one-third of all depressives fell into the retarded class. On the BCC system, mixed cases of depression and anxiety were common.

Mild psychiatric disorder in GP has often been regarded as non-specific (Goldberg, 1982), corresponding to a group of 'distress syndromes' where psychiatric diagnoses may be of limited value. In spite of these difficulties, an attempt at diagnostic distinction is nevertheless necessary at the level where decisions are being made regarding use of antidepressant and other treatments.

Most subjects in our samples were able to be diagnosed, though the common occurrence of mixed cases was shown by their frequency in the BCC system. Both CATEGO and RDC constrain mixed cases to single diagnoses by hierarchical rules, which may favour depression. A proportion of the anxiety diagnoses found in these systems might also be due to arbitrary assignment of mixed cases, and some of the other diagnoses found may be due to difficulties in assignment at the lower limits of diagnostic criteria. Some reflect misdiagnosis by GPs and failure to appreciate a predominance of other symptoms in the presence of depression.

Our study suggests that about a quarter of patients treated by GPs with antidepressants fail to meet psychiatric criteria for depression, and that substantial numbers of patients who do reach these criteria are unrecognised and untreated. Nevertheless, the large majority of GP depressives do satisfy criteria for psychiatric cases, although the disorder is milder, less specific in diagnosis, and less characteristic in quality than that treated by psychiatrists.

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Depression in General Practice:
Clinical Features and Comparison with Out-Patients

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Summary: General practice (GP) depressives prescribed an antidepressant were compared with those given other treatment, and with antidepressant-treated psychiatric out-patient depressives. GP depressives were considerably less severely ill than out-patients, with fewer depressive symptoms and shorter illness, as well as less primary and less endogenous depression. The two groups of GP depressives differed less, but those receiving other treatment tended to have less severe depression than those receiving antidepressants and were less likely to satisfy diagnostic criteria for depression. Depressives in GP differ considerably in clinical characteristics from psychiatric out-patient depressives, and clinical features influence the GP's decision to treat with antidepressants.

This is the second paper of a series on depressed patients in general practice (GP). The study concerned differs from previous ones in the use of explicit definitions of samples, the inclusion of a non-antidepressant treated sample, and the application of recently developed epidemiological, diagnostic, and classificatory criteria. A previous paper (Sireling *et al*, 1985) has presented the overall methodology and the findings regarding main diagnoses and epidemiological case thresholds. This paper reports clinical features of depression recognised and treated by GPs, and compares them with psychiatric out-patient depressives; its data include history, symptoms, classificatory sub-types, and relationships to medical illness and to psychosocial stresses. Two issues are considered: (1)

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differences between GP depressives and out-patient depressives, (2) differences between depressives whom the GP treats with anti-depressants and those whom he treats in other ways.

Method

General practice samples

Full details of sampling and data collection for the GP samples are given in the previous paper (Sireling *et al*, 1985). GP subjects were drawn from patients aged 18 to 64 attending 36 GPs, situated in and around South West London and not already attending psychiatrists or referred at the initial consultation. Three samples were selected, of which two are the subject of this paper.

Antidepressant: Depressed patients receiving a new prescription of a drug from the antidepressant section of the British National Formulary.

Other treatment: Subjects identified by their GPs as depressed enough to require some other treatment, which might be a drug other than an antidepressant, social support, or surveillance with a definite further appointment. Patients were excluded from either sample if they had already been prescribed an antidepressant in the preceding three months. The third sample, of major depressives not recognised by the GP, is described further and compared with recognised major depressives in a separate report (Freeling *et al*, in press).

Out-patient depressives

The out-patient depressives comprised the first 89 subjects from the pre placebo-washout phase of a previously published trial of phenelzine, amitriptyline, and placebo (Rowan *et al*, 1982). They were patients aged 21-64, newly referred by GPs, with depression of at least two weeks' duration (with or without associated anxiety, phobic or obsessional symptoms, or personality disorder), and with a score of between 7 and 11 (inclusive) on the Raskin Three Area Depression Scale (Raskin *et al*, 1970). The following were excluded: in-patients, typical endogenous depressives scoring 8 or more on the Newcastle Scale (Carney *et al*, 1965), bipolar manic-depressives, patients with physical illness, those already receiving an anti-depressant in adequate dosage and those with depression subsidiary to another predominant syndrome. Patients came from the two hospitals, St. George's and Sutton, that received referrals from most of the general practices included in the study.

