1949 was, however, of only slight degree. By and large, therefore, it would appear that there was not a great difference between the dental condition of these two groups of children examined at an interval of two years, though there was perhaps a little more caries in the 1951 group and rather less hypoplasia. Moreover, for each type of tooth there was a somewhat greater amount of caries associated with each grade of M-hypoplasia in this group, although within each of the groups the usual structure-carries relationship held—that is, the worse the structure the greater the liability to caries.

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THE DIAGNOSIS OF DEPRESSION*

BY

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The most characteristic feature of depression as a psychiatric symptom is the feeling tone of sadness, which may be of any degree, from a thin veil spreading over all the patient thinks and does to a despair without hope which overwhelms his mental life. With it goes an insufficiency and inadequacy, subjectively felt and objectively observed, from which the patient's typical complaints spring: whatever he experiences seems sad and painful. Even ordinarily enjoyable events have this effect; they make the patient more aware of his incapacity for normal appreciation, or else he shows his ingenuity for seeing the bad side of everything. He feels at home only in unhappiness. His whole life is miserable and agonizing.

Early Signs

If the physician is acquainted with the patient he can easily diagnose the beginning of a depression from the change in general appearance. The patient has a look of fatigue and self-concern, his posture, movement, and facial expression reflect his sadness of mood. Retardation, which is usually present from the start, reduces the normal freshness and freedom of expression and gesture. Observant relatives and friends may have noticed the change but mistaken it for fatigue through overwork or for bodily illness. If the latter has been excluded, the physician should always consider the diagnosis of depression, especially in middle-aged and elderly patients. If he only thinks of it half the battle is already won. The depth of the depressive affect cannot easily be measured from its outward expression, and in some cases a feeling of indifference may prevail and mask the underlying depression. The silent shedding of tears may be seen in an otherwise expressionless face; other

patients mock themselves and their illness with grim humour and call themselves frauds or fools; a sudden smile or expression of cheerfulness will deceive the practitioner about the severity of the suppressed emotion.

Nowadays it is not rare for the patient himself to complain of depression; but equally often the complaint is of sudden and complete loss of interest and enjoyment in his usual work and play; of an uncomfortable realization of slowing of thought and action; of difficulty with customarily easy mental activities; of inability to reach any decision, even in trifling matters; of "loss of will power"; or of a feeling of incapacity, perhaps abolished only by increasing quantities of alcohol, coffee, or amphetamines. Bodily symptoms may be to the fore—for example, a general feeling of languor, of a band around the head or pressure on the chest, of heaviness of all limbs, of disturbed sleep, loss of appetite, and constipation. Based on these and other unpleasant physical sensations, the patient may develop exaggerated hypochondriasis, remaining querulously convinced of his constipation or insomnia even after it has been adequately treated and the symptom removed, or making some other physical symptom the subject of fresh complaints. A frequent complaint is that of pain in the face or at some other part of the body, or of "general" pain. There has probably in the early stages of the depression been some coincidental physical cause of the pain, which later has become the focus of expression for the patient's gloominess and remains his primary symptom. His "persistent petulant querulousness . . . distract(s) attention from underlying depressive symptoms which are usually regarded by the patient as secondary" (Partridge, 1954). No wonder that the patient is unable to solve the problem of cause and effect, which we ourselves are often at a loss to disentangle. Hypochondriacs may refer also to psychological symptoms, such as fears and anxieties, especially the fear of insanity; such symptoms, and also self-reproach and delusional ideas of guilt, may in certain patients constitute the only complaint.

When anxiety is part of the mood or is in the foreground, as it often is, especially in the middle-aged patient, retardation may be absent, and this can make diagnosis more difficult. But anxiety attacks or states of more or less persistent fear, arising without clear motivation in the higher age group, are always suspect of being the manifestation of an endogenous depression. If the anxiety is accompanied by cardiac and other vascular symptoms the diagnosis may be made more difficult; but the existence of a neurotic reaction in middle life should always be doubted if there is no history of a similar tendency to anxiety and to reactive somatic response earlier in life.

