Diagnosing depression: Symptoms and vocabulary used by a sample of general practitioners.

Diagnosticando depresión: síntomas y vocabulario usado por una muestra de médicos generales.

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RESUMEN

Objetivos: Identificar la sintomatología considerada como útil para diagnosticar depresión por médicos generales (MGs), el vocabulario local utilizado y comparar los síntomas listados con criterios diagnósticos estandarizados. ***Material y Métodos:*** Setenta y tres MGs participaron en una encuesta en Lima-Perú. Sesenta y cinco MGs respondieron a una pregunta abierta sobre listar síntomas útiles para realizar el diagnóstico de depresión. Los síntomas se clasificaron de acuerdo a los criterios requeridos para un diagnóstico de episodio depresivo mayor (criterio A, únicamente) del DSM-IV-TR (DSM) y para el episodio depresivo leve (F32.0) de la Clasificación Internacional de enfermedades-10ma revisión (CIE). ***Resultados:*** Diverso vocabulario médico y coloquial fue utilizado para describir síntomas depresivos. Criterios suficientes para realizar un diagnóstico de depresión de acuerdo al CIE y el DSM fueron listados, respectivamente, por 32,3% y 16,9% de MGs. ***Conclusiones:*** Estos hallazgos pueden ayudar al desarrollo de intervenciones para mejorar el entrenamiento de los MGs y la calidad de atención en relación a la detección de depresión y evaluación de riesgo suicida. Sin embargo, casi un tercio de MGs fueron capaces de recordar suficientes síntomas depresivos para cumplir criterios para un diagnóstico según la CIE, referencia usada extensamente en servicios no-psiquiátricos. *(Rev Neuropsiquiatr 2010;73:77-83).*

PALABRAS CLAVE: Depresión, atención primaria, médicos generales.

SUMMARY

Objective: To identify the symptomatology deemed by General Practitioners (GPs) as useful to diagnose depression, the local vocabulary used to describe it, and to compare the reported symptoms with standardized criteria. ***Material and Methods:*** Seventy-three GPs participated in a survey in Lima, Peru. Sixty-five GPs responded to an open-ended question to list symptoms useful to diagnose depression. Symptoms were classified according to criteria required for a Major Depressive Episode (Criterion-A only) of the DSM-IV-TR (DSM) and for a Mild Depressive

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Episode (F32.0) of the International Classification of Diseases-10th Revision (ICD). ***Results:*** Diverse medical and colloquial wording were used to describe depressive symptomatology. Sufficient criteria to make a diagnosis of depression according to the ICD and the DSM were listed, respectively, by 32.3% and 16.9% of GPs. ***Conclusions:*** These findings could aid in the development of training and quality improvement interventions to facilitate the detection of depression and suicide risk assessment. Still, almost one-third of GPs were able to directly recall sufficient depressive symptoms to meet criteria for an ICD diagnosis, a classification widely used in non-psychiatric settings. *(Rev Neuropsiquiatr 2010;73:77-83).*

KEYWORDS: Depression, primary care, general practitioners.

INTRODUCTION

Depression was estimated to be the fourth leading cause of disease burden for year 2000; accounting for almost 12% of all total years lived in disability worldwide (1). During the past several decades, studies in developed and developing countries have shown that patients with depression are most commonly seen in primary care setting by no-mental health specialists and usually are not properly diagnosed (2-4). Barriers for effective diagnosis are diverse and encompass a number of factors related to the patients themselves and the clinicians evaluating them (5). For example, the presence of somatic, atypical features and medical co-morbidities that could mask the diagnosis (6,7), the physicians attitude related to the treatment of mentally-ill patients, need for adequate training (8-11), and time constraints during medical visits, among others. Additionally, there is a growing interest in the translation of diagnostic criteria in a manner that is relevant to the patients and clinicians' cultural context (12).

The aims of this study was to learn about symptomatology deemed by general practitioners (GPs) in Lima, Peru as *useful to diagnose depression* and the most common vocabulary used to describe the symptoms. Additionally, we aimed at comparing the listed depressive symptoms with standardized diagnostic criteria of the DSM-IV-TR (13) and the International Classification of Diseases-10th revision (ICD-10) (14).

MATERIAL AND METHODS

Our team reviewed and reanalyzed a data base generated in a previous study that was conducted after approval from the Universidad Peruana Cayetano Heredia (UPCH) (15). The methodology and data collection were described in more detail in two reports published elsewhere (16,17). In brief, a survey was administered to Attending and Resident physicians participating in three Internal Medicine programs affiliated to the UPCH, located in the Hospital Arzobispo Loayza, Hospital Nacional Cayetano Heredia and Hospital General María Auxiliadora in Lima city and who provided outpatient general medical care between April and May of 1998.

