To; Leonard
From: Diane

Based on
10 Bay Area
women who
were in
Napa State, 1957-61

ELECTROCONVULSIVE THERAPY, THE SELF, AND FAMILY RELATIONS

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This paper is concerned with the implications of electroconvulsive shock therapy (ECT) for the self and for family relationships. The perspective is interactionist, stressing the meanings of ECT to those who have undergone it: their interpretations of its purposes and effects, and its impact on their lives. This viewpoint, which has similarities to a "consumer" view of medical treatment, contrasts with the medical-model orientation of the psychiatrist ordering shock, and with the organizational perspective of the nurse administering it.

The data for the analysis are intensive interviews with ten women diagnosed as schizophrenic, and with their husbands, during the patient and expatient phases of their moral careers as mental patients (1). These ten women were among 17 admissions to California's Napa State Hospital in 1957-1961 who were the focus of a large-scale study of mental hospitalization and the family, the "Bay Area" study (2).

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The women were all white, were from lower to lower middle class backgrounds, had at least one child, were currently married, and ranged in age from 26 to 40. All but two were first admissions; all were interviewed at Napa State Hospital, where they stayed for an average of 19 weeks. The interviews began with the week of admission to Napa, and ended up to 100 weeks following release. The mean number of interviews with husbands or wives in the patient and expatient phases of the moral career was about 50 (3). A number of studies dealing directly or indirectly with these data have been published in the decades since the data collection. This paper is part of a larger re-analysis of the data (4).

An additional source of data is reinterviews with the original Bay Area sample in 1972, done by John Clausen and his colleagues at Berkeley. These interviews were one-shot, and took place with either the husband, the wife, or both where available. Although questions about ECT were not systematically asked in the reinterviews (which were focused on the marital relationship and the couple's children), the records include comments about ECT from five of the families.

The intensive interview method is an ideal one for developing an understanding of patients' interpretation of ECT and other therapies, since the interview focuses on verbalized meanings. Similarly, the ethnographic or observational method used by Goffman (1961), Perruci (1974) and other analysts of mental hospitalization and therapy is ideal for developing an understanding of the organizational or social control aspects of hospital life, since these methods focus on everyday life in the mental hospital ward.

The interest of the Bay Area data is both historical and contemporary. While ECT was frequently the therapy of choice in state mental hospitals in the 1950s, it fell into disfavor in the 1960s and 1970s, although not necessarily disuse. Between 40,000 and 50,000 patients yearly were given shock in the United States in the 1970s. In the 1970s and 1980s, private and voluntary "shock shops" sprung up in some metropolitan areas for the "quick and easy" treatment of depression at $30 and up at a rate of one patient every four minutes (5). Mental hospitals are once more proposing ECT as a useful, and, ironically, "innovative" last resort treatment for the suicidally depressed or catatonically schizophrenic.

ECT's return to favor as a therapeutic practice is occurring not so much in state hospitals—some states, such as Massachusetts, forbid its use in public mental hospitals—but rather in private hospitals and private practices (6). In a survey of the membership of the American Psychiatric Association published in 1981, only 6.2 percent of those members who completed the questionnaire (80 percent of the total membership of 600) reported using ECT in their practices (7); in 1985, however, a study estimated that 16 percent of APA psychiatrists used ECT (8). The greatest growth of ECT use in the early 1980s was in private psychiatric hospitals and psychiatric wings of private general hospitals (9). The impact of ECT on the selves and lives of its consumers, then, is of contemporary as well as historical significance.

THE HISTORY AND PRACTICE OF ECT

The use of electric shock in psychiatric medicine has a long history, predating the scientific and medical models of illness by many centuries:

> The use of nonconvulsive electrotherapy as a method for alleviating symptoms through suggestion dates back to Scribonius Largus (c. AD 47), who treated the headaches of the Roman Emperor with an electric eel (10).

The first electroconvulsive treatment for mental illness was, "Probably. . . administered by a French physician, J.B. Leroy, in 1755 on a patient with a psychogenic blindness." (11). The modern use of ECT began in the 1930s in Italy (12). Its use was premised on the claim of a Hungarian asylum superintendent that schizophrenia could not coexist with epilepsy in a human organism. There was no such thing as an epileptic schizophrenic; therefore, his reasoning went, the electroconvulsive (or insulin-coma) inducement of grand mal seizures would cure schizophrenia (13).

