Symptoms profile of patients with major depression in Baghdad

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ABSTRACT

Background: Many studies had stated that there are marked variations in the clinical presentation of depressive states between different cultures.

Objectives: The main aim of the study is to identify the symptoms profile of patients with major depressive disorder living in Baghdad.

Method: Ninety two patients with major depressive disorder consulting Ibn-Rushd psychiatric teaching hospital were studied thoroughly to identify the frequency of symptoms among them. The fifth edition of the Arabic version of the Mini-International Neuropsychiatric Interview (M.I.N.I) was used to identify the Diagnostic and Statistical Manual – fourth edition (DSM-IV) symptoms. A list of other symptoms, which were found to present variably in depression according to culture, was gathered from previous studies and modified was included to calculate their frequency and to compare them to the DSM-IV symptoms.

Results: All the 9 DSM-IV symptoms were more common than all the other symptoms. The DSM-IV symptoms did not differ significantly according to sociodemographic variables. Regarding the other symptoms: "Numbness or crawling sensation", "sex and libido"and "crying "symptoms were all significantly more common in females than in males; "Sex and libido" symptoms differ significantly according to the marital status and to education; &"Hypochondriasis" was significantly more common in elderly group Patients with major depressive disorder with psychotic features were presented with less auditory hallucinations and more visual hallucinations as compared to studies in western societies.

Conclusion: The presentation of depression in patients from Baghdad is not different from patients around the world, and the DSM-IV symptoms are the most common symptoms in patients with major depressive disorder from Baghdad.

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Depression disorders are common as it has prevalence of 5-10% in primary care settings. They rank 4th as causes of disability worldwide [1]. The prevalence of mood disorder does not differ among races [2]. The World Health Organization (WHO) predicted that in the year 2020 depression will be, worldwide, the second most important cause of disability after ischaemic heart disease[3]. In spite that depression is a universal phenomenon, culture influences its clinical picture. Culture influences the sources, the symptoms and the idioms of distress; the individuals' explanatory models, their coping mechanisms and their help-seeking behavior; as well as the social response to distress and to disability [4]. Studying the effect of culture on the clinical presentations of various psychiatric disorders is regarded in the field of "cultural psychiatry" which shows a vigorous growth in the 20th and the 21st centuries [5]. Somatizing depression/ idiom of distress we use the word mood to describe pervasive feelings that are in part purely psychical but also have a powerfully physical component. When we feel happy we tend to feel more energetic, physically comfortable and lighter in limb [6]. There is cultural variation in the clinical presentation of depressive states but in most countries depression appears to be under- diagnosed. While somatic features are undoubtedly found in all societies, they are more frequent and prominent in non-western cultures [7]. Arthur Kleinman, a professor of cross-cultural psychiatry, has pointed in his paper "culture and depression" to the experience of depression in the Chinese society where the expression is rather physical than psychological and had stated that: "Culture confounds diagnosis and management by influencing not only the experience of depression, but also the seeking of help, patient-practitioner, communication, and professional practice"[8]. For example, the presence and severity of the guilt in depression are found to differ across cultures, being more common in western cultures [9].

Okasha, who has done many studies focusing on the subject of cultural influence on presentation of symptoms in Egypt has stated in a newly published article that "Depression among Egyptian patients is manifested mainly by agitation, somatic symptoms, hypochondriasis, physiological changes such as decreased libido, anorexia and insomnia, which is not characterized by early morning awakening."[10]. In a cross-national study comparing presentation between the USA and Korea it was for that in Americans "depressed mood" initially appeared, whereas "psychomotor retardation or agitation," "feeling guilty or worthless," and "concentration difficulty" did not occur until depression was more severe. In Koreans, "concentration difficulty" and "low energy" appeared earlier than other symptoms while "feeling guilty or worthless," "thoughts of death," "and "psychomotor retardation or agitation" occurred when depression was more severe[11]. Depression appears to be less evident in the Chinese and more likely to be expressed somatically one study concluded. Although the

same study did find a change in the picture of presentation of depression in China in the last decades stating that "Western influences on Chinese society and on the detection and identification of depression are likely to have modified the expression of depressive illness quite sharply since the early 1980s" [12].

