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SYMPTOMATOLOGY OF DEPRESSION IN DIFFERENT AGE GROUPS

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ABSTRACT: BACKGROUND: The "typical" depression presentation in primary care is dominated by physical (somatic) complaints as opposed to psychological complaints. More than 50% of patients with depression report somatic complaints only and at least 60% of these somatic complaints are pain related. **AIMS & OBJECTIVES:** 1. To study the symptomatology of depression in different age groups. 2. To compare the symptomatology of depression found in each age groups. **MATERALS & METHODS:** Patients who have attended out-patient psychiatric department of tertiary general hospital in urban area and diagnosed as having depression were divided in four age groups (<21years, 21-40years, 41-60years, >60years) and were evaluated for depressive symptomatology. The SYMPTOMATOLOGY part was assessed by using two scales, (1) Inventory of depressive symptomatology scale (IDS-30) and (2) Hamilton depression rating scale (HDRS-17). **RESULTS:** There is high frequency of somatic symptoms (both general and gastrointestinal) spontaneously as well as on systemic evaluation across all age groups amongst which most disturbing was headache followed by fatigue in all age groups. In all age groups who have reported primary depressive features like sadness and loss of pleasure, most of them had history of previous affective episodes so that they might have some insight into their depression. **CONCLUSION:** Our patients cannot voice their complaints spontaneously as there is a more of somatic symptoms presentation and striking rarity of spontaneously expressed depressed mood but it is invariably present on systemic interview across all age groups.
KEYWORDS: Symptomatology, depression, age groups.

INTRODUCTION: Depression affects people of all ages. It is estimated that one in five people will suffer from depression at some point in his or her life.[1] Depression can affect anyone, irrespective of gender, age, race or socio-economic background. According to the WHO, depression affects 121 million people worldwide. A depressive disorder is an illness that involves the body, mood and thoughts. Depression has been called "the common cold of mental health" because it is the most frequently encountered mental illness.

The causal mechanisms for depression, like all other mental disorders, are likely to be related to an interplay between genetic vulnerability and precipitating factors in a person's psychosocial environment.[2] Globally, there is evidence to support both these pathways, as well as the potential interaction between them.[2] In South Asia, most of the evidence on determinants of depression focus on psychosocial factors.[3]

The relationship between female gender and depression is also known as female have 2:1 ratio of depression with male. This increased risk is both due to the harsher social environments for women (for example, their exposure to interpersonal violence) as well as reproductive and maternal factors.[4]

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In three studies from India[5-7] people who are less educated were at greatest risk to suffer from depression. There is association is between low education and high risk for depression.[7]

The relationship between, violence and trauma (e.g. such as spousal violence or trauma following conflict or a disaster) is a major determinant of depression.[8-10]

After heart disease, depression is expected to become the second leading cause of disease burden by the year 2020.[11,12]

The prevalence of pain ranged from 15% to 100% (Mean prevalence 65%) in 14 studies investigating pain symptoms in cases of major depression (Bair et al 2003).

The "typical" depression presentation in primary care is dominated by physical (somatic) complaints as opposed to psychological complaints. More than 50% of patients with depression report somatic complaints only[13-15] and at least 60% of these somatic complaints are pain related.[16-19]

The study has shown that if all primary care patients presenting with variety of pain conditions (e.g. abdominal pain, headache, joint pain and back pain) were evaluated for possible depression, 60% of previously undetected depression cases could have been recognized (Katon W 1984).[20]

Some studies suggest that patients in non-Western cultures or developing countries report somatic symptoms and deny psychological symptoms more frequently than patients in Western or developed countries.[21-24] One conclusion drawn from these data is that patients from non-Western cultures and those of lower socioeconomic status are less willing or less able to express emotional distress.[25-28]

AIMS AND OBJECTIVES:
1. To study the symptomatology of depression in different age groups attending Psychiatry out-patient department in urban tertiary general hospital.
2. To compare the symptomatology of depression found in each age group.
3. To study the general socio-demographic profile of subjects in each age groups.

