Transcultural Study of Depressive Symptomatology

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ABSTRACT

Teja et al. (1971) carried out a study in which they compared the types of symptoms exhibited by Indian depressed patients with those exhibited by Western (British) depressed patients. The present work has been planned with the aim of comparing the types of symptoms exhibited by Egyptian depressed patients with those of Indian and British patients as presented in the study of Teja et al. Important features and differences were discussed and possible explanations for the various findings have been offered.

INTRODUCTION

Differences in the symptomatological pattern of depression in different cultural groups have been a subject of many investigations. In Africa, Prince (1968) noticed that prior to 1957 fourteen authors have reported that true psychotic depressions are rare and that if they do occur they are brief lived and of little severity. Ideas of worthlessness and self depreciation are very rare indeed and suicide uncommon. From 1957 onward Prince noticed that 21 papers have been published which express the contrary view that depressive illness is a common phenomenon in Africa. Nevertheless these more recent authors continue to agree that these illnesses vary from what is seen in the European culture in that patients rarely say that they are unhappy, rarely depreciate themselves and rarely commit suicide. On the other hand projective mechanisms and hypochondriasis are common.

Collomb and Zwingestein (1961) reported that depression in the Africans of Senegal is peculiar in that patients do not appear to be deeply unhappy or miserable, ideas of self accusation and guilt are absent, suicide is rare, the disorder is characterized rather by ideas of persecution, anxiety, hypochondriasis and somatic complaints and there is an excellent response to treatment with E.C.T.

Shaheen and Rakhawy (1971) noticed that in the Egyptian culture depression is not associated with guilt and suicide is very rare. Instead hypochondriasis as well as "putting the blame" on others are frequent.

Kiev (1972) pointed out that among Africans depressive illnesses are frequently associated with confusional symptoms and are of short duration while in Japan and other advanced societies they are commonly associated with obsessive compulsive disorders.

Murphy **et al.** (1967) noticed, through a transcultural study, that depressive mood, insomnia and lass of interest were reported for depression in Asia. Guilt feelings were rarely reported in the Phillipines, Japan and India. Diurnal mood changes, anorexia and constipation were uncommon among Indians, while preoccupation with body and mind, religion and family as well as loss of libido and theatrical grief were common. Venkoba Rao (1966) conducted a study on depressed patients in South India and reported that symptoms of anxiety, agitation, somatic complaints and suicidal tendency were found to be common while feelings of sin, guilt and self reproach were present only in one fourth of the cases. Neki (1973) noticed that among the symptoms of depression, agitation has been reported more commonly among depressed patients from North and South India, which contrasts with the greater prevalence of retardation seen in the west.

Teja **et al.** (1971) noticed that a number of studies have been conducted in the West with the aim of formulating the types of symptom patterns of endogenous and reactive groups of depressed patients. These studies, in which objective criteria and rigorous statistical measures have been used, showed a perfect agreement in that endogenous depressives in the West are characterized as being retarded, deeply depressed, lacking in reactivity to environmental changes, showing a loss of interest in life, absence of precipitating factors, having visceral symptoms and middle insomnia and as not showing self-pity. Self-reproach or guilt feelings as characteristic of endogenous depression were found in 75% of these studies. Murphy (1965) tried to draw profiles of depressive symptoms reported from different European countries. It was noticed that the

French had a rather low incidence of suicide with a high incidence of somatic preoccupations, the Germans a high incidence of anorexia, the Polish a high incidence of preoccupation with poverty and the Scandanavians a high frequency of guilt feelings and suicide.

MATERIAL AND METHOD

A sample of 100 Egyptian depressed patients diagnosed according to the Egyptian Diagnostic Manual of Psychiatric Disorders (D M P—I) was selected randomly from Kasr El-Eini outpatient psychiatric clinic. Of the 100 cases 10 were diagnosed as manic-depressive depressed, 3 were involutional melancholia, 3 were reactive psychosis of the depressive type, 7 were depressive illness not elsewhere specified and 77 were neurotic depression. The presence or absence of a particular symptom was rated on Hamilton's rating scale for depression. The symptoms exhibited by the Egyptian patients were then compared with those reported in three other studies: one Indian by Teja **et. al.**, 1971 (Far East) and two British by Kiloh and Garside, 1963 and Carney **et al.**, 1965) (West).

