# The African Journal of MEDICAL SCIENCES





Volume 3

1972

BLACKWELL SCIENTIFIC PUBLICATIONS
Oxford London Edinburgh Melbourne

*Afr. J. med. Sci.* (1972) **3**, 149–155.

# Some Observations on Depressive Illness in Nigerians Attending a Psychiatric Out-Patients Clinic*

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(*Received* 17 *May* 1971)

**Summary.** Some of the clinical features of depressive illness in twenty-five Nigerian out-patients (eleven males and fourteen females) making contact for the first time with a psychiatrist at the University College Hospital Ibadan, over a 7-month period are presented. The relevant data are collected in such a way as to make a distinction between symptoms volunteered by, and those admitted to, or denied by, the patients.

The usual manifestations of depression (including suicidal thoughts and act) were elicited to varying extents in a high proportion of the patients. Severe psychotic depression with marked psychomotor retardation, ideas of guilt and unworthiness was rarely encountered.

Somatic symptoms (usually multiple) were prominent and volunteered, but psychological ones, were elicited usually on questioning. Twenty-four out of the twenty-five patients volunteered or admitted to sadness of mood, but most of them attributed this to their somatic symptoms. The possible reasons for this mode of presentation are discussed.

The study underlines the need to elicit psychological symptoms by questioning patients and the need for medical practitioners to be aware that depressed patients might 'masquerade' in their clinics as suffering from a physical illness. The need for more work in this area is emphasized.

**Résumé.** On presente ici plusieurs traits cliniques de la depression chez des patients ambulants nigerians (11 hommes et 14 femmes) qui sont entres en contact avec un psychiatre a l'Hopital Universitaire d'Ibadan pour la première fois et le sont restes pendant une periode de 7 mois. Les observations sont classess d'une facon qui permets d'etablir une distinction entre les symptomes indiques et admis par le patients mémes et ceux qui furent nies.

On a pu decouvrir les manifestations habituelles de la depression (y compris l'idée et l'execution du suicide) chez un grand nombre des patients et a un degree

* Modified from a paper read at the Annual Scientific Conference of the Association of Physicians in Nigeria, held at University of Ibadan Conference Centre in December, 1970.

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varie. Par contre, ce n'est que tres rarement que l'on a pu rencontrer des depressions psychotiques severes accompagness d'un retard psychmoteur et d'un sentiment de culpabilite et d'inferiorite.

Les symptomes somatiques (habituellement multiples) sont preponderants et volontairement admis par les patients, mais les symptomes psychologiques n'en sont reconnus qu'a la suite de questions. 24 sur 25 patients indiquerent et admirent une tristesse generale, mais la plupart d'entre eux l'attribuainet a leur symptomes somatiques. Les raisons possibles pour cette facon depresentation sont discutes.

Cette etude souligne la necessite de bien delimiter les symptomes psychologiques en questionnant le patient et pour le practicien la necessite d'etre conscient du fait qu'un patient depressif peut passer comme quelqu'un qui souffre d'une maladie physique.

## INTRODUCTION

Workers in the field of psychiatry in Africa have given differing reports on the prevalence of depressive states among Africans. Some, for example, Tooth (1950) and Carothers (1953) reported low prevalence rates among the populations they studied, while others, for example, Forster (1958), Field (1960), Aubin (1961) and Collomb & Zwingelstein (1961) reported higher prevalence rates.

Several workers, for example, Lambo (1956) and Asuni (1961) among others, have stressed the difference in clinical presentation of depressive illness between Africans and those from Western European cultures. Asuni (1961) from his study of suicide in the Western Region of Nigeria, concluded as follows: 'depression as manifested by guilt, unworthiness and self-reproach is rare'.

Depression is a clinical syndrome and an important criterion for diagnosis should be a depressed or sad mood; emphasis should not be laid unduly on guilt feelings and self-reproach. Such symptoms commonly found in Western Europe cultures could be secondarily elaborated ones.

The study of depression is useful because, of the psychiatric states, it is one of those most amenable to treatment. Although depression *per se*, could have a poor prognosis, for example Sainsbury (1968) reported that one in six patients diagnosed as manic-depressive was likely to commit suicide, it has a better prognosis than, for example, most types of schizophrenia.

This report presents the author's experience of depressed out-patients in the University College Hospital, Ibadan. Its aim is to present some of the clinical features of depressive illness among Nigerians.

## METHOD OF STUDY

The case notes of all depressed out-patients making contact with the author from April to November, 1970 in the University College Hospital, Ibadan, were reviewed and information relevant to this report abstracted from them. Only patients in whom the diagnosis of depression was certain were included. Patients in whom depressive symptoms featured in the clinical presentation, but were diagnosed as other clinical entities, for example, schizophrenia and epilepsy, were not included. No distinction was made between psychotic and neurotic depression. Patients were included only if they were new, that is, making contact with the psychiatric out-patient service for the first time during the period under review.

