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Depression Across Cultures

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Introduction

Comments have been frequently made on the differences in the symptomatological pattern of depression in different cultural groups. Kraepelin (1921), in his study on the incidence of depressive illness in Asian countries, mentioned that depression in Java was characterized almost exclusively by excitement and confusion and that ideas of sin and suicidal tendencies were absent. Carothers (1958) could not elicit feelings of guilt or self abasement in depression among the Africans of Kenya. Lambo (1956), of Nigeria, thought that the rarity of depression observed by many workers in African countries might be due to erroneous diagnosis, and that most of the cases remain concealed by the label of 'neurasthenia'. Out of fifteen cases of definite affective psychosis seen by him only one showed guilt feelings, self-condemnation and anticipation of punishment. Multiple somatic features, phobic and obsessional symptoms and anxiety were common. Yap (1965), commenting on the findings of various workers about depression in African countries, states 'there is agreement among these authors on the rarity of outspoken affective illness, lightness and short duration of depression with an absence of ideas of sin and guilt, the relative frequency of manic pictures, the common association with confusional symptoms, and a very low suicide rate.' He also refers to Pfeiffer's findings about the frequency of hypochondriacal depression in the Chinese. The absence of delusions of sin in Chinese as well as in Japanese depressives has also been noted by Yap (1958). On the other hand, Eaton and Weil (1955), in a study concerning the Hutterites, have reported a high incidence of guilt-ridden depression.

In an analysis of South Indian depressive patients, Venkoba Rao (1966) 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. As a possible explanation for the low incidence of depression in South India, this author has put forward the hypothesis of prolonged mourning rituals with diminished sense of guilt among the Hindus. Teja and Narang (1970), however, contest this in view of their findings of a high incidence of depression among the North Indians, although the Hindus there have similar mourning rituals to those in South India. Bagadia *et al.* (1970) found a low percentage of agitation (27 per cent), hypochondriasis (15 per cent) and guilt feelings (5·3 per cent) in their 233 depressives from Bombay in West India. Murphy *et al.* (1967) have also reported that guilt feelings and diurnal variation are uncommon among the Hindus.

Most of the above studies have been of an impressionistic nature. It is refreshing to note that a few studies have recently been reported from the West in which objective criteria and rigorous statistical measures have been used to formulate the types of symptom patterns of their endogenous and reactive depressive groups. Hamilton and White (1959), Kiloh and Garside (1963), Carney *et al.* (1965), Rosenthal and Klerman (1966), Mendels and Cochrane (1968) and Rosenthal and Gudeman (1967) as a result of such studies found 'perfect' agreement (items on which all studies were agreed in the direction and significance of an item's loadings were said to be in 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 only 75 per cent of these studies.

Objects

We shared some of the impressions about the pattern of symptoms exhibited by Indian depressives in our part of the country. The clinical impression which had grown with us over the years was that our depressives exhibit less of guilt feelings and are more often agitated.

The present study was undertaken with the aim of studying the types of symptoms exhibited by Indian depressive patients, to compare these with the symptoms exhibited by Western depressives and thereby validate or reject the impressions about differences in symptomatology.

Methods

One hundred cases with primary 'functional' depressive illness were studied in detail. Of these, 67 were seen in the psychiatric clinic of the All-India Institute of Medical Sciences, New Delhi, and 33 in the Postgraduate Institute of Medical Education and Research, Chandigarh. These patients had initially been selected for two double-blind drug trials, the first group for protriptyline and a placebo (Teja, Aggarwal and Prabhu, 1969), and the second for Go 2998, Go 2330 and imipramine (Teja and Narang, 1970). A detailed psychiatric and family history, including premorbid personality traits, precipitating factors, past history and any other important factors in the history, was taken. The presence or absence and the severity of a particular symptom was rated on Hamilton's scale for depression (1960). The diagnosis was arrived at after independent assessment by two psychiatrists; in case of any doubt or disagreement the diagnosis was finalized after discussion. The diagnostic terms used were the ones in line with the International Classification of Diseases (1965 revision) of W.H.O. Some of the patients were admitted and the others were treated as out-patients.

The symptoms reported in three other studies on depressive patients were compared amongst each other and with those exhibited by the patients in the present study. One of these studies was on South Indian depressives (Venkoba Rao, 1966), and the other two were from Newcastle upon Tyne on British depressives (Kiloh and Garside, 1963; Carney, Roth and Garside, 1965).

