How does depression present in general practice?

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This was a retrospective study of the records of Chinese patients diagnosed as having depression in a general practice clinic in Hong Kong. The records of 66 newly diagnosed patients during the period 1 September 1992 to 30 April 1994 were reviewed for their initial presenting symptoms and depressive symptoms. Ninety-four per cent of the patients with depression initially presented with somatic symptoms. The spectrum of complaints was broad with symptoms referred to various organ systems. The most common presenting complaint was sleep disturbance. Ninety per cent of the patients had three or more DSM-III-R depressive symptoms. One third satisfied the DSM-III-R criteria for depression by having five or more symptoms. The study showed that general practice patients with depression have a broad spectrum of illnesses with a wide variety of presentations, symptomatology, and severity. Chinese patients with depression tend to present initially with somatic symptoms but admit to having psychological symptoms on further exploration. General practitioners need to ask specifically for psychological symptoms in order to detect the hidden depression of many Chinese patients.

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Introduction

The early detection of depression is important because it is associated with many disabilities across all cultures,[1] but it is very treatable.[2] Freeling et al found that patients with unrecognised depression had worse outcomes than those with recognised depression, although only a few of the latter completed a course of antidepressant drugs.[2] Unfortunately, depression is often missed in general practice;[2-6] studies have shown that general practitioners fail to diagnose depression in 50% to 70% of their patients[2,4-6] Goldberg et al showed that a psychiatrist missed depression in 30% of patients in the general practice setting,[3] and a recent study conducted in a general practice in Hong Kong showed that 70% of elderly patients with significant depressive symptoms had not previously been diagnosed as having depression.[6]

Various screening instruments have been developed to help general practitioners detect depression, but these are still in the experimental stage.[3,7,8] A gold standard instrument for general practice use is still not available.[8] The diagnosis of depression still largely depends on the general practitioner's ability to recognise its presenting symptoms and signs.

The most widely accepted diagnostic criteria for depression are those listed in the Diagnostic and Statistical Manual for Mental Disorders, the revised third edition (DSM-III-R) by the American Psychiatric Association.[9] There are nine symptoms of depression: depressed mood, loss of interest or pleasure, loss of self-confidence/feelings of guilt, loss of future perspectives/suicidal thoughts, loss of concentration, psychomotor retardation or agitation, loss of energy/fatigue, loss of appetite and libido, and sleep disturbance. The first two are core symptoms. It requires five or more symptoms (including at least one core symptom) for the diagnosis of depression.

The DSM-III-R criteria are quite clear, so why is depression often overlooked in general practice? These diagnostic criteria were developed by psychiatrists whose patients may not be the same as those in general practice. Patients presenting to general practitioners often have milder or undifferentiated illnesses. Hence, they may not have obvious depressive symptoms, and even if they have, they may not think they are worth telling their general practitioners.

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Goldberg believes that somatisation, the expression of distress in the language of somatic symptoms, is the most common reason why psychiatric illnesses are missed.[10] Somatisation of psychological illness has been found to be a common phenomenon in the Chinese and somatic symptoms have frequently been found in Chinese patients with depression.[11-16] Kleinman found that most depressive patients in his study in China initially presented with somatic symptoms and usually did not regard their psychological symptoms as their main concern.[11] Lau et al found that 92% of the patients with depression detected by a screening questionnaire in a general practice initially presented with only somatic symptoms.[16] Some believe that somatisation as a help-seeking behaviour for psychological problems is reinforced in the Chinese culture.[11,12]

Most of the previous studies on Chinese depressive patients were conducted overseas by psychiatrists.[11-16] The local study in general practice by Lau et al was conducted more than 10 years ago.[16] There has been more public education on the awareness and acceptability of psychiatric illness in recent years in Hong Kong. Has this made our Chinese patients more likely to present their psychological symptoms to their general practitioners?

The aim of our study was to determine the presenting symptoms of patients with depression which were detected clinically by general practitioners. We wanted to find out what their initial presenting symptoms were and what depressive symptoms were found. The information could help general practitioners to recognise depression more readily in their Chinese patients.

