CONTROVERSIAL ISSUES IN MENTAL HEALTH

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DEBATE 9

Should ECT Be Prohibited?

Leonard Roy Frank emphatically argues YES. In 1962, Mr. Frank was involuntarily committed to a psychiatric facility and later forcibly administered thirty-five electroshocks in combination with fifty insulin coma shocks. He has been active in the psychiatric survivors' movement since 1972 when he joined the staff of *Madness Network News*. Two years later he cofounded the Network Against Psychiatric Assault (NAPA). In 1978 he edited and published *The History of Shock Treatment*. He has lived in San Francisco for thirty-three years.

Arguing NO are Susan L. McNeill and André Ivanoff. Ms. McNeill is a social worker on the Inpatient Psychiatry Unit of the University of Washington Medical Center. She has worked in psychiatric and emergency room social work since receiving her M.S.W. from the University of Washington in 1984. Her thesis was "Suicidal Behavior, Alcohol Use, and Emergency Room Disposition." Recently she helped develop a managed care plan for dual diagnosis psychiatric inpatients.

Dr. André Ivanoff is an Associate Professor at Columbia University School of Social Work. She received her M.S.W. and Ph.D. from the University of Washington and worked as a mental health practitioner in Outpatient Psychiatry at the University of Washington Medical Center. She has written articles and chapters on mental health and suicidal behavior, particularly in prison populations, and is coauthoring a book entitled *Research-Based Practice with Involuntary Clients*. Her research interests include the concomitants of suicidal behavior and the development and testing of prevention-focused interventions for populations at high risk for health and mental health problems.

YES

LEONARD ROY FRANK

Electroshock Is a Crime against the Spirit

Electroshock (also known as shock treatment, electroconvulsive therapy, and ECT) is a procedure used in psychiatry as a treatment for people diagnosed as "mentally ill."

Since its introduction in 1938, electroshock has been administered to between 10 and 15 million people worldwide. In the United States alone, about 100,000 people are now being electroshocked yearly, and the number appears to be growing. Recent media accounts report a resurgence of ECT interest and use.

About two-thirds of those undergoing ECT are women. About 95 percent of those administering ECT are men. A 1978 American Psychiatric Association (APA, 1978) survey showed that 22 percent of its members used ECT. Based on this figure and the current APA membership, there are now more than 8,000 ECT practitioners in the United States.

Except for infants, individuals from all age groups have been subjected to ECT. In the 1940s psychiatrist Lauretta Bender, best known as the originator of the Bender Gestalt Test, supervised a program in which 100 children (all under twelve years of age, the youngest being just under three) were electroshocked at New York's Bellevue Hospital (Bender, 1947; 1955). ECT practitioners continue to shock children and adolescents. Young and middle-aged adults had born the brunt of ECT until recent years when the trend shifted toward the elderly. A growing proportion of ECT subjects, now estimated at 50 percent, are 65 years of age and older. According to a 1989 report in a professional journal, persons over 100 are being electroshocked (Alexopoulos, Young & Abrams, 1989).

Most ECT is now being administered in the psychiatric wards of general hospitals and in private psychiatric facilities. Formerly, state hospitals were the centers of ECT activity. Currently, the most common diagnosis of ECT subjects is depression; a much smaller percentage bear the diagnosis of schizophrenia and mania. A relatively small number of ECT practitioners in the 1978 APA survey cited above reported using the procedure recently in cases of "anorexia nervosa, drug or alcohol abuse, intractable pain, personality disorder, toxic dementia, and sexual dysfunction (APA, 1978).

Electroshock is usually given in a series, which in cases of depression ranges from six to fifteen individual seizures administered three times a week. In cases of schizophrenia, the series ranges from fifteen to thirty-five seizures. The procedure usually entails three to four weeks of hospitalization, but a small proportion of subjects are treated as outpatients at hospitals and in the offices of ECT specialists. Some of these outpatients return for individual ECTs periodically as a preventive measure in what is called "maintenance ECT." Others return for individual ECTs at the first sign of a recurrence of symptoms.

