

Authors' reply: Sue Kemsley has raised some important issues regarding ECT. The use of ECT without consent has not declined in absolute numbers since 1985 but, as discussed in our editorial (Eranti & McLoughlin, 2003), the total number of patients receiving ECT has substantially fallen during this period. Little research has been directed at understanding this change in the pattern of ECT use. One possibility is that there exists a core group of patients with severe depressive illness and possible psychosis that requires treatment with ECT, while the decline in use predominantly occurs in people with less severe illness. So why has the use of ECT declined in this latter group?

As we have already suggested, we believe that this is due to historical changes in general psychiatry, especially psychopharmacology. One has to bear in mind that, following its introduction in 1938, ECT was one of the first truly effective treatments for severe debilitating psychiatric disorders and thus its use rapidly became widespread (Fink, 2001). We are currently investigating trends in ECT practice over the past 50 years in the Maudsley and Bethlem Royal Hospitals in south London. Its use peaked in 1956 when 34% of admissions were treated with ECT. This rate fell steadily thereafter to 30% in 1959, 21% in 1968 and 5% in 1987. It is interesting to note here that imipramine was introduced in 1958, coinciding with the beginning of this decline in use of ECT. Similarly, ECT use further declined after the introduction of fluoxetine, the first of the selective serotonin reuptake inhibitors, in 1988, such that by 1991 2% of admissions received ECT. Currently, less than 1% of admissions are treated with ECT and nearly 90% of these have a diagnosis of major depressive disorder, which is well-established as being the main indication for contemporary ECT (Carney *et al*, 2003).

Carney, S., Cowen, P., Geddes, J., et al (2003) Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet*, **361**, 799–808.

Eranti, S. V. & McLoughlin, D. M. (2003) Electroconvulsive therapy – state of the art. *British Journal of Psychiatry*, **182**, 8–9.

Fink, M. (2001) Convulsive therapy: a review of the first 55 years. *Journal of Affective Disorders*, **63**, 1–15.

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Inappropriate use of psychostimulants

Rey & Sawyer (2003) ask 'Are psychostimulant drugs being used appropriately to treat child and adolescent disorders?' – the answer is no. Like most articles on psychostimulants, they avoid discussion of the fundamental question that needs tackling for their conclusions to have any meaning – is attention-deficit hyperactivity disorder (ADHD) a valid medical disorder? The answer is no (see Timimi, 2002). This disorder is best understood as a cultural creation. Rey & Sawyer illustrate how deeply practice in this area is influenced by cultural dynamics. They show how there are large variations in the way diagnostic criteria are used both between countries (not surprisingly, they only mention Western ones) and within them. They show that there are also large variations in the way psychostimulants are used.

Children are already the losers here. There are reports of some primary schools where nearly 40% of the students were taking psychostimulants (Runnheim, 1996). Rates of diagnosis of ADHD and subsequent medication use continue to rise alarmingly in most Western countries. This is a massive, dangerous and scandalous experiment in which millions of children are being exposed to highly toxic, addictive and brain-disabling drugs whose medium- and long-term efficacy and safety have not been established (Breggin, 2002). The only winner is the profit margin of the pharmaceutical industry.

I realise this is emotive language, but then the business of what values we hold when it comes to children is too important to allow us to hide behind dry, detached, academic pretence. We live in a culture that has a deep intolerance for children. This is at the heart of why we are labelling physically healthy children with fictional medical disorders. Doctors become a symptom of this intolerance, not part of the solution.

This is all so unnecessary. For years I have been working with these children and their families using diverse perspectives based on a more humanitarian value system (Timimi, 2002). Not only are my clients grateful for this, they often recommend others to come and see me.

Breggin, P. (2002) *The Ritalin Fact Book*. Cambridge, MA: Perseus.

Rey, J. M. & Sawyer, M. G. (2003) Are psychostimulant drugs being used appropriately to treat child and

adolescent disorders? *British Journal of Psychiatry*, **182**, 284–286.

Runnheim, V. A. (1996) Medicating students with emotional and behavioural disorders and ADHD: a state survey. *Behavioural Disorders*, **21**, 306–314.

Timimi, S. (2002) *Pathological Child Psychiatry and the Medicalization of Childhood*. Hove: Brunner-Routledge.

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Stigma as a cause of suicide

We read with great interest the article by Eagles *et al* (2003) in which, among the various interventions discussed to prevent suicide, it was suggested that according to patients' opinions there should be a decrease in the stigma attached to psychiatric illness. We share that opinion and suggest that another goal of suicide prevention is the reduction of the stigma attached to suicide.

The term stigma refers to a mark that denotes a shameful quality in the individual so marked. Mental illness is widely considered to be such a quality, an assumption supported by a number of beliefs such as the association between mental illness and irrational and unpredictable violence as portrayed by the media and the notion that mental illness is not a 'true' illness like organic disease. And yet, people do fear mental illness and do not know how to avoid it by following the types of precautions and guidelines available for so many organic disorders.

Not only does the stigmatisation of mental illness prevent people from seeking treatment, which in turn exposes them to a greater risk of suicide, but also suicide can appear to be the best solution for a stigmatised individual. A number of environments can be traced where this process takes place. In the family, the family members' relationship to the patient may affect the extent to which the patient's stigma is transferred to the family members, as in the case of schizophrenia (Phelan *et al*, 1998). In such extreme cases, difficulties in dealing with a chronic disease, which often results in relapses, hospitalisations and social impairment, leads family members to stigmatise the patients. They behave in a way that may lead the patient to assume that suicide might be a solution for their situation. Family members may also unconsciously believe that suicide might be a solution. In the hospital, staff's