remark on strange chewing movements without convulsions, another may have observed the climax of an occasional grand mal seizure, while the patient's family may seem more concerned about his behavioural disorder, regarding the fits as a doubtfully related condition which, anyway, to their eyes has been "improving" because the actual fits are now less severe and less frequent than formerly. It requires an understanding observer to synthesize all these features into one connected clinical story.

I cannot survey here all the evidence which would relate these various manifestations to the temporal lobe. Some may argue that epilepsy arising in other parts of the brain may show similar characteristics. However, of all the patients with the amnesic aconvulsive type of seizure who have been operated on for various lesions in this unit during the past three years (approximately 50 patients) only one, a patient with a unilateral suprasellar meningioma, had an obvious lesion which was not directly involving the temporal lobe, and even this lesion was in close proximity to the temporal lobe. Even the E.E.G. localization is not a hard-and-fast criterion of distinction, for in several instances in which an inferior frontal focus was reported the actual lesion was yet found to be involving the temporal lobe. For those who would seek further I have indicated references to some of the more important articles in the literature.

It will be noted from the cases described that temporal lobe epilepsy can affect patients at all ages and can be caused by a great variety of lesions. Some of these lesions, such as tumours, cysts, vascular malformations, and porencephaly, can be appreciated by the naked eye, and can also often be demonstrated pre-operatively by neurological and radiological means. Others, such as areas of focal atrophy and gliosis, may be appreciated only by microscopical examination. The occurrence of epilepsy, therefore, is not determined by the nature of the lesion so much as by its site. Therefore in any patient in whom the clinical features suggest a temporal lobe origin but in whom the neurological and radiological investigations are negative, the diagnosis made should not be idiopathic epilepsy (with the feeling of hopelessness which this term engenders), but temporal lobe epilepsy secondary to some pathological change as yet undetermined.

It is not my purpose to discuss the details of pathological diagnosis and treatment in such patients. Temporal lobe epilepsy is so common and yet so often benign that it is impracticable to submit every suspect to the fullest investigation. The following broad principles, however, should give some guidance:

1. The recent appearance of temporal lobe seizures may signal the presence of a cerebral tumour. This diagnosis becomes obvious if appropriate neurological signs or features of raised intracranial pressure are present. If the suspicion of cerebral tumour arises in any particular patient, neurological investigation supplemented by appropriate radiological studies is indicated.

2. In cases in which the fits are of long standing, and there is nothing obvious in the clinical picture to suggest tumour, an attempt should be made to control the seizures by drugs. Phenobarbitone and phenytoin ("epanutin") have been our chief stand-bys, but the recently introduced drug primidone ("mysoline") has also been claimed to have beneficial properties.

3. In cases in which the fits cannot be properly controlled and are disabling, or in which there is a severe personality disorder, recourse should be made to full neurological, radiological, and E.E.G. investigations. Of the various diagnostic procedures, the E.E.G. in our experience is the one which is most likely to give a decisive answer, but this investigation may have to be repeated over a long period and under special circumstances, such as during induced sleep and with sphenoidal electrodes (Hill, 1953). In a patient with intractable epilepsy the E.E.G. demonstration of an epileptic focus which is confined to one temporal lobe, or if bilateral predominantly on one side, is in our experience an indication for operation.

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DENTAL STRUCTURE AND CARIES IN 5-YEAR-OLD CHILDREN ATTENDING L.C.C. SCHOOLS (1949 AND 1951)

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This paper describes the findings in the sixth of a series of surveys of the dental condition of 5-year-old children attending day schools under the authority of the London County Council, and makes reference to the earlier surveys begun in 1929 by one of us (M. M.). Owing to unforeseen circumstances the publication of the results has been delayed until now. Visits were paid to 26 schools, most of which had been included in the earlier studies. The total number of children examined for dental structure and caries was 1,395, each of whom had achieved his fifth but not his sixth birthday at the time of inspection.