There is basically no theory of how or why ECT works, merely a belief on the part of some doctors that it does, and of others that it doesn't (14). Those in favor of the treatment claim that it relieves severe depression and that it is less harmful, in many cases, than alternative treatments such as psychoactive drugs. Opponents of ECT claim that it has never been proven scientifically to be of use, and that it often causes permanent long-term memory loss or even brain damage. Other side effects, agreed upon by proponents and opponents, are headaches, dizziness, loss of appetite, missed menstruation, flat affect or "slap happy" silliness, and short-term memory loss (15). The most problematic ECT side effect of ECT, however, is short-term memory loss (16). Experts and informants disagree over whether full memory finally recurs for all patients or whether it remains patchy, for at least some patients, in the long term (17).

Apart from the side effects, opponents of ECT respond negatively to the procedure itself. Unlike other body-related psychiatric therapies, such as taking pills, ECT is a culturally unfamiliar procedure which seems both strange and horrible to the observer. Friedberg describes the administration of shock as practiced in the early 1960s:

> In *bilateral ECT,* the most common technique, electrodes are applied to the patient's temples; in *unilateral ECT* they are placed over the forehead and occipit of one side of the patient's head. An electrolyte paste is used to reduce skin resistance and prevent burns. The voltage necessary to reach seizure threshold and induce a grand mal epileptic seizure—the object of the procedure—ranges from 70 to 150 volts and the current, which varies inversely with impedance, may be up to 1 ampere. The duration of the discharge is preset at .5 to 1 second. As the button is pushed there is an involuntary tonic spasm of the patient's facial musculature. This is followed, after several seconds, by violent shaking, the

grand mal convulsion. . . Most authors refer to the average use of 6 to 10 or 12 treatments of depressive illness and 18 to 25 treatments for schizophrenic illness (18).

One of the Bay Area patients describes ECT (probably bilateral) from an experiential perspective:

(Donna Urey)[1] "And you have been getting shock, you say this morning?"
"Yeah—I got shock this morning."
"What is that like?"
"Uh—it doesn't feel very good."
"Tell me about it, will you."
"Well, it's uh, it's like a blunt thing that hits your head—it doesn't feel very good."
"How long does that go on?"
"Oh just for a while, just for an instant, you know. . . . It's like a big thing, and uh it—takes both sides of your head, it goes *boom* like that, and all of a sudden you feel something, and after that you—don't feel anything."
"Are you conscious after that?"
"No, you're out completely."
"For about how long—have you any idea?"
"For about a half-hour."
"Then what?"
"Then you wake up—then you find you've been under shock."

PERSPECTIVES ON ECT

The medical, organizational and interactionist perspectives on ECT focus on different aspects of the treatment, within different sets of relationships and tasks at hand. The medical model is an organismic one, in which the cure of mental illness is presumed to come from changes in the structure or functioning of the brain. Like other psychiatric treatments, ECT has undergone changes over time, both in its manner of administration and in the disorders for which it is presumed effective. The convulsions and grimaces of the face noted by Friedberg (quoted above) have been eliminated by use of the new combinations of drugs, which have also greatly lessened the risk of fractured vertebrae or coronary arrest (19). Where ECT was used in the 1950s mainly for schizophrenia, and as an initial treatment, today the American Psychiatric Association recommends that its use be restricted to cases of severe depression, with limited indications for schizophrenia, and as a last resort treatment. There is some evidence, however, that even today ECT is used instead of other therapies, rather than as a last resort (20, 21).

The organizational perspective focuses on everyday control of patients on psychiatric wards. ECT can be used by nursing staff to maintain their positions of control over patients by the arousal of fear of ECT or by its sedative effect. As one Napa nurse said to a Bay Area interviewer:

(Eve Low) "Eve is to start ECT on Friday." Another staff member spoke up saying, "Boy, I wish they'd start her on it tonight, she can really be annoying. Wish you could see her at bedtime."

The interactionist perspective is concerned with the meanings of ECT and other treatments to the patient. Although there is no interactionist literature per se on ECT, there are numerous autobiographical accounts and case studies on which an analyst may draw. Most of the autobiographical accounts are of patients who have been forced into ECT against their will, and thus are highly critical of the procedure (22). Some of these "railroaded" expatients have joined together in political protests against ECT through patients' rights organizations. Since in both the 1950s and the 1980s about two-thirds of those receiving ECT were women (23, 24, 25), there is also a specifically feminist protest against it (26).

