Masked Depression: Cultural Aspects

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Abstract

Depression is not only the commonest illness seen in the practice of psychiatry, but it is also one of the commonest illnesses seen in the general practice of medicine. Unfortunately, the diagnosis is often missed because of a lack of appreciation of the various symptoms of depression by both the general public and professionals. This is particularly unfortunate since depression is essentially a treatable illness today.

One of the common causes of missed diagnosis is that in a certain number of patients depression is present in an unusual or atypical fashion. This has been referred to as "masked depression" or "depressive equivalent".

Some causes of this unusual presentation and how not to miss them are discussed. An informal clinical study, which points to certain social-cultural factors that may be important in such presentations, is reported. The patients from a cultural and linguistic minority group living in a larger and dominant culture may be more vulnerable to the "masking" of depression and thus cause misdiagnosis and mistreatment.

Key words: *Major depression, masked depression, socio-cultural factors.*

Depression is one of the commonest disorders seen in psychiatric practice and psychiatrists are generally well aware of its fatal potential, as well as the immense suffering which it causes the patient and the family. But the number of depressed patients seen by the psychiatrist represents only the "tip of the iceberg", for depression is also commonly seen in the general practice of medicine and is often unrecognized. According to one estimate, 20% of all patients seen in a large diagnostic hospital clinic suffer from depression. Other estimates vary from 15% to 30%. This does not include the much larger number of patients suffering from depression, who see no one. This shows how large this iceberg indeed is. Watts,[1] a general practitioner in England, on becoming acutely aware of this, tried to systematically estimate the size of this iceberg. It was shown that out of one thousand persons, 165 were depressed, and of those; three saw a psychiatrist, 12 saw a general practitioner, and 150 did not consult a doctor.[1,2]

This is not just a phenomenon of Western culture. Various surveys and estimates have shown that this matter cuts across national and cultural boundaries. For instance, Nandi et al[3] reported the results of a door-to-door survey in rural Bengal, India, showing that 38 persons per 1000 showed some evidence of clinical depression. Watts made a similar survey in South Africa and reached the same conclusion.[2]

The National Institute of Mental Health (N.I.M.H.) study[4] commissioned by President Carter, surveyed three communities and found that the six month prevalence of affective disorders is about 6%. Current estimates are that one in 12, or about 20 million Americans will suffer a mood disorder in their lifetime.

The mortality (i.e., suicide) rate stemming from depression is probably much greater than reported. The statistics available show the rate to vary from 10

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to 20 per hundred thousand of population. What is beyond estimation is the number of lost-jobs, broken-marriages, ill-advised life decisions, inappropriate medical and surgical hospital admissions and treatments, relapses of alcohol, and dozens of other examples of damage to life caused from less severe or atypical depression which psychiatrists never see and which primary care physicians seldom diagnose.

All of these facts lend support to Kline's[5] contention a few years ago that "More human suffering has resulted from depression than any other single disease affecting mankind." and "Our failure to diagnose and deal with depression adequately constitutes a national scandal, or else it certainly is a national tragedy." What makes the tragedy even more devastating is that depression is not only the commonest of psychiatric illnesses, but it is also the one which has been more successfully treated than any other psychiatric disorder. Depression is essentially a treatable disorder today. This has led to the opinion by some that "antidepressant drugs have made psychiatry respectable."

There are basically three sources of difficulties leading to this under-diagnosis and under-treatment of depressive illness:

1. Lack of general awareness of prevalence and symptoms of depression in the general public as well as health professionals. What is needed here is more information on this matter in the lay-press, on radio and television, as well as in professional journals.
2. Semantics of depression. The different meanings of the word 'depression', as well as the confused terminology of depressive disorders, does not help matters. The word "depression" is used to describe various conditions by-lay people as well as professionals, such as:

a) A type of feeling:
Depression is a fundamental human feeling, which everyone has experienced. Normal people say they are depressed when they experience a lowering of mood from their normal base line. For example, a person experiencing transient sadness or loneliness may describe himself as depressed, or a person failing an examination or turned down for a promotion, may be "depressed." To become depressed is the normal reaction to these life situations. Is this depression an illness requiring treatment? In most cases the answer is "no."
Basic scientists use the word in a quantitative sense meaning a reduction of something. For example, physiologists talk about depressed respiration, depressed central nervous system activity. Meteorologists speak of low barometric pressure as depression. Similarly, economists speak of economic depression, and slums are described as depressed urban areas.

