British Journal of Psychiatry (1985), **147**, 113–119

Depression in General Practice:
Case Thresholds and Diagnosis

L. I. SIRELING, E. S. PAYKEL, P. FREELING, B. M. RAO and S. P. PATEL

Summary: Using multiple diagnostic and epidemiological criteria, three samples of general practice (GP) depressives were studied: those prescribed a new course of antidepressants, those given other treatment, and those missed by the GP. The majority of patients qualified as psychiatric cases on the PSE Index of Definition, the Bedford College Criteria, and the Research Diagnostic Criteria. Most satisfied diagnostic criteria for depression, or (fewer) anxiety. The disorders were relatively mild and often borderline on all three systems. Depressives given other treatment most often failed to meet diagnostic criteria. About half the antidepressant treated patients received RDC diagnoses of major depression. Among the other treatment sample, only one-fifth met these criteria, and half had non-depressive diagnoses. Most cases of depression treated by GPs satisfy criteria for psychiatric disorder, but tend to be relatively mild and borderline in quality.

The majority of depressed patients are managed in general practice (GP). The 1971 National Morbidity Survey (OPCS, 1974) reported a one-year consultation rate of 35.5/1000 for depression. In contrast, the Chichester/Salisbury Study found an annual referral rate of about three per thousand (Grad de Alarcon *et al*, 1975). One study found that only 17% of GP depressives were ultimately referred to psychiatrists (Fahy, 1974a).

Treatment with antidepressants is common. In 1982, there were approximately 7.5 million GP antidepressant prescriptions in Great Britain (Office of Health Economics, 1984). Most of the evidence as to the efficacy of these drugs derives, however, from studies of depressed in-patients and out-patients treated by psychiatrists. Extrapolation would be acceptable if psychiatric and GP depressives were similar, but available evidence suggests that they are not.

Fahy *et al* (1969) studied the clinical features of 133 GP depressives; a small sub-sample that was compared with depressed in-patients (Fahy, 1974b) was found to be more mildly ill and less retarded. Johnson (Johnson, 1973, 1974; Johnson & Mellor, 1977) found that new cases of depression in GP tended to be mild, with a high incidence of social stress; most received antidepressants, and the outcome was mainly good. In Australia, Davies & Blashki (1973) also found milder symptoms in GP depressives than in in-patients, while Pilowsky & Spence (1978) found no difference in severity, but less endogenous depression in GP.

These studies, although useful, leave some issues unclear. In all of them, selection was by the GP, thus excluding undetected depressives. Sensitivity to psychiatric disorder varies among GPs (Marks *et al*, 1979), but has probably increased in recent years. Rates for neurotic depression in GP increased more than twenty-fold between the National Morbidity Surveys of 1955 and 1971 (Research Unit of the Royal College of General Practitioners, 1976). In most studies, the diagnosis of depression appears to have been equivalent to treatment with antidepressants, so that the apparently numerous depressives treated with benzodiazepines or in other ways (Tyrer, 1978; Clare, 1981) were ignored.

Two major instruments are now available which embody defined criteria and thresholds for depression in the mild range and for classificatory subgroups: the Research Diagnostic Criteria (RDC) (Spitzer *et al*, 1978) and the Present State Examination (PSE) (Wing *et al*, 1974) with the Index of Definition (ID) and CATEGO classes (Wing, 1976).

The Bedford College Criteria (BCC) are based upon the PSE (Brown & Harris, 1978); they originally involved consensus judgements of caseness, but were later adapted for computer assignment (Finlay Jones *et al*, 1980). These methods have not been applied to GP depression, however, in the past.

Incorporation of such instruments allows a further issue to be considered: the nature of psychiatric disorder in the community. Recent studies show high rates of depression in the community, but it has been debated whether this is equivalent in quality to psychiatric illness, or

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

whether it represents milder distress (Brown & Harris, 1978; Bebbington *et al,* 1981b). Available evidence suggests that the majority of community cases with psychiatric disorder consult their GP, although many are not recognised then (Goldberg & Huxley, 1980). Therefore, it is legitimate to make some inferences regarding the quality of disorder in the community from that presenting to the GP, particularly if patients not recognised by the GP are also included.

