Keeping in mind the shortcomings of previous transcultural studies on depression, we have compared in detail the symptomatology of depression, between samples from India and U.S.A. taking them to be representatives of eastern and western cultures respectively. Symptoms of fifty patients from India are compared with the same set of symptoms of sixty four patients of depression reported from U.S.A. The core symptoms were similar in both the samples. Many interesting differences as well as similarities are found between the two samples.

Transcultural Psychiatry has come a long way since the pioneering surveys of persons like Obersteiner and Kraepelin. Though transcultural psychiatry is not a new field any more it is probably still in its formative stages. On one hand transcultural psychiatry has expanded to include more and more studies in different areas, but on the other hand a need has still been felt by Lipsedge and Littlewood (1979) for detailed studies of phenomenology of mental illnesses in different cultures.

In the transcultural aspects of depression, one just cannot overlook the contributions of great persons like Kraepelin (1904), Lambo (1956), Field (1958). Murphy (1967) and many others who have inspired later investigators in this field. It is unfortunately impossible to present the review of all the studies, but most of these researchers have presented casual observations like deviation from classical textbook picture of depression in non western cultures, absence or infrequency of ideas of sin and guilt, absence of suicidal ideas, more somatic complaints, etc. If one reviews comparatively recent studies of investigators like Bhattacharya (1969), Teja and Narang (1979), Rafiq Waziri (1973), Escobar and Gomez (1983) and Venkoba Rao (1984), one finds a little different and at times contradictory picture. Though the symptoms like guilt feelings and suicidal ideas have been reported with more frequency than previous studies, the range of percentage of population in which it is reported is very wide. One also finds that the number of symptoms reported in each study is very small.

The present study, keeping all the shortcomings of the previous studies in mind tries to compare the symptomatology of depression between samples from India and U.S.A., taking them to be representatives of eastern and western cultures respectively. In the present study the assessment instrument used for both the groups has been kept identical and it also contains ninetynine items covering most of the symptoms of depression reported in the international literature.
Hence we have tried to make the comparison more comprehensive and less deceptive. We have also used the DSM-III (1980) criteria for inclusion, which would make future comparisons more accurate. Thus we have made an effort to present a comparison of depressive symptomatology between samples from India and U.S.A. that may lead to a greater understanding of transcultural aspects of depression.

Material and Methods

Fifty patients with the diagnosis of Major Unipolar Depression and Bipolar Affective Disorder-current episode depressed according to DMS-III (1980) classification, were selected quasirandomly from the outpatient and inpatient departments of Sheth V.S. General Hospital, Ahmedabad-India. All the Patients were personally interviewed by the same investigator using a semi-structured proforma containing ninety-one symptoms. The symptomatology of this sample from India was compared with the symptomatology of a sample with sixty-four patients of depression, interviewed for the same set of symptoms and reported by Mezzich (1980) from Columbus-U.S.A.

Results and Discussion

Complaints Voiced

Initially patients were allowed to voice a maximum of five complaints on their own. Out of the group of ten most frequent complaints, three i.e. sadness, headache, and anxiety were common to both the Indian and U.S. samples. There were five 'somatic' complaints in the Indian sample, compared to only one in the U.S. sample. This clearly shows the tendency of depressed patients in the Indian sample to bring out their somatic complaints in the foreground. This could be due to many reasons like preconceived ideas regarding what complaint requires medical attention, feeling that the psychological complaints are secondary to their physical illness, lack of psychological orientation or the stigma attached to psychiatric problems.

