TRANSFERENCE AND COUNTERTRANSFERENCE IN SOMATIC THERAPIES

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Since the introduction of the shock therapies, there has been much controversy concerning their mode of action. In 1948, Gordon (11) was able to list 50 shock therapy "theories". The present article will not enter into the controversy but will adduce some evidence which will draw further attention to the psychological implications of the shock therapies. The psychological impact of shock therapy upon the patient has been studied by many authors. Reviews of the literature and new considerations have been presented by Abse (1, 2), Boyer (5), and Fisher, Fisher and Hilkevitch (7) among others.

An excellent review which presents both sides of the argument is that by Hill (13). In part of his study he reports the opinions given him concerning shock therapy by 11 Freudian and Jungian analysts. After reviewing the opinions of these workers, Hill states, "Many of my correspondents returned again and again to the idea of what matters is not what is done to the patient but *how it is done*, and this particularly applies to the treatment of psychotics. The whole question of the countertransference—the hidden unconscious attitudes of the doctor towards his patient, which motivate his behavior towards the patient and his responses to the patient's behavior—this is the urgent preoccupation of all those psychoanalysts and Jungians who are now working on the psychotherapy of the psychoses."

In this study we are presenting material which enables us to consider first the transference and then the countertransference aspects of somatic therapies.

PART I—PSYCHODYNAMIC ASPECTS

Discussion of methodology

Analytic psychotherapy of the neuroses and psychoses is not only therapy, or attempted therapy; it is also a useful research tool. Today, in some quarters, there is a tendency to minimize the value of clinical operational research of this kind without elaborations consisting of controls and statistics and experiments devised to make findings "objective". However valuable these refinements may often be, it is sometimes the case that obfuscation rather than clarification results. In this discussion, at any rate, no attempt will be made to refer to findings other than those achieved through research in the psychotherapeutic process.

Since psychotherapeutic operational research employed on its own has contributed considerable insight in regard to the origin and development of the neuroses and psychoses and the operative forces and conditions in their development, it is no great step to its trial for the purpose of uncovering the forces at work in those therapeutic interventions into the natural history of these diseases aggregated as "shock treatment". As a matter of fact, it happens that when during the course of psychotherapy attention is focused *as occasion permits* upon the meaning to the patient of the shock therapy which has been at one time or another meted out, we are confronted by interesting and fruitful observations. The words "as occasion permits" have been italicized above because they indicate the fundamental condition which enables the more valuable observations.

It is possible, of course, to ask one by one a series of patients who had previously been exposed to shock therapy some such questions as "What do you think of the treatment you had?" or "What did the treatment mean to you?" The question might be refined or altered in one way or another in each individual case in an attempt at inducing valid communication, but the context of communication would still never approach that achieved in prolonged intensive psychotherapy. Classification and statistical treatment of the replies, though interesting, would not repair any deficiency in the original context of communication. Obs

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vations obtained *as occasion permits* during the course of psychotherapy are of an entirely different order. This is perhaps best demonstrated by a concrete example:

A highly intelligent and cultivated woman of 30 had suffered a severe depression accompanied by expressed suicidal wishes, and had been treated by a course of electroshock therapy (EST) with a favorable clinical result. One year later she suffered a relapse and was then brought into prolonged intensive analytically oriented psychotherapy. The psychiatrist who had one year previously treated her with EST reported that not only had she apparently recovered following the treatment, but that she had spoken of considerable gratitude for her relief. Indeed, this was attested by the woman herself during the initial stages of psychotherapy. The treatment, she reported, had been wonderful; and she expatiated upon the theme that it had relieved her of her feelings of ill-being, of morbid thoughts of self-destruction, and it had enabled her to recommence her work. However, *later on* in psychotherapy she was expressing views upon the theme that the shock therapist had perpetrated an outrage upon her person, that he had punished her without reason, and that he was a cruel heartless man.

This was later on, and she had never been questioned about the shock therapy directly. Since this is a common occurrence with patients in psychotherapy who have previously been exposed to shock treatment, it demands considerable scrutiny. We have first to understand the setting in which, and the time at which, the patient expresses views antagonistic to the shock therapist and the shock treatment, so contrary to her avowed initial attitude. Also, we have to understand that both the earlier and later communications about the shock therapy have a validity each in its own right, and taken together they communicate much more than a mere sum which would equal about nothing.