Electroshock involves the production of a grand mal convulsion, similar to an epileptic seizure, by passing from 100 to 400 volts of electric current through the brain for from 0.5 to 5 seconds. Before application, ECT subjects are typically given anesthetic and muscle-paralyzing drugs to reduce fear, pain, and the risk—from violent muscle spasms—of fracture (particularly of the spine, a common occurrence in the earlier history of ECT when muscle-paralyzers were not used). These drugs carry their own risks and also raise the individual's convulsive threshold so that more current is needed to induce the convulsion. Because electricity is the most destructive component in the ECT procedure, the more current used, the greater is the risk of injury.

The electrically induced convulsion usually lasts between thirty and sixty seconds and may produce life-threatening complications, such as apnea and cardiac arrest. The convulsion is followed by a period of unconsciousness lasting several minutes. On awakening, the subject experiences a number of effects, including disorientation, confusion, grogginess, headache, nausea, delirium, amnesia, apathy or euphoria, and physical weakness. Most of these effects subside after a few hours or days, but amnesia, learning difficulties, and decreased creativity, emotionality, and energy may continue for weeks or months. Very often, one or more of these residual effects are permanent; the amnesia always is. The intensity, number, and spacing of the individual electroshocks in a series, together with the subject's physical condition, influence the severity and persistence of these effects.

In a 1983 letter printed in a professional periodical, neurologist Sidney Sament described the clinical picture of someone who has undergone ECT:

> I have seen many patients after ECT, and I have no doubt that ECT produces effects identical to those of a head injury. After multiple sessions of ECT, a patient has symptoms identical to those of a retired, punch-drunk boxer. After one session of ECT the symptoms are the same as those of a concussion (including retrograde and anterograde amnesia). After a few sessions of ECT the symptoms are those of a moderate cerebral contusion, and further enthusiastic use of ECT may result in the patient functioning at a subhuman level. (p. 11)

ECT's effects, as described in the two previous paragraphs, point clearly to what in medicine is called *organic brain syndrome*, or in lay terms *brain damage*, which by its very nature is irreversible. Brain cells—unlike skin cells, for example—do not renew themselves: destroyed once is destroyed forever. Although there is a large body of evidence (including human autopsy reports, animal and brain-wave studies, and clinical observations) in the professional literature, psychiatrists have yet to acknowledge, at least publicly, the causal relationship between electroshock and brain damage. What they think privately is another matter. In the above cited 1978 APA survey, 41 percent of psychiatrist-

respondents, who were anonymous, agreed with the statement, "It is likely that ECT produces slight or subtle brain damage." Only 26 percent disagreed.

Some of the most striking evidence of brain damage from electroshock was revealed in psychiatrist David Impastato's 1957 study of 254 ECT-related deaths (Impastato, 1957). Based mainly on previously published reports which included autopsy findings, Impastato, a leading electroshock proponent, identified sixty-six "cerebral deaths."

Ironically, brain damage is one reason the procedure supposedly "works." As in other cases of serious head injury, ECT causes amnesia, denial, euphoria, apathy, mood swings, helplessness, and docility. Amnesia victims, having forgotten some problems, tend to complain less. As a result of denial, other problems are minimized or no longer recognized as such. With euphoria, the subject's depression seems to lift. With apathy, the subject's "agitation" (if that had been a factor in the original diagnosis) seems to diminish. Dependency and submissiveness tend to make what may have been a resistive, hostile subject more cooperative and friendly. In hailing the wonders of electroshock, psychiatrists have simply redefined the symptoms of psychiatrogenic brain damage as signs of improvement or recovery.

The theory that electroshock "works" by damaging the brain has been corroborated by Paul H. Hoch, an outspoken defender of both electroshock and lobotomy, who in 1948 stated at a professional meeting, "This brings us for a moment to a discussion of the brain damage produced by electroshock. . . . Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that improvement takes place by a definite damage of certain parts of the brain."