There are few autobiographical or case study sources on patients who volunteer for ECT or who are favorable toward the treatment. In a recent study of 166 patients in a Scottish hospital, 74 percent said the ECT had improved their condition, and 65 percent said that they would be willing to have it again. While 39 percent said it was a frightening procedure, half of these said that it was less frightening than going to a dentist. Almost a third, however, reported a lasting impairment of memory (27).

Neither the political nor the medical assessments of ECT are focused directly on interactionist issues of meaning and social relationships. The political critiques are concerned with ECT in relation to medical (and sometimes marital) dominance, while the clinical studies are concerned with outcome evaluation (28). The analysis in this paper is directed at other issues. How do patients perceive ECT—what do they think is being done to them? And what do they see as the purposes of the persons behind such doings? Do patients interpret ECT medically, organizationally, or in some other way? What, in sum, is the impact of ECT on self and family relationships?

ECT, THE SELF, AND FAMILY RELATIONS

As indicated, and with no pun intended, ECT is a shocking experience. Unlike many general medical procedures, such as pill popping, ECT has no cultural precedent available to consumers from magazines or TV advertisements. While the Bay Area patients often did not bother to discuss or worry about the pills they were receiving from Napa psychiatrists, they never failed to attend to the fact of current or proposed sessions of ECT (29).

Responses to ECT varied both between patients and over time according to the women's self-assessment of feeling better or worse as a result of it. But the most significant experiential feature of ECT, for these women, was the memory

loss attendant upon it. The interpretive work that they and their spouses engaged in, therefore, generally focused on the purposes and effects of memory loss in the context of their psychiatric treatment and of their everyday lives.

Interpretations of ECT

The situation of these hospitalized mental patients was one of uncertainty and lack of information, combined with submission to medical authorities (30). Especially for those wives committed by their hubands, hospitalization also meant arraying medical and spousal authority against them in a sort of conspiratorial betrayal (31, 32). The meaning of ECT, therefore—like the meaning of much of the hospitalization experience—reflected these themes.

The Bay Area women were completely uninformed by the Napa staff about every single detail of their ECT treatment.[2] They were not told what it was for, how often they would get it, what it would be like, or what the expected affects on their memory, physical sensations, or menstrual cycles would be. They relied almost totally on the patient grapevine for information. Other women patients, not staff, were almost always the source of information on such matters as ECT's effect on menstruation.

> (Shirley Arlen). "I haven't had a period for three months—but a lot of people that were on shock didn't have their periods right away."

One result of this lack of official information was that a number of women, including Shirley Arlen, spent some time worrying that they might have become pregnant prior to hospitalization.

Another feature of the lack of information in the hospital setting is what I have called, elsewhere, the "therapeutization of the everyday." Goffman (1961) has commented on the fact that staff tend to "symptomatize" the behavior of patients, imputing psychiatric meaning to even the most mundane activities. A parallel process is that of patients' "therapeutization" of the behavior of the staff, imputing medical meaning to even the most mundane activities (33). Thus, what doctors interpret as the "side effects" of therapeutic interventions—such as the memory loss attendant upon ECT—are liable to be interpreted by the patient as intended therapeutic effects.

Since the Bay Area patients therapeutized all hospital experiences that flowed in their direction, it is not surprising that the most commonly experienced effect of ECT, the erasure of memory, was construed as the *purpose* of ECT. For example, Shirley Arlen said:

> "I think the shock treatments are supposed to make you forget—when you do break down or whatever it is you do to get in here—I mean you're pretty sick and I think shock treatment is to make you forget a lot of things that got you sick and the way you felt and everything

like that—I mean it succeeded with me—I can't remember a lot of things—but I'd rather not. There's some things I'd like to but I think it was for the best that I can't remember a lot of things."

Among those who interpreted ECT as intended to erase their memories of their problems, some, like Shirley Arlen, were pleased with this idea. In the 1972 reinterview Shirley Arlen numbered ECT among the treatments that had helped her over the years. Joan Baker, too, wanted to get shock treatment to help her forget, and thus become a "different person":

I asked Mrs. Baker about the idea of getting shock treatments. She said, "I don't care what they do, as long as it helps me—helps me not to be depressed—helps me to be a different person, to like people. I want to forget—I don't know if I can or if I know what I mean when I say it—but my father never liking me as a child made me feel I was a monster, I was different, making me hide in my bedroom."