In this particular case, the antagonistic feelings about shock treatment were ventilated in a setting of talk about her father's punitive attitudes during her childhood. He insisted on her accompanying him every Sunday morning on a walk during which he regularly lectured her, expressing his disappointment with her and disapproval of her reported misbehavior during the week. For her, this regular weekly ambulation had been a repeated painful experience; it was following these reminiscences that she switched to talking about her regular shock treatments. Before she had come to these painful reminiscences and thus to express her hate of her father, she had been complaining that her therapist had little to say to her, let her do all the talking, and was losing interest in her.

Without going further into this setting, it is clear that this talk about her father's peripatetic lectures every Sunday morning took place under the sway of markedly ambivalent transference emotions, and this was followed by her attacking the psychiatrist who had first treated her, and by many elaborations about the shock therapy. Of course, it was easier for her to transfer her wrath to the other fellow, and thus split her father-figures into the good and the bad; that was a help for an immediate solution of a conflict of ambivalence. The point is, however, that the psychiatrist by utilizing EST had invited this position in her mind, and that this position is in our experience regularly achieved and comes into evidence in the setting and at the time of transference phenomena of this kind.

Findings in prolonged psychotherapy

It is found, time and again, with different patients in psychotherapy, that the associations of the patient as they crop up in connection with experiences of EST are saturated with anxiety, especially fears of destruction, and ideas concerned with punishment, expiation and making a fresh start. This constellation of thoughts and feelings and of related phantasies occurs in connection with shock therapy in the setting of transference phenomena which point up a revival of threatening and punitive parental figures. Often enough, these are credited too with good intentions.

To amplify this phenomenon of the association of shock therapy (and everything and everyone connected with it) with phantasies of punishment and expiation in the setting of ambivalent transference emotions would require detailed case-reporting so repetitious that the patience of the reader would be too sorely tried. The phantasies of punishment vary con-

siderably in content – purgatory or hell is pictured, castration is adumbrated, or sensations of being helplessly seduced and overwhelmed are conjured. Similarly, in regard to expiation and rebirth, the content is differently clothed from time to time. Sometimes memories of childhood, concerned with a whipping after naughtiness and the subsequent events of finding love restored, are connected with the experiences following shock therapy and the kindness of the physician. The patient may talk about his having found a fresh start after shock therapy, only to follow this with associations derived from a birth phantasy. Sometimes the elucidation of a dream may point up the wish to start again with a clean slate and then connect in the patient's mind with experiences in former shock therapy. Thus when the shock experiences enter into the spontaneous associations of the patient, they are always in a typical nexus of anxiety feelings, notions and memories concerned with punishment, phantasies of expiation and rebirth; and this typical nexus occurs as transference conditions permit.

This indicates that the patient finds the meaning of shock therapy unconsciously (whatever his more proximate conscious attitude) as a punishment which makes him anxious and at the same time diminishes his sense of guilt and offers him the prospect of forgiveness and a fresh start. It should be added that not only is this revealed in detail in psychotherapy, but observations of the behavior of the patient during the course of shock treatment show too that shock therapy induces anxiety, though it is often the correlative defenses which are more obvious, such as fight or attempted flight.

Physiological events, consequent psychic reflections, and the total treatment field

As pointed out in previous papers (1, 2), the meaning of the shock therapy as it later becomes apparent in psychotherapy is hardly surprising in view of the fact that this form of treatment is a means of effecting reversible physiological disruption. Of course, the experience consists of discontinuous and repetitious disruption within a total treatment configuration which includes physicians, nurses, apparatus and the general business of something being done. In other words, the experience of the patient which he carries with him afterward is compounded of the psychic reflections of thi repetitious disruption in a setting of medica care. In a report of a panel discussion by fou patients of their reactions to somatic therapy (4), the aversive and anxiety reactions as wel as feelings of gratitude are verbalized in a per missive group atmosphere. It is only, however in lengthy psychotherapy that the unconscious connections of the experience in shock therapy become available for more thorough study.