In the Indian study of Teja **et al.**, 100 cases with primary functional depressive illness were studied and Hamilton's rating scale was utilised for rating the symptoms. Of the 100 cases, 72 were diagnosed as manic-depressive, depressed and endogeous depression, 13 were involutional melancholia and 15 were depressive neurosis.

Kiloch and Garsid's study included 143 depressed patients (53 of the endogenous and 90 of the neurotic type) who were selected from the out-patients for a double blind trial on imipramine and a further factor analytic study on the independence of neurotic and endogenous depression. Sixty items in relation to depression were assessed in each case, out of these a detailed analysis of 35 items was carried out.

The study of Carney **et al.** included 116 depressed patients, 63 of the neurotic and 53 of the endogenous type. They were all admitted for

E.C.T. and each case was assessed on the same items which were used in Kiloch and Garside's study before the first E.C.T.

It is noticed that the nosological disciplines used by the four studies are not uniform. For the purposes of this study we tried to group the different diagnoses in ternis of a psychotic-neurotic distinction. This distinction is used descriptively to denote the severity of the depressive illness and is meant only as an operational procedure to facilitate the comparison.

RESULTS

— Table 1 shows the percentages psychotic and neurotic depressed patients in the four studies arranged in an order of decreasing frequency of psychotic depressed patients. The Indian sample comes first, followed by the British sample of Carney **et al.,** the second British sample of Kiloh and Garside and lastly the Egyptian sample. This can be utilised as an index of the severity of depression among the four studies which might have its reflections on the comparison.

TABLE I

Persentages of Psychotic and Neurotic Depressed Patients in the Four Studies

Study	(1) Psychotic depression	(2) Neurotic depression
1. Teja et al. (Indian)	85%	15%
2. Carney et al. (British)	46%	54%
3. Kiloh & Garside (British)	37%	63%
4. Egyptian study	23%	77%

(1) Includes the diagnoses: endogenous depression, psychotic depression, manic depressive-depressive, involutional melancholia, and categories 06.5 & 06.9 of the Egyptian Manual.

(2) Neurotic or reactive depression.

— Table II shows the frequency distribution in percentages of various symptoms in the four studies. The results of the chi-square test (P of X2) which was utilised for the detection of the statistically significant differences in various symptoms among the four studies are shown in table III.

TABLE II

Frequency Distribution in Percentages of Various Symptoms in the Four Studies

S Y M P T O M S	Egyptian	Indian (Teja et al)	British (Carney et al)	British (Kh. & Gsd)
1. Depressed mood	100	100	60	63
2. Guilt Feelings	23	48	59	31
3. Suicidal trends	93	80	48	60
4. Insomnia, Initial	55	84	75	61
5. Insomnia, Late	23	92	67	37
6. Retardation	40	77	50	36
7. Agitation	8	68	INA+	41
8. Anxiety	99	80	61	48
9. Somatic symptoms	87x	76x	13	INA
10. Hypochondriasis	31	73	51	57
11. Diurnal variation	31	58	41	41
12. Paranoid symptoms	25	14	28	19
13. Obsessional symptoms	18	3	INA	29

x) Average of somatic GI, somatic general, and anxiety somatic.

+) INA = Information not available.

TABLE III

Statistical Significant Differences (P of X2) in Various Symptoms Among the Four Studies

S Y M P T O M S	Eg. Vs Teja	Eg. Vs Carn.	Eg. Vs Kh & Gsd	Teja Vs Carn.	Teja Vs Kh & Gsd	Kh. &Gsd. Vs Carn.
Depressed mood	Ns	.01	.01	.01	.01	Ns
Guilt	.01	.01	Ns	Ns	.01	.01
Suicidal trends	.01	.01	.01	.01	.01	Ns
Insomnia, Initial	.01	.01	Ns	Ns	.01	.05
Insomnia, Late	.01	.01	.02	.01	.01	.01
Retardation	.01	Ns	Ns	.01	.01	.05
Agitation	.01	-	.01	-	.01	-
Anxiety	.01	.01	.01	.01	.01	.05
Somatic symptoms	.05	.01	-	.01	-	-
Hypochondriasis	.01	.01	.01	.01	.02	Ns
Diurnal variation	.01	Ns	Ns	.05	.02	Ns
Paranoid symptoms	.05	Ns	Ns	.02	Ns	Ns
Obsessional symptoms	.01	-	.05	-	.01	-

Vs = Versus
Ns = Not significant

Figure 1 illustrates the percentages of various symptoms in the four studies compared.