The aims of this study are to identify the symptom profile of patients with major depression living in Baghdad as a representative sample of Iraqi patients. Also to compare the results with other studies done worldwide and with studies done in Iraq previously and to see if there is a significant association between symptoms and socio demographic variables

Method: The study was carried out in Baghdad city during the period from the first of July 2008 to the first of January 2009. The target population of this study was outpatient and inpatients in Ibn Rushd hospital in Baghdad. The participants were given a detailed explanation of the objectives of the study; they were free to decline participation, and anonymity was encouraged. No patient refused to participate in the sample. The sampling was randomly done in 2 days per week (every Monday and Wednesday) in the morning working hours. The first questions were about the demographic variables that were sex, age group, education, and marital status. The patients were selected after being diagnosed as having major depressive disorder by a consultant psychiatrist. The Arabic version of the Mini- International Neuropsychiatric Interview (M.I.N.I.) was applied to each case to confirm the diagnosis and to calculate the frequency of each of the nine criteria of major depressive disorder (Appendix 1). The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-IV and the CIDI (a structured interview developed by the World Health Organization for lay interviewers for ICD-10). The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores. Sixteen other questions were added about: "verbal aggression, physical aggression, paranoid ideation, hypochondriasis, gastrointestinal symptoms, cardiovascular symptoms, respiratory symptoms, numbness or crawling sensation, headache, pains (other than headache), tremor, sweating, heat sensation, psychotic symptoms, history of mania, and obsessions". All these were added because they were found to be common in earlier studies.

Adding questions or modifying a questionnaire has been used in studies examining the effect of culture on presentation of common psychiatric disorders [13]. A mental state examination was done to each patient.

Results: Characteristics of the sample; the subjects were 107 patients with major depressive episode at first. Fifteen patients were excluded due to different causes, table 1. After excluding the 15 cases; ninety two cases remain in the sample (47 females & 45 males). Their age ranges from 20-80 (females 20-73 years old; males 22-80 years old) with total mean age of 47 years old (females mean age 47 years old; males mean age 46 years old). Distribution of sample according to sex, marital status, age group, and educational level are shown in tables 2-5.The frequency of symptoms manifested by the depressive patients is presented in tables 6 and 7. Frequency of symptoms by order of frequency is as follows: Present in 76-100% of patients: depressed mood (97%), sleep problems (88%), tiredness (79%), lost interest (76%), and worthlessness (76%) Present in 51-75% of patients: thoughts of death (69%), and trouble thinking (56%). Present in 26-50% of patients: Appetite problems (48%), slowness/restlessness (47%), crying (44%), cardiovascular system complaints (43%), verbal aggression (42%), respiratory system complaints (34%), numbness or crawling sensation (34%), pains anywhere in the body except headache (33%), gastrointestinal symptoms (31%) and sexual problems (29%).Present in 1-25% of patients: psychotic symptoms (24%), physical aggression (21%), paranoid symptoms (13%), hands/body shaky (9%), hypochondriasis (5%), heat sensation (3%), sweating (3%),obsessions (3%), and history of mania (3%).

All the DSM-IV criteria were more common than the "other" symptoms. The least common DSM-IV symptom was the psychomotor symptoms (slowness/restlessness) by a frequency of 47%, while the most common among the "other" symptoms were, in order of frequency: crying (44%), cardiovascular complaints (43%), and verbal aggression (42%).

The DSM-IV symptoms did not differ significantly according to the sociodemographic variables. Some of the "other" symptoms differ according to the sociodemographic variables. Three of the "other" symptoms differ significantly according to sex: "numbness or crawling sensations", "sexual or libidinal symptoms" and "crying" were all significantly more common in females, table 8. The "sexual or libidinal symptoms" were significantly more common in the married marital group than in the widows and widowers, singles, and divorced groups, table 9. The symptom of hypochondriasis" was significantly more common in the elderly age group, table 10.