In psychotherapy, we not only come to un derstand this essential inner meaning for th patient, but we can also descry its effects. Fo example again, in the case of the patient men tioned above, the attitude of her father as re resented in his weekly compulsory walks aggra vated the difficulties this woman experience in becoming able to relate satisfactorily to me She suffered from a severe inhibition of spo taneity in the presence of men, for she w frightened of them for reasons altogether o side the realm of her adult conscious unde standing before psychotherapy. To isolate important element from a complicated matr she had been frightened of her father, and t anxiety engendered a severe ego restriction her later behavior with men. When the con tions of treatment made it possible for her discuss this, often enough at the time of dis sion she also spoke of the psychiatrist who previously treated her, and she came to dis how she had been glad to say she was grat and then to make off. She came to recognize existence of emotions in relation to the st therapist in the later psychotherapy, whic the time of her actual contact with him r it typically necessary for her to resort to fense in severe inhibition and to present self simply as a "model patient". He ha became evident in psychotherapy, put hi in the position of a castigating father-i with whom she must comply, and from w she could expect encouragement provide did. It became clear that the shock th enabled her to re-enact a relationship encompassed not only punishment but al giveness, at a time when she was otherwi in an internal psychic drama which pro no such bonus; but the therapy was in helpless to enable a working through in ference with eventual psychodynamic s

as was afforded in intensive psychother-
. She remained fixed in her ways of relating
others and remained basically a frustrated
resentful woman liable to a renewed attack
vere depression.

he different shock therapies represent a vari-
upon the same theme, but the variations
acteristic of each type of shock therapy are
eat importance. The psychic reflections of
organic events as observed in psychother-
show up the differences as well as the simi-
es. The fact that these physiological
ts occur without conscious representation,
d often in the absence of consciousness,
s that conscious perceptual organization
necessary for these psychic reflections to
r. Memory is a phenomenon which is only
partially covered by an understanding of
nental processes involved in conscious re-
Just as some psychologists have brought
ory theory into relation with instinct
y by means of such concepts as Jung's
al memories" (14) or Spencer's "inherited
ized experience" (17), so we can connect
sychic reflections in psychotherapy with
hysiological events which occurred in the
ce of consciousness. Besides, ontogenet-
bodily experiences register in the psyche
e the evolution of ego-organization; bodily
iences are in fact largely responsible for
evolution, and the "body-ego" is the core
e ego-organization.

us it happens that the special features of
hysiological events which occur during
n coma treatment show up in the later
ion of the patient in psychotherapy. Dur-
sulin coma treatment, hypoglycemia and
e hunger" are created as special features
e traumatic situation. Later the associa-
of the patient are colored by this repeti-
bodily experience. Reference to insulin
ment often occurs when the associations
e patient are constellated around events
rned with breast-feeding in infancy, and
tasies related thereto. The insulin coma
nation is a corrective experience of loving
and the "symbolic realization" of this
organically regressed to helpless depend-
nd overwhelming tension is a therapeutic
of great importance in the treatment of
phrenic patients.

viously, one aspect "threat and punish-
ment" has been emphasized, whereas "loving care" has been only barely alluded to. It so happens that it is just in insulin treatment where this latter becomes less overshadowed. The very conditions of insulin treatment require the acting out of considerable care and attention to the patient who, in his turn, is very ready to cast the nurses into the role of nursing mother, feeding him, as they do, when he is helpless and hungry. It seems that this loving care aspect, so emphatic in insulin coma treatment and occurring at a primitive level between patient and nurse, is a very important operative factor in the success of the treatment. Linford Rees in his careful comparative study of the value of insulin coma, electronarcosis, electroshock and leukotomy in the treatment of schizophrenia (16) shows that insulin coma is the most effective, adequately-tested organic therapy of schizophrenia.

As the patient becomes more responsive following insulin coma therapy, a one-to-one relationship with a nurse becomes more effective. In other words, the development of a need-satisfying though otherwise defective object relationship can be cultivated towards a more rewarding one by a person trained in the principles of psychiatric nursing. Relationship therapy under psychiatric supervision can considerably further the corrective experience involved in insulin treatment "mechanically" conducted. Of course, it is already involved in the "mechanics", but by making its presence understood by the nurses, and by utilizing it more fully, the efficacy of insulin therapy can be markedly improved. It is probable that the differential response of depressives and schizophrenics, the one category more rapidly to EST and the other more fully to insulin coma treatment, is related to such factors as the ratio of "threat and punishment" to "loving care" implied in the procedures, respectively. Of course, there are so called schizo-affective disorders, and in such cases combination therapy can alter the ratio of these elements involved in the mechanical procedures. In all cases, more understanding of the patient is required to enable more effective relationship therapy by the nurses, and more effective psychotherapy by the physician.

There are many subsidiary therapeutic factors involved in shock therapy, one of which

has been emphasized by Flescher (8). This is the discharge of tension involved, for example, as in the convulsion itself in EST. The periodic discharge of tension, which itself is largely the result of frustration and rage, leaves the patient often more composed and accessible. This would not persist long—the tension would, of course, build up again rapidly were it not for the mobilization of defenses and stimulation of ego-organization which results from exposure to shock therapy.

