

Cross-cultural Comparative Study of Depressive Signs and Symptoms between Egyptian and Saudi Out-Patient Samples with Depression above the Age of 40 years as Measured by WHO/SADD

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Abstract

Two outpatient clinic samples of patients were selected randomly during the period from January 1994 till the end of March 1994. Both of them were chosen from private hospital one is Cairo, Egypt. The second in Al Khobar, Eastern province of the Kingdom of Saudi Arabia. The first sample consisted of 45 Egyptian patients and the second sample consisted of 83 Saudi patient. Their inclusion criteria were patients have the diagnosis of mood disorder, depressive episode, either first episode or recurrent, according to the diagnostic criteria for research of ICD-10 (International classification of mental and behavioral disorders, WHO 1993)., the patients' score on Hamilton depressive scale should be above 18., the patients' ages are above 40 years. Psychiatric interview and application of Hamilton rating scale for depression and World Health Organization, Schedule for a standardized assessment of depressive disorders (WHO, SADD) 5th revision. The present study showed that all patients in the two samples had symptoms of depressed mood, sadness, joblessness and inability to enjoy. Followed by loss of interest, with variable frequencies of other signs and symptoms. This finding of similarities for the core depressive symptoms with differences in the predominant mode of expression between the two cultures (Egyptian and Saudi) agrees with the results which means that there are some depressive symptoms that can manifest themselves in all patients cross-culturally, while other symptoms are more affected by the culture, hence vary in frequency and severity from one culture to another.

Introduction

Depressive disorders are common and are common and are responsible for a high proportion of total psychiatric morbidity (Kendell, 1988). The study of depression is important not only because of the human misery it causes, but also, because it may lead to suicide, which is a leading cause of death in certain age group. (Ibrahim, 1990). Depression also contributes to problems of alcoholism, drug dependence, libider and somatic complaints (Hamilton, 1989). Moreover it has a bad effect on the national income. Like other illnesses, depressive disorder clusters into signs and symptomatology that constitutes what DSM IV (APA, 1994) and ICD-10 (WHO 1992) term major

depressive episode. There is a consensus that there must be disturbances in all four spheres: Mood, psychomotor activity, cognitive and vegetative; for a definitive diagnosis for major depressive disorder (Hagob and Akiskal, 1995). However there are different views regarding the significance or prominence of particular symptoms. Also it is not clear which aspects of the clinical picture are fixed, core symptoms and which are likely to be modified by variables such as age, sex, race and culture (Kaplan et al., 1994). Differences in the symptomatological pattern of depression in different cultures have been a subject of many researches

(Ibrahim, 1990). Murphy et al., 1967 conducted a questionnaire survey of psychiatrists around the world. He concluded that depressive mood, insomnia and loss of interest were reported for depression in Asia, while guilt feelings were rarely reported (Murphy et al., 1967). In Africa prince noticed through re-evaluation of 21 papers that patients rarely say that they are unhappy, rarely depreciate themselves and rarely commit suicide. On the other hand projective mechanisms and hypo-chondriasis are common. (Quoted from Gawad and Arafa 1980). It is important, However, to be cautious in interpreting their early studies, their observations based upon different nosological disciplines. Recent cross cultural studies using better methodological techniques i.e. more precise definition of the disorder, well-matched samples and using the same rating instruments, showed similarities in the symptoms of depression among cultures, but, also, differences predominant mode of expression. (Ulusahin et al., 1994) through a cross-cultural comparison between Britain and Turkey found similarities in the core symptoms of depression of both samples. But, there were higher rates in the British sample for core depressive symptoms and higher rates in the Turkish samples for symptoms reflecting Somatization (Ulusahin et al., 1994). Takenchi K. et al., (1994) found that the differences between Japanese and American samples were in the mean ratings for severity of depressive symptoms which were higher in the Japanese than Americans (Takenchi et al., 1994). Also Komohashi et al., in 1997 found that another point of difference, which was that Canadian aged people express their depressed moods more clearly and spontaneously than the Japanese aged

