

DEPRESSION AND GUILT IN INDIAN AND NORTH AMERICAN PATIENTS: A COMPARATIVE STUDY

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SUMMARY

One hundred and nineteen Indian and one hundred and fourteen North American depressed patients were compared to assess the differences in psychopathology. The study revealed two important findings: 1) Indian patients scored significantly higher than American patients on the HAMD items of poor appetite, hypochondriasis, diurnal variation, and psychomotor retardation; and lower on the items of anxiety and middle insomnia. 2) Guilt was expressed less often by Indian patients. Guilt was more common among those who felt that God was responsible for their depression and in those who believed in reincarnation. These differences may be related to cultural factors and not to religious beliefs.

INTRODUCTION

Guilt is an important symptom in the phenomenology of depression. In fact, a significant correlation between guilt and depression has been demonstrated (Beck, 1967). Psychodynamically, guilt and depression seem to be intertwined. Freud (1950) hypothesized that depression was due to introjected anger as a result of severe guilt, and Rado (1928) believed that depression was simply self-punishing behavior consequent to guilt. Hence, guilt may indicate severity of depression clinically, and etiologically, can play a part in the production of depression.

Guilt has been studied for a long time in depressed patients from different cultures by various investigators. Kraepelin (1921) expressed his belief that depressive patients in Java seldom presented with guilt. The results of these studies by various investigators indicate a paucity of guilt feelings in African (Lambo, 1956; Amara, 1967; Asuni, 1962; Carothers, 1953), Iranian (Bazzoui, 1970), and Chinese (Yap, 1958 & 1965) depressive patients implying that guilt is socio-culturally based and not an essential clinical feature of depression.

In a preliminary study of thirty Moslem patients, Rahman (1970) observed self-reproach and guilt in only four. Furthermore, Murphy et al (1967) reported on the rarity of guilt among the non-Christian depressives. Hence, it is argued (Collomb, 1966; Pfeiffer, 1966; Murphy, 1964) that a low frequency of guilt is related to one's religion, based on the hypothesis that Christianity elicits guilt, while Hindu and Islamic religions elicit shame. Therefore, guilt seems to have a strong bond to depressive illness in Western societies, but the same seems tenuous in non-Western countries.

There are a few reports on the symptomatology of depression in India, a predominantly Hindu country. In two studies with 30 and 62 depressives, Venkoba Rao (1966, 1970) noted guilt in only eight and five patients respectively. Supporting this hypothesis, a low incidence of guilt feelings, varying between 5.3% to 26.7%, has been reported by other investigators (Bagadia et al, 1973; Sethi et al, 1973). Such a finding may be related to the inter-

dependence (Neki, 1973) or development of the external ego (Kakkar, 1978) which takes away the individual's responsibility for either success or failure in one's life and thereby alleviates the origin of guilt. In addition, reincarnation, by removing the responsibility for past deeds provides an excellent buffer to absorb all the shocks and miseries and thus may eliminate guilt.

However, there are contrary reports as well. Comparing their own 100 depressed patients with those of Venkoba Rao (1973) and two other British studies, Teja et al (1971) found that the occurrence of guilt was similar in all the three samples. Ansari (1969) noted that guilt feelings were present in 67.5% of his 40 depressed patients. Furthermore, Trivedi et al (1981), by using projective tests, noted that guilt feelings were not infrequent among Indian depressed patients. Therefore, they concluded that the low incidence of guilt reported in Indian patients was related to a deficiency in eliciting guilt during the clinical interview. Fakir (1969) found that the incidence of guilt was the same in Moslems and Christians.

Thus, the data regarding the incidence of guilt and its relationship to socio-cultural factors among Indian depressed patients are inconclusive. It is possible that a low incidence of guilt may be related to religion, belief in reincarnation, and personality development or may simply reflect deficiencies in eliciting it. These divergent findings may also be related to methodological deficiencies such as the lack of criteria based diagnosis of depression, non-use of rating scales and deficiency of a standard method of eliciting guilt. Furthermore, many of the studies were conducted by Western psychiatrists who were not well versed with the non-Western cultural modes of expression of guilt. Currently, there is not a single controlled comparative study which has utilized similar methodology to assess patients from two cultures. Therefore, this study was undertaken to assess and compare the depressive symptoms, particularly the incidence of guilt feelings in Indian and North American depressed patients by employing identical methods of assessment; and to evaluate the relationship between the belief system and guilt in the Indian depressed patients.