The main objectives of this study were to determine the clinical and diagnostic characteristics of depressives in GP, the difference between those treated with antidepressants and those treated by other means, the frequency and characteristics of depression missed by GPs, and the outcome on follow-up. This paper will report overall methods and findings about the proportion of patients who fit rigorous diagnostic and epidemiological criteria, especially those for clinical depression. A companion paper (Sireling *et al,* 1985) deals with more detailed symptom and history measures on treated depressives, as well as comparisons with psychiatric out-patients. Subsequent papers will report detailed characteristics of missed depressives and outcome on follow-up.

Method

General practitioners

GPs in South-West London and adjacent Surrey were circulated, and 62 agreed to participate, of whom 36 provided at least one patient. They ranged from vocational trainees to experienced doctors approaching retirement, and came from 31 practices, all urban or suburban but varying from single handed shop-front surgeries to large new purpose-built Health Centres, from predominantly working class to middle class districts, and geographically from Battersea to Epsom.

Subjects and sampling

The design and sampling procedures are summarised in Figure 1. Subjects were aged 18 to 64, and were consulting their GPs about themselves or a child. Patients under the care of the psychiatric services in the previous three months or referred as a result of the index consultation were excluded, as were those who had received a prescription for antidepressant drugs in the previous three months and those unable to converse in English. During the study period, the GPs were asked to notify all patients sufficiently depressed to need treatment; they were given a reminder card to keep in their consulting rooms, and each was telephoned twice a week to facilitate notification of details. In addition, at selected consultation sessions, a screening process was applied to find missed depressives. Three samples were thus obtained:

1. Antidepressant. Patients identified as depressed by the GP and started on a new course of a drug from the antidepressant section of the British National Formulary. This includes tricyclics and related drugs, monoamine oxidase inhibitors, tryptophan, and flupenthixol.

2. Other treatment. Patients identified by the GP and offered treatment for depression other than an antidepressant. This might comprise tranquillisers or other medication, social treatment such as a referral to a social worker, or surveillance with a definite further appointment rather than merely an instruction to reattend if symptoms did not improve. This treatment did not necessarily comprise a new course.

3. Missed major depression. Patients with probable or definite major depressive disorder on the Research Diagnostic Criteria, RDC, (Spitzer *et al,* 1978) who were detected by screening but not identified as depressed by their GP. These patients were detected by a two-stage screening technique, applied to selected consultation sessions which included at least one morning and one evening session for each GP, and covered all working days. All age-eligible surgery attenders were asked to complete the 30-item General Health Questionnaire, GHQ, (Goldberg, 1972), before seeing their doctor.

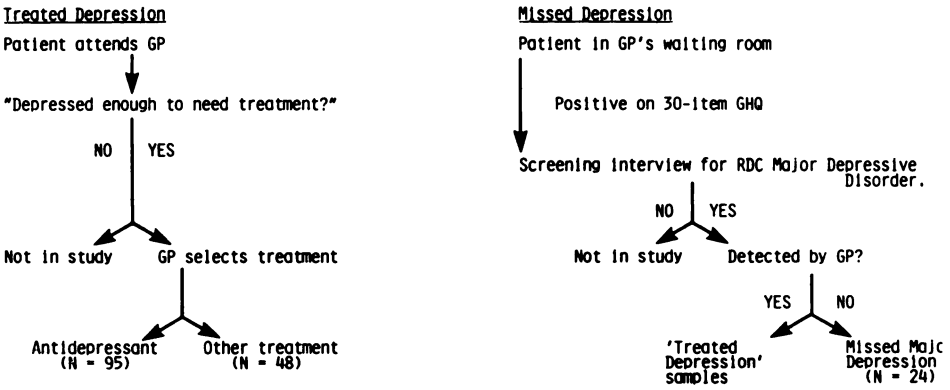


FIG. 1 Study design.

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

Patients scoring 5 or above were interviewed at home within one week by the research psychiatrist (LIS). A brief screening interview based on the Schedule for Affective Disorders and Schizophrenia, (SADS), (Endicott & Spitzer, 1978) was used, and patients with RDC major depressive disorder were studied further.

Over the 14 months of the study a total of 167 subjects were included, comprising 95 receiving antidepressants, 48 receiving other treatment, and 24 missed major depressives. The missed depressives were found during 182 consultation sessions from 1099 completed GHQs; 29 surgery attenders were unable to complete the GHQ and 113 refused. The completion rate was thus 89%. Two-hundred and sixty-four (24%) scored above the cut-off point, of whom 90 refused interview; among the 174 interviewed, 24 were found to have RDC major depression. An additional 17 GHQ-positive patients had been identified by GPs and given antidepressants or other treatment.