Subjects and methods

The study was conducted in the general practice clinic of the General Practice Unit of the University of Hong Kong. The practice has two full-time and two part-time doctors and is situated in the government-funded Ap Lei Chau Clinic which was opened in September, 1992. The patients of the practice are mainly from the lower socioeconomic group, with many from fisherman families. A detailed manual record is kept for each patient in the practice, and all patient morbidities are also entered into the computerised patient database at the end of each day by the consulting doctors. All morbidities are coded according to the International Classification of Primary Care (ICPC).[17]

All patients who had received a diagnosis of depression (ICPC code P76) during the period 1 September 1992 to 30 April 1994 were identified from the patient database of our practice. The age and sex of patients were also obtained. Patients with only a diagnosis of feeling depressed (ICPC code P03) were not included. The records of all patients with depression were reviewed by the author to retrieve the following information:

1. Whether the diagnosis of depression was first made by general practitioners of the General Practice Unit.
2. The initial presenting symptoms in the consultation in which the diagnosis of depression was first made.
3. The presence of the depressive symptoms described by the DSM-III-R.

The data were than analysed by simple frequency statistics.

Results

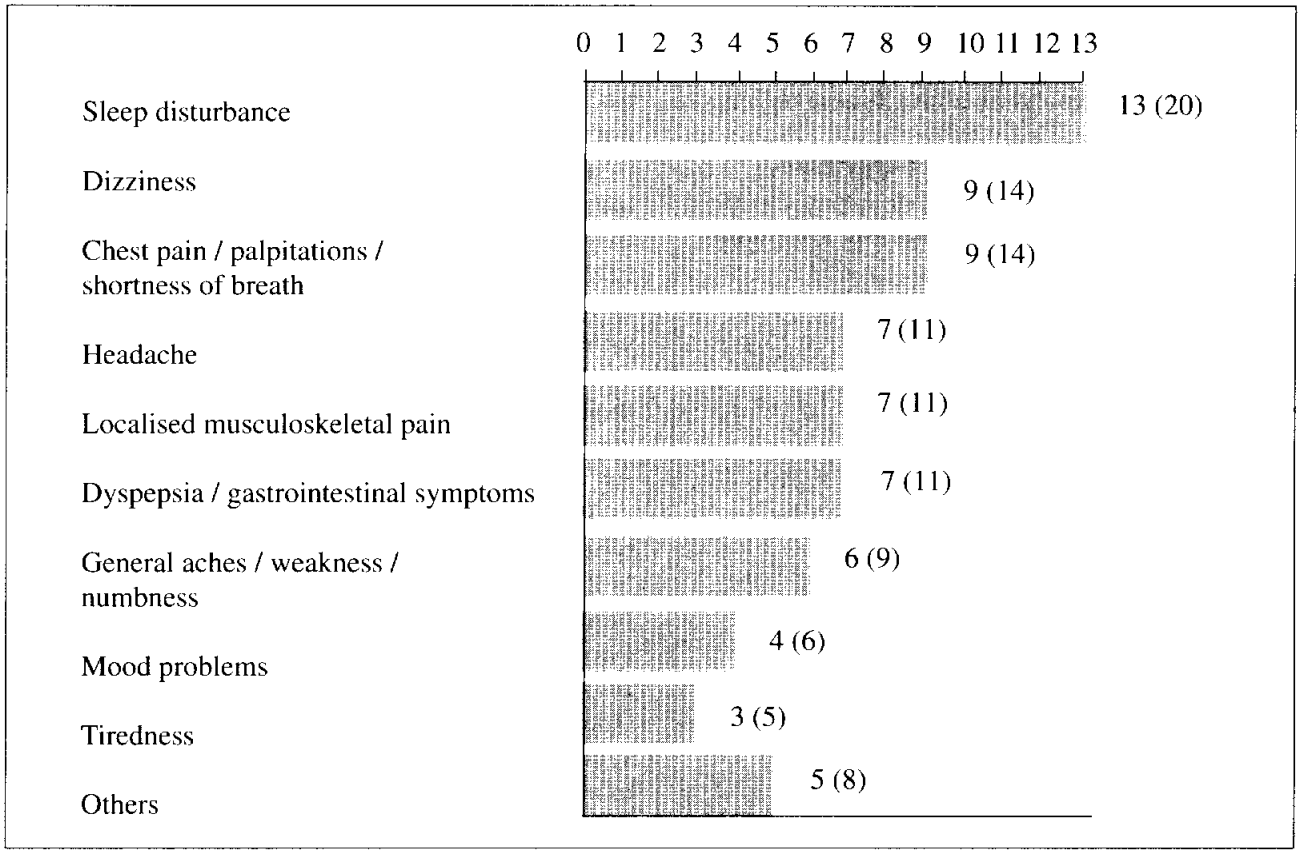
A total of 4516 patients attended the General Practice Unit during the study period, all of whom were Chinese. One hundred of these had a diagnosis of depression recorded, which gave an overall prevalence of 2.2%. All 100 depressive patients were older than 30 years (range, 33 to 84 years); the mean age was 56.7 years (SD 13.7 years). There were 2711 patients (1988 females and 723 males) older than 30 years in the practice. The age-adjusted prevalence was 3.7% (4.5% for women, 1.5% for men).