METHOD

The patients were interviewed on the basis of which a diagnosis of major affective disorder was made utilizing DSM III criteria. During the interview, the Hamilton Rating Scale for Depression (HAMD) was completed and the demographic variables were entered into a data sheet. The investigators from India and North America were both trained in psychiatry at the National Institute of Mental Health and Neurosciences, Bangalore as well as in a Western country. They evaluated and rated several patients on the HAMD together until inter-rater reliability was reached. To elicit guilt, the same specific questions were put to both groups of patients which included the following: 1. Do you feel guilty? 2. Do you feel that something that you have done in the past is responsible for your depression? 3. Is there anything in your past that you wish to forget? In addition, the Indian patients were also asked whether or not they believed in reincarnation and whether God was responsible for their depression for the purpose of assessing the relationship between guilt and religion.

A brief physical examination and a battery of laboratory investigations, including RBC, WBC total and differential count, SGOT, SGPT, alkaline phosphatase, bilirubin, BUN, fasting blood sugar and urinalysis, were conducted to eliminate an organic cause in all patients who were diagnosed as having major depression.

Experimental Population

The Indian population consisted of 119 depressed patients, 57 males and 62 females. Their mean HAMD score was 25.8. Ninety five were Hindus, 14 were Moslems and 10 were Christians. 7.6% were professionals, 20.2% businessmen, 15.3% farmers, 6.7% laborers, 45.2% housewives, 2% students, and 3% were unemployed. All the patients had major depression (72 bipolar, 47 unipolar). The mean age was 42 years (+/- 11.5) with a range between 14 and 70 years.

The North American population consisted of 114 depressed patients, 35 of which were males and 79 were females. The mean HAMD score was 24.4. The mean age was 45 and ranged from 22-70. All patients had major affective disorder of unipolar (113) and bipolar type (1). All had a minimum of grade 10 education with 30% having college education.

RESULTS

I. Comparison of the North American and Indian groups.

HAMD scores: The mean HAMD score was 25.8 for the Indian population and 24.4 for the North American population. There was no statistically significant differences between the HAMD scores of Hindus, Muslims and Christians of the Indian group.

Guilt: Eighty four percent of the North Americans (96 out of 114) had evidence of guilt and this value did not vary significantly with regard to gender (male=80%, female=86%). The same was true with the Indian patients

with 62% (74 out of 119) overall having guilt (61% and 62% for males and females, respectively). When the incidence of guilt between the two populations was compared, North Americans were significantly over represented (Pearson Chi-square value 249.441; df=4; $p < .001$).

To ascertain the relationship between the degree of depression and guilt, those with and without guilt were compared. In the North Americans, those with guilt did not differ significantly in their HAMD scores from those without, with a mean of 24.5 as compared to 23.6, respectively. Among the Indian group, those who had guilt had a mean HAMD score of 27.57 as compared to 22.91 in those who did not. This difference was statistically significant ($t=4.976$; $df=117$; $p < 0.001$). As to be expected, their HAMD scores correlated positively with age ($r=0.161$).

Table 1. Differences in HAMD item scores between North American and Indian Patients.

HAMD Items	Mean Score of HAMD Items		Level of Significance
	Americans	Indians	
Middle insomnia	1.61	1.02	<0.01
Anxiety (psychic)	2.39	1.49	<0.005
Anxiety (somatic)	1.92	0.89	<0.001
Delayed insomnia	1.10	1.65	<0.025
Psychomotor retard.	0.46	1.80	<0.001
Loss of appetite	0.85	1.23	<0.005
Hypochondriasis	0.65	1.32	<0.001
Diurnal variation	1.04	1.66	<0.01

Item analysis: The two groups were compared to assess the differences in their scores on various items of HAMD (Table 1). As noted on Table 1, there was a statistically significant difference between the two groups on a number of items. Middle insomnia, anxiety psychic, and anxiety somatic were more prominent in the American group and the items of delayed insomnia, psychomotor retardation, loss of appetite, hypochondriasis, and diurnal variation were more severe in the Indian group.