b) A symptom complex or syndrome of depression: A cluster of symptoms of low mood, deviation of feeling, cognition and behavior, insomnia, poor appetite, etc., presented as part of other illnesses, for example, organic brain syndrome, or physical illness.

c) A well defined disease entity which, in addition to signs and symptoms of depression is assumed to have a specific type of onset, course, duration and outcome. In medicine a clinical entity, in addition to the above characteristics, is supposed to have specific etiology and be responsive to a specific treatment. There is a considerable body of evidence that this clinical entity, depression, responds to certain drugs and/or electro convulsion therapy (ECT), but there is no consensus as yet to its etiology, although considerable progress has been made in this direction. This depressive illness has often been referred to as "endogenous depression", and under the present nosological system, Diagnostic and Statistical Manual IIIR (DSM-IIIR)[7], it is called "Major Depression." The use of the term "depression" for this illness is unfortunate because symptoms of depression may be absent and almost always other symptoms, besides sadness, are present, i.e., one may be depressed but not have depression, and one may have depression but not be depressed. To confuse matters further, there are terms like neurotic depression, psychotic depression, reactive depression, bipolar depression, unipolar depression, involutional depression, recurring depression, situational depression, characterological depression, etc.

One result of this confusion is that there are "depressions" which do not require treatment, but treatment is not sought when it *is* required, such as in the case of *illness* of depression. A recent survey among the staff and undergraduate and postgraduate students of a psychology department of a university in the United States showed that: 100% of those surveyed believed that most people had experienced depression at sometime in their life. 91% believed that depression was not the same as just feeling unhappy. However, 83% were also convinced that dealing with depression by oneself was better than seeing a psychiatrist. Moreover, 82% felt that in depression a friend was more helpful than a doctor. Further, 93% believed that any recovery from depression should be mostly credited to the affected individual himself.

First Lady Barbara Bush recently[6] confided in an interview that in 1976 she suffered from severe depression for over six months, but sought no medical help. She now feels that she should have seen a doctor. This belief system of a sophisticated sector of North American population today, may

Table 1. Symptoms of depression

Psychological	Vegetative	Somatic (may be present)
Sad, blue, depresed	Poor sleep	Headaches
Crying spells	Poor appetite	Atypical facial pain
Life not worth living	Loss of weight	Other aches and pains
Death wishes - suicidal thoughts	Reduced libido	- backache
Hopelessness	Lack of energy	- joint pains
Slow thinking - poor concentration	Tiredness	Constipation
Irritability	Fatigability	Dyspnea
Self-depreciation		Urinary trouble
Nihilistic delusions		- frequency
		- retention, etc

Table 2. Symptoms of masked depression.

Somatic	Vegetative	Psychological*
Headaches	Poor sleep	Sad, blue, depressed
Atypical facial pain	Poor appetite	Crying spells
Other aches and pains	Loss of weight	Life not worth living
- backache	Reduced libido	Death wishes - suicidal thoughts
- joint paints	Lack of energy	Slow thinking - poor concentration
Constipation	Tiredness	Irritability
Dyspnea	Fatigability	Self-depreciation
Urinary trouble		Nihilistic delusions
- frequency		
- retention, etc.		

*Absent, or are admitted to on direct questioning.

come as a surprise to many psychiatrists.

3. The third source of difficulty arises from the fact that a fairly significant number of patients with depression do not present with feelings of sadness or depressed mood. They may present with a somatic or physical complaint, most frequently pain, burning or cardiovascular symptom. Some of these patients would deny feeling depressed when directly asked. This type of depression has been referred to as "masked depression" or "depression without depression" or "depression equivalent."