Methods and Criteria

The examination procedure and standards used were essentially the same as those devised on the basis of earlier animal experimental work and clinical investigations and employed in all the surveys undertaken by one of us (M. M.) and her colleagues since 1923. For a detailed description of the methods and criteria see Mellanby and Coumoulos (1946).

In all the work from 1943 onwards the incidence and extent of surface structural defects, as well as caries, have been estimated and analysed for each tooth, since this detailed system gives the best guide to the condition of the teeth of any group of children. By making an assessment for every tooth examined, and, in the case of caries, by including in the assessment any tooth known or assumed to have been extracted because of disease (which, except in 1929, could only have been a very small proportion of the whole), the trend of the abnormalities from survey to survey

can be seen for any type of tooth or for all teeth together in a group of individuals. As mentioned in previous reports, obvious undermining decay was taken into account in judging the size of a cavity. Filled teeth were counted as having been carious, and in allotting them to one of the categories a small allowance was made for removal of extra tooth substance in preparation for the filling. As regards the extent of structural defects and caries, it must once more be emphasized that for the A.H.F. (average hypoplasia figure) and the A.C.F. (average caries figure) the maximum possible value is 3; therefore the greater the number of teeth with severe hypoplasia or caries the nearer the figures approach this number.

It was not thought practicable or necessary in surveys of this kind to make x-ray examinations of the teeth. Had this additional method been used, further instances of early caries would undoubtedly have been found, but since approximately the same proportion would probably have been diagnosed in all the surveys, it would not have affected the relative findings.

FIG. 1.—Relative percentages of the different grades of M-hypoplasia as compared with gross hypoplasia for all types of teeth together in 1943–51.

Results

The detailed findings in the 1951 survey on 1,395 children are given side by side with those obtained in the study made in 1949 on 692 children, since the latter, though published in a summarized form (Mellonby and Mellonby, 1950), have not previously been given in full. Some comparison is also made with the earlier surveys. It is not possible to give detailed figures for 1929, since the analysis of the findings in this survey, which formed part of an investigation

by various workers for the Board of Education (1931), was made only on a "per child" basis and the data are not now available for further resolution. It may be stated at once that the proportion of children classified as caries-free or almost caries-free in 1951 was nearly the same as in 1949—23.5% compared with 24.9%. This is a great improvement on the 1929 figure of 4.7%, but is much below that of 1947, when 37.5% were placed in this category.

Surface Structure

In Table I are shown the percentages of each type of tooth, and of all types combined, graded into various structure categories. The corresponding A.H.F.s are also given. It will be seen that the structure was on the whole better in the latest survey than in the previous one, and that in all but the upper second molars there was a higher percentage of each type free from hypoplasia. In both surveys, as was the case in the earlier studies, it was found that in the lower incisors there were the least surface defects, and in the molars, particularly those of the upper jaw, the most. The upper incisors were much more hypoplastic than the lower ones, and, as might be expected and as is shown later, had a greater tendency to become carious. In neither year was any type of tooth much affected by either severe M-hypoplasia or gross defects, but, comparing the incidence of gross hypoplasia with that of the total incidence of M-hypoplasia, it is seen how vast is the difference—0.7 compared with 67.2% in 1949, and 1.6 compared with 56.1% in 1951.

A very low incidence of gross hypoplasia as compared with that of M-hypoplasia has constantly been found in this series of surveys as well as in other similar studies and, indeed, since the early days of the investigations on human teeth (Mellonby, 1927a). In regard to the five surveys made by one of us (M.M.) from 1943 onwards, this fact is clearly illustrated in Fig. 1, which

FIG. 2.—Average hypoplasia figures for all types of teeth together in 1943–51.