Symptoms systematically explored

For the purpose of discussion, we will break up the symptoms in various groups.

| Table 1 General Symptoms |
|---------------------------|
| Symptom                   | Percentage | U.S. | India |
|---------------------------|------------|------|-------|
| Fatigue                   |            | 90   | 96    |
| Appetite                  | Diminished | 84   | 90    |
|                           | Increased  | 5    | 4     |
| Weight                    | Gain       | 8    | 16    |
|                           | Loss       | 75   | 70    |
| Daily fluctuation of depression |   | 70   | 54 t  |
| Worse in morning          | 40         | 38   |       |
| Worse in afternoon        | 18         | 26   |       |
| Worse in evening          | 42         | 18*  |       |
| Sleep                     | Daily hours of sleep |   |       |
|                           | 0—5        | 56   | 88*   |
|                           | 6—8        | 31   | 8*    |
|                           | More than 9| 12   | 4     |
| Initial insomnia          | 78         | 82   |       |
| Interrupted sleep         | 78         | 70   |       |
| Early morning awakening   | 47         | 72*  |       |
| Excessive dreams/nightmares| 31         | 38   |       |
| Tired awakening           | 78         | 88   |       |
| Diurnal sleep             | 29         | 46*  |       |
| Hypersomnia               | 9          | 14   |       |

* Significant at P less than .001
† Significant at P less than .05

It is obvious from Table-1 that most of the general symptoms are reported with similar frequency in both the population. Significant differences are found in daily fluctuation of depression and sleep symptoms. Significantly less patients from the Indian sample report such fluctuation of depression, and in those who do so, sig-
significantly less report feeling worst in the evening. In sleep related symptoms, significantly more patients from the Indian sample have reduced sleep and particularly early morning awakening than the patients from the U.S. sample. Probably due to this very reason the Indian patients also report diurnal sleep more frequently.

Table 2
Somatic Symptoms

| Symptoms          | Percentage | U.S. | India |
|-------------------|------------|------|-------|
| CHEST             |            |      |       |
| Precordial Pain   | 29.7       | 52 * |       |
| Palpitation       | 56.2       | 80 * |       |
| Chest Opression   | 31.2       | 68 * |       |
| Difficult breathing | 32.8     | 30   |       |
| Sighing           | 46.9       | 24   |       |
| GIT               |            |      |       |
| Dry/bitter mouth  | 50.0       | 90 * |       |
| Dyspepsia         | 23.4       | 58 * |       |
| Nausea            | 35.9       | 58 * |       |
| Vomiting          | 18.8       | 20   |       |
| Belching          | 17.2       | 38 * |       |
| Flatulence        | 32.8       | 56 * |       |
| Constipation      | 31.2       | 52 * |       |
| Diarrhea          | 17.2       | 12   |       |
| URINARY           |            |      |       |
| Urinary frequency | 34.4       | 28   |       |
| Dysuria           | 17.2       | 30 * |       |
| Nocturia          | 23.4       | 14   |       |
| SEXUAL            |            |      |       |
| Loss of Sexual desire | 57.8     | 28   |       |
| Increased Sexual desire | 0.0   | 0    |       |
| Inability to reach orgasm | 23.4  | 72 * |       |
| In man (n = 18/17) |            |      |       |
| Difficult erection | 22.2     | 47.5 * |       |
| Premature ejaculation | 5.6      | 29.4 * |       |
| Delayed ejaculation | 11.1    | 0 +  |       |
| In Woman (n = 30/25) with catamenia |         |      |       |
| Menstrual dysfunction | 6.7     | 16   |       |
| Oligomenorrhea    | 13.3       | 28 * |       |
| Polymenorrhea     |            |      |       |
| Somatic dysmenorrhea |        |      |       |
| Abdominal distention | 3.3      | 28 * |       |
| Tender breast     | 0.0        | 24 * |       |
| Menstrual cramps  | 13.3       | 72 * |       |
| Psychic dysmenorrhea |        |      |       |
| Irritability      | 30.3       | 60 * |       |
| Depression        | 20.0       | 68 * |       |