The age, sex, marital status of all the new out-patients making contact with the author over the period under review were also abstracted in addition to clinical and other information about the depressed group. A distinction was made between symptoms which the patients volunteered and those which they admitted to or denied on questioning.

## RESULTS

During the period under review, eighty-seven new patients made contact with the author. Twenty-five of them were diagnosed as schizophrenics, twenty-five as depressives, fifteen as psychoneurotics, two as epileptics and two as organic brain syndrome. Thirteen patients belonged to a miscellaneous group of diagnoses (for example, alcoholism and psychopathy) while the diagnoses were uncertain in five patients.

### *Sex, age, marital status, and educational background*

Tables 1, 2 and 3 show that there was no significant difference between depressed patients and the other diagnostic categories put together, with respect to sex distribution, marital status and age distribution.

Patients were not related to social class but a simple classification of the depressed patients into those who received a minimum of secondary school education or more and those who did not, showed that twelve patients fell into the former category with thirteen in the latter category. There was no difference in the mode of clinical presentation of the two groups.

TABLE 1. Comparison of sex distribution of depressed and other patients

| Diagnostic category | Sex | | Total |
|---|---|---|---|
| | Male | Female | |
| Depressed patients | 11 | 14 | 25 |
| Patients in other diagnostic categories | 28 | 34 | 62 |
| Total | 39 | 48 | 87 |

$\chi^2 = 0{\cdot}02$, d.f. $= 1$, $P < 0{\cdot}05$.

TABLE 2. Comparison of age distribution of depressed and other patients

| Diagnostic category | Age (years) | | Total |
|---|---|---|---|
| | 40 or under | Over 40 | |
| Depressed patients | 20 | 3 | 23 |
| Patients in other diagnostic categories | 54 | 7 | 61 |
| Total | 74 | 10 | 84* |

* The ages of three patients were not known.
$\chi^2 = 0{\cdot}3$, d.f. $= 1$, $P < 0{\cdot}05$.

TABLE 3. Comparison of marital status of depressed and other patients

| Diagnostic category | Marital status | | |
|---|---|---|---|
| | Married | Single | Total |
| Depressed patients | 19 | 6 | 25 |
| Patients in other diagnostic categories | 37 | 24 | 61 |
| Total | 56 | 30 | 86* |

* The marital status of one patient was not known.
$\chi^2 = 1{\cdot}22$, d.f. = 1, $P < 0{\cdot}05$.

*Family history and previous personal history of psychiatric illness of the depressed patients*

Three patients admitted to a family history of psychiatric illness, while nineteen did not. This information was not known in the case of three patients.

Seven patients gave a history of, and seventeen denied a previous psychiatric illness. This information was not known in the case of one patient.

*Clinical features of depression*

Only one patient volunteered the symptom of sadness of mood. Nineteen patients admitted to being sad, while five denied it. The patient who volunteered a depressed mood put it this way, 'I am not my usual self. I feel depressed as if something is making me unhappy'. One of the patients who admitted to feeling depressed, said, 'I can't feel happy without alcohol'.

Though a high proportion of patients admitted to being depressed, most of such patients attributed their depressed mood to the somatic symptoms which they had and considered the most important ones. A few patients however, admitted to being depressed without any reason, for example, one patient said, 'I feel unhappy always without any reason'.

Seventeen patients admitted to diurnal variation in mood; two denied this, while this information was not ascertained from six patients. Eleven of the seventeen patients felt better in the evenings than in the mornings, while six of them felt better in the mornings than in the evenings.

Only two patients admitted to having unwarranted guilt feelings and making self-condemnatory remarks. These were denied by twenty patients while these symptoms were not elicited in the case of three patients. Twenty-one patients admitted to being slower than before, losing interest in their usual routine and forcing themselves to carry out their usual chores. One of these patients said, 'I feel pity when I see the children and I cannot do what I used to do for them'. Two patients denied these symptoms while they were not elicited in two patients.

No patient volunteered crying or feeling like crying. Thirteen patients admitted to, and twelve denied, this. One patient said 'I cry sometimes, but I do not allow my wife to see me crying'.

Twenty-four patients manifested sleep disturbance, with only three of them volunteering this information. Five of these twenty-four patients had difficulty in getting off to sleep, seven complained of early morning waking, while ten complained of both types of sleep

disturbance. The pattern of sleep disturbance was not ascertained with respect to two patients. Three patients volunteered and fifteen admitted to, a decrease in appetite. Six denied any change in appetite while this information was not available in the case of one patient.