TABLE I.—Structure of the Various Types of Teeth in 1949 and 1951

Type of Tooth	Total No. of Teeth Examined for Structure		Percentage of Teeth Hy ₀		Percentage of Teeth M-Hy ₁		Percentage of Teeth M-Hy ₂		Percentage of Teeth M-Hy ₃		Total Percentage of Teeth M-Hy		Percentage of Teeth with Gross-Hy		A.H.F.*	
	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951
Upper jaw:																
Central incisors	1,230	2,468	36.0	40.5	43.1	41.3	18.1	15.2	0.5	0.1	61.7	56.6	2.3	3.0	0.83	0.74
Lateral incisors	1,308	2,617	34.7	45.7	54.6	43.6	8.5	7.8	0.1	0.0	63.2	51.4	2.1	2.8	0.73	0.61
Canines	1,365	2,758	35.9	50.1	57.9	44.7	5.9	3.8	0.2	0.0	64.0	48.5	0.2	1.3	0.70	0.53
1st molars	1,246	2,577	4.0	7.2	52.2	48.5	41.7	42.6	1.4	0.4	95.3	91.5	0.6	1.3	1.41	1.37
2nd molars	1,307	2,653	1.6	1.6	44.8	35.5	51.1	58.8	2.3	3.2	98.2	97.3	0.2	1.1	1.54	1.64
Total upper jaw	6,456	13,073	22.6	29.1	50.6	42.7	24.8	25.5	0.9	0.8	76.3	69.0	1.1	1.9	1.04	0.98
Lower jaw:																
Central incisors	1,044	2,141	86.6	92.5	12.8	6.9	0.2	0.3	0.0	0.0	13.0	7.2	0.4	0.3	0.13	0.07
Lateral incisors	1,333	2,709	58.3	81.4	41.4	18.0	0.1	0.3	0.0	0.0	41.5	18.3	0.2	0.4	0.42	0.19
Canines	1,372†	2,780	44.1	67.8	52.8	29.2	1.7	1.0	0.0	0.0	54.5	30.2	0.0	2.0	0.57	0.32
1st molars	1,172	2,342	13.1	21.8	49.8	44.9	35.7	31.0	0.6	0.6	86.1	76.5	0.8	1.7	1.24	1.11
2nd molars	1,171	2,368	10.2	15.6	62.6	56.7	25.2	25.0	1.5	0.8	89.3	82.6	0.4	1.9	1.18	1.11
Total lower jaw	6,092	12,340	42.0	56.3	44.8	31.1	12.1	11.0	0.4	0.3	57.3	42.4	0.3	1.3	0.71	0.55
Totals	12,548	25,413	32.0	42.3	47.8	37.1	18.7	18.5	0.7	0.5	67.2	56.1	0.7	1.6	0.88	0.77

Total hypoplasia figure

*A.H.F. (average hypoplasia figure) = Total number of teeth examined for structure (excluding those with G-hypoplasia or unclassified hypoplasia)

† A few of these teeth could not be classified into any of the grades shown in this table. Because of this the percentages do not add up to 100.

also shows that, even in 1947, the best year so far as the dental condition of the children was concerned, over 50% of the deciduous teeth observed showed some form of structural defect. The extent of M-hypoplasia, expressed as the A.H.F. for all types of teeth together (Fig. 2), shows a similar pattern to that for the incidence (percentage) of hypoplasia (Fig. 1), the only difference being that in 1949, although structural defects were very common, a fairly large percentage were only slight (M-Hy₁) and the A.H.F. was thus relatively low.

Caries

Assessment of the individual teeth according to the above-mentioned criteria indicates that the findings were very similar for the two surveys and that in each case over 70% of the teeth were free from caries. A slightly greater proportion were diseased in 1951 than in 1949—27.5% compared with 26.7% (see Table II)—but the difference was not significant, being only 0.8 ± 0.47 . The slight advantage experienced by the children examined in 1949 was due mainly to the condition of the lower teeth; for the upper teeth the percentage carious was practically the same in each year for all teeth combined, though it varied slightly from tooth to tooth, sometimes to the advantage of the 1949 group, sometimes to that of the 1951 group. For the lower teeth, the experience of 1951 was consistently rather worse for each type, but it was only for the second molars that the difference reached the level of significance, 3.8 ± 1.6 . The A.C.F.s for several types of teeth were similar in the two years, but were higher in 1951 for upper second molars and lower first and second molars, indicating that the extent, as well as

FIG. 3.—Relative percentages of the different grades of caries for all types of teeth together in 1943–51.

the incidence, of caries was greater in these teeth in the latest survey. Upper first molars and upper canines, on the other hand, had a slightly lower A.C.F. in 1951.

