The Washington Post

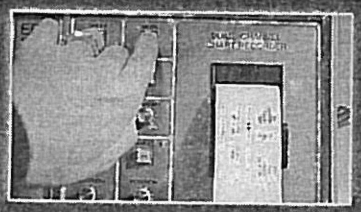
TUESDAY, SEPTEMBER 24, 1996

HEALTH

ECT – controversy WP 1996

Shock Therapy

IT'S BACK



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Cancer Society Advises Eating Less Meat

Dietary Shift Toward Fruits, Grains and Vegetables Might Prevent 30 Percent of Cancer Deaths

By Sally Squires
Washington Post Staff Writer

The American Cancer Society issued dietary guidelines last week that thrust the organization into a growing debate about Americans' meat and alcohol consumption.

The guidelines, which the society devised in light of the estimated 167,000 cancer deaths linked each year to dietary habits, echo long-standing recommendations from the federal government and other organizations to cut back on fat consumption and eat more fruits and vegetables.

But the cancer society guidelines are tougher, particularly on the subject of eating red meat and drinking alcohol.

Where the latest federal guidelines advise consuming "up to two to three servings of lean fish, poultry and meats daily," the cancer society recommends that people "limit consumption of meats, especially high-fat meats." The society did not place a specific limit on meat consumption but advised that other high-protein foods could be substituted regularly for meat.

Where the U.S. dietary guidelines suggest limiting "intake of high-fat processed meats, such as sausages, salami and other cold cuts," the cancer society advises that people avoid processed meats and choose "beans, seafood and poultry as an alternative to beef, pork and lamb."

The cancer society is not advocating that red meat be eliminated from the diet. "Our intent was . . . to shift the balance toward a more plant-based diet," said Michael Thun, director of analytic epidemiology at the American Cancer Society.

Meat "is not poison," said Meir Stampfer, professor of epidemiology and nutrition at the Harvard School of Public Health and an advocate of cutting the average American's meat consumption. He noted that he and his family still eat red meat in small amounts. "It's okay to have some meat, but the less the better."

Both the federal guidelines and the cancer society recommendations emphasize that lean cuts of meat are best. The U.S. dietary guidelines encourage people to choose meats that are labeled "lean" or "extra lean" and advises trimming fat from meat and removing the skin from poultry. The cancer society adds to that recommendation the importance of baking and broiling meats as a healthier alternative to frying.

Despite the cancer society's recommendation to eat less meat, meat producers said they were generally satisfied with the dietary guidelines. "They are not awfully different from what we have heard before," said Janet Collins Williams, vice president of scientific and technical affairs at the American Meat Institute, a trade group that represents packers, processors and suppliers of beef, pork, lamb, veal and turkey products throughout North America. "Our members have really reduced the fat in products. We are not unhappy with the guidelines."

At the same time, some scientists said that the cancer society did not go far enough in advocating dietary changes that could reduce cancer deaths. "I would have had even stronger wording to further cut down on meat," said Stampfer. The main reason to do so, Stampfer said, is "to lower the risks of colon and prostate cancer. There really is no good evidence to support the view that if you eat lean meat it is okay, that the bad thing in the meat is the fat. We don't know that."

Why red meat is associated with the increased cancer risk is unknown. One of the most popular theories is the meat's high fat content. Meat and other animal products generally contain a high percentage of saturated fat, which scientists suspect may be involved in the development of cancer. There's also some evidence that people who eat a lot of meat may be doing so at the expense of other foods, such as fruits and vegetables. In addition, the cooking process may play a role. For example, at high temperatures—such as those that occur during frying—cancer-causing substances have been shown to form in meat.

The link between diet and cancer was highlighted in 1981, when Oxford University researchers Richard Peto and Richard Doll analyzed U.S. data and concluded that about 35 percent of U.S. cancer deaths could be avoided by a change in diet. The statistical association varied depending on the type of cancer, and Peto and Doll also noted that the number of preventable deaths was far from ironclad and could be as low as 10 percent or as high as 80 percent.

Harvard School of Public Health investigator Walter C. Willett then studied U.S. cancer deaths in the 15 years following the Oxford University report and concluded that about 32 percent of cancer deaths in the United States could be avoided by altering what people eat. Willett also found a narrower range, estimating that the percentages were as low as 20 percent and as high as 40 percent.

"When we say that diet is responsible, it doesn't say that diet is full of bad things that give you cancer," Willett said. Diet composition—the percentage of fat and number of fruits and vegetables eaten—as well as total amount of calories also play an important role in cancer risk, he said.

"What we have learned is that the lack of protective factors may be even more important than too many bad things in the diet," said Willett.

Experts have debated the effects of eating meat for decades. The first federal public health recommendation to cut back on meat was issued by the members of the U.S. government's Select Committee on Nutrition and Human Needs in its "Dietary Goals for the United States" in 1977.

"They were blown out of the water at congressional hearings," said Marion Nestle, who chairs New York University's

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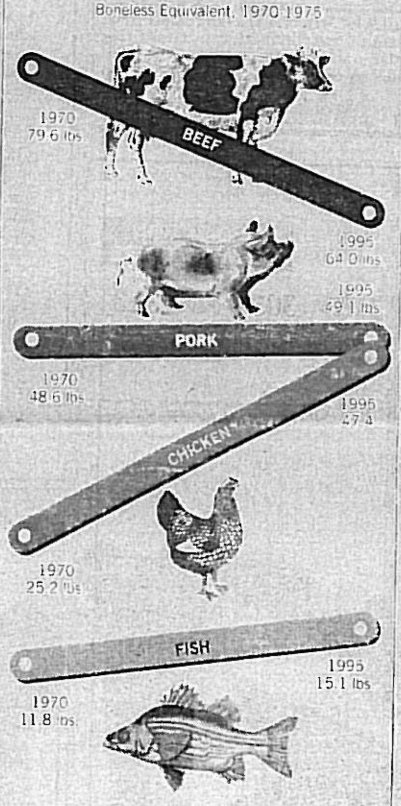
PER CAPITA CONSUMPTION OF MEAT, POULTRY AND FISH, IN POUNDS



For Anti-Cancer Appetites

The American Cancer Society advisory committee guidelines offered answers to some common questions, including these:

Does cholesterol in the diet increase cancer risk? Cholesterol in the diet comes from animal sources—meat, dairy, eggs and fats. At the present time, little evidence is available to determine whether dietary cholesterol itself or the foods containing this substance might be responsible for the increase in cancer risk associated with eating foods from animal sources. Low blood cholesterol has been found to be more common in people with cancer, but is an effect of cancer, not its cause. There is no evidence that lowering blood cholesterol increases cancer risk.

Does drinking coffee cause cancer? Several years ago, a highly publicized study suggested that coffee might increase the risk for cancer of the pancreas. Because caffeine may heighten symptoms of fibrocystic breast lumps in some women, media stories also have focused concern about coffee and breast cancer. Many studies in recent years, however, have found no relationship at all between coffee and the risk of pancreatic, breast or any other type of cancer.

What is olestra and is it related to cancer? Although several fat substitutes are under development for use in the food supply, only one—olestra (trademarked Olean)—has been approved for marketing. Olestra may reduce fat intake, but it also reduces the absorption of fat-soluble carotenes [vitamin A derivatives] and other potentially cancer-protective phytochemicals in fruits and vegetables. The overall effect of this type of fat substitute on cancer risk is unknown at present.

Does olive oil affect cancer risk? Olive oil, like all fats, is high in calories but its fat is mostly monounsaturated. Consumption of olive oil is not associated with any increase in risk of cancer, and most likely is neutral with respect to cancer risk.

Does vitamin C lower cancer risk? Vitamin C is found in many fruits and vegetables. Many studies have linked consumption of vitamin C-rich foods with a reduced risk of cancer. The few studies in which vitamin C has been given as a supplement, however, have not shown a reduced risk of cancer.

For more information, call the American Cancer Society's toll-free information line: 1-800-ACS-2345.

HEALTH NEWS

CANCER, *From Page 9*

department of nutrition and food studies. "There were speeches in Congress, protests from lobbying groups and volumes of testimony in the Federal Record objecting to it." The goals were revised to include what Nestle calls the euphemism of eating "lean cuts of meat."

Both the cancer society and the federal guidelines emphasize the benefits of eating five or more servings of fruits and vegetables each day and consuming a diet rich in beans and whole grains, such as breads, pasta, rice and cereals. And both urge people to limit the intake of high-fat foods.

They part company again on the subject of alcohol. While acknowledging a variety of medical problems that can be caused by abuse of alcohol, the federal officials urged, "If you drink alcoholic beverages, do so in moderation." The U.S. Dietary Guidelines noted that "alcoholic beverages have been used to enhance the enjoyment of meals by many societies throughout human history."

