Indian J. Psychiat. (1982), **24**(4), 380—382

DEPRESSIVE SYMPTOMS—AN INTERCENTRE COMPARISON

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SUMMARY

45 Psychotic Depressives from PGI, Chandigarh have been compared with 90 Psychotic Depressives from Madurai Centre on 40 symptoms using SADD schedule. Differences in the symptomatology have been highlightened.

Many studies have reported a higher prevalence of depressive disorders in North India as compared to the South (Sethi and Gupta, 1970 ; Davis *et al.*, 1965 ; Satyavati 1964 ; and Venkova Rao, 1966 ; Bagadia *et al.*, 1970). Various hypothesis have been put forward to explain these differences. Whether this is due to diagnosis bias, tolerance to depressive symptoms (Teja & Narang, 1970), genuine differences in susceptibility to illness (Singh, 1979) or demographic and cultural differences is open to question. All these explanations are impressionistic and have not been put to test. Our problem in drawing firm conclusions from the studies reported on North versus South India is the differences in the methodology and criteria used for assessment of psychopathology. It is not implied, however that these findings should be totally ignored if, as reported there is such a vast difference in prevalence of depressive disorders between North and South India, it is worthwhile to investigate the differences in symptomatology as well. Though some workers (Bagadia *et al.*, 1970 ; Venkoba Rao 1966 ; Ponnudurai *et al.*, 1981) have studied the symptomatology of depressive disorders at various clinics in India, barring one (Teja *et al.*, 1971) no study has done intercentre comparisons. Thus, it was decided to compare the symptomatology of depression between two different centres in India, Chandigarh and Madurai, from North and South India, respectively.

MATERIAL AND METHOD

The sample of this study consisted of 45 patients of psychotic depression who attended psychiatric clinic of PGIMER, Chandigarh from June 77 to Dec. 77. They were assessed on schedule for Standardized Assessment for Depressive Disorders (SADD, 5th draft March 1977 drafted by WHO) Venkoba Rao (1981) had also used the SADD in assessment of 90 psychotic depressives. Since both the centres have used the same tool, data from these centres can be easily compared. In the present study 45 cases of our centre have been compared with 90 psychotic depressives from Madurai (Venkoba Rao, 1981) on 40 symptoms profile.

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TABLE No. 1—*Showing Depressive symptoms on which the two groups have differed significantly*

Depressive symptoms	Chandigarh study N=45	Madurai study N=90	Level of significant
1. Joylessness	43	64	<0.01
2. Disruption of social functioning	44	55	,,
3. Lack of self confidence	30	32	,,
4. Early awakening	36	48	,,
5. Lack of appetite	35	43	,,
6. Feeling of pressure	30	16	,,
7. Other psychological symptoms	33	40	,,
8. Psychomotor restlessness	34	38	,,
9. Mood worsening in the morning	30	25	,,
10. Hypochondriasis	12	48	,,
11. Subjective experience of memory loss	40	53	,,
12. Lack of energy	43	72	<0.05
13. Loss of ability to concentrate	37	58	,,
14. Psychomotor retardation	35	50	,,
15. Guilt feelings	17	18	,,
16 Restless sleep	27	38	,,

TABLE No. 2 *Showing Depressive symptoms on which the two groups did not differ significantly.*

1. Sadness
2. Anxiety
3. Aggression
4. Irritability
5. Desire to be alone
6. Thought retardation
7. Inability to fall asleep
8. Hypersomnia
9. Suicidal ideas
10. Hopelessness
11. Loss of interest
12. Ideas of impovrishment
13. Change of body weight
14. Change of time perception
15. Indecisiveness
16. Constipation
17. Other somatic signs and symptoms
18. Decrease of libido
19. Disorder of perception
20. Ideas of insufficiency
21. Ideas of reference persecution
22. Other delusions
23. Mood worse in the evening
24. Physical disease or infirmity.

RESULTS AND DISCUSSION

Patient groups in two centres have differed significantly on a number of symptoms. The Chandigarh group reported more of joylessness, disruption of social functioning, lack of self confidence, early awakening, lack of appetite, feeling of pressure, other psychological symptoms, psychomotor restlessness, mood worsening in the morning, subjective experience of memory loss, retardation and guilt feelings. Significantly more patients from Madurai-centre reported only hypochondriasis. The two groups did not differ on a number of symptoms, viz. anxiety, sadness, aggression, irritability, desire to be alone, thought retardation, change of body weight, ideas of insufficiency, indecisiveness, inability to fall asleep, constipation, decrease of libido, suicidal ideas, morning worsening, disorders of perception, ideas of reference and persecution, other delusions, physical disease or infirmity.

A higher frequency of depressive symptoms has been made from our centre. Psychotic symptoms like ideas of reference, persecution, other delusions and disorders of perception were reported by a very small

number of patients in both the groups. Similarly, other workers in India have also noted towards low occurance of paranoid symptoms in depressives (Bagadia *et al.*, 1970 ; Teja *et al.*, 1971). Teja *et al.* (1971) compared their own groups of depressed patients with those from Madurai (Venkoba Rao, 1966) and two British studies and observed that North Indian sample did not differ significantly from South Indian sample in the number of symptoms like guilt, agitation, anxiety, somatic and genital symptoms, depersonalization, and obsessional symptoms. Symptoms such as suicidal ideas and diurnal variation were significantly more marked in Venkoba Rao's sample whereas retardation and hypochondriasis were more frequent in North Indian sample.

Some significant findings emerge when study done by Teja *et al.* and the present study are compared. Total number of depressive symptoms reported had been greater in our study in comparison to that of Teja *et al.* (1971). Hypochondriasis which was more commonly reported by Teja *et al.* in North Indian sample has shown a reverse trend in the present study. This difference may be due to rating of hypochondriasis as a symptom which was considered present only if it was of delusional intensity (Venkoba Rao, 1966). In the same study (Teja *et al.*, 1971) guilt feelings were reported equally by both groups. Significantly more patients from our centre reported guilt feelings in comparison in Venkoba Rao (1966) and Teja *et al.* (1971). Reporting of this symptom by our patients was more of impersonal character and usually attributed to possible bad deeds in previous life. Could these be labelled as guilt feeling is also open to question.

Thus, in the present work we have highlighted the symptom differences and similarities of two culturally different groups. Our work becomes more important, since no other worker has used the same standardized tool for a comparative assessment of depressive disorders in diagnostically homogenous groups.

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