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The Utmost Discretion: How Presumed Prudence Leaves Children Susceptible to Electroshock

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This article examines the controversial and largely publicly undocumented practice of administering electroconvulsive therapy (ECT or electroshock) to children who are undergoing psychiatric treatment. Conventional psychiatric beliefs and practices are challenged, along with a presentation of the history of scientific research which questions electroshock's 'effectiveness' and outlines its brain-damaging and incapacitating effects. As such, we provide counterarguments regarding the legitimacy of ECT as a treatment option, deconstructing the principle of presumed prudence in its use. Our analysis leads us to conclude that the 'principle of presumed prudence' should be eschewed in favour of the 'precautionary principle', in order to underscore and uphold the medical ethos 'to do no harm' *and to ensure the application of children's rights within the psychiatric system.* © *2014 John Wiley & Sons Ltd and National Children's Bureau*

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Introduction

Most people in the general public are not aware that children are given electroshock (also known as ECT or Electroconvulsive Therapy). However, many professionals who work with children know otherwise and some of those professionals, worldwide, have united in calling for a ban on electroshock. (See for example the British Psychological Society. www.bps.org.uk) The dearth of information on the use of ECT with children from nation states, governments, psychiatric facilities, professionals, and academics, is of concern as the anecdotal evidence of its usage suggests that it is far more widespread than thought (see for example, Wells & Zlomislic, 2012; UK ECT Review Group, 2013). That is, anecdotal evidence suggests that the use of electroshock on children may be more widespread within the USA, Canada, and part of Australia, than in the UK. However, real comparisons require the analysis of statistics. These statistics are either not kept or are not released to the public within most juris-

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dictions around the world, thus precluding an ability to raise awareness on this issue worldwide. Without publicly available reliable statistics, we can neither claim that it is a rare phenomenon nor that is widespread. However, anecdotal evidence from young people, families and (often quietly) dissenting practitioners, suggests that we, along with other children's rights advocates, must demand transparency of its practice and the divulging of numbers of children who are currently subject to electroshock, within all countries around the world. The ongoing and growing interest within psychiatry in prescribing electroshock or shock-like procedures for treating certain behaviours or conditions deemed *psychoneurologic* in children is of grave concern, given that the plethora of evidence that electroshock has at its very core an intent to damage and incapacitate the brain appears to be ignored. With this in mind, the purpose of this article is to raise awareness of the unacknowledged risks for children generated from policies, practices, position statements and the academic literature that suggest *discretion* to be the deciding factor whether children receive electroshock or not. We affirm that the administration of ECT, and this use of professional *discretion,* constitutes a children's rights issue falling under the United Nations Convention on the Rights of the Child (UNCRC, 1989).

Defining electroshock

Electroshock is a procedure that involves the passing of 100–190 volts of electricity through a patient's brain in order to cause a convulsion or grand mal seizure (Breggin, 1998). This procedure is usually prescribed for psychiatric diagnoses of major depression, bipolar disorder, mania, some forms of schizophrenia and, as of late, for some forms of autism (Gomez, 2004). The procedure can be performed either bilaterally or unilaterally, with bilateral by far being the most commonly used and most destructive to autobiographical memory (Breggin, 1998). Whilst the voltage used to induce a seizure varies with the age and gender of the person, the procedure now always involves a general anaesthetic, a powerful muscle-paralysing agent used in order to prevent fractures, and artificial respiration with oxygen because the muscle paralysis renders the person unable to breathe independently. However, these 'improvements' raise the seizure threshold, which therefore requires increased electrical energy in order to cause a seizure (Breggin, 1998). Whilst a typical course of electroshock for adults is six to 12 treatments, administered two to three times a week (Gomez, 2004), the typical course for children and young people remains intangible.