One of the surest indicators of brain damage is memory loss, which, not surprisingly, is the most common effect of ECT reported by ECT survivors. The loss stretching backward in time from the treatment period is called *retrograde amnesia* and may cover many months or years. The memory loss from the treatment period forward in time is called *anterograde amnesia* and usually covers several months, often including the treatment period itself. The amnesia may be global or patchy; some memories return, others are permanently lost. These losses can have a devastating effect on one's entire personality and are often experienced as a diminution of self. They not only impair one's ability to function in everyday affairs but also in the higher realms of spiritual and creative activity.

If electroshock is as destructive as portrayed here, how can its growing use be explained? Indeed, how can its ever having been used be explained? The answer is complex. Here are some factors that should be considered (Frank, 1976; 1978; 1990).

1. At a time when insurance companies are increasingly reluctant to pay for other psychiatric services, they almost always cover electroshock costs without serious questioning. In more than 70 percent of ECT cases, insurance companies pay the cost, which runs upwards of $35,000 per series. Twenty-five to thirty days of hospitalization ($600 to $800/day) for a series of 8 to 12 individual ECT treatments ($800 to $1000/treatment, including the ECT specialist's and anesthesiologist's fee, treatment-room rental, cost of premedications) is routine. Five or six people can be easily shocked in a couple of hours, at $300 per treatment for the psychiatrist. The yearly earnings of psychiatrists specializing in ECT may be twice that of other psychiatrists. In short, for psychiatrists and hospitals alike, ECT is an important money-maker: overall a $2 to $3 billion a year industry.

2. For more than fifty years the psychiatric profession has been promoting one of the biggest frauds in medical history. Through lies, distortions, and omissions it has completely misrepresented the truth about electroshock and, in so doing, has duped almost everyone, themselves included, into accepting the notion that ECT is a beneficial procedure.

By way of illustration, in 1990 the American Psychiatric Association published a 186-page Task Force Report entitled, "The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging" (APA, 1990). This authoritative report, whose publication was announced with much fanfare, including a press conference uncritically reported by the Associated Press, informed psychiatrists that "in light of available evidence, 'brain damage' need not be included as a potential risk [in the informed consent form for ECT]." Such "available evidence" as the Impastato study, cited above, reporting sixty-six "cerebral deaths" following ECT; the 1978 APA survey, also cited above, showing 41 percent of the responding psychiatrists agreeing that ECT produces some brain damage; and psychiatrist Peter Breggin's fully documented studies of electroshock as a brain-damaging procedure (Breggin 1979, 1991, 1992) are nowhere mentioned in the report. Breggin and Impastato are also excluded from its bibliography of 342 references.

In another instance of deception, the same report, referring to Freeman and Kendell's frequently cited 1980 follow-up study of ECT patients in Scotland, concluded that "a small minority of patients . . . report persistent [memory] deficits" (APA, 1990). In this study, about which the report had nothing further to say, 64 percent of 166 patients interviewed one to seven years following ECT reported "memory impairment" from ECT (25 percent "thought symptom severe," 39 percent "thought symptom mild"). Twenty-eight percent agreed with the statement that "ECT causes permanent changes to memory." An appendix to the APA report included an example of an ECT consent form, which stated, "A small minority of patients, perhaps 1 in 200, report severe problems in memory that remain for months or even years" (p. 158). Thus the report grossly understated the risk of memory loss following ECT and then added to its deceit by referring to both the 28 percent in the Freeman and Kendell study and the 0.5% in its own consent form as "a small minority."

3. Electroshock is useful as a method of social control. Individuals who fall or step out of line become troublesome to themselves or others. Not only does the use or threatened use of ECT usually bring them back into line, but the knowledge of its availability has an intimidating effect on many other people as well. At some level of their consciousness the message has come home: stay in line—or else (Warren, 1986)!