It is this type of depression that is the subject of this paper. Failure to recognize and treat this subgroup of patients appropriately is particularly unfortunate, because these patients come from that small group of patients with depression who did go to a doctor for help.

Table 1 shows the usual presentation of depression. Table 2 shows how this presentation is reversed in "masked depression", where symptoms of feeling sad, blue, depressed may be admitted to only on direct questioning, or may be denied even then. Every clinician knows that masked depression does exist because he has seen one and treated one. However, they do not exist in DSM-IIIR[7] and are relegated generally to a footnote in most textbooks of psychiatry. The criteria for the diagnosis of depression in DSM-IIIR are shown in Appendix 1. According to these criteria, no one can be diagnosed as suffering from major depression if they do not meet criteria A, i.e., persistent depressed and dysphoric mood.

The term "masked depression" is not accepted in psychiatric classification for three basic reasons:

a) It is not a unique type of disease or syndrome, but a state or stage which is part of the depressive syndrome.
b) No special list of symptoms which has enough specificity, reliability and validity can be drawn in order to describe this state.
c) The term "masked" is vague and is in contradiction to the basic necessity to describe what is observed in contrast to what is unobservable and masked.

Thus, there is a basic paradox here that classifications like DSM-IIIR[7] which clarify our thinking about various diagnoses and increase the specificity, reliability and validity, also preclude diagnosis of conditions like masked depression, which are evidently quite common, have deep meaning and beg recognition, and failure to do so may prove disastrous.

Even though reports on masked depression have appeared in the literature since the 1950s, the concept of masked depression has been "slow in catching

on."[8]

Cassidy, et al[9] reported a systematic study of the nature of symptoms of manic depressive disease, i.e., major depression - recurrent depression, in today's terminology. They compared one hundred depressed patients with 50 medically sick controls and one hundred healthy controls. An analysis of the chief complaint showed that fully 31% of the depressed patients presented with a chief complaint which was of a medical nature (the rest had psychological or "other" chief complaint). They also analyzed the frequency of symptoms of present illness. Most physical symptoms, with the exception of palpitation, were more commonly seen in depressed patients compared to the medically sick controls. Watts[10,11] reported on the presenting symptoms in one hundred patients with mild endogenous depression, grouping them into various systems. Only 60% of the patients had presenting symptoms of a nervous and psychiatric nature, while 40% presented with symptoms related to other systems such as gastrointestinal, respiratory, musculo-skeletal, etc. Beck[12] reported that only 53% of the mildly depressed patients acknowledged feeling sad or unhappy, while 47% had other symptoms. Bradly[13] reported 35 cases of depression in which the chief complaint was severe localized pain. Lesse[14] first pointed out that "atypical facial pain syndromes" were perhaps masked depressions. He has been crusading for the recognition of masked depression for the past 25 years in his numerous articles and one edited book on masked depression. He recently published his 17 year study of 1465 patients with masked depression[15]. I would think that these examples from the literature would suffice to make the point - that masked depression does exist.

What can we say about masked depression?

1. How common is it?
   The incidence of masked depression has apparently increased during the last few years. Lesse[15,16] claims that it is as frequent as overt depression, that is 50%. But he has a specialized practice where he sees a large number of selected patients referred to him from neurology and psychiatry. Most estimates place the incidence of masked depression between 10% and 15% of all cases of depression.
2. Who suffers from masked depression?
   Anyone who suffers from depression and can have it masked, from children to senior citizens:

a) Children: Finally the controversy of whether children suffer from depression has been laid to rest. Most depressions in childhood are masked, typically presenting as acting out, temper tantrums, cruelty to animals, etc.

b) Adolescents: In adolescents depression is common and is more commonly masked. The typical masks in adolescents are acting out behavior, alcohol and drug abuse, sexual promiscuity, etc. Recent statistics clearly show that the suicide rate in adolescents has been increasing. However, there is no corresponding increase in the diagnosis of depression. Is it possible that many depressions in adolescents are masked and missed, and that suicide gives the first clue to the depression - a clue coming too late.