Current international trends with children

Recently, the Western Australia Mental Health Minister released draft legislation that enables children as young as age 12 to consent to electroshock and psychosurgery without parental consent (Whitley, 2012). This development is puzzling because in 2009 the same government sanctioned a ban on electroshock on children under the age of 12. This ban came on the heels of substantial publicity stemming from Australian Medicare statistics that recorded 203 ECT treatments on children younger than 14 — including 55 aged four and younger — in the space of only 12 months (Hale, 2009). Whilst psychologists in the UK have recently called for a ban on ECT in children, citing it as inhumane, ineffective and damaging (Hagan, 2011), there nonetheless appears to be a renewed campaign promoting the use of electroshock extending its use on children with autism. The *Autism Key,* an online information and support network, states that ECT is being recommended and used on autistic children who self-harm and warns about more 'widespread autism applications', noting a lack of evidence that electroshock is safe for children (see www.autismkey.com). Yet, Max Fink (2009), arguably the most influential ECT doctor of the last several decades, has publicly argued that the 'prejudice against the use of ECT in this population warrants reconsideration' (p. 93). He

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effects on the functional architecture of the brain' occur in the same areas as lobotomy (Perrin and others, 2012, p.1). Nearly 35 years ago, Freeman and Kendell (1980) found that 74% of former ECT patients reported continuing memory impairment and approximately one-third stated that their memory had been permanently affected a year or more afterwards. Similarly, the Consensus Development Conference on Electroconvulsive Therapy organised by the National Institutes of Health (1985) found that patients reported memory impairments as long as 3 years after treatment. Following years of criticism over the failure to acknowledge interminable memory loss as an outcome of ECT, internationally renowned electroshock proponent Sackeim and others (2007) followed up 347 adult patients given ECT in routine outpatient practice, evaluating them with neuropsychological testing up to 6 months later. For all types of ECT, they found lasting serious effects on mental function, including three tests for memory retention, one test for attention and one for the all-important autobiographical memory test, which was severe. Most patients showed unresolved deficits on the modified Mini-Mental Status examination: a test for dementia, which by definition reflects underlying brain damage. Given these negative impacts on 'developed' adult brains, it raises serious questions about not only the use of ECT on adults but also on the trauma-sensitive growing brains of children.

The ECT position paper from the Canadian Psychiatric Association (Enns and others, 2009; p.3) acknowledges that multiple ECTs are 'not supported by scientific evidence, and are not recommended'. However, the next sentence endorses it 'if a particularly rapid treatment response is required', implying ECT might be a lifesaver if all else fails (p. 8). However, Breggin (2008) aptly demonstrates that ECT is anything but lifesaving. Instead, a recent study found an overall increase in suicide in patients previously given ECT and a 'greatly increased risk' in patients treated within the previous week with ECT (Munk-Olson and others, 2007; p. 437). In addition, there is little evidence for any overall effectiveness, and Ross (2006) argues that there is no evidence for any positive effects beyond 4 weeks after the last ECT, suggesting this as the reason many patients are prescribed what is called 'Maintenance ECT' (Ross, 2006).

Breggin's (2008) analysis of the research literature demonstrates that the brain incapacitating and brain-damaging effects of ECT are directly sought through the procedure. That is, proponents indicate that ECT has its impact by purposely damaging the brain. The *temporary* resultant euphoria or, more commonly, the resultant apathy and indifference, are considered an improvement and resemble a 'taming effect' (Abrams and Taylor, 1983) which are uncritically treated as markers of success (see also Burstow, 2006; 2012). With so little known about the formation and process of children's physically developing brains (Baker, 1996), purposely inducing damage through a scientifically unfounded procedure (Enns and others, 2009; Ross, 2006) arguably represents unacceptable high risk experimentation on children.

Problematic concepts emerging in the literature: controversy, scarcity and discretion

An examination of the literature regarding the use of electroshock specifically in children reveals various thought-provoking trends. These include calls for discretionary use, presenting ECT as a 'last resort treatment', and citing the controversial nature of the procedure and the scarcity of sufficient empirical evidence concerning the efficacy and safety of ECT in children as the reason for discretion. However, apart from Baldwin (1996) and the British Psychology Society (Hagan, 2011), no others have argued for a complete ban.