|       | U.S. | India |
|-------|------|-------|
| In Menopause (n = 18/8) |      |       |
| Time since menopause |      |       |
| 0—5 years             | 53.3 | 62.5  |
| More than 6 years     | 46.7 | 37.5  |
| Hot flashes            | 46.7 | 0.0 * |
| SKIN                   |      |       |
| Pruritus               | 28.1 | 14 §  |
| Neurodermatitis        | 10.9 | 2     |
| Eczema                 | 9.4  | 2     |
| Urticaria (red blotches) | 7.8   | 0     |
| Hand Sweating          | 37.5 | 28    |
| General Sweating       | 48.4 | 60    |
| SPECIAL SENSES         |      |       |
| Auditory ringing or bussing | 23.4 | 38 §  |
| Blurred vision         | 20.4 | 34 §  |
| Alteration in taste   | 28.1 | 72 *  |
| PAIN (MUSCULOSKELETAL) |      |       |
| Headache               | 53.1 | 88 *  |
| Muscular pain (others) |      |       |
| Neck                   | 28.1 | 40    |
| Back                   | 29.7 | 58 *  |
| Limbs                  | 14.1 | 68 *  |
| Pain in joints         | 15.6 | 36 +  |
| OTHERS                 |      |       |
| Dizziness and vertigo  | 45.3 | 80 *  |
| Hand tremors           | 62.5 | 52    |
| Acroerythema           | 25.0 | 42 §  |
| (Cold hand and/or feet)|      |       |
| Acroparaesthesia       | 31.2 | 62 *  |
| (numbness, tingling)   |      |       |
| Motor retardation      | 40.6 | 84 *  |

* Significant at P less than .001
§ Significant at P less than .05
† Significant at P less than .01

From Table-2, with Somatic Symptoms one cannot help but observe the overwhelming preponderence of somatic complaints in the Indian sample. This coincided well with earlier reports of higher somatic complaints in eastern cultures. Three groups of symptoms that come out strongly, to be present significantly more in the Indian sample are chest symptoms, Pain (musculo-skeletal) symptoms and sexual symptoms. But at the same time it is observed that symptoms of few groups like urinary symptoms and skin related symptoms are similar in both the samples.
| Symptoms                        | Percentage | U.S. | India |
|--------------------------------|------------|------|-------|
| Psychic retardation            | 59.4       | 96   |
| Sadness                        | 95.3       | 100  |
| Crying                         | 81.2       | 74   |
| Anxiety                        | 84.4       | 78   |
| Irritability                   | 75.0       | 92 t |
| Hopelessness                    | 76.6       | 86   |
| Lack of emotional reactivity to external stimuli | 51.6 | 52 |
| Loss of humor                  | 75.0       | 80   |
| Feelings of emptiness in life  | 84.4       | 80   |
| Guilt feelings                 | 65.6       | 52   |
| Inferiority feelings           | 67.2       | 24 t |
| Feelings of personal insufficiency | 85.9 | 26 t |
| Hypochondriacal preoccupation  | 28.1       | 34   |
| Deathwishes                    | 81.2       | 86   |
| Suicidal ideas                 | 67.2       | 62   |
| Suicidal attempts              | 31.2       | 10 t |
| Confusion of ideas             | 70.3       | 82   |
| Difficulty in making decisions | 79.7       | 80   |
| Loss of interest               | 87.5       | 100  |
| Abulia, Hypobulia              | 79.7       | 88   |
| Difficulty in concentration    | 75.0       | 88 t |
| Difficulty in recalling         |            |      |
| Recent events                  | 53.1       | 92 t |
| Past events                    | 10.9       | 12   |
| Phobias                        | 12.5       | 2 t  |
| Delusions                      | 18.8       | 14   |
| Obsessive ruminations          | 45.3       | 24 t |
| Compulsions                    | 14.1       | 10   |
| Illusions                      | 7.8        | 4    |
| Hallucinations                 | 15.6       | 2 t  |
| Depersonalization              | 26.6       | 6 t  |
| Derealizations                 | 14.1       | 10   |
| Increased alcohol intake       | 20.3       | 2 t  |
| Marital arguments              | 34.4       | 32   |
| Tendency to seclusion          | 53.1       | 88 t |

