Decreased usage of electroconvulsive therapy: implications

Our interest in this topic was re-awakened when, in 2003, the then National Institute for Clinical Excellence (NICE) published clinical guidelines that intended to restrict the circumstances for the use of electroconvulsive therapy (ECT).1 The guidance was controversial, and the Royal College of Psychiatrists subsequently published its own guidance that argued that NICE was too restrictive about the place of ECT in the treatment of major depression, the most common contemporary indication for ECT.2 It was therefore unclear whether NICE would achieve its aim of reducing the use of ECT. We have already reported that there was no early effect of the NICE guidance in that the rates of usage of ECT in Edinburgh were virtually identical in the individual years 2003–2005.3

We now report the most dramatic fall in the rate of usage of ECT that we have ever observed between consecutive years. In the years 2006 and 2007 the rates of usage were only 0.82 and 0.88 patients per 10,000 total population. This is approximately a third less than the rate in 2005, and three-quarters less than the rate in 1993.3

The clinical significance of the decrease has never been systematically assessed. Observers have suggested that there is less need for ECT as the number of effective alternative options increases, and as psychiatrists become more experienced with these options. One only hopes that those people who are severely ill who were formally treated with ECT are now offered equally effective alternatives, but this is open to doubt. Electroconvulsive therapy is still the most efficacious treatment for major depression, particularly when the symptoms are severe.4 The results of the recent STAR*D trial were salutary: the cumulative remission rate from major depression was only 67% after four sequential and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006; 163: 1905–17.

One aspect of their pioneering report did raise alarm at the population health level. The new questionnaire showed greater ‘callous and unemotional’ ratings for subgroups with ‘Black and minority ethnicity’.1 All seven items scored could have very different norms within different cultural or religious traditions; for example, my formative years were in India and when I read the item ‘shallow or fast-changing emotions’ I prejudicially translated that as ‘British’. The research findings may be especially open to unconscious prejudice where the teacher and the child grew up in different ethnic-cultural groups. There is not room here to discuss US transcultural debates (such as whether the term ‘rascal’ is specifically overapplied by White adults to African–American children), but consider the questionnaire item ‘too full of his/her own abilities’. My personal view from work with youth offending teams5 and Health of Looked After Children and Young People6 is that the difficulties (adult) professionals have in comprehending the needs of young people are greatly amplified if a cultural misunderstanding is also present.

Moran et al recognise that they need to know more about the properties of their ‘callous and unemotional trait scale’, and since the Royal College of Psychiatrists has a valuable special interest group in transcultural psychiatry it could be timely to seek their expert advice before targeting too many young ‘fledgling psychopaths’.

3 Caan W. Not overlooked any more (Foreword). In Health of Looked After Children and Young People (ed K Dunnett). Russell House, 2006.
Origin of Species,2 and when Darwinian principles have become the organising framework for all biological sciences, continue to think in pre-Darwinian terms. Dr O’Connell’s letter3 is therefore a welcome reminder of this rather anomalous state of affairs.

The most common challenge leveled at evolutionary approaches to mental disorders is that they are ‘just so’ stories (i.e. that they are unstable and irrefutable). This challenge can be easily met. Evolutionary-based hypotheses are propositions that stand or fall by the evidence and by their predictive value and should be discarded if refuted. Hence, the evolutionary theories that propose that schizophrenia is a disorder of the social brain,4,5 or related to the evolution of brain asymmetry and language,6 await support or refutation by empirical evidence. Similarly, the theory that eating disorders (an area where non-evolutionary theorising has been particularly sterile) represent disorders of female mating strategy7,8 will be tested and discarded or amended based on empirical evidence.

One major insight of evolutionary theory is that species not only have traits and characteristics but also a distinctive history during which these traits were shaped by a process of natural and sexual selection. And it is the careful piecing together of this history, utilising evidence from a myriad of disciplines (archeology, geology, primatology, molecular biology, etc.) that produces the consilience of evidence that is unique to the evolutionary approach.9 Thus, placing the human mind back within the realm of evolutionary biology where it belongs has the potential of generating insights that would otherwise be impossible to conceive. It is rather intriguing that there is a determined and vocal opposition to the application of Darwinian theory to human psychology, and the mind there has almost no objection to the hermeneutic approach to psychiatry, which is a self-confessed antiscientific approach that excludes mental phenomena from the laws of causality altogether. Is it time to for our College to consider incorporating evolutionary psychiatry/psychology into the training curriculum for the MRCPsych? Also, is the time ripe for members/fellows of the College to form a College special interest group and to demand sessional time at the College Annual Meeting to present and debate research and theoretical work within these fields?