answer questions about what problems, if any, they encountered in "supporting" the elderly person.

JOHN M. EAGLES

The Ross Clinic
Cornhill Road
Aberdeen AB9 2ZF

Concept of Mild Endogenous Depression

SIR: Unfortunately, Snaith's essay (*Journal*, March 1987, **150**, 387–393) is representative of most discussions about the use of the term 'endogenous' depression, being just another example of defining words by other words at the same level of abstraction.

When multiple clinical items of depression are aggregated, the resulting scale of categories can be arranged as a hierarchy. The hierarchical arrangement provides a clear idea of what is contained in the total scale score of the individual items. The most simple model for evaluating hierarchical aggregations is the Rasch model, because items here will obtain equal weights if they fulfil the model (Bech, 1981). Applying Rasch models on the universe of items defined by the Melancholia Scale and the Newcastle Scales (Bech *et al*, 1983), we have found one dimension of severity of depression and two dimensions for the diagnostic type of depression (Bech & Allerup, 1987).

In total, 11 items constituted the dimension of severity, which in increasing hierarchical order are: difficulties in carrying out usual work; lack of interests and pleasure; reduced sleep; more apprehensive or irritable than usual; more emotionally introverted than usual; difficulties in concentration; more tired than usual; self-depreciation or guilt feeling; pronounced inertia in conversation; clear motor retardation; and suicidal thoughts or impulses.

In relation to the two diagnostic dimensions, we found that five items constituted endogenous depression: persistence of clinical picture; weight loss; early waking; worse in the morning; and distinct quality. Another five items constituted reactive depression: duration of current episode; somatic anxiety; character neurosis; reactivity of symptoms; and psychological stressors.

According to these dimensions we can classify patients into minor or major depression and diagnostically into endogenous or reactive depression.

The state of anhedonia described by Snaith is nothing more than mild endogenous depression. 'Anhedonia' is traditionally used to describe the borderline personality who suffers from a painful lack of vitality based on a narcisistic distance from other people. According to Vanggaard (1979): "Not infrequently this anhedonia is called 'depression', and this is erroneous. An anhedonic state is a far cry, phenomenologically and theoretically, from a depressive one, as different as the general personalities of persons harbouring such states, if the terms are properly understood and used".

From a psychopharmacological point of view anhedonia should be treated with neuroleptics, whereas mild endogenous depression should be treated with antidepressants. Patients who do not respond to antidepressants should be diagnostically reconsidered, as they might be borderline cases.

PER BECH

Frederiksborg General Hospital
48, Dyrehavevej
DK-3400 Hillerød
Denmark

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Tuberous Sclerosis and the Autistic Syndrome

SIR: I was surprised to read that Lawlor & Maurer (*Journal*, March 1987, **150**, 396–397) believe tuberous sclerosis (TS) to be a rare cause of the autistic syndrome. Parents of children with TS have known otherwise for some years, and child psychiatrists, paediatricians and others have been made aware of it more recently. Lawlor & Maurer fail to point out that the autistic syndrome is closely linked to the early occurrence of *infantile spasms* (Kolvin *et al*, 1971, Hunt & Dennis, 1987) and, much less so, to other forms of epilepsy.

The point I wish to make is that TS is not as rare as was once thought. In the Oxford Region in 1984, the prevalence was 1 in 15 400 for children under five. Children with TS do present at departments of child psychiatry from time to time, and I support the conclusion of Lawlor & Maurer that a high index of suspicion should be maintained when confronted with an autistic child who has fits – but also, I would say, when assessing hyperkinetic, aggressive, and sleep disordered children with fits. Furthermore, in my experience, the diagnosis of TS has been made in

children who show the behavioural disorders but who have never had a fit.

MURIEL BLACKBURN
Child and Adolescent Psychiatric Centre
Worthing Road
Horsham RH12 1JB

Delusional Infestation in Late Life

SIR: Renvoize *et al* (*Journal*, March 1987, **150**, 403–405) provide a useful review of the literature, including the German literature, in reporting their interesting patient whose delusions of infestation occurred during the course of a dementing illness. We have been interested to find that delusions of infestation are seen quite commonly among the patients referred to our psychiatric services for the elderly and we recently reviewed seven cases that presented between 1983 and 1986. There were two men and five women. Their ages ranged from 69 to 76 – a little above the boundary of 'late middle age', the age-group from which patients are most frequently reported, but not very old (patients aged 75 and above constitute about three quarters of our referrals).

All seven were found to be depressed. None were seriously demented, although in three there was clear evidence of some organic cerebral impairment and in only one could we be sure that there was no such pathology. In two patients the delusions of infestation developed in the context of guilt at not maintaining cleanliness in the home after the death of a spouse. In three, previous neurotic preoccupation with cleanliness or 'phobia' of 'creepy-crawlies' had become delusional in the setting of severe depression, and in the last two the delusion was part of a systematic belief that the body was changed and degenerating.

In most of our patients the delusions appeared when powerful change of affect occurred with mild organic change. This is a potent combination in the genesis of delusions (Hay *et al*, 1974). Successful treatment of the mood disorder has led to resolution of the delusions of infestation in the six cases we have known longest. Thus, in this age group delusions of infestation may be less persistent and pernicious than those of the monosymptomatic psychoses that are reported more commonly in younger middle-aged patients. The presence of some organic impairment should not detract from the treatability of the condition through an appreciation of the mood disorder.

MICHAEL MORRIS
DAVID J. JOLLEY

Withington Hospital
West Didsbury, Manchester M20 8LR

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Hysterical Personality Disorder

SIR: Thompson & Goldberg (*Journal*, February 1987, **150**, 241–245) question the validity, reliability, and utility of the diagnosis of hysterical personality disorder. Though such issues are properly raised about a vexing construct, I believe the authors' gloomy conclusions may not be wholly warranted.

Based on a retrospective review of case notes, Thompson & Goldberg observe that the diagnosis "is frequently made without the core features being present". Their finding may tell us less about the construct, hysterical personality disorder, than it does about diagnostic practice and documentation at Withington Hospital in 1975. Had the authors tabulated the "core features" present in the case notes of patients with another diagnosis we would be better able to judge where the problem lay.

This matter is of considerable importance because the authors fear that the diagnosis of hysterical personality disorder may be used "to label those patients who are perceived as hostile, difficult, and uncooperative, with the result that the doctor is distracted from recognising an underlying diagnosis". Prominent among such proposed underlying conditions is 'primary affective disorder', which the authors claim that McHugh and I found (Slavney & McHugh, 1974) in a sample of patients with the diagnosis of hysterical personality disorder. I feel constrained to point out that what we noted was not 'primary' affective disorder, but rather the frequent occurrence of depressed mood and self-injury, phenomena which we interpreted as the responses of self-dramatising and emotionally labile people to stressful circumstances (i.e. as 'secondary' to events such as romantic disappointment). What was 'underlying', then, was the personality disorder, the recognition of which a psychiatrist should not be distracted from by the presence of affective symptoms. The validation of the trait of self-dramatisation has yet to be accomplished, but there is some support (Slavney & Rich, 1980) for the existence of emotional lability as an actual attribute of patients who receive the diagnosis of hysterical personality disorder.

Finally, the authors observed low inter-rater reliability in the assessment of hysterical traits based on brief videotaped interviews. The diagnosis of personality disorders in the clinical setting, however, depends to a great extent on the description of