people (Komohashi et al., 1997). Cross-cultural studies of depressive symptomatology in Arabic culture are relatively few and it have been done by using a particular methodology i.e. to compare results of a local study with the results in Western or other Non-Arab cultures, but not among Arab themselves. Among these studies Gawad and Arafa in 1980 compared the results of an Egyptian study with a previous studies done in India and Britain and found that somatic symptoms and anxiety were present in a higher percentage in the Egyptian and Indian depressed patients compared to the British patients (the difference was statistically significant). While agitation, hypo-chondriasis, guilt feelings, obsessional and paranoid symptoms were less frequent in Egyptian patients. (Gawad and Arafa 1980). Ibrahim in 1990 compared the results of Saudi sample with counterparts American rates and found that somatic symptoms were more reported by Saudi than their American counterparts rates (Ibrahim, 1990). However, inspite of the increasing number of the cross-cultural studies, still, we are facing many problems, mainly due to the way of sample selection and the research tools used. So the validity and reliability of the studies are under question (Blager 1995). The aim of this study is to apply the WHO/SADD in Egyptian and Saudi depressive patients above the age of 40 year to detect similarities and differences of depressive symptomatology.

Subjects and Method

Two outpatient clinic samples of patients were selected randomly during the period from January 1994 till the end of March 1994. Both of them were chosen from private hospital one is Cairo, Egypt. The

second in Al Khobar, Eastern province of the Kingdom of Saudi Arabia. The first sample consisted of 45 Egyptian patients and the second sample consisted of 83 Saudi patient. Their inclusion criteria were:

1. Patients have the diagnosis of mood disorder, depressive episode, either first episode or recurrent, according to the diagnostic criteria for research of ICD-10 (International classification of mental and behavioral disorders, WHO 1993).
2. The patients' score on Hamilton depressive scale should be above 18.
3. The patients' ages are above 40 years. Psychiatric interview and application of Hamilton rating scale for depression and World Health Organization, Schedule for a standardized assessment of depressive disorders (WHO, SADD) 5th revision.

Data of the Egyptian sample was presented in the 6th congress of Al-Azhar Faculty of medicine that was held on October 26-28th, 1994 in Cairo, Egypt. (Abdel Ghany et al., 1994).

Tools

1. Semi-structured psychiatric interview was done to reach the diagnosis of mood disorder, depressive episode. The psychiatric interviews were done by senior psychiatrists; M.D. qualified with minimum 8 years experience. Their diagnoses were based on the same classificatory manual.
2. World Health Organization schedule for a standardized assessment of depressive disorder (WHO, SADD) 5 the revision. It consists of 4 parts: part 1. Identification data part. 2. The symptoms, signs and history, there are 40 symptoms and signs, each one is coded as: absent, present mildly or present continuously or in severe form. Part 3. Treatment in present episode. Part

4. Diagnosis and classification. In this study we are concerned mainly with part 2 to get information about type and severity of the depressive symptoms and signs.

3. Hamilton rating scale for depression is one of the eldest observer rating scales and it is the most popular one. It is better to be used in the end of the clinical interview. It is not a diagnostic instrument, it was designed to measure the severity of the illness. The scale consists of 17 items. The scores are summed to give a total score to assess the severity of the illness. AR patients in this study have a score above 18, which means that the depressive symptoms are of clinical significance.

Results

The existing study was carried out on 45 Egyptian patients and 83 Saudi patients. All patients had the diagnosis of mood disorder, depressive episode, either first episode or recurrent and the age of every one of them was above 40 years. Table (1) shows some sociodemographics of the studied patients. Most off the two samples are females; 53.3% of the Egyptian patients and 63.9% of the Saudi patients, with no statistical significance to the difference between the two percentages. Most of the two samples are married; 64.4% of the Egyptian patients and 59% of the Saudi patients, while the least are divorced 6.7% of the Egyptian patients and no widows were recorded in the Saudi sample. University graduated patients are represented more in the Egyptian sample (33.39c), while patients that spend from 5 to 12 years of school are represented more in the Saudi sample (50.6%). Patients whoop spend less than 5 years school are least represented in the two samples i.e. 8.9% of the Egyptian patients and 6% only of the Saudi patients. Differences between

the two samples as regards marital status and educational level are of high statistical significance i.e. $P < 0.001$.

Positive family history of affective disorders is present more in the Saudi patients (49.4%) as compared to 40% only in the Egyptian patients but with no statistical significance. Also, Saudi patients have more positive family history of non-affective disorder (37.3%) as compared to 8.9% only in the Egyptian patient, that difference is of statistical significance i.e. $P < 0.01$ (Tabled 2).