Part II—The Attitudes of Shock Therapists

Modern trends of thought regard all physician-patient relationships as worthy of study, but it is in psychiatry that emphasis on the interpersonal relationship has assumed greatest importance. In any dynamic psychotherapeutic relationship there must be awareness of countertransference on the part of the therapist. Feelings and defenses of the therapist which may interfere with the treatment process require recognition and clarification for their control or deletion. Unfortunately, there has been inadequate consideration of this factor in all the physical methods of therapy including the shock therapies and the use of modern "wonder drugs". A fuller understanding of this aspect of the physical therapies may enable them to be used more effectively. In addition we may gain further clues concerning the controversial question of the mode of action of these therapies.

Fenichel (6) states that, in personal experience in analyzing doctors who apply shock treatment, "The (conscious or unconscious) attitude of the doctors toward the treatment was regularly that of 'killing and bringing alive again,' which idea, of course, provoked different emotions in different personalities. It may be that the impression the treatment gives to the doctors corresponds to an impression it gives to the patients. It seems that they, too, experience a kind of death and rebirth."

Wayne (18) has recently drawn attention to the fact that the characteristics of a method of treatment can unconsciously evoke responses in a doctor which may be obscure to him. The use or avoidance of the method itself may be motivated, at least in part, by these same obscure responses. He lists the characteristics of electroconvulsive therapy (EST), pointing out how the unconsciousness, seizure and coma show all the characteristics of an overwhelming assault. Wayne then discusses the unconscious constellations which may inaugurate a decision to use EST or lead to an emotionally toned prejudice against its use. He cites the case of a physician who suffered back pain on the days he had administered EST. Analysis revealed guilt over unconscious hostility toward the sick patients.

We realize the potential pitfalls were we merely to question shock therapists concerning their feelings. Another approach, therefore, is to consider the statements made by psychiatric colleagues in their "off guard" moments. Psychiatrists discussing shock therapies with with relatives of patients are often very guarded in their remarks. Even though they are usually very frank about the possible physical effects of this treatment, one feels that they are carefully weighing their words concerning the psychological implications. In marked contrast are the casual, often lighthearted comments of the shock therapist before his professional colleagues. Remarks made at such times will tend more nearly to reflect feelings and attitudes of the shock therapist than might be obtained by any other method short of psychoanalysis. One of us (J. A. E.) has collected these statements over a period of eight years in Britain and the United States. Most of them have been heard on many occasions. Colleagues who have seen the list of comments have confirmed our findings that many affect-laden colloquialisms are regularly used by shock therapists in referring to their therapy. Undoubtedly the following list could be lengthened, but only personally collected remarks are used, and only remarks uttered by experienced shock therapists who would seem to have had time enough to develop fairly consistent attitudes. The feelings of the resident in psychiatry are, we believe, often quite confused when he first becomes involved with shock therapy. The statements listed were made by 19 shock therapists out of a possible total of 25. Numbers 1 through 8 and 12 and 14 were heard (with minor variations) from three or more therapists on independent occasions. Numbers 10, 11 and 13 were heard twice each.

It is important to point out that many shock therapists (including some of those whose re

marks are cited below) have denied any particular feeling about shock therapy when directly questioned. Even the suggestion that statements such as "Hit him with all we've got" are not used without significance is met with strong protests from some therapists. Thus, it seems very probable to us that the insistence of some workers upon exclusively physical explanations represents a defense against unacceptable unconscious feelings.

Statements of shock therapists in U.S.A and Britain

1. "Let's give him the works."
2. "Hit him with all we've got."
3. "Why don't you throw the book at him?"
4. "Knock him out with EST."
5. "Let's see if a few shocks will knock him out of it."
6. "Why don't you put him on the assembly line?" (This comment has been heard in a hospital where the assembly line technique was indeed used to cope with large numbers of patients on shock therapy. The implied lack of awareness of any interpersonal relationship between therapist and patient is very obvious.)
7. "If he would not get better with one course, give him a double-sized course now."
8. "The patient was noisy and resistive so I put him on intensive EST three times a day."
9. Recently one of us was consulted by the husband of a woman alcoholic as he had been advised by a psychiatrist to let her have EST. The psychiatrist had explained the procedure to the husband and had given his opinion that it would prove beneficial to the patient by virtue of its effect as "A mental spanking."
10. "I'm going to gas him."
11. "Why don't you give him the gas?"
12. "I spend my entire mornings looking after the insulin therapy patients."
13. "I take my insulin therapy patients to the doors of death, and when they are knocking on the doors, I snatch them back."
14. "She's too nice a patient for us to give her EST."

