DEPRESSION IN AFRICAN PATIENTS*

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There is some diversity of opinion as to the incidence and prevalence of depressive illness among African populations. Several studies in West Africa found that depression is a common illness,[1-5] but others assert that it is rare in its standard forms.[6] Affective disorders are rarely encountered in South African mental hospital patients,[7] and suicide rates are low in Nigeria.[8]

Although genuine geographical variations cannot be excluded, it is likely that this difference is more apparent than real and consideration of possible underlying factors should prove heuristically fertile.

Firstly, the depressed patient may not be considered ill.[1] Social compatibility is considered an important criterion of normality in most African cultures[9] and for this reason it is likely that many cases remain in the community, where any treatment they receive is given by traditional healers.[10]

Secondly, personality patterns vary with culture,[11,12] and there are also 'culture-bound' psychiatric disturbances. It follows that there are likely to be clinical differences in psychiatric illness which parallel cultural variations. Where the psychiatrist is working in a culture different from the one in which he trained, the diagnosis may be obscure.

It is important that descriptions of local variations in clinical manifestations be undertaken,[5] as rapid social changes in emergent countries may produce rapid changes in patterns of mental illness;[13] for example, a study of reactive depression among old people in Nigeria implicated urbanization and educational status as contributory factors.

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Several such descriptions have been undertaken and have revealed important differences from usually accepted patterns of depressive illness, notably in the importance of physical symptoms in the presentation, e.g. dramatic weight loss.[14]

With these considerations in mind, a survey of depression was undertaken among African patients referred to the psychiatric outpatient clinic of a general hospital in Bulawayo.

The patients were all seen and treated by myself and the diagnosis was sustained in retrospective review. This entailed the rejection of large numbers of patients either treated by other psychiatrists or in whom the recorded data were insufficient to justify the diagnosis.

Although the patients were therefore selected to some extent, they nevertheless appeared to form a fairly representative sample of the work done in the practice.

MATERIAL AND METHODS

Seventy-six patients were selected from the records available for the 3-year period 1 January 1965 - 31 December 1967.

Diagnostic Criteria

As it was uncertain whether the usual, controversial division into endogenous and reactive depression would hold with African patients, and as the relevant environmental factors were also putative, this dichotomy was abandoned and all cases were simply considered as depression.

The diagnosis depended on subjective feelings of de-

pression without objective evidence in 23 patients, but one of these patients attempted suicide and 11 others expressed suicidal ideas. Physiological symptoms of depression were present in 5 others.

The diagnosis depended on objective evidence of depression in 8 cases, but in 5 of these were corroborative physiological symptoms.

In the remaining 45 patients both subjective and objective evidence of depression was present; two of these patients attempted suicide and 8 more expressed suicidal ideas.

Evidence of any disorder of stream, form or possession of thinking was taken to indicate a schizophrenic illness. Disorders of thought content such as delusions or hallucinations were not construed as necessarily invalidating the diagnosis of depression.

The term 'schizo-affective illness' was not used and any such cases were classified as schizophrenic.

Any degree of clouding of consciousness was taken to indicate an underlying organic illness and to exclude a diagnosis of depression.

Patients

There were 36 male and 40 female patients, with a slightly different age grouping in the 2 sexes. Thirteen of the male patients but only 5 of the female patients fell in the 20 - 29-year age-group, whereas 15 of the female but only 8 of the male patients fell in the 30 - 39-years group. Five of each sex fell in the 10 - 19-years group, and the differences in the 40 - 49-years and 50-years-and-over groups were not significant. Four patients of each sex were merely classified as adult.

Presenting Symptoms

Only 15 patients presented with psychological symptoms, which were classified into 8 categories.

Five patients complained of subjective feelings of confusion, three complained of feelings of fear and two more of anxiety not amounting to fear.

Each of the remaining 5 patients presented with one of the following symptoms: bad dreams, irritability, failing concentration, attempted suicide, and adolescent crisis of identity.

No fewer than 61 patients presented with physical symptoms; these are set out in Table I.

There had obviously been considerable difficulty with diagnosis in these patients and many had been extensively investigated—sometimes as inpatients—for physical illness before being referred to the psychiatric clinic.

The duration of the illness, before referral, was often an index of this difficulty. Ten patients had been ill for less than 3 months; a further 10 had been ill for longer than 3 but less than 6 months. No fewer than 35 patients had been ill for longer than 6 months, 14 of them for 2 years or longer. The duration of the illness was not recorded in 6 cases.

Clinical Picture

The patients were evaluated according to the following scheme:

(i) *Physiological symptoms*: early awaking, diurnal mood variation, appetite change, weight change, sex-drive change.

(ii) *Psychological symptoms*: subjective and objective depression, retardation, feelings of unworthiness, guilt or inadequacy delusions, concern about life situation (excessive rumination or circularity of thinking), hallucinations, apathy and weakness.