Five patients had a normal and seven a diminished libido. This information was not obtained with respect to thirteen patients. Ten patients admitted to feeling that life was not worth living and had contemplated ending their lives without actually doing so, while fifteen denied this. Two out of the twenty-five patients had attempted suicide unsuccessfully during their illness.

Anxiety symptoms, for example, palpitations, fear, panic, tremors, dizziness and excessive sweating, were present in sixteen and absent in seven patients. This information was not sought in two patients. Three patients volunteered, ten admitted to, and three denied having a poor concentration. This information was not available in nine cases. Increased irritability was present in seven, absent in nine and not elicited in nine patients.

Nineteen patients volunteered and one admitted to, somatic symptoms, while five patients denied them. The somatic symptoms which were usually multiple included headaches, heaviness in the head, nausea, something moving about in the body, aches, constipation, hiccup, biting sensation and sensation of heat in the head or all over the body. A precipitating factor was thought to be present in fourteen but absent in eleven patients.

Twenty-four of the twenty-five patients looked depressed at the time of their first attendance at the out-patient clinic. No patient looked severely retarded but thirteen showed evidence of slight psychomotor retardation, while twelve patients looked agitated at their first attendance. All the patients received a physical examination and in no case were there any physical abnormalities to account for their symptoms.

## DISCUSSION

One limitation of this study is that some information was missing at the time of analysis. Another limitation is that of a possible personal bias in diagnosis. However, since the object of the study was to determine clinical presentation and not the prevelance of depressive illness, that limitation is not relevant. An unknown selection factor might have been present in the sense that the author saw only a particular type of depressed out-patients. This was unlikely as he saw whoever was referred to him in the clinic and he did not indicate any particular clinical or research interest in depressed patients.

The preponderance of females, married people and people under 40 years among the depressed group of patients reflects the pattern among the author's out-patient population over the period under review (Tables 1–3). Anumonye (1970) found that people under 40 and males predominated among the psychiatric outpatients of the same hospital from 1958–63. Anumonye's figures relate however to all the psychiatric outpatients while the present figures relate to patients seen by one psychiatrist.

Certain features stand out clearly in the clinical presentation of depression among the patients studied. One of them is the rarity of severe depression with marked psychomotor retardation. This confirms the experience of previous workers for example, Lambo (1956), Asuni (1961) and Carothers (1961). The reason for this is not clear but it should be noted that depression is a self-limiting illness and that most Nigerian patients be they Westernized or not, usually apply traditional medication before coming to hospital. Such factors could alter

the clinical picture by the time they get to hospital. It is known that severe depression does not carry the same social problems as severe mania. Whereas the patient suffering from severe mania is considered a nuisance to other people, the depressed patient is not. Thus, whereas maniacal patients have to be taken to treatment centres, severely depressed patients might not.

The depressed patients rarely expressed ideas of self-condemnation and guilt. This finding is similar to that reported by Lambo (1956) and Asuni (1961). This might reflect a cultural variation in the mode of presentation. On the other hand, it could reflect the severity of the illness among the patients seen. It has been said that some of those in our communities, who condemn themselves as witches or confess to atrocities attributable to witchcraft probably suffer from depressive illness. This is an area that needs further study.

Another important finding is that of multiple somatic complaints. This mode of presentation has been reported by several workers for example, Lambo (1956) and Collomb & Zwingelshein (1961). The somatic complaints are in fact what the patients complain about and consider the most important. Collomb & Zwingelstein (1961) have linked this somatization of symptoms to 'a theme of persecution with magical mechanisms of bewitching, possession and poisoning'. In other words, the patient attributes his problems to external sources, suggestive in psychoanalytic terms, of the absence of an 'introverted super-ego'. Whatever the explanations that have been offered for this mode of presentation, one should bear in mind the image which the average Nigerian has of a doctor. The doctor trained in Western medicine is expected to deal with physical symptoms and it is these symptoms that even psychiatric patients present to him.

Carothers (1961) said 'depression in the mental sense is rarely admitted' by depressed Africans. This is not confirmed in this study where twenty out of twenty-five patients volunteered or admitted to sadness of mood or depression. This study shows that one has to ask the patient about sadness of mood or depression as the patient is unlikely to volunteer this symptom or indeed other symptoms which are not somatic. This is important for doctors to bear in mind as the somatic symptoms could obscure a depressive illness. It should be pointed out that most Nigerian languages do not have a single word for depression, nor can the phrase 'sadness of mood' be accurately translated into most of them. However, when an approximate translation is made, patients who experience the symptom will admit it.

It should be borne in mind that this study relates to out-patients seen by one psychiatrist and that the findings do not necessarily apply to the generality of depressed patients in the community. The extent of the problem is not known. It is important to ascertain this and the various presentations of this illness in the community, as it is highly amenable to treatment.

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