A number of women, dimly aware that they had said and done embarrassing things in the prehospital phase, were glad to have forgotten the details.

Other patients inclined to the belief that such forgetfulness would do them harm, by not dealing with their problems consciously. Eve Low said that:

"I did not feel that I wanted shock, because I don't think it is to my advantage to forget the incidents that happened to me as a child because it seemed to me that—ah—those incidents that were buried in my subconscious. . .so terribly unpleasant. . .it caused me to have a complex. . .Well after I remembered these different things, it explained to me why I felt as I did."

It is an irony of shock treatment combined with psychotherapeutic interventions that the one treatment involves an imputed medical authorization to forget, while the other involves the injunction to remember. A number of the patients were perplexed about this issue. Mary Yale, for example, had "Many questions concerning whether she should think about her troubles and feelings and history (her term: "analyze"), or forget them (her term: "repress")."

As indicated medical authority as well as uncertainty was an invariant feature of the hospital situation. In the late 1950s (although not in the 1980s) state mental patients could be given ECT without their consent. Thus, the use of ECT was experienced as coercive medical control. Eve Low discussed the unpleasant effects of shock, and the way in which "forcing" the treatment on her exacerbated her "paranoia":

"I don't believe that I can speak as coherently—I don't think my train of thought is connected. I am more apprehensive. I am more fearful at. . .what will happen to me. . .because. . .until I received shock I had never really been forced to do anything.

Like the feminist critics of shock treatment in the 1970s and 1980s, Eve Low was also concerned with the combined impact of medical and spousal authority in her "treatment":

> She went on to say that she'd been getting shock, though against her wish, and that she feels its purpose is to make her forget things, and to change her attitude, including her resentment toward her husband for committing her.

But medical control has subtle as well as overtly coercive aspects. The medical model of mental illness proposes a scientific treatment which is both appropriate and benign. Lidz et al. (49) indicate that patients are persuaded to consent to ECT by psychiatrists who asserted that they could do nothing else for the patients. Patients who are feeling severe distress and who are given no other alterations may agree to ECT and see it as helpful. This seemed to be the case with the Bay Area patients:

> (Ruth Quinn) Mrs. Quinn stated that she is afraid of shock treatment but she feels it has helped her a great deal.
> (Rita Vick) I asked Mrs. Vick whether she thinks ECT is helping her. She said, "I have noticed some improvement. I can be a little gayer for longer periods."

But reactions to the helpfulness of ECT varied with the patient's feelings in the given situation. In an interview the next week, Rita Vick said:

> "I thought the shock treatments would help." (Have they?) "I don't think so. They made me forget some things, but not enough. I haven't had enough, I guess." (Are they supposed to make you forget?) "That's what I heard—that's what everybody tells you—that it's to make you forget."

ECT, Memory and the Self

The self upon which ECT impacted had not only a contemporary dimension—mental patienthood—but also a historical one. The memory loss attendant upon ECT was interpreted by these patients in a context that included the historical self and its network of social relationships, and general cultural values such as the preference for remembering over forgetting. The Bay Area patients' memory losses related to everyday life as well as to their emotional troubles, and were integrated into historical self-conceptions related to personal competence at remembering.

The women were divided on the advisability of forgetting one's difficulties, but uniformly disliked the loss of everyday memory, as well as associated effects such as losing one's train of thought, incoherent speech or slowness of affect. What specifically was forgotten varied from the matters of everyday routine to the existence of one or more of one's children (see below). Donna Urey, two days after her second shock treatment said:

"Ever since I had that shock I can't even remember reading things."
"How does it feel to suddenly be like this?"
"It feels awful. Because usually I can remember pretty much of everything but knowing something and not remembering is pretty terrible."
"When did you first notice it?"
"Right after I got my first shock treatment."