(iii) *Anxiety symptoms*: sleep disturbance, frightening dreams, palpitations, dyspnoea, feelings of fear.

(iv) *Hysterical symptoms.*

(v) *Environmental stress*: social, marital, domestic, occupational, physical illness.

(vi) *Personality factors*: well-adjusted, specific inadequacy in relation to the stress, chronic general inadequacy.

In the evaluation, only the presence or absence of symptoms was recorded and no attempt was made to assess severity. Every effort was made to avoid suggesting symptoms or leading answers.

(*i*) *Physiological symptoms.* Five symptoms were evaluated, but only one patient reported all 5, and 2 others reported 4 out of the 5 symptoms.

Twenty-four patients showed no physiological symptoms at all, whereas 18, 17 and 14 patients admitted to 1, 2 and 3 symptoms respectively.

The most common symptom was loss of weight, which was reported 42 times. Curiously enough, this often occurred in the absence of any loss of appetite, which was reported only 25 times.

Diurnal variation of mood was reported 19 times; this proved a somewhat difficult symptom to evaluate and the usual procedure was to ask the patient if he or she had a preferred time of day for undertaking a particularly difficult task. Early awaking was reported 14 times, and the only sex-drive change reported was impotence in 7 men. Among the 18 patients with a single physiological symptom, 10 reported weight loss, 4 diurnal variation, 3 appetite loss and one early awaking. Thus the symptoms occurred in the same descending order of frequency, whether single or multiple.

(*ii*) *Psychological symptoms.* Six symptoms (other than depression) were evaluated. Sixteen patients had no symptoms in this category; on the other hand, no patient had 5 or 6 symptoms and only 7 patients had 3 or 4 symptoms. Thirty patients reported a single symptom and 23 patients reported 2 symptoms.

The most common symptom was apathy and weakness, which was reported 36 times. This was closely followed

TABLE I. PHYSICAL SYMPTOMS

Presenting symptom	*No. of patients*
Abdominal pain	16
Headache	11
Chest pain	9
Palpitations	3
General body pains	2
Painful arm	2
Painful feet	2
Formication	2
Dizziness	1
Shortness of breath	1
Sleepiness	1
Difficulty with swallowing	1
Difficulty with vision	1
Loss of voice	1
Painful hip	1
Vomiting blood	1
Pain in shoulders	1
Loss of consciousness	1
Weakness of the R. side	1
Backache	1
Swelling of the abdomen	1
Pain in the R. side	1
Total	61

by circularity of thinking, reported 34 times, then psychomotor retardation, reported 15 times. Much less common were hallucinations, feelings of unworthiness, etc., and delusions, which were reported 6, 5 and 3 times respectively.

The comparative rarity of feelings of unworthiness, guilt or inadequacy is notable.

Among the 30 patients reporting a single symptom in this category, apathy and weakness, circularity of thinking and retardation were again the three most common, having occurred in 14, 11 and 2 cases respectively.

Hallucinations or delusions alone were rare.

(*iii*) *Anxiety symptoms.* All the symptoms in this group were extremely common; in some cases they even overshadowed the depressive aspect of the illness. However, a diagnosis of anxiety neurosis was not considered tenable in the presence of depression.

Twelve patients exhibited no anxiety symptoms, but 10 patients reported all 5 symptoms. One, 2, 3 and 4 symptoms were reported in 17, 9, 12 and 16 cases respectively.

The most common symptom was sleep disturbance, which was reported 54 times; this was commonly associated with frightening dreams, which were reported 31 times. Palpitations, dyspnoea and feelings of fear were reported 36, 27 and 37 times respectively.

In its most complete form the clinical picture consisted of the patient awaking during the night from a frightening dream, with a feeling of fear accompanied by palpitations and shortness of breath.

(*iv*) *Hysterical symptoms.* These occurred in 12 patients and consisted of objectively disturbed behaviour (e.g. purposeless running to and fro, screaming) in 4 cases, and attacks of unconsciousness in 4 cases, while dysphagia, aphonia, paralysis of the leg and self-mutilation (pushing needles under the skin) occurred in one case each.

In two cases of disturbed behaviour there was subsequent amnesia.

The prominence of attacks of disturbed behaviour and loss of consciousness suggested that such patients might be admitted to hospital in terms of the Mental Disorders Act.

A search of the records of patients admitted to the hospital under certificates during the same period and subsequently diagnosed as suffering from neurotic illness, revealed 69 such patients. Of these, 17 were rejected, leaving 52 in whom the diagnosis could be sustained in retrospective review. Using the same criteria as for the outpatients, depression was diagnosed in 30 patients.

The presenting symptoms (as recorded by the certifying physician) of these 30 patients were grouped roughly into 4 categories, viz. disturbed or incomprehensible behaviour, antisocial behaviour, aggressive behaviour and social incompetence. Sixteen patients presented with symptoms in a single category, 11 patients with symptoms in 2 categories and 3 patients with symptoms in 3 categories.

