Clinical Characteristics of Depression

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Abstract: The epidemiology, premorbid character, diagnosis, and symptoms were overviewed regarding clinical features of depression. Depression is observed in all age groups from childhood to senescence, and its lifetime prevalence exceeds 10% and that among women is 1.3 to 1.7 times higher than that among men. Its prevalence in old age so far reported is generally low. The premorbid characters of depression known in Japan and Germany are Kretschmer’s cycloid, Tellenbach’s melancholic and manic types, and Shimoda’s immodithymia. Recently, Ihda proposed the structural theory for immodithymic character. The diagnostics of depressive episodes (ICD-10) and the relationship between culture and depressive symptoms are discussed. Depression in non-European cultures as reported previously rarely manifested self-blame or suicidal ideas, and depressive symptoms were not severe. In Japan, there have been reports of withdrawal depression where the patient tries to escape from his/her studies or work without much self-guilt. At least some of the depressive symptoms are culturally defined, and the diversified clinical pictures of depression may reflect the cultural and social situations of the contemporary time.

Key words: Prevalence; Premorbid character; Comparative cultural psychiatry; Mood disorder

Introduction

Depression is primarily characterized by depressive moods and diminished ability to think or act, accompanied by varying degrees of functional deteriorations in emotion, drive, cognition, thinking, and behavior. It is accompanied by somatic symptoms such as insomnia, anorexia, and autonomic imbalance as well as anxiety, fretfulness, and occasional delusion. Its symptoms show diurnal variation, leading to alleviation toward evening. Some patients experience several prolonged phases of depression in their life even with development of drug therapies, and may gradually recover to the premorbid level.

This paper discusses the clinical features of depression including its epidemiology, premorbid character, diagnosis, and symptoms. An attempt is made to view depression from the...
viewpoint of comparative cultural psychiatry in order to gain a deeper understanding of the clinical features of depression.

**Epidemiology**

1. **Prevalence**
   
   Epidemiological surveys based on DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, third edition, revised) that have been conducted on the general population have revealed point prevalence of depression of 1–5%, one-year prevalence of 4–10%, and lifetime prevalence of 13–17%. Epidemiological studies using DSM-III that were conducted in Western countries and Korea in the 1980s, revealed somewhat lower prevalence (3.3 to 12.6% for lifetime prevalence), suggesting an increased tendency for depression in recent years.

2. **Gender**
   
   The one-year prevalence of depression among women is 1.7 to 2.5 times higher than that among men, and the lifetime prevalence among women is 1.3 to 1.7 times higher than that among men. This indicates that more women are suffering from depression than men.

3. **Age at first onset**
   
   In 1967 Akimoto *et al.* studied the age of first onset of primary manic-depressive illness in Japan. According to their report, onset occurs most frequently among individuals in their twenties, followed by those in their 30s, and onset occurs in a considerable number of individuals in their 40–50s. According to recent studies performed in Western countries, the average age for the first-time episode is the mid-twenties, and the first-time onset is observed in all age groups ranging from childhood to old age. Manic-depressive illness in children and youths begins to appear after approximately 11 years of age.

4. **Senile depression**
   
   A comparatively large number of studies on senile depression have been conducted in Japan. As for its prevalence among those aged 65 years or older reported in studies conducted on the general population in Japan, Hasegawa *et al.* reported a prevalence of senile depression of 0.9% in Tokyo; Naito *et al.* reported a prevalence of 2.1 to 4.8% in three districts in Niigata; Ihara *et al.* reported a prevalence of 0.37%, and Kamahashi *et al.* reported a prevalence of 0.4% in Tochigi Prefecture. According to studies conducted in Western countries since 1980, the point prevalence of senile depression among the population aged 65 years or older is 1–4%, and the lifetime prevalence is also approximately 1–4%. Thus, the prevalence of depression reported in studies on senile depression is generally lower than that reported in studies performed on populations without age limitations.