4. Last, electroshock reinforces the biological model of "mental illness." Under this model, which dominates contemporary psychiatry, mental illness is seen as a brain, hormonal, metabolic, or genetic disorder. Biological psychiatrists, as those psychiatrists who have adopted this model are usually called, regard people as objects to be manipulated and fixed. But human beings are much more than that. Biology is not destiny. Character is. And character is shaped primarily by the manner in which individuals choose to conduct themselves and by what is done for and to them throughout their lives. By reducing the individual's ability to function spiritually, intellectually, emotionally, and physically, electroshock undermines character and, along with it, freedom and responsibility. It has no place in a free society; wherever it is used, society cannot be truly free.

In conclusion, if the body is the temple of the spirit, the brain may be seen as the inner sanctum of the body, the holiest of holy places. To invade, violate, and injure the brain, as electroshock unfailingly does, is a crime against the spirit and a desecration of the soul.

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Rejoinder to Mr. Frank

Susan L. McNeill and André Ivanoff

ECT is one of the most controversial treatments in psychiatry. Although the arguments against ECT are cogent and compelling, they fall short of convincing us that ECT should never be used. The rhetoric of fear based on reports twenty to fifty years old must be separated from the current standards, procedures, and protections surrounding the use of ECT. Philosophically and pragmatically, the decision to ban this medical procedure is a complex one, raising many questions. Do some people benefit from the procedure? Is ECT used primarily to hurt, control, and abuse? Do the side effects outweigh the benefits? From a critical perspective, what does the outcome research say?

Case study reports and standardized mental health measures document marked improvement in depression among geriatric populations as a result of ECT. The current use of ECT in the United States is regulated in each state; its primary purpose here is as treatment. Misuse of ECT clearly has occurred in the past. In some countries, ECT is used as political torture and is misused on vulnerable and institutionalized populations. In the United States however, ECT is no more an instrument of social control than the use of psychotropic medications and institutionalization; few advocate totally abolishing these. Important

larger issues of psychiatry's role in defining mental health or illness and the ascendancy of biologic psychiatry are not appropriately focused on this single procedure.

Measurement of permanent and significant memory dysfunction has not been documented in research. Blaine's (1986) summation of current use reports ECT to be an extremely safe procedure and shows no evidence that ECT produces brain damage. The rates of amnesia resulting from properly administered ECT are not known (Martin, 1986). Those who speak out against the procedure, however, are those who feel they have been harmed by it and attest to these dysfunctions.

Research examining the outcome of ECT with depressed geriatric individuals has found significant improvement in the commonly accepted vegetative and affective symptoms associated with depression. Investigations of ECT and many other psychiatric treatments are often limited to case study reports and small or nonrandomized samples of patients; methodologically, better research is needed.

A pervasive suggestion throughout Frank's arguments is that current ECT procedures and safeguards are no different than those of thirty to fifty years ago. This is not the case. The work of Frank and others has been in large part responsible for establishing the regulations that currently govern the use of ECT in all fifty states. These regulations were developed in direct response to the misuses described. The arguments presented here against ECT contain numerous minor exaggerations. Positioned to incite anger and fear, they interweave fact with experiential interpretation and result in a politically and personally frightening picture. Just one example is the suggestion that ECT is disproportionately used on women by male psychiatrists. Unfortunately, this is true of all psychiatric and psychotherapeutic interventions, not just ECT.

ECT is usually not a treatment of first choice; however, with geriatric patients suffering from depression there is evidence that it is an effective treatment. Protecting the rights of patients unable to advocate for themselves is a paramount concern. Part of protecting patient rights, however, is ensuring the widest availability of treatment options. The deterioration of spirit and body resulting from refractory depression is horrible to witness in a loved one. When a course of ECT results in an individual reconnecting with family, deciding to eat, and regaining, after many months, an interest in a favorite object or pastime, the procedure seems both humane and worthwhile.

The decision to use ECT must be made carefully with the informed involvement of family members and, to the fullest extent possible, the patient. Our positive experiences with clients, patients, and loved ones have created a willingness to include ECT among the range of treatment options. Mental health practitioners, whether opposed to or in favor of ECT, cannot defer these decisions solely to medical colleagues. We are responsible for educating those involved and helping them weigh, with intelligence and compassion, the possible

side effects of the procedure against its potential benefits. The unfortunate use of frightening images may prevent informed consideration by those who might benefit from the procedure.