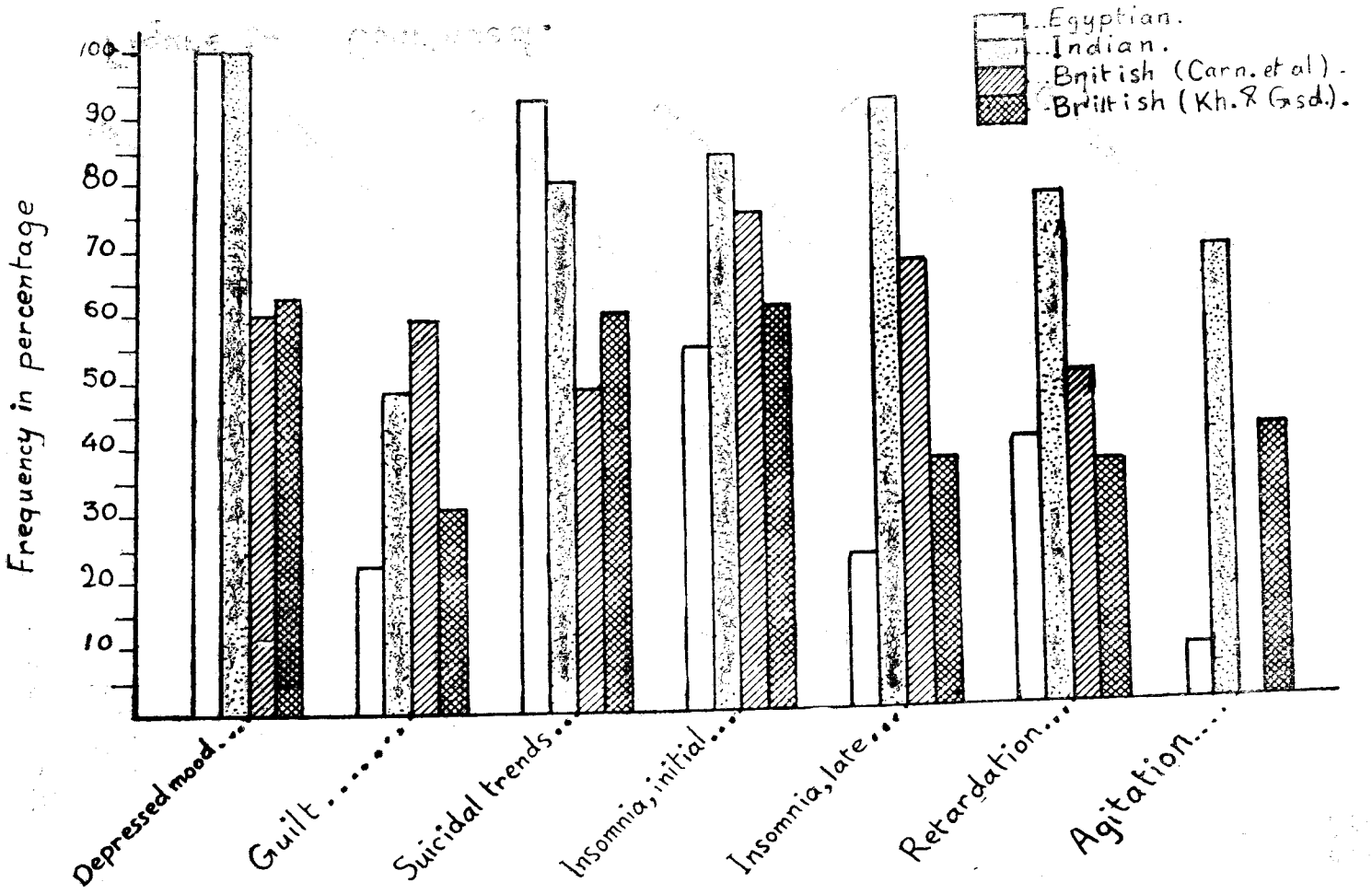

Figure 1- Percentages of various symptoms in the four studies compared.