II. Analysis of guilt related variables in the Indian sample.

In the Indian population, other factors were looked at besides the HAMD scores, to see what may be related to the presence of guilt feelings. Environmental issues such as area of domicile, education, and occupation had no relationship to guilt feelings. Guilt occurred in highly educated professionals living in an urban area just as often as it did in illiterate farmers. Neither gender nor age had any effect on its prevalence. Hindus, Moslems, and Christians were equally affected. The only two factors related to guilt were the beliefs that [a] God was responsible for the depression, (Pearson Chi-square 10.424; $df=2$; $p < 0.005$) and [b] reincarnation, (Pearson Chi-square 57.756; $df=2$; $p < 0.001$). Among the 74 who had guilt, 52 believed in reincarnation, 6 did not, and 16 had doubts or were unsure. Among the 45 without guilt, 6 believed, 35 did not, and 4 were unsure about reincarnation. For the

belief that God was responsible for depression, among the 74 with guilt, 32 believed, 7 doubted, and 35 did not believe; whereas, among the 45 patients with no guilt, 10 believed, 3 doubted, and 32 did not believe that God was responsible.

CONCLUSIONS

Our study revealed two important findings. The symptom profile of depression among Indian patients was somewhat different from that in North American patients. Indian patients scored significantly higher on the HAMD items of poor appetite, hypochondriasis, diurnal variation, and psychomotor retardation, and lower on the items of anxiety and middle insomnia. These differences may be related to cultural factors such as sick role which is different in different societies. In India, depression is often not considered to be a sickness, and it is the individual's responsibility to get well. Therefore, mere depression may not provide a sick role in Indian society, but hypochondriasis and loss of appetite, being physical symptoms, may provide passports for assuming a sick role and obtaining treatment.

The other important finding is that the occurrence of guilt is significantly lower among Indian depressed patients than in the American group. This finding concurs with many of the previous reports that guilt is rare in depressed Indian patients. This, in our study, was not related to socio economic factors, age, or gender of the Indians. In contrast to our findings, Teja et al (1966) did not find any difference in the occurrence of guilt between depressed Indian and British patients. As this study compared the findings of four groups of patients (two Indian and two British) conducted with different designs, and employing different criteria, methodological considerations might have affected their results. The rate of occurrence of guilt noted in our study is higher than that in other Indian studies and lower than that of the North American group. Perhaps the relatively high incidence of guilt in our study is reflective of the interviewing techniques used such as direct questioning and rating on the HAMD.

In the Indian sample, both the beliefs in reincarnation and that God was responsible for depression, correlated significantly with increased guilt and higher HAMD scores. Hence, these beliefs may, instead of protecting the patients from guilt, actually contribute to guilt. Furthermore, there were no differences in guilt and depression scores between Hindu, Moslem, and Christian Indian depressed patients. This may also be interpreted to mean that culture has a greater influence on an individual than religion alone, since reincarnation is not an Islamic or Christian belief. These two findings suggest that religion may not be related to the Indian personality development and its characteristics. The Indian ego is external in contrast to the North American ego which is internal; this external ego lies in the family rather than in the individual (Kakkar, 1978). Indians are nurtured from birth to respect elders and to live in harmony with the family, community, society, and nature (Neki, 1975). Both of these mask an

individual's responsibility for success or failure and thereby decrease guilt in depressed patients.

Our results raise the possibility that our findings may be related to the diagnostic differences in the experimental samples of the two groups. The Indian group was heavily weighted with bipolar rather than unipolar depressed patients, while the North American group consisted of exclusively unipolar depression. Beigel and Murphy (1971) found that the only differentiating items between bipolar and unipolar depressed patients were agitation and hypochondriasis, both being severe in unipolar depression. While increased psychomotor retardation in the Indian population may therefore be attributable to the inclusion of bipolar patients, increased loss of appetite, delayed insomnia, and hypochondriasis are unrelated to bipolar diagnosis, indicating that our findings are not related to the differences in diagnostic categories.

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