Discussion. In this study, frequency of DSM-IV and "other" symptoms of depression in a sample of Iraqi depressed patients was calculated.

Depressed mood; Recent studies show controversy, some support the previously held belief in that culture affects the symptom of low mood, and that this core symptom have little salience in some countries [14, 15]. On the other hand, there are studies that found no difference in the symptom of low mood between cultures [16, 17].

Worthlessness; Worthlessness, guilt and hopelessness are regarded as one criterion in DSM-IV. Since early in the 20th century some studies found differences in the symptoms of depression and many said that guilt are more prominent in the western, while somatizations are more common prominent in the eastern cultures, nevertheless new studies found that this difference is exaggerated and a recent study regarding the feelings of guilt found that it is presented similarly across cultures [9].

Thoughts of Death; Suicidal thoughts varies in the general population between countries, even in Europe were the countries share relatively similar culture the prevalence of suicidal thoughts varies between 2-14% [18].

Table 1: Excluded patients.

Cause of exclusion	Number
Pervious diagnosis of schizophrenia	7
Well at time of interview	3
Dependence on alcohol &/or drugs	2
Stroke	1
Hypothyroidism	1
Parkinson's disease	1
Total	15

Table 2: Distribution of sex.

	Number	Percentage (%)
Males	45	49
Females	47	51
Total	92	100

Table 3: Distribution of marital status.

Marital status	Number	Percentage (%)
Single	16	17
Married	54	59
Divorced	10	11
Widow	12	13
Total	92	100

Table 4: Distribution of age group.

Age group	Age group	Percentage (%)
Adulthood (20-64 years)	Adulthood (20-64 years)	91
Elderly (65 & above)	Elderly (65 & above)	9
Total	Total	100

Table 5: Distribution of educational level.

	Number	Percentage (%)
No school	15	16
Primary school	20	22
Post primary	43	37
University and higher	14	15
Education	92	100

Table 6: Frequency of DSM IV symptoms.

	Number (total=92)	Percentage (%)
Depressed mood	89	97
Lost interest	70	76
Appetite problems	44	48
Sleep problems	81	88
Slowness/restlessness	43	47
Tiredness	73	79
Worthlessness	70	76
Trouble thinking	52	56
Thoughts of death	64	69

Table 7: Frequency of "other" symptoms.

Symptoms	Number (total of 92)	Percentage (%)
Verbal aggression	39	42
Physical aggression	19	21
Paranoid symptoms	12	13
Hypochondriasis	5	5
GIT	29	31
CVS	40	43
Respiratory	31	34
Numbness or crawling	31	34
Sex & libido	27	29
Crying	41	44
Running out of home	13	14
Headache	34	37
Pains	30	33
Hands/body shaky	8	9
Sweating	3	3
Heat sensation	3	3

Table 8: Frequency of "other" symptoms according to sex.

Symptoms	Males (total of 45)		Females (total of 47)		P value
	Number	Percentage	Number	Percentage	
Numbness or crawling	10	22	21	45	0.023*
Sex and Libido	8	18	19	40	0.017*
Crying	15	33	26	55	0.034*

*Significant using Pearson chi-squared test at 0.05 level of significance.

Table 9: Distribution of "other" symptoms according to marital status.

	Married		Single (n=16)		Divorced (n=10)		Widows &widowers (n=12)		P value
	No.	%	No.	%	No.	%	No.	%	
Sexual	22	41	1	6	3	30	1	8	0.018*

Table 10: Distribution of "other" symptoms according to age groups.

	Adulthood (20-65) Total of 84		Elderly (above 65) Total of 8		P value
	No.	%	No.	%	
Hypochondriasis	3	4	2	25	0.011*

*Significance using Pearson chisquared test at 0.05 level of significance.

It is possible that the reported differences may be due to variations in method, differences between the sampling frames, or cross-national differences in the willingness to admit suicidal ideation or in the individual risk and protective factors for each country. Suicidal ideation is present in the general population and not only in major depression patients.