MATERIAL AND METHODS: Patients who have attended out-patient psychiatric department of tertiary general hospital in urban area and diagnosed as having depression were divided in four age groups (<21years, 21-40years, 41-60years, >60years) and thirty patients in each age groups were evaluated for depressive symptomatology.
The basic criteria for inclusion of subjects in the sample were:
1. The diagnosis of unipolar depression or bipolar mood disorder with current episode depression, according to DSM-IV TR.
2. Patient is having pure depression without any psychotic features and also having fresh episode of depression and should not be on any medication for the current episode.

ASSESSMENT TOOL: All the subjects were interviewed personally by same investigator using semi-structured proforma. The assessment proforma consisted of two parts.

The GENERAL INFORMATION part consisted of socio-demographic variables, patient's voiced complaints, history of present episode, previous affective episodes, history of present or past physical illness, addiction, family history and personal history.
The SYMPTOMATOLOGY part was assessed by using two scales:

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1. Inventory of depressive symptomatology scale (IDS-30)
2. Hamilton depression rating scale (HDRS-17).

Inventory of depressive symptomatology (IDS-30) and Hamilton depression rating scale (HDRS-17) are usually cover all the symptoms of depression.

Modified Prasad classification was used in all age groups for obtaining socio-economical class.

STATISTICAL ANALYSIS: Statistical analysis was done for the study by using SPSS software. Two statistical tests used for the study were chi-square test and ANOVA test (as comparison was between four age groups).

RESULT AND ANALYSIS:
SOCIODEMOGRAPHIC DATA:

Sex	<21 years	21-40 years	41-60 years	>60 years
Male	12(40%)	12(40%)	14(46.7%)	19(63.3%)
Female	18(60%)	18(60%)	16(53.3%)	11(36.7%)
Table 1: Sex Distribution				

Chi-square=4.378, df=3, p value is 0.22 that is >0.05 so the difference is not significant.

Education	<21years	21-40years	41-60years	>60years
Illiterate	2(6.7%)	9(30%)	12(40%)	10(33.3%)
Primary	3(10%)	3(10%)	5(16.7%)	7(23.3%)
Middle	8(26.7%)	10(33.3%)	6(20%)	6(20%)
SSC	7(23.3%)	3(10%)	6(20%)	3(10%)
HSC	8(26.7%)	1(3.3%)	0(0%)	2(6.7%)
Diploma	1(3.3%)	0(0%)	0(0%)	0(0%)
Graduate	1(3.3%)	4(13.4%)	1(3.3%)	2(6.7%)
Table 2: Education Distribution				

Marital Status	<21 years	21-40 years	41-60 years	>60 years
Married	6(20%)	28(93.3%)	21(70%)	24(80%)
Unmarried	23(76.7%)	2(6.7%)	2(6.7%)	0(0%)
Divorce	1(3.3%)	0(0%)	1(3.3%)	0(0%)
Widow	0(0%)	0(0%)	6(20%)	6(20%)
Table 3: Marital Status Distribution				

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Socio-economical class (Modified Prasad)	<21 years	21-40 years	41-60 years	>60 years
I	1(3.3%)	2(6.7%)	0(0%)	4(13.3%)
II	9(30%)	4(13.2%)	7(23.3%)	2(6.7%)
III	11(36.7%)	11(36.7%)	10(33.3%)	9(30%)
IV	8(26.7%)	11(36.7%)	11(36.7%)	11(36.7%)
V	1(3.3%)	2(6.7%)	2(6.7%)	4(13.3%)
Table 4: Socio-Economical Class Distribution				

As patients were taken from the tertiary general hospital, most of the patients were belonging to the lower socio-economical class as per modified Prasad classification in each age group.

Family type	<21years	21-40years	41-60years	>60years
Joint	9(30%)	7(23.3%)	9(30%)	8(26.7%)
Nuclear	21(70%)	23(76.7%)	21(70%)	22(73.3%)
Table 5: Family Type Distribution				

Chi-square=0.459, df=3, p value is 0.93 that is >0.05 so the difference is not significant.

DETAILS ABOUT THE PRESENT EPISODE:

Type of onset	<21years	21-40years	41-60years	>60years
Gradual	15(50%)	17(56.7%)	17(56.7%)	19(63.3%)
Sudden	15(50%)	13(43.3%)	13(43.3%)	11(36.7%)
Table 6: Type of Onset				

Chi-square=1.086, df=3, p value is 0.78 that is >0.05 so the difference is not significant.

