, impairment in a variety of health domains,
and problems in socio-occupational and other important areas of functioning (Akiskal, 2001). This is further reflected by studies which have clearly shown impairments in quality of life (QOL), functioning, social support and marital adjustment among patients with dysthymia (Frances, 1993; Chakrabarti et al., 1993; McCullough et al., 1994; Ron et al., 1995; Leader and Klein, 1996; Kulhara and Chopra, 1996; Gupta et al., 1998; Zlotnick et al., 2000; Bell et al., 2004).

However, the amount of research data on the subject is still relatively scarce compared to the size of the problem. The focus of such research has more often been on patients with double depression, rather than those with uncomplicated dysthymia (e.g. Bell et al., 2004). Moreover, certain areas such as social support and marital adjustment have remained relatively unexplored.

The current study attempted a more comprehensive assessment of the psychosocial impact of dysthymia in terms of QOL, disability, perceived social support and marital adjustment among patients of dysthymia without additional comorbidity. Comparisons were carried out with patients with recurrent major depressive disorder (RDD) and normal/medically ill controls. Clinical and demographic factors which could influence these psychosocial parameters were also explored.

2. Method

2.1. Patients

Consecutive patients with a provisional diagnosis of dysthymic disorder who attended the psychiatric facility of a large multispeciality hospital in north-India were screened.

To be included they had to have a DSM-IV (APA, 1994) diagnosis of dysthymic disorder, be married and be of 18–50 years of age. Those with comorbid psychiatric disorders (e.g. double depression), substance dependence, psychosis, personality disorder, organic brain syndrome, mental retardation or any major debilitating physical illness were excluded.

2.2. Controls

2.2.1. RDD

Purposive sampling was used to identify a group of patients with DSM-IV recurrent major depressive disorder matched on age, sex, education and duration of illness with the dysthymic group. Patients had to have had at least one episode of the depression in the last 2 years and had to be currently on antidepressant treatment for a minimum of 4 weeks. Other selection criteria were similar to patients.

2.2.2. Normal/medically ill controls

Age and sex matched normal/medically ill (diabetic) controls were derived from previous studies conducted in the same centre (for QOL and social support), or from other Indian studies (for disability and marital adjustment), which had used the same scales to assess these variables. Additionally, these studies had ruled out psychiatric morbidity in their control populations, which enhanced their suitability for inclusion as comparison subjects in the current study.

2.3. Assessments

Diagnoses were established using the Structured Clinical Interview for DSM-IV Axis-I Disorders, Clinician Version (SCID I-CV — First et al., 1997). Sociodemographic and clinical data was recorded from case notes. Severity of depression was rated using the Montgomery–Asberg Depression Rating Scale (MADRS — Montgomery and Asberg, 1979).

2.3.1. Psychosocial indices

i) QOL was assessed using the WHO Quality of Life-Bref Version (WHO-QOL-BREF — Saxena et al., 1988), a shorter version of the WHO-QOL-100, with different domains including general wellbeing, physical health, psychological health, social relationships and environment.

ii) Disability was evaluated using the Schedule for Assessment of Psychiatric Disability (SAPD — Thara et al., 1988), a modification of the World Health Organisation Disability Assessment Schedule-II, with items grouped into 4 main areas of personal, social, occupational and global disability.

iii) Social support was measured using the Social Support Questionnaire (SSQ — Nehra and Kulhara, 1987), a modification of the original Pollack and Harris questionnaire, with 18 items assessing perceived social support.

iv) Marital adjustment was rated using a translated version of the Dyadic Adjustment Scale (DAS — Spanier, 1976), a scale with 4 different domains namely dyadic satisfaction, dyadic consensus, dyadic cohesion and affectional expression.

All these four instruments were available in Hindi (the local language). In addition, they had adequate psychometric properties (internal consistency and/or
inter-rater reliability ranging from 0.75 to 0.96), and had been used in several other studies from India.

2.4. Approval/consent

The project was approved by the Thesis and Ethics Committees of the institute. Written informed consent was obtained from all participants and other ethical safeguards were followed during the conduct of the study.

