age when dementia is uncommon. In two studies, when the authors' rates of severe and moderate dementia are added together, the rates increase to 5.3% and 7.7%, the latter being higher than any other rate in the Table. In the study by Maule *et al* (1984) the rate of severe + moderate dementia is only 2.9%, but the *overall* rate is 8.6%, which is higher than the overall Newcastle rate of 6.2%.

This leaves only the London–New York cross-national study of Gurland *et al* (1983), in which the London rate of 2.5% compares with the New York rate of 5.8%, a striking difference for which there is no ready explanation; but as the authors point out, replication is needed. Finally, in the overall prevalence Table, the Melton Mowbray survey rate of 4.5% in a population aged 75+ is lower than expected (Clarke *et al*, 1986), but is based on one brief questionnaire.

There seems to be no good reason to think that dementia among the elderly at home is appreciably rarer than the Newcastle rates of 5–6%; in Newcastle, institutions added less than 1% to the rate, but the ratio of cases at home and in institutions will vary. In Finland, for instance, *severe* dementia is found in 3.8% of people aged 65+ at home and in 6.7% when institutions are included (Sulkava *et al*, 1985). The problem is that in the community the range of cognitive impairment is wide and degrees of severity are not yet adequately defined.

In fact, Kay elsewhere (Kay, 1972) reported the Newcastle rates as 6.2% ('severe') and 2.6% ('mild'). This just goes to show the state of confusion the grading of dementia is in.

D. W. K. Kay
MRC Neurochemical Pathology Unit
Newcastle General Hospital
Newcastle upon Tyne NE4 6BE

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History of Depressive Disorder

Sir: The recent article by Berrios (*Journal*, September 1988, **153**, 298–304) suggests that depressive disorder became conceived as an emotional disorder in the 19th century. Not all the descriptions from that time would concur with this. Those of Griesinger (1867), Lewis (1889), and, a little later, Mendel (1908) suggest that a disturbance of energy may be the basis of the condition.

My own personal experience of the disorder over a period of 20 years and objective view of it during the past 10 years in general practice has led me to the conviction that depression is primarily a disorder of energy, both qualitative and quantitative, with mood changes being secondary. I favour the term dysenergia, which was used by Dioscorides in the 1st century AD, and which is no longer extant, to describe this.

In the early 20th century, when the term 'affective disorder' was gaining usage, caution was nevertheless exhibited by some writers. Craig (1912) observed that, "as with other disorders the mistake was made of naming the disease according to its most prominent symptom"; Bleuler (1923) wrote: "the disturbance of the affect represents merely the most conspicuous symptom of a general transformation of the psyche that cannot as yet be comprehended".

Over the past 40 years the idea that depression is a single system disorder of mood has become increasingly accepted. The biochemical evidence is conflicting, and I can find no phenomenological evidence to support it. I wonder if it is a long-standing assumption which needs examination.

W. H. Goss
12 Honeythorn Close
Hempsted
Gloucester GL2 6LU

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Supportive Analytical Psychotherapy

Sir: Holmes (*Journal*, June 1988, **152**, 824–829) proposes a carefully planned admixture of dynamic and supportive therapy which I suspect could only be

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