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Somatic Symptoms in Depressive Illness

A Problem of Referral for General Practitioners

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It is widely recognized that somatic complaints are frequently encountered in depressive illness and in some instances these may predominate in the clinical presentation. Studies relating to the occurrence of such symptoms in depression have been reviewed by Cleghorn and Curtis (1959), who point out that in a number of patients mood disturbance may not be readily apparent. It is not unusual for these patients to be referred initially to a general medical or surgical clinic, where after investigation it is concluded that their complaints cannot be understood in terms of physical disease (Stoeckle and Davidson, 1962).

The Present Study

It might be anticipated that physical symptoms would be more evident in those patients with depressive illness who were sent initially to a physician or surgeon than in those where such examination did not precede psychiatric referral. However, this would not seem to be the only factor determining the direction of initial referral, as somatic complaints are often prominent in depressed patients who are sent directly to a psychiatrist by the general practitioner. These persons do not, as it were, take the more devious route through the medical or surgical department before psychiatric appraisal is sought.

This report summarizes the results of an investigation which was undertaken in order to explore some of the factors which might influence the direction for referral of depressed patients by the general practitioner.

A total of 160 patients were considered. All subjects had been diagnosed in this department as suffering from a depressive illness and were coded as 301·1 under the International Classification of Diseases. For ease of reference the 80 consecutive referrals from general practitioners to the Department of Mental Health will be called Group G. These patients were sent to hospital by a total of 26 doctors. Group H consisted of a further 80 referrals from hospital physicians, again consecutive, with the exception that those patients who were admitted to a general hospital on account of a suicidal attempt were excluded.

Each patient had had a detailed psychiatric interview as an out-patient, and those who were admitted (71 per cent.) had further detailed assessment. Forty-six patients (29 per cent.) were not admitted. In the majority of these the severity of their illness was such that treatment could be continued on an out-patient basis; in several other instances, patients refused to accept treatment.

Each patient's clinical records were analysed in terms of the various items to be presented in the results of the investigation.

In the analysis the findings were subjected to the Chi-squared test, in order to assess the significance of any differences.

Results

Whilst the most common presenting feature in Group G was a subjective feeling of depression (55 per cent.), others complained primarily of loss of interest, inability to cope, "tension", or poor concentration. However, in 34 patients (43 per cent.) somatic symptoms were particularly prominent amongst their complaints. The most frequent presenting symptom in Group H was abdominal discomfort and this was noted in 22 subjects (28 per cent.). "Weakness" or "tiredness" were frequently encountered and appeared to be major complaints in 18 patients (23 per cent.). Other common presenting symptoms were nausea, headache, chest pain,

"tension" and anorexia. On direct questioning each patient in Group H, with two exceptions, admitted to feeling depressed. There was no significant difference between the groups in terms of duration of illness, sleep disturbance, psychomotor behaviour, or morbid ideas.

Table I presents the major differences between the groups.

Discussion

In many patients with psychiatric illness the presenting complaints are suggestive of physical disease, and the clinician may often be misled into advising extensive and unrewarding investigations in an attempt to define some organic pathology. This difficulty in recognition is not, of course, confined to patients with depressive illnesses. However, in this particular group, delay in psychiatric management results in unwarranted and often increasing distress, and this may eventually culminate in suicide.

A major obstacle leading to delay in diagnosis and treatment of psychiatric disorders would seem to be various barriers to communication between patient and doctor (Gibson, 1962).

This study would suggest that, in depressed patients at least, the general practitioner's decision regarding the direction of initial referral is determined by a number of factors in addition to the current clinical presentation.

As was expected, somatic symptoms predominated in those referred initially to a medical extern. It must be questioned whether preoccupation with physical complaints in these patients was fostered, until it eventually assumed major significance, by the attitude of doctors invariably considering the illness in terms of physical disease and neglecting to take emotional disturbance into account. Some patients feel that their doctors are reluctant to countenance discussion of illness in terms of emotional problems, and therefore they can communicate their distress only by presentation of somatic complaints.

Nevertheless, in this investigation almost half of the patients referred directly for psychiatric appraisal had prominent somatic com-

Table I

	Group G	Group H
Sex	Males—49% : Females—51%	Males—41% : Females—59%
Age	Mean—48·25 years (Range 26–72 years)	Mean—52·5 years (Range 30–75 years)
Drug therapy designed to improve mood prior to referral ..	3 or more preparations 8% 2 preparations 10% 1 preparation 33% Untreated 49%	All untreated
Specific emotional disturbance preceding illness	34%	8% $\chi^2=15\cdot27$; $P<0\cdot001$
Previous depressive illness	31% (one-third treated in hospital with E.C.T.)	15% (half treated in hospital with E.C.T.) $\chi^2=4\cdot06$; $Po<0\cdot05$
Hospital attendance in previous 5 years for physical illness ..	19%	40% $\chi^2=9\cdot76$; $P<0\cdot01$
Family history of mental illness ..	28% (half treated in hospital for depression)	13% (2 suicides: two-fifths treated in hospital for depression)
		$\chi^2=5\cdot50$; $P<0\cdot02$

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plaints. It would seem, therefore, that the general practitioner must be influenced by other considerations when deciding where to refer his patient.

Specific emotional disturbance preceding the onset of symptoms was most common in those patients referred directly to the psychiatrist. Such events, related in time to the onset of the illness, may alert the doctor to the possibility of the illness being emotionally determined. Those patients in whom no specific psychogenic factors had preceded their illness were more likely to be considered as having a physical disorder.

If a patient had a previous psychiatric illness he was more usually referred again for psychiatric treatment. Nevertheless, a number of patients who had such a history were sent initially to a physician. It may be that in some instances the patient had been under the care of another general practitioner during his earlier illness and had not communicated this to his current doctor. We had no information on this possibility.

It is of interest that if a patient had suffered from a physical illness in the previous 5 years, the general practitioner was more liable once again to consider the new illness as having a physical basis. It is possible that patients having a physical illness in the recent past may tend to become unduly preoccupied with the somatic concomitants of any subsequent psychiatric illness.

A positive family history of psychiatric disorder would also seem to be taken into consideration by the general practitioner.

Probably a most important consideration, but one which could not be assessed here, is the gross disparity in training in psychiatric as compared with physical diagnosis (Rawnsley and Loudon, 1962). For an analysis of this sort, the number of patients in the study here reported is too small and the catchment area for this department is too large.

Summary

This study was undertaken in order to explore the question whether factors other than the form of clinical presentation determined the direction of initial hospital referral for depressed patients. Whilst somatic complaints were more frequent in those initially sent for physical assessment, there was also more commonly a history of unrelated physical disease in the previous 5 years. If psychogenic disturbance preceded the onset of the illness, a psychiatric opinion was more often sought, and there was some indication that this was also the case if there was a previous or family history of psychiatric disturbance.

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