Persons may characterize themselves, or be characterized by others as having "good" or "bad" memories. Donna Urey characterized herself in the interview above as having a good memory for things she had read, and was therefore bothered by the ECT-related loss of memory in that area. In another interview, however, she characterized herself as typically forgetful; the ECT loss of memory, therefore, was just another in a series of "shocking" but normal-for-her forgettings:

(Donna Urey). "How does it feel to have memory sort of—go out on you like this?"
"I don't know, it feels shocking—when I was at home—it happened the same way."
"It did? Can you tell me about what happened at home?"
"If I-if the kids don't remind me of something—then I forget—like if their Daddy tells me to phone them at work, during the day, and if they don't remind me then I forget—"..."Well you know one thing I would be kind of interested in, is if you could kind of collect your impressions of what it's like to be—to suddenly—have some holes in your memory?"
"It's not unusual."
"Not unusual for you?"
"No."

In asking the patients questions about ECT, the interviewers sometimes encountered an interesting research problem: they knew from the records that the women had had ECT, but when they asked about the treatment they discovered that ECT itself had been forgotten. In the 1972 reinterview, Wanda Karr described herself as unable to tell whether or not ECT treatments had affected her memory, since she didn't remember having the treatments:

She remembers only the last ECT, for which she was awake: "I remember the clamps on my head, the sparks as it started, and I was very frightened. Afterwards I woke up with the most terrible headache I ever had. It was like being hit on the head with a bat. It was really an awful experience." I asked if it had affected her memory. She said that immediately after the last one she couldn't remember things, but she doesn't know about the others since she doesn't remember the treatment at all. In talking about memory she said, "You know I can't remember anything about the hospital."

Like many contemporary psychiatric proponents of ECT (34), Mrs. Karr attributed her lack of memory of the hospital to her psychiatric disturbance rather than to the ECT treatments.

There is evidence from the Bay Area interviews that ECT may function repressively—that is, allow the person to forget disturbing events or persons.

Rita Vick, who was illegitimate and who had lost custody of five of her seven children, complained that "I can't remember my children's birthdays or my birthday." After a weekend visit,[3] which Mr. Yale described as very tense, the interviewer talked to Mary Yale:

> I asked very early about her visit home, and she looked puzzled. I recalled that we had talked last week about her plans to visit home, and she couldn't recall this. She stated flatly that she had not been home over the weekend. Later in the interview she was slightly troubled and doubtful over the questions I had raised about the weekend, and was wondering it if was perhaps possible that she had been home. What she did recall of the weekend was a very vivid nightmare, the first since hospitalization.

The patients may have been aware that their forgetting was at times repressive. Mary Yale said that she was bothered by her loss of memory because "I want to know *why* I forget those things."

Troubling life-events and relationships commonly forgotten by these women included the existence of their husbands and children, their own names, and their psychiatrists. Elsewhere, I have analyzed these women's resentments of their housewife-mother role, their sense of isolation and lack of identity, and of the combined medical-marital power that facilitated their hospitalization (35).

Forgetting can have a reparative or a disintegrative function for the self and social relations. Repressive forgetting may be useful in restoring a person's or a family's equilibrium following traumatic experiences. The specific impact of forgetting events in the past depends upon the salience of the events to the person in the present; while forgetting traumatic events may be restorative, forgetting mundane events may be traumatic. As the phenomenologists have pointed out, the reality of everyday life is the bedrock upon which we humans build our sense of a secure self in the world. Losing touch with everyday life—with a book read, with a church service attended—can threaten that sense.

Forgetting persons, which was frequent, seems to be a truly interactional difficulty; the image that the patient does not want to project is that of a person unable to carry on routine social interaction. This may be complicated by fears of insulting the other—that s/he is not important enough to be remembered. It is clear that *one* function of remembering someone's name is to demonstrate that one has the social competence necessary to participate in an ongoing social relationship: to the other's name are attached items of the common culture. There are probably other devices that people use in an unaware way which perform this same function, such as recalling an event experienced in common, or making a private joke. One function of the filling-in phenomenon—reminding the ECT expatient of past events—was to aid the forgetter in maintaining a favorable self-image: the image of a competent person.

It is difficult to assess, in everyday life as opposed to experimental settings, the restoration of memory in ECT patients. The ECT patients in the Bay Area

study were embedded in social networks that included husband, children, and other relatives who could and did perform a filling-in role. Thus, the restoration of memory may be in part—or entirely—a process of relearning, after ECT, under the tutelage of others.