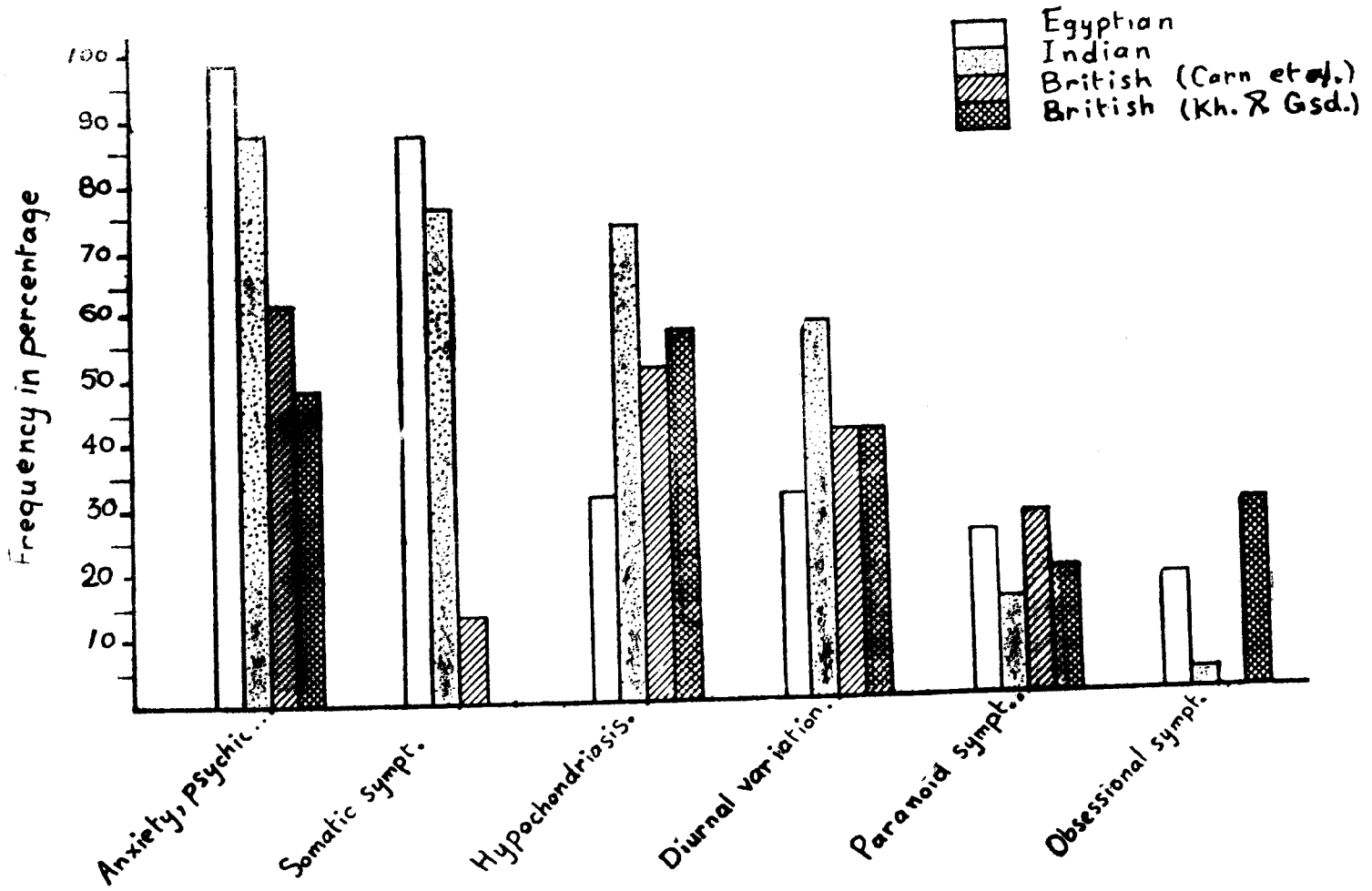

Figure 1- Continued.

