Depression, Anxiety and Headache

Pages with reference to book, From 277 To 280

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Abstract

One hundred and forty four patients with headache as the first presenting symptoms were analysed. Neither the character, site and extension of headache nor the distribution of other somatic symptoms were of any help in the diagnosis. The 'site on top' was more frequent in tension headache/ anxiety and 'giddiness' in depression. The diagnostic breakdown was: Depression 58.33%, tension headache/anxiety 33.3%, schizophrenia 6.3% and obsession 2.1% (JPMA 31:276, 1981).

Introduction

Somatization of symptoms are more frequently the presentation of psychiatric illness in developing countries as reported from Africa (Gordon, 1936; Lambo, 1956; Lambo, 1965; Binitie, 1975) and Asia (Rao, 1966; Teja et al., 1971; Ahmed, 1969). While the cross cultural aspects of diagnosis and out-come of schizophrenia is receiving attention (WHO, 1975), the identification of depression and anxiety with florid somatic symptoms in developing countries has been ignored.

According to strict criteria suggested by Feighner et al(1972) almost all the cases of anxiety and depression would fall into the diagnosis of hysteria if somatic symptoms are given the importance as they present. The DSM-III (Diagnostic & Statistical Manual of Mental Disorder, 1980) is based on the syndromes seen in North American and the ICD-9 (WHO, 1978) is rather vague.

Presently in Pakistan the British orientation is determining the diagnostic trend. For the diagnosis of depression and anxiety such orientation emphasises emotional differentiation with bias to psychophysiological symptoms for anxiety. This trend, perhaps leads to overdiagnosis of anxiety where bodily symptoms are predominent.

The purpose of this paper is not to resolve but to identify an aspect of the problem. It was decided to elicit somatic and associated symptoms in a group of patients presenting with 'headache' as the first symptom. Clinical diagnosis on the basis of criteria laid down was made and the frequency of symptoms in the two major diagnostic group is compared.

Headache was selected because it was the most frequent single symptom presented at the out patient. Headache as the presenting or associated symptom of schizophrenia, depression, anxiety state and hysteria has been reported from the west as well (Curren, 1939; Lance and Curren, 1964; Merskey, 1980).

Material and Methods

All patients attending the out-patient department of Neuro-psychiatric Unit, Jinnab Postgraduate Medical Centre, Karachi, during July 1979-February 1980 complaining of headache as the first symptom were reviewed. They were further screened and selected on the basis of criteria: constant headache with or without exacerbation, no organicity (doubtful cases were referred to neurology section of the department), ages between 15-60 years, and minimum of one month duration of symptom.

All the cases included in this study were evaluated on a prestructured proforma which included socio-demographic characteristics, pattern of headache and associated somatic and biological symptoms. The clinical diagnosis for schizophrenia, depression and obsession was made on the modified diagnostic

criteria of Feighner etal(1972). The modification for schizophrenia was in the duration of illness i.e. six months were substituted for one month; and for anxiety state, 'age of onset prior to 40' in section A and 'there must have been at least six anxiety attacks, each separated by at least a week from the other' in section B was deleted. For tension headache ICD-9 (Psychalgia 307.8) definition was used. In the final analysis it became difficult to separate anxiety and tension headache. They were therefore merged into tension headache/anxiety group.

Results

Out of 144 patients presenting with constant headache as the first symptom, only 25 (17.4%) were males and 119 (82.6%) females. Among females 95 (80%) were married. Mean age was 31 years (69 between 15-30 years, 75 between 31-60 years), 59 (41%) were pre-literate, family income of 105 (73%) was below Rs. 1000/-. The mean duration of symptoms was 32.7 months.
The character, site, extension of headache and frequency of associated somatic and biological symptoms are given in table I, II, and III.

Table I

Frequency Distribution According to Aharacter Site and Extension of Headache. N=144

Variables	*Number*	%
CHARACTER		
Steady	37	25.7
Throbbing	33	22.9
Spliting	71	49.3
Others	3	2.8
SITE		
On top	62	43.1
Frontal	18	12.5
Occipital	13	9.2
Temple	12	8.3
All over	39	27.1
EXTENSION		
Eyes	70	48.6
Neck & Shoulders	37	25.7
Others	26	18.1

Table II

Frequency Distribution of Associated Somatic Symptoms According to Target Organs. N=144

Symptoms	*Number*	*%*
HEAD		
Giddiness	116	80.6
Heaviness and blurred vision	70	48.6
Heaviness	25	17.4
Hyperventillation	16	11.1
Others	15	10.4
HEART		
Palpitation	98	68.1
Sinking	14	9.7
Pain	14	9.7
ABDOMEN		
Nausea and vomiting	80	55.6
Pain	34	23.6
Constipation	28	19.4
Gas	28	19.4
Others	4	2.8
SKELETOMOTOR		
Pain	42	29.2
Weakness	33	22.9
Numbness	16	11.1
Tingling	14	9.7
Cold	13	9.1
Warm	5	3.47
URINARY		
Frequency	15	10.4
Burning	28	19.4
Frequency and burning	11	7.6

Table III
Frequency Distribution of Biological Symptoms

Symptoms	*Number*	*%*
SLEEP N=144		
Normal	32	22.2
Disturbed	98	68.1
Early morning waking	14	9.2
APPETITE N=144		
Poor	111	77.1
Excessive	2	1.4
MENSTRUAL HISTORY N=119		
Regular	74	62.2
Irregular	28	23.5
Amenorhoea	4	3.4
Menopause	18	15.1

The diagnostic breakdown was depression 58.3%, tension headache/anxiety 33.3%, schizophrenia 6.3%, obsessive compulsive state 2.1 % (Table IV).