The notion of ECT as a last resort treatment for children emerges most often alongside claims for its necessity in specific situations, i.e. for children with 'life-threatening illnesses' (Case and others, 2013; Cizaldo and Wheaton, 1995; Cohen and others, 2000; Esmaili and

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Malek, 2007; Ghaziuddin and others, 2000; Rabheru, 2001; and Wachtel and others, 2011) and for those children whose 'illness' has proven 'unresponsive' to medications (Bloch and others, 2001; Case and others, 2013; Cohen and others, 2000; Ghaziuddin and others, 2000; Kutcher and Robertson, 1995; Rey and Walter, 1997; Shoirah and Hamoda, 2011; Walter and others, 1997; Willoughby and others, 1997). With many distressed patients — both adults and children — experiencing a lack of improvement or increased distress with medication use (Whitaker, 2010), this presumably leaves many patients susceptible to 'last resort treatment'. Moreover, resorting to treating children with 'life-threatening illnesses' using a procedure that itself may be life-threatening, given its association with increased suicide (Munk-Olson and others, 2007), seems self-defeating.

An additional salient thread in the literature is the caution that electroshock is to be used in children only with extreme discretion (Kutcher and Robertson, 1995; Rabheru, 2001; Shoirah and Hamoda, 2011; Wachtel and others, 2011; Willoughby and others, 1997). A variety of concepts were used to support these cautions, including raising issues around consent, risk, cost-benefit analyses, lack of knowledge, dearth of literature and electroshock's controversy. However, discretion is a concept that inherently summons the subjective judgment of the clinician, and this unilateralism ultimately and problematically positions the clinician to have the final say in the administration of electroshock.

Another noteworthy trend in the literature is the claim that electroshock is either rarely or very infrequently given to children and adolescents (Case and others, 2013; Cohen and others, 2000; Ghaziuddin and others, 2000; Taieb and others, 2002; Walter and others, 1997; Willoughby and others, 1997). However, these arguments are routinely made without reference to actual statistics, thus ignoring the lack of available data necessary in order to make these claims (Jones and Baldwin, 1996). The scarcity of literature in the area of electroshock and children is noted by several authors, along with an acknowledgement that the literature that is available consists of only small anecdotal case reports and studies of very small sample sizes (Bloch and others, 2001; The Brown University Child and Adolescent Psychopharmacology Update, 2005; Cizaldo and Wheaton, 1995; Taieb and others, 2002).

Advocates of ECT acknowledge that the treatment is controversial and that most child psychiatrists report inadequate knowledge and cite these as reason for showing caution in administering it to children (Bloch and others, 2001; The Brown University Child and Adolescent Psychopharmacology Update, 2005; Cohen and others, 2000; Esmaili and Malek, 2007; Garry and others, 1997; Rabheru, 2001; Shoirah and Hamoda, 2011; Wachtel and others, 2011). However, perhaps the most troubling trend in the literature is the attempt to cast doubt on first-person narratives describing the damaging side effects of ECT. For example, Shorter and Healy (2007) state that 'the charge of brain damage from ECT is an urban myth' (p. 3), claiming that 'therapeutic convulsions induced by electricity, by contrast [to epilepsy], do not harm the brain and can save lives' (p. 9). The crux of their argument seeks to cast doubt on personal testimonies (see van Daalen-Smith, 2011; Weitz, 2013) of permanent memory loss from electroshock, opting rather to endorse extreme or intensive electroshock, whilst at the same time describing its devastating impact. Citing Bender (1947), Shorter and Healy (2007) give a positive assessment of using intensive electroshock on children yet describe the goal of intensive electroshock as the reduction of the individual to a state of 'neurological dilapidation'. In so doing, proponents take no responsibility for presenting the lack of efficacy of electroshock and more importantly, its proven risk of causing persistent cognitive deficits, dementia and brain damage.

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Children's rights and electroshock

Within the UNCRC is a 25-year call for access to information, to freedom from any form of mental or physical harm, and a requirement that any child in any form of state care has frequent reviews of the treatment he/she receives. Child-serving professionals and advocates would do well to turn their attention to the renewed psychiatric interest in ECT for children and young people, with specific reference to children's rights legislation.