Aetiology

When discussing depression as a symptom, as I have done so far, we reluctantly come to a point where aetiology has to be taken account of. Hence the use of the terms "endogenous" and "reactive" in the preceding paragraph. Depression may be a symptom of an affective psychosis belonging to a mainly constitutionally determined group of mental disorders, also called "cyclothymia." Or it may be reactive—that is, an exaggerated response to an extraordinary stress in life, such as severe air attacks or battle exhaustion in war, or the loss of a beloved relative or of work or promotion in peacetime. If one holds the view, as many psychiatrists do, that there is no difference in kind but only one of degree between neurotic reactions, including reactive depression and affective disorders, one will not be in the least surprised when a case labelled neurasthenia develops into a severe agitated depression or into a depressive stupor. If, however, as I think, a real distinction exists demanding different practical measures in each of the two alternatives, the differential diagnosis must be made with great care.

In milder cases of each kind, features of the original personality and the psychic content supplied by recent or remote emotional experiences make up so much of the

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clinical picture that the primary lowering of mood is often missed until prolonged observation has made it unmistakable. One has to beware not to accept unreservedly the patient's explanations—that, for instance, his “nervous breakdown” is due to his failure in business or to a disappointment in love—when the sequence of events was really the reverse. There can be no exact measurement of the relative contribution of external and of constitutional factors to the development of a state of depression; nevertheless it is important from both the prognostic and the therapeutic points of view to differentiate between, for example, a constitutional recurrent depressive illness, a hysterical type of personality suffering from a largely psychogenic depression, and a comparatively normal well-balanced type of personality in a state of depression reactive to particular external circumstances.

Differentiation between Endogenous and Reactive Depression

This differentiation is important and topical because cases of reactive depression have of late become more frequent in the psychiatrist's consulting-room than they were twenty years ago. This may be due to the fact that their psychological nature is recognized at an earlier stage, and they are sent to the specialist before more severe neurotic symptoms have appeared. But neurotic symptoms have always been influenced by the fashion of medicine and the spirit of the times; these seem to favour depression at the moment. A history of repeated attacks of depression may be misleading, because the personality predisposed to this type of psychoneurotic reaction may show it whenever he is in difficulties. “If family history, constitutional make-up, and the objective data of the patient's life are fully known and collated with the clinical picture, a decision can be reached in most cases, provided these factors are not merely enumerated but weighed with judgment and insight, and the observer does not lose his way in a thicket of unimportant details” (Mayer-Gross, Slater, and Roth, 1954).

The reactive depressive has had all his depressions in response to the stress of circumstance; a purely endogenous mood change is unknown to him. The endogenous cyclothymic, on the other hand, will know at once what the physician means when he inquires about endogenous mood changes; daily fluctuation in mood will also be familiar to him. The morning gloom which lifts more and more during the day and has almost cleared towards the evening is a very characteristic sign of cyclothymia. The depressive mood of the reactive patient is much more responsive to the immediate environment than an endogenous depression, and will generally be alleviated for a few hours by such things as the society of cheerful friends. The reactive depressive “snaps out of it when the telephone rings or there is talk of going to a party” (Partridge, 1954). The cyclothymic depression is persistent and seems never to lift. Retardation is most unusual in reactive states; and insomnia, when it occurs, is mainly a difficulty in dropping off to sleep and not, as is generally the case in endogenous depressions, a tendency to wake in the early hours.

The judgment is often based on clinical intuition only. It must, however, be made; for if there are important precipitating environmental circumstances they may have to be dealt with, and the neurotic personality may in given circumstances respond well to psychotherapy, whereas the endogenous depression will remain uninfluenced until convulsion treatment is applied, or natural remission sets in with the passage of time. As to other problems of differential diagnosis, epileptic mood swings may simulate endogenous depressive episodes; the history of epileptic attacks and the E.E.G. should remove doubts. From schizophrenia the differentiation is often difficult. The schizophrenic may complain of increasing shallowness of affect, of a feeling of loss of sympathy, and of depression of spirits, using words and phrases very similar to those used by the depressive; but the setting is different. The schizophrenic lacks the warmth and natural expression of the depressive. The

same similarity of symptoms and difference are seen in the schizophrenic's complaint of loss of energy and will-power, which may closely resemble the subjective experience of retardation.