Precipitating factor(s)	<21years	21-40years	41-60years	>60years
Yes	5(16.7%)	8(26.7%)	10(33.3%)	7(23.3%)
No	25(83.3%)	22(73.3%)	20(66.7%)	23(76.7%)
Table 7: Precipitating factor(s)				

Chi-square=2.311, df=3, p value is 0.51 that is >0.05 so the difference is not significant.

Diagnosis	<21years	21-40years	41-60years	>60years
Unipolar Depression	29(96.7%)	29(96.7%)	28(93.3%)	28(93.3%)
Bipolar Depression	1(3.3%)	1(3.3%)	2(6.7%)	2(6.7%)
Table 8: Diagnosis				

In all age groups most of the patients were diagnosed as having unipolar depression.

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Previous affective episodes	<21years	21-40years	41-60years	>60years
Yes	4(13.3%)	10(33.3%)	14(46.7%)	13(43.3%)
No	26(86.7%)	20(66.7%)	16(53.3%)	17(56.7%)
Table 9: Previous affective episodes				

In age group<21years there were less number of patients with history of previous affective episodes than remaining age groups.

Type of previous affective episodes	<21years	21-40years	41-60years	>60years
Depression	3(10%)	8(26.7%)	12(40%)	11(36.6%)
Mania	1(3.3%)	1(3.3%)	0(0%)	0(0%)
Both	0(0%)	1(3.3%)	2(6.7%)	2(6.7%)
No	26(86.7%)	20(66.7%)	16(53.3%)	17(56.7%)
Table 10: Type of previous affective episodes				

In most of the patients who had previous affective episodes, the type of previous affective episode which was most common in all age groups was depression.

Family history	<21years	21-40years	41-60years	>60years
Depression	4(13.3%)	4(13.4%)	4(13.3%)	1(3.3%)
Bipolar mood disorder	2(6.7%)	1(3.3%)	3(10%)	2(6.7%)
Psychosis	2(6.7%)	1(3.3%)	0(0%)	1(3.3%)
No	22(73.3%)	24(80%)	23(76.7%)	26(86.7%)
Table 11: Family history				

In age group>60years family history of bipolar mood disorder was more than unipolar mood disorder while in rest of age groups family history of unipolar mood disorder was more than bipolar mood disorder. There was also family history of psychosis.

PATIENT'S VOICED COMPLAINTS:

Pts's voice complaints	<21 Yrs.		21-40 Yrs.		41-60 Yrs.		> 60 Yrs.	
	Yrs.	%	Yrs.	%	Yrs.	%	Yrs.	%
Sadness	5	16.7	9	30.0	10	33.3	6	20.0
Loss of pleasure	9	30.0	13	43.3	10	33.3	12	40.0
Worthlessness	1	3.3	1	3.3	3	10.0	1	3.3
Poor concentration	10	33.3	3	10.0	4	13.3	1	3.3
Excessive thoughts	2	6.7	5	16.7	9	30.0	1	3.3
Lack of confidence	4	13.3	0	0	1	3.3	1	3.3
Suicidal thoughts	10	33.3	1	3.3	3	10.0	1	3.3
Suicidal attempts	2	6.7	0	0	0	0	0	0
Indecisiveness	1	3.3	0	0	2	6.7	0	0
Crying spells	4	13.3	1	3.3	1	3.3	1	3.3
Irritability	12	40.0	2	6.7	5	16.7	9	30.0

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Agitation	2	6.7	0	0	1	3.3	7	23.3
Ghabrahat	7	23.3	6	20.0	5	16.7	3	10.0
Bechani	6	20.0	8	26.7	5	16.7	3	10.0
Sleep disturbance	13	43.3	10	33.3	13	43.3	9	30.0
Appetite disturbance	1	3.3	8	26.7	5	16.7	2	6.7
Fatigability	3	10.0	10	33.3	11	36.7	6	20.0
Headache	10	33.3	13	43.3	7	23.3	12	40.0
Leg pain	0	0	0	0	1	3.3	2	6.7
Body ache	2	6.7	4	13.3	3	10.0	3	10.0
Abdominal pain	2	6.7	2	6.7	0	0	2	6.7
Joint pain	0	0	1	3.3	1	3.3	1	3.3
Weakness	1	3.3	1	3.3	3	10.0	2	6.7
Tremors	0	0	2	6.7	2	6.7	1	3.3
Giddiness	4	13.3	5	16.7	2	6.7	3	10.0
Nausea	1	3.3	1	3.3	2	6.7	1	3.3
Forgetfulness	0	0	0	0	0	0	4	13.3
Loss of libido	0	0	2	6.7	0	0	0	0
Tingling & numbness	1	3.3	1	3.3	1	3.3	1	3.3