Interview procedures

GP patients were interviewed by a research psychiatrist (LIS) in their own homes, within a week, and usually within three days, of seeing their GPs. The interview procedure is described in Sireling *et al*, 1985. Symptoms were rated on a combined clinical interview incorporating the Present State Examination, (PSE), (Wing *et al*, 1974), (GP sample only), multiple depression rating scales, classificatory, historical, and demographic data. The out-patient depressives had been interviewed in the clinic at the time of referral, by one of four psychiatrists. All four had been trained until good agreement was achieved, and one subsequently trained the rater responsible for the GP ratings to a high level of reliability.

Interview data

The following ratings will be reported:

1. *Hamilton Rating Scale for Depression* (Hamilton, 1967). The 17-item version of this scale was completed.
2. *Clinical Interview for Depression* (Paykel *et al*, 1970; Paykel, in press) a semi-structured interview covering 27 symptoms and eight observed items linked with depression, each rated on a seven-point scale with detailed anchoring points.
3. *Raskin Three Area Depression Scale* (Raskin *et al*, 1970) for the severity of depression, ranging from a total score of 3 to 15, derived by summing separate 1 to 5 scales for verbal report, appearance, and secondary symptoms of depression.
4. *Newcastle Diagnostic Index* (Carney *et al*, 1965).
5. *Research Diagnostic Criteria* (RDC) (Spitzer *et al*, 1978) define criteria for ten depressive sub-types, applying only to probable or definite major depression; these will be reported here.
6. *History* of present and previous illness, family, social, and personal, rated on defined criteria. Episodes of illness were dated from the beginning of definite deterioration from either normality or chronic mild symptoms, and if relapsing and remitting, from the last three-month symptom-free period.
7. *Relationship with physical illness.* Ratings were made by the psychiatrist for the GP sample on two five-point scales. One assessed the severity of physical illness or handicap (as defined by the PSE). The other made a global judgement of the contribution of any physical condition to the development and maintenance of the depression, taking into account the degree of stress inherent in the condition, its physical effects, its relationship to the onset or exacerbation of the depression, and the content of the depressive thought. These ratings utilised information about physical illness known to the GP.
8. *Problems at presentation.* Social stress was examined by questioning the patient for 81 listed problems. Areas covered were employment, education, finance, health, legal and housing, family and social, marital and dating, bereavement, and other miscellaneous problems. A problem might result from an earlier life event or from a persisting situation, and was defined as a currently existing circumstance in the patient's environment, at least mildly stressful in terms of objectively rated negative impact. The method and scoring system are described elsewhere (Paykel *et al*, 1984). Ratings were made of the degree that each problem was independent of psychiatric illness, and of its objective negative impact, irrespective of the patient's perception. In the out-patient sample, these data had been obtained by a research interviewer (BMR) who subsequently trained the research psychiatrist in the use of the interview.

Data analysis

Data were analysed using the Statistical Package for the

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Social Sciences (Nie *et al*, 1975). Difference between groups was tested by chi-square for qualitative variables, and by two-tailed t-tests for continuous variables, with 5% significance levels.

Two sets of comparisons were made: (1) between the out-patient sample and the GP antidepressant sample; these two populations were chosen for comparison because the out-patient sample was similarly restricted to antidepressant-treated patients, (2) between the two GP samples.

Results

Demographic characteristics and history

Table I displays selected demographic and history variables of the three groups. There were no significant differences in demographic characteristics. Mean age was in the mid-thirties, all groups were predominantly female, and about half the subjects were married.

There were significant differences in length of illness, with longer illnesses in the out-patients than in the GP patients, but no differences between the two GP samples. In all groups, about half the patients had experienced previous episodes of psychiatric illness.

Severity

Table II shows the main measures of severity. The mean Hamilton score was considerably higher in the out-patients than in the two GP samples. There were smaller, but still significant differences between the GP samples. Only 36% of GP antidepressant-treated patients and 14% of those receiving other treatments had a Hamilton score of 17 or more—a common inclusion criterion for out-

TABLE I

Demographic characteristics and history of illness

	Outpatient	*General Practice*		*Significance*	
	(n = 89)	*Antidepressant (n = 95)*	*Other treatment (n =48)*	*OP vs GP Antidepressant*	*GP Antidepressant vs other treatment*
Mean age	34.6	35.5	37.2	NS	NS
Percentage of women	80	85	79	NS	NS
Marital status (%):					
single	26	23	25		
married	55	56	52	NS	NS
widowed, divorced, separated	19	21	23		
Social class (%):					
I + II	27	36	27		
III	51	52	54	NS	NS
IV + V	22	13	19		
Duration of present episode[1] (%):					
up to one month	8	23	16		
one month to one year	70	51	56		
more than one year	22	26	28	<.01	NS
One or more previous episodes of psychiatric illness (%)	54	41	48	NS	NS

[1] Excluding one subject in each general practice group with no defined episode.