The cancer society guidelines are more restrictive, suggesting that people "limit consumption of alcoholic beverages, if you drink at all." The cancer society said that drinking alcohol, along with cigarette smoking and use of snuff and chewing tobacco, "cause cancers of the oral cavity, esophagus and larynx. Cancer risk starts to rise with as few as two drinks per day, the guidelines warn, noting that a drink is "defined as 12 ounces of regular beer, 5 ounces of wine and 1.5 ounces of 80-proof distilled spirits."

At the same time, some experts warned that recommendations for alcohol involve more than looking at the risk for cancer. Moderate alcohol consumption has been shown to be beneficial in protecting against heart disease, for example.

"The benefits for heart disease are very pronounced," Stampfer said. "It seems clear that moderate alcohol consumption is part of a healthy lifestyle. . . . Every study has shown that moderate drinkers have lower total mortality, and most of it is because of [protection against] heart disease." ■

When Parents Have Their Hands Full

Help for Children Who Need More Than the Usual Share of It

By Laura Sessions Stepp
Washington Post Staff Writer

■ **It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents**
By Harold S. Koplewicz, MD
Times Books, New York
294 pp.; $25

■ **The Challenging Child: Understanding, Raising and Enjoying the Five "Difficult" Types of Children**
By Stanley I. Greenspan, MD, with Jacqueline Salmon
Addison-Wesley Publishing Company, New York
309 pp.; $23

■ **Growing Up Sad: Childhood Depression and Its Treatment**
By Leon Cytryn and Donald McKnew, MDs
W. Norton & Company, New York
183 pp.; $25

Nothing is quite as challenging as raising a child. Under the best of conditions, it tests our intelligence, patience and sense of humor; if a child shows severe behavioral problems, one can feel truly helpless and alone.

But as these three books indicate, the parent of the troubled child is neither alone nor helpless. About 12 percent of U.S. residents under the age of 18, or 7.5 million children and adolescents, have a diagnosable brain malfunction, according to the Institute of Medicine. So about 15 million parents are touched in some way. And those who yearn to see their children lead normal lives have a better shot at that than ever before, thanks to a rapidly advancing science of the brain.

These books, all written by psychiatrists, are designed to help parents identify unsettling behaviors and start down the road toward healing. Two of them, "It's Nobody's Fault" and "The Challenging Child," describe a variety of childhood problems and treatments; the other, "Growing Up Sad," focuses on depression.

"It's Nobody's Fault" is by far the most comprehensive and the easiest to read. It is also, in my view, the most disturbing. Author Harold Koplewicz appears to have had only three goals in mind: relieving parents of guilt, directing them to the right psychiatrist and encouraging the use of medication. It may be just the book for parents on the go and seeking a quick fix, or parents who don't want to think too deeply about the role they or other family members play in their kids' problems. But for those who believe that nurture is as important as nature, Koplewicz leaves a lot to be desired.

The chief of child and adolescent psychiatry at Long Island Jewish Medical Center, Koplewicz defines behavioral problems strictly in medical terms. Hyperactivity and aggressiveness, for example, fall under the label attention deficit hyperactivity disorder (ADHD). Extreme shyness is called social phobia. Such conditions exist "not because of what a child's parents do but because of how his brain works, the brain that he was born with," Koplewicz says.

— ILLUSTRATION BY SCOTT SWALES FOR THE WASHINGTON POST

He explains that sophisticated imaging of adult brains, allowing scientists to watch certain physiological processes, has led researchers to believe that chemical deficiencies in the brain trigger behavioral problems. In his view (and the view of many other clinicians), man-made chemicals, or medication, can and should be used to restore the brain to its proper balance.

One can applaud medical advances such as neuroimaging, and believe that some kids benefit from drug therapy, and not buy into the numbers of children Koplewicz would treat with drugs nor the speed with which he recommends treatment.

Don't assume children will outgrow behavioral problems, Koplewicz says. The restless 2-year-old may have a full-blown case of ADHD by 6; the shy child may be a prime target for drug abuse when he or she gets older; the overly conscientious, anxious child may become severely depressed.

If a child shows any signs of distress for more than two weeks—such as stomachaches with no physical cause, loss of interest in activities, change in sleep patterns, unacceptable classroom behavior—the parent should seek psychiatric help, he says.

Two weeks? Most children I know, including my own, have swings in behavior that may last three or four weeks or even longer, but these usually can be resolved with a little help from parents, a school counselor or a family doctor.

Koplewicz gives parents little guidance in distinguishing a serious disorder from a temporary emotional problem. He leaves me wondering what kind of message the parent sends a child by marching him or her off to a psychiatrist at the first sign that's something wrong. And isn't it likely that a psychiatrist might be too quick to diagnose a medical condition? Koplewicz makes no mention of the pressure psychiatrists are under now from health insurers to prescribe medication rather than hospital stays or months of outpatient therapy.

Koplewicz defends his preference for psychiatry by repeating that brain disorders are organic, not unlike diabetes, and therefore should be diagnosed and treated by a physician. In most cases, treatment combines behavioral therapy—aimed at changing behavior, not understanding the environment—and medication, he says. Stimulants, antidepressants, antipsychotics and other drugs are indispensable.

While acknowledging that clinical testing of most of these drugs on troubled children has been far from conclusive, he says he has seen too many individual cases where they help to doubt their effectiveness. "We don't know why they work, just that they do work," he says.

I know that they can work; I have a very close friend whose son, diagnosed with ADHD, is performing much better in school now that he is under medication. Another relative teaches a special education class and swears by the drugs that some of her kids take. But Koplewicz goes too far with statements such as: "When the child [on drugs] doesn't get better, it shouldn't be assumed the drug isn't working. The child may simply need more of it."

Stanley Greenspan, author with Washington Post staff writer Jacqueline Salmon of "The Challenging Child" and clinical professor of psychiatry at the George Washington University Medical School, takes a different tack. He does not deny that the brains of some kids are wired differently from birth, or that in rare cases medication is appropriate to change the wiring. But he also raises another recent finding of science: that early experiences can alter brain activity. This suggests that appropriate parenting may make medication unnecessary.

"We have found that how parents relate to their children can make a huge difference in how youngsters feel about themselves and respond to their world," he writes.

Eschewing medical labels, Greenspan says disturbed children tend to display one of five behaviors: highly sensitive, self-absorbed, defiant, inattentive and active/aggressive. These behaviors are based on a child's sensitivities to sights, sounds, touch, odors and movement, he says.

One child may overreact to noise, for example, while another child may barely react at all. The wise parent tunes into such sensitivities and communicates to the child accordingly; then, as the child gets older, the parent helps the child understand herself and take charge of her own environment.

Readers of Greenspan's earlier child-raising books will not be surprised that he tells parents of challenging children to increase the amount of time they spend with their kids. One cannot really tune into a child if one is constantly on the go, he says.

In a paragraph that seems written for ambitious Washington careerists, he suggests that working parents trying to choose between getting an A+ in their job and an F from their family, or an F on their job and an A+ from their family, settle for doing a B job at both. "In real life," he writes, "being a healthy, nurturing parent to our children sometimes means . . . you may have to deliberately stop short of your best in order to ensure that your spouse and children get their fair share."

Greenspan thinks behavioral therapy and family counseling are often helpful. Unlike

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BOOKS

BOOKS, *From Page 11*

Koplewicz, he tells parents not to expect too much too soon. Challenging children "all have a wider range of behavior" than other kids, he says. The worst behavior may only become "not so difficult." Greenspan suggests giving involvement with the child and therapy eight to 12 months to work before turning to medication.

Leon Cytryn and Donald McKnew, authors of "Growing Up Sad," are also strong proponents of family therapy and family time. Having worked in the field of childhood depression for more than 30 years, they offer a balanced if overly academic perspective on childhood's most common mental disorder.

As recently as a generation ago, they report, medical experts didn't believe children suffered from depression. Depressed children were often the "nice, quiet kids" and hard to spot. Now experts put the proportion of these young sufferers at 5 to 10 percent of children.

According to the authors, who are also affiliated with George Washington University, telltale signs of depression sometimes emerge within the first two years of life. The infant or toddler has a sad face, fails to react to stimulus or to initiate activity and withdraws from people. The older child may stop seeing friends, shun family members and drop activities he previously enjoyed. He or she also may frequently express feelings of worthlessness and talk about death and suicide.

While most depressed children suffer from this pervasive feeling of sadness only, according to the authors, a few swing back and forth between depression and mania characterized by hyperactivity and racing thoughts.

Depression among children is usually brought on by several factors, Cytryn and McKnew say. The strongest, in their opinion, is the presence of a depressed parent. The child may have inherited that parent's biological vulnerability to depression, or identify closely with the parent.

Parental absence also can pose a problem. If a parent leaves the child—dies, departs or simply doesn't pay attention—the youngster may end up feeling alone and rejected and the groundwork may be laid for future depression.

The authors hold to the concept that children are particularly attached to their mothers and that a severe break in this attachment can lead to depression. Unfortunately, they barely mention the effect of father absence; studies of the father-child relationship are still in the initial stages, they say. Their assessment may leave many mothers who work outside the home feeling unduly guilty, even if their husbands share in the child-raising or they have arranged suitable child care.