Table 12

MOST FREQUENTLY VOICED COMPLAINTS IN EACH AGE GROUP:

AGE GROUP <21YEARS:	
Sleep disturbance	- 43.3%
Irritability	- 40.0%
Suicidal behavior	- 40.0%
Headache	- 33.3%
Poor concentration	- 33.3%
Loss of pleasure	- 33.0%
AGE GROUP 21-40YEARS:	
Headache	- 43.3%
Loss of pleasure	- 43.3%
Fatigability	- 33.3%
Sleep disturbance	- 33.3%
Sadness	- 30.0%
Appetite disturbance	- 26.7%
AGE GROUP 41-60YEARS:	
Sleep disturbance	- 43.3%
Fatigability	- 36.7%
Sadness	- 33.3%

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Loss of pleasure	- 33.3%
Excessive thoughts	- 30.0%
Headache	- 23.3%
AGE GROUP >60YEARS:	
Headache	- 40.0%
Loss of pleasure	- 40.0%
Irritability	- 30.0%
Sleep disturbance	- 30.0%
Agitation	- 23.3%
Table 13	

SYMPTOMS SYSTEMATICALLY EXPLORED:

IDS SUBSCALES	Anova Test	<21 years	21-40 years	41-60 years	>60 years	P value
Sleep Onset Insomnia	Mean	1.77	1.37	1.8	1.43	0.392
	Std.Deviation	1.104	1.245	1.245	1.305	
Mid-Nocturnal Insomnia	Mean	0.83	1.27	1.1	1.33	0.359
	Std.Deviation	0.95	1.172	1.269	1.269	
Early Morning Insomnia	Mean	1.33	1.7	1.47	1.57	0.675
	Std.Deviation	1.269	1.208	1.167	1.104	
Hypersomnia	Mean	0.07	0	0	0	0.396
	Std.Deviation	0.365	0	0	0	
Mood (Sad)	Mean	2.13	2.17	2.3	2.3	0.575
	Std.Deviation	0.571	0.669	0.596	0.466	
Mood (Irritable)	Mean	1.93	0.77	1.37	1.73	0.00
	Std.Deviation	0.868	1.04	1.129	1.015	
Mood (Anxious)	Mean	1.57	1.23	1.37	0.93	0.07
	Std.Deviation	0.774	1.104	0.89	0.868	
Reactivity of Mood	Mean	1.77	1.83	2.17	2.07	0.07
	Std.Deviation	0.774	0.648	0.747	0.45	
Mood Variation	Mean	0.63	0.87	0.77	0.27	0.04
	Std.Deviation	0.928	0.937	0.858	0.64	
Quality of Mood	Mean	1.7	1.73	1.87	2	0.163
	Std.Deviation	0.596	0.691	0.571	0.371	
Appetite (Decreased)	Mean	1.1	1.47	1.47	1.73	0.026
	Std.Deviation	0.759	0.86	0.819	0.74	
Appetite (Increased)	Mean	0.03	0	0	0	0.396
	Std.Deviation	0.183	0	0	0	
Weight (Decrease)	Mean	0.63	0.8	0.8	1.23	0.059
	Std.Deviation	0.669	1.031	0.847	0.935	
Weight (Increase)	Mean	0	0	0	0	NA
	Std.Deviation	0	0	0	0	
Concentration/Decision Making	Mean	2.1	2.13	2.17	2.03	0.862
	Std.Deviation	0.712	0.571	0.592	0.615	
Outlook (Self)	Mean	1.03	1.3	0.97	1.37	0.244
	Std.Deviation	0.89	0.952	0.85	0.928	