Table (3) shows that more than halves of the Egyptian patients (55.6%) have no disordered premorbid personality, which the later, represents less than half of the Saudi patients (47%). Obsessive and paranoid personality traits are the commonest among the Egyptian patients (13.3%) and 11.1% respectively). While dependant obsessive and paranoid personality traits are the commonest among the Saudi patients (13.3%, 12% and 10.8% respectively). However, the differences in the distribution of the pre-morbid personality traits between the two samples are of no statistical significance i.e. $p > 0.05$. About 60% of the Egyptian patients have no continual psychic stress, while 79.5% of the Saudi patients have continual psychic stress. Most of the continual psychic stress are familial, 13.3% of the Egyptian patients and 60.2% of the Saudi patients. That difference is of high statistical significance i.e. $p < 0.001$.

More than half of the two samples have no precipitating stress. Death of the spouse is the commonest to occur in the Egyptian patients (17.8%) while family problems are the commonest in the Saudi patients (44.6%). Those differences are of high statistical significance i.e. $P < 0.001$.

Table (4) shows that 40% of the Egyptian patients have no previous depressive episodes but a 27.7% only of the Saudi patients have no previous episodes. 42.2% of the Saudi patients have 4 and more previous depressive episodes but 4.45% only of the Egyptian patients have 4 and more previous episodes. That difference is of high statistical significance i.e. $P < 0.001$. Most of the cases occurred with slow onset (66.7%) of the Egyptian patients and 83.1% of the Saudi patients). Less than half of the Egyptian patients have a duration of the index episode lasting from one month to less than 3 months (42.2%), while most of the Saudi patients (62.7%) have a duration of the index episode lasting less than one month. There is a tendency of the index episode to be of a long duration in the Egyptian patients and of a short duration in the Saudi patients. Those differences are of high statistical significance i.e. $P < 0.001$.

Table (5) clarifies that sadness, depressed mood, joblessness and inability to enjoy are the commonest symptoms and present in all patients (100% of the two Samples). Loss of interest occurs in all Egyptian patients (100%) but occurs in 87.9% only of the Saudi patients. Irritability, lack of energy and inability to fall asleep occurs in all Saudi patients (100%), but they occur in 71.1% 71.1% and 64.4% respectively in the Egyptian patients. Other symptom and signs are presented in a lesser frequency. The least present symptoms in the Egyptian patients are Hypersomnia, aggression, illusions or hallucination and other delusions.

The least present symptoms in the Saudi patients are physical disease or infirmity, hypochondriasis, other psychological symptoms and other delusions.

Table (6) shows the same results as regards the degree of severity. The overall degree of severity of depressive signs and

symptoms, is more in the Saudi patients than in the Egyptian patients, with a significant statistical difference ($P < 0.01$)

Table 1: Comparison between Egyptian and Saudi samples as regards some socio-demographic variables

Data		Egyptian sample		Saudi sample		Statistical Technique	
		No	%	No	%	Value	P
Sex	Males	21	46.7	30	36.1	C.R.*	> 0.05
	Females	24	53.3	53	63.9	1.16	
Marital status	Married	29	64.4	49	59	$X^2 = 19.89$	< 0.001
	Widow	8	17.8	--	--		
	Divorced	3	6.7	8	6.9		
	Single	5	11.1	26	31.3		
Educational level	Illiterate	9	20	9	10.8	$X^2 = 18.99$ < 0.001	
	Less than 5 years school	4	8.9	5	6.0		
	5-12 years of school	11	24.4	24	50.6		
	More than 12 years of school but not university	6	13.3	20	24.1		
	University graduate	15	33.3	7	4.8		

C.R. = Critical Ratio

Table 2: Comparison between Egyptian and Saudi samples as regards traits of pre-morbid personality and the stresses (Continual and precipitating).