Interview data

All patients were interviewed by the research psychiatrist in their homes (unless they requested otherwise) within a week, or more usually three days, of consulting the GP. No information was provided to the GPs about the patients. The main interview instrument was a combined clinical interview, constructed to incorporate: (i) PSE; (ii) RDC; (iii) Hamilton Rating Scale for Depression (Hamilton, 1967); (iv) Clinical Interview for Depression (Paykel *et al,* 1970; Paykel, in press); (v) Newcastle Diagnostic Index (Carney *et al,* 1965); (vi) Raskin Three Area Depression Scale (Raskin *et al,* 1970).

The combined clinical interview was designed so that the PSE questions could act as stem questions. Where these could not elicit enough information to rate the other instruments on that symptom, further questions (based on the SADS in the case of RDC symptoms) were inserted. Symptoms were rated over the month before interview for the PSE and over the current episode for the RDC, except where criteria for the latter required lifetime rating. The interview also gathered information on demographic characteristics; history of present illness; previous, family, social, and personal histories; and current problems indicating social stress. Most of these clinical data are presented in Sireling *et al* (1985).

Epidemiological and diagnostic measures

Research Diagnostic Criteria. Subjects were assigned on this set of operationally defined psychiatric diagnoses. The RDC diagnosis of major depressive disorder requires at least two weeks of depressed mood, loss of interest or pleasure, with at least five out of a possible eight concomitant symptoms involving appetite, sleep, energy, activity, interests, concentration, guilt, and suicidal thoughts or activity. The subject must have sought or been referred for help, taken medication, or been socially impaired. The diagnosis is excluded by certain symptoms of schizophrenia. A probable rather than definite diagnosis is made if the symptoms have lasted only one week, or if only four of the eight concomitant symptoms are present. Other depressive diagnoses are milder and include minor depression, intermittent depression (chronic mild depression), and cyclothymic and labile personality. Anxiety diagnoses are generalised anxiety disorder, phobic disorder and panic disorder. The RDC have been applied to community samples (Weissman & Myers, 1978, Dean *et al,* 1983) and to an American primary care sample (Hoeper *et al,* 1979).

Index of definition (ID) and CATEGO. Scores were assigned on the PSE Index of Definition (Wing, 1976; Wing *et al,* 1978)—a measure of the degree of certainty that the subject is a psychiatric 'case', ranging from level 1 where no symptoms are present, through the threshold level (ID5) to the levels of definite cases (ID6–8). Patients at or above the threshold level were allocated by the CATEGO computer programme (Wing *et al,* 1974) to diagnostic classes.

Bedford College Criteria. Brown & Harris (1978) used PSE ratings to decide whether subjects fitted their criteria for a case or borderline case of depression, anxiety, or both. The method depended on consensus judgements, but Finlay-Jones *et al* (1980) described a clinical checklist set of criteria, also based on PSE ratings, which could be used for assignment of caseness and was employed by Dean *et al* (1983) in an Edinburgh community survey. In the present study, it was used for computerised assignment.

Data analyses.

Data were recorded on precoded forms and analysed using the Statistical Package for the Social Sciences (Nie *et al,* 1975) at the University of London Computer Centre. Significance of differences between groups was tested by chi-square for qualitative variables and by analysis of variance for continuous variables. The MRC Social Psychiatry Unit computed the ID scores and CATEGO classification.

Results

Demographic characteristics

Demographic characteristics are shown in Table I. There were no significant differences at the 5% level between the three groups. Mean ages were approximately 36 years, and a high proportion of the subjects were women. Social class distributions reflect the nature of the practices studied. There was a non-significant trend for more married subjects among the missed major depressives.

Research Diagnostic Criteria

RDC diagnoses are not mutually exclusive; some multiple diagnoses are permitted, although mixed anxiety and depression is more likely to be regarded as depression. Therefore, the diagnoses were arranged hierarchically for analysis, with major depressive disorder given preference over any other disorder. Next ranked were other depressive disorders, including minor or intermittent depression and affective personality disorders. Among those not receiving these diagnoses, anxiety disorders (generalised anxiety, phobic, or panic disorder) were given precedence over other diagnoses.

