Behavioural and Cognitive Psychotherapy, 1996, **24**, 319–322

ECT and Minors: When More is Less

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In a diverse therapeutic context, multiple interventions are available for use with disordered or dysfunctional minors. With this population, electroshock administration is always inappropriate.

James (1996) presents a potentially misleading set of claims based on an uncontrolled series of anecdotal clinical cases. Whilst there is merit in a debate, the use of an inadequate methodology undermines the claims made. Mann (1996) rightly opposes the use of an inappropriate technique, when many effective alternatives are available.

In reply to James (1996), the common failure to distinguish between studies completed with adult and minor clients is compounded in this paper. Also the author focuses on their own anecdotal administration of ECT given to teenagers, whilst no mention is made of widespread use of ECT with children and infants.

The calculation of prevalence rates as stated (James, 1996) is epidemiologically unsound, and misleading. It is incorrect to extrapolate data in the manner prescribed by that author. Interpretation of the data reported in Table 1 confirms the idiosyncratic and uncontrolled use of ECT with teenagers. In the cohort, 50% did *not* give consent, which should prompt moral, ethical, clinical, philosophical, and legal challenges. Amongst the other 50%, it is unclear whether the consent obtained was *free and unfettered.* Specifically: were the possible negative consequences of ECT discussed with the teenagers? Did psychiatric staff comply with legislation? Was an independent advocate appointed to represent the minor? Although it is claimed "... the patient was fully informed ...", this does *not* constitute legal consent.

The data reported as "response" are not real outcome measures. As

Acknowledgements: We are grateful to Paul Salkovskis for his judicious editorship in a difficult publishing climate. We also acknowledge the comments of a third referee, who declined to participate in the debate. This paper is dedicated to Jay: get that degree.

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acknowledged by the author, the failure to separate the clinical aspects of ECT administration and the subsequent collection of data for a research process undermines the validity and reliability of these observations. They are unlikely to illuminate either the clinical or research aspects of ECT administration. From these data, it is impossible to evaluate clinical outcomes. At follow-up, 25% had relapsed, and one teenager had committed suicide. Such data *disconfirm the utility of ECT with teenagers*. The claims made by that author are unscientific, in the absence of either single case-controls or a control group experimental design.

In teenagers, there are *no established clinical indications for ECT*. Even with adults, use of ECT with psychotic disorders risks *irreparable psychological damage*, whatever the conjectural psychiatric benefits. A meta-analysis of 217 cases of documented ECT use with infants, children and adolescents has confirmed the negative psychological sequelae from electroshock (Baldwin and Oxlad, 1996a).

In this report, the data used to justify ECT are misleading. For example, two teenagers with mania have been reconstituted as "a group" (sic). The use of one physical treatment (ECT) in an attempt to counteract the negative consequences of another (a selective serotonin re-uptake inhibitor antidepressant) is an instance of *compounded iatrogenesis*. It is also highly revealing about the psychiatric practice of the author.

The data presented do *not* support the judicious use of ECT with minors. It has been conceded that psychiatrists do *not* use systematic audit of the treatment, and the presentation here of yet more uncontrolled anecdotal case material is inappropriately used to propel an already thin argument about clinical efficacy. In none of these instances was prior alternative treatments described (e.g. behaviour therapy, cognitive behaviour therapy, psychotherapy). Mental health professionals should, however, accept the legitimate challenge to evaluate outcomes of cognitive behaviour therapy with adolescents who have psychotic disorders. A randomized controlled trial should follow, with comparisons to cognitive behaviour therapy, behaviour therapy and pharmacotherapy, in some combination.

In reply to Mann (1996), the original call for the ban of ECT/electroshock with minors was made in 1990 (Baldwin, 1990) not 1993. When MIND were approached in 1990 about the use of ECT with minors, their response stated that was not part of their policy agenda. Rightly, they had modified this indifferent stance by 1993. Other calls for a ban followed, from representatives of the Royal College of Nursing, although six years later the organization has yet to form a coherent policy about this most urgent core business. Monitoring or auditing psychiatrists' use of ECT with minors is a distraction and a displacement activity, in the context of calls for a ban.

In the UK, current mental health legislation is inadequate to protect the inalienable rights of vulnerable and at-risk minors, people with an intellectual disability, and elderly people. ECT use has been noted in each of these populations (Baldwin and Oxlad, 1996a; Baldwin and Oxlad, 1996b; Oxlad and Baldwin, 1995). In 1990, when objections were first raised about ECT use with minors (Baldwin and Jones, 1990), it transpired that the same psychiatrist who gave the ECT had also written the relevant local mental health legislation (Baldwin and Jones, 1991). Closure of *that* child psychiatric unit, and the dismissal of some staff, was one step in the right direction. About import of new technology from the USA (Mann, 1996) more caution is required. Cameron (1994) has noted that modern electroshock technology is *more* dangerous than the established machinery, with delivery of *larger* electric currents.

Undoubtedly, *psychiatrists* benefit from the delivery of ECT to minors. ECT can *appear* effective, when pharmacotherapy has failed, and when intense pressure is exerted on medical staff by family and relatives of children who are dysfunctional. As a "quick fix", ECT may appeal to the psychological needs of hard-pressed professionals. A recent meta-analysis of published cases of electroshock with minors (Baldwin and Oxlad, 1996a) has substantiated this claim. Interpretations of data from this survey have confirmed that ECT is often used *routinely* with minors, as a "treatment of choice" and not as a "treatment of last resort".

Behaviour therapists and cognitive therapists who wish to support a ban on ECT with minors should write to the Senior Author.

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Behavioural and Cognitive Psychotherapy, 1996, **24**, 323–329

The Effect of Stimulation on Stereotyped Behaviour of a Woman with a Profound Learning Disability

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The introduction of two sessions a day on two days a week of cognitive and physical stimulation was found to reduce the stereotypic behaviour of a woman with a profound learning disability. The effect was shown to last for several hours with indications that it may have lasted several weeks.

Introduction

Stereotypical behaviours, or stereotypies, are highly consistent and repetitious motor movements inappropriate for the social context in which they occur (cf Repp, Karsh, Deitz and Singh, 1992), that are very commonly found among people with severe and profound learning disabilities (Tierney, Fraser, Maguire and Walton, 1981). These behaviours are normally regarded as negative as they stigmatize the individual who shows them and interfere with more positive behaviours and the opportunity to learn new adaptive behaviours (cf Wehmeyer, 1995).

Although there are a number of alternative theories regarding the cause and maintenance of stereotpyies (see Rojahn and Sisson, 1990 for a review) it has been well argued by Guess and Carr (1991) that, at least for some clients, stereotypies function as self-stimulation and allow the client to maintain an optimal level of stimulation. Recent evidence for this has been provided by Repp et al. (1992) who demonstrated that there is a sub group of individuals whose level of stereotypies covaried with other overt behaviours so that their overall level of activity remained the same, the implications of this being that overt behaviours, other than stereotypies, can also have a self-stimulatory effect. Therefore increasing other overt behaviours should result in a decrease in stereotypies.

The present study reports on the introduction of structured activity sessions into the routine of a woman who showed stereotypies. The study

Acknowledgement: We are grateful to Dr Stephen Morley for help and advice on the analysis of the data.

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