In a number of reports the incidence of depression is reported to be less in South India and comparatively high in North India (Teja and Narang, 1970). It was therefore considered worthwhile to select a study from a part of the country where the reported incidence is low, particularly since, in most of the studies on African populations in which differences in symptomatology have been commented on, prevalence of the disease is stated to be low. There were 30 depressives in Venkoba Rao's study. Though a clear diagnostic term has not been mentioned for these cases anywhere in the paper, they were probably all of the endogenous type; this conclusion is based on suicidal tendency and insomnia being present in all 30 of them, diurnal variation in 25 and loss of libido in 22 out of the 25 males in the sample. The author also mentions in one place, 'anxiety of mild to severe intensity occurs in an appreciable number of patients with endogenous depression (80 per cent in the present series)'. In the symptom analysis which has been given only 80 per cent (24 out of 30) of patients had anxiety. These 30 patients were selected from out of the personal non-hospital series of the author. The symptom analysis of these patients has been given under somatic and psychological heads.

Kiloh and Garside's (1963) study included 143 depressives, 53 of the endogenous and 90 of the neurotic type. The diagnosis was made with reasonable confidence in 92 of these (31 of endogenous and 61 of neurotic depression) and was doubtful in the remaining 51 (22 of endogenous and 29 of neurotic depression). Of these, 97 cases had initially been selected for a double-blind trial of imipramine. Data from another 46 depressives was included for the purposes of a factor-analytic study on the independence of neurotic and endogenous depression. Sixty items in relation to depression were assessed in each of the 143 cases; out of these a detailed analysis of 35 items was carried out. The global degree of severity of the illness

in the sample has not been mentioned by the authors. However, Carney, Roth and Garside (1965), in their comment on this material, state that since the study was confined to the out-patients many milder cases might have been included.

In this study of Carney, Roth and Garside out of 129 patients of primary functional affective illness there were 116 patients with definitive diagnosis; 63 of these were of neurotic and 53 of endogenous depression, the remaining 13 with doubtful diagnosis were excluded. They were all admitted for ECT in three psychiatric units in Newcastle upon Tyne under the care of ten different consultant psychiatrists. The decision to admit to the hospital was made by the appropriate consultant independently of the investigators. The diagnosis was established within a few days of admission to hospital by a review of all the available clinical information. Before the first ECT, each patient was assessed on the same 35 items which were used in Kiloh and Garside's study (*loc. cit*). The patients in this study were probably more severely depressed than in Kiloh and Garside's since admission, and ECT were considered imperative for them.

Results

Out of the 100 depressives in our series, 64 were males and 36 females, with an age range of 24 to 65 years and a mean of 44·5 years. The duration of illness was less than 6 months in 62, between 6 to 12 months in 23 and more than one year in 15 of the cases. Forty per cent of the patients had previous history of depression or mania. Family history of mental illness was present in 14 per cent of the cases, and precipitating factors were seen in 31 per cent. Sixty-six patients had severe, 32 moderate and 2 mild degree of depression.

The diagnostic breakdown of the sample is given in Table I.

Table II shows the frequency of symptoms of depression as seen in the 100 patients.

A reference to Table II indicates that most of the symptoms of depression on the Hamilton scale were present in between 50 to 100 per cent of the cases. Retardation was seen in 77 per cent of the cases, and agitation in 68 per cent. This apparent contradiction is explained by the fact that while rating a patient on Hamilton's scale one takes into account not only the symptoms as exhibited at the time of the interview but also those apparent in day to day life outside the interview situation. Both retardation and agitation would be rated if they were present in a particular patient during different periods of a day. Somatic anxiety was seen in a higher percentage (92 per cent) of the cases than psychic anxiety (80 per cent). Hypochondriasis and somatic symptoms (both GI and general) were seen in nearly 70 per cent of the cases.