Prevalence and risk factors for suicide and its immediate precursors – suicidal ideation, plans and attempts – are unavailable in many countries around the world, particularly in less developed countries. There is a paucity of epidemiologically sound national data on suicidal behavior in Malaysia despite its public health importance. A national epidemiological survey using a self-rated questionnaire done in 2006 showed that the prevalence of suicidal ideation in the population was 6.3% [19].

In depression this percentage increases to 64-70% [20] and while it was found to be 70-73 in Hamilton classical study, recent studies found percentages between 64-99% [21]. In this study prevalence of thoughts of death was 69% which is Comparable to other studies worldwide.

Aggression and paranoid symptoms; Paranoid ideation is linked the defense mechanism "projection". Projection is considered as a primitive, or narcissistic, defense mechanism, used when other more mature defense mechanisms are not developed. Aggression is linked to paranoid symptoms, but it is also linked to frustration, and hence to depression. Any association between mood disorders and violence has been comparatively overlooked. It appears that there may be more evidence relating mood disorders and violence than many clinicians realize [22].

Hypochondriasis; In this study the prevalence of hypochondriasis was significantly more common in the elderly age group than in the adult age group (p=0.011). This is similar to reports in other studies about the more common prevalence of hypochondriasis in elderly patients [23].

Gastrointestinal symptoms, cardiovascular symptoms, respiratory symptoms, headache and pains anywhere in the body, hand/body shaking, and sweating and heat sensation were all present in a frequency similar to other studies.

Numbness or crawling sensation, sexual problems, and crying will be discussed together because they were the only three presentations that were significantly more common in female patients (p=0.023, p=0.017, and p=0.034 respectively).

It was found in studies around the world that females tend to somatise their symptoms of depression more than males [24]. Sexual problems were significantly more common in the married marital group than in the single, widowed, and divorced marital groups. And this is logically accepted since it is culturally prohibited to have sex, and hence complain of sexual and libidinal problems, in the non married groups.

Psychotic symptoms; Psychotic symptoms were present in 24% in the sample of this study. Psychotic symptoms have been shown to be present in up to 19% of depressed individuals living in the community and 25% of depressed patients in psychiatric hospitals [25]. The sample in this study is a mixture of patients of depression, some were outpatients, others were inpatients, thus the percentage of psychotic symptoms in this study is relatively high. May be the higher prevalence of psychotic symptoms in this study is due to the fact that Iraqi depressive do not consult a psychiatrist only when its symptoms are severe and disturbing.

Most of the reported hallucinations in depression with psychotic symptoms are usually auditory in a percentage of 96.7% [26]. In this study the frequencies of auditory, visual and somatic hallucinations were 73%, 20%, and 7% respectively, which differs from most studies done in the western societies and this might be explained that our culture put some importance to the "visions" seen by some people, hence patients might not feel very estranged to have visual hallucinations. Although some new evidence from the western world also seems to counteract the widely held traditional view that visual hallucination is atypical or uncommon in psychosis. A new study found that 15% of patients with affective psychosis have visual hallucinations and that this is linked to linked to a more severe psychopathological profile and less favorable outcome [27].

A study about the frequency of psychotic symptoms in depression with a big sample found that frequency of delusions in depression is 4% in those with relatively mild depression, while about 33% in those with more severe depression [26]. In our study there were 13 (14%) patients

suffering from delusion and this percentage is within the average of worldwide studies.

In conclusion, the finding that the DSM-IV symptoms were all more common than the "other" symptoms suggests that Iraqi patients do not have that big difference in presentation of depression than in other countries.It is a well known fact among psychiatrists and people working in the field of psychiatry in Iraq that depression is presented mainly in somatic features in our country.

In this study the sample was taken from an urban area in the center of Baghdad which may be not representative of all the population of Iraq. We recommend that another study be done in a rural area, or taking a big sample including rural and urban areas. However, there may be a change in presentation of depression in Iraqi patients in the last decades with a rise in "worthlessness" and "thoughts of death" symptoms. The presentation of depression may be more similar around the world than it was thought previously.

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