Original Article

Bangladesh Journal of Psychiatry, December, 1995, 8, 2, 14

SYMPTOM PRESENTATIONS OF MAJOR DEPRESSIVE DISORDER

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Summary

Fifty two patients suffering from major depressive disorder (MDD) were included in this study in order to determine and assess the presentations of major depressive disorder in our culture. Diagnosis was made on the basis of DSM–IV criteria for MDD. Somatic symptoms are almost a constant feature among patients with depressive disorder. Out of 52 patients 41 (78.85%) patients were found to have associated significant somatic symptoms. Burning all over the body, heat in the head, headache, bodyache and gastrointestinal symptoms were the common associated somatic presentations. Agitation (16 cases) were more than retardation (13 cases). A good member of patients were house–wives (44.23%).

Introduction

Most psychiatrists who work in a general hospital psychiatric unit are referred from general physicians and surgeons patients who complain of severe and chronic physical symptoms for which no organic cause can be found[1,2]. Many of them are suffering from depressive disorder which is a common psychiatric problem. In our culture many patients presents with complaints that are not enlisted in DSM–IV criteria for Major depressive Disorder[3]. One study reported that a large number of patients presenting with somatic complaints may be suffering from depression[4]. Non–specific medical entities has been found often to be affective or anxiety syndrome in disguise.

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The objective of the study is to determine and assess the presentations of symptoms of Major Depressive Disorder in our culture.

Materials and methods

The study was carried out on 52 patients collected over a period of seven months from both the in–patients and out–patient department of the psychiatry of Institute of Post–Graduate Medicine and Research, Dhaka.

A semi–structured questionnaire was designed to interview the patients. Informations were collected from the patients and their relatives. Relevant Sociodemographic informations and informations relating to depressive disorder and accompanying somatic features were carefully noted.

The diagnosis of depressive disorder was based on DSM–IV diagnostic criteria for Major

Depressive Disorder. The data were presented in tabulation form and statistical analysis was done where required.

Results:

Among the 52 patients under study 41 patients were found to have associated somatic symptoms (Table No. 3a). This finding is

patients were from 19 yrs to 60 yrs with mean age 39.69 years. Twenty seven patients were female and 25 patients were male and the male female ratio was – 1:1.08. Twenty three (44.23%) patients out of 52 were housewives (Table No. 1).

Table No. 2 shows the DSM–IV criteria for Major Depressive Disorder (MDD). All the the patients fulfilled the DSM–IV criteria for MDD. Agitation was more (16 cases) than retardation (13 cases). Table No. 3b shows the associated

Table No. I: Socio–demographic characteristics of the patients

Characteristics	No.	%
Age		
15–24	4	7.70
25–34	14	26.92
35–44	16	30.76
45–54	13	25.00
55–64	5	9.62
Mean = 39.69 (SD = 11.02) yrs		
Range = 19 – 60 yrs		
Sex		
Male	25	48.08
Female	27	51.92
Male : Female = 1:1.08		
Marital status		
Unmarried	9	17.30
Married	39	75.00
Separated	2	33.85
Divorced	2	3.85

Characteristics	No.	%
Occupation		
House wife	23	44.23
Business	5	9.60
Service	14	26.92
Retired	3	5.76
Unemployed	2	3.85
Cultivator	2	3.85
Student	3	.76
Education		
Illiterate	10	19.23
Primary	11	21.15
Secondary	4	7.70
S.S.C	5	9.62
H.S.C	11	21.15
Graduate	8	15.38
Post–graduate	3	5.76
Social background		
Urban	35	67.31
Rural	17	32.69

Table No. II : DSM–IV criteria for Depressive present among the patients.
(More than one symptom was present)

Symptoms	No. of Patients
a. Depressed mood	49
b. Loss of interest and pleasure	49
c. Weight loss (no weight gain was reported)	9
d. i. Insomnia	46
ii. Hypersomnia	2
e. i. Psychomotor agiatation	16
ii. Psychomotor retardation	13
f. Fatigue or loss of energy	41
g. Feeling of worthlessness and guilt	38
h. Diminished ability to think concentrate or indecisiveness	46
i. Recurrent thoughts of death or recurrent suicidal ideation suicide attempt specific plan for committing suicide	32

Table No. III : Patients with associated somatic symptoms.