Items about demographics, care of mentally-ill patients in general medical settings, and depression and its treatment were included. Frequency of responses to an item asking to "*list the symptoms considered as useful for a diagnosis of depression*" were previously only partially reported (17) and specific details of these answers are subject of this report. The particular vocabulary used by GPs to describe each symptom was tabulated and their frequency was rated.

The symptoms listed by the GPs were compared with the DSM-IV-TR's Criterion-A for Major Depressive Episode (13) and with the ICD-10's Mild Depressive Episode (F32.0) (14), the later was used as reference because it requires the minimum number of symptoms to establish a diagnosis of depression. Table 1 shows comparatively the diagnostic criteria of the DSM-IV-TR and ICD-10 used as reference. Of note, ICD separates "decreased self-esteem" from "ideas of unworthiness", although both are feelings of self-depreciation or loss of self-regard. Specific wording to denote any "feelings of worthlessness" and "low self-esteem" were separated accordingly to tabulate ICD criteria but joint together for DSM criteria.

RESULTS

Out of the 73 physicians who agreed to participate, 65 (89%) responded to the item on *symptoms useful to diagnose depression* of interest for this report. This

Table 1. Diagnostic criteria for the diagnosis of depression in DSM-IV-TR and ICD-10.

Symptomatology*	DSM-IV-TR (Major Depressive Episode, Criterion-A only)**	ICD-10 (Mild Depressive Episode, F32.0)***
Depressed mood	X	X
Anhedonia (loss of interest/pleasure/enjoyment)	X	X
Weight loss/gain or Decreased/increased appetite	X	
Diminished appetite		X
Sleep disturbances	X	X
Psychomotor agitation or retardation	X	
Fatigue or loss of energy	X	X
Feelings of worthlessness or excessive guilt	X	X
Diminished concentration, indecisiveness	X	X
Reduced self-esteem/self-confidence		X
Suicidal thoughts or acts of self-harm or suicide	X	X
Bleak and pessimistic views of the future		X

* Symptoms are to be present for at least 2 weeks.
** For DSM-IV-TR: Five or more of the symptoms are required for a Major Depressive Episode (Criterion-A only); at least one of them is either depressed mood or loss of interest or pleasure (anhedonia).
*** For ICD-10: At least two of these three: Depressed mood, loss of interest and enjoyment, and increased fatigability, plus at least two of the other symptoms should usually be present for a definite diagnosis of Mild Depressive Episode.

group was composed of 38 Attending (58.5%) and 25 Resident physicians (41.5%), the majority were male (76.9%). The mean age was 36.32 (Standard deviation (SD)=7.8) and the mean years of graduation from medical school was 9.28 years (SD=7.7).

Diverse medical and colloquial wording were used to describe depressive symptoms. Table 2 shows the breakdown of symptoms listed as *useful to diagnose depression* and the specific vocabulary used to describe them in Spanish and English. Among the most frequently listed symptoms were sleep disturbances, depressed mood, appetite or weight disturbances, anhedonia, and somatic symptoms. All subjects who listed weight changes (included as DSM criteria) also listed appetite changes. Suicidal ideation was mentioned only by one-fifth of GPs.

Table 3 shows the rate of listed symptoms that matched the DSM-IV-TR (Criterion-A only) and ICD-10 (F32.0) criteria. Sufficient criteria to potentially establish a definite diagnosis of Mild Depressive Episode by the ICD-10 definition were listed by 32.3% of the GPs; whereas, 16.9% of GPs listed sufficient symptoms for the Criterion A of the Major Depressive Episode according to the DSM-IV-TR. GPs who listed sufficient ICD criteria for depression did not differ from those who listed insufficient criteria in terms of mean age (38.09 vs. 35.96 years, $t(63)=-0.0723$, $p=0.483$), gender ($chi^2=0.009$, $df=1$, $p>0.999$), and mean years from graduation (9.91 vs. 9.15 years, $t(63)=-0.297$, $p=0.767$). Similarly, those who listed sufficient DSM criteria, did not differ from others in terms of mean age (37.48 vs. 35.77 years, $t(63)=-0.821$, $p=0.415$), gender ($chi^2=0.179$, $df=1$, $p>0.999$), and mean years

Table 2. List of symptoms 'useful for the diagnosis of depression' recorded by general practitioners (GPs), Spanish wording and English translations (n = 65 GPs).