The older the depressed child gets without being treated, the worse the prognosis, according to the authors. The first episode of depression is usually associated with a stressful experience, but later episodes can occur without any obvious provocation. Scientists now believe the initial episode changes the brain's circuitry, as do subsequent episodes. Over time the depression becomes more internalized, less dependent on the environment and harder to treat.

The parent who suspects his or her child is depressed should seek help right away, Cytryn and McKnew say; a child as young as 5 or 6 can be helped by psychotherapy and behavior modification. On the subject of medicating children, they are less optimistic.

"No published study has proven the superiority [of antidepressants] over a placebo" for depressed children, they write. They note, however, that more and more clinicians are prescribing antidepressant medication for kids with reported success and that additional research is underway.

Cytryn and McKnew's book raises several challenging questions. If biology is destiny, why do one-quarter of children who are diagnosed as depressed recover spontaneously within two weeks? Why do only one-third of the children of depressed parents become depressed themselves, when two-thirds do not?

As Robert Plomin, a behavioral geneticist, is quoted as saying, "Genetic factors do not account for more than about half of the variance for behavioral disorders." Science seems to be saying what most parents know already: As important as genes are, how we care for our children does make a difference, from day one. ■

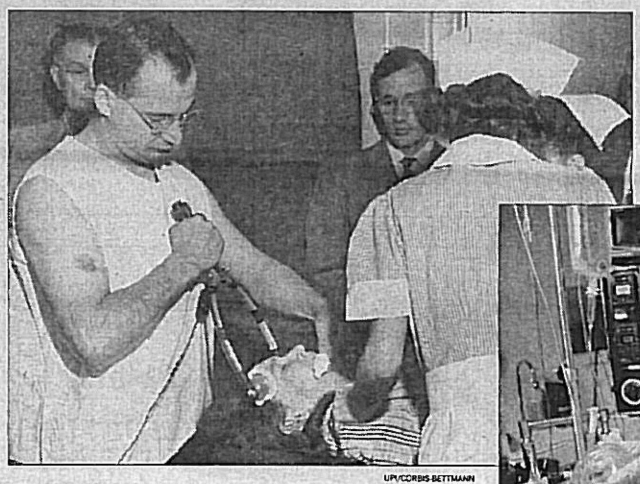
Shock Therapy IT'S BACK

BY SANDRA G. BOODMAN

It is unlike any other treatment in psychiatry, a therapy that still arouses such passionate controversy after 60 years that supporters and opponents cannot even agree on its name.

Proponents call it electroconvulsive therapy, or ECT. They say it is an unfairly maligned, poorly understood and remarkably effective treatment for intractable depression.

Critics call it by its old name: electroshock. They claim that it temporarily "lifts" depression by causing transient personality changes similar to those seen in head injury patients: euphoria, confusion and memory loss.



UPI/CORBIS-BETTMANN

Psychiatrist James G. Shanklin administers electroshock to a state hospital patient in 1949.

Both camps agree that ECT, which is administered annually to an estimated 100,000 Americans, most of them women, is a simple procedure—so simple that an ad for the most widely used shock machine tells doctors they need only set a dial to a patient's age and press a button.

Electrodes connected to an ECT machine, which resembles a stereo receiver, are attached to the scalp of a patient who has received general anesthesia and a muscle relaxant. With the flip of a switch the machine delivers enough electricity to power a light bulb for a fraction of a second. The current causes a brief convulsion, reflected in the involuntary twitching of the patient's toe. A few minutes later the patient wakes up severely confused and without any memory of events surrounding the treatment,

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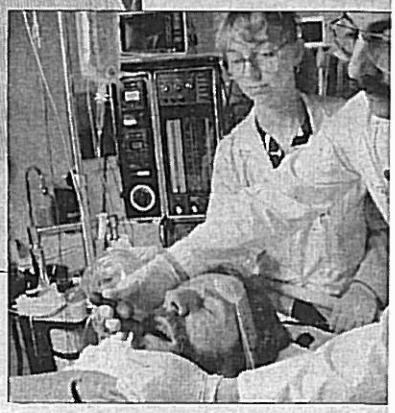

A psychiatrist prepares a patient for modern one-sided E

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Alliance for the Mentally Ill, an influential

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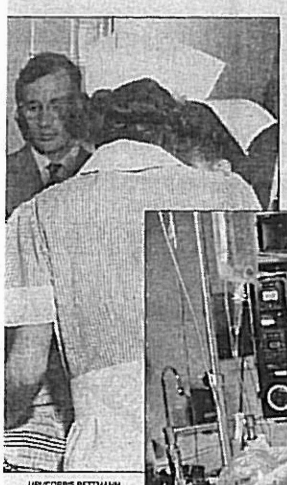

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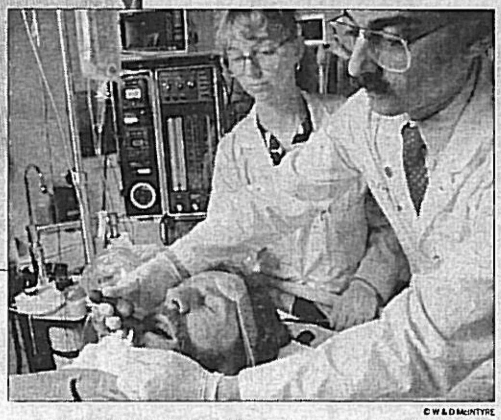

© W & D McINTYRE

A psychiatrist prepares a patient for modern one-sided ECT treatment.

which is typically repeated three times a week for about a month.

No one knows how or why ECT works, or what the convulsion, similar to a grand mal epileptic seizure, does to the brain. But many psychiatrists and some patients who have undergone ECT say it succeeds when all else—drugs, psychotherapy, hospitalization—have failed. The American Psychiatric Association (APA) says that about 80 percent of patients who undergo ECT show substantial improvement. By contrast antidepressant drugs, the cornerstone of treatment for depression, are effective for 60 to 70 percent of patients.

"ECT is one of God's gifts to mankind," said Max Fink, a professor of psychiatry at the State University of New York at Stony Brook. "There is nothing like it, nothing equal to it in efficacy or safety in all of psychiatry," declared Fink, who is so committed to the treatment that he remembers the precise date in 1952 that he first administered it.

There is no doubt that mainstream medicine is solidly behind ECT. The National Institutes of Health has endorsed it and for years has funded research into the treatment. The National Alliance for the Mentally Ill, an influential lobbying group composed of relatives of people with chronic mental illness, supports the use of ECT as does the National Depressive and Manic Depressive Association, an organization composed of

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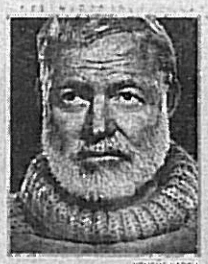
Famous Patients Who Had ECT



—YOUSUF KARSH

Ernest Hemingway fatally shot himself after being released from the Mayo Clinic, where he had undergone ECT.

James Forrest… secretary of d… suicide in 194… had received a… coma treatme… ECT.

—THE WASHINGTON POST

Former Sen. Thomas Eagleton (D-Mo.) was forced to relinquish his spot as vice presidential candidate on the Democratic ticket in 1972.

Performer and… Paul Robeson… se… tre… in…

—ASSOCIATED PRESS

Film actress Frances Farmer received shock treatments while confined to a state mental hospital in Washington.

New Ze… Frame d… harrowi… ECT in a…

Former Boston Red Sox outfielder Jimmy Pie… helped pull him out of a serious depressior…

ıree times a week for about a month. ECT works, or what the convulsion, tic seizure, does to the brain. But many ıts who have undergone ECT say it gs, psychotherapy, hospitalization— sychiatric Association (APA) says that who undergo ECT show substantial improvement. By contrast antidepressant drugs, the cornerstone of treatment for depression, are effective for 60 to 70 percent of patients.

"ECT is one of God's gifts to mankind," said Max Fink, a professor of psychiatry at the State University of New York at Stony Brook. "There is nothing like it, nothing equal to it in efficacy or safety in all of psychiatry," declared Fink, who is so committed to the treatment that he remembers the precise date in 1952 that he first administered it.

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ıtment.

There is no doubt that ıe National Institutes of Health has ınto the treatment. The National ying group composed of relatives of e use of ECT as does the National an organization composed of

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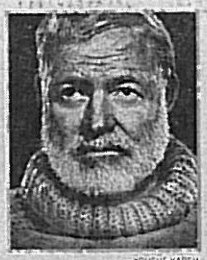
Famous Patients Who Had ECT



—YOUSUF KARSH

Ernest Hemingway fatally shot himself after being released from the Mayo Clinic, where he had undergone ECT.

—U.S. NAVY

James Forrestal, the first U.S. secretary of defense, committed suicide in 1949. Forrestal, 57, had received a series of insulin coma treatments, a precursor of ECT.