TABLE II

Severity of depression

		Outpatient	*General practice*		*Significance*	
		(n =89)	*Antidepressant (n = 95)*	*Other treatment (n = 48)*	*OP vs GP Antidepressant*	*GP Antidepressant vs other treatment*
Hamilton total (% of patients)	0–10	2	20	33		
	11–16	12	44	53		
	17–24	53	33	14	<.001*	<.05*
	25+	33	3	0		
Hamilton mean total		21.9	14.8	13.0	<.001	<.05
Raskin mean total		8.6	7.3	6.4	<.001	<.05

* 0–16, 17 or more.

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patient drug trials. The Raskin score showed a similar pattern: a total score of 7 is another common inclusion criterion. On this criterion, 34% of antidepressant-treated and 60% of other-treated patients would be excluded from many drug studies.

Symptom patterns

Detailed symptoms were examined on the Clinical Interview for Depression (Table III). Out-patient depressives again differed considerably from the GP antidepressant sample, with significant differences on 18 of 35 individual symptoms. The two GP groups differed less from each other, with significant differences on six symptoms. Out-patient depressives had significantly more evidence of depressive symptoms including depressed feelings. distinct quality of depression, morning worsening, impairment of work, guilt, hopelessness, loss of energy, anorexia, weight loss, retardation, depressed appearance, obsessional symptoms, paranoid ideas, and self-pity. They had more increased sleep and tended to show less insomnia than GP antidepressant subjects (in contrast to GP subjects receiving other treatment). The pattern was mixed for anxiety symptoms: out-patients had higher scores for generalised anxiety and panic attacks, but lower scores for phobic anxiety. There was no significant difference on a rating of suicidal feelings.

Differences between the two GP samples were less, but those prescribed antidepressants had more depressed feelings, phobic anxiety, initial and middle insomnia, a more depressed appearance at interview, and less reactivity of mood.

The Clinical Interview produced two scores—one for depressive symptoms and one for anxiety. The depression score was higher in out-patients than in the GP antidepressant sample, and lowest in the sample receiving other treatment. There were no significant differences for anxiety.

Sub-types of depression

RDC major depressive disorder can be classified into a number of operationally defined sub-types, most of which are independent of each other. Because there were only nine major depressives in the other treatment group, Table IV presents only comparisons between the out-patient and the GP major depressives treated with antidepressants. Most of the out-patients were major depressives, but only half of the GP antidepressant sample were. There were significant differences between the two groups of major depressives. More of the out-patient sample were primary (i.e. with no previous history of another diagnosis). More were endogenous—a sub-type defined by symptom pattern in the RDC; 30% of out-patients but only 9% of GP patients ($P < .01$) satisfied the more stringent criterion for definite endogenous depression (not shown). More out-patients had retarded and more had simple depression (i.e. no other diagnosis in the previous year). Unexpectedly, more out-patients were rated as situational (i.e. related to external events). On

TABLE III

Clinical interview symptom ratings[1]

	Outpatient	*General practice*		*Significance*[2]	
	(n = 89)	*Antidepressant (n = 95)*	*Other treatment (n = 48)*	*OP vs GP Antidepressant*	*GP Antidepressant vs other treatment*
Feelings of depressed mood	4.5	3.9	3.3	<.001	<.001
Distinct quality of depression	4.7	3.7	3.6	<.001	NS
Diurnal variation—symptoms worse in morning	2.4	1.6	1.7	<.001	NS
Reactivity to social environment	3.7	3.8	4.3	NS	<.01
Guilt, lowered self-esteem and worthlessness	3.8	2.2	2.1	<.001	NS
Pessimism and hopelessness	4.0	2.7	2.3	<.001	NS
Obsessional symptoms	1.5	1.3	1.2	<.05	NS
Work and interests	3.9	3.3	3.0	<.001	NS
Energy and fatigue	4.2	3.6	3.4	<.001	NS
Anxiety psychic-generalised	4.3	3.4	3.5	<.001	NS
Panic attacks	2.1	1.6	1.6	<.05	NS
Phobic anxiety	2.0	2.8	2.3	<.001	<.05
Anorexia	2.9	2.2	2.1	<.01	NS
Weight loss	2.4	1.9	2.2	<.05	NS
Initial insomnia	2.3	2.6	1.9	NS	<.01
Middle insomnia	2.0	2.2	1.6	NS	<.01
Increased sleep	1.8	1.2	1.3	<.001	NS
Paranoid ideas	1.8	1.3	1.2	<.001	NS
Self-pity	2.7	1.4	1.2	<.001	NS
Retardation	1.8	1.3	1.1	<.001	NS
Depressed appearance	2.8	2.5	2.1	<.05	<.05
TOTAL DEPRESSION SCORE	27.1	21.4	18.8	<.001	<.01
TOTAL ANXIETY SCORE	11.3	10.4	9.3	NS	NS

