

References

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Failure to Convulse with Electroconvulsive Therapy

SIR: Replying belatedly to this report by Sharpe and Andrew (*Journal*, January 1988, **152**, 134–136), I would like first to ask why their electrodes are soaked for 30 seconds? I suggest that they would have fewer failures if they ensured soaking of at least 30 minutes.

But to return to the basic problem of the ECT-resistant patient: the simple answer for 25 years has been inhalent convulsant therapy with flurothyl (Indoklon). I still have a small supply, but this preparation is no longer manufactured. I have for some little time been trying to get production re-started, although the Ohio Chemical Company no longer exists. The main reason for this therapy falling into desuetude was the unreliability (less so with great care) of the face-mask contact, which I hope to resolve – perhaps using a more concentrated mixture.

A case in point: a few months ago I was called in by a colleague to consider planning a course of ECT for one of his patients. The patient failed to respond on seven consecutive occasions with three different machines, but, switching to flurothyl, we achieved a fully successful programme with satisfactory outcome.

If anyone is interested I have a tape made here last year; the original study was reported by Rose & Watson (1967).

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Depression in Adolescents and Young Adults

SIR: Klerman (*Journal*, January 1988, **152**, 4–14) proposes an increase in depressive illness in adolescents and young adults to explain recent studies. He also mentions an increase of depression in children. What he is describing is the unexplained phenomena of the symptomatology of minimal brain dysfunction or attention deficit disorder (ADD), which always contained signs of depressed mood being ascribed to depressive illness. The overlaps of depressive illness and attention deficit disorder according to DSM-III criteria has been repeatedly documented.

A child with attention deficit disorder, experiencing continual social and academic failure, has good reason to feel depressed. This does not warrant a diagnosis of depressive illness.

All children or adolescents with behavioural difficulties have depressive symptoms. Their parents frequently suffer from the same genetically transmitted instability, and for the same reason present intermittent symptoms of depression. The majority of suicide attempters are overreactive, labile, and impulsive, the traits associated with ADD. Unfortunately, they are treated with antidepressants at full dosage, experience unpleasant side-effects, and do not return for further treatment. Most of these individuals achieve greater stability with small doses of antidepressants (Huessy & Wright, 1970). But this positive response to tricyclics, in small doses with immediate improvement, cannot be used as an argument for the diagnosis of depression. The immediate response to small doses represents a biochemically different response from the one seen to bigger doses over three weeks in major depressive illness.

Since 13% of all children suffer from identifiable problems of overreaction, lability, and impulsivity, and since these childhood problems turn out to be lifetime problems, there are many more young adults with depressive symptoms secondary to their lifelong problems of instability than there are individuals with major depressive illness. We have compared adults with depressive illness with patients with the adult form of childhood behavioural disorders, and documented how they differed in drug response and family history (Huessy *et al.*, 1979). Both types met DSM-III criteria for major depression.

It is this diagnostic confusion which lies at the basis of Dr Klerman's discussion and which is leading to unfortunate contamination of recent epidemiological studies.

Patients with major depressive illness have 'clean' childhood histories. Adults with behaviour disorders have problem childhood histories and family histories. Since, numerically, there are many more of the