ABSTRACT

While the use of ECT has declined in recent years, nevertheless, it is still used in psychiatry for the treatment of depression and/or suicidal ideation. Proponents of ECT argue that it is "quick, clean and efficient," bringing an otherwise chronically depressed/suicidal individual back to normal or even outgoing psychosocial functioning in a relatively brief period of time. Unfortunately, the extant evidence suggests that ECT "works" by inducing an acute organic brain syndrome with accompanying memory and cognitive deficits. As patients are often given repeated treatments, it is apparent that ECT is a symptomatic procedure which probably adds to the individual's pre-existing psychological difficulties. The present paper summarises some of the literature pertaining to the adverse effects of ECT.

In recent years, the use of Electroconvulsive Shock Therapy (ECT) has declined somewhat in the treatment of depressed and suicidal patients (Kramer, 1985). This decline has been partly a response to public outcry against the procedure, particularly by former mental hospital patients, informed citizens, and even neurologists and psychiatrists (cf. Breggin, 1979; Friedberg, 1976, 1977). Psychiatric nurses (who run the risk of being denied registration if they refuse to participate in the administration of ECT) have also criticised ECT as inhumane and potentially intellectually damaging (e.g. Ross, 1981; Whyte, 1982; Packham, 1984). As these various authors (who are intimately acquainted with the "grass roots" application of ECT) have pointed out, the continued use of ECT remains highly controversial. If the procedures used were entirely safe and effective such controversy would not persist.

According to Ross (1981, p.20), some psychiatric patients receive literally hundreds of treatments with concomitant brain damage. Confusion, memory loss, headache and nausea generally follow each treatment (p.21). In psychiatric hospitals, patients are often treated involuntarily (p.22). ECT is clearly not able to prevent relapses of depression and suicidal ideation, as it is not uncommon for patients to receive repeated treatments at regular intervals (Whyte, 1982, p.42). According to him (p.43), "Psychiatry has relatively little to offer in terms of treatment once ECT has been used." Packham (1984, p.19) reported that ECT is often administered by junior psychiatrists and that most consultants who prescribe ECT do not administer it themselves. Over two-thirds of psychiatrists who use ECT typically employ bilateral rather than unilateral procedures (p.19). From a Royal College of Psychiatrists' report in The Lancet, Packham (p.20) reiterated that, "ECT was often given in large open dormitory wards with rows of patients lying on unscreened or only partially screened beds, with the treatment and anaesthetic machines being trundled from bed to bed...Many patients waiting for treatment could either see or hear the treatment being given to others." The resulting fear of ECT among psychiatric patients (cf. Jenike, 1983) is quite understandable. Packham (p.20) also
l'ewfik, 1984; Wise, 1984; Daniel, 1985. The use of multiple SC?

Apart from memory dysfunction following ECT, another major difficulty is the concomitant need to apply stronger electrical stimuli to induce the fixederg. Jenike et al., 1982. Price et al., 1984. Modified ECT given "straight" is not supported from reviews of the literature.

Causes of the brain dysfunction and cerebral damage e.g., Jenike, 1983, p.36, is apparent that modified ECT may indeed produce greater brain damage than SC?.

Using a brief pulse electrical stimulus rather than a sinusoidal galvanic current can avoid interference with normal brain functioning as evidenced by abnormal SEG recordings and the associated cognitive impairment which may persist, more or less, indefinitely in some cases. Breggin, 1979; Weiner et al., 1980.

In cases where MECT is used, prolonged seizures of up to one hour's duration have been recorded Abrams, p. 81; Weiner et al., 1980. Under these circumstances, reports supporting the efficacy of SC? cannot be accepted at face value.

While memory and cognitive deficits are frequent consequences of ECT, even those by Freeman et al. 1980, Shellenberger et al., 1981, Squire 1981, treatment with SC? results in a significant loss of personal self-identity. Retrograde amnesia sometimes extending back two or three years prior to treatment can be abolished and that it is not effective in treating depression and suicidal threats and concerns of patients with personality disorders are not likely to be accepted at face value.

It is good to have it superseded by better treatments.


PUBLICATIONS--Gregory J. Boyle

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Books in Preparation:


THESES