Two of the 100 patients had transferred to another practice and consequently their records could not be included. All remaining records were reviewed. The diagnosis of depression was first made by doctors of the General Practice Unit in 66 patients. Thirty-two patients were diagnosed as having depression before they joined our practice and were excluded from further analysis.

Initial presenting symptoms of depression

Figure 1 shows the distribution of the initial presenting symptoms of the 66 patients whose depression was first diagnosed in our practice. Some patients presented with more than one symptom. The most common initial presenting symptom was sleep disturbance (20%), followed by dizziness (14%) and headache (11%). Symptoms simulating heart disease (chest pain or tightness, palpitations and shortness of breath) were common as a group, were vague, and did not conform to the pattern of any organic disease. Many presented with various types of localised musculoskeletal pain including those of the neck, shoulders, hips, back, and knees. Only four individuals (6%) presented with mood-related complaints such as recent bereavement, anxiety,

Fig 1. Presenting complaints of patients with depression, n=66 (%)



and depressed mood. Other presenting symptoms included skin rash (1), chronic sore throat (1), floaters (1), itchy skin (1), and non-compliance in taking long-term medication (1).

Symptoms of depression

Table 1 shows the prevalence of the various symptoms of depression documented in the records of the 66 patients whose depression was first diagnosed in our clinic. The most common depressive symptom was sleep disturbance, and a majority complained of early-morning wakening. Depressed mood (83%) and loss of interest (52%) were common findings.

Anxiety, irritability, and agitation were much more common psychomotor symptoms than classical retardation. Psychomotor retardation was usually described as a loss of memory. Guilt or loss of self-confidence, often described as a feeling of shame, were not often reported.

Table 2 shows the number of depressive symptoms that were documented in patient records. The number of depressive symptoms ranged from one to seven. All but five patients had at least one of the two core symptoms of depressed mood or loss of interest. Ninety per cent of the patients had three or more depressive symptoms. The most frequent number of symptoms was four. Approximately one third (31%) had five or more symptoms of depression.

Table 1. Prevalence of symptoms of depression in assessed patients

Symptoms	Proportion with symptom present n=66 (%)
Depressed mood	83
Loss of interest	52
Sleep disturbance	98
Psychomotor symptoms	59 (44% anxiety)
Loss of future perspectives	32 (21% suicidal)
Loss of energy	27
Loss of appetite	27
Loss of concentration	14
Loss of confidence/guilt	9

Discussion

This study revealed that depression was present in 3.7% of our adult patients aged 30 years or older, similar to the 4% found in adult Chinese patients in primary care in Shanghai.[1] Those diagnosed probably represent no more than 50% of all cases as shown by previous studies.[2,4-6] Hence, the true prevalence of depression might be as high as 8% of the adult population—a common problem indeed!