Table IV

Diagnostic Breakdown of Patients Presenting with Headache

Diagnosis	*Number*	%
Depression	84	58.3
Tension headache/Anxiety	48	33.3
Schizophrenia	9	6.3
Obsession	3	2.1

On the basis of symptomatology it was difficult to distinguish between tension headache and anxiety. The most frequent symptoms as they occur in depression and tension headache/ anxiety were compared (table V).

Table V

Comparison of Symptoms in Depression and Tension Headache/Anxiety.

Variables	*Depression N=84*	*Tension Headache/ Anxiety N=48*	*Significance*
Spliting	40	27	N.S.
Site on Top	39	31	Significant
Giddiness	67	23	Significant*
Extension to eye	40	22	N.S.
Heaviness and blurredvision	46	21	N.S.
Palpitation	55	34	N.S.
Nausea and vomiting	49	25	N.S.
Abdominal pain	23	17	N.S.
Sleep disturbance	51	31	N.S.
Poor appetite	65	34	N.S.

Level of Significance $P < 0.05$, $P < 0.01$*

Discussion

The majority were married females with an average age of 31 years and duration of headache 32.7 months. The character, site and extension of heachache nor the distribution of somatic symptoms between depression and tension headache/anxiety was different except 'giddiness' in the former and 'site on top' in the later which were significantly more frequent.

The presentation of somatic symptom was therefore of no help in the diagnosis. The emphasis on somatic symptoms should not, therefore, lead to the diagnosis of anxiety. In this series more than half of the patients were diagnosed as depression though Lance and Curren (1964) found one third of their patients having symptom of depression. The difference could be due to selection criteria.

In Karachi or even in Pakistan depression or anxiety is not an offered symptom but deducted diagnosis though sometime anxiety finds expression in 'Ghabrahat' and 'Ikhtilaj' (agitation and palpitation). In fact acceptance of depression is denied-I cannot sleep/eat/go to work because of headache/weakness. The situation is not for a day or week but for months. If this is the dynamic mechanism of denial and a

form of symptom substitution the diagnosis on the basis of somatic symptoms should be 'hysteria' according to Feighner's criteria. But for identification of depressive illness and anxiety state, for reasons of planning treatment, the somatic features had to be ignored. The psychological symptoms in depression and to a certain extent anxiety could be discerned inspite of denial. The distinction between anxiety and tension headache was very difficult but the latter could be labelled as conversion hysteria.

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References

1. Ahmed, S.H. (1969) Anxiety State; diagnosis and treatment. Pakistan Med. Rev. ,3:13.
2. American Psychiatric Association Diagnostic and statistical manual of mental disorder (DSM-III). Washington, American Psychiatric Ass., 1980.
3. Binitie, A. (1975) A factor-analytical study of depression across culture (African and F,uropean). Br. J. Psychiatry, 127:559.
4. Curren, D. (1939) Headache as an early symptom of nervous and mental disorder. Br. Med. J., 2:717.
5. Feighner, J.P., Robins, E., Cuze, S.B., Woodruff, R.A., Winokur, G. and Munoz, R. (1972) Diagnostic criteria for use in psychiatric research. Arch. Gen. Psychiatry, 26:57.
6. Gordon, H.L. (1936) An inquiry into the correlation of African civilization and mental disorder in the Kenya native. East Afr. Med. J., 12:327.
7. Lambo, T.A. (1956) Neuropsychiatric observations in Western regions of Nigeria. Br. Med. J., 2:1388.
8. Lambo, T.A. Schizophrenia and border line states trans-cultural psychiatry, in transcultural psychiatry. Ed. Avs De Reusk and R. Porter, London Churchill Ltd., 1965, 71.
9. Lance, J.W., Curren, D.A. (1964) Treatment of chronic tension headache. Lancet, 1:1236.
10. Merskev, H. (1980) Psychiatry and the treatment of pain. Br. J. Psychiatry, 136:600.
11. Rao, A.V. (1966) Depression-a psychiatric analysis of thirty cases. Indian T. Psychiatry, 8:143.
12. Teja, J.S., Narang, R.L., Aggarwal, A.K. (1971) Depression across culture. Br. J. Psychiatry, 119:253.
13. World Health Organization. Schizophrenia; a multinational study, Public Health Papers, scries 63. Geneva, WHO, 1975.
14. World Health Organization. Mental disorders; glossary and guide to their classification in accordance with ninth revision of the International classification of diseases (ICD-9). Geneva, WHO, 1978.