3. Results

3.1. Sample

Thirty five patients with (only) dysthymia were identified during the study period of 8 months. Three of these did not satisfy DSM-IV criteria following the SCID interview; 2 patients did not complete their assessments, leaving 30 who could be inducted for the study. Thirty patients with RDD formed the patient control group.

3.2. Demographic and clinical profile: dysthymia and RDD (Table 1)

A majority (70%) of the patients were women. Patients were in their late thirties. Although a majority (70%) had secondary levels of education and most (57%) were employed, income levels were low in 80% of cases. Patients were mostly from nuclear families (62%) and urban localities (55%) They had been ill for 5–13 years; those with RDD had had an average of about 3 episodes during this period. There were no significant differences between the dysthymia and RDD groups on any of the demographic parameters. Somewhat expectedly, patients with RDD had significantly later ages of onset as well as higher MADRS scores (Table 1).

3.3. Psychosocial impact of dysthymia

3.3.1. Comparison with RDD (Table 2)

Average scores of QOL, disability, perceived social support and marital adjustment indicated that both

<table>
<thead>
<tr>
<th>Sociodemographic and clinical profile of dysthymia and RDD¹</th>
<th>Dysthymia (N=30)</th>
<th>RDD (N=30)</th>
<th>Chi-square/t-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)♣ (Mean±SD)</td>
<td>38.20±7.35</td>
<td>38.20±7.35</td>
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</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
<td>08</td>
<td>10</td>
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</tr>
<tr>
<td>Female</td>
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<td>20</td>
<td></td>
</tr>
<tr>
<td>Years of schooling</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10</td>
<td>10</td>
<td>08</td>
<td></td>
</tr>
<tr>
<td>10 or more</td>
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<td>22</td>
<td>0.31</td>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>Not employed</td>
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</tr>
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<td>Income (in INR²)</td>
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<tr>
<td>Less than 3000/month</td>
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<tr>
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<tr>
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<td>Rural</td>
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<td>0.60</td>
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<tr>
<td>Age at onset in months♣ (Mean±SD)</td>
<td>339.20±95.11</td>
<td>393.93±98.70</td>
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<tr>
<td>Duration of illness in months♣ (Mean±SD)</td>
<td>112.40±62.43</td>
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</tr>
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<td>No of depressive episodes (Mean±SD)</td>
<td>–</td>
<td>02.97±01.63</td>
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<tr>
<td>Ever hospitalised</td>
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<td>00</td>
<td>03</td>
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<td>No</td>
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<tr>
<td>MADRS³ scores♣ (Mean±SD)</td>
<td>11.57±4.55</td>
<td>15.47±8.94</td>
<td>2.13*</td>
</tr>
</tbody>
</table>

♣t-values; *p value <0.05.

1: RDD — Recurrent major depressive disorder.
2: INR — Indian National Rupees.
3: MADRS — Montgomery–Asberg Depression Rating Scale.
groups of patients were impaired on these parameters. However, the only significant difference between the two groups was in the area of social support where scores of patients with dysthymia were lower than those of patients with RDD. This difference could not be explained (Table 2).

3.3.2. Comparison with medically ill/normal controls (Table 2)

These comparisons clearly showed that patients with dysthymia were significantly impaired in the areas of QOL, disability, perceived social support and marital adjustment, compared to matched medically ill or normal controls.
3.4. Correlates of psychosocial impairment in dysthymia and RDD

Although there were a number of significant associations (using the Spearman’s correlation coefficient), the most consistent ones common to both patient groups were:

i) Longer duration of illness demonstrated significant negative correlations with general wellbeing domain of QOL in both patients with dysthymia ($p<0.05$) and RDD ($p<0.05$).

ii) Higher MADRS scores showed:

— significant negative correlations with the overall QOL score in both patients with dysthymia ($p<0.01$) and RDD ($p<0.01$).

— significant associations with lower scores in the QOL domains of general wellbeing ($p<0.01$), physical health ($p<0.01$), psychological health ($p<0.01$) and social relationship ($p<0.05$) among patients with dysthymia.

— significant negative correlations with scores in the QOL domains of general wellbeing ($p<0.01$), physical health ($p<0.01$), psychological health ($p<0.05$) and environment ($p<0.01$) among patients with RDD.