ECT and Family Relationships

Memory is not only something experienced by the self, it is also an aspect of social interaction. Thus, the effects of ECT upon memory and the expectation of memory loss were both at issue in the Bay Area women's relationships—especially their family relationships, and especially in the expatient phase of the moral career. In addition, ECT-related memory loss was an issue, at times, in the interview situation.

It appeared to some of the Bay Area interviewers that their respondents used ECT-related memory loss as an excuse to forget. Although difficult to document through other than inference, their suspicion was of "purposeful" forgetting and the use of ECT as a rationalizing account:

> (Donna Urey). Throughout the interview the effects of ECT were marked in her slowed and somewhat thickened, flattened affect, and her mild confusion. She seemed to be discovering her memory loss only as I asked her for information which she could not remember. When, after a while, I switched to inquiries about her family, she brightened and said with comparative enthusiasm (and perhaps relief). "Now that's something I can tell you about!" . . . Although her memory loss is obvious, there were times when I felt that she was helping this along. This was principally when I was probing about her and her husband's feelings about her working.

The context for producing forgetfulness, as indicated by this example, was not wanting to talk about subjects that were painful, embarrassing, or revealing.

The social production of forgetfulness in order to avoid interview topics is, thus, paradigmatic of the social production of forgetfulness in other social situations. Expatients who have had ECT can conveniently "forget," and use ECT as an excuse; one Bay Area patient, waiting to be served with a subpoena in a civil case, said that she planned to tell the court that she had had ECT and therefore "couldn't remember a thing." She told the interviewer, however, that she "actually" recalled it all.

But the impact of ECT-related memory loss on family and marital relationships was not confined to the expatients' production of forgetfulness. Husbands and other relatives could and did use their wives' memory loss as an occasion for purposely not reminding the wives of things that the husbands did not want remembered, or (very rarely) for reminding the wives of events that had not in fact occurred. Although generally couched in the language of "doing it for her own good," these interactive memory strategies were related to the relative's relational purposes-at-hand.

All parties use ECT related memory (alleged + assumed) as a rationalization for deception.

Evidently, the memory purposes of husbands and wives could be at odds, with wives wanting to remember and failing to and husbands wanting them to forget and not reminding them—or any logical combination of these stances. The outcome of such divergent relational purposes was conflict over the content of past marital communications; thus, ECT-related memory loss became part of the everyday dynamics of marital interaction for some of the Bay Area families in the hospital and posthospital phases of the moral career, especially in the weeks immediately following release.

Husbands might wish to have their wives forget the emotional troubles, including marital strife, which precipitated hospitalization. Mr. Karr commented on his wife's long-term memory loss as proof of her successful cure by ECT, saying that her memory was still gone, especially for the period when she felt ill, and that "they did a good job there." These husbands used their wives' memory loss to establish their own definitions of past situations in the marital relationship:

> (Mr. Karr). Mr. Karr said that Wanda "couldn't remember anything" that happened after Christmas. He feels this is all for the good. "We (that is mama) have decided if she remembers what she did OK, but we're not going to tell her." He doubts (or perhaps I should say hopes) that she will not remember, not that she did anything to be ashamed of, of course. But she "wasn't herself" then.

Other relatives, too, found it in their interest to have the expatients forget; thus they could freely re-define past situations without challenge:

> (Eve Low). "Now I am sure that my memory (of being molested, as a child, by her mother's brother) is true, even though my mother, who came down last week, said that it is all nonsense. However, before we left the house last Sunday night, she was explaining to [other relatives] why she wanted me up here, you know, she wants me to have the full treatment she says. I should think that would entail a great deal more than what I've had apparently, but she said that she thought it would make me forget all those things. . . I'm afraid my mother wants me to have more shock so I'll forget all those things that happened. But I don't want this."

Different relatives had different interests in either recalling incidents forgotten because of ECT, or in collaborating with the patient's forgetfulness.

> During the post-hospital episode, on the occasion of her mother 'bringing up' embarrassing incidents connected with her psychotic episode, Wanda told her: "Mama, stop telling me those things! I went to the hospital and they made me forget them. Now don't keep bringing them up! You're not doing me any good." When asked if her mother had stopped, Mrs. Karr said, "Well, in her way." Mr. Karr, for his part, expressed pleasure to the research interviewer that electroshock therapy had made his wife forget her hostile outbursts against him in the pre-hospital period.

