The first electro shock was given to an Italian man known only by his initials as S.E. He had been arrested by the police department for vagrancy and was referred to hospital for observation. After a diagnosis of schizophrenia, he was identified as a first subject in the study. Although Cerletti sought permission to experiment on hogs he did not pursue the same procedure when conducting this human trial. He administered the first shock, which failed to induce a convulsion, because the voltage had been set too low. Whilst Cerletti discussed with colleagues how to proceed, he proceeded with his experimentation, and using a higher voltage, induced epileptic fits as a form of treatment. In 1938 Cerletti supplied the electricity through the head for the treatment of mania, brain wasting, dementia and melancholia. Strabeneck, 1986. It was, however, the independent practices of Meduna and Sakel who set the precedents for the induction of electroshock treatments. In 1872, Clifford Allbutt used the passage of electric current to backup its continued use. However, 'psychic' and 'psychiatry' were terms associated with ECT in the past. Modern-day psychiatry is concerned with how ECT works, and ECT maintenance.
of affect as an improvement in the person’s psychological state. It is at a great personal cost to the individual that psychiatric teams often meet their own goals.

ECT is a way in which psychiatrists, families and sometimes clinical teams deal with challenging and troublesome people. It is surely wrong to add force to the administration of ECT, though sectioning people under the Mental Health Act remains an option. People who are about to undergo ECT receive an abundance of information based on psychiatric literature, which fails to acknowledge the risks involved. They are often not given a clear picture of the risk of death, permanent brain damage and loss of memory [Hughes, Barraclough and Reeve, 1981]. With this information, people are coerced into taking a voluntary decision to receive ECT.

the repackaging of ECT

Although many studies have been undertaken to evaluate ECT, few have reached the minimal requirements necessary to establish scientific validity. With the limited material available to support the therapeutic use of ECT, the underlying basis for the widespread use of this intervention should be explored.

One explanation is that the way in which ECT is documented presents an imbalanced view. Although clinical evidence exists to demonstrate that ECT damages the brain. For example, “Generalised EEG-slowing both regular and irregular in morphology is the most prominent electro-physiological correlate of ECT. It is a non-specific abnormality consistent with diffuse cortical and sub-cortical impairment” [Weiner, 1980]. Weiner concluded that although the slowing had usually returned to baseline levels by three months, in some people it can persist for longer. This information is rarely quoted.

In contrast, leading texts promote ECT as a safe treatment, devoid of serious side effects. The uniform view is dismissive of many specific case histories in which extensive side effects are noted. For example, a survey [Freeman and Kendall, 1980] found that 30 per cent of shock victims reported permanent memory impairment following treatment.

In another example [Frank, 1990] “Each shock treatment was for me a Hiroshima. The shocking destroyed large parts of my memory including the two-year period preceding the last shock”. In addition, alternative literature which suggests that ECT is harmful is either ignored, or dismissed as a campaign by a minority group with extreme views.

Significantly, an overview of psychiatric literature demonstrates that the method of presenting ECT has changed. Early texts included many references to the incidence of brain damage associated with ECT. For example, Bini (1938) suggested that the “favourable transformation of the morbid psychic picture in schizophrenia was brought about by very severe and irreversible alterations in the nervous system”. Fink (1958) wrote that “the biochemical basis for convulsive therapy is similar to that of cranial cerebral trauma”; Hirsch Gordon achieved in plain English, “imbecility replaces insanity” (1948).

Many articles documenting long-term impairment, personality changes and brain damage following ECT appeared in psychiatric journals in the 1940s and 1950s. In the 1960s the neurologist Symonds stated, “after a series of bi-weekly treatments the clinical picture is like that of a more severe head injury” [Symonds, 1966]. In addition Lewis admitted that electro shock certainly produced tissue damage in the brain and concomitant impairment of mental functions including perception and capacity to learn [Lewis, 1967]. Neither Symonds nor Lewis were anti-psychiatrists.

An example of the change in the way that ECT is promoted is the “disappearing memory loss trick”. In the first (1946) edition of Psychiatric theory and practice for nurses, this quote appears: “There is a possibility of damage to the brain substance. Furthermore convulsions not only result in amnesia for the fits, but also enlarge memory gaps which may extend far back into the past”. By the fifth edition of the same book in 1962 the possibility of damage to the brain substance had become “remote” and a disclaimer had been added: “most of these memory gaps are eventually closed” [Beckle, 1946].

Advocates of ECT introduced the contra-indications of brain damage and many sources refer to “the need for careful consideration when deciding upon ECT as a treatment for clients who rely on their memory for employment”. Herskovitz, writing in the Philadelphia Psychiatric Society Journal in 1943, reported finding memory deficits among 174 people treated with ECT “to be rather general and prominent. Therefore patients whose occupation requires intellectual ability are selected for treatment with caution” [quoted in Frank, 1990]. Current texts often fail to report the negative consequences of ECT although adequate research to dismiss the possibility of permanent memory loss does not exist.

ECT results in acute brain syndrome. Sament, a neurologist, published his views on the brain-damaging effects of ECT in a letter to the editor of a professional journal, “I have seen many patients after ECT and I have no doubt that ECT produces effects identical to those of a head injury” [quoted in Frank, 1990].

Salzman (1947) investigated what he termed the “malignant effects of shock therapy on the personality of the individual”. He discovered that “the most persistent impression obtained is that shock patients show a picture resembling the post lobotomy syndrome”. McClelland (1988) believes that the changes Salzman observed in shock patients-disinhibition, euphoria and blunting are the classic signs of injury to the frontal lobes of the brain.