[1] 1–7 Scales except for total scores.

[2] The following additional items showed no significant differences: diurnal variation-symptoms worse in p.m.; suicidal feelings; depersonalisation; somatic anxiety; increased appetite; weight gain; irritability; delayed insomnia; depressive delusions; over-emphasis of symptoms; hysterical symptoms; hypochondriasis; hostility; agitation.

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TABLE IV

Subtypes of Research Diagnostic Criteria major depression[1] and Newcastle diagnostic index

		Out-patient (n = 83) %	*GP Anti-depressant (n = 53) %*	*Significance*
Primary		90	64	<.01
Secondary		10	36	<.01
Recurrent		54	36	NS
Psychotic		4	2	NS
Incapacitating		17	6	NS
Endogenous		67	47	<.05
Retarded		24	2	<.001
Agitated		8	4	NS
Situational		81	42	<.001
Simple		87	60	<.001
Newcastle diagnostic index (% of whole samples)	0–3	65	64	
	4–5	24	32	NS
	6+	11	3	

[1]Probable and definite combined.

the more stringent Newcastle Diagnostic Index scores in both samples were distributed mainly in the non-endogenous range (0 to 5), but the out-patients tended to be more endogenous.

Problems

Table V sets out the numbers of patients in each group experiencing problems independent of psychiatric illness, patients being allocated to the level of their most severe problem on a rating of objective negative impact, similar in meaning to the rating of contextual threat used by Brown & Harris (1978). The GP antidepressant patients were more likely to have problems, and of significantly greater severity, than were out-patients. Differences between the two GP groups were not significant, although the other treatment group tended to show less social stress.

Relationship with physical illness

Information on physical illness and its relationship with depression was not gathered in the out-patient study, from which patients with major physical illness were excluded. Comparison between the two GP groups shows no significant differences; contrary to expectation, the incidence of physical illness was low. Only 34% of the antidepressant sample and 38% of the other treatment sample had some physical disorder, and in only a very small minority was this judged serious. Of those depressives with a physical disorder, in only 16% and 22% respectively was it judged to have played a major role in precipitating or maintaining the depression.

Discussion

This paper is concerned with two major issues: the features which distinguish GP depressives from those referred to a psychiatric out-patient clinic, and the features which distinguish those patients the GP treats with antidepressants from those he treats in other ways. Demographic features did not distinguish between the samples, but a previous paper (Sireling *et al*, 1985) has described major differences in patterns of diagnosis between the two GP samples.

General practice and out-patient depression

Because the out-patient sample had all been judged suitable for antidepressants, valid comparisons were limited to GP patients also being started on antidepressants. The differences were considerable: the GP depressives were less severely ill, had shorter illnesses, a lower incidence of primary, endogenous or retarded major depression, and milder symptoms of depressed mood, biological and psychomotor changes. On the Hamilton scale, a total score of 17 is often used as an inclusion criterion in antidepressant trials: 86% of the out-patient sample fitted this criterion, but only 36% of the GP patients treated with antidepressants did so.

However, the nature of the comparison must be kept in mind. The out-patient depressives were not a random sample, since all met criteria for a study of antidepressants, but we would regard them as fairly

TABLE V

Independent problems at presentation

	Outpatient	*General practice*		*Significance*	
	(n = 80)[1]	*Antidepressant (n = 95)*	*Other treatment (n = 48)*	*OP vs GP Antidepressant*	*GP Antidepressant vs other treatment*
Objective negative impact:					
Maximum per subject(%)—					
none	29	10	17	NS	NS
mild	21	28	29		
moderate	31	39	40		
marked or severe	19	22	14		
Mean per subject	2.83	3.22	2.81	<.001	NS

[1] Not rated in 9 subjects.