c) Adults: Most cases of masked depression are found in the middle age adults. In fact most cases of depression are also found in the middle age. Masked depression appears to be two to three times more common in females than in males. Lesse has described it essentially as a "syndrome of middle age women."[8,15,16]

3. Masked depressions are basically of two categories: a) The depressed patients who do not feel true sadness. b) The depressed patients who feel sadness deep inside but cannot or do not express it verbally.
4. Why masking occurs is not clearly understood, but a number of factors appear to be operational, such as:

a) The patient may simply be unable to grasp, feel and describe the feeling of sadness and depression. This usually occurs in patients from non-literate cultures and patients from rural settings and with low education. Instead, they will come and say they are sick or they hurt.

b) Unable to accept feeling depressed. For a variety of sociocultural and psychological reasons, it is difficult for some patients to accept feeling depressed. To admit feeling depressed is to admit being weak. Somatic symptoms are more socially acceptable. Sometimes depression is denied with a forced smile, so-called smiling depressions. In some cultures feeling depressed is equated with lack of faith in God or lack of manliness. This is one reason why diagnosed depression is more common in females.

c) Lopez Ibor[17] feels that through altered pathophysiology and specific psychophysiology, masked depressions are simply a function of altered perception, i.e. these patients are simply wired wrong, feelings of depression are perceived as something else, for example, headaches or abdominal pain. An example of this is normally seen in children where they cannot always interpret the physical sensation correctly. For example, a child may be hungry and feel discomfort from hunger, but be unable to accurately perceive and express this hunger. He may simply cry instead.

d) Alexithymia - In the last 15 years there has been an accumulation of studies and observations of an affective and cognitive disturbance which Sifneos has called "Alexithymia"[18] - literally no language for affect. These patients have great difficulty in describing affect and feelings.

Table 3. Demographic characteristics of 14 patients with masked depression.

	Number	Percent
Sex		
Male	4	28
Female	10	72
Age (years)		
20-40	6	43
40	8	57
Socioeconomic class		
Lower, lower middle	9	64
Upper, upper middle	5	36
Race		
White	5	36
Black	1	7
Hispanic (Mexican American)	8	57

Galveston, Texas, is a town of about 75,000 people on the Gulf coast of Texas with a Mexican/American population of about 20%. For a period of approximately one year in a 16 bed inpatient general psychiatric unit, the author saw 14 patients with a confirmed diagnosis of truly masked depression. The total number of admissions on the unit in one year was 150, those with the diagnosis of an affective disorder were 60 (i.e., 40%), and those with masked depression were 14 (i.e., 23%) of the depressed patients.

These patients presented with a variety of somatic or physical complaints and maintained that that was the only problem they had. Their chief symptoms included severe headaches, "nervous stomach", burning of the skin of the face eyelids, urinary problems (one patient with indwelling catheter), weakness, etc. The diagnoses of depression were confirmed with dexamethasone suppression test, past and family history, and unequivocal response to treatment with antidepressant medication or ECT. The demographic characteristics of these 14 patients are shown in Table 3. There were more females than males, and more in the age group above 40 and more from lower and lower middle class. Fifty Seven percent of the patients were Hispanic, that is Spanish speaking Mexican-Americans, whereas their population in the country is barely 20%.

This finding suggests that sociocultural factors are of major importance in the pathogenecies of this syndrome of masked depression. More specifically it appears that patients from a cultural and linguistic minority group living within a larger and dominant culture, may be more vulnerable to the "masking of depression" and thus to misdiagnosis and mistreatment. These findings are similar to an earlier study which the author carried out in Ottawa, Canada, where the French speaking French Canadian minority were over-represented in the group of masked depressions.

These findings may be of special significance for Muslims living in North America, where we are a cultural and religious minority, submerged in a larger and dominant non-Islamic culture.

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Appendix 1

Diagnostic Criteria for Major Depression - DSM IIIR

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptom is either (1) depressed mood, or (2) loss of interest or pleasure.

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance
(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)

NOTE: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.

C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

D. Not superimposed on Schizophrenial, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.