

Frequency of Phenomenology in Depressive Illness

Taufiq Iqtidar, Jameel Ayesha, Naheed Shagufta, Hamirani Muneer, Zulqernain Ali

ABSTRACT

OBJECTIVE: To compare the frequency of depressive symptoms in both genders among the depressive patients at a psychiatric clinic of tertiary care hospital.

STUDY DESIGN: Cross sectional study

SETTING: Department of Psychiatry, Jinnah Post Graduate Medical Center, Karachi

DURATION: Six months (Nov-2006 to May 2007)

SUBJECTS AND METHODS: A sample of 100 new consecutive patients including both the genders coming to the researcher's consulting room was assessed for caseness of depression. Diagnosis was made by using ICD-10 Diagnostic Criteria for Research. Diagnosed patients were then seen for the severity of illness by rating them on Hamilton Rating Scale for Depression (HRSD).

RESULTS: Analysis indicated that among the psychological symptoms, feeling sad was the most common seen in 34% of the patients. In males, compared to females, hopelessness and lack of confidence was predominant (11.8% vs 1.5%), while high proportions of females, compared to male patients, complaint of irritability (27.3% vs 8.8%) and feeling like crying all the time (34.8% vs 14.7%). Among the somatic complaints headache was the most common reported by 39% of patients, which was significantly higher in females than males (47.0 vs 23.5%).

CONCLUSION: Men and women in this study reported similar patterns and severity symptoms of depression. No evidence that presentation of depressive symptoms differs by gender was found. Understanding of phenomenology is a major tool to aid in early detection and diagnosis of depression.

KEYWORDS: Depression, symptoms, Hemiltom scale, phenomenology, severity.

INTRODUCTION

Major depression is one of the commonest disorders in industrialized countries and is considered to be the fourth leading source of global burden of disease (GBD) projected to become the world's second most debilitating disorder by the year 2020.¹

It is a disorder characterized by persistent and pervasive low mood, anhedonia, impaired concentration, disturbed sleep, appetite and morbid death wishes.²

Being clinically depressed is very different from just feeling low or blue. Depressive episodes can last as long as months, sometimes years, and can interfere with one's social life and functionality. Unfortunately, depressive episodes also tend to recur and, if left untreated, will become more frequent and/or more severe as the disease progresses. The actual basis of depression is unknown but it is widely accepted to be influenced by genetic, environmental and neurobiological factors. Depression does run in families but it is difficult to determine whether this is genetic or simply reflects the kind of parenting a depressed person is able to offers his/her child. In addition there are many environmental factors such as loss of a loved one, unemployment, an unexpected medical illness, that

appear to increase the likelihood of depression. Some of the brain chemicals (neurotransmitters) and hormones have been linked to the development of depression in vulnerable population.³

We must acknowledge that depression can be difficult to diagnose as it can masquerade as a physical illness affecting various body systems. In spite of the exponential rise in the knowledge about the management of depression, a large majority of afflicted patients continues to remain untreated. Without adequate treatment 10-15% of depressive people commit suicide.⁴

Investigations has shown that depression increases medical utilization for a variety of somatic complaints like; weakness, lethargy, headaches, backaches, insomnia and gastrointestinal disorders. These complaints often produce unnecessary hospitalizations, diagnostic test and use of emergency services three to four times as often.⁵

High prevalence in women is seen particularly during childbearing years. There have also been differences reported between men and women in the nature of depressive symptoms, course of illness and response to treatment. Women more commonly present with reverse vegetative symptoms of depression (example.

hypersomnia, hyperphagia, carbohydrate craving and weight gain) compared with men.⁶

Women also endorse a greater number of depressive symptoms and, for a particular level of severity, a higher degree of subjective distress. Specifically sleep disturbance, psychomotor retardation, feelings of worthlessness or guilt, anxiety, and somatization are endorsed more often by women.⁶

Studies have demonstrated that women also exhibit a higher prevalence of somatic depression (that is fatigue, appetite and sleep disturbance) than men.⁶

Depression in adulthood remains a very common and under treated condition resulting in a high degree of disability.⁷

It should be borne in mind that Major Depressive Disorder has significant potential morbidity and mortality. Suicide is the second leading cause of death in persons aged 20-35 years and depressive disorder is a major factor in around 50% of these deaths.⁸

Although increased prevalence of depression in women is well documented there has been less studies regarding gender differences in phenomenology. This study was designed to determine the sex specific frequency of severity of depression and depressive symptoms among the depressive patients at a psychiatric clinic of tertiary care hospital for appropriate screening of the illness in the most productive years of life, as early interventions may be critical in the prevention of morbidity and mortality.