Table I

Diagnostic breakdown of the sample

Diagnosis	N = 100 Number of patients
Manic-depressive, depressed, and endogenous depression	72
Involutional melancholia	13
Depressive neurosis	15

Table II

Frequency of symptoms in 100 depressives

Symptom	Percentage
Depressed mood	100
Work and interest difficulty	100
Late insomnia	92
Anxiety, somatic	92
Initial insomnia	84
Anxiety, psychic	80
Suicidal ideas	80
Retardation	77
Loss of insight	77
Middle insomnia	76
Genital symptoms	74
Hypochondriasis	73
Somatic symptoms (GI)	70
Agitation	68
Somatic symptoms (General)	67
Diurnal variation	58
Guilt	48
Depersonalization	17
Paranoid symptoms	14
Obsessional symptoms	3
Loss of weight	Information not reliable

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Guilt was the least frequent of the cardinal symptoms of depression, being present in 48 per cent of the cases. Obsessional symptoms were seen in only 3 per cent, and most of our patients could not give reliable information about loss of weight.

The results of the analysis comparing the symptoms exhibited by the depressive patients in the four studies (two Indian and two British) are given in Tables III and IV.

A reference to Tables III and IV brings out the following features:

1. A comparison of Venkoba Rao's and Kiloh's studies indicates that no significant differences are seen in the symptoms of guilt and hypochondriasis besides those of depression, late insomnia and retardation. Suicide, agitation, anxiety and diurnal variation were significantly more in Rao's group of South Indian patients, indicating that they were more severely depressed than Kiloh's group. In spite of this, the British patients of Kiloh and Garside had significantly more obsessional symptoms.

2. A comparison of Rao's and Carney's studies indicates that no significant difference is seen in the symptoms of anxiety and hypochondriasis. Guilt, late insomnia and retardation were significantly more in Carney's group of depressives, while depression, suicide, diurnal variation, and especially somatic symptoms were significantly more in Rao's group.

3. All excepting two of the symptoms were significantly more frequent in our group of 100 North Indian patients when compared with Kiloh and Garside's group. Again, in spite of this the obsessional symptoms were significantly more frequent in Western depressives. Paranoid symptoms were also more frequent in Kiloh and Garside's group but not to a statistically significant degree.

4. Our patients had most of the symptoms to a significantly greater frequency when compared to Carney *et al.*'s group. The differences once again were most marked in somatic symptoms. In spite of our patients being more severely depressed, paranoid symptoms were seen to a significantly greater degree in Carney's group. No significant difference was seen among the two groups in guilt feelings, though these

TABLE III

Frequency distribution in percentages *of various symptoms in the four studies*

Symptoms	Teja *et al.* N = 100	V. Rao N = 30	Kiloh and Garside N = 143	Carney *et al.* N = 116
Depression	100	83	63	60
Guilt	48	27	31	59
Suicidal tendency	80	100	60	48
Insomnia, initial	84	INA	61	75
Insomnia, middle	76	INA	INA	INA
Insomnia, late	92	33	37	67
Work difficulty	100	INA	INA	INA
Retardation	77	27	36	50
Agitation	68	70	41	INA
Anxiety	80	80	48	61
Somatic symptoms	76*	63	INA	13
Genital symptoms	74	73	INA	INA
Hypochondriasis	73	40	57	51
Loss of insight	77	INA	INA	INA
Diurnal variation	58	83	41	41
Depersonalization	17	7	INA	INA
Paranoid symptoms	14	INA	19	28
Obsessional symptoms	3	7	29	INA

INA = Information not available.

* Average of somatic GI, somatic general and anxiety somatic.

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TABLE IV

Statistical significant differences (p of χ^2) in various symptoms among the four studies

Symptoms	V. Rao versus Kh. and Gsd.	V. Rao versus Carney *et al.*	Teja *et al.* versus Kh and Gsd.	Teja *et al.* versus Carney *et al.*	Teja *et al.* versus V. Rao	Kh. and Gsd. versus Carney *et al.*
Depression	NS	·05	·01	·01	·01	NS
Guilt	NS	·01	·01	NS	NS	·01
Suicide	·01	·01	·01	·01	·02	NS
Insomnia, initial ..	—	—	·01	NS	—	·05
Insomnia, late	NS	·01	·01	·01	·01	·01
Retardation	NS	·05	·01	·01	·01	·05
Agitation	·01	—	·01	—	NS	—
Anxiety	·01	NS	·01	·01	NS	·05
Somatic symptoms ..	—	·01	—	·01	NS	—
Genital symptoms ..	—	—	—	—	NS	—
Hypochondriasis ..	NS	NS	·02	·01	·01	NS
Diurnal variation ..	·01	·01	·02	·05	·05	NS
Depersonalization ..	—	—	—	—	NS	—
Paranoid symptoms ..	—	—	NS	·02	—	NS
Obsessional symptoms ..	·02	—	·01	—	NS	—

were observed in a larger percentage of cases in Carney's group.