In one family, the forgetfulness attendant upon ECT treatment had a dampening effect on an extra-marital romance between a Bay Area expatient and a male expatient, thus contributing to the possible repair of a disintegrating marital relationship. Upon the resumption of their contact in the expatient phase of the moral career, these two patients were embarrassed by mutual memory lapses, perhaps as much by their status as reminders than anything else:

> (Ruth Quinn) [on her meeting with the male expatient] "it was rather strained at first. I found that there was a great deal he didn't remember. He was in the process of 12 shock treatments when I met him. And when I met him I think I was about two or three weeks off shock. So perhaps I don't remember some of the things but it seems that I do. But he didn't remember half the things that he told me. He didn't remember that I had two children. But he thought I was divorced and was surprised to hear that I'm not divorced."

The original Bay Area researchers noted that ECT can have a positive effect on the restoration of harmonious family relationships once the patient has been restored to the family, citing "the specific effects of electroshock therapy in blurring memories incongruent with the selves the patients and her intimates are reconstituting." (36).

The effect of ECT-related memory loss on family relations was not always counter-disintegrative; at times it had negative implications for the emotional ties between family members. As indicated above, several of the Bay Area patients forgot, after one or more ECT treatments, that they had children. One patient, admitted for post-partum depression, forgot that she had given birth to her child, who was nine months old at the time she was released to resume care of him. Although she had been reminded by others of his existence, she appeared to have lost her affective memory of him *as* her child:

> (Shirley Arlen) "I guess I feel sort of strange with him. In being with him. I don't know, I guess I just feel sort of strange with him. . .I just don't even feel like he's mine, for some reason. . .I think he's nine months now. . .I really don't know. I can't even remember when he was born."

The impact of ECT on family relationships was not confined to the negotiation of memory. ECT also affected marital communication and shared interpretive processes. For some of the couples, ECT provided a convenient rationale for the wife's untoward behavior. For some of the women, the fear of ECT hampered communcation with their husbands, while for some of the husbands, fear of their wives' reactions hampered the attempt to repair ECT-related memory deficits.

Both patients and their husbands utilized ECT to explain away a variety of problematic behaviors, including memory loss itself. The range of awareness of memory lapses in these families seemed increased over normal; that is, not

only were memory lapses explained via ECT that otherwise might have been explained differently (say, tiredness or upset), but many memory lapses that might otherwise not have been explained at all were remarked and categorized via ECT:

> Mr. Yale is eager to ask the hospital doctor one question: how long the shock treatment will go on. He has mentioned this on several previous interviews, and the interviewer asks why this particular question is so important. He said it was because of her lack of memory, and "I have the completely unscientific idea that when the shock treatment stops her memory will come back and then she will be well."

Other sorts of undesirable behavior were rationalized by patients or their intimates as a consequence of ECT rather than of renewed emotional disturbance:

> Mr. Yale visited Mary on the ward a few days ago and finds her behavior very disturbing. He called his friend. . . .tonight and asked him if he thought Mary's reaction was from shock treatment.
> Mary Yale "some days I'm not functioning well, not thinking clearly. It's not all the time, not every day. Maybe I want to blame it on shock."

The fear of being rehospitalized and receiving ECT against their will affected at least three of the Bay Area patients throughout the decade following their first admission. Rather than communicating various emotional disturbances and thoughts to their husbands, these women refrained from communication for fear of a resumption of medical-marital control of their lives. Mary Yale, in 1972, said that she had "a dread fear of shock" and was afraid to express her feelings to her husband for fear of reprisal in the form of ECT. She added, "Shock treatment is a helluva way to treat marital problems—the problems involved both of us."

Marital communication can also be affected the other way around. In the expatient phase of the patient's moral career, the Bay Area husbands tended to treat their wives with "kid gloves," refraining from saying or doing things that might "set them off." Sometimes, the husband's kid glove approach conflicted with the wife's search for her past. In one instance, Rita Vick had forgotten, after ECT, the five of her seven children who had been removed from her custody. One day she found an album in the Vick house and asked her husband "who were all those children?" For fear of upsetting her with renewed thoughts of the custody loss, Mr. Vick told her that they were a neighbor's children. Later, when Mrs. Vick discovered through another relative that these were in fact her children, she was "furious" with her husband for lying to her.