Table 2. Number of symptoms of depression

Symptoms (No.)	Proportion with symptoms present n=66 (%)	
Seven	3	(4.5)
Six	4	(6.0)
Five	14	(21.2)
Four	24	(36.4)
Three	14	(21.2)
Two	5	(7.6)
One	2	(3.0)

Our results confirmed the tendency for Chinese patients with depression to present initially with somatic symptoms. This has not changed since Kleinman's study in 1980.[11] Only 4% of patients presented psychological symptoms as their chief complaint, which was similar to previous findings in other studies.[11-16] There are many theories as to why Chinese people tend to somatise their psychological problems. Kleinman believed that somatisation stems from the somatopsychic orientation of traditional Chinese medicine, which explains psychological symptoms in terms of organic pathology in the body, and is positively sanctioned by cultural norms in Chinese societies.[11] Goldberg and Bridges traced somatisation in Chinese back to ancient Buddhist scriptures which regarded psychologisation as a primitive and maladaptive response to stress. Somatisation was regarded as an adaptive achievement of mankind, lessening psychic pain and exchanging it for physical pains for which there have always been treatments.[10] Cheng believed somatisation was a culture-related illness behaviour of neurotic patients.[12]

However, our patients did admit to having depressive symptoms, especially depressed mood, when specifically asked by the doctor. Many patients satisfied the DSM-III-R diagnostic criteria. Therefore, the belief that Chinese patients are not willing to admit their psychological symptoms is more a myth than a fact. Doctors should not assume that psychological symptoms are absent if patients do not volunteer them. Depression is most often missed because doctors do not ask about symptoms. Studies have shown that patients with unrecognised depression had similar depressive symptoms to those with recognised depression, although they often presented initially with physical symptoms.[2-6]

Patients with depression could present with any type of somatic symptom referring to any organ system in the body except the mind.[11-13,16] Only sleep disturbance and loss of energy are included as symptoms of depression in the DSM-III-R, but they accounted for only one fourth of the initial presenting (somatic) symptoms of our patients. Other somatic symptoms such as dizziness, headache, chest symptoms, and localised musculoskeletal pain are not regarded as symptoms of depression although they have been found to be common among Chinese depressive patients.[8,16] All of these are common symptoms and might be caused by a number of other diseases seen in general practice. It is not surprising that general practitioners sometimes fail to recognise hidden depression in the large number of unselected patients presenting to them every day.

General practitioners need to meet the challenge by taking more initiative in asking about symptoms of depression in Chinese patients, instead of waiting for patients to mention them. Practitioners should be aware of the possibility of depression hidden behind the many different somatic complaints. Marks et al showed that general practitioners who were empathic, asked about a patient's family, and had a psychiatric focus were more likely to detect psychiatric illnesses in their patients.[18] General practitioners need to show Chinese patients that it is appropriate and important for them to talk about their psychological symptoms so that they do not need to use somatic symptoms to call for help. They need to enquire beyond the physical symptoms into the patient's psychological state and family situation. Asking patients about their mood, interests, feelings, and other losses are as important as asking about the presence of pain. This is what the concept of whole patient care is about.

We found that our patients with depression had a wide spectrum of illness. They ranged from those who were suicidal to those with very few symptoms. The majority did not have five or more DSM-III-R depressive symptoms documented in their records. This could be due to incompleteness of recording, but it also raises the issue that the diagnosis of an illness is not guided by diagnostic criteria alone. The diagnostic process involved in a general practitioner's mind is much more complex than a simple deductive calculation against a set of criteria. There are other factors, many still not defined, that the general practitioner also takes into account in the formulation of the diagnostic label of an illness. More research is required to reveal some of the missing links between an illness and the diagnosis.

This was a retrospective study on data retrieved from patient records. The results were limited by problems of incomplete or inaccurate recording of information. We also did not have information on patients whose depression was not diagnosed. As most of our patients belong to the lower socioeconomic and older age groups, caution is needed in generalisation of the results to other age and socioeconomic groups. Further studies are required to ascertain if patients who are younger or from other socioeconomic backgrounds present their depression differently.

In spite of the above shortcomings, this study has provided us with some insight into the common initial presenting somatic symptoms and the spectrum of psychological symptoms of depressive patients in general practice. I hope that this study can stimulate general practitioners to be more active in detecting depression in their patients.

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