5. A comparison of the North Indian with the South Indian depressives (Teja *et al.*, *v* V. Rao's) Group) indicates that there are no significant differences in the two groups in the symptoms of guilt, agitation, anxiety, somatic and genital symptoms, depersonalization and obsessional symptoms. Symptoms of suicide and diurnal variation were significantly more marked in Venkoba Rao's group of patients, whereas retardation and hypochondriasis were significantly more in our group of patients.

6. A comparison of Kiloh's with those of Carney's group of depressives revealed that depression, suicide, hypochondriasis, diurnal variation and paranoid symptoms were not significantly different between the two groups. Symptoms of guilt, insomnia, retardation and anxiety were significantly more in Carney's group of patients. There was no symptom which was significantly more frequent in Kiloh and Garside's group. The observed differences in symptoms of these two groups are, therefore, likely to be a reflection of the severity only.

The symptoms of suicidal tendency and diurnal variation have been encountered most frequently in Venkoba Rao's study as compared to the other three. This is likely to be due to some selection bias.

DISCUSSION

The comparisons made among the four studies have revealed a number of differences from study to study. Some of these differences are likely to have been determined by differences in the number of endogenous and neurotic depressives in these studies. The relative percentage distribution of endogenous depressives in order of decreasing frequency in the four studies was: Venkoba Rao, Teja *et al.*, Carney *et al.*, and Kiloh and Garside. The neurotic depressives were distributed in the reverse order. Whereas this factor is likely to explain certain differences among the four studies, there are aspects in which the Indian depressives in both the studies differ from depressives in both the British studies. Some of these latter differences are likely to be a reflection of the background cultural factors operative in determining the content of symptoms in depression.

Somatic symptoms are present in both North and South Indian depressives in an outstandingly greater frequency in comparison to the

British depressives; there being no significant difference in the frequency of these symptoms among the two Indian groups. A preponderance of somatic symptoms has also been observed among the African depressives, and these may in fact completely mask the underlying depression in them (Lambo, 1956). Bagadia *et al.* (1970) from West India found somatic symptoms in 78·2 per cent of their depressives, these being the most common of the presenting symptoms. In contrast such symptoms were seen in only 13 per cent of British depressive patients (Carney *et al.*, 1965). These differences might be a reflection of the level of cultural emancipation of a particular patient population and of the social group. In psychiatric illnesses, symptoms which are assigned the status of an illness by the group to which the patient belongs, as also the expectancy on the part of patients of what the local medical men consider as an illness, become important determinants in the choice of symptoms. The chances of purely psychological symptoms being dismissed as not of much consequence are high in less sophisticated groups. The Indian patient, therefore, uses the medium of the body more often for expressing inner tensions. The differences concerning the high incidence of hysterical symptoms among Indian and open anxiety among British soldiers under similar situations of stress during the last world war tend to suggest the same (Williams, 1950).

Hypochondriasis was significantly more frequent in our group of patients as compared to both the Western as also South Indian groups of depressives. No significant difference was seen in the frequency of this symptom between Venkoba Rao's group and the Western depressives, even though it was least frequent of the symptoms seen in his material. Venkoba Rao, however, has given the frequency of this symptom only when it was of delusional intensity. This was not the case in any of the other three studies. The possible reasons for hypochondriasis being more frequent in Indian depressives are likely to be the same as for the somatic symptoms.

Indian depressives are significantly more often agitated and anxious than the Western cases. There is no difference with regard to these symptoms between the North and South Indian depressives. This tends to support our earlier impression, and may be due to the fact that patients with lower level of emancipation are more likely to express their inner turmoil in an agitated manner. They hardly make any endeavour to constrain the outflow of inner tension into the external channels of emotional expression. Similar findings had earlier been reported in depressives from Java (Kraepelin, 1921), Africa (Yap, 1965) and South India (Venkoba Rao, 1966). Bagadia *et al.* (1970) on the other hand found agitation in only one fourth of the depressives from West India. Their patient population was, however, very heterogeneous and included widely different diagnostic groups with symptoms of depression.