DISCUSSION

Berger and Kellner (1970) analyze the ways in which marriage creates a stable world of meanings for the participants, while Goffman (1971) notes the "havoc" that is wreaked on family life by the symptomatic prepatient member. Hospitalization interrupts both the havoc and its world, while treatments such as ECT intervene between the prehospital and posthospital reality-negotiations of marital partners. In the wake of hospital treatment, the couple "constructs not only present reality but reconstructs past reality as well, fabricating a common memory that integrates the recollections of the two individual pasts." (37). When the recollections of one partner are to some degree erased, the dynamic reconstruction of reality shifts a little, or a lot.

In practical terms, if certain treatments affect not only the self but the marital relationship, then it would seem useful to develop a further perspective on hospitalization in addition to the medical-model, organizational, and political perspectives. This is the interactional perspective on mental health treatments. If treatments are evaluated according to their intrusiveness into the individual's sphere of personal competence and liberty (38), then they should also be evaluated for their intrusiveness into the individual's sphere of relationships in everyday life. And, since ECT is particularly implicated in this aspect of psychiatric treatment, it would seem useful to encourage further research into this aspect of ECT and other highly invasive treatments.

ECT is an intrusive treatment that affects both the social relationship and the sense of self of the mental patient. For some, this invasion is welcomed as a means of forgetting, or, alternatively, as a means of manipulating the marital interpretive world. For others, it is unwelcome. For the majority of the Bay Area women and other patients who have undergone ECT, the bizarreness of the procedures and the loss of memory represent both a loss of continuity in the experience of life, and a loss of control over past, present and future; over body, mind and emotions.

Empirical studies, although sparse and variable by method and by geographical location, indicate a resurgence of ECT in the late 1970s and early 1980s following a decline in the mid-1960s to mid-1970s. In a New York study, Morrisey and his colleagues indicated that there was a 38 percent decrease (from 26,400 to 16,482) in the reported number of ECT treatments between 1972 and 1977, with a decline in the number of patients from 3,035 to 2,194 (28 percent) (39). In California between 1977 and 1983, however, ECT treatments rose from 12,879 to 15,446, an increase of 19.9 percent, while the number of patients rose by 16.9 percent, from 2,422 to 2,831.[4]

The increase in ECT use is in a different type of hospital, and with a different clientele, than in the 1950s. In the 1950s, ECT was utilized mainly in the state hospitals, often on an involuntary basis, and with a clientele that was more lower and possibly minority (40) than middle class. In the 1980s, on the other

hand, ECT is utilized mainly in private hospitals, with a white, middle class, elderly clientele (41, 42, 43). The only clear commonality throughout the 1950s-1980s is that ECT is, and was, used predominantly (from 60-70 percent) on women (44).

ECT is regaining popularity as a treatment which is fast, inexpensive, and easily reimbursable by third-party insurance payment schemes (45, 46). DRGs should increase this trend (47). Robitscher (1980) comments that ECT fulfills both economic and social control functions for private hospitals, suggesting that an economic model of interpreting therapies is a useful supplement to the medical model. Noting that private, proprietary hospitals sometimes shock up to three quarters of their inpatients, he notes that:

> The economics of electroconvulsive therapy show why this treatment modality appeals to the venal. The electroshock machine is inexpensive. The patient who is receiving electroshock is easy to manage, sleeps a great deal, does not need much nursing care, and uses the hospital much as a hotel or motel. Blue Cross, Blue Shield, Medicaid and other third-party plans pay without any questioning (48).

There have been changes since the 1950s not only in the clientele and location of ECT treatments but also in the methods of administration and the informed consent procedures (49). There have also been changes in the structure of marriage, and in the place of women in society. Yet at the same time, the family remains at the center of life's nomic ordering, and ECT continues to affect memory. In the face of the resurgence of this most invasive treatment it would perhaps be wise to attempt a reassessment of its impact on the self and family relationships.

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NOTES

1. The pseudonyms used in this study are those used in earlier analyses of the Bay Area data (see Sampson et al., 1964).
2. This lack of information about ECT in hospital settings has improved considerably since the 1950s (Lidz, 1984).
3. In the 1950s, psychiatric inpatients were allowed weekend visits home under certain conditions.
4. This increase occurred at a time when the California inpatient population was declining steadily year by year (Warren, 1987).

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