—UNITED PRESS INTERNATIONAL

Poet Sylvia Plath described her shock treatments in her 1971 book, "The Bell Jar." She wrote, "With each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant."

—THE WASHINGTON POST

Former Sen. Thomas Eagleton (D-Mo.) was forced to relinquish his spot as vice presidential candidate on the Democratic ticket in 1972.

—RUTGERS UNIVERSITY

Performer and political activist Paul Robeson underwent a series of ECT treatments in London in 1961.

—REUTERS

At 17, rock star Lou Reed was given shock treatments designed to "cure" his homosexuality at a New York state mental hospital.

—ASSOCIATED PRESS

Film actress Frances Farmer received shock treatments while confined to a state mental hospital in Washington.

—FILE PHOTO

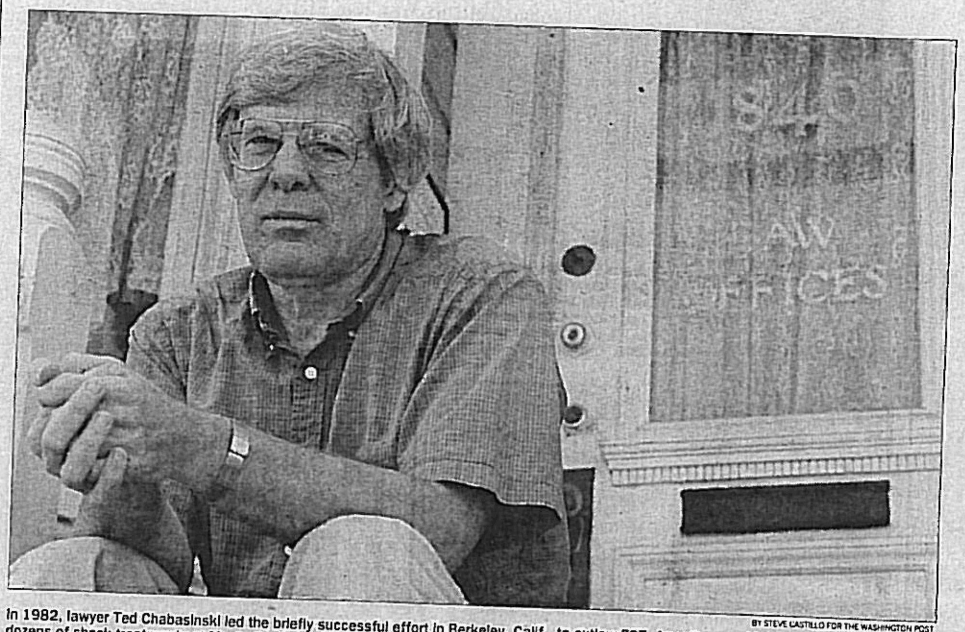
New Zealand writer Janet Frame described her harrowing experiences with ECT in a 1961 autobiography.

Former Boston Red Sox outfielder Jimmy Piersall wrote that ECT helped pull him out of a serious depression in the early 1950s.

—BETTMANN ARCHIVE

—FILE PHOTO

Vaslav Nijinksy, the famed ballet dancer, underwent a series of insulin coma treatments in Europe in the 1930s.



BY STEVE CASTILLO FOR THE WASHINGTON POST

In 1982, lawyer Ted Chabasinski led the briefly successful effort in Berkeley, Calif., to outlaw ECT. As a 6-year-old Chabasinski received dozens of shock treatments at Manhattan's Bellevue Hospital as part of an experiment. "It made me want to die," he recalled.

Questions About Memory Loss Persist

Does ECT cause long-term memory loss?

The model consent form drafted by the American Psychiatric Association and copied by hospitals says that "perhaps 1 in 200" patients report lasting memory problems. "The reasons for these rare reports of long-lasting memory impairment are not fully understood," it concludes.

Critics such as David Oaks, director of the Support Coalition of Eugene, Ore., an advocacy group composed of former psychiatric patients, say that the 1 in 200 statistic is a sham. "It's totally fictional and without scientific justification and is designed to be reassuring," said Oaks. Complaints about long-term memory loss are widespread among patients, Oaks said. Some insist that ECT wiped out memories of distant events, such as high school, or impaired their ability to learn new material.

Harold A. Sackeim, chief of biological psychiatry at the New York State Psychiatric Institute and a member of the APA's six-member shock therapy task force, says that the 1 in 200 figure is not derived from any scientific studies. It is, Sackeim said, "an impressionistic number" provided by New York psychiatrist and ECT advocate Max Fink in 1979. The figure will likely be deleted from future APA reports, Sackeim said.

No one knows how many patients suffer from severe memory problems, said Sackeim, although he believes that the number is quite small.

"I know it happens because I've seen it," he said. He attributes such cases to improperly performed ECT. Yet even when properly administered, Sackeim notes that greater memory loss is more likely after bilateral treatment—when electrodes are attached to both sides of the head—rather than one side. Because doctors believe bilateral ECT is more effective, it is administered more often, experts say.

While blaming ECT for memory problems is understandable, it may not be accurate, noted Larry R. Squire, a neuroscientist at the University of California at San Diego.

In a series of studies in the 1970s and 1980s Squire, a memory expert who has spent years studying ECT, compared more than 100 patients who underwent ECT with those who never had the treatment. He found that memories from the days shortly before, during and after shock treatments were probably lost forever. In addition, some patients demonstrated memory problems for events up to six months before ECT and as long as six months after treatment ended.

After six months, however, Squire said that ECT patients "perform as well on new learning tests and on remote memory tests as they performed before treatment" and as well as a control group of patients who never had ECT.

The widespread perception that ECT has permanently impaired memory is "an easy way to explain impairment," Squire said in interview. When patients are pressured to have ECT, he said, "outrage . . . combined with a sense of loss or low sense of self-esteem" could account for such a belief, even if there is no empirical evidence to support it.

Some psychiatrists are skeptical of Squire's hypothesis. They question the ability of standard tests to detect subtle memory problems and point to their own clinical experiences with patients.

Daniel B. Fisher, a psychiatrist and director of a community mental health center near Boston, has "grave reservations" about ECT's effects on memory and says he has never recommended it to a patient.

"The variability is still there, the unpredictability and uncertainty about the nature of the side effects," said Fisher, who has a doctorate in neurochemistry and worked as a neuroscientist at the National Institute of Mental Health before he went to medical school. "You see these people who can perform routine functions [after ECT] but have lost some of the more complex skills." Among them, he said, is a woman he treated who coped adequately with everyday life but no longer remembered how to play the piano.

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psychiatric patients. The APA, the Washington-based trade association that represents the nation's psychiatrists, has long battled efforts by lawmakers to regulate or restrict shock therapy and in recent years has sought to make ECT a first-line therapy for depression and other mental illnesses, rather than the treatment of last resort.

And the Food and Drug Administration has proposed relaxing restrictions on the use of ECT machines, even though the devices have never undergone the rigorous safety testing that has been required of medical devices for the past two decades. (Because the machines had been used for years before the passage of the 1976 Medical Device Act, they were grandfathered in with the understanding that they would someday undergo testing for safety and effectiveness.)

Many of the nation's most prestigious teaching hospitals—Massachusetts General in Boston, the Mayo Clinic, the University of Iowa, New York's Columbia Presbyterian, Duke University Medical Center, Chicago's Rush-Presbyterian-St. Luke's—regularly administer ECT. In the past three years a few of these institutions have begun to use the treatment on children, some as young as 8.

Managed care organizations, which have sharply cut back on reimbursement for psychiatric treatment, apparently look with favor upon ECT, even though it is performed in a hospital and typically requires the presence of two physicians—a psychiatrist and an anesthesiologist—and, sometimes, a cardiologist as well. The cost per treatment ranges from $300 to more than $1,000 and takes about 15 minutes.

Medicare, the federal government's insurance program for the elderly, which has become the single biggest source of reimbursement for ECT, pays psychiatrists more to do ECT than to perform medication checks or psychotherapy. Increasingly, the treatment is being administered on an outpatient basis.

In the Washington area more than a dozen hospitals perform ECT, according to Frank Moscarillo, executive director of the Washington Society for ECT and chief of the ECT service at Sibley Hospital, a private hospital in Northwest Washington. Moscarillo said that Sibley administers about 1,000 ECT treatments annually, more than all other local hospitals combined.

"With the insurance companies there isn't a limit [for ECT] like there is for psychotherapy," said Gary Litovitz, medical director of Dominion Hospital, a private 100-bed psychiatric facility in Falls Church. "That's because it's a concrete treatment they can get their hands around. We have not run into a situation where a managed care company cut us off prematurely."

Anecdotal Miracles

Because of the stigma of psychiatric illness in general and of shock treatment in particular, most patients do not openly discuss their experiences. Among the few who have is talk show host Dick Cavett, who underwent ECT in 1980. In a 1992 account of his treatment Cavett told People magazine that he had suffered from periodic, debilitating depressions since 1959 when he graduated from Yale. In 1975 a psychiatrist prescribed an antidepressant that worked so well that once Cavett felt better, he simply stopped taking it.