The following significant features can be observed :

1. The differences as regards the somatic symptoms are the most prominent in the comparison. They are present in both the Egyptian and Indian patients in an outstanding great frequency in comparison with the British patients (the figures are : 87% in Egyptians, 76% in Indians and 13% in the British). The frequency is higher in the Egyptian patients than in the Indians but the difference is not marked (only significant at 0.05)

2. Hypochondriasis is highest in the Indian patients (73%) and lowest in the Egyptians (31%) while the British come in between (51% & 57%).

3. While agitation is lowest in the Egyptian patients (8%) it is highest in the Indians (68%). On the other hand anxiety, though quite frequent in the Indian patients (80%), is significantly higher in the Egyptians (99%). Meanwhile the frequencies of both symptoms in the Western studies show a relatively moderate representation, (agitation 41%, anxiety 61% & 48%).

4. The frequency of guilt feelings though highest in the British patients of Carney et al. (59%), yet it is not significantly different from that reported in the Indian sutdy. On the other hand, the frequency in Egyptian patients, though lowest (23%) yet it is not significantly different from that reported in Kiloh and Garsid's study.

5. Paranoid and obsessional symptoms are generally higher in the Western patients than in the Egyptians and Indians. However, paranoid symptoms in the Egyptian patients are relatively high (25%) but their frequency is not significantly different from that of British patients (28% & 19%). Obsessional symptoms on the other hand are consistently higher in the British depressed patients (29%) than in both the Egyptian (18%) and the Indian patients (3%).

6. Depressed mood is reported in all the Egyptian and Indian patients (100%). A significantly lower frequency is reported in the British patients (60% & 63%).

7. Suicidal trends appear in a significantly higher frequency in the Egyptian and Indian patients (93% & 80%) as compared with the British (60% & 48%).
8. Symptoms of retardation, insomnia and diurnal variation generally follow an order of decreasing frequency being highest in the Indian group, followed by Carney, et al's group, then Kiloh and and Garsid's group and are lowest in the Egyptian group.

DISCUSSION

Analysis of the results of the four studies revealed a number of significant differences. Some of these are likely to have been determined by differences in the relative number of psychotic and neurotic patients in these studies, but it might be equally true that other significant differences are but a reflection of background cultural factors. This may be clarified by comparing the depressive symptoms exhibited by the various groups.

— Somatic symptoms :

The remarkably higher frequency of these symptoms in both the Egyptian and Indian patients compared with the British brings forth the possibility that such symptoms are frequent association or presentation of depression in developing or Eastern cultures. A good bulk of research seems to support this possibility. According to Lambo (1956), a preponderance of somatic symptoms has been observed among the African depressed patients, and these somatic symptoms may in fact completely mask the underlying depression in them. Collomb and Zwingestein (1961) made similar observations based on their studies in Senegal. In India, Bagadis et al. (1970) found somatic symptoms in 78.2% of their depressed patients, these being the most common of the presenting symptoms.

Many speculations have been put forward to explain this phenomenon. Leff (1973) and Wittkower and Prince (1974), stated that it could be explained in terms of a lower differentiation of emotional states or in other words an incapacity to verbalize feelings in developing societies so much so that patients will tend to stress instead the somatic concomitants of emotions. This phenomenon, however, might not be restricted to developing societies. Willis (1976) noticed that people of lower social class and poorer education (even in the West) tend to express emotional stress in somatic terms. Another explanation might be related to the cultural concept of illness. Patients may complain of bodily rather than emotional symptoms because they believe that doctors treat physical illness and expect physical symptoms to be complained of. This may be particularly true in unsophisticated, poorly educated patients of lower social class. In our Egyptian patients we cannot give a major role to the first possibility. The Arabic culture and language are fairly well developed and differentiated expressions of emotional states are not lacking unless considerations of a lower social class and poor education are involved. The second possibility of the cultural concept of illness probably weighs more in explaining this phenomenon.

— Hypochondriasis :

This symptom is closely related to the previous one since in depression the attention is likely to become fixed on bodily disturbances, largely because they are actually occuring, and it is on the basis of these actual bodily symptoms that an exaggerated hypochondriasis may develop (Slater & Roth, 1969).