Criteria	N (%)	Description of the symptom (Spanish)	English translation
Sleep disorder	49 (75.4)	Alteración del sueño o del patrón / ritmo del sueño, insomnio y/o hipersomnia, somnolencia, insomnio del amanecer, polo matutino, sueño no reparador, insomnio con pesadillas.	Sleep disturbance or changes in sleep pattern, insomnia and/or hypersomnia, somnolence, early morning awakening, non restful sleep, sleep with nightmares
Depressed mood	43 (66.2)	Ánimo deprimido, ánimo decaído, trastorno del ánimo, tristeza, infelicidad, abatimiento, desaliento, melancolía, llanto fácil/inexplicado/espontáneo. Labilidad/inestabilidad emocional, cambios de humor, irritabilidad.	Depressed mood, mood disturbance, sadness, unhappiness, 'feeling down', "discouragement", melancholia, easily crying, and unexplained or spontaneous crying. Emotional lability/instability, mood changes, irritability.
Appetite and/or weight disturbance	34 (52.3)	Hiporexia, falta de apetito, cambios o trastornos del apetito o de hábitos alimentarios, anorexia, pérdida o cambios de peso.	Lack of appetite, change or disturbance of appetite or eating habits, anorexia, weight loss/changes.
Anhedonia	31 (47.7)	Anhedonia; pérdida o falta de interés; desinterés por el entorno, por la vida, o por las labores habituales; falta de satisfacción; falta de deseo, ganas y/o placer; apatía, desgano.	Anhedonia, loss or lack of interest, lack of interest about surroundings, life or usual duties; lack of pleasure; lack of "desire"; apathy; unwillingness.
Any somatic complaint	28 (43.1)	Dolor; dolores inespecíficos, inexplicables o de difícil localización; polisintomatología inespecífica, cefalea, mialgias, lumbalgia, síntomas gastrointestinales / digestivos, malestares inespecíficos, somatización, alteraciones psicosomáticas.	Pain; unspecific, inexplicable or difficult to localize pain; unspecific poli-symptomatology, headache, myalgias, lumbar pain, gastro-intestinal/digestive symptoms, unspecific complaints, somatization, psychosomatic disturbances.
Lack of energy	25 (38.5)	Cansancio, fatiga, astenia, debilidad, desaliento, decaimiento, disminución o falta de energía, disminución de la energía vital, falta de vigor para labores habituales, sentir que se levanta solo por cumplir sus obligaciones.	Fatigue, weakness, weariness, diminished "vital energy", lack of strength for usual duties, feeling like "just getting up to fulfill duties"
Suicidal ideas	14 (21.5)	Ideas/pensamientos/tendencias suicidas o ideas de muerte, ideas de autoeliminación.	Suicidal ideas/thoughts/tendencies, ideas of death, ideas of self-termination.
Functional impairment	15 (23.1)	Dificultad para realizar labores habituales, alteración en las actividades diarias, bajo rendimiento, desajuste familiar o laboral, aislamiento social, falta de comunicación con familiares, descuido de la apariencia personal, cambio en relaciones interpersonales	Difficulty to perform usual tasks, changes in daily life activities, poor performance, disruption of family or work duties, social isolation, lack of communication with family, neglect of personal appearance, changed interpersonal relations.
Lack of concentration	12 (20.0)	Dificultad/falta/pérdida/incapacidad de concentración, dificultad con la capacidad de cálculo y discernimiento, olvidos.	Diminished/lack/loss of concentration, difficulties with calculations or discern, forgetfulness.
Diminished libido or any sexual dysfunction	11 (16.9)	Disminución o pérdida de la libido, trastornos sexuales, alteraciones de la esfera sexual, impotencia.	Diminished or loss of libido, sexual disturbances, changes on sexual life, impotence.
Feelings of worthlessness or excessive or inappropriate guilt (DSM)	9 (13.8)	Falta/disminución/pérdida de la autoestima, sensación de minusvalía, sentirse inútil, sentimientos de culpa, autoreproche.	Diminished/lack/loss of self-esteem, feelings of worthlessness, feelings of guilt, self-loathing.
Ideas of guilt and unworthiness (ICD)	5 (7.7)	Sensación de minusvalía, sentirse inútil, sentimientos de culpa, autoreproche.	Feelings of worthlessness, feelings of guilt, self-loathing.
Reduced self-esteem and self-confidence (ICD)	8 (12.3)	Falta/disminución/pérdida de la autoestima, inseguridad	Diminished/lack/loss of self-esteem, insecurity.
Anxiety	8 (12.3)	Ansiedad, nerviosismo.	Anxiety, nervousness.
Bleak and pessimistic views of the future	6 (9.2)	Pesimismo, desesperanza, desamparo, pérdida del sentido de la vida.	Pessimism, hopelessness, helplessness, loss of life sense.
Other psychological complaints	3 (4.5)	Pérdida del bienestar, cuestionamientos personales, stress.	Loss of well being, stress.
Psychomotor disturbance	2 (3.1)	Hipoactividad, adinamia.	Hypoactivity.
Others	4 (6.2)	Mutismo, síndrome conversivo, consumo de alcohol, cogniciones negativas	Mutism, conversion disorder, alcohol use, negative cognitions.