The teeth least affected by caries in both years now under review were the lower incisors, with only 2.6 to 3.8% showing any degree of decay and with A.C.F.s of 0.05 to 0.06, while the most severely affected were the lower molars, of which 54.0 to

65.1% were carious, and for which the A.C.F. ranged from 1.22 to 1.34. The upper incisors had much more caries than the lower. These findings are typical of those obtained throughout the series of surveys and in other studies made in private schools and institutions (Coulmoules and Mellanby, 1947), and indeed are generally recognized in dental practice.

A comparison of the incidence and extent of caries for all types of teeth together in the five surveys of 5-year-old children in L.C.C. schools from 1943 onwards is given in Figs. 3 and 4, from which it is very clear that 1947 was the year in which the best results were obtained. From 30.1% of carious teeth in 1943, the figure was reduced to 26.5% in 1945 and 20.3% in 1947; after that time it rose again to 26.7% in 1949—that is, to the 1945 level—but in 1951 there was only an insignificant increase to 27.5%. A similar trend is seen in the A.C.F. values, so that it appears from these figures that the spread of the disease, noted in 1949, may have been continuing up to 1951, but to a much less extent than between 1947 and 1949.

The "pattern" of caries incidence and extent in the five surveys, as shown in Figs. 3 and 4, differs somewhat from that of hypoplasia incidence and extent, as seen in Figs. 1 and 2, in that, whereas there was an increase in caries from 1947 onwards (although from 1949 to 1951 it was not significant), there was more structural defect in the teeth examined in 1949 than in those observed in 1951.

Relationship Between Structure and Caries

It was shown many years ago (May Mellanby, 1927b, 1934) that, according to the standards used, the incidence of caries bore a direct relationship to the surface structure of the teeth and that this, in general, reflected the internal structure. This was particularly evident in the case of the deciduous dentition. The structure-caries association has been demonstrated in all the previous surveys, and is again shown in the two under review. Table III indicates that in each type of tooth, and in all types

FIG. 4.—Average caries figures for all types of teeth together in 1943–51.

TABLE II.—Caries Incidence and Extent in Various Types of Teeth in 1949 and 1951

Type of Tooth	Total No. of Teeth Assessed for Caries (inc. extractions)		Percentage of Teeth C ₀		Percentage of Teeth C ₁		Percentage of Teeth C ₂		Percentage of Teeth C ₃		Total Percentage of Carious Teeth		A.C.F.*	
	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951
Upper jaw:														
Central incisors ..	1,274	2,573	69.9	70.0	9.3	9.1	15.5	15.7	5.2	5.2	30.1	30.0	0.56	0.56
Lateral incisors ..	1,351	2,723	85.5	84.6	4.5	5.8	6.3	7.5	3.7	2.4	14.5	15.4	0.28	0.28
Canines ..	1,384	2,790	90.9	92.8	2.2	1.6	5.4	4.9	1.4	0.6	9.1	7.2	0.17	0.13
1st molars ..	1,384	2,790	64.3	65.8	6.9	6.5	15.2	17.4	13.7	10.3	35.7	34.2	0.78	0.72
2nd molars ..	1,384	2,790	55.8	52.3	18.4	17.8	16.5	20.9	9.4	9.0	44.2	47.7	0.79	0.87
Total upper jaw ..	6,777	13,668	73.3	73.1	8.3	8.1	11.7	13.3	6.7	5.5	26.7	26.9	0.52	0.51
Lower jaw:														
Central incisors ..	1,061	2,150	96.7	96.2	2.2	2.1	0.9	1.6	0.2	0.05	3.3	3.8	0.05	0.05
Lateral incisors ..	1,338	2,721	97.4	96.5	0.7	1.1	1.7	2.1	0.2	0.3	2.6	3.5	0.05	0.06
Canines ..	1,384	2,789	94.5	94.4	1.9	1.0	2.7	4.2	0.9	0.3	5.5	8.6	0.10	0.10
1st molars ..	1,384	2,790	46.0	43.1	9.5	7.4	20.5	26.5	24.0	23.0	54.0	58.9	1.22	1.29
2nd molars ..	1,384	2,790	38.7	34.9	19.1	18.4	16.8	24.1	25.4	22.6	61.3	65.1	1.29	1.34
Total lower jaw ..	6,551	13,240	73.4	71.8	6.9	6.2	9.0	12.3	10.7	9.7	26.6	28.2	0.57	0.60
Totals ..	13,328	26,906	73.3	72.5	7.6	7.2	10.4	12.8	8.7	7.6	26.7	27.5	0.54	0.56