MATERIAL AND METHOD

The setting for the study was Psychiatry Department of Jinnah Post-Graduate Medical Centre (JPMC), which is a tertiary care hospital located in the center of the provincial capital of Sindh, Karachi. It consists of busy outpatient and twenty-four inpatient units equally divided for males and females. It is a teaching institute affiliated to the Sindh Medical College. Treatment is free in this hospital and patients are predominantly from the lower middle social classes of the main city as well as from other small cities and villages from the interior of the Sindh province. JPMC is the referral center for psychiatric patients from all over Sindh. Most of the in-patients are routed through OPD.

The sample of 100 consecutive patients diagnosed to have depressive disorder according to ICD-10 Diagnostic criteria for research (WHO 1993) were included falling in the age group between 20-40 and of both the genders; while patients suffering from any other psychiatric disorder, substance misuse, mental retardation or any other severe physical illness like; diabetes

mellitus, hypertension, chronic chest disease were excluded from the study.

All the new patients to the researcher's consulting room were assessed for caseness of depression. The diagnosis of depressive disorder was established by using ICD-10 Diagnostic Criteria for Research by taking proper and detailed history and mental state examination. The diagnosed patients were then seen for severity of depressive symptoms by rating them on Hamilton rating scale for depression (HRSD). Rating of the scale is as follows: 0 to 7-none, 8 to 17-mild, 18 to 24-moderate, and 25 or above- severe. The presence of any severe physical illness was ruled out by examination and relevant laboratory investigations if required. Ethical issues such as consent for inclusion in the study and confidentiality were taken care of. Socio-demographic variables like age, sex, occupation, marital status, and education were recorded. Statistical analysis was performed through SPSS version-16.0. Frequencies and percentages were computed to present all categorical variables like marital status, education, occupation, course of illness, duration of illness, parental status, family type, family size, patients' personal history and HAM-D score groups. Chi-square test was used to compare proportions of the above-mentioned categorical variables between males and females (Genders). P-value up to 0.05 was considered statistically significant.

RESULTS

Table I describes the socio demographic details of the study subjects. Among 100 patients, 34 (34%) were males and 66 (66%) females with (M: F = 1: 2). Mean age of patients was 31.21 ± 7.08 (ranging from 20 to 40) years. Mean age of male patients was 30.5 ± 7.81 and of female patients was 31.55 ± 6.74 , however this difference was statistically insignificant ($t = -0.76$, $p = 0.449$).

Significant majority of the female patients were household (80.3%) while 8 (23.5%) males were jobless. Three (4.5%) females were teachers, 3 (4.5%) were students and 4 (6.1%) were skilled workers. Among 34 male patients, instead of particular profession limited to specific class or community, a variety of professions was observed. The difference of occupation between the genders was thus significantly different ($p < 0.001$).

There was significant majority (77%) of married patients but the proportions of married patients were not significantly different between males and females. However, significantly high proportion of unmarried singles were found in younger age group (i.e. 20 – 25

years) while high proportion of married patients was found in higher age group (36 – 40 years).

Illiteracy rate was significantly higher in females than males (23.5% vs. 54.5%), but the proportion of graduates was almost equal in males and females (i.e. 11.8% and 12.1% respectively). However, the proportion of males having basic education was higher than females.

When the patients were asked about their parental status, majority (41%) had both parents alive while 23 patients had been deprived from both parents. However, parental status between the genders was statistically insignificant.

Family type and family size were evaluated among the patients. Forty-nine patients had nuclear families and 51 are living in joint families. The difference of family type between the genders was statistically insignificant (p=0.122). Vast majority (95%) of the patients had more than two siblings and its difference between male and female patients was statistically insignificant (p=0.771). Among 100 patients, 35 had not yet a single baby whereas 41 patients had more than 3 children. The family structure between the genders was statistically insignificant.

Mean score of Hamilton rating scale of depression (HAM-D) was computed 24.5±7.18 (ranging from 8 to 39). It was further classified and observed that proportion of female patients had HAM-D score towards high side (> 24) that was 56.1 vs. 44.1, however this difference of proportion was statistically insignificant (**Figure I**).

