Depressive illness in private practice

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AN EXTENSIVE LITERATURE exists on depressive illness in various developing countries of the world (Yap, 1965; Pfeiffer, 1962; Asuni, 1962; Lambo, 1956 & 1960; Tooth, 1950). However, as far as can be ascertained, no clinical study has been published on depressive illness in Singapore or its neighbouring country, Malaysia.

Depression, as stated by Fry, is a "non-hospital disease" and only a small proportion of patients find their way to a mental hospital. This is particularly true of the mild forms of depression which are mostly seen and treated in private practice. A study of such an illness seen in private practice will thus give a more accurate impression of depression in the community as the hospital impression may often be distorted.

The use of the term "depression" is often not defined. Most normal people experience fleeting periods in which their mood is below its normal acceptable level (Slater & Roth, 1969). Depression, as a disease entity, may only be said to have set in when these periods become protracted and mood change is intense. Classification of depressive illness is a problem which is still being argued. No attempt is made in this study to place patients into categories such as: Reactive, Endogenous and Involutional. Depression secondary to schizophrenia is excluded.

This paper is done with the hope of bringing to light the pattern and characteristics of depressive illness in a multi-racial and multi-cultural society with a predominant Chinese population.

Method of study

This is a retrospective study of the first 100 patients diagnosed as suffering from "depression" seen and treated by the author in a private psychiatric practice in Singapore. A previous study done by the author of patients suffering from schizophrenia enables a compairson to be made between patients with depression and patients with schizophrenia.

Characteristics of Patients studied

Sex distribution

Table 1

Sex distribution of depressive patients compared with schizophrenic patients and practice population.

Type of patients	No. of male	No. of female	Total
Depressive patients	33	67100	
Schizophrenic patients	55	45	100
Practice population*	272 (54.4%)	228 (45.6%)	500 (100%)

*The practice population consists of the first 500 patients seen and treated at the private psychiatric clinic for two years (1968 & 1969).

Of the patients with depression, there is an excess of women over men. This sex ratio of twice as many female to male is, however, not found among schizophrenic patients.

Age of onset of illness

Table 2

A comparison of age of onset of depressive and schizophrenic illness.

Age of onset of illness	Depressive illness		Total No.	
	No. of male	No. of female	Depressive patients	Schizophrenic patients
13–14	–	–	–	1
15–19	–	6	6	29
20–29	10	24	34	41
30–39	7	25	32	22
40–49	10	8	18	6
over 50	6	4	10	1
Total	33	67	100	100

The incidence of depression and schizophrenia arising from different age groups is shown in table 2. It can be observed that in depressive illness, the number of female patients reaches a sharp peak in the age range of 20–29. For male depressive patients, there is no peak.

Comparing the age of onset of the two major functional mental disorders, it is found that 71 schizophrenic but only 40 depressive patients had their onset of illness in age range of 13–29. This would indicate that schizophrenia begins at an earlier age than depressive illness.

Marital status

Table 3

A breakdown of marital status of depressive and schizophrenic patients compared with practice population.

Marital status	Depressive patients	Schizophrenic patients	Practice population
Married	73	39	263 (52.6%)
Single	22	57	223 (44.6%)
Widowed	3	3	10 (2.0%)
Divorced	2	1	2 (0.4%)
Unknown	–	–	2 (0.4%)
Total	100	100	500 (100%)

There is a higher incidence of depression in married than single patients – 73 are married and 22 are single. In the case of patients with schizophrenia, the position is reversed – 57 are single and 39 are married.

Social class

Table 4

Social class of depressive patients compared with schizophrenic patients.

Social class	Occupation	No. of depressive patients	No. of schizophrenic patients
1	Managerial, professional	47	20
2	Semi-managerial, semi-professional	7	13
3	Skilled worker, clerical	36	30
4	Semi-skilled worker	5	19
5	Unskilled	5	16
6	Unemployed	–	2
Total		100	100

These two groups of patients are assigned into six social classes, according to occupations of the head of the family. As expected, the case materials obtained from a specialist private practice are highly selective, especially with regard to social class. However, this being a comparison, the result obtained should not be affected by such a selective sampling. From table 4, 90 depressive patients but only 63 schizophrenic patients are found in social class 1, 2 and 3. Thus, the social class of depressive patients is found to be higher than that of the schizophrenic patients.