Table 3. Rate of general practitioners who listed useful symptoms to diagnose depression that matched DSM-IV-TR (Criterion A) and ICD-10 diagnostic criteria (N = 65)

	Symptoms listed	General Practitioners who listed the symptoms N (%)
DSM-IV-TR	Depressed mood and/or anhedonia (at least 1)	55 (84.6)
DSM-IV-TR	5 or more criteria (including depressed mood and/or anhedonia)	11 (**16.9**)
ICD-10	Depressed mood and/or anhedonia and/or loss of energy (at least 2 out of 3)	36 (55.4)
ICD-10	4 or more criteria (including at least 2 of the following: depressed mood and/or anhedonia and/or loss of energy)	21 (**32.3**)

from graduation (10.14 vs. 8.86 years, $t(63)=-0.624$, $p=0.535$).

DISCUSSION

This analysis allows us to gain insight into two key aspects involved in diagnosing depression in this sample of GPs. First, learning what symptoms were considered by GPs as "useful" for a diagnosis of depression and the diverse local vocabulary to describe them. Second, learning how these "useful" symptoms compare with standardized diagnostic criteria. Almost one-third of GPs straightforwardly listed sufficient symptoms to meet criteria for a Mild Depressive Episode by the ICD-10 definition; still, a smaller number (about 17%) of GPs listed sufficient criteria for the Criterion A of the Major Depressive Episode according to the DSM-IV-TR. The ICD is the classification reference most frequently used in non-psychiatric settings worldwide and requires fewer symptoms to be present for a Mild Depressive Episode than for DSM diagnoses.

The most frequently listed symptom was sleep disturbances; however, only two-thirds of GPs mentioned depressed mood and less than half listed anhedonia, which are essential criteria for both ICD and DSM diagnoses. Depressed mood refers to any negative affective arousal (18) described in various ways such as depressed, mournful, and irritable, among others. Irritability is known to be a more usual manifestation of depression in children and adolescents. It was assumed here that terms suggesting mood instability were used by some GPs when describing manifestations of depressed mood such as crying spells or tearfulness. It is important to clarify that this should not be confused with pathological and extreme variations of mood that may be present in other conditions.

Suicidal ideas were mentioned only by a minority of GPs, despite of the importance of inquiring about safety risks (19) in non-mental health settings. Failure to detect suicidal risk can be life-threatening as evidenced by literature documenting that nearly one-half of the people who die by suicide have seen a primary care physician within a month of death (20).

Other symptoms that are *per se* not part of the diagnostic criteria for depression were listed. Somatic complaints, frequently mentioned, evidence the importance of somatization in depressed patients seen in general medical settings. Similarly, decreased libido and sexual dysfunction can be found associated to depression or its pharmacological treatment. Anxiety, commonly coexisting with depression, is a criterion for the ICD "Mixed Anxiety and Depressive Disorder" (F41.2), which should be used when symptoms of both anxiety and depression are present, but neither set of symptoms, considered separately, is sufficiently severe to justify a diagnosis (14); likewise, "Mixed Anxiety Depression" is currently listed in Appendix B "Criteria Sets and Axes for Further Study" of the DSM-V draft

(21). Misinterpretation of symptoms not only leads to missing the proper diagnosis but also can increase the rate of false positive cases (22).

Aside from the small sample size, the strongest limitation is that this analysis corresponds to data generated a decade ago. Most studies focus on contrasting the diagnosis made by a clinician against a screening/diagnostic instrument. Nevertheless, literature on the value given to particular symptoms of depression in general medical settings and how symptoms are interpreted (e.g. the usual local vocabulary) and routinely and properly used to yield a confident diagnosis is lacking.

In general, these results are consistent with worldwide literature regarding limitations in diagnosing depression accurately in primary care settings. These findings could aid in the development of training and quality improvement interventions to facilitate the detection of depression and in raising awareness of the need for routine depression screening and safety risk assessment (e.g. suicidality).

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