* A.C.F. (average caries figure) = $\frac{\text{Total caries figure}}{\text{Total number of teeth (including extractions)}}$

TABLE III.—Incidence and Extent of Caries in Teeth with Varying Grades of Structure in 1949 and 1951

Grade of Structure	Incisors						Canines						Molars						All Types					
	Total No. Examined		Percentage Carious		A.C.F.		Total No. Examined		Percentage Carious		A.C.F.		Total No. Examined		Percentage Carious		A.C.F.		Total No. Examined		Percentage Carious		A.C.F.	
	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951	1949	1951
Hy ₀	2,578	6,380	3.9	4.7	0.06	0.07	1,095	3,266	2.6	2.7	0.04	0.05	345	1,107	16.2	30.1	0.26	0.48	4,018	10,753	4.6	6.7	0.07	0.11
M-Hy ₁	1,930	2,798	17.7	19.9	0.30	0.33	1,514	2,046	8.1	10.0	0.14	0.18	2,552	4,586	38.1	43.1	0.68	0.77	5,996	8,422	24.4	29.0	0.42	0.51
M-Hy ₂	337	592	32.3	44.6	0.62	0.83	105	134	21.9	23.9	0.40	0.47	1,901	3,972	50.3	50.6	0.96	0.96	2,343	4,698	46.4	49.1	0.88	0.93
M-Hy ₃	7	4	(28.6)	(100.0)	(0.86)	(2.25)	2	0	(50.0)	—	(0.50)	—	73	129	65.8	75.2	1.45	1.50	82	133	62.2	75.9	1.38	1.53
Gross Hy	63	163	39.7	27.0	0.81	0.46	2	92	(100.0)	3.3	(3.00)	0.04	25	146	36.0	45.9	0.84	0.81	90	401	40.0	28.4	0.87	0.49

taken together, the percentage of carious teeth and the A.C.F. increased with the degree of M-hypoplasia. For instance, whereas only 3.9% in 1949 and 4.7% in 1951 of the incisors of good structure were carious, 32.3 and 44.6% respectively of those with a moderate degree of M-hypoplasia (M-Hy₂) were diseased. The A.C.F. showed corresponding increases. (There were not enough teeth in the severe M-hypoplasia grade (M-Hy₃) to make an assessment.) Again, in the case of the molars, 16.2 and 30.1% of those without hypoplasia were carious in the two years, and the proportion increased with each degree of M-hypoplasia, so that 65.8 and 75.2% respectively of those with severe defects (M-Hy₃) were carious. The A.C.F. also increased in each case with the amount of M-hypoplasia, as would be expected. The incidence and extent of caries associated with the relatively small amount of gross hypoplasia is also shown in Table III.