Educational level

Table 5

A comparison of education level of depressive patients and schizophrenic patients.

Category	Educational level	No. of depressive patients	No. of schizophrenic patients
1	University		11
2	Pre-U 1 & 2, college	14	19
3	Secondary 1–4	45	37
4	Primary 1–6	23	27
5	No formal education	7	12
	Total	100	100

The patients are categorised in table 5 according to their educational level. It is observed that there is not much difference in the educational level of the two groups of patients.

Ethnic group

Table 6

A breakdown of the ethnic grouping of depressive patients compared with schizophrenic patients and with the mid-1968 Singapore population.

Ethnic group	Depressive patients	Schizophrenic patients	Singapore population %
Chinese	68	80	74.2
Malay	1	3	14.6
Indian	5	10	8.1
Caucasian	19	5	
Jew	3	–	3.1
Eurasian	3	1	
Others	1	1	
Total	100	100	100%

Ethnic grouping shows an over-presentation of the Caucasian, Jewish and Eurasian groups. Malay in this series is under-represented. It is felt that a further study comparing the patients of the major racial groups in Singapore suffering from depression might provide some insight into inter-cultural differences as well as the dynamics of depressive illness.

Symptoms in depressive illness

When the symptoms of the patients are considered, disturbance in sleep is found to be the most frequent symptom, being present in 78 of the patients and ideas of suicide is next, being present in 72 patients. The other symptoms in order of frequency are:

loss of appetite	55
tension	53
crying	52
excessive worrying	47
irritability	44
feeling of apprehension	44
restlessness	40
loss of interest	30
poor concentration	18
suspiciousness	17
retardation	16
morning depression	12
guilt-feelings	9
sweating	7
dryness of mouth	7
black magic	6
paranoid ideas	4
blaming others	3
jealousy	3

Physical symptoms, such as headache, giddiness, chest pain, difficulty in breathing, epigastric pain, palpitations, constipation and lack of energy are fairly frequent symptoms. In 26 cases, they form an important part of the illness. These symptoms can readily suggest physical disease, especially if the depressive mood is not promiment and if the disorder manifests mainly in hypochondriacal complaints. Such a variety of depressive reaction is termed by some authors as "masked form" of depression (Maslow & Mittelmann, 1951; Hordern, Burt and Holt, 1965). Both Lambo and Field pointed out that depression might be missed because of a veneer of psychosomatic symptoms. As mentioned by Yap, "it is not rare that depressive illness is being masked often by hypochondriacal (psychosomatic) and confusional symptoms".

In the analysis of the symptomatology of depressive patients, the absence of delusion of sin as a symptom is interesting (Yap, 1958 and Lin, 1953). Of the nine patients with guilt feelings, six of them are Caucasians. The severity of the self-reproach in the three Chinese patients is also less severe than that of the Caucasian patients (Murphy, Wittkower and Chance, 1964).

Suicidal attempts

Table 7

A breakdown of age, sex and marital distribution of suicidal patients in depression.

Age of patients	Male	Female		
		Single	Married	Divorced
13–19	–	2	–	–
20–29	2	1	4	1
30–39	2	1	8	–
40–49	3	–	3	–
over 50	–	–	1	–
Total	7	4	16	1

Depressive illness is the mental disorder with the highest suicidal risk. In this survey, 28 patients had made previous attempts at suicide. From the table, a female:male ratio of 3:1 is found. It is noteworthy that over 75% of both male and female patients are under the age of 40. The youngest female is 18. For married women, the peak age-group is 30–39, which appears to be a turbulent period of their life. There are only seven male patients and they are all married.

Table 8

Methods of attempted suicide.

Methods	Male	Female
Barbiturate, hypnotics, tranquillisers and other drugs	4	17
Lysol	–	1
Hanging	1	4
Cutting instruments	2	1
Drowning	1	2
Running at oncoming cars	–	1
Repeated attempts	3	8

Table 8 shows the variety of methods employed as well as their frequency. In both sexes, the use of drugs predominated and accounted for 61% of the methods used. Seven patients had made repeated attempts at suicide. There are three women who made three attempts and one woman who used multiple methods.