* Significant at \( P < 0.001 \)
\( \dagger \) Significant at \( P < 0.05 \)
\( \ddagger \) Significant at \( P < 0.01 \)

It is also seen that most of the GIT symptoms are more in the Indian sample. If one takes an overall view of the somatic symptoms then it is obvious that by and large, the symptoms found to be present in significantly more frequency in Indian sample, would cover the symptoms of Anxiety Disorder. This could raise the possibility of Indian patients having more of anxiety combined with depression. This could throw light on another reason for higher somatic complaints in certain cultures, apart from reasons like patients expectations as to what medical man would consider illness (Teja 1971), stigma of psychiatric illness or lack of psychological orientation in certain cultures (Escobar & Gomez 1983) and their languages (Mehta 1984).

Taking an overall view of Table - 3 with Psychological Symptoms, one finds that out of the total 34 symptoms only 14 symptoms are significantly different in both the samples. Out of these 14 symptoms, half the symptoms are reported more frequently in the Indian sample. This would mean that though patients from Indian sample have voiced more somatic complaints on their own, they have come out with considerable psychological symptoms on systematic exploration. Certain interesting findings from this table are worth mentioning. Guilt feelings was found to be similar in both the groups. This is contrary to many studies in the past but at the same time such results have been reported by Teja and Narang (1971) and Venkoba Rao (1973). In the Indian sample more males were found to have guilt. During the interview we noticed a relationship between guilt, and the ability to carry out one's "responsibilities". Due to this, probably most of the men who were not able to earn presented more with guilt, while most of the women who were carrying out their routine work, in spite of the illness, were surprised when questioned about guilt. If low reporting of inferiority feeling is taken into consideration, one could suggest that the guilt may be of an impersonal nature rather than individualized guilt. One should also take into consideration the
rapid industrialization and modernization of India, which is changing the social fabric and could be also changing the symptoms of depression in India.

Hypochondriacal preoccupation is similar in both the groups. Hypochondriasis reported in the Indian sample is in agreement with that reported by Venkoba Rao (1966) and Gupta (1982). Though the patients from Indian sample voiced more somatic symptoms, comparatively fewer had hypochondriacal preoccupation. While death wish and suicidal ideas are similar in both the samples, suicidal attempts are reported significantly higher in U.S. sample. The reasons for low suicidal attempts in the Indian sample could be due to concealment of information, moral and religious considerations, care of family and fear of stigma on family after one's death, as reported by Venkoba Rao (1984) and Shastri (1984).

Lastly if one takes all the symptoms together, then sadness, sleep disturbance, fatigue, loss of interest and diminished appetite were common in the list of ‘Ten most frequent symptoms’ from both the samples. These could be called ‘CORE’ symptoms. They compare well with the core symptoms of depression found by Mezzich (1980) in U.S. and Peru, and Waziri (1973) in Afghanistan.

Though it would be difficult to summarise various aspects of this study in brief, accepting the limitations of this study, like small number of patients, different investigators in the two samples and subtle differences in meanings of words in different languages, we can summarise as follows.

1. Patients from the Indian sample voiced more somatic complaints on their own than the U.S. sample.
2. Certain ‘CORE’ symptoms like sadness, sleep disturbance, fatigue, loss of interest and diminished appetite are reported with high frequency in both samples.
3. There is a higher frequency of SOMATIC symptoms in the Indian sample than the U.S. sample on systematic exploration. This could be probably due to the Indian patients having more anxiety combined with depression.
4. PSYCHOLOGICAL symptoms are reported with higher frequency in both the samples. Both the samples show their individual preferences for different, as well as some common symptoms.
5. Guilt feeling is found to be similar in both the samples, with probably different directions of guilt.

Thus we come across these and many other absorbing differences as well as similarities in symptomatology of depression between the U.S. and the Indian sample. Looking at these results, we wish that this study aids further investigations in this field and becomes one of the link of a chain of cross-cultural studies on depression.

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