Findings for this hierarchy are shown in Table II.

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

TABLE I
Demographic characteristics

		Anti-depressant (n = 95)		*Other treatment (n = 48)*		*Missed major (n = 24)*		*Significance of difference*[1]
		n	%	*n*	%	*n*	%	
Age (years)	18–34	51	54	24	50	11	46	NS
	35–54	36	38	17	35	12	50	
	55–64	8	8	7	15	1	4	
Mean age		35.5		37.2		36.4		NS[2]
Sex	Male	14	15	10	21	4	17	NS
	Female	81	85	38	79	20	83	
Social class (Registrar General's Classification)	I + II	34	36	13	27	6	25	
	III	49	52	26	54	13	54	NS
	IV + V	12	13	9	19	5	21	
Marital status	Single	22	23	12	25	2	8	
	Married	53	56	25	52	18	75	
	Widowed, divorced or separated	20	21	11	23	4	17	NS

[1] By χ^2
[2] Analysis of variance

TABLE II
Research Diagnostic Criteria diagnoses[1]

	A (n = 95)		*B (n = 48)*		*C (n = 24)*	
	n	%	*n*	%	*n*	%
Major depressive disorder	53	56	9	19	24	100
Other depressive disorders[2]	22	23	15	31	—	—
Anxiety disorders[3]	6	6	10	21	—	—
Other diagnoses	10	11	10	21	—	—
Currently not mentally ill	4	4	4	8	—	—

For antidepressant *vs* other treatment, $\chi^2 = 20.29$, 4 df, $P < .001$
[1] In hierarchical grouping (see text). [2] Minor and intermittent depressive disorders, cyclothymic and labile personality disorders. [3] Generalised anxiety disorder, phobic disorder, panic disorder.
A = Antidepressant. B = Other treatment. C = Missed major.

Missed depressives were omitted from significance testing because, by definition, all of them fitted the criteria for major depression. The proportions with major depression were considerably different between the other two groups ($P < .001$). Among the antidepressant-treated sample, more than half were major depressives and a quarter received other less severe depressive diagnoses. This contrasted with the other treatment sample, among whom only a fifth were major depressives and a third had lesser depressive disorders. Altogether, four-fifths of the antidepressant sample received a depressive diagnosis, in contrast to one-half of the other treatment sample.

Some additional data (not shown in the table) are relevant: three of the antidepressant sample and one of the missed major depressives had a bipolar disorder. Among the antidepressant sample, a third of the major depressives received only a probable diagnosis, compared with two-thirds of the major depressives in the other treatment sample and half of the missed major depressives. This reinforces the impression of milder disorder in the other treatment sample. Twenty-nine of the 37 patients with depressive disorders other than major depression had minor depression, and the rest intermittent depression. Of the anxiety diagnoses, half were generalised anxiety, one-quarter phobic, and one-quarter panic disorders. Most of the other RD2 diagnoses comprised a miscellaneous category of 'other psychiatric disorder' not classifiable on the RDC system. In addition three schizophrenics, one alcoholic and one patient with drug abuse were identified.

Index of definition

In all three groups, the majority of patients were at or above the threshold level for a psychiatric case on the ID (Table III), but there were significant differences between the three groups. Only one patient (4%) of the missed major depressives failed to reach threshold level, compared to 18% of the antidepressant and 29% of the other treatment samples. Among those qualifying as cases, the majority in all samples were in the relatively mild range, with approximately half at threshold level and the remainder mainly at level 6. The other treatment sample scored lowest on the ID, with a greater proportion of non-cases and cases at lower levels.

CATEGO classes

CATEGO classes were allocated only to ID cases (ID5–8). Differences between groups in the pattern of classes were tested for significance, with non-cases excluded, and reached the 1% level. The most common class was neurotic depression (N+), accounting for about half the cases in the antidepressant and missed major depressive groups and a third in the other treatment group (Table IV). The next most common class was retarded depression

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

TABLE III

PSE index of definition

	A (n = 95)		B (n = 48)		C (n = 24)	
	n	%	n	%	n	%
Definite disorders						
8	1		0		0	
7	12	43	3	35	3	54
6	28		14		10	
Threshold cases						
5	37	39	17	35	10	42
Non-cases						
4 (specific symptoms)	12		12		1	
3 (non-specific	3	18	1	29	0	4
2 symptoms)	1		1		0	
1 (no symptoms)	1		0		0	