Majority (53%) of the patients in both males and females had duration of illness between 1 to 5 years followed by 27% less than 1 year, 11% between 6-10 years and 9% had more than 10 years of duration of illness. Duration of illness ranges from 2 weeks to 27 years. The difference of duration of illness between the genders was statistically insignificant (**Figure II**).

Regarding pattern of depressive symptoms as observed loss of interest was the commonest feeling that was reported by 90 patients, followed by fatigue in 89, feeling of weakness in 69, recurrent thoughts of death in 61, lack of reactivity in 51, guilt in 48 and indecisiveness in 47 patients. However, the difference in depressive symptoms between males and females was not statistically significant. Insomnia (E) was significantly high that was found in 87 patients, followed by insomnia (L) in 73 and insomnia (M) in 69 patients, however the difference of proportions between the genders was insignificant.

Psychic anxiety was the commonest patients' behav-

ior that was found in 87 patients followed by general somatic symptoms in 81, somatic anxiety in 80, hypochondriasis in 70, somatic symptoms (G. I. T) in 63, agitation in 44 and genital symptoms in 41 patients. Significantly high proportions in females was observed in somatic anxiety (p=0.006), somatic symptoms (p=0.001) and agitation (p=0.001).

Insight was the commonest state of mind that was reported by 95 patients followed by diurnal variation in 59, worse depression in the morning in 34, Obsessions symptoms in 28, depersonalization/ derealization in 24 and paranoid in 14 patients. However, the pattern of mental status between the genders was statistically insignificant.

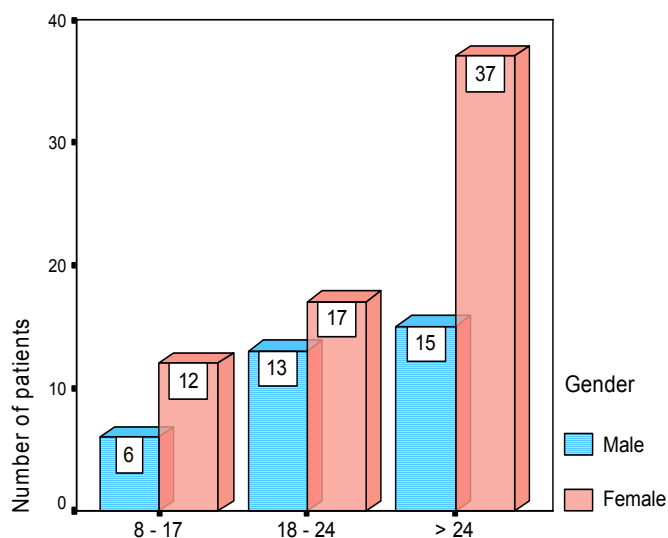
Out of 100 patients, 33 had retardation. Insignificant difference between two males and females regarding the proportion of retardation was observed (32.4 vs. 33.3% respectively) as given in **Table II**.

TABLE I: SOCIO-DEMOGRAPHIC FEATURES OF DEPRESSIVE PATIENTS ACCORDING TO GENDER

Variables	Male (n = 34)	Female (n = 66)	p-value
Occupations			
• Unemployed	8 (23.5)	53(80.3)*	<0.001
• Skilled laborer	24 (70.6)*	10 (15.1)	
• Student	2 (5.9)	3 (4.6)	
Marital status			
• Unmarried	10 (29.4)	10 (15.2)	0.251
• Married	24 (70.6)	53 (80.3)	
• Divorced	0 (0)	2 (3.0)	
• Widowed	0 (0)	1 (1.5)	
Family type			
• Nuclear	13 (38.2)	36 (54.5)	0.122
• Joint	21 (61.8)	30 (45.5)	
Number of siblings			
• Two or less	02 (5.90)	03 (4.50)	0.771
• More than 2	32 (94.1)	63 (95.5)	
Number of children			
• None	14 (41.2)	21 (31.8)	0.442
• 1 – 3	09 (26.5)	15 (22.7)	
• > 3	11 (32.3)	30 (45.5)	
Parental status			
• Both parents alive	17 (50.0)	24 (36.4)	0.494
• Both died	6 (17.6)	17 (25.8)	
• Mother alive	7 (20.6)	19 (28.8)	
• Father alive	4 (11.8)	6 (9.10)	

Key: Values given in parentheses are percentages.