Suicide

In this series, to the author's knowledge, there are two suicides. Because of the small number of suicides, the impression obtained about suicide in depressive illness in this study may be inaccurate. Further study is needed to find out about suicide in depression and what proportion of depressive patients commit suicide. According to Etthinger and Flordh, attempted suicides were eight to ten times more frequent than actual suicides. Stengel stated that of surveys in the United Kingdom and in the United States, the number of suicidal attempts was six to eight times that of the suicides, at least in urban communities.

Precipitating factors

In searching for precipitating factors for depressive illness, one faces problems: firstly, whether the stress is a result of the illness rather than a cause of it; and secondly, how much importance the stress plays in patients with personality disorder, especially where the personality and illness emerge imperceptibly the one into the other (Forrest, 1965). However, inspite of such problems, an attempt is being made to list the environmental and medical data which may be considered as significant precipitating stresses in the hundred patients studied.

Social factors

Marital discord	46
Family discord	23
Financial stresses	18
Unhappy with job	17
Domestic problems	9
Rejection by boy/girl friend	6
Business problems	5
Loneliness	4
Separation	4
Unemployment	3
Rejection by family	1

Medical factors

Alcoholism	11
Post-operative	4
Menopause	3
Post-partum	1
Influenza – post	1
Lesbianism	1
Drug – reserpine	1
Post cerebro-vascular accident	2

In the analysis of the precipitating factors, it is often found that it is not a single but several factors which seem to add up and spell mental disorder for the individual.

Discussion

The most striking finding in this study is that in depressive illness, the female predominates. A similar finding has been reported in other studies in different parts of the world for depressive patients seen in private practice (Porter, 1970; Bazzoui, 1970; Watts, 1964). The sex ratio of female:male of 2:1 is in agreement with reports for Affective Reactions obtained from private and general hospitals in the United States (Freeman, Kaplan and Kaplan, 1967). It is again noteworthy that such a ratio is also found by Kellner for neurosis in general practice and Taylor in medical outpatients for both anxiety state and depression.

In this survey, it is found that there is an apparent tendency for the first attack of depressive female patients to occur at the age range of 20–39. Forty of the 49 patients are married and they form an interesting 'housewife group' (Taylor, 1969). In this group, marital and domestic problems are important factors which add up to produce mental disturbance. Yap stated that there is a tendency for the first attack to occur more frequently at an early age in women. The result of this study has shown that six female and no male patients have their onset of illness at the age range of 15–19. In this group of young patients, rejection by family and boy friend, and unhappiness in job are significant precipitating factors for their illness.

In depressive illness, married persons are particularly at risk (Porter, 1970). In schizophrenia, the reverse is the case. This pattern of marital status for affective disorder and other functional psychosis have been repeatedly observed in studies in the United States, Britain and Norway (Faris and Durham, 1959). The social class of depressive patients is also much higher than that of schizophrenic patients. In accordance with reports from other countries, schizophrenics tend to occur mostly in the lower class while depressive illness occupies the upper social class (Myre Sim, 1968; Rawnsley, 1968).

An over-representation of Caucasian patients, especially Americans in such a selected sample, is not unexpected. Of these 19 patients, 15 are women. The Malays are represented by only one patient.

In depressive illness, ideas of suicide is a common symptom and, as shown in this survey, the risk of attempted suicide and suicide is very high. Attempted suicide is more common among the women and the peak level of incidence in women occurs in the age range of 30–39, which is slightly older than that obtained by Tsoi's study of "Attempted suicide in General Hospital".

Summary

The characteristics and clinical features of 100 patients suffering from depressive illness of various degree is presented. In this study, a comparison is also made of these 100 depressive patients with 100 schizophrenic patients studied by the author in a previous paper. The differences between the two groups regarding their sex distribution, age of onset of illness, maritial status, social and educational levels are analysed and discussed.

In the analysis of the symptomatology of the depressive patients, an absence of delusion of sin and rarity of severe guilt feelings among the Chinese population of this sample is interesting.

Depression is a common illness in the community and it may be presented in a "masked form" and be missed because of a veneer of hypochondriacal (psychosomatic) and confusional symptoms. The risk of attempted suicide and suicide, however, is great.

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