Fifty-four articles of the UNCRC together ensure children's provision, protection and participation rights. Whilst article 24, which argues that children have a *right to health*, might seem to be the most obviously applicable article; it is other articles in relation to participation and protection rights that beg the attention of those that would seek to ensure the rights of children who find themselves in the psychiatric care of state parties. Article 19 argues that children have the right to be free of mental or physical violence within institutions. Article 12 states that children have a right to have a say in matters that affect them. Article 13 states that children have a right to information — full and truthful information, particularly when it affects their lives. Article 25 states that children have the right to have treatment reviewed and Article 37 argues that detainment of any kind must be viewed as a last resort.

The UNCRC's three guiding principles of *non-discrimination, participation and best interest* are important to consider. Due in part to the 'inherent adultism within society generally and within children's services specifically' as identified in a study documenting children's experiences with psychiatric hospitalisation (LeFrançois, 2008, 2013), the *Best Interest* principle is often one of the most misapplied. Rooted in insular notions of adults-know-best, children's 'innate decisional incapacity', and the exhaustion of (albeit limited) treatment options, electroshock becomes characterised as the 'last resort'. In so doing, conceptualisations of *Best Interest* become perilous, adultist and paternalistic.

Consistent with the UNCRC, children in psychiatric facilities legally and technically have the right to a say in matters that affect them, to full and truthful information and to be given the opportunity to consent or refuse treatment. Children only lose such rights when they are deemed incompetent and involuntarily detained in psychiatric facilities. However, children who are 'voluntarily' admitted to psychiatric facilities, or who 'voluntarily' receive outpatient treatment, continue to hold the right to informed consent to treatment — a right that is embedded in the policies and statutes within most countries and jurisdictions (In some countries, there is an age-based cut-off of, for example 12 or 14, where younger children are automatically deemed incompetent and lacking capacity to consent, with other countries granting this right to all children regardless of age, as long as they are not deemed incompetent to consent to treatment). Given that most child patients hold voluntary status in the UK (Partridge and others, 2010; Tulloch and others, 2008) and, indeed, elsewhere in the world (LeFrançois, 2014), these children and their parents or carers must be given full and unbiased information regarding the effects of electroshock prior to giving or withholding consent. If this information is not forthcoming or incomplete, consent cannot be considered 'informed'.

The term 'voluntary' here refers to those children who are admitted to psychiatric hospitals without being detained formally, to make a distinction between those who are 'involuntarily' detained through mental health or children's specific legislation. However, it must be stressed that children who are 'voluntary' patients generally do not volunteer themselves for admission, but instead are volunteered by their parents or carers. As such, arguments have been made in the literature that the term 'informal' ought to be substituted for 'voluntary' as a more accurate description of the ways in which the majority of children are admitted to

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psychiatric hospitals and to underscore the misnomer in the application of 'voluntary' to child patient (Coppock, 2002; LeFrançois, 2008).

By contrast, when children are detained 'involuntarily', although they no longer retain the right to consent to admission and treatment, there is nonetheless a legal framework in most jurisdictions that outlines policies and practices that must be followed and that are monitored to ensure other specific rights (such as the right to review, the right to appeal, etc.). For the most part, this legal framework and monitoring — and hence the accountability demanded of child psychiatric institutions — is absent for children who are 'voluntarily' detained, even though their 'voluntary' status enables them the right to consent to treatment. As a result, children's rights generally within 'voluntary' committal are largely unmonitored, and often not accorded (LeFrançois, 2008).

