

Patients presenting with depression to a psychiatry clinic: a descriptive survey

Thilini Rajapakse and Abeera Sivapalasingam

Summary

Clinical experience suggests that depression is common in Sri Lanka. This study aims to describe the characteristics of patients with depressive symptoms presenting to a psychiatry clinic at a teaching hospital in central Sri Lanka, over a period of one year. Information was collected retrospectively, based on clinic notes. Relatively older patients (mean age 41

years), female patients (65.3%) and those with a recent history of attempted self harm (28.5%) were common. Attempted self-poisoning was the commonest method of attempted self harm. Patients with co-morbid alcohol use disorders (5.6%), and those with prominent symptoms of somatisation (31.2%), were less than expected.

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Introduction

Depression is a common disorder, with a high disease burden (1). The WHO has listed depression as the fourth highest cause of years lost due to disability worldwide. In the United States, the lifetime prevalence of depression was reported to be 16.6% (2). Prevalence data for Sri Lanka is more limited. Ball et al (3) in their study conducted in Colombo, Sri Lanka, reported the lifetime prevalence of depression to be 6.6%, which was considerably lower than rates reported from the West (2). In contrast a study conducted among Sri Lankan school-going adolescents reported depressive symptoms to be present among 57.7%, a relatively high figure (4). Clinical experience suggests that depression is common in Sri Lanka. The lower prevalence described by some studies (3) maybe partly a reflection of diagnostic variation due to cross-cultural differences (5). A previous international WHO study reported that up to 50% of patients suffering from depression may present with somatisation (6). Parker et al in their comparison of Chinese and Australian patients with depression, reported dimensional differences in presentation; while both categories of patients were likely to endorse a high rate of somatic symptoms, Chinese patients were more likely to nominate somatic symptoms and less likely to report psychological symptoms compared to their Australian counterparts (7). In Sri Lanka too patients with depressive symptoms tend to endorse many somatic symptoms. This maybe in part due to patients' beliefs that reporting of somatic symptoms is a more appropriate route for seeking help from a primary care physician (6). However evidence regarding the common presentation of depression to hospital services in this country is limited. There is little or no evidence about the characteristics of depressed patients presenting with depressive symptoms to tertiary care services

The objective of this study is to describe the characteristics of patients with depressive symptoms who have presented to an outpatient psychiatry clinic

in a tertiary care hospital over a one year period. It is hoped this would provide a better understanding of the social, cultural and psychopathological aspects of the presentation of depressive disorder in a Sri Lankan context and that this would be of benefit in the planning of future services.

Method

Patients presenting to a psychiatry clinic of a teaching hospital in central Sri Lanka were included. They were mostly from both urban and rural sectors of the Central province of the country. Patients presented via self-referral, were brought by family members, or were referred by clinicians in the same hospital or from other hospitals. The name, clinic number and diagnosis of all new patients seen in the adult psychiatry clinic (treating patients aged 16 years and over) were recorded in the clinic register. For the purpose of this study, new patients diagnosed to be suffering from a current depressive episode during the year 2009 were identified by perusal of the clinic register. The diagnosis had been made by a consultant, acting consultant or senior registrar in psychiatry after an individual assessment, and was based on ICD-10 diagnostic criteria for depression.

The clinic records of the identified patients were retrieved and relevant information was obtained using an interviewer administered questionnaire. The data obtained was based on the findings recorded during the patient's first visit to the clinic, as patients are comprehensively reviewed by both the registrar and consultant in psychiatry at this time. To minimise errors, where the information in the clinic notes was unclear, the clinic record was perused by both authors and after discussion, relevant information was extracted as far as possible. In order to ensure confidentiality, the completed questionnaires were identified by an index number only. Descriptive statistical analysis was carried out using SPSS software.

Results

The socio-demographic details of the sample are listed in Table 1. A total of 144 new patients with a depressive disorder were seen in the clinic during the period under review. Of these patients, 94 (65.3%) were females. The age of the patients ranged from 16 to 77 years, with a mean age of 41 years. Most patients (100 or 69.4%) were married. A majority were either homemakers (37.5%) or unemployed (18.0%). Among patients who presented with depression, a moderate depressive episode was the commonest (56 or 38.9%). Among the study sample, 45 patients (or 31.2%) presented with prominent somatic symptoms. The commonly reported somatic complaints were headache (44.4%), burning sensation of the body (17.7%), body ache and back ache (28.8%) and chest pain (13.3%).

Only fifteen patients (10.4%) were found to have severe depression with psychotic features at the time of presentation. Eleven patients (7.6%) reported hallucinations, most commonly second person auditory hallucinations. Fifteen patients (10.4%) had delusional beliefs, most commonly delusions of infidelity or delusions of persecution. Eight patients (5.6%) had co-morbid alcohol use disorder (either abuse or dependency). Other substance misuse was less, with only three patients (2.1%) reporting co-morbid cannabis use. Nicotine use could not be ascertained as this information was not recorded in the clinic notes.

Of those who were assessed in the study, 57 patients (39.6%) expressed suicidal ideation at presentation, and 28.5% (n=41) had a history of a prior self harm attempt, most commonly by self-poisoning (68.2%). Of those who had previously attempted self harm, the majority (56%) had made the attempt during the three months preceding their presentation to services.

Over a quarter of the patients (28.5%, n= 41) had a family history of psychiatric illness. More than one third (36.8%, n=53) had received some treatment for depression from a general practitioner prior to presentation to the clinic.