Data	Egyptian sample		Saudi Sample		X2	
	No	%	No	%	Value	p
Traits of Pre-morbid Personality					6.31	> 0.05
Obsessive traits	6	13.3	10	12		
Paranoid traits	5	11.1	9	10.8		
Histrionic traits	3	6.7	4	8.7		
Avoidant traits	3	6.7	6	7.2		
Depressive traits	1	2.2	1	1.2		
Dependant traits	1	2.2	11	13.3		
schizoid traits	1	2.2	3	3.9		
No characteristic Personality traits	25	55.6	39	47		
Continual Psychic Stress					39.53	< 0.001
Family problems	6	13.3	50	60.2		
Financial problems	4	8.9	14	16.9		
Work problems	3	6.7	2	2.4		
Death of a spouse	2	4.4	--	--		
Physical Disability	1	2.2	--	--		
Living alone	1	2.2	--	--		
None	28	60	17	20.5		
Precipitating Stress					39.53	< 0.001
Death of a spouse	8	17.8	--	--		
Family troubles	6	13.3	37	44.6		
Work troubles	4	8.9	1	1.3		
Financial problems	3	6.7	1	1.2		
None	24	53.3	44	5.3		

Table 3: Comparison between Egyptian and Saudi samples as regards Family history.

Date	Egyptian Sample		Saudi Sample		C.R.	P
	No	%	No	%		
Affective disorder					1.02	>0.05
absent	27	60	24	50.6		
present	18	40	41	49.4		
Non-affective disorder					3.42	< 0.1
absent	41	91.1	52	62.7		
present	4	8.9	31	37.3		

Table (4): Comparison between Egyptian and Saudi samples as regards: The number of previous depressive episodes, type of onset of current episode and the duration of the present condition.

	Egyptian Sample		Saudi Sample		X ²	
	No	%	No	%	Value	P
Number of Previous Depressive Episodes					28.47	< 0.001
No episodes	18	4	32	27.7		
One episode	10	22.2	19	22.9		
2-3 episodes	14	31.1	6	7.2		
4 and more	2	4.4	35	42.2		
Unknown	1	2.2	--	--		
Type of onset of current episode:					9.08	< 0.05
Sudden	15	33.3	11	13.3		
Slow	30	66.7	69	83.1		
Unknown	--	--	3	3.6		
Duration of present condition:						
Less than one month	3	6.7	52	62.7	61.63	<0.001
one month less than 3 months	19	42.2	6	7.2		
3-less than 6 months	12	26.7	5	6		
6 months - less than one year	6	13.3	2	2.4		
1-less than 2 years	3	6.7	1	1.2		
2 years and more	2	4.4	17	20.5		

Table (5): Comparison between Egyptian and Saudi samples as regards: The frequency of depressive symptoms.

Date	Egyptian sample		Saudi Sample		X ²	P
	No	%	No	%	Value	
Sadness, depressed mood	45	100	38	100	--	--
Joylessness, inability to enjoy	45	100	38	100	--	--
Hopelessness	24	5.3	72	86.8	4.17	< 0.01
Anxiety and/or tension	29	64.4	67	80.7	2.03	< 0.05
Aggression	12	26.7	39	46.9	2.25	< 0.05
Irritability	32	71.1	83	100	4.99	< 0.01
Lack of energy	32	71.1	83	100	4.99	< 0.01
Disruption of social function	33	73.3	49	59.1	1.61	-
Desire to be alone	24	53.3	71	85.5	3.97	< 0.01
Subjective experience of slowness and retardation of thought.	27	60	61	73.5	1.56	-
Indecisiveness	32	71.1	50	60.2	1.22	-
Lack of self-confidence	30	66.7	62	74.7	0.96	-
Loss of interest	45	100	73	87.9	2.4	< 0.05
Loss of ability to concentrate	26	57.8	75	90.1	4.25	< 0.01
Subjective experience of loss of memory	18	40	70	84.3	5.13	< 0.01
Early awakening.	33	73.3	44	53.1	2.24	< 0.05
Inability to fall asleep.	29	64.4	83	100	5.71	< 0.01
Fitful, restless sleeps.	32	71.1	50	60.2	1.22	--
Hypersomnia.	11	24.4	16	19.3	0.69	--
Lack of appetite.	26	57.8	76	91.6	4.48	< 0.01
Change of body weight	24	53.3	66	79.5	3.09	< 0.01

Table (5) continued.