**Premorbid Character**

As to the premorbid characters of depression, the Kretschmer’s cycloid, Shimoda’s immodithymic character, and H. Tellenbach’s melancholic and manic types are known. Ihda *et al.* recently summarized these characters in a paper published in this journal. Shimoda’s immodithymic character is characterized by hard work, perfectionism, thoroughness, honesty, orderliness, strong senses of justice, obligation and responsibility, and inability to deceive or to be sloppy. Hirasawa amended Shimoda’s emphasis on troublesomeness and enthusiasm of immodithymic character by pointing out that patients with depression have “apparent smooth and sociable attitude toward others with excessive sensitiveness of others’ opinion of him.” Kasahara reported that the melancholic type cannot be distinguished from obsessionalism (anankastic character) by merely observing orderliness or punctuality, and that one should note that a patient with the melancholic type “takes care to maintain a smooth relationship with others.” By pointing out this inclination for orderliness in one’s relationship with others, Kasahara em-
phasized that the immodithymic character is syntonic, which is a basic characteristic of the cyclothymic personality.

According to Ihda, Shimoda’s immodithymic character is not only unipolar but is also a premorbid character for manic-depressive illness in general and includes both H. Tellenbach’s melancholic and manic types. Ihda schematized the structure of immodithymic character as shown in Fig. 1. According to Ihda, at the nucleus of the premorbid character for manic-depressive illness (affective disorder) is Kretschmer’s cycloid, which is surrounded by the melancholic type and manic type, and the immodithymic character includes both the melancholic type and manic type.

In Western countries, such temperament or character models were barely noted as premorbid characters for depression except by Titley et al. who published the theory in the 1930s. Although the theory of character and temperament consisting of seven-factor models proposed by Cloninger has recently attracted attention in Western countries, it is still in a stage awaiting further development regarding its relationship with the premorbid character of depression. According to Akiskal, the perfectionism and obsessive-compulsive traits of premorbid character are not recognized as much in the United States as in Japan or Germany. Akiskal et al. pointed out introversion as the premorbid character of unipolar depression, and Angst et al. pointed out neuroticism.

The following case report describes a patient who is melancholic as well as cyclothymic.

[Case report]

Mr. K is a 36-year-old computer engineer and the elder of two sons. Following graduation from university, he entered the company at which he is currently working, married three years ago and has a son. Although his wife complains that he spends too little time with his family, the family live harmoniously and have no problems.

He is faithful, has a strong sense of responsibility, and is capable at work with many ideas. He is proud of his supervisor’s high opinion of him. Since his promotion two years ago to the position of leader of computer network structuring, he has been overworked because he could not say no to numerous jobs that were assigned to him. One year prior to the first episode, he was assigned to several large-scale projects as a leader and during the three months preceding the onset, he worked nearly every day. Looking back on those days, Mr. K mentioned that he was overworked and dissatisfied with the results of his work partly because he was a perfectionist, and that his mood might have been elevated just prior to the onset of depression.

One day, a circuit breakdown paralyzed the entire computer network. As a leader, he felt strongly responsible and became depressive following the accident. Because of easy fatigue and loss of appetite, he saw an internist thinking that something was wrong with his stomach. Gradually, he experienced depressive moods, insomnia, diminished willingness to work, and reluctance to repair the broken circuit. He became increasingly guilt-ridden and fretful.

He visited a psychiatric clinic of a nearby general hospital, accompanied by his wife and supervisor of the company. As his suicidal ideas and depressive mood were quite serious at the first interview, the physician recommended hospitalization. He was fearful of becoming socially ostracized by abandoning his work by hospitalization, and needed to be persuaded by his wife and supervisor to consent to hospitalization.

In the hospital, he was placed on drug therapy with an anti-depressant and was able to obtain good-quality rest. He recovered smoothly. At two weeks following the date of admission, he was aware of his improved condition, and two months after the start of treatment, he was discharged. He returned to work under the doctor’s instructions, and had a reduced workload.
Diagnosis and Symptoms

1. Diagnosis

Table 1 shows the simplified diagnostic criteria for depressive episodes according to the ICD-10 (International Classification of Diseases, 10th revision) published by the WHO.\(^{17}\)

By confirming the presence of several items and by elimination, the diagnosis of depressive episode may be established.