With the persistent consideration of ECT as a viable treatment option within psychiatry generally and within child psychiatry specifically (see, for example, Fink, 2009), it is hard to imagine professionals within child psychiatry providing children and their carers with information that debunks the positive claims and underscores the damaging effects that have been highlighted in several studies (see Read and Bentall, 2010; Sackeim and others, 2007; Sackeim and others, 1993) as noted above. Again, this puts into question the extent to which consent to electroshock may be considered *informed*. The right to informed consent in the UNCRC gives children the right to voice their opinion and engage in decision-making on an equal footing with the views expressed by professionals and by their parents/carers (Article 12), as well as the right to the provision of information (Article 13). As such, article 12 and 13 should be applied in practice within child psychiatry when any treatment is prescribed, including electroshock. This is crucial because the extent to which children's rights to information and expressing their views in relation to proposed treatment has been found to be limited or non-existent with 'voluntary' child patients (LeFrançois, 2007, 2008, 2014). That is, after informal admission to a psychiatric facility, children may be assumed to have consented to all forms of treatment by professionals or professionals may believe that children should not be allowed to participate in decision-making (Department of Health, 2010; LeFrançois, 2007) regardless of their status as legally 'competent.' With the looser protocols around accountability within child psychiatry in relation to 'voluntary' patients in many jurisdictions, this lack of appropriate process to obtain consent to individual forms of treatment or the outright refusal to adhere to children's rights to consent by some practitioners (Department of Health, 2010), for the most part, remains undocumented. This lack of documentation and monitoring ultimately leads to little or no opportunities for redress, particularly for those children who are not aware of their rights to consent or refuse consent to treatment in the first instance. The lack of safeguarding and adherence to the right to informed consent with 'voluntary' child patients within child and adolescent psychiatry leaves children at increased risk for being administered electroshock — even if deemed only a 'last resort' — and succumbing to the damaging effects that it produces.

The trouble with the tenet of 'last resort'

Claims that electroshock is a treatment of last resort can be readily found within policy manuals, practice guides and published reports. Rooting the 'last resort' decision in a child's 'failure' to respond to 'typical treatments' — most often meaning powerful cocktails of dangerous drugs (see Breggin, this volume and Mills, this volume) — situates responsibility for said failure on children themselves and not on the psychiatric drugs, with their multiple side effects (see Breggin, 2007; LeFrançois, 2006). Suggesting there is a *last* resort fails to

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adequately search for or explore other modalities: modalities perhaps outside the typical biogenetic paradigm.

Apart from suggesting that giving electroshock to children is a rarity and a treatment of 'last resort', when in practice it does not appear to be so in many jurisdictions, proponents seemingly ignore or dismiss the testimony of thousands of electroshock survivors who have recounted the myriad ways that electroshock has damaged them (van Daalen-Smith, 2011; Weitz, 2013; Edjaredar and Hagen, 2013; Ejaredar and Hagen, 2014; Rose, Wykes, Bindman and Fleischman, 2005). Rather than acknowledging the volume of evidence that ECT damages the brain, many proponents of electroshock suggest that the barriers to electroshock are stigma and resistance (Wachtel and others, 2011) or unrealistic fears (Cohen and others, 2000). Failing to fully recognise the scientific basis for the resistance to electroshock treatment, and rendering the evidence of damage invisible, are disservices to the children and young people to whom this procedure is prescribed. In many instances, the rationale provided for the use of this procedure roots itself not in proof of safety or assurances of non-maleficence, but rather in promises of beneficence and a desperate attempt to 'do something'.

Perhaps most troubling is the palpable assumption that promises of prudence and 'the utmost discretion' will keep paediatric use of the procedure to a bare minimum. Psychiatry has always promised to use its most damaging treatments, such as lobotomy and electroshock, as a last resort, asking society to trust that its prudence will impose self-restraint. Meanwhile, psychiatric discretion has involuntarily incarcerated, drugged, electroshocked, lobotomised and confined millions of people worldwide — including children and young people.

The problem with presumed prudence

Any presumption is problematic, but when a child's life as well as his or her current and future brain function lies in the balance, a presumption of prudence — someone else's prudence — is an unacceptable and insufficient measure to protect the child from harm. Even when embedded in models of individualised or family-centred care, presumptions of prudence regarding the application of electricity to a child's developing brain assumes that for *some* children it would be warranted. Various antishock advocates have voiced ethical objections to electroshocking children and young people. Jones and Baldwin (1996), for example, report on the ethical problem of over-selective reporting and omission of negative effects of electroshock in the literature. They attribute this reporting problem to strategic marketing of electroshock to avoid negative feedback and censure from the public. Yet, codes of ethics exist and are created in order to govern the moral conduct of practitioners, including psychologists, physicians, nurses, social workers or most other cognate professionals. Whilst there may be slight linguistic variations among them, many codes of ethics for medicine, nursing, and social work view client autonomy, beneficence, and non-maleficence as central. When considering these principles in the context of child psychiatry in general, and the use of electroshock with children more specifically, presumptions of prudence leave practitioners on a perilous perch.