It is of great practical importance, because of their remarkable response to physical treatments, to recognize endogenous depressions beneath the disguises they so often assume. The symptoms may take the form of physical symptoms; and clinical acumen in the differential diagnosis between a depressive and some form of physical illness may be necessary. Ziegler (1939) collected 111 cases of depression “who first came to a surgeon's or internist's office for the relief of bodily ailments” and gave a brief report of how they were grossly and universally misunderstood. The exclusion of physical illness must rest on negative findings in the physical examination. Unfortunately, general medicine is not always able to provide a clear negative answer in cases of dyspepsia, cardiovascular disturbances, or similar “functional” complaints of a mild type. Bleuler (1943), dealing with the problem of depression in general practice, insists that these physical complaints represent the “autonomic expression of the depression itself.” However that may be, if they occur periodically and have an effect on the patient's well-being, exceeding by far the objective findings, affective disorder should be suspected as the underlying cause of the physical disability and psychiatric treatment instituted.

Symptoms of the Digestive System

These sometimes precede the psychological signs of depression, and are of special interest. Anorexia is but one aspect of the inertia of the whole digestive and metabolic system. Food may be resolutely refused for this reason, but other motives, such as desire for death and belief in an utter unworthiness, even of being fed and supported by others, not infrequently play a part. Constipation is very common, sometimes fairly severe, and is of great moment to the patients—so much so that slight constitutional depressives are sometimes treated for years for “nervous dyspepsia.” Loss of weight may occur very early and may be out of proportion to the diminished intake of food. Menstruation may diminish, and not infrequently ceases during a depressive phase: sexual desire and potency are reduced. The general appearance indicates a lowering of all bodily activities. The skin is dry, the vasomotor responses are sluggish, and the patient looks years older than he does when in health.

Hysteria

Equally frequent is the discovery of an endogenous depression under the guise of a more florid neurotic picture, especially of hysteria. Demonstrative displays of mental distress, exaggerated histrionic complaints of the most improbable nature, with outbursts of threatened suicide, demands for pity and compassion, acting-out of scenes of desperation in the presence of relations and friends, may be the positive clinical picture behind which one would scarcely suspect a depressive illness. Nevertheless, in quieter moments, the completely changed temperamental colour and its reduced animation and negative attitude to life become visible and reveal the diagnosis. And, what is more remarkable, the application of E.C.T., otherwise entirely ineffective in hysteria proper, leads to full success. The opposite source of diagnostic error is much less common, organic cerebral illness presenting as depression. It has recently been exemplified by Smith (1954), who also discussed its mechanism in detail.

Depression of Old Age

Only recently, mainly through the work of Roth and Morrissey (1952), has this group of depressive illnesses been paid the attention it deserves.

The problem here is to differentiate between endogenous depressive illness and depressive symptoms occurring in the

setting of cerebral disease. As so frequently happens in diagnostic problems, a reliable history of the patient almost decides the issue. In a true depression the history will reveal that until recently the patient was going about his life in a normal way, showing no intellectual impairment of memory, or of grasp, or initiative, until the fairly rapid onset of a depressive mood and gloomy outlook. When such a history is obtained one is very unlikely to be dealing with a senile dementia or other organic disorder. Even though the patient's appearance may be more apathetic than depressed, and the depressive ideas are stereotyped and grotesque, the correct diagnosis is probably endogenous depression. Cases with clouding of consciousness may present difficulties. Here again the development of the condition is the best guide; if it is of recent onset and has evolved with rapidity, some degree of clouding is quite consistent with affective disorder, provided there is nothing to suggest a cerebrovascular lesion. In the case of an organic disorder the history will reveal a slow, insidious onset of negative symptoms such as impairment of memory, disorientation, blunting of emotion, and deterioration of habits; such symptoms have been noticeable in the usual case for many months before he comes under observation. In most cases of organic disorder, moreover, the depressive symptoms are ill-sustained, shallow, and fragmentary.