His worst depression occurred in May

1980 when he became so agitated that he was taken off a London-bound Concorde jet and driven to Columbia-Presbyterian Hospital. There he was treated with ECT. "I was so disoriented I couldn't figure out what they were asking me to sign, but I signed [the release for treatment] anyway," he wrote.

"In my case ECT was miraculous," he continued. "My wife was dubious, but when she came into my room afterward, I sat up and said, 'Look who's back among the living.' It was like a magic wand." Cavett, who was in the hospital for six weeks, said that he has taken antidepressants ever since.

Twice in the past six years writer Martha Manning, who for years practiced as a clinical psychologist in Northern Virginia, has undergone a series of ECT treatments. In her 1994 book entitled "Undercurrents," Manning wrote that months of psychotherapy and numerous antidepressants failed to arrest her precipitous slide into suicidal depression. When her psychologist Kay Redfield Jamison suggested shock treatments, Manning was horrified. She had been trained to regard shock as a risky and barbaric procedure reserved for those who had exhausted every other option. Ultimately Manning decided that she had too.

In 1990 she underwent six ECT treatments while a patient at Arlington Hospital. She said she suffered permanent memory loss for events surrounding the treatment and was so confused for several weeks that she got lost driving around her neighborhood and didn't remember her sister's visit 24 hours after it occurred.

"It *is* scary, despite anybody's promises to the contrary," Manning said in an interview. Although some of her memories before and during ECT have been forever obliterated, Manning said she suffered no other lasting problems. "I felt I got 30 IQ points back" once the depression lifted.

"I was lucky," said Manning, who says her depression is now controlled by medication. "ECT was safe for me and very, very helpful. It was a break in the action, not a cure."

"I'm coming from a position of seeing ECT at its best," added Manning, who said she would have ECT again if she needed it. "I'm sure there are other people who've seen it at its worst."

Vanished Memories

Ted Chabasinski is one of those people.

A lawyer in Berkeley, Calif., Chabasinski, 59, says he has spent years trying to recover from the dozens of ECT treatments he underwent more than a half-century ago. At age 6, he was taken from a foster family in the Bronx and sent to New York's Bellevue Hospital to be treated by the late child psychiatrist Lauretta Bender.

As a child Chabasinski was precocious but very withdrawn, behaviors that a social worker who regularly visited the foster family believed were the beginnings of schizophrenia, the same illness from which his mother, who was poor and unmarried, suffered. "At the time hereditary causes of mental illness were fashionable," he said.

Chabasinski was one of the first children to receive shock treatments, which were administered without anesthesia or muscle relaxants. "It made me want to die," he recalled. "I remember that they would stick a rag in my mouth so I wouldn't bite through my tongue and that it took three attendants to hold me down. I knew that in the morn-

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Famous Patients Who Had ECT

—CORNELL UNIVERSITY LIBRARY

Writer Zelda Fitzgerald underwent insulin coma treatments, a precursor of ECT, at a North Carolina hospital.

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Literary critic Seymour Krim, a chronicler of the Beat Generation, received ECT in the late 1950s.

—UNITED PRESS INTERNATIONAL

Movie actress Gene Tierney underwent eight shock treatments in 1955, according to her autobiography.

—FILE PHOTO

Film star Vivien Leigh, pictured in "Gone with the Wind," received shock treatments.

—FILE PHOTO

Talk show host Dick Cavett had a series of ECT treatments in 1980. "In my case, ECT was miraculous," he wrote.

—PHIL MacMULLAN

Pulitzer prize-winning poet Robert Lowell was hospitalized repeatedly for manic depression and alcoholism.

Robert Pirsig described his experiences with ECT in his 1974 best-selling book, "Zen and the Art of Motorcycle Maintenance."

—M. A. FELDSTEIN FOR THE WASHINGTON POST

Piano virtuoso Vladimir Horowitz received shock treatments for depression and later returned to the concert stage.

—FILE PHOTO

Concert pianist Oscar Levant described his 18 ECT treatments in his book "Memoirs of an Amnesiac."

—FILE PHOTO

ECT Experts' Ties to Shock Machine Industry

Among the small fraternity of electroshock experts, psychiatrist Richard Abrams is widely regarded as one of the most prominent.

Abrams, 59, who retired recently as a professor at the University of Health Sciences/Chicago Medical School, is the author of psychiatry's standard textbook on ECT. He is a member of the editorial board of several psychiatric journals. The American Psychiatric Association's 1990 task force report on ECT is studded with references to more than 60 articles he has authored. Abrams, whose interest in ECT dates back to his residency in 1960s, has served on the elite committee that planned the National Institutes of Health's 1985 consensus conference on ECT. In addition he has long been a sought-after expert defense witness on behalf of doctors or hospitals sued by patients who allege that ECT damaged their brains.

What is less well known is that Abrams owns Somatics, one of the world's largest ECT machine companies. Based in Lake Bluff, Ill., Somatics manufactures at least half of the ECT machines sold worldwide, Abrams said. Most of the rest are made by MECTA, a privately held company in Lake Oswego, Ore.

Yet Abrams's 340-page textbook never mentions his financial interest in Somatics, the company he founded in 1983 with Conrad Melton Swartz, 49, a professor of psychiatry at East Carolina University in Greenville, N.C. Neither does the 1994 instruction manual for the device written by Abrams and Swartz, the company's sole owners and directors, which contains extensive biographical information.

Financial ties between device manufacturers, drug companies and biotech firms "are a growing reality of health care and a growing problem," said Arthur L. Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine.

For doctors "the questions that such financial conflicts of interest generate are, do patients get adequate full disclosure of options or are you skewing how you present the facts because you have a financial stake in the treatment and you personally profit from it every time it's used?" Caplan asked.

"It's especially disturbing with ECT because it's so controversial" and public mistrust of the treatment is so great, he added.

Abrams said his publisher at Oxford University Press knew about his ownership of Somatics. "No one ever suggested I list it," said Abrams. "Why should it be?" Abrams said he has disclosed his directorship of Somatics after several medical journals began requiring information about potential conflicts of interest. Caplan said that a growing number of medical journals are requiring disclosure of payments greater than $1,000.

Abrams said he sees "no specific conflict" between his role as an ECT expert and his ownership of a company that makes shock machines. He said he has not decided whether to list his ownership in the third edition of his book, which is due out next year.

Abrams declined to say how much he has earned from Somatics. Approximately 1,250 machines, priced at nearly $10,000, have been sold to hospitals worldwide, he said. Between 150 and 200 machines are sold annually, according to Abrams. Somatics also sells reusable mouthguards for $29, which are designed to minimize the risks of chipped teeth or a lacerated tongue.

Swartz, 49, declined to be interviewed. Last year USA Today reported that he considered his financial interest in Somatics to be "a non-issue." Swartz is quoted as saying that the company was founded to provide better machines and to "advance ECT."

"Psychiatrists don't make much money and by practicing ECT they can bring their income almost up to the level of the family practitioner or internist," Swartz is quoted as saying. Swartz also said that the profits from Somatics are comparable to having an additional psychiatry practice. (Last year psychiatrists earned an average of $132,000, according to the American Medical Association.)

Abrams and Swartz are not the only ECT experts with financial ties to the industry.

Max Fink, 73, a professor of psychiatry at the State University of New York at Stony Brook, whose passionate advocacy is widely credited with reviving interest in ECT, receives royalties from two videos he made a decade ago. Fink is one of six ECT experts who served on the APA's 1990 ECT task force, which drafted guidelines for the treatment.

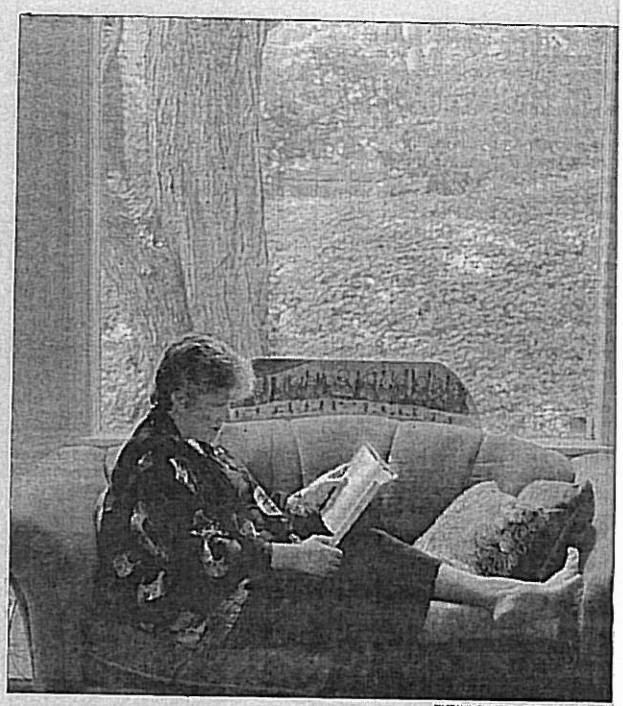
In 1986 he made two videos about ECT, one for patients and their families, the other for hospital staff. Each sells for $350 and is used by hospitals that administer ECT. Fink said that Somatics paid him $18,000 for the rights to the videotapes; he said he receives 8 percent of the royalties. He declined to disclose how much money he has earned from the videos.