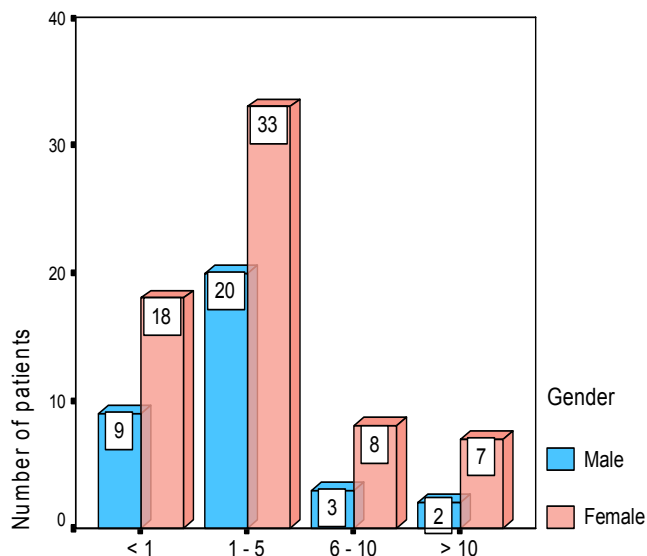
**FIGURE I:
TOTAL SCORE OF HAMILTON RATING SCALE
OF DEPRESSION ACCORDING TO GENDER**



Total Score of Hamilton Rating Scale (HAM-D)

Insignificant difference between two groups ($\chi^2=1.78$, $p=0.410$)

FIGURE II: COMPARISON OF DURATION OF ILLNESS (n=100)



Duration of illness (years)

Insignificant difference between genders ($\chi^2=1.113$, $p=0.774$)

TABLE II: OBSERVER RATED PROFILE OF DEPRESSIVE SYMPTOMS ACCORDING TO GENDER

Variables	Male (n = 34)	Female (n = 66)	p-value
Loss of interest	28 (82.4)	62 (93.9)	0.085
Fatigue	28 (82.4)	61 (92.4)	0.127
Feeling of worthlessness	25 (73.5)	44 (66.7)	0.482
Recurrent thoughts of death	17 (50.0)	44 (66.7)	0.106
Lack of reactivity to normally pleasurable events	17 (50.0)	34 (51.5)	0.886
Guilt	18 (52.9)	30 (45.5)	0.478
Indecisiveness	15 (44.1)	32 (48.5)	0.679
Weight loss	09 (26.5)	25 (37.9)	0.254
Insomnia (Early)	32 (94.1)	55 (83.3)	0.129
Insomnia (Middle)	20 (58.8)	49 (74.2)	0.114
Insomnia (Late)	24 (70.6)	49 (74.2)	0.697
Psychic anxiety	29 (85.3)	58 (87.9)	0.716

General somatic symptoms	26 (76.5)	55 (83.3)	0.407
Somatic anxiety	22 (64.7)	58(87.9)*	0.006
Hypochondriasis	26 (76.5)	44 (66.7)	0.311
Somatic symptoms (G. I. T)	13 (38.2)	50(75.8)*	0.001
Agitation	07 (20.6)	37(56.1)*	0.001
Genital symptoms	14 (41.2)	27 (40.9)	0.979
Insight	33 (97.1)	62 (93.9)	0.659
Diurnal variation	20 (58.8)	39 (59.1)	0.979
Depression worse in morning	13 (38.2)	21 (31.8)	0.521
Obsessions symptoms	9 (26.5)	19 (28.8)	0.807
Depersonalization/ Derealization	5 (14.7)	19 (28.8)	0.118
Paranoid	7 (20.6)	7 (10.6)	0.173
Retardation	11 (32.4)	22 (33.3)	0.921

Key: Values given in parentheses are percentages. *Shows statistical significant difference at $p\leq 0.05$.

DISCUSSION

The current study designed to assess the phenomenology of depression with respect to gender. It is widely recognized that cultural variations may affect clinical presentations of depression. Culture specific symptoms may lead to under recognition or misidentification of psychological disorders.⁹ Analysis of results has brought out many important findings. Some key findings and issues emerging out of this research are discussed here.