Table No. IIIa

Somatic symptoms	No. of Patients	%
Yes	41	78.85
No	11	21.15
Total	52	100.00

$X^2 = 17.31$, $df = 1$, $P < 0.001$

Table No. IIIb

Somatic symptoms	No. of patients
1. Vomiting	3
2. Buring all over the body and heat in head	16
3. Headahe	15
4. Gas in Abdomen	8
5. Bowel disturbance	6
6. Pain all over the body	8
7. Abdominal pain	2
8. White discharge with urine	4
9. Sound in ear	3

(More than one symptom was present)

Table No. IV : Treatment received by the patients

Drugs	No. of patients
Imipramine	20
Fluoxetine	18
Amitriptyline	11
Thioridozine	9

(Some of the patients received more than one drug).

somatic symptoms. Burning all over the body, heat in the head, headache, bodyache and gastro–intestinal symptoms were the common associated somatic symptoms.

The patients were treated with Imipramine, Fluoxetine, Amitriptyline and Thioridazine (Table No. 4)

Discussion

Fifty two patients suffering from depressive disorder collected over a period of seven months from both the in–patient and out–patient department of the psychiatry unit of Institute of Post–graduate Medicine and Research, Dhaka were included in the present study. Out of 52 patients 41 patients were found to have associated somatic sumptoms (which is highly significant) like buring sensations, heat in the head, headache, body ache and gastrointestinal symptoms. A large proportion of patients who consults physicians with somatic symptoms are suffering from depressive illness[3,4,5]. Often patients do not mention about their depressive mood to doctors. Several factors are thought to influence this presentation. One more important stigma is that mentally ill patients belief that doctors are more interested in physical than psychological complaints[6]. Appropriate diagnosis is important because the bodily symptoms are commonly used as reason for coming to the doctor.

The present study findings reveal that somatic symptoms are almost a constant feature among patients with depressive disorder. This finding is consistent with the findings of another study done in our culture by Karim and Mullick[4].

Out of 52 patients 23 patients were housewife. This number is quite big and this is consistent with the fact that the women population without full–time or part–time employment outside home are more vulnerable to depression[7]. The common presentaing somatic features were burning all over the body, heat in the head, headache, bodyache and gastrointestinal disturbances. Four patients complaining of white discharge with urine met the criteria of major depressive disorder. This finding is consistent with the findings of another study where 38.79% patients having white discharge with urine were suffering from depression[8].

It is known that depression is twice as common in women than men and female patients usually complain more somatic symptoms than male. In our study male female ratio is 1:1.08. This is most probably due to the fact that females are more neglected group in our country and usually avoid hospital or seek treatment due to various cultural factors. Psychomotor agitation was slightly more than psychomotor retardation. Actually in our culture among depressed patients agitation is more than retardation. Patients were treated with imipramine, Fluoxetine, Amitriptyline and Thioridazine. We know that thioridazine is very effective in agitated depressed patients[6] but we could not prescribe it sufficiently becuase of its high price. Nine patients out of 16 agitated depressed received thioridazine therapy.

Conclusion

It may be said on the basis of the present study that culture can influence the experience and communication of symptoms of depression.

Underdiagnosis or misdiagnosis can be reduced by being alert and vigilant to ethnic or cultural specificity in the presenting complaints of a Major Depressive episode. In some cultures depression may be experienced largely in somatic terms rather than with the feeling of sadness or guilt.

The present study findings reveal that the development of a new diagnostic scale for depressive disorder may be very useful in our culture and thus misdiagnosis and underdiagnosis can be avoided.

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