Treatment of Teeth

The amount of conservative treatment and percentage of extractions experienced by the children up to the time of the two surveys are shown in Table IV. It will be seen

TABLE IV.—Carious Teeth Extracted, Treated by Silver Nitrate, or Filled in 1949 and 1951

Year	Total No. of Carious Teeth (including Extractions)	Treatment			Total Percentage of Carious Teeth Treated
		% Extracted	% Silver Nitrate	% Filled	
1949	3,553	15.3	0.6	3.9	19.8
1951	7,412	13.0	0.1	6.1	19.2

that the total extent of treatment was similar in each case, but that the proportion of teeth filled was rather higher and the percentage of extractions a little lower in the 1951 group of children, which would appear to be a step in the right direction.

Superficial Staining of Teeth

As in former surveys of the same kind, the amount of superficial stain on the children's teeth was noted in the two studies under review. It had previously been observed, both in this series of surveys and by other workers, that mouths in which black or dark-brown stains occurred at least on some teeth were associated with a lower incidence of caries, whereas those with green stains tended to have a higher incidence than those in which no staining was found. This was again the case in 1949 and 1951, as is seen from Table V.

TABLE V.—Percentage Incidence of Carious Teeth in Children With and Without Superficial Staining of Teeth in 1949 and 1951

	1949	1951
Children having:		
No stain	25.8%	28.5%
Black and dark brown stains	16.9%	14.4%
Green stain	30.0%	33.6%

Comment

Since the cause of caries is not yet known, it is impossible to state categorically the reasons for the increased incidence and spread of the disease since 1947, when the lowest figures

in these surveys were recorded. It seems probable, however, that these may be due, in part at least, to changes in the diet, some of which would tend to increase and others to decrease the liability to dental caries, the former overbalancing the latter. The availability of supplies of calcium- and vitamin-D-containing foods, including milk, eggs, and cod-liver oil, may have been similar for both the 1947 and the more recent groups of children examined, but to what relative extent they were taken up by the mothers during pregnancy and by the children themselves from birth onwards is, of course, not known. There is some circumstantial evidence, however, that the consumption of these particular foods fell as a wider range of foods came on the market during the post-war years.

On the other hand, oatmeal and other cereals and cereal products, which had been rationed through the points scheme, became more plentiful from 1948 onwards with the lifting of many controls; and, as these foods are comparatively cheap and generally popular, there was a tendency for their consumption to be increased, particularly in families of limited means, sometimes to the exclusion of some other foods of better value from the standpoint of the teeth. It is known that when more cereals are eaten, other things being equal, more calcium and vitamin D are needed to counteract the effect, both on dental structure and on the spread of decay, of some factors present in the cereals, especially in oatmeal. Although sugar and sweets (including chocolate) continued to be rationed from 1942 until after the latest of these surveys was finished, the allocations to individuals were on a slightly higher level from 1948 to 1951 than formerly. It seems unlikely, however, that the extra amount was sufficient to have much direct influence on the initiation and spread of caries, or an indirect one by limiting the consumption of other foods.

Summary

A detailed analysis has been given of the incidence and extent of structural defects and caries in the teeth of two groups of 5-year-old school-children examined in 1949 and 1951 respectively, and some comparisons have been made with the findings in other surveys made between 1929 and 1947.

It had previously been shown that up to 1947, and particularly from 1943 to that time, there had been a continued improvement in the dental condition of children of this age group attending L.C.C. schools, but that in 1949 there was an apparent setback. Fewer children were free from caries, and the amount of hypoplasia and caries in individual teeth had increased. A further survey was therefore undertaken in 1951 in order to see how the trend had resolved itself.

In broad outline, the following observations were made in the latest survey: the percentage of caries-free or almost caries-free children was very similar to that found in 1949—23.5 compared with 24.9—as was the percentage of caries-free teeth, 72.5 compared with 73.3; the structure of the teeth, on the other hand, was on the whole better, 42.3% being non-hypoplastic as against 32.0% in 1949. A good deal of the M-hypoplasia seen in

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*

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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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