Disturbed behaviour was described 23 times, antisocial behaviour 10 times, aggressive behaviour 5 times and social incompetence 9 times.

(*v*) *Environmental stress.* There was no evidence of environmental stress in 14 patients. In 57 cases a single stress factor was identified and in a further 15 cases two such factors were identified. Thus in 61 patients a possible precipitating stress was detected.

Occupational stress was recorded 18 times, closely followed by domestic stress which was recorded 16 times; bereavement was listed as a particular domestic stress in 7 cases.

Marital stress was recorded 13 times, while social stress and physical illness were recorded 10 times each.

(*vi*) *Previous personality.* The previous personality was assessed as well-adjusted unless there was definite evidence, such as a grossly disturbed work pattern, of previous instability or obvious inadequacy in dealing with current environmental stress.

Forty-eight patients were rated well-adjusted, 14 as showing a specific situational inadequacy and 14 as showing chronic general inadequacy.

Hysterical symptoms were associated with general or specific inadequacy in 8 patients and with previously well-adjusted personalities in only 4 patients.

Bearing in mind the loading in favour of the well-adjusted category, it appears that the inadequate personalities reacted to depression with dissociation. This may well have been influenced by cultural factors, firstly because spirit possession, trances and visions have been recognized as acceptable forms of expression in certain cultures,[10] and, secondly, because the patient may not be recognized as ill unless his behaviour becomes obviously disturbed.

TREATMENT AND OUTCOME

Of the 76 patients, 32 were admitted to hospital as voluntary patients for treatment. Admission was not always related to the severity of the illness; quite often social factors, such as distance of domicile from hospital, were the determinants.

Follow-through records were available for only 18 of the 44 outpatients; unfortunately the drugs used were entered on the prescription card retained by the patient and rarely noted in the other records.

In the inpatient group, one patient refused treatment and was discharged within a few days; she was rated 'worse'. Two patients only had ECT. One of these was an inadequate young man with hysterical paralysis of his leg, of several years' duration. When he presented he was weeping copiously and expressing suicidal ideas; he was therefore classified as depressed. There was no improvement with treatment, although he was induced to walk during periods of post-ictal confusion.

The other patient to receive ECT was a schoolmaster with pronounced feelings of inadequacy and physiological symptoms of nearly a year's duration. He was discharged, recovered, after 5 weeks' treatment.

The remaining 30 patients were treated with drugs; all patients received occupational therapy and simple supportive psychotherapy. The drug treatments followed four principal schedules, viz.:

(*a*)	Antidepressants + phenothiazines	11 patients
(*b*)	Antidepressants + minor tranquillizers	8 patients
(*c*)	Antidepressants alone	4 patients
(*d*)	Minor tranquillizers alone	6 patients

In only one case was an MAOI used; in all other cases the term antidepressant refers to tricyclic drugs, usually imipramine.

The results in this group were very satisfactory. Twenty patients were discharged within a month. Of these 20, 14 were rated recovered, 2 improved, 2 unchanged and 2 worse on discharge.

A further 10 patients were discharged within 3 months; 9 of these were rated recovered and one improved on discharge.

Only two patients remained in hospital longer than 3 months. One of these patients died—an elderly female who had been suffering from depression secondary to congestive cardiac failure. The other patient recovered and was discharged within 6 months.

There was no evidence that any particular regimen of treatment was more effective than another.

The results of the 18 patients in the outpatient group were not nearly so satisfactory. The details of the length of follow-through and outcome are set out in Table II.

The table indicates that progress is slower and qualitatively inferior in the outpatient group, which underlines the importance of adequate initial treatment.

TABLE II. OUTPATIENT GROUP RESULTS

Length of follow-through	*Outcome*	*No. of patients*
2 - 3 weeks	Worse	1
	Improved	3
	Unchanged	1
4 - 11 weeks	Worse	2
	Improved	3
	Unchanged	1
12 - 25 weeks	Unchanged	2
	Improved	1
	Recovered	1
26 - 52 weeks	Unchanged	1
	Improved	1
	Recovered	1
	Total	18

CONCLUSION

Depressive illness in African patients presents some differences from the usual pattern. In particular physical symptoms, anxiety symptoms and florid behavioural disturbances are important presenting features.

These differences may lead to difficulties in diagnosis which may, in turn, account for differences of opinion about the incidence and prevalence of depression in various parts of Africa.

Provided adequate treatment is given, preferably in hospital, the outlook is very good.

SUMMARY

Seventy-six depressed African patients who presented at the psychiatric clinic of a general hospital over a 3-year period are reviewed. Diagnostic difficulties, presenting symptoms and other clinical features are discussed; the presenting symptoms of 30 other depressed patients admitted to a mental hospital as certified patients during the same period are compared. Environmental features, treatment and outcome are also discussed.

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