A = Antidepressant. B = Other treatment. C = Missed major.
For levels 5–8 *vs* 1–4 $\chi^2 = 6.68$, df = 2, $P < .05$

TABLE IV

CATEGO classes for cases at or above Index of Definition level 5

	A (n = 95)		B (n = 48)		C (n = 24)	
	n	%	n	%	n	%
Class						
Neurotic depression (N+)	43	45	13	27	10	42
Retarded depression (R+)[1]	25	26	6	13	10	42
Anxiety states (A+)	7	7	8	17	2	8
Other diagnoses	3	3	7	15	1	4
Non-cases (ID below 5)	17	18	14	29	1	4

[1] Includes one patient in antidepressant sample with psychotic depression (D+). Excluding non-cases, $\chi^2 = 17.69$, 6df, $P < .01$.
A = Antidepressant. B = Other treatment. C = Missed major.

(R+). Only one patient, in the antidepressant group, was a psychotic depressive (D+). Altogether, a CATEGO depression class was assigned to 87% of antidepressant treated cases, 56% of other treatment cases, and 87% of missed depressive cases (72%, 40% and 83% respectively of all patients in each sample). Patients in the other treatment sample were more likely to be assigned an anxiety class than those in the other two samples.

Bedford College Criteria

The BCC assign separately as cases, borderline cases, and non-cases of depression and anxiety, with all possible combinations permitted. Cases predominated in all samples with a minority of borderline cases and few non-cases (Table V). The other treatment sample showed the lowest proportion of definite cases (56%) and the highest proportion of non-cases (17%). Most of the antidepressant-treated sample were cases, and the remainder borderline cases, while the missed major depressives were almost all cases; differences just failed to reach significance ($P = .06$). Diagnostically, the cases and borderlines were either pure depression or, more often, depression with anxiety, with few showing pure anxiety.

TABLE V

Bedford College criteria

	A (n = 95)		B (n = 48)		C (n = 24)	
Cases						
Case depression	20		10		7	
Case depression and borderline anxiety	28		10		9	
Case depression and case anxiety	13	67%	1	56%	4	83%
Case anxiety and borderline depression	2		2		0	
Case anxiety	1		4		0	
Borderline cases						
Borderline depression	11		6		2	
Borderline depression and borderline anxiety	7	27%	3	27%	0	13%
Borderline anxiety	8		4		1	
Non-cases	5	5%	8	17%	1	4%

For cases vs borderline cases vs non-cases, $\chi^2 = 9.12$, 4df, NS ($P < .06$)
A = Antidepressant. B = Other treatment. C = Missed major.

Discussion

The study applied structured criteria to three separately defined samples of GP depressives; the majority satisfied criteria for psychiatric disorder on the RDC, ID, and BCC. However, the disorder is predominantly mild, with most cases at or just above the threshold level on the ID, and many mild or borderline diagnoses on the other systems. Diagnostically, cases are nor pure, with many of those given other treatments receiving a non-depressive RDC diagnosis. This group is also the most mildly ill.

Sampling

The study differed from previous studies of GP depression in obtaining representative samples of three defined groups. Previous studies have relied on identification by the GP, usually without explicit guidelines. Most such patients have been treated with antidepressants (Johnson, 1973), since GPs tend to attach a diagnostic label to justify a treatment decision (Howie, 1972).

Both the additional samples are important. Given varying treatment practices amongst GPs and criticism of their use of benzodiazepines (Tyrer, 1978), patients who were given other treatment obviously required study. They were least depressed, with more non-cases, more diagnoses of mild forms of depression, and of other disorders. Since the missed depressives were selected on stringent criteria, it is not surprising that they met other criteria for a case of depression. Their specific features are examined in a separate paper (Freeling *et al*, in press).

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

The two samples of treated depressives depended on GP identification and notification, which in spite of continuous reminders may have been incomplete. However, during the GHQ screening, notification of treated depression was reliably obtained by interviewing the GP after each session, though some GHQ positives refused interview, and we did not interview patients scoring below 5. No missed major depressive scored below 10. In other studies, all RDC major depressives (Hoeper *et al,* 1979), and all BCC cases of depression in general practice (Finlay-Jones & Murphy, 1979) have been found to be GHQ cases.