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NO

Susan L. McNeill and André Ivanoff

Electroconvulsive therapy (ECT) has been a controversial treatment since it was first used in Italy in 1933. It is an inelegant and invasive procedure, frightening to think about, and the reasons why it is effective remain poorly understood. There is no doubt that there has been inappropriate use of ECT in the past and that some current usage may be questionable. We do not attempt to defend all uses of ECT. The efficacy of ECT with children, adolescents, or patients suffering from psychotic disorders is not well established. Data do support the effectiveness of ECT, however, in the treatment and management of refractory depression when more conservative treatments have failed.

ECT was used before the advent of psychotropic medications and before patients' rights to information and to refuse treatment were recognized. Reports suggest that, even during this time, when ECT was used in a less knowledgeable and less discriminating manner, it was more effective at reducing the physical symptoms of depression than no treatment at all (Martin, 1986). During this early period, anesthesia and muscle relaxants were not used during ECT. Patients were not only terrified, they suffered complications such as memory loss, fractures, and even death. Informed consent was not obtained and patients were often subjected to ECT involuntarily and without regard for civil liberties. Considering how barbaric the procedure was and the lack of understanding about how ECT actually changed things, it is not surprising that strong biases developed against its use. When these biases are coupled with evidence of overuse, misuse, and abuse, they become even stronger and fear-based. Nightmare images of ECT used to control uncooperative patients (as portrayed, for example, in Kesey's "One Flew Over the Cuckoo's Nest") and the use of ECT to punish political dissidents have led to lasting negative impressions. The argument for not abolishing ECT, however, is the same as for other controversial, potentially overused

and abusive methods of treatment that have proved useful (e.g., hysterectomy, cesarean section deliveries, drugs with high abuse potential such as cocaine and heroin): The prohibition of ECT would be to the detriment of those individuals who can truly benefit from the procedure.

Because of the increasing use of psychotropic drugs to treat depression and ECT's misuse and subsequent bad reputation, use of ECT declined through the 1970s. During the 1980s, however, ECT regained some acceptance as a relatively safe, low-risk, and effective treatment for depression. This increased use may be attributed to three developments: (1) new techniques for administering ECT; (2) recognition of the limitations of medications for some patient groups; and (3) data demonstrating its effective use in the treatment of suicidal and geriatric patients.

Administration

A first priority in the ethical use of ECT is informed consent of the patient. Although individual rules vary across the country, all states have regulations governing the use of ECT. This is a general model of how informed consent is obtained. First the details of the ECT procedure, including anticipated risks and benefits, are explained to the patient and to the family. They are then shown a video demonstrating the procedure. Patients are given time to consider their options and ask questions. A second physician opinion is usually required. Last, the patient must sign an informed consent form, acknowledging an understanding of the procedure and its risks, before ECT can be performed. In the case of a patient who may not be competent to make decisions about his or her medical care, a court hearing is required before administering ECT. A guardian or other individual with power of attorney cannot make the decision for the patient.

The patient receives a thorough medical examination to ensure that there are no contraindications for the procedure. On ECT administration days, the patient is not allowed oral intake after midnight because a general anesthetic is used. An operating room or special unit prepared for anesthesia and ventilation is used for ECT. A short-acting anesthetic and a muscle relaxant are administered to prevent injury and provide for patient comfort. Cardiac monitoring continues throughout treatment and recovery. The electrical stimulus is administered and adjusted so that the patient has a seizure lasting twenty-five or more seconds. A brief pulse sine wave current is used. This method of triggering seizures results in fewer side effects than the use of continuous sine wave current which was formerly used. Treatments are given two or three times per week, and the average number of treatments ranges from seven to twelve. The patient remains in the recovery room until he or she recovers from the effects of the anesthesia and then returns to the regular unit.