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IDS SUBSCALES	Anova Test	<21 years	21-40 years	41-60 years	>60 years	P value
Outlook (Future)	Mean	0.93	1.13	1.17	1.37	0.248
	Std.Deviation	0.828	0.819	0.834	0.809	
Suicidal Ideation	Mean	1.4	0.7	1.4	1.53	0.005
	Std.Deviation	1.037	0.877	1.07	0.9	
Involvement	Mean	1.67	1.97	1.93	1.7	0.189
	Std.Deviation	0.661	0.809	0.521	0.651	
Energy/Fatigability	Mean	1.27	1.6	1.77	1.87	0.071
	Std.Deviation	0.994	1.037	0.817	0.9	
Pleasure/Enjoyment (exclude sexual activities)	Mean	1.6	1.67	1.83	1.9	0.263
	Std.Deviation	0.675	0.711	0.592	0.662	
Sexual Interest	Mean	0.27	1.1	1.03	1	0
	Std.Deviation	0.45	0.923	0.89	0.83	
Psychomotor Slowing	Mean	0.5	0.5	0.43	0.5	0.976
	Std.Deviation	0.682	0.63	0.679	0.777	
Psychomotor Agitation	Mean	0.67	0.1	0.63	0.63	0.004
	Std.Deviation	0.802	0.305	0.718	0.809	
Somatic Complaints	Mean	1.27	1.5	1.17	1.37	0.53
	Std.Deviation	0.98	0.9	0.913	0.809	
Sympathetic Arousal	Mean	1.07	1.03	1.03	0.63	0.049
	Std.Deviation	0.64	0.765	0.669	0.669	
Panic/Phobic Symptoms	Mean	0.37	0.53	0.4	0.3	0.617
	Std.Deviation	0.556	0.776	0.563	0.837	
Gastrointestinal	Mean	0.5	0.6	0.57	0.73	0.732
	Std.Deviation	0.731	0.894	0.774	0.868	
Interpersonal Sensitivity	Mean	0.47	0.43	0.67	0.4	0.525
	Std.Deviation	0.73	0.774	0.844	0.675	
Leaden Paralysis/Physical Energy	Mean	0.2	0.4	0.4	0.07	0.026
	Std.Deviation	0.407	0.675	0.563	0.254	

Table 14

From above table only statistically significant results are discussed. Results which are not statistically significant across the age groups are not discussed (the subscales which has p value >0.05 are statistically not significant).

HDRS SUBSCALES	Anova Test	<21 years	21-40 years	41-60 years	>60 years	P value
DEPRESSED MOOD	Mean	2.37	2.47	2.57	2.27	0.343
	Std.Deviation	0.809	0.681	0.568	0.568	
FEELING OF GUILT	Mean	0.7	1.03	0.97	1.23	0.069
	Std.Deviation	0.651	0.809	0.89	0.728	
SUICIDE	Mean	1.5	0.73	1.3	1.53	0.009
	Std.Deviation	1.167	0.907	1.055	0.86	
INSOMNIA EARLY	Mean	1.2	0.83	1.27	0.9	0.1
	Std.Deviation	0.714	0.791	0.868	0.845	
INSOMNIA MIDDLE	Mean	0.63	0.8	0.77	0.87	0.701
	Std.Deviation	0.669	0.761	0.858	0.819	
INSOMNIA LATE	Mean	0.87	1	1.03	1.07	0.818
	Std.Deviation	0.937	0.91	0.809	0.785	
WORK AND ACTIVITIES	Mean	2.2	2.17	2.23	2.1	0.887
	Std.Deviation	0.664	0.874	0.568	0.548	