— significant associations with higher levels of behavioural, social role, occupational and overall disability levels among patients of dysthymia as well as RDD ($p<0.01$ in all instances).

4. Discussion

In contrast to the psychosocial impact of depression, fewer studies have assessed the impact of the depressive spectrum disorders such as dysthymia. The current study attempted this by focusing on relatively “pure” patients of dysthymic disorder without associated comorbidity. Married patients were chosen to determine the effects of dysthymia on people other than the patients themselves. A comprehensive evaluation of several psychosocial aspects was attempted, particularly by including areas such as social support and marital adjustment, which have received relatively little consideration in previous studies. Standardized diagnoses and well-validated instruments, previously used among Indian patient populations, were used to increase the relevance of the results. For a better perspective the psychosocial impact of dysthymia was compared with matched samples of RDD, and normal/medically ill controls. However, normal/medically ill controls were derived from other studies, albeit those using the same scales among similar populations. Thus, uniformity of assessments could not be completely ensured among controls. This, apart from the relatively small number of patients who were all hospital attendees and the cross-sectional nature of assessments, were the obvious limitations of this study.

Nonetheless, the adverse psychosocial impact of dysthymia found in the current study was in accord with similar patterns of impaired QOL (Ron et al., 1995; Leader and Klein, 1996; Gupta et al., 1998; Bell et al., 2004), high levels of disability (Frances, 1993; Chakraborti et al., 1993; Bell et al., 2004), inadequate social support (Kulhara and Chopra, 1996) and poor marital adjustment (McCullough et al., 1994; Zlotnick et al., 2000), found among patients with dysthymia in earlier studies. Some of these studies (e.g. Ron et al., 1995) have shown that patients with dysthymia are significantly more impaired in these areas than healthy adults or people with chronic medical conditions such as hypertension or diabetes mellitus. This was similar to the significantly higher levels of impairment among patients with dysthymia, compared to normal/medically ill controls, of the present study. Furthermore, the lack of major differences in psychosocial impairment between dysthymia and RDD observed in this study echoed the equivalent levels of impairment reported by several other comparisons of dysthymia and major depression (Frances, 1993; Ron et al., 1995; Leader and Klein, 1996; Zlotnick et al., 2000). Severity of depression and duration of illness emerged as important determinants of the negative psychosocial impact of both dysthymia and RDD, particularly of QOL and disability in the current study. Others have similarly reported that severity of depression, chronicity of illness and comorbidity are the major determinants of the negative social impact of dysthymia (Leader and Klein, 1996; Bell et al., 2004).

In addition to the above, results of the present study also suggested that the psychosocial sequelae of dysthymia in these areas is likely to be universal and cuts across cultures. They also highlighted the fact that apart from being sizeable, such impairment is widespread and pervasive since several areas of psychosocial functioning are affected simultaneously.

Together with findings of earlier studies this helps to further dispel the notion that minor depressive conditions do not usually have untoward social effects. They thus underline the need for increased awareness and sensitivity among clinicians and researchers alike about the unfavourable psychosocial impact of dysthymia. The likelihood of factors such as severity, chronicity and comorbidity being important correlates of such
impairment raises the possibility of being able to identify those at risk for these untoward social consequences. These correlates might also be of help in improving the poor recognition of the disorder. The ultimate aim of improved identification would be the provision of effective treatment. Fortunately, there is now ample evidence that treatment with antidepressants and psychotherapy can help lessen the suffering of patients with dysthymia, even those without comorbid major depression (e.g. Kocsis et al., 1997; Williams et al., 2000). These trials have also shown the benefits of such treatment in improving QOL and functioning of patients of dysthymia. Given the chronic nature of dysthymia, the next challenge would be to document the long-term effects of treatment on psychosocial outcomes. This will require prospective, longitudinal follow-up of larger, community-based samples. It can be hoped that more such studies will help delineate the true extent of the negative psychosocial impact of dysthymia, and also clarify the role of treatment in containing it.

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Nothing declared.

Conflict of interest
There are no actual or potential conflicts of interest including any financial, personal or other relationships with other people or organizations within three (3) years of beginning the work submitted that could inappropriately influence, or be perceived to influence, their work.

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References