Side Effects

Immediately after treatment, and lasting for several hours, the most common adverse reactions are a transient headache and some nausea, which can be symptomatically treated. Post-treatment confusion is common, but not long-lasting, and usually clears in a matter of hours or a few days. Memory loss is the most widely reported and controversial side effect of ECT. Many, but not all, patients report amnesia for a period of time immediately surrounding the treatment. Recovery of memory begins in a few weeks and is completely restored in three to six months. Permanent memory loss that occurs as a result of current ECT administration procedures cannot be objectively documented (Pearlman, 1991). The procedure is remarkably safe, with a mortality rate of three to five patients per 100,000 treatments, which is similar to that of outpatient dental surgery.

Effectiveness

The efficacy of ECT in treating major depression has been demonstrated. Rates of improvement are reported at 70 percent to 80 percent. This is particularly impressive when one considers that most of today's ECT patients have failed medication trials and other more conservative treatments. ECT has been shown to be as effective as or superior to medications and to sham ECT in controlled, double-blind studies with patients suffering from diagnosed major depression (Pearlman, 1991).

In cases of severe depression, the risk of suicide is always present. Because ECT provides more rapid response than medication or psychological treatments, it may more directly reduce suicide risk. At least one study reports reduced suicidal behavior and improved survival rates in ECT versus drug-treated patients (Tanney, 1986). ECT has also been successfully used on an outpatient maintenance basis to prevent relapse to major depression and psychiatric rehospitalization (Thienhaus, Margletta, & Bennett, 1990).

ECT is frequently the treatment of choice for geriatric patients. The very elderly often have medical conditions that make the use of antidepressants problematic. These medications also have side effects that are very poorly tolerated in the geriatric population. For this patient group, ECT is a relatively safe and effective treatment that can add much to the quality of life for the older patient. Older patients respond well, and as their depression lifts, memory, rather than being impaired, often also improves (Martin, 1986). Not surprisingly, complications may occur at a higher frequency among the very old and those in poor health, but the risks of complication have not been found to outweigh the benefits of treatment (Burke, Rubin, Zorumski, & Wetzel, 1987).

Case Study

Ms. R. is a 72-year-old woman who was admitted to the psychiatric unit of an urban hospital following four years in a nursing home. The reason for this long stay was unclear as she had recovered from the bowel resection that initially necessitated the placement and had no other major or ongoing medical problems. She was severely depressed and would not eat, drink, or respond to questions. She stayed in bed all day with her eyes closed except to use the bathroom. Although a feeding tube was in place, she was starving herself to death; her skin was breaking down and wasting was evident. ECT was initiated. After her second ECT treatment, Ms. R. was opening her eyes and giving the nurse orders. After the third treatment she began eating a bit and complained about the food. After a few more treatments she improved enough to participate in physical therapy and independently went into the day room and interacted with other patients. By the end of treatment she was joking and telling the nurses that she looked forward to physical therapy because the therapists were "such hunks." At the time of her discharge, her son reported his mother had not looked so well in over five years.

Dramatic? Yes. Unusual? No. The use of ECT as a treatment for serious refractory depression is adequately established as safe, effective, and appropriate. It can prolong and improve the quality of life. Data on current methods support the use of ECT. To abolish it based on overuse and misuse would deny treatment to a subset of persons for whom no other equally effective treatment exists.

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Annotated Bibliography

Martin, B. A. (1986). Electroconvulsive therapy: Contemporary standards of practice. *Canadian Journal of Psychiatry, 31,* 759–771.

This article reviews the history and effectiveness of ECT with a variety of disorders and identifies knowledge gaps.

Pearlman, C. (1991). Electroconvulsive therapy: Current concepts. *General Hospital Psychiatry, 13,* 128–137.

This article reviews recent developments in the practice and theory of ECT. It describes treatment procedures in detail and medical considerations.

Taub, S. (1987). Electroconvulsive therapy, malpractice, and informed consent. *The Journal of Psychiatry and Law, 15,* 7–54.

This is an excellent overview of the use of, research on, and legal issues concerning ECT. It addresses malpractice and patients' rights.