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HDRS SUBSCALES	Anova Test	<21 years	21-40 years	41-60 years	>60 years	P value
RETARDATION	Mean	0.5	0.5	0.37	0.5	0.825
	Std.Deviation	0.682	0.63	0.556	0.777	
AGITATION	Mean	0.7	0.27	0.6	0.63	0.17
	Std.Deviation	0.877	0.785	0.77	0.809	
ANXIETY PSYCHIC	Mean	1.97	1.7	1.93	1.33	0.002
	Std.Deviation	0.669	0.702	0.74	0.661	
ANXIETY SOMATIC	Mean	1.33	1.2	1.47	0.9	0.025
	Std.Deviation	0.606	0.714	0.629	0.96	
SOMATIC SYMPTOMS GASTRO-INTESTINAL	Mean	1.03	1.03	1.13	1.07	0.898
	Std.Deviation	0.556	0.556	0.681	0.521	
SOMATIC SYMPTOMS GENERAL	Mean	1.13	1.07	1.1	1	0.872
	Std.Deviation	0.73	0.64	0.662	0.525	
GENITAL SYMPTOMS	Mean	0.47	0.67	0.67	0.67	0.475
	Std.Deviation	0.681	0.606	0.606	0.479	
HYPOCHONDRIASIS	Mean	0.97	1.1	1.1	0.9	0.76
	Std.Deviation	0.809	0.885	0.845	0.96	
LOSS OF WEIGHT	Mean	0.5	0.73	0.67	1.07	0.017
	Std.Deviation	0.572	0.828	0.661	0.691	
INSIGHT	Mean	0.67	0.83	0.67	0.47	0.209
	Std.Deviation	0.711	0.699	0.711	0.507	

Table 15

As discussed above only statistically significant results are discussed. Results which are not statistically significant across the age groups are not discussed (the subscales which has p value >0.05 are statistically not significant).

LIMITATIONS OF THE STUDY:
1. As only patients without psychotic features were taken into the study the psychotic presentation of depressive patients was not studied.
2. As patients who were on treatment for present episode also not taken into the study, the effect of medication on symptoms of depression was not studied.
3. The sample that was studied was from a hospital in urban general setting. This undoubtedly must have led to some degree of bias.

CONCLUSION: Females are more prone to depression than males because female gender has increased stress sensitivity, maladaptive coping strategies and multiple social roles. In males substance use disorders can mask depressive symptoms (Kaplan and Sadock, CTP 2009).[1]

As patients were taken from out-patient psychiatric department of tertiary general hospital situated in urban area, most of the patients were from the locality that is from urban area. This finding can be correlated partly due to greater exposure to stressor and partly due to knowledge about illness and accessibility to psychiatric treatment and also due to lesser awareness of rural population about depression (Blazer et al 1994).[29]

Lower the level of education more prone to develop depression (Kaplon and Sadock, CTP 2009).[1] Now in recent years considerable amount of weight has been put on child's education, more numbers of patients in age groups <21 years were having higher level of education than rest of the age groups.

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In Indian tradition most of the females in the family have to divert toward household work, take care of the children's, younger siblings, parents, in-laws. All most all the patients who were doing household work were females.

Being single for male or female makes them prone to develop depression to some extent but other factors like socio-economic status, lack of intimate relation, stressful life events also operate to development of depression. Marital status per se does not predict higher frequency as revealed by Paykel et al 1982.[30]

In individual with lower socio-economic status have a lower level of education, lower income and poorer living conditions as well as a higher rate of unemployment (Mohandas E. 2009).[31]

In each age group most of the patients were belonging to the nuclear family as most of the patients were also residing in urban areas where nuclear families are more common than joint families. Depression is more common in those residing in nuclear families as found out by Sethi BB (1980).[32]

Sudden onset of depression is more common in acute life events while gradual onset is more common in continuous presence of stressors.

There was no difference in effect of precipitating factor(s) on present episode in all age groups.

Social stressors, in general, have been well recognized as risk factors for mood disorders. Different kinds of social stressors (i.e. childhood vs. adulthood events, acute vs. chronic stressors, positive vs. negative life events) can play different role in the predisposition and precipitation of depressive disorders (Kaplan and Sadock 2009).[1]

Diagnosis of depression as a unipolar or bipolar is important as difference in the presentation of symptoms of unipolar and bipolar depression like psychomotor retardation and hypersomnia are more common in bipolar depression while agitation and insomnia are more common in unipolar depression (Kaplan and Sadock, 2009).[1]

Previous affective episodes have major impact on the presentation of present episode inform of symptomatology, duration between onset of symptoms and first consultation, compliance with the treatment and insight into the illness.

Amongst who had depression in past, most of the patients spontaneously voiced primary depressive features like loss of pleasure and sadness.

Mood disorder runs in the family and major depression is the most common mood disorder in the family of both bipolar and unipolar proband (Kaplan and Sadock, 2009)[1].