In the current study there were 34 males (34%) and 66 females (66%) with a M:F ratio 1:2 which is consistent with other studies.^{3, 6, 7, 10-12}

However some studies suggest that M:F ratio is 1.5:3.1.¹³ The gender differences in prevalence and incidence rates of depression is one of the consistent findings in psychiatric epidemiology.¹⁴ This gender difference is explained in various ways. From a psychological perspective two factors contribute to gender differences: interpersonal orientation and ruminations. Higher levels of these constructs are found in females and are associated with high rates of depression.¹⁵ Gonadal hormones influence neurotransmitter functioning and circadian rhythms through both genomic and non genomic effects and contribute to personality features and coping responses to stress. A sharp increase in depression rates in females occur usually around mid puberty. A direct relationship between levels of gonadal hormones and negative effect has been reported.¹⁶

Activation of the hypothalamic-pituitary-adrenal axis, impaired negative feedback control and associated adrenal hypertrophy are mediators of the environmental influences on depression onset. The axis seems to be more reactive to stress in females than in males, possibly due to a modulating role of gonadal hormones. The gender difference can be explained in association with the influence of social roles, social status and gender differences in the ways of coping with stressful life events. Above all, gender bias within family may contribute to the higher recorded rates of depression in women.⁶

The age group most vulnerable in both the genders in the current study was 23-40 years with the mean age of 31.21 + 7.08 which is in conformity with other studies¹¹ but this finding could not be generalized since in this study adults only from 20-40 were included. Contrary to the finding Fombonne et al and Kovac et al suggested juvenile depression to be increasing in frequency.^{17,18} On the other hand some studies suggest adolescent depression to be increasing in frequency.¹⁹ In the present study family size were evaluated among 100 patients, 35 had yet not had a single baby, 41 patients had more than 3 children. This finding is consistent with aetiological model of depression reported

by another study.²⁰ Majority of the female patients were not working outside home (80.3%) that is were house wives having more than three children which is major risk factor in the development of depression as shown in studies.²⁰

Regarding marital status findings of the current study revealed that majority (77%) of the patients were married but the proportion of married patients were not significantly different between male and females. Results of the current study are not consistent with another study who recognized that unmarried are more exposed than the married to emotional problems.¹⁵ Other study also show consistency that people with spouses are more likely to enjoy psychological well-being than those without.²¹

It is difficult to compare with other studies because of the confoundability of marriage and having young children. Studies have suggested that marriage does not seem to be a risk factor for depression in females by itself but because of the association with the risk factor of children.¹⁰

Illiteracy rate was significantly higher among patient (44%), which in turn was even higher in females than males (23% vs. 54.5%). This result is consistent with the study suggesting that awareness plays a protective role for depressive symptoms and also demonstrating increased risk of persistent depression after one year in women compared with men having less than ten years of education.⁶

The role of marriage, parity, and educational level in the etiology of depressive illness in women has been explored in detail. Costello and colleagues studied the association between depression and educational history, marital status, child rearing, or employment. Results showed that women who were mothers and still in their first marriage (that is married with children) were somewhat healthier and happier than others. However women in the high school education, even when married with children were at a four-fold risk for depression compared to college educated women. Among those with high school education or less employment outside of the home significantly reduced the risk for depression. Employment did not further reduce the risk for depression for college-educated women who were married with children. Single mothers appeared to have approximately two fold greater risk for depression than married mothers which may be influenced by the increased likelihood for single mothers to be in financial hardship.⁶

One of the cross cultural longitudinal studies showed that urban/rural and male/female differences in prevalence of depressive disorders are likely to be related to different exposure to life events of different levels of social support networks. Highly educated women who have studied certain professional courses before mar-

riage could not use their qualification and skills after marriage. Their role is mainly limited to household chores. These women may have been depressed as they feel useless and likely to develop low self esteem.²²

Findings of the current study regarding parental status suggested that majority (41%) had both parents alive while 23 patients had been deprived from both the parents. However parental status between the genders was not significant. However in a study it was found that early parental loss was significantly more common among the depressed patients.²⁰ Difference is possibly due to difference in sample selection and study design.

Regarding course and length of episode current research indicates there is no significant difference in relation with gender, findings are controversial. However some studies report higher rates of first onset depression in females rather than greater number or longer duration of episodes.¹⁶ Others show a female preponderance in recurrent and chronic depression.²³

In the present study the distribution of severity on HAM-D was similar for both male and female. This finding is consistent with other studies on clinical sample. However, studies on the community sample regarding chronic depressive patients suggest that women reported greater severity than men.¹²

In this study the phenomenology in descending order of presentation regarding psychological complaints is: feeling sad, excessive thoughts and feeling like crying all the time, suffocation (Ghabrahat), excessive anger, excessive worries, irritability, don't feel like talking to anybody, don't feel like doing anything. Other psychological complaints were dizziness, excessive fear, and hopelessness, feel like killing myself, lack of confidence, laziness, and want to stay alone.