Whilst the problem with presumed prudence lays mostly in its hope that *someone else* will have made sure the intervention will not do damage, that it is the right treatment and that it will help the situation of distressed (or distressing) children, we must consider and analyse another aspect of presumed prudence. Specifically, presumptions of prudence fail to adequately underscore the culpability of everyone working in some way with children receiving electroshock. All professionals, even those seemingly on the periphery of children's receipt of electroshock, bear ethical responsibility for their complicity in this procedure.

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In the best interest: adoption of the precautionary principle

Perhaps an extension of medicine's ethos *'to do no harm'*, the Precautionary Principle has direct and compelling application to the rights of children in psychiatric care. It states: 'if an action or policy has a suspected risk of causing harm to the public or to the environment, in the absence of scientific consensus that the action or policy is harmful, the burden of proof that it is *not* harmful falls on those taking the action' (European Union Communication on the Precautionary Principle, 2000; Science and Environmental Health Network, 2000). The relevance of this principle to the use of electroshock for children is apparent, given the overwhelming evidence of brain damage in adults and animals. For as argued by academics at the Wingspread Consensus, 'when an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically' (Wingspread Consensus, cited in Weir and others, 2010; see also, http://www.sehn.org/wing.html).

Conclusion: a reliance on discretion is never enough

A noticeable gap in the literature is a focus on prevention — prevention of the various reasons many children come to be prescribed electroshock. Trauma/abuse and the self-harm associated with autism diagnoses serve as two examples. An upstream approach to children's health and quality of life focuses on determining the causes in the first place rather than situating efforts *downstream* in an attempt to address symptoms or cure illness (Butterfield, 1990). With the recent exponential rise in autism statistics in North America prompting Autism Canada to call the rise a 'public health emergency', it is of concern that electroshock has made it into the list of possible treatments (The Autism Key, 2013). The suggestion is that electroshock *might* be able to extinguish some of the more challenging symptoms associated with autism spectrum disorder, such as self-harming. However, in the absence of anything but unproven theories backing electroshock, proponents hope to attack and incapacitate *only* the brain cells responsible for self-harming, amongst other symptoms. This type of cure is precarious at best, where approaches that seek to prevent the distress in the first instance would extinguish the need to explore such treatments.

No amount of discretion is enough to protect children from the damage that electroshocking their brains brings. Further, presumptions of prudence serve only to excuse, justify or demand the silence of cadres of practitioners who are aware that this procedure is being done to children. The failure of psychiatric drugs, the persistent lack of upstream strategies, or compelling arguments that there are no alternatives, ought not to mean that children and young people are subjected to a procedure whose sole intent is to incapacitate and damage the brain. The logic is dangerously skewed and is counter to the rights enshrined in the UNCRC. Consider the evidence regarding electroshock procedures for children and young people: it infringes upon their rights, particularly when it comes to the question of informed consent; it carries a high likelihood of brain damage; the concept of 'last resort' is a misrepresentation; first-person accounts suggesting the efficacy of such procedures are in short supply; and, there is a lack of documented verification that such procedures are non-maleficent. In the light of these factors, we may in good faith draw only one conclusion: submitting children and young people to electroshock procedures is never justifiable. Psychiatry cannot be left with this unlimited power to decide who should or should not be subjected to brain-damaging procedures. We argue that the precautionary principle rather than psychiatric discretion be the ordinance which determines how best to support distressed (or distressing) children. To that end, given the volume of evidence

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demonstrating its substantive brain-damaging outcomes, we call for an immediate global ban on the use of electroshock on all children. Further, we call upon the United Nations to strike a committee exploring the rights of children who are undergoing psychiatric treatment.

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