In all age groups somatic symptoms were most frequently complained, of which headache and fatigability were most commonly voiced.

The prevalence of pain ranged from 15% to 100% (Mean prevalence 65%) in 14 studies investigating pain symptoms in cases of major depression (Bair et al 2003).

This finding are also similar to what Ajit Avasthi (2010)[11] stated in his study on overview of Indian research in depression. He stated that One common theme with regard to symptomatology of depression, which has been reported by most of the researchers, is high prevalence of somatic symptoms and some studies report that somatic symptoms are the most common manifestation of depression in India.

The irritability was most common presentation in age group<21years and also in age group>60years.

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Suicidal behavior which included both suicidal thoughts and suicidal attempts was most common in age group<21years. This finding is also comparable with finding of Ajit Avasthi et al (2010).[11] Studies which have evaluated depressed subjects with suicidal ideation have shown that 16.6% of these subjects make suicidal attempt and a higher risk of suicidal attempt is found in individuals less than 30 years of age, single men, married women and students and higher education.

Sleep disturbance was complained by all age groups patients with most disturbing in age group<21years and age group 41-60years.

Agitation was noticed more frequently in age group>60years compared to other groups. With respect to somatic symptoms, depressed older women report more appetite disturbance than men, whereas older men report more agitation (Kockler & Heun, 2002).[33]

In all age groups who have reported primary depressive features like sadness and loss of pleasure, most of them had history of previous affective episodes so that they might have some insight into their depression.

Forgetfulness was also the complaint only reported by patients of age group>60years (13.3%). Subjective complaints of poor memory and concentration are common among depressed older adults. Slower cognitive processing speed and executive dysfunction are frequent findings from objective testing (Butters et al, 2004).[34]

Studies have evaluated the symptomatology of depression in elderly depressed subjects too and have reported that the common symptoms in order of frequency were sadness, depressed mood, somatic symptoms and signs, suicidal ideas, lack of energy, anxiety or tension, inability to fall asleep, early awakening, hopelessness, irritability and inability to enjoy (Venkoba Rao et al 1983).[35]

Another study, which compared the symptomatology of children and adults, showed that more children than the adults presented with the somatic symptoms and the predominant mood symptom in children was irritability in contrast to sadness in adults (Bhargava et al 2005).[36]

Other commonly reported symptoms of depression in children's across studies include low mood, diminished interest in play and activities, excessive tiredness, low self- esteem, problems with concentration, behavior symptoms like anger and aggression, decreased interest in school and recent deterioration in school performance, death wish and suicidal behavior (Krishna Kumar et al 2006 and Tharoor et al 2002).[37, 38]

CONCLUSION: Our patients cannot voice their complaints spontaneously as there is a striking rarity of spontaneously expressed depressed mood but it is invariably present on systemic interview across all age groups.

There is high frequency of somatic symptoms (both general and gastrointestinal) spontaneously as well as on systemic evaluation across all age groups amongst which most disturbing was headache followed by fatigue in all age groups.

Most of the patients who have reported primary depressive features like sadness and loss of pleasure, had past history of affective episodes which may have impact on the presentation due to some insight into their depression due to past experiences.

STATISTICALLY SIGNIFICANT RESULTS: Irritability was most disturbing in age group<21years followed by >60years, 41-60years and 21-40years.

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Diurnal variation of depressed mood was most complaint by age groups 21-40years and 41-60years than rest of age groups.

Both loss of appetite and loss of weight were most disturbing in age group >60years followed by age groups 21-40years and 41-60years and with lowest frequency by age group <21years.

Suicidal behavior was spontaneously reported more in age group<21years but on systemic evaluation found out more in > 60years followed by <21years with suicidal attempts more in <21years.

Sexual interest which was absent (of loss of sexual interest) in nearly all patients in age groups <21years due to unmarried status of most of the patients in this age groups (23 out of 30).

Psychomotor agitation which was reported more by age group >60years but on systemic evaluation found out to be more in age groups <21years with age group 41-60years and age group >60years follow it and with lowest in age group 21-40years.

Anxiety (psychic and somatic) was higher in age groups <21years and 41-60years.

Leaden paralysis as a symptom of depression on systemic interview was present with high frequency in age groups 21-40years and 41-60years.

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