Duke University's Richard D. Weiner, 51, chairman of the APA task force on ECT, appears on a MECTA videotape. Weiner said he served as a consultant to the company about 10 years ago but has not "received any money directly" for his services. Instead MECTA deposited between $3,000 and $5,000 in a university account that Weiner controls which, according to a Duke spokesman, is earmarked for "research support and other educational functions."

Harold A. Sackeim, director of ECT research at New York's Columbia-Presbyterian Hospital, is also a member of the APA task force on ECT. Sackeim, who has consulted for both MECTA and Somatics, says he has not accepted cash payments from the manufacturers because he does not want to be perceived as "benefiting personally" from ECT. Instead both companies have made payments to his lab. Sackeim estimates that his lab has received about $1,000 from Somatics and "several tens of thousands of dollars" from MECTA.

Ethicist Caplan said that he believes such donations raise fewer ethical questions than do direct payments to a doctor or an equity interest in a company. Even so, he said, it is up to physicians who receive such payments to disclose this to the public and especially to prospective patients.

"There needs to be full disclosure in writing and the information needs to be repeated over and over again," Caplan said. "Doctors need to give patients the opportunity to ask questions if they want, not to make those decisions for them by saying they won't be interested."



BY FRANK JOHNSTON—THE WASHINGTON POST

Clinical psychologist and writer Martha Manning of Northern Virginia has undergone two courses of ECT treatments since 1990. She says they pulled her out of suicidal depressions.

SHOCK THERAPY, *From Page 17*

ings that I didn't get any breakfast I was going to get shock treatment." He spent the next 10 years in a state mental hospital.

Bender, who shocked 100 children, the youngest of whom was 3, abandoned the use of ECT in the 1950s. She is best known as the co-developer of a widely used neuropsychological test that bears her name, not as a pioneer in the use of ECT on children. That work was discredited by researchers who found that the children she treated either showed no improvement or got worse.

The experience left Chabasinski with the conviction that ECT was barbaric and should be outlawed. He convinced residents of his adopted hometown; in 1982 Berkeley voters overwhelmingly passed a referendum banning the treatment. That law was overturned by a court after the APA challenged its constitutionality.

The Old and the New

There is little dispute that ECT administered before the late 1960s, commonly referred to as "unmodified," was different from later treatment. When Chabasinski underwent ECT, patients did not routinely receive general anesthesia and muscle paralyzing drugs to prevent muscle spasms and fractures, as well as continuous oxygen to protect the brain. Nor was there monitoring by an electroencephalogram. All of these are standard today. In the old days shock machines used sine-wave electricity, a different—and ECT supporters say riskier—form of electrical impulse than the brief pulse current dispensed by contemporary machines.

But critics contend that these changes are largely cosmetic and that "modified" ECT merely obscures one of the most disturbing manifestations of earlier treatments—a patient grimacing and jerking during a convulsion. Some opponents say that the newer machines are actually more dangerous because the intensity of the current is greater. Others note that modified treatment requires that patients undergo repeated general anesthesia, which carries its own risks.

"The characteristics of the treatment that caused people to be outraged and shocked are now kind of masked so that the procedure looks rather benign," said New York psychiatrist Hugh L. Polk, an ECT opponent who is medical director of the Glendale Mental Health Clinic in Queens.

"The basic treatment hasn't changed," he added. "It involves passing a large amount of electricity through people's brains. There's no denying that ECT is a profound shock to the brain, [an organ that is] enormously complicated and of which we have only the barest understanding."

Fifty years after Chabasinski was treated at Bellevue, Theresa E. Adamchik, a 39-year-old computer technician, underwent ECT as an outpatient at a hospital in Austin, Tex. Adamchik said that two years of therapy, antidepressants and repeated hospitalizations had failed to alleviate an unremitting depression caused in part by the breakup of her second marriage.

Adamchik said she agreed to have the treatments, which were covered by her

health maintenance organization, after doctors assured her "it would snap me right out of my depression." When she asked about memory loss, she said, "They told me it would kill as many brain cells as if I went out and got drunk one night."

But Adamchik said that her memory problems persisted much longer than her doctors had predicted. "It's very strange. Sometimes there are memories without emotions and emotions without memories. I have flashes of things—bits and pieces," she said. The treatments also erased memories of events that occurred years earlier, such as the 1978 funeral of her 2-year-old son, who drowned in a backyard swimming pool.

Adamchik said that although she has returned to work and is no longer depressed, she would never again consent to shock treatments. "I didn't have any memory problems before ECT," she said. "I do now. Sometimes I'll be in the middle of a sentence and I'll just forget what I'm talking about."

Sketchy Data

One of the chief problems in evaluating the effectiveness of ECT, noted University of Maryland anesthesiologist Beatrice L. Selvin, who reviewed more than 100 ECT studies conducted since the 1940s, is that "even the more recent literature is still rife with contradictory findings. . . . few research papers report well-controlled studies, similar procedures, measurements, techniques, protocols or data analyses," Selvin concluded in a 1987 article in the journal Anesthesiology. Her conclusion echoes a 1985 report by an NIH consensus conference, which cited the poor quality of ECT research.

A 1993 APA fact sheet said that at least 80 percent of patients with severe, intractable depression will show substantial improvement after ECT. Studies have shown that after a course of six to 12 treatments 80 percent of patients have better scores on a commonly used test to measure depression, usually the Hamilton depression scale.

But what the APA fact sheet does not mention is that improvement is only temporary and that the relapse rate is high. No study has demonstrated an effect from ECT longer than four weeks, which is why growing numbers of psychiatrists are recommending monthly maintenance, or "booster," shock treatments, even though there is little evidence that these are effective.

Many studies indicate that the relapse rate is high even for patients who take antidepressant drugs after ECT. A 1993 study by researchers at Columbia University published in the New England Journal of Medicine, found that while 79 percent of patients got better after ECT—one week after their last treatment they had improved scores on the Hamilton scale—59 percent were depressed two months later.

Richard D. Weiner, a Duke University psychiatrist who is chairman of the APA's ECT task force, says that ECT is not a cure for depression. "ECT is a treatment that's used to bring someone out of an episode," said Weiner, who compares it to the use of antibiotics to treat pneumonia.

Yet other psychiatrists may not be as convinced of ECT's effectiveness. sAn article by researchers at Harvard Medical School published last year in the American Journal of

See SHOCK THERAPY, Page 20

BY TOM ALLEN—THE WASHINGTON POST

Over a dozen local hospitals offer ECT, said Frank Moscarillo, executive director of the Washington Society for ECT and chief of the ECT service at Sibley Hospital.

Changes in Population and Insurance Make Elderly Women Most Common Patients

Forty years ago, the typical ECT patient resembled Randall P. McMurphy, the antihero immortalized by actor Jack Nicholson in "One Flew Over the Cuckoo's Nest." Like McMurphy, ECT recipients tended to be under 40, male and impoverished—patients confined to state mental hospitals, often against their will.

These days the typical ECT patient is an elderly white woman—clinically depressed, and usually middle or upper middle class—who has signed herself into a private hospital. Because she is over 65 her bill is paid, in whole or in part, by Medicare, the federal government's insurance program for the elderly.

The profound shift in the demographics of ECT reflects several factors, experts say. Among them are the dramatic growth of the nation's elderly population and of Medicare; a growing awareness by doctors of the problem of geriatric depression, and the push by insurers that psychiatrists provide more fast-acting "medical" treatments and less talk therapy.

A 1990 report by the American Psychiatric Association concluded that advanced age is no bar to ECT; it cited the case of a 102-year-old patient who received the treatment. Because some psychiatrists believe shock therapy works faster and is less risky than drugs, it is increasingly being administered to elderly patients. Frank Moscarillo, director of ECT at Washington's Sibley Hospital, said the typical patient at his hospital is over 60. His oldest patient was 98, "a little old lady" in Moscarillo's words.