According to the ICD-10 as shown in Table 1, depressed mood, loss of interest, and increased fatiguability are typical symptoms of depression. Even without the subjective symptom of depressed mood, if additional symptoms besides the remaining two items are manifested, it is possible to diagnose a mild or moderate depressive episode. Loss of self-esteem, feeling of self-reproach and presence of suicidal ideas as well as diminished ability to think or concentrate, agitation or retardation, sleep and dietary disturbances are additional symptoms. The sleep and dietary disturbances include not only insomnia and loss of appetite, but also hypersomnia and increase in appetite.

Depressed mood, diminished ability to think and act, loss of confidence, and self-blame are frequently encountered when diagnosing depression in Japanese patients. However, some patients are in a depressive state where these symptoms can not be easily determined. While clinicians should naturally be careful not to overly increase the number of cases diagnosed as depression, it is also important not to overlook depression in patients who have few complaints but who are observed to be depressed, and in those whose depressed mood and inhibitions are not apparent, but who are hypochondriac (masked depression\(^{18}\)).

2. Relationship between culture and depressive symptoms

The symptoms of mental disorders may present different themes according to the gender, age, and social status of the patient. The characteristics of depressive symptoms, particularly delusions in depression, are discussed from the viewpoint of comparative cultural psychiatry\(^{19,20}\) referring mainly to Kondo’s paper.\(^{19}\)

Depression observed in non-European cultures such as in African countries used to be described as lacking self-blame and suicidal ideas, and was associated with not very serious depressive conditions. Table 2 is quoted from

<table>
<thead>
<tr>
<th>Table 1 Criteria for Diagnosis of Depressive Episodes (ICD-10)</th>
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<tbody>
<tr>
<td>A. Episode lasts for at least two weeks</td>
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<tr>
<td>B. Typical symptoms</td>
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<tr>
<td>(1) Depressed mood</td>
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<td>(2) Loss of interest or pleasure</td>
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<tr>
<td>(3) Decreased energy or increased fatiguability</td>
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<tr>
<td>C. Additional symptoms</td>
</tr>
<tr>
<td>(1) Loss of confidence or self-esteem</td>
</tr>
<tr>
<td>(2) Self-reproach or guilt</td>
</tr>
<tr>
<td>(3) Suicidal thoughts or behaviours</td>
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<td>(4) Diminished ability to think or concentrate</td>
</tr>
<tr>
<td>(5) Change in psychomotor activity, with agitation or retardation</td>
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<td>(6) Sleep disturbance</td>
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<td>(7) Change in appetite</td>
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Mild episode: At least two items of B, and at least four items of B and C
Moderate episode: At least two items of B, and at least six items of B and C
Severe episode: At least three items of B, and at least eight items of B and C
Prince.21) According to Prince, depression in Africa prior to 1957 (independence of Ghana) was characterized by (1) few complaints of depressed mood, (2) rare instances of self-blame, (3) uncommon suicide, (4) and prevailing hypochondria and physical complaints.

Three major themes of delusion that depressive patients often complain about are hypochondria, sense of guilt, and fear of poverty. The hypochondriacal delusions of depression are considered to be affected by the medical knowledge shared by the society in which the patient resides. As shown by the concept of masked depression,18) the fact that depressive patients are hypochondriac and not delusive, may be a cross-cultural phenomenon. The theme of guilt delusions may be affected by the religion and social systems defining the individual’s sense of responsibility. In Japan, patients often blame themselves in view of the interests of the company they work, colleagues and their relationship with family system rather than having a religious sense of guilt. The delusion of poverty is also strongly affected by culture. The manifestation of delusion of poverty is based on the existence of a widely accepted idea in the society that each individual is responsible for his/her future financial conditions, and one might suggest that in a society lacking such an idea, delusion of poverty would barely appear.