Rejoinder to Ms. McNeill and Dr. Ivanoff

Leonard Roy Frank

In presenting their case for electroshock, Ms. McNeill and Dr. Ivanoff have made many serious errors. This brief rebuttal addresses a few of the most important ones.

The authors discuss the early period of ECT (for example, "how barbaric the procedure was," implying that it no longer is) and comment that there was "evidence of overuse, misuse, and abuse." If the procedure was barbaric, as it undoubtedly was, its wrongful use was not the issue: it shouldn't have been used at all. While there have been minor, mostly cosmetic, changes in the method of administration, electroshock—as commonly used today with higher doses of electricity and longer seizures—is usually more damaging to the brain, and thus more barbaric, than it was previously.

The authors talk about informed consent as "a first priority in the ethical use of ECT." What ECT practitioners try to obtain from their subjects would be better called *misinformed* consent. The possibility of brain damage, the single most obvious and significant effect of ECT, is rarely if ever mentioned in consent forms. These forms also grossly understate the risk of permanent and severe memory loss from electroshock. Moreover, the inherent coerciveness of psychiatric wards, where most ECT is administered, and the threat of forced treatment (masquerading as legitimate court-ordered treatment for persons ruled incompetent or incapable of giving consent) render free choice impossible.

Memory loss is not "completely restored in three to six months," as the authors assert. In addition to the findings of permanent amnesia from ECT in the Freeman and Kendell study (1980), there is the three-year follow-up study by research psychologist Larry Squire (1983). He found that of thirty-one people who had been electroshocked three years before testing, seventeen (55 percent) still had memory difficulties that they attributed to ECT.

The authors state that ECT's effectiveness in "treating major depression has been demonstrated." The standard way to test for ECT effectiveness is by comparing real ECT and sham ECT (the subject is anesthetized but not shocked) in controlled double-blind studies. At the First European Symposium on ECT in Graz, Austria, in March 1992, two psychiatrists from England, Graham P. Sheppard and Saad K. Ahmed, delivered a paper entitled, "A Critical Review of the Controlled Real Versus Sham ECT Studies in Depressive Illness." Sheppard and Ahmed concluded that the thirteen such studies under review and analysis "do not offer significant evidence that real ECT is more therapeutically effective than sham ECT in depressive illness." (p. 80) The Crowe and Johnstone review published in the *Annals of the New York Academy of Sciences* (1986) drew the same conclusion from a smaller number of studies.

Given the reports cited above, the absence of solid double-blind studies showing long-term effectiveness, and electroshock's demonstrated harmfulness, one must conclude that there is no scientific justification for using ECT.

McNeill and Ivanoff echo the claims of ECT specialists that for those elderly who respond poorly to antidepressant drugs ECT is a "relatively safe and effective treatment." While it is true that antidepressants carry serious risks for the elderly, particularly the infirm and those with heart disease, the very ones who tolerate these drugs least are the most vulnerable to ECT's damaging effects. ECT is a more invasive procedure than the antidepressants. It is for this reason that biological psychiatrists generally use antidepressants before resorting to ECT. It should also be noted that Impastato (1957) estimated that the ECT death rate for the elderly was five times higher than for the young.

The authors go on to say that ECT often improves the memory of the elderly. The notion that ECT, with its resultant brain damage, improves memory is preposterous. What happens is that some individuals, previously mute or taciturn, are more responsive to questions after undergoing ECT. This does not signify that the ECT has improved their memory. It merely indicates that they are more motivated to answer questions following ECT than they had been before.

The quality of life for the elderly is crucially linked to memory. It is often their most valued possession. And well it should be, for memory is the soul's companion and a bulwark of human dignity. As Emerson once wrote, "[To remember] what is best in our experience is our splendid privilege." Whether or not they talk about it, many elderly people are deeply troubled by their loss of memory, whatever the cause. To claim, as McNeill and Ivanoff do, that electroshock, a known memory destroyer, "can add much to the quality of life for the older patient" is shameful.

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