But some published studies have found that shock treatment can be risky, particularly for elderly patients with significant medical problems. They include the following:

- A 1993 study by Brown University psychiatrists of 65 hospitalized patients over age 80 found that those who received ECT had a higher mortality rate up to three years after treatment than did a group treated with medication. Of 28 patients who received drugs, 3.6 percent were dead after one year. Of 37 patients who got ECT, 27 percent were dead within a year. The authors concluded that the differences in death rates were not primarily due to ECT, but to the fact that ECT patients had more serious physical problems.
- A 1987 study of 136 patients by researchers at Washington University in St. Louis found that complications after ECT, including severe confusion and heart and lung problems, increased with age.
- A 1984 study by doctors at New York Hospital-Cornell Medical Center found that geriatric patients developed significantly more complications, not all of them reversible, after ECT than did younger patients. Problems included irregular heartbeats, heart failure and aspiration pneumonia, which occurs when an anesthetized patient inhales vomit into the lungs. All three conditions can be fatal.
- A 1982 study of 42 ECT patients at New York's Payne Whitney Clinic found that 28 percent developed heart problems after ECT. Seventy percent of patients previously known to have cardiac problems experienced complications.

Even so, all of the researchers concluded that the potential benefits of ECT for depressed elderly patients tend to outweigh the risks. Shock, they say, is effective in quickly treating life-threatening dehydration or weight loss caused by severe depression.

At the same time, there is concern that the elderly are particularly vulnerable to inappropriate or dangerous treatments.

Last year the Illinois Appellate Court ruled that ECT was too risky and not in the best interests of Lucille Austwick, an 82-year-old nursing home patient who suffers from dementia and chronic depression.

The state's highest court reversed the decision of a lower court in Chicago that had ordered Austwick, a retired telephone operator, to undergo as many as 12 ECT treatments at Rush-Presbyterian-St. Luke's Hospital against her will. Austwick, who has no family, had previously been declared incompetent by a court.

In a strongly worded opinion the judges detailed contradictions in the testimony of Austwick's psychiatrist, who said he had sought a court order "because medication therapy would take a long time [and] he felt it would be better to get [the patient] out of here [the hospital] rather than stay here and spend time and money."

In Wisconsin, the state agency that protects the rights of the mentally ill last year issued a report detailing nine cases in which patients at St. Mary's Hospital in Madison received ECT against their will or without proper informed consent.

All but one of the patients was over 60 and female. Two were coerced into having ECT, the report by the Wisconsin Coalition on Advocacy stated. In another case the hospital threatened to get a court order to administer shock over a spouse's objections, investigators said.

The agency concluded that "medical and nursing practices surrounding ECT at St. Mary's psychiatric unit may not consistently reflect the minimum standards required by state law and relevant professional standards."

Hospital officials denied that St. Mary's had violated patients' rights. They noted that regulatory officials had not taken any action. The hospital made changes in its ECT consent documents, but not as a result of the commission's report, officials said.

Discovered in 1938, Electroshock Has Fluctuated in Popularity

Even its most ardent defenders agree that ECT arouses primitive fears: of being struck by lightning, of Dr. Frankenstein's experiments, of electrocution and the electric chair.

"ECT is something that just because of its nature doesn't look good," said Richard D. Weiner, chairman of the American Psychiatric Association's 1990 task force on ECT and an associate professor of psychiatry at Duke University Medical Center. "You're talking about putting electricity on top of somebody's head."

"ECT is a bizarre treatment," agreed Harold A. Sackeim, chief of the ECT service at New York's Columbia-Presbyterian Hospital. "In terms of its surface features, it has a horrific aspect to it."

For thousands of years, the notion of using electricity to treat illness has held a fascination for doctors. In 47 A.D. Roman healers applied electric eels to the heads of headache sufferers. In the 1920s and '30s American and European psychiatrists began treating some mental illnesses by inducing epileptic-like convulsions through massive doses of insulin and other drugs. They discovered that some patients showed dramatic, albeit temporary, improvement.

ECT was discovered somewhat by accident in 1938 after an Italian psychiatrist adapted a pair of tongs used to stun hogs before slaughter and applied them to the temples of a 39-year-old engineer from Milan, shocking him out of a delirious state in which he spoke only gibberish.

By the 1940s insulin coma and electric shock treatments were widely used in American mental hospitals, especially the overcrowded public institutions that housed as many as 8,000 patients and as few as 10 doctors.

Historical accounts are replete with examples of shock used to subdue and punish patients, sometimes under the guise of treatment. Particularly troublesome patients received hundreds of shocks, often several in a single day.

"ECT stands practically alone among the medical/surgical interventions in that misuse was not the goal of curing but of controlling the patients for the benefits of the hospital staff," medical historian David J. Rothman of Columbia University told an NIH consensus conference in 1985. "Whatever the misuse of penicillin or coronary artery bypass grafts, the issue of staff convenience was not nearly as prominent as with ECT."

The invention of Thorazine and other antipsychotic drugs led to a decline in the use of ECT. So did published accounts of abusive treatment. The most famous was "One Flew Over the Cuckoo's Nest," Ken Kesey's 1962 novel based on his experiences in an Oregon state mental hospital, which in 1975 was made into a movie starring Jack Nicholson.

By the mid-1970s ECT had fallen into disrepute. Psychiatrists increasingly turned to drugs, which were cheaper and easier to administer and aroused less opposition. In addition, a series of landmark cases involving the abuses of shock therapy helped form the basis for patients' rights and informed consent legislation.

The late 1980s marked a resurgence in the use of ECT, and in recent years ECT opponents in a few states have tried to restrict or ban the treatment. In 1993 the Church of Scientology, which opposes psychiatric treatment, and several groups of anti-ECT activists helped persuade Texas lawmakers to bar ECT for children under 16 and to require hospitals to report deaths within 14 days of treatment.

Last year a bill to ban ECT was the subject of a two-day public hearing before a Texas legislative committee that heard testimony from 58 witnesses. That bill died in committee but its sponsors predict it will be resurrected next year when the legislature reconvenes.

SHOCK THERAPY, *From Page 19*

Psychiatry found such disparities in the use of ECT in 317 metropolitan areas in the United States that they called the treatment "among the highest variation procedures in medicine." The researchers, who attributed the disparities to doubts about ECT, found that the popularity of the treatment was "strongly associated with the presence of an academic medical center."

ECT use was highest in several relatively small metropolitan areas: Rochester, Minn. (Mayo Clinic), Charlottesville (University of Virginia), Iowa City (University of Iowa Hospitals), Ann Arbor (University of Michigan) and Raleigh-Durham (Duke University Medical Center).

Another unresolved question about ECT is its mortality rate. According to the 1990 APA report, one in 10,000 patients dies as a result of modern ECT. This figure is derived from a study of deaths within 24 hours of ECT reported to California officials between 1977 and 1983.

But more recent statistics suggest that the death rate may be higher. Three years ago, Texas became the only state to require doctors to report deaths of patients that occur within 14 days of shock treatment and one of only four states to require any reporting of ECT. Officials at the Texas Department of Mental Health and Mental Retardation report that between June 1, 1993, and September 1, 1996, they received reports of 21 deaths among an estimated 2,000 patients.

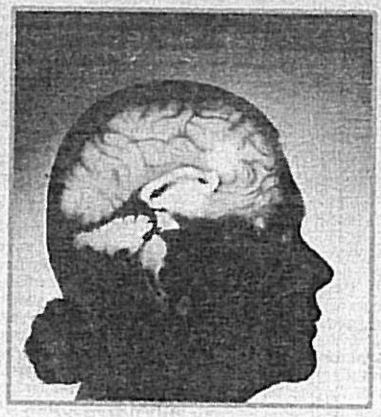
"Texas collects data no one else collects," said Steven P. Shon, the department's medical director. The state, however, does not require an autopsy in these cases. "We need to be very careful" of attributing these deaths to ECT, he added. "Unless there's an autopsy, there's no way to make a causal connection."

Records show that four deaths were suicides, all of which occurred less than one week after ECT. One man died in an automobile accident in which he was a passenger. In four cases the cause of death was listed as cardiac arrest or heart attack. One patient died of lung cancer. Two deaths were complications of general anesthesia. In eight cases there was no information on the cause of death. At least two-thirds of patients were over 65, and in nearly every case treatment was funded by Medicare or Medicaid.

Suicide Preventive?

One of the most common reasons cited by doctors for performing ECT is that it prevents suicide. The report of the 1985 NIH Consensus Conference states that "the immediate risk of suicide" that can't be managed by other treatments "is a clear indication for consideration of ECT."

In fact there is no proof that ECT prevents suicide. Some critics suggest that there is anecdotal evidence that the confusion and memory loss after treatment may even precipitate suicide in some people. They point to Ernest Hemingway, who shot himself in July 1961, days after being released from the Mayo Clinic where he had received more than 20 shock treatments. Before his death Hemingway complained to his biographer A.E. Hotchner, "What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure, but we lost the patient."



No study has demonstrated an effect from ECT longer than four weeks.

A 1986 study by Indiana University researchers of 1,500 psychiatric patients found that those who committed suicide five to seven years after hospitalization were somewhat more likely to have had ECT than those who died from other causes.

The researchers, who also reviewed the literature on ECT and suicide, concluded that these findings "do not support the commonly held belief that ECT exerts long-range protective effects against suicide."

"It appears to us that the undeniable efficacy of ECT to dissipate depression and symptoms of suicidal thinking and behavior has generalized to the belief that it has long-range protective effects," concluded the researchers in an article in Convulsive Therapy, a journal for ECT practitioners.