In comparison with the two Western studies the significantly higher frequency reported by Teja **et al.** is consistent with the agreement of many authors on the high incidence of hypochondriasis in depressed patients both in Asia and Africa (German, 1972 & Teja **et al.**, 1971). In Egypt hypochondriasis has also been reported as being frequent in depressed patients (Shaheen & Rakhawy, 1971 & Okasha, 1977). The relatively low frequency of this symptom in the present Egyptian study

seems to contradict this general agreement. However, the frequency of somatic symptoms in the Egyptian study is significantly high. This may explain the apparent contradiction which is probably related to difficulty in delineation, on clinical grounds, between somatic complaints and hypochondriasis.

— Agitation and anxiety :

These two symptoms are closely related for while anxiety is usually defined as a condition of hightened inner tension accompanied with vague feelings of uneasiness and impending disaster, agitation is spoken of when anxiety is severe and overflows into the musclar system producing gross motor restlessness.

The results of the Indian study are consistent with similar earlier findings indicating a high incidence of agitation in Jafa (Kraeplin, 1921), Africa (Yap, 1965) and South India (Venkoba Rao, 1966). Teja et al. (1971) explain this phenomenon as due to the lower level of emancipation of such patients who would more likely express their inner turmoil in an agitated manner with little constraint.

The results of the Egyptian study as regards agitation are not consistent with the above mentioned findings. However, the low frequency of agitation in our patients is contrasted by a high frequency of anxiety. This probably denotes a lesser tendency to psychomotor expressiveness or an inclination to constrain the outflow of inner tension in Egyptian depressed patients. Alternatively, there is a possibility that the results of the Egyptian study are influenced by the relatively low number of patients presenting with psychotic depression in the sample compared with the Indian sample.

— Guilt Feelings :

Although the frequency of this symptom is generally higher in the British depressed patients than in both the Indian and Egyptian patients,

yet the difference is not statistically significant. Such a result does not confirm the widely held assumptions that guilt is rare in non-Western, non-Christian societies (Prince, 1968, German, 1972, Kiev, 1972...). We may assume that the difference is not quantitative but rather related to the quality of guilt. In Western cultures the higher degree of individuality, assumption of self-responsibility and independent role playing foster a guilt feeling emanating from internalized or intrapsychic superego dictates thus giving guilt a personal individualistic character. Moreover, the Christian religious concept of original sin may contribute to these feelings of self-guilt. In Eastern cultures on the other hand, there is a lower degree of individuality, assumption of self-responsibility and life roles are viewed more as part of a social system than as belonging to a unique individual. Accordingly, the superego continues to be dependent on external sources to a large extent and guilt feelings take an impersonal, externally directed character. This quality of guilt is commonly observed in our Egyptian depressed patiens and matches with similar observations made by Teja **et al.** in their Indian study.

— Paranoid and Obsessional Symptoms :

The frequency of these symptoms is generally higher in the Western patients than in Egyptians and Indians. However, paranoid symptoms are relatively high in Egyptian patients and this finding matches with the conclusions of German (1972) from his study of psychiatric morbidity in Sub-Saharan Africa. German has confirmed the widespread use of projective mechanisms in Africa as shown from the frequency with which paranoid thinking of the persecutory type dominates the symptomatology of many illnesses.

The relatively low frequency of paranoid symptoms in Indian patients as compared with the British has been explained by Teja **et al.** to be due to the more competitive existence in the Western culture which fosters the development of a suspicious paranoid attitude.

The high frequency of obsessional symptoms in British patients

confirms the previous observations of Kiev (1971) that depressive illnesses in developed societies are more commonly associated with obsessive-compulsive symptoms.

— Depressed Mood :

Inspite of its importance, the comparison of this symptom is not valid in the present study. In both British studies depressed mood was reported only for patients having a "distinctive quality of depression" which was defined as being distinct from the depression with which these patients normally react to adversity. Such a distinction was not followed in both the Egyptian and Indian studies.

— Suicidal Tendency :

The apparently higher frequency of this symptom in the Egyptian and Indian patients as compared to the British contradicts the generally held assumption that suicide in developing countries is considerably lower than in developed societies (Kiev, 1972 & German, 1972).