The relatively less frequent occurence of guilt feelings among the Eastern patients has been commented on by a number of workers (Kraepelin, 1921; Lambo, 1956; Yap, 1958; V. Rao, 1966; Bagadia *et al.*, 1970). We have, however, failed to find a substantial support for these claims. Guilt was indeed the least frequent of the symptoms seen in our own and in V. Rao's group of patients, but this was also true of Kiloh and Garside's British depressives. The frequency occurrence of guilt feelings in the various studies was 59 per cent (Carney *et al.*), 48 per cent (Teja *et al.*), 31 per cent (Kiloh and Garside) and 27 per cent (Venkoba Rao). It was significantly more in Carney *et al.*'s group of patients in comparison both to Kiloh and Garside's and V. Rao's groups. There were no significant differences in the frequency of this symptom in Carney *et al.* versus Teja *et al.* groups, on the one hand, and Kiloh and Garside versus V. Rao's groups on the other. Between the two Indian groups also there were no significant differences in this symptom. When the two Indian and the two British studies were combined, the frequencies of this symptom were respectively 43 per cent and 44 per cent. The differences were not statistically significant.

Whereas the incidence of guilt feeling is similar in the Indian and British depressives, a qualitative difference in the content of these possibly exists. The guilt feelings reported by the Indian patients are generally of an

impersonal character. The present suffering is usually attributed to possible bad deeds in a previous life, a consequence of one's 'Karmas' (actions). Individualized guilt is less often experienced, and that too by the more educated patients.

Conformity in the Indian social system is highly valued. Individuation and the assumption of self responsibility for one's acts is less well developed. An average Indian views his life roles more as part of a social system than as belonging to a unique individual. In the face of failure the experience of lowered self-esteem, even in the adult Indian, emanates more from external sources (feelings like 'what will others say?' are dominant) rather than from one's individually experienced shortcomings (real or imagined). The superego dictates continue to be dependent on external sources to a fairly large extent. In contrast, the assumption of a greater degree of individual responsibility and independent role-playing in the average Westerner are likely to foster a sense of guilt emanating from one's own realization, as such, of self failures. An attempt has at times been made to describe the experience of remorse emanating from external sources as 'shame' and that resulting from intrapsychic superego dictates as 'guilt'; many semantic difficulties are, however, involved in such a differentiation (Yap, 1965). Both the experience of guilt and lowered self-esteem occupy a central place in the psychopathological understanding of depression, and the differences in the psychic organizations of the two cultural groups may be responsible for differences in the content of guilt feelings in the two groups. The strong Christian religious concept of original sin may also contribute to feelings of self-guilt in the Western depressive (Yap, 1965; Wig, 1970).

One of the interesting findings which has emerged from the present study concerns the peripheral symptoms of obsession and paranoid features. Both these have been encountered to a significantly greater degree in the Western as compared to the Indian depressives. Rituals being a well accepted day to day practice of the Indian socio-religious system, such features are not likely to be considered as hampering symptoms by the patient or by his relatives.

The relatively more competitive existence of the Western individual probably fosters to an extent the development of a certain degree of suspicious paranoid attitude, and this may possibly explain the greater frequency of this symptom among the British depressives. The pattern of the types of schizophrenics admitted to mental hospitals in the U.S.A. has changed over the years from a predominance of catatonics to one of paranoids (Arieti, 1959). This finding may have a bearing in the same direction.

Summary

The relevant literature on the differences in symptomatology of depressive illnesses in different cultures has been reviewed. A note has been made about the impressionistic nature of most of the reported studies.

The symptoms exhibited by one hundred depressives from two North Indian clinics were studied in detail and rated on the Hamilton scale for depression. A statistical comparison was made of the symptoms seen in our patients with the symptoms of a study on 30 South Indian depressives and 116 and 143 British depressives reported in two studies from Newcastle upon Tyne.

It was seen that somatic symptoms, hypochondriasis, anxiety and agitation were present in a significantly larger percentage of Indian depressives. The study did not support the frequent reports of less incidence of guilt feelings among the depressives from the East. A difference in the content of guilt feelings is, however, likely. Obsessional and paranoid symptoms were significantly less frequent among the Indian depressives. Possible explanations for the various observed differences have been offered.

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