Constipation	15	33.3	50	60.2	2.91	<0.01
Feelings of pressure	29	64.4	76	9.16	3.81	<0.01
Other somatic signs and symptoms	26	57.8	22	26.5	3.5	<0.01
Other psychological symptoms	14	31.3	5	6	3.91	<0.01
Decrease of libido	35	77.8	67	80.7	0.39	--
Change of perception of time	15	33.3	55	66.3	3.57	<0.01
Suicidal ideas	15	33.3	38	45.8	1.37	--
Feelings and/or ideas of guilt and self-reproach	15	33.3	54	65.1	3.43	< 0.01
Ideas of insufficiency, inadequacy and worthlessness.	27	60	56	76.5	0.84	--
Hypochondriasis	27	60	6	7.2	6.58	<0.01
Ideas of impoverishment	14	31.3	53	63.9	3.54	<0.01
Ideas of reference and/or persecution	24	53.3	61	73.5	2.3	<0.05
Other delusions	-	-	7	8.4	2.09	< 0.05
Disorders of perception: illusions or Hallucinations	11	24.4	17	20.5	0.53	--
Psychomotor retardation	26	57.8	60	72.3	1.67	--
Psychomotor restlessness and agitation, diurnal fluctuation of mood	14	31.1	44	53	2.38	<0.01
Worth in the morning	26	57.8	33	39.8	1.95	--
Worth in the evening	14	31.1	39	46.9	1.74	--
Physical disease or infirmity	21	46.	4	4.8	5.76	< 0.01

Symptoms are numbered and arranged according to WHO/SADD C.R. = Critical Ratio.

Table (6): Comparison between Egyptian and Saudi samples as regards: degree of severity of depressive symptoms.

Date	Egyptian Sample	Saudi Sample
Sadness, depressed mood	1.8	1.64
Joylessness, inability to enjoy	1.47	1.42
Hopelessness	0.83	1.14
Anxiety and/or tension	0.8	1.28
Aggression	0.3	0.5
Irritability,	0.83	1.36
Lack of energy	0.87	1.14
Disruption of social function	1	0.86
Desire to be alone	0.73	1.22
Subjective experience of slowness and retardation of thought	0.73	0.78
Indecisiveness	0.9	0.92
Lack of self-confidence	0.83	1
Loss of interest	1.6	1.22
Loss of ability to concentrate	0.73	1.5
Subjective experience of loss of memory	0.5	1.58
Early awakening	1.07	0.72
Inability to fall asleep	0.87	1.72
Fitful, restless sleep	0.73	0.92
Hypersomnia	0.27	0.31
Lack of appetite	0.77	1.64
Change of body weight.	0.57	1.14
Constipation	-.**	0.86

Table (6) continued

Feelings of pressure	0.87	1.58
Other somatic signs and symptoms	..**	0.29
Other psychological symptoms	..**	0.08
Decrease of libido	1.3	1.14
Change of perception of time	0.33	0.86
Suicidal ideas	0.43	0.58
Feelings and/or ideas of guilt and self reproach	0.43	1
Ideas of insufficiency, inadequacy and worthlessness	0.9	1.08
Hypochondriasis	0.8	0.11
Ideas of impoverishment	0.4	1.22
Ideas of reference and/or persecution	0.8	1.07
Other delusions	--	0.12
Disorders of perception: illusions or Hallucinations	0.3	0.29
Psychomotor retardation	0.7	1.28
Psychomotor restlessness and agitation, diurnal fluctuation of mood	0.33	0.96
Worth in the morning	0.73	0.64
Worth in the evening	0.33	0.86
Physical disease or infirmity	--**	0.06

Symptom are numbered and arranged according to NMO/SADD

* Degree of severity was not available in the data presented in the 6th Congress of *Al-Azhar*, Faculty of Medicine by *Abd El Ghany et al., 1994*.

Discussion

The most consistent finding across epidemiological studies of the mood disorders is the relatively higher prevalence of major depressive disorder in women than in man (Blazer, 1995). Our results go with that. Many factors have been suggested to account for this sex difference, such as endocrine physiology and genetic, with no consistent theory to account for that sex difference. However, Psychosocial explanations for that difference are currently considered the most promising, for example the greater stress for women of maintaining multiple role (Blazer, 1995).