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representative of out-patient depressives, most of whom receive antidepressants. The out-patient study criteria were deliberately set fairly wide, with low thresholds for severity: all were new referrals, identified by interviewing the majority of new out-patients whose referral letters suggested a diagnosis of depression. The sample included patients who failed to be included in the drug trial because of rapid response to placebo or failure to re-attend after an initial placebo washout week.

Three previous studies have made comparisons between GP and psychiatric depressives, but with in-patients rather than the more relevant out-patients, and with less extensive ratings than the present study. Findings were similar to ours, with GP depressives more mildly ill and less retarded (Fahy, 1974b; Davies & Blashki, 1973). Pilowsky & Spence (1978) found less endogenous depression in their GP sample, but no difference in severity; they used a self-report questionnaire, and such scales differentiate levels of severity poorly (Paykel *et al,* 1973).

There was one anomalous finding in the data: GP depressives were diagnosed as situational on the RDC less frequently than out-patients, but scored higher on the problem interview. The RDC definition refers to stress at onset rather than at presentation, and this may explain the difference, but it was more likely caused by unreliability of the simple global judgement used by the RDC, compared with the systematic interview.

Antidepressants and other treatment

A feature of this study was the explicit identification of those depressives receiving treatment other than antidepressants. In earlier studies, most subjects selected were receiving antidepressants. Johnson (1974) in a GP depressed sample diagnosed initially by the practitioner, found that 92% were given tricyclics at initial presentation and 7% given minor tranquillizers, although he did not distinguish the two groups in further analyses.

GPs have been criticised for their extensive use of minor tranquillisers in depression (Trethowan, 1975; Tyrer, 1978; Dennis, 1979) and we considered it important to examine the characteristics of these patients separately. The most striking difference between the two GP samples concerned diagnoses, and was reported in our previous paper (Sireling *et al,* 1985). On the RDC, half of the antidepressant-treated subjects received diagnoses of major depression and a further quarter that of minor or intermittent depression. By contrast, only a fifth of depressives receiving other treatment were major depressives, a third were minor depressives, and nearly half received other diagnoses, particularly of anxiety disorders.

The main differences in the present findings were in the severity of depression and associated symptoms, reinforcing this picture of milder, less typical depression in patients given other treatment. The two groups were similar regarding demographic variables, history of illness, previous illness, level of social stress, and physical illness.

Of the treated depressives, 65% had no associated physical illnesses; this is in keeping with Johnson's (1973) figure of 60% of newly treated GP depressives, and 63% of GP patients newly given psychotropic prescriptions (Williams *et al,* 1982). The finding of Shepherd *et al* (1964) that 32% of the total psychiatric morbidity in GP populations was related to psychosomatic conditions and to organic illness with psychiatric overlay is also remarkably close. In our study, however, the contribution of the physical disorder to the depression was mainly rated as small.

Decision-making by general practitioners

The differences between groups in this paper permit some inferences as to GP's treatment decisions. Important factors associated with psychiatric referral appear to be severity and chronicity of the depression. This contrasts with Fahy's findings (1974a) that neither factor played a major part, although both might be expected to do so.

GPs appear to make treatment decisions on a rational basis for those patients they manage themselves: the more severe and less reactive the depressed mood, the more likely the doctor is to prescribe antidepressants. Some treatment other than antidepressants is likely to be offered to the more mildly depressed and to those with other diagnoses who are considered to be depressed. Endogenous or biological symptoms did not differentiate treatment groups consistently, but the evidence that these symptoms predict antidepressant responsiveness in mild depression is scanty. It also appears that the degree of stress of the patient's circumstances does not influence the GP in the decision to prescribe antidepressants. Among the most marked differences between the two GP groups were the ratings of initial and middle insomnia, supporting the view that antidepressants may be prescribed partly for their sedative effects (Tyrer, 1978).

The findings suggest that on the whole, GPs prescribe antidepressants appropriately and are able to distinguish degrees of severity of depression in the short time available for each appointment. It seems that this criterion of severity is used as a basis

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for the treatment decision, with reactivity of mood and sleep disturbance as additional factors.

Almost all the evidence of the efficacy of antidepressants and responsive sub-groups however, is derived from studies of psychiatric in-patients and out-patients. Even in these samples, predictors of drug-placebo differences in mild cases are not clear. Although one British placebo-controlled study in GP showed clear efficacy for amitriptyline (Thomson *et al*, 1982) another trial of imipramine was negative (Porter, 1970). The differences found in the present study from psychiatric out-patient depression are large enough to indicate strongly the importance of further controlled trials of treatments for depression in general practice.

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