The debate remains about whether the damage is permanent, and if so, what is the incidence and severity? Anderson noted that every psychiatrist has seen such (post shock) amnesia last for years after treatment (1951). Memory impairment is a recognised side effect of ECT [Freeman, 1989]. Valentine (1968) gave the following description of memory loss: “a patient with marked ECT amnesia is likely to have substantial memory loss for the sequence of events immediately prior to treatment and also a very partial and scattered amnesia particularly for names, people and events extending backwards in time for many months”. Current psychiatric literature frequently does not address if this damage is permanent.
The figures for the Regional Health Authorities show wide variation. A study of individual consultants in one region (Gill and Lambourn, 1978) demonstrated that approximately one third of shock is given where a region is the most severe depression without ECT, while in the 1980s, only 1 to 2 percent of shock was given in regions where ECT is given. These figures confirm that there is still wide disagreement about the usefulness of shock.

There are very few psychiatrists in Britain who never use shock. Pippard (1981) found that psychiatrists who favoured physical treatments tended to have conservative social values and be tough-minded. Gill and Lambourn's embarrassing questions, have been ignored ever since: 'Why didn't the introduction of antidepressant drugs at the end of the 1950s do more to reduce the use of ECT?'

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when he refused to prescribe ECT. "When eventually I was in a position to refuse to give any more I was blacklisted from further promotion in a psychiatric career and was obliged to transfer to general practice."

The Royal College guidelines (Freeman, 1989) endorse ECT as a treatment not only for "severe depressive illness" but also for "less severe depressive illness", and as having a place in the treatment of mania, anorexia and schizophrenia (research to support the guidelines does not exist, nor are they a legal document).

In 1984 the medical newspaper Pulse reported that a Dr Woodland had for years used Electroconvulsive Therapy on his patients in general practice. According to the report, he had given more than 10,000 treatments to his patients in Falmouth, Devon, and then in London. At some point one in seven of the patients on Dr Woodland's list were receiving ECT as treatment. Dr Woodland claimed it helped patients suffering from arthritis, indigestion, irritable bowel syndrome and aphthous ulcers. He admits that he did not always obtain informed consent from his patients. Can these actions be justified? Many doctors think not. Dr Woodland has addressed meetings where audiences walk out. He has described his work as "research" and claims that stricter controls on research would "limit basic freedoms to practised medicine". One can conclude that psychiatry presently is beyond the law.

elderly people

There has been a dramatic increase in the number of elderly people who receive ECT. In the 1940s only four per cent of people given ECT for depression were over 66 (Karagulla, 1950); today half are over 65 years of age. Doctors claim that this group respond well to ECT and do not tolerate antidepressant drugs.

Is ECT-incurred brain damage, then, to be termed senility?

ethnic minorities

People from ethnic minorities appear to be over-represented among people who have received ECT when the diagnosis is schizophrenia, but not among people being treated for depression (Fernando, 1988).

women

Women form the majority of shock patients, with a ratio of 1:2.27 (Pippard and Ellam, 1981). Professor E. Paykel (Daily Telegraph, 31 January 1990) states that women suffer from depression more than men because life is more difficult for women. If this is so then ECT can be viewed as a punitive, oppressive, rather than curative, intervention which stops women complaining about their difficult lives.

children

Some psychiatrists administer ECT to children. This has constituted criminal assault (Baldwin and Jones, 1990). The youngest child reported to have received ECT was 34.5 months old (Bender, 1974).

ECT is administered to people in Great Britain, Scandinavia and many third world countries. It is less available in France, Germany, Holland and Italy (Fink, 1984).

in conclusion

In a changing health care system all professional services are required to demonstrate effectiveness. This is a major change for the medical profession which has historically enjoyed autonomy and not been subjected to such intense scrutiny. Society places tremendous pressure on doctors to "provide cures for all ills" and it is difficult for the medical profession to disclose a lack of advanced techniques in some clinical areas.

Within psychiatry it is not surprising that with the introduction of clinical audit some psychiatrists are now being confronted with their own lack of adequate training and professional skills to deal with complex human dysfunction. Psychiatrists threatened by their own professional limitations feel out of control and can often resort to using machinery and invasive physical techniques to achieve results. In some instances, as the psychiatrist's personal power is restored even bad results seem better than no results at all. Advocates of ECT will give many explanations to rationalise its continued use. ECT has been so strategically re-packaged that other professionals often tolerate and condone the use of ECT even with the most controversial client groups. Recently some of the most radical and frightening ideas to surface have been expressed by Max Fink (Fink, 1990). His recommendations have no scientific basis but appear in mainstream literature. Fink recommends the use of ECT not only in major depressive disorders but especially in those disorders marked by psychosis, melancholia, mania, catatonic states and Parkinsonism. He dismisses the medical risks associated with ECT and claims it is now safe to administer it with people previously considered to be in a high risk category. For example, people with heart/lung conditions, osteoporosis, brain pathology such as tumours, multiple sclerosis and even in pregnancy. As previously noted the same Fink in 1958 wrote that "the biochemical basis for convulsive therapy is similar to that of cranial cerebral trauma". Today he completely ignores that ECT works by damaging the brain and recommends maintenance ECT for people who relapse quickly. In fact Fink is also of the belief that manufacturers of ECT devices should design a machine with higher energy levels, thus advocating more damage to the brain.

Little has changed since 40 years ago when one psychiatrist wrote about constantly seeing:

... patients who have some serious trouble, some constant anxiety or fear, who have been given insulin, convulsions (shock treatment), prolonged narcosis or what not, yet no-one has taken them aside and treated them as human beings... These physicians who rush to apply mechanical treatments without proper psychological investigations are demonstrating their own ignorance.
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