During 182 GP sessions which were screened, eight antidepressant and nine other treatment cases were notified, while 24 missed major depressives were detected. This would suggest that at a rate of 40 surgery sessions per month, the average GP initiates two antidepressant courses, gives two patients other treatment for depression, and fails to identify at least five major depressives as in need of treatment. Unlike antidepressant treatment, other treatment was not necessarily a new course. These rates are comparable to the figure of 3.7 new episodes of treated depression per GP per month, found in the West of Scotland (Watson & Barber, 1981). Other studies have found that GPs fail to detect about one-third of presenting psychiatric illness (Goldberg & Blackwell, 1970; Zintl-Wiegand & Cooper, 1979). Brown & Harris (1978) found that of definite cases consulting their GP, one-fifth were untreated, and almost all the rest received psychotropic drugs. In the present study, major depression was more often unrecognised than recognised.

Demographically, all three groups were closely similar, suggesting that such factors do not select for recognition or prescribing. The picture of patients who are predominantly female, under 40, and married is very similar to that of milder out-patient neurotic depressives (Parker & Blignault, 1983) and of depressives identified in community samples (Bebbington *et al,* 1981a). It has also been found in GP (Porter, 1970), but not consistently (Skegg *et al,* 1977; Clare, 1981).

Psychiatric caseness and community disorder

One of our aims was to explore the nature of psychiatric disorder in the community—if a high proportion of the population shows symptoms, do these indicate illness? Brown & Harris (1978) reported 17% cases among Camberwell women, while Bebbington *et al* (1981a) argued that these tended to be transient stress disorders rather than clinical illnesses. Because prevalence levels depend on criteria for disorder, Dean *et al* (1983) applied multiple criteria to women in a community survey, and found case rates of psychiatric disorder highest in the BCC system and lowest on ID CATEGO, with RDC intermediate. For depression, the pattern was different, with RDC highest, BCC lowest, and ID CATEGO intermediate.

In the present study, the antidepressant and other treatment samples permit some comparison of the selectivity of the different criteria. All three systems behaved similarly, identifying most subjects as cases and more of those receiving other treatment as non-cases. The highest proportion of cases was on the RDC and the lowest on ID CATEGO, with the BCC intermediate (but rigorous, if borderline cases are excluded). In Brown's studies, caseness has usually been determined by consensus judgements rather than by the computerised formal criteria used in our study and by Dean *et al* (1983). It is still possible that these formal criteria might operate more rigorously.

The majority of GP depressives in all three samples satisfied psychiatric criteria, supporting similar claims for depression in the community, but the cases were mostly mild. This can be seen clearly by comparing a series of psychiatric patients reported by Wing (1976). We found 18% of the antidepressant sample and 29% of those receiving other treatment to be ID non-cases, a little more than Wing's figure of 17% for out-patients, but very different from his 1% for in-patients. About 40% of GP depressives scored at the threshold level of ID5, and most of the remaining cases ID6. Only 20% of out-patients and 11% of in-patients scored at the threshold level, 20% of out-patients and 59% of in-patients scoring 7 or 8.

Diagnoses

Although virtually all the missed major depressives were given depressive diagnoses on all three systems, as might be expected from their selection criteria, the other two samples were diagnostically diverse. On the RDC, about 20% of the antidepressant sample and 40% of the other treatment sample had non-depressive diagnoses, most commonly anxiety. Even in the antidepressant sample, there was a moderate proportion of minor depressive diagnoses, distinguished from major depression by lower severity and fewer concomitant symptoms. This was the most common diagnosis in depressives receiving other treatment, whereas most drug-treated out-patient depressives had RDC major depression (Sireling *et al,* 1985). On CATEGO, the largest group was neurotic depressives; psychotic depressives were virtually absent, although about

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press

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.

Acknowledgements

This study was supported by a grant from the Medical Research Council. We also wish to thank Dr N. Kreitman, for an early copy of the combined PSE and RDC used in his studies, and Professor J. K. Wing for assignment on the ID and CATEGO, Dr and Mrs R. Burton, Mrs C. Taylor, Dr P. Hughes, and all the general practitioners who participated.

British Journal of Psychiatry (1985), **147**, 119–126

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

L. I. SIRELING, P. FREELING, E. S. PAYKEL and B. M. RAO

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)

https://doi.org/10.1192/bjp.147.2.113 Published online by Cambridge University Press