That this distinction is not only of theoretical interest but has its basis in the natural history of the illness is shown by the results of Roth's follow-up of patients over 60 years admitted to a mental hospital because of apparently senile psychoses: within six months of admission more than 60% of cases with affective psychosis were discharged; of the truly senile psychotics, almost 60% were dead: the proportion of patients still in hospital was 27% and 33% respectively. Before the introduction of physical treatments over half the patients with affective disorder were still in hospital six months after admission and only about a third were discharged, but the pattern of outcome was even then very different from that of the two main organic disorders of old age—senile and arteriosclerotic psychosis. When the patients were followed up two years after admission the patterns of outcome remained distinct; the "peak" is seen in the same column as at six months for each group. In the case of affective disorder, discharges reach about 65%, while in senile psychosis, by this time, over 80% of the patients have died.

These findings have recently been confirmed by a follow-up study of similar material, aged 65 and over, at the Crichton Royal: 45 out of 64 patients diagnosed as cases of senile or arteriosclerotic dementia had died after two years, only two patients lived at home, as invalids, while 17 out of 33 depressives were at home and socially recovered (O'Connell, 1954).

To sum up: with the increase of life-span in the general population, not only the probability of degenerative cerebral changes has increased, but also the prevalence of depression for which we fortunately have some effective remedy.

Summary

Depression as a psychiatric symptom is probably the most common complaint of psychiatric patients to-day. During the last twenty years it has become more frequent as the presenting symptom of neurosis, and this has aggravated the diagnostic problem.

For rational therapy the reactive, neurotic form of depression has to be differentiated from the endogenous depression with little or no environmental aetiology. Physical treatment methods, especially convulsive therapy, can rapidly relieve depression in many patients. This treatment has to be based on an aetiological diagnosis and combined with other measures adapted to the special circumstances of the case.

Many patients suffering from periodic indigestion, "bilious attacks," and other intestinal complaints are,

in fact, suffering from recurrent depression, as are some cases diagnosed as "hysteria." Finally, the differential diagnosis of depression in the elderly from senile dementia and arteriosclerosis is of great value in the treatment and disposal of geriatric patients.

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PROGNOSIS OF DEPRESSION WITH ELECTRICAL TREATMENT

BY

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A factual study has been made of the effects of electrical treatment on 338 cases of depression, in the hope of being able to answer more precisely the sort of questions that are legitimately asked by patients, their relatives, and doctors about (1) the probable length of stay in hospital, (2) the number of treatments likely to be necessary, (3) the chances of recovery, and (4) the likelihood of recurrence. This has necessarily involved secondary considerations of the different response to treatment and therefore different prognosis of various types of depressive illness.

The 338 cases were given electrical treatment for depression in the wards of the psychiatric unit attached to St. George's Hospital. Thirty-one of these showed schizophrenic or paranoid features or a history of previous manic or hypomanic attacks in addition to the depressive illness itself. It is with the remaining 307 that this paper is primarily concerned. None of these patients was certified, though some were certifiable, and it must be accepted that the conditions treated in this unit are probably less severe than many that are seen in mental hospitals. Owing to the fact that up to two years ago there were few beds available for men, there were more female cases than male. Of the 307 patients, 219 were women and 88 were men. Out-patient electrical treatment was available, but the clinical condition in each case was severe enough to warrant admission.

It should be noted that the patients did not receive electrical treatment alone. In all cases, psychotherapy, sedation, and an occupational programme were given according to their needs; nor were the social problems arising directly or indirectly from these illnesses disregarded. In particular, the help of the nursing staff was invaluable. These factors were invariably present, however, and do not invalidate the results from electrical treatment itself.

Diagnosis

The diagnosis and assessment of prognosis of these patients were not made by any one psychiatrist, but there is an approximate conformity as all cases are discussed among the three consultants and registrars on the staff of this unit. The diagnostic groupings are those commonly used in psychiatry. These, and indeed all other diagnostic terms, have been criticized by different writers—for example, Lewis (1934)