

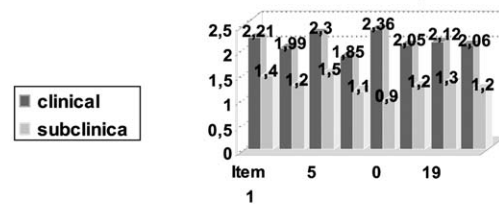
Letter to the Editor

**Subclinical depression in primary care and somatic symptoms**

Sir: Studies concerning depression in primary care emphasize the fact that several clinical features of these mood disorders do not satisfy the diagnostic criteria of psychiatric classifications [4]. These primary care patients have been classified as subclinical depression, subthreshold depression, or patients with “depressive symptoms only” [2]. We compared using analysis of variance and Mann–Whitney statistics, a randomized group of 43 patients presenting clinical depressive symptoms (Beck Depression Inventory >16, cut-score validated in Spanish version [1,3]), with another group of 41 “subclinical” patients (BDI scores: 10–16). We considered statistically significant difference  $P < 0.01$ .

Analyzing the results, we observed that phenomenological difference between both groups appears at the expense of symptoms showed in the Table 1 and Figure 1. All these clinical features are essentially of mood quality, and they constitute the phenomenological core of the concept of depression. “Subclinical” depression presented nonspecific somatic symptomatology such as also showed in Table 1—which might be caused by somatic disease. The quality of

Differential items of BDI  
Clinical vs “Subclinical” depression.



1=sadness, 3=low self-esteem and feelings of inadequacy  
5=feelings of guilt, 9=disatisfaction, anhedonia, suicidal thoughts  
10=crying, 18=anorexia, 19=distal insomnia, 20=hypochondrial thoughts

Fig. 1.

“subclinical” depression may also be related to symptoms which are not really related phenomenologically to mood changes but are determined more by the patients personality traits: irritability, insecurity about making decisions, and self-image as we show in Table 1.

On this argumental line, “subclinical” depressions in primary care exist, but several cases can be in relation with “somatic” nonspecific symptoms. This matter is essential in differential diagnosis with the medical diseases of the patients. Despite the current proliferation of studies which use this concept, our results support the view that “mild” or “subclinical” depression do not appear with mood phenomenological clinical features. Many scales used in primary care studies are composed of several physical items, as well as cognitive and affective items. This fact may introduce an important variance of interpretation: subclinical depression and somatic symptoms: “affective” or “organic” etiology? Additional studies are needed in order to design assessment instruments for primary care patients that differentiate the primary phenomenological etiology of physical symptoms. As may occur in another fields of psychiatry, phenomenological approach is essential in order to differentiate the primary etiology of symptoms.

Table 1

Clinical (BDI > 16,  $n = 43$  outpatients) vs. subclinical depressive symptoms ( $10 < \text{BDI} < 16$ ,  $n = 41$  outpatients): differences and similarities in Beck Depression Inventory items

Differences: mood quality symptoms, “core” of the concept of depression

- Sadness (item 1,  $P < 10^{-3}$ )
- Low self-esteem and feelings of inadequacy (item 3,  $P < 10^{-3}$ )
- Dissatisfaction and anhedonia (item 9,  $P < 10^{-2}$ )
- Feelings of guilt (item 5,  $P < 10^{-3}$ )
- Suicidal thoughts (item 9,  $P < 10^{-2}$ )
- Crying (item 10,  $P < 10^{-4}$ )
- Distal insomnia (item 19,  $P < 10^{-3}$ )
- Anorexia (item 18,  $P < 10^{-3}$ )
- Hypochondrial thoughts (item 20,  $P < 10^{-3}$ )

Similarities: essentially nonspecific somatic symptomatology, and symptoms determined by patient’s personality traits. Importance of phenomenological differential diagnosis with organic diseases

- Loss of energy (item 15,  $P = 0.08$ )
- Fatigue (item 17,  $P = 0.02$ )
- Weight loss (item 19,  $P = 0.58$ )
- Changes in physical state and external appearance (item 14,  $P = 0.22$ )
- Sexual dysfunction (item 21,  $P = 0.03$ )
- Irritability (item 11)
- Insecurity about making decisions (item 13)
- Self-image (item 13)

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