BJPsych | The British Journal of Psychiatry (2008) 192, 476–477

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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 carefully supervised acute treatment schedules.[5]

The research implications are clearer. Edinburgh has a long history of ECT research, but the latest fall in usage has meant that we have not been able to complete a controlled comparison of magnetic seizure therapy and orthodox ECT. If the Edinburgh experience is replicated elsewhere, the only options for future clinical research would be to support collaborations among several ECT clinics or the establishment of a regional or national affective disorders research centre, plus a research programme that includes ECT.

1 National Institute for Clinical Excellence. *Guidance on the Use of Electroconvulsive Therapy*. NICE, 2003.

2 Royal College of Psychiatrists. *The ECT Handbook* (2nd edn). Council Report CR128. Royal College of Psychiatrists, 2005.

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4 Ebmeier KP, Donaghey C, Steele JD. Recent developments and current controversies in depression. *Lancet* 2006; **367**: 153–67.

5 Rush AJ, Trivedi MH, Wisniewski SR, Nierenberg AA, Stewart JW, Warden D, Niederehe G, Thase ME, Lavori PW, Lebowitz BD, McGrath PJ, Rosenbaum JF, Sackeim HA, Kupfer DJ, Luther J, Fava M. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. *Am J Psychiatry* 2006; **163**: 1905–17.

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doi: 10.1192/bjp.192.6.476

Pioneering, but open to prejudice

Moran *et al* deserve praise for their large-scale study of schoolchildren that combines parental assessments of psychopathology with teacher assessments of emotional traits.[1] Opportunities for (unspecified) early intervention to prevent antisocial behaviour seem a worthy focus for community research, although I am not sure how many schoolchildren would welcome their label 'fledgling psychopaths'.

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 teams[2] and *Health of Looked After Children and Young People*[3] 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'.

1 Moran P, Ford T, Butler G, Goodman R. Callous and unemotional traits in children and adolescents living in Britain. *Br J Psychiatry* 2008; **192**: 65–6.

2 McKay I, Caan W. Free expression: tailoring health services to young offenders in Barking & Dagenham and Havering. In *Listen to Me: Consulting Young People on Health and Health Issues*: 91–100. Barnardo's, 2002.

3 Caan W. Not overlooked any more (Foreword). In *Health of Looked After Children and Young People* (ed K Dunnett). Russell House, 2006.

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doi: 10.1192/bjp.192.6.476a

Evolutionary psychiatry on the 150th anniversary of *On the Origin of Species*

It was Theodosius G. Dobzhansky, the renowned geneticist and evolutionary biologist who wrote that 'nothing in biology makes sense except in the light of evolution',[1] yet psychologists and psychiatrist, 150 years after the publication of Darwin's *On the*