Incidence of Depression in One Family Physician's Practice

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Although recent years have seen increasing interest in the behavioral sciences in family medicine, the literature is still sparse in terms of documented incidence of specific behavioral disorders. Depression has been generally recognized as a common entity in family practice, but few reports of its actual incidence in practice settings have been published. This paper summarizes the major findings of a retrospective study of depression in one family practice setting.

Methods

This retrospective study included the charts of all patients who had been seen in this office for more than ten years and who had made at least one visit in the last five years. Patients who had moved to another area or who had died in the last five years were excluded from the review. A total of 538 charts were reviewed. Of these, 429 (81 percent) belonged to females and 109 (19 percent) to males. Of the 538 patients, 67 had been seen in this office for 15 years or more; the rest for at least ten years.

The diagnostic categories were arrived at with the help of the *Manual of Mental Disorders*, second edition.[1] A patient was put into the diagnostic category of depression if (1) the patient complained about being depressed, and if the physician agreed with the patient that his symptoms were indeed those of depression; (2) the physician felt the patient was depressed and then, upon questioning, the patient agreed with the physician's diagnosis of depression; (3) the patient's symptoms indicated depression – he denied it, but then responded to the usual treatment of depression by improving. There were only a few patients in the latter category.

A patient was not put in the category of being "depressed" if the depression was caused by a normal grief reaction due to the loss of an important person, although he might have been seen two or three times during the period of grieving to make certain that recovery was progressing satisfactorily. A pathologic depression was not diagnosed unless the grieving process was unduly prolonged or seemed excessively severe.

There were some patients who had two diagnoses, especially in the alcoholic category. A patient whose major difficulties were with alcoholism, and secondarily depression, was put into the alcoholic category. If the reverse was true, he was put into the depression category. There were also patients who were neurotic and depressed. In this situation, the physician had to make a judgment into which category to place the patient. The category chosen was the one presenting the major problem.

Results

Table 1 shows the distribution of psychiatric diagnoses which occurred among the 538 patients whose charts were reviewed. From these figures it would appear that of all the psychiatric diagnoses by far the most common, representing about two thirds of the total number of 214 diagnoses, was depression. That also represents 23.5 percent of the total number of 538 patients seen continuously in this office over the last ten to 15 years.

The 129 depressed patients were divided further into categories according to their occupation and age, as shown in Table 2.

The group of 129 depressed patients was reviewed in regard to presenting complaint. As is shown in Table 3, 51 (40 percent) of the 129 patients presented with the symptoms or complaints of depression, nervousness, and fatigue, while 78 (60 percent) complained of somatic distress (abdominal pain, headache, etc) or presented for a "checkup" with no complaint.

The study group of depressed patients was also reviewed with respect to a precipitating cause of the depression. A precipitating cause might be an organic illness, the

Table 1. Distribution of Psychiatric Diagnoses

Diagnosis	Total	Male	Female
Depressed	129	8	121
Drug and alcohol abuse	16	6	10
Psychotic	11	1	10
Anxiety neurosis	25	2	23
Organic brain syndrome	17	6	11
Psychoneurosis	16	0	16
Totals	214	23	191

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Table 2. Age and Occupation of Depressed Patients				
Age in Years	Professional and White Collar Workers	Housewives	Non-Professional and Blue Collar	Total
0 – 25	10	3	5	18
25 – 50	23	14	32	69
50 – 75	11	23	8	42
Totals	44	40	45	129

Table 3. Presenting Symptoms of Depressed Patients			
Age in Years	"Depression, fatigue, nervousness"	Somatic complaint or no complaint	Total
0 – 25	9	9	18
25 – 50	27	40	67
50 – 75	15	29	44
Totals	51 (40%)	78 (60%)	129

presence of an alcoholic spouse, or some radical change in the family constellation. If no significant event could be identified, either by the physician or the patient, the patient was put into the category of "no precipitating cause." In 76 patients, or 60 percent, a precipitating cause could be identified; in 53 patients, or 40 percent of the total of 129 patients, no precipitating cause could be found. (See Table 4.)

Table 4. Precipitating Cause Identified			
Age in Years	Yes	No	Total
0 – 25	11	7	18
25 – 50	37	30	67
50 – 75	28	16	44
Totals	76 (60%)	53 (40%)	129

An attempt was made to see how many of the 129 patients with depression over the past ten to 15 years had more than one episode of depression. In order for a patient to be considered as having had more than one episode, there had to be at least one year of remission between episodes of depression. Thirty-two patients were considered to have had more than one episode of depression out of the 129, which represents approximately 30 percent.

The number of patients who were depressed and considered suicidal in nature were five, and those who actually made suicide attempts were six, so there was a total of 11 patients, or 8.5 percent, who were considered suicidal.

Comment

It is of interest that 214 of the 538 patients (38 percent) had a psychiatric diagnosis (including a spectrum from psychosis to a temporary mild depression) at some time during their attendance over the last ten to 15 years at this office. This figure is close to that quoted by Burnum in his recent article reporting a figure of 41 percent of psychiatric diagnoses among patients seen in a primary care office.[2]

In the present study, 40 percent of the depressed patients presented "depression, nervousness, or fatigue" as the chief complaint. This is comparable to Locke and Gardner's study which reported that 35 percent of patients with emotional problems presented the emotional problem as the chief complaint.[3]

This brief paper is a beginning attempt to better document the incidence of depression as seen in family practice. Much more needs to be done before we can adequately understand the occurrence and natural history of this common problem in everyday practice.

References

1. Diagnostic and Statistical Manual of Mental Disorders, ed 2. (DSM-II). Washington DC, American Psychiatric Association, 1968
2. Burnum JF: Primary care within the academic tradition. JAMA 233:974-975, 1975
3. Locke BZ, Gardner EA: Psychiatric disorders among the patients of general practitioners and internists. Public Health Reports 84 (2):167-173, 1969