Another factor in ECT's growing popularity is economic, suggests Tampa psychiatrist Walter E. Afield. It can be summed up in one word: reimbursement.

"Shock is coming back, I think, because of the change in psychiatric reimbursement," said Afield, former a consultant to Johns Hopkins Hospital who founded one of the nation's first managed mental health care companies. "[Insurers] no longer will pay psychiatrists to do psychotherapy, but they will pay for shock or for medical tests."

"We're being pushed as a specialty to do what's going to pay," said Afield, who is not opposed to ECT, but to its indiscriminate use. "Finances are dictating the treatment. In the old days when insurance companies paid for long-term hospitalization, we had patients who were hospitalized for a long time. Who pays the bill determines what kind of treatment gets done."

The growing popularity of ECT concerns some psychiatrists. "It's better than it used to be, but I have grave reservations about it," said Boston area psychiatrist Daniel B. Fisher, who has never recommended ECT for a patient. "I see it now being used as a quick and easy and not very lasting solution and that worries me." ■

BY JAY SIWEK, MD

High Cholesterol Levels

Q. *I'm a 35-year-old woman in excellent health, except that I have a cholesterol level of 280. One doctor has recommended cholesterol-lowering medication, but another said that medication isn't indicated given my age and lack of other risk factors for heart disease. I do not smoke, am not overweight; I exercise regularly, follow a good diet and have no family history of heart disease. What guidelines are there about treating my situation?*

A. You can find experts on both sides of the fence on this question. I think most would say that given your age, sex and lack of other risk factors, it would be excessive for you to take any medicine for that level of cholesterol. But some would argue that cholesterol levels are an important risk factor for heart disease, and that it should be treated if diet alone isn't enough.

All experts agree that diet is first-line treatment for high cholesterol levels. To lower your cholesterol, you'll need a low-fat, high-fiber diet. So-called "low cholesterol" or "cholesterol-free" foods aren't enough. It's the fat, especially saturated fat, in foods that's the real culprit.

Cholesterol is found only in animal products (meat, fish, fowl, eggs, milk, butter). There's no cholesterol in fruits, grains or vegetables; yet vegetable products, especially vegetable oils, can contain a lot of fat. So the first point about diet is to watch the amount of fat you eat. For the average diet of 2,000 calories, the recommended daily allowance is 65 grams of fat. But someone trying to lower their cholesterol should aim for much less, in the range of 20 to 30 grams a day for a strict low-fat diet.

The typical American diet contains lots of fat, especially fat that's not always readily apparent. For this reason, I recommend reading food labels and getting a book to learn about the fat content of foods and how to eat well on a low-fat diet. And if you're embarking on what may be a lifelong change in eating, I also recommend getting professional advice from a registered dietitian or nutritionist.

So far, I've just been talking about your total cholesterol level. But it's the components of your total cholesterol that matter. One is known as LDL (low-density lipoproteins, the "bad cholesterol"). The higher the LDL, the greater your risk of heart disease. In addition, the lower your HDL (high-density lipoproteins, the "good cholesterol") the higher your risk. It's possible to have a high total cholesterol, but a low LDL and high HDL, and no increased risk of heart disease.

If your LDL is below 130, and you have no risk factors for heart disease, you needn't do anything. If it's between 130 and 160, you might consider lowering your risk by exercising and eating a low-fat, high-fiber diet. If it's above 160, the National Institutes of Health recommends diet therapy. If you have two or more risk factors for heart disease, NIH recommends diet therapy for LDL levels above 130; and if you already have heart disease, NIH recommends diet therapy if your LDL is above 100.

For purposes of these recommendations, risk factors include being a man 45 or older, a woman 55 or older, having a family history of early heart disease, smoking cigarettes, having high blood pressure, having diabetes or having an HDL below 35.

As for drug therapy, the NIH National Cholesterol Education Program recommends discussing medication with your health professional if your LDL is above 190 even if you are using diet therapy and have fewer than two risk factors. However, for men under 35 and women before menopause, drug treatment isn't usually recommended until your LDL gets above 220.

For people with two or more risk factors, you should consider drug therapy if your LDL is above 160. And if you already have heart disease, such as having had a heart attack, you should consider taking medication for LDL levels above 130.

If all this seems complicated, you should know that these guidelines are controversial. Some experts think they go too far, while others think they don't go far enough. For example, studies suggest that for women below 45, treating high cholesterol wouldn't reduce their overall rate of death. And other studies conclude that it would cost several million dollars per year of life saved to treat low-risk 35-year-old women.

But other studies suggest that treating high cholesterol in people without heart disease prevents heart attacks and reduces death from heart disease. The question boils down to one of weighing the cost of treatment (including changing your diet, prescription costs, doctor visits, blood tests) against the potential for some small but measurable gain in life expectancy in the future. ■

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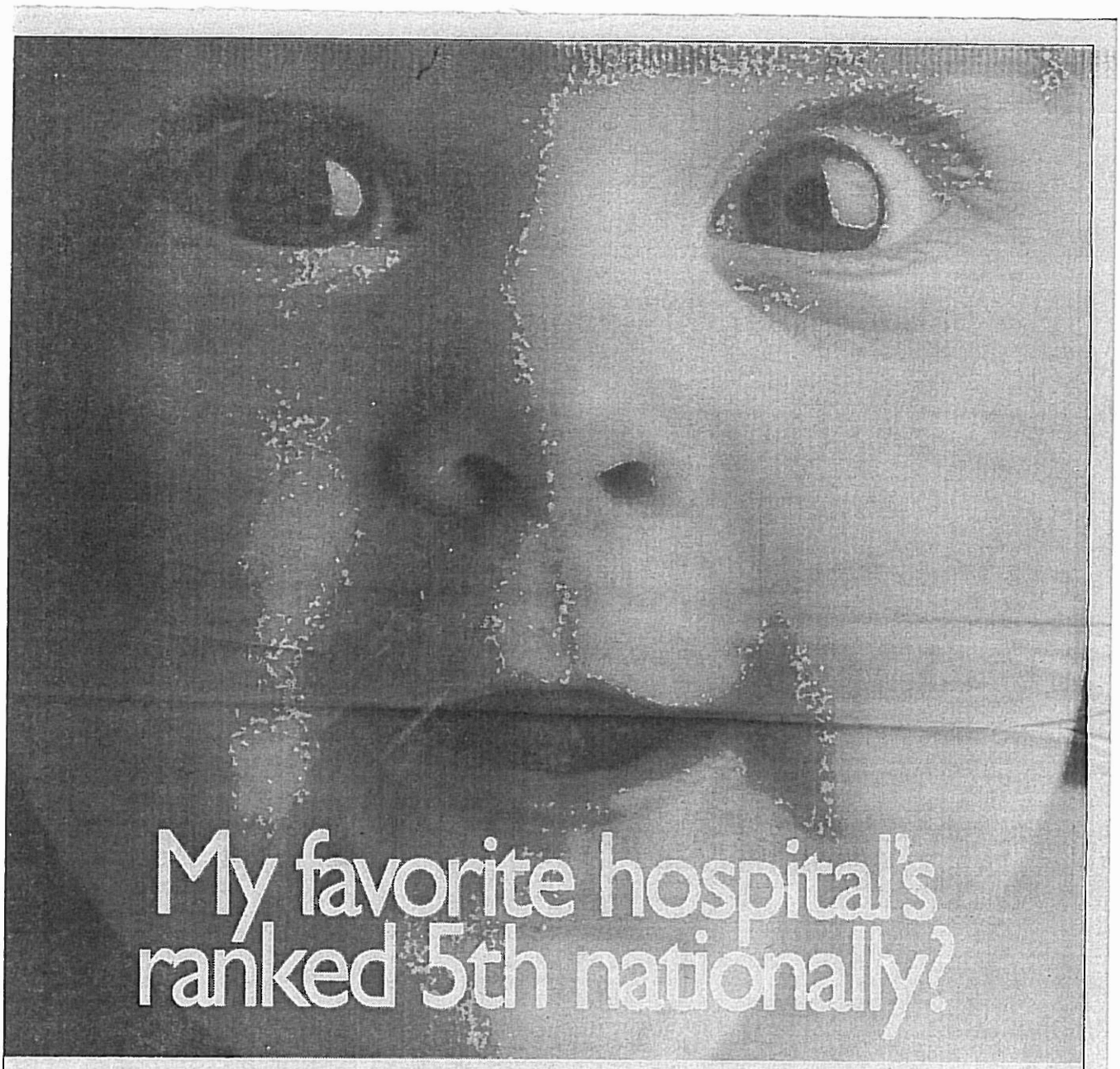
Consultation is a health education column and is not a substitute for medical advice from your physician. Send questions to Consultation, Health Section, The Washington Post, 1150 15th St. NW, Washington, D.C. 20071. Questions cannot be answered personally.



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