In Egypt, suicide has been usually reported as being infrequent and this is believed to be related to the Moslem religious background in which suicide is looked upon as a taboo (Shaheen & Rakhawy, 1971 and Okasha, 1977). In our opinion the results of this study denoting a higher frequency or suicidal tendency in both Egypt and India than in Britain are not valid representation for the status of this symptom in the three cultures. The error is most probably due to different criteria for defining or justifying the presence of the symptom. Hamilton's rating scale which was used in both the Egyptian and Indian studies allows for mild thoughts related to death (e.g. feeling life is not worth living or wishes of death to the self) as justifying the presence of suicidal tendency.

— Retardation, Insomnia and Diurnal Variation :

The order of decreasing frequency of these symptoms is the same

order of decreasing frequency of psychotic depression in the four studies (table I). Their comparative differences among the four studies are most probably reflections of the severity of depression and the relative number of psychotic and neurotic patients rather than relevant differences in the cultural background.

This is particularly true for late insomnia and diurnal variation (with more severe depression in the morning) which are usually considered characteristic of psychotic (endogenous) depression (Slater & Roth, 1969).

CONCLUSIONS

The comparison between the symptomatological pattern of depression in the samples studied from the three cultures (Egyptian, Indian and British) showed the following features :

1. Somatic symptoms and anxiety were present in a significantly higher percentage of Egyptian and Indian depressed patients as compared to the British patients.

2. Agitation and hypochondriasis were highest in Indian depressed patients followed by the British, and both symptoms were comparatively lowest in Egyptian patients.

3. The frequency of guilt feelings was generally higher in British depressed patients. However the difference was not marked enough to give support to the frequent reports of low incidence of guilt in non-Western, non-Christian cultures. A possible qualiative rather than quantitative difference should be considered in this respect.

4. Obsessional and paranoid symptoms were generally more frequent in British depressed patients. However, the difference between the Egyptian and British patients as regards paranoid symptoms was not satistically significant.

5. The differences in other symptoms were more likely reflections of the severity of depression than effects of background cultural factors.

The conclusions obtained from this study are limited by certain factors :

1) The criteria for defining and judging the symptoms were not uniform among the four studies. The Egyptian and Indian studies using the same tool (Hamilton's rating scale) were more comparable, while different criteria were used by the British studies for some of the symptoms and this has affected the validity of the comparison as shown in the symptoms of depressed mood and suicidal tendency.

2) The comparisons were also affected by the different number of psychotic and neurotic patients in the four studies.

3) Both British studies as well as the Indian study were not originally meant to fulfill the aim of such cross-cultural comparison but only the informations presented in them were utilised for this purpose.

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الموجـــز

دراسة مقارنة لأعراض مرض الاكتئاب ما بين بيئات مختلفة

من القضـــايا التى ثار حـــولها النقاش فى الطب النفسي تلك المتعلقة بالاختلافات التى لوحظت فى نمط أعراض الاكتئاب فى البيئات المختلفة ، وقد قام تيجا وآخرون عام ١٩٧١ بدراسة قارنوا فيها أعراض الاكتئاب فى مرضى من الهنود ومرضى أوروبيين من بريطانيا بهدف اكتشاف الفروق المحتملة التى يمكن أن تكون نابعة من الاختلافات البيئية والحضارية . من هنا فقد تم تخطيط البحث الحالى بهدف دراسة النمط الاكلينيكى وأنواع الأعراض التى يمـكن أن يتميز بها مرضى الاكتئاب فى مصر وذلك بالمقارنة بأعراض مرضى الاكتئاب من الهند وبريطانيا الذين سبقت مقارنتهم فى دراسة تيجا وزملائه .

وقد ناقش البحث الملامح والملاحظات البارزة فى المقارنة بين أعراض المرض فى البيئات الثلاثة مع تقديم التفسيرات المحتملة للظواهر الملحوظة .

ABSTRAIT

Une étude transculturelle de la symptomatologie depressive.

Téja et al. (1971) accomplirent une étude dans laquelle ils comparèrent les types de symptomes exhibés par des malades indiens en état de dépression avec eux exhibés par des malades occidentaux (britanniques) en état de dépression.

Ce travail actuel vise à comparer les types de symptômes exhibés par des malades égyptiens en état de dépression avec ceux exhibés par les maladies indiens et britanniques tels que présentés dans l'étude de Téja et al.

Des traits et des différences importantes ont été discutés, et les explications probables aux divers résultats ont été soumises.