Feeling sad or staying upset was the most common psychological complaint. Casey et al reported those with depressive illness used the term 'a weight', 'a cloud', 'a darkness' in an attempt to capture the most exact emotional feeling.²⁴ Another study showed that depression even influenced perception.²⁵ The phenomenon of "I feel like killing myself" as found in the current study is consistent with previous studies. Depression was regarded as a final common pathway leading to suicide. The authors imply depression the emotion of hopelessness, which arises from feeling defeated in life with feeling closed in with no possible escape or rescue.²⁵

When males and females were compared for psychological complaints, in males significant complaints were hopelessness and lack of confidence, while significantly higher proportion of female patients' complaint of irritability and feeling like crying all the time. Contradictory to the present study where more women

than men complaint of irritability Kovacs et al reported that girls were more likely to experience irritability during their mid teens and less so as they got older, whereas about two thirds of the boys were consistently irritable during depressive episodes.¹⁸

Among the somatic complaints headache was the most frequent complaint followed by lack of sleep, heavy head, palpitations and painful tense shoulder muscles, numb mind and dizziness. Relationship between number of somatic symptoms and presence of depressive disorders.²⁶

The phenomenology reported in the current study is in line with another study that compared the somatic symptoms in old age depression with young adults and found that younger depressives frequently reported head hot and burning, heavy head, head about to burst, stomach fluttering, stomach burning, indigestion, nausea, excessive wind or gas, and they were also more constipated. The younger age depression was characterized by symptoms of palpitations, weak or sinking heart, sweating palms, sweating a lot, hands and feet cold, giddy or dizzy feeling, skin burning, feeling of heat inside body and tingling all over the body. The youngster were more likely to express low back trouble, leg pains, tired most of the times, whole body heavy, and frequency of micturition. They also had reported more chest pressure and marked chest pain.²⁷

The reason of presentation of psychological distress in the form of bodily symptoms could be, the emphasis upon and rewards occurring from bodily symptoms in childhood and in many cultures patients often selectively complaint about physical symptoms to minimize the mood disorder and cognitive aspects of depression. Somatization in other words is a coping mechanism that protects an individual for a time from psychological pain. As a method of expression of emotion it is frequently reported in trans-cultural studies especially in the Indian subcontinent.²⁵

When males and females were compared for somatic complaints there were none significantly higher in males than female patients but the proportion of headache was significantly higher in females than males followed by burning and painful eyes. Somatic symptoms are a very common mode of expression of underlying psychological distress in our society especially in lower socio economic class and female population.²⁸ This might be due to the cultural and social factors, which determine the health seeking behavior. Women having psychological symptoms are paid less attention and are considered magic spell 'Asar' and taken to 'Moulvis' or 'Pirs' (Priests or traditional healers). However if they have physical complaints it is taken seriously and homeopaths or doctors are consulted.²⁹

Complaining of emotional dysphoria in terms of somatic symptoms may reflect the limitation of the family in paying attention and of doctors in listening to the complaints other than physical.

Limitations of the study are the following for which reason the results should be generalized with caution: The current study has limitations involving self selection, that is, the study population is composed of individuals who voluntarily come for treatment.

Patients were studied in a hospital setting; there may be a different presentation in community setting/General practice.

These findings could not be generalized because of the sample selection bias.

CONCLUSION

In this study no evidence that the presentation of depressive symptoms differs by gender was found.

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AUTHOR AFFILIATION:

Dr. Taufiq Iqtidar

Assistant Professor, Department of Psychiatry
Liaquat National Hospital and Medical College
Karachi, Sindh-Pakistan.

Dr. Jameel Ayesha

Consultant Psychiatrist, Department of Psychiatry
Karvan-e-Hayat Hospital
Karachi, Sindh-Pakistan.

Dr. Naheed Shagufta

Consultant Gynaecologist Department of Gynae & Obs
Fauji Foundation Hospital
Karachi, Sindh-Pakistan.

Dr. Hamirani Muneer

Professor, Department of Psychiatry
Karachi Medical and Dental College
Karachi, Sindh-Pakistan.

Dr. Zulqernain Ali

Assistant Professor, Department of Psychiatry
Sargodha Medical College Punjab.