Marriage was associated with markedly increased levels of depression. Okasha in 1990 found the same result in his study on depressive morbidity in an Egyptian population. (Okasha, 1990). Nadin et al. (1985) reached the same result on their study on socio-demographics of new referrals to the psychiatric out-patient clinic in Qatar (Nadine et al., 1985).

Depressive symptoms were common among those with lower education than with university graduated. This result agrees with that of Bahri and Wilson in their study about the relationship between the educational standard and psychiatric disorders (Bahri and Wilson, 1997). Positive family history for affective disorder and non-affective disorders are more common in the Saudi sample as compared with the Egyptian sample. This result goes with the observation about the Saudi community being have more +ve consanguinity than the Egyptian community, but unfortunately, there are no valid statistical data about that. No single personality trait predisposes to depression. All humans of whatever personality pattern can and do become depressed under certain

circumstances, however, certain personality types oral, dependent, obsessive and histrionic, may be at greater risk for depression than antisocial, paranoid and other personality types (Scott, 1988). In the present study we found that the majority of the Egyptian and Saudi sample did not have abnormal personality traits.

Stressful life events precede to great extent the episodes of depression. This results agree the results of Rabe about the life settings in which mental illness occurs (Rabe, 1980). That coincidence was more clear among the Saudi patients than among the Egyptian patients, an observation, that we did not find a valid explanation for it.

In the current study we found that about 47% of the two samples had precipitating stress, where death of a spouse was the commonest in the Egyptian patients, that stress was not present in the Saudi patients, may be due the relative meaning and consequences of loss between the two cultures. As in Egypt loss of spouse may lead to decrease of income and difficulty of subsequent marriage with its effects upon the unity of the families and it drawback for the children, this may not happened in the Saudi community. Continual psychic stress was present in 40% of the Egyptian patients and about 80% of the Saudi patients, where family problems were the commonest among the two groups of patients. This finding agrees with most of Arab studies that stress the importance of family unity and structure in the life of Arabs in contrary to the Western studies that stress the importance of work and its problems.

The majority of the two groups of patients had from one to four depressive episodes prior to the index one. Also in the majority

of patients, the duration of the present condition lasted from one month to 6 months. However, in Saudi patients 62.7% of the patients had a duration less than one month compared to 6.7% only among the Egyptian patients. a finding that may reflect the efficiency of the referral system in Kingdom of Saudi Arabia and availability of psychiatric services their and/or the lower tolerance among the Saudi people towards the depressive symptoms or due to specific short time episode of depression inside. However there is more tendency of the Saudi patients (about 20.5% of the sample) to develop chronically than the Egyptian patients, an observation, that we did not find a valid explanation to it.

The present study showed that all patients in the two samples had symptoms of depressed mood, sadness, joblessness and inability to enjoy. Followed by loss of interest, with variable frequencies of other signs and symptoms. This finding of similarities for the core depressive symptoms with differences in the predominant mode of expression between the two cultures (Egyptian and Saudi) agrees with the results of Ulushin et al., in 1994 in their cross-cultural comparison of the symptomatology of depression in Britain and Turkey (Ulusahin et al., 1994). Also, that finding agrees with the results of Takeuchi et al., on 1994 in their comparison of depressive symptoms among Japanese and American. (Takeuchi et al., 1994). Komahashi et al (1997) found similar results in their comparative study among Japanese and Canadian aged people (Komahashi et al., 1997).

Earlier Egyptian studies like that by Gawad and Arafa on 1980 in their study of depressive symptoms in Egypt as compared to study of Teja et al., 1971 (Gawad and

Arafa, 1980) did not find unified pattern of expression of depressive symptoms among the different cultures i.e. Egyptian, Indian and British. However, they were aware of the limitation of their study, mainly: the criteria for defining and judging the symptoms were not uniform, use of different tools and the comparisons were affected by the different number of psychotic and neurotic patients in the samples (Gawad and Arafa, 1980).

It seems from the above that there are some depressive symptoms that can manifest themselves in all patients cross-culturally, while other symptoms are more affected by the culture, hence vary in frequency and severity from one culture to another.

Conclusion:

Symptoms as Depressed mood, sadness, joblessness and inability to enjoy and to a lesser extent loss of interest, can cross the boundaries between cultures, while other Symptoms of depression are more affected by local psychosocial factors.

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