Discussion

This study population consists of patients who have self-referred, or who have been referred to the psychiatry clinic at a tertiary care hospital. The mean age of the sample is relatively older than the peak age of onset for depression described in epidemiological studies (8). Although the age of the patients in this study ranged from 16 to 77 years, the mean age of 41 years raises the question as to whether younger patients with depression in the community are being missed.

The male: female ratio was 1:1.8, with a dominance of females. This may be partly a reflection of the higher prevalence of depression in females (9). Females may also be more likely to seek treatment for the symptoms of depression in comparison to males, who may choose alternate methods of coping such as self-medication with alcohol.

Among those who were assessed, 38.9% were moderately depressed. A lower percentage (22%) was mildly depressed, and only 10.4% of the patients were suffering

depressed, and only 10.4% of the patients were suffering from severe depression with psychotic features. Although these findings are limited by the fact that we were unable to ascertain illness severity in fifteen patients, these findings suggest that the type of depressed patient who is most likely to be seen at a tertiary care outpatient clinic would be moderately depressed. While severely depressed patients are more likely to receive inpatient care, those with mild depression maybe treated by primary care services or even missed. This is in keeping with international findings which report that compared to patients seen in clinics, depressed patients seen in general practice tend to have milder forms of the illness (10).

Surprisingly, the prevalence of alcohol misuse in this study is low. Most studies indicate that alcohol misuse is associated with depression, with a complex relationship between the two (11). Likewise a study of adolescents in Sri Lanka reported that alcohol was significantly associated with depressive symptoms in males (4). The relatively low rates of alcohol misuse reported in this study maybe in part due to the higher percentage of female patients, who are less likely to misuse alcohol in Sri Lanka. Another possible explanation is that depressed males who also misuse alcohol are less likely to seek help from hospital; and when they do present, they maybe seen in substance misuse clinics or in medical wards due to the complications of alcohol misuse.

An unexpected finding is that while one third of the patients had presented to the clinic with prominent somatic symptoms, this rate is in fact lower than the rates reported internationally regarding the prevalence of somatisation in depression, i.e. somatic symptoms as the presenting complaint, or the presence of multiple unexplained somatic complaints (6). A possible explanation is that many of the depressed patients with prominent somatisation, given the nature of their presenting complaints, were more likely to present to services other than a psychiatry clinic such as the hospital outpatients' department, medical clinics and to general practitioners. In such presentations, the underlying diagnosis of depression maybe missed. In support of this are the findings of a case control study of patients who presented to outpatients departments in Sri Lanka with multiple somatic complaints, which reported that while these patients have a higher chance of having a common mental disorder, they are also unlikely to volunteer depressive symptomology such as suicidal ideation (12).

Table 1- Socio-demographic characteristics of sample

Characteristic	Frequency (n=144)	Percentage
Gender-female	94	65.3
Mean age	41 (range 16-77)	
Married	100	69.4
Occupational status		
Unskilled labourers	21	14.5
Skilled workers	10	6.9
Technicians, teachers, nurses	22	15.2
University students	8	5.6
Homemaker	54	37.5
Unemployed	26	18.0

Almost a third of the patients (28.5%) had attempted self harm prior to presentation at the clinic, and more than half these attempts were made within the three months prior to attending the clinic. A majority of these self harm attempts were by self-poisoning. Furthermore, 39.6% of patients (n=57) expressed suicidal ideation at the time of presenting to the clinic.

Sri Lanka has a high rate of attempted self-poisoning and these findings are consistent with this trend (13, 14). However a possible confounding factor is that patients who were admitted to the medical wards of this tertiary care centre for the management of acute self-poisoning were also likely to be referred to the psychiatry clinic for follow up. Therefore patients who present with a history of self-poisoning maybe over-represented within the clinic population, compared to others who present differently, for instance with symptoms of prominent somatisation.

Limitations

The chief limitation of this study is that it is a retrospective study based on clinic records. While every effort was made to standardise data collection with the use of a questionnaire and to limit data collection to the patient's first clinic visit where the patient was extensively reviewed, the data we could obtain was limited to what was recorded in the clinic notes. Certain information such as the prevalence of nicotine use in patients was not recorded and therefore was not available. Details of illness severity were extracted from clinic notes as far as possible, and could be ascertained for most but not all patients. Some information of interest, such as the routes by which the patient was referred to the clinic and the degree of functional impairment at presentation could not be extracted in a comprehensive manner (i.e. for all patients) and therefore could not be included in the overall analysis. To minimise errors during data extraction in instances where the information in clinic notes was unclear, the clinic record was perused by both authors and after discussion, relevant information was extracted as far as possible. A further limitation was that this study examined clinic records in an outpatient psychiatry clinic in one hospital only. While we believe that this information was fairly representative of psychiatry clinics in state run hospitals in the country, further multicentre prospective studies could provide valuable data.

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Declaration of interest

None

Thilini Rajapakse, MBBS, MD (Psych)

Lecturer, Department of Psychiatry

Abeera Sivapalasingam MBBS,

Temporary Lecturer, Department of Psychiatry,

Faculty of Medicine, University of Peradeniya, Sri Lanka

Corresponding author

Thilini Rajapakse, Department of Psychiatry, Faculty of Medicine, University of Peradeniya, Sri Lanka

E mail: gemba471@gmail.com

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