In a world where people equally aim at economic development on the global scale, discussing the cultural characteristics of depression per se seems to be quite difficult. However, we should point out that the characteristics of the contemporary social system (or psychological introjection, projection and formed super-ego when expressed in terms of psychodynamics) that drive depressive patients to despairing self-guilt and suicidal ideation should not be disregarded. The physician’s instruction for rest and guarantee of security to depressive patients may be meaningful in that they are issued by a person who is recognized as carrying out a prescribed role in that social system.

3. Changes in the clinical features of depression in Japan

Ihda described the following22): After the mid-Edo period, the so-called popular morals of diligence (or hard work), frugality, and submission became the motives for modern Japanese capitalism and the historical background for immodithymic character,23–25) but they declined after World War II, particularly among younger generations. The new generation who are characterized by dependence and “apathy” and who grew up under overprotection and a let-alone policy, emerged. The changes in the clinical features of depression are classified into two types; the dependent type and narcissistic type. The former includes neurotic depres-

<table>
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<tr>
<th>Year</th>
<th>Author</th>
<th>Description</th>
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<tbody>
<tr>
<td>1895</td>
<td>Greenlees TD</td>
<td>Rare examples of melancholia</td>
</tr>
<tr>
<td>1936</td>
<td>Gordon HL</td>
<td>Remarkable absence of affective disturbance except for elated type</td>
</tr>
<tr>
<td>1937</td>
<td>Laubscher BJF</td>
<td>Severe depressions and depressions with agitation are hardly ever seen, suicide is extremely rare</td>
</tr>
<tr>
<td>1947</td>
<td>Carothers JC</td>
<td>Manic-depressive insanity is relatively uncommon, ideas of guilt are consistently absent</td>
</tr>
<tr>
<td>1950</td>
<td>Tooth G</td>
<td>Rarity of depressive reactions, suicide and self-reproach</td>
</tr>
<tr>
<td>1953</td>
<td>Lamont AM and Blignault WJ</td>
<td>Rarity of depressive psychoses, not a single case with delusions of guilt</td>
</tr>
<tr>
<td>1955</td>
<td>Moffison A</td>
<td>Manics are observed but depression is very rare</td>
</tr>
</tbody>
</table>

Source: Prince (1968)21)
sion or somatized depression where physical symptoms are predominant, while the latter includes withdrawal depression and apathetic syndrome.\(^{3,26,27}\)

According to Hirose,\(^{28}\) melancholic-type patients fall into a depressive state as they struggle with changes in situations, whereas withdrawal- and apathetic-type patients simply abandon efforts for a solution once they realize the difficulty of overcoming the changes by conventional methods, and jump into a depressive state where they are free from uneasiness and pain. Very few patients in the latter group become self-blaming and very few manifest strong suicidal ideas or attempts.

The premorbid character and clinical features of depression change as the contemporary system of society changes.\(^{10,25}\) Alternatively, the clinical features of depression may stand on various psychological defense mechanisms. When chronic depression in Japan and Germany are compared, dependence, which develops to a neurotic tendency, becomes more apparent in Japan, while development to an autistic tendency is more evident in Germany. Clinicians should attend to patients by being aware that there are diversified types of depressed state depending on the individual’s personality and the situation in which he/she is placed.

**Conclusion**

The epidemiology, premorbid character, diagnosis, and symptoms of depression were reviewed with regard to its clinical features. Depression is observed in all ages from childhood to senescence at high prevalence, and is observed at a higher frequency among women than among men. The premorbid characters of depression include cycloid, immodithymic character, melancholic, and manic types. We mentioned the structural theory of immodithymic character (Ihda), summarized the ICD-10 criteria for diagnosis of depression, and discussed the relationship between culture and depressive symptoms. Based on previous reports on depression in Africa and on withdrawal depression in Japan, one may assume that the emergence of a symptom such as self-reproach is largely prescribed by the cultural situation. Clinicians should be aware of the diversified and varied clinical features of depression, which reflect changes in the social system.

**REFERENCES**


10) Sato, A., Yokoyama, T. and Ihda, S.: Premorbid personality of manic-depressive illness in Japan — Change of concept and struc-