The first 9 of the above statements were made about EST. Clearly, the main attitudes expressed are those of hostility and punishment. In marked contrast are the remarks about insulin therapy. Here we observe that the idea of a threat is overshadowed by the concept of rescue of the patient from destruction. Number 13 above refers to the theme of death and rebirth, with the therapist more emphatically in the role of the "good" figure who saves the patient's life. Statements such as number 14 are usually spoken in jest, but behind the words used we can detect the therapist's reaction against the sadistic implication of shock therapy.

Our experience in the observation of CO_2 therapy has been limited, but here again in remarks numbers 10 and 11 we may suspect a hostile, punishing attitude. CO_2 therapy has been in use for much less time than EST, and possibly the use of colloquial terms to represent CO_2 will yet develop. More often we have heard therapists refer to CO_2 therapy in terms of assumed action, e.g., "Let's give her CO_2 to help her express her hostility." It is not our intention to discuss the possible [illegible] action of CO_2. However, we have observed equally violent abreactions following experimental work with nitrogen inhalations in psychiatric patients. The lack of a full amnesia in association with the gassing or choking "attack" of the therapist might well provoke expression of hostility in the patient irrespective of any physiological effect of the gas used. In observing CO_2 therapy, it has seemed that the least excited and aggressive reactions occur in depressed patients who appeared to "take their punishment lying down."

While many workers with CO_2 therapy have tended to study only the pharmacological effects of the gas, the psychological meaning of its use was investigated by Hargrove *et al.* (12). They concluded (in part), "The use of carbon dioxide therapy in our hands added no specific therapeutic effect but did add problems of transference and resistance that retarded or prevented therapy." These findings were confirmed by Freedman (9) who concluded that the reactions of each patient followed the transference reactions to the therapist administering the treatment. He noted also that in the CO_2 treatment situation there seemed to be intensification of the transference reactions even on relatively brief contact between therapist and patient.

There is another situation in shock therapy which, though frequent, has received little at-

tention. In certain clinics and state hospitals where large numbers of patients are treated, the shock therapist may be a stranger to the patient. While it may be desirable for the psychiatrist to be present at the somatic treatment of his patient, this is not always possible. Here then we have a situation which is worthy of investigation. There is a need for studies to compare and contrast the results, and the transference and countertransference reactions, in various somatic therapies given by the patient's own therapist on the one hand and by a strange shock therapist on the other. Of course, the patient's therapist is the responsible decision maker, and he may seem to be the punisher by proxy in some instances; however, it has happened at times that the transference reactions of the patient to the two therapists have differed.

Nurses and attendants are not only auxiliaries of the shock therapist in the actual shock treatment session, but are more intimately and continuously in contact with the patient. Scrutiny of the reactions of nurses and attendants to their participation in somatic therapies should also be rewarding, but spontaneous "off-guard" expressions have not been sufficiently available to us. It is, of course, the frequent experience of a physician in a state hospital to be approached by a nurse who suggests a "few shocks" for a patient because he has been fighting, resistive, uncooperative or even merely obscene in his talk. In one hospital which employed a large number of relatively untrained personnel, it was clear that such members of the staff used EST as a threat. Even non-psychotic voluntary patients reported threats of "You will go on the shock list" for such lack of cooperation as disinclination to eat a full meal! Certainly such openly threatening remarks are usually confined to the least understanding and most junior attendants who are enjoying a newfound sense of power. This is sometimes connected with an unconscious participation in the "omnipotence" of the shock therapist.

Discussion

The most interesting feature about the remarks listed is that all those which display hostile or punishment attitudes refer to the briefer forms of therapy. These, of course, are dramatic therapies and involve much action. They also bring the therapist into a much shorter contact with the patient.

In marked contrast are the prolonged care and watching over the patient during many hours of insulin therapy.

Electroshock and insulin therapy actually engender different attitudes in the therapist by virtue of the mechanisms and techniques involved. In the case of the latter there is prolonged display of the "tender loving care" about which Abse has written (2).

In talking about the hostile, attacking nature of EST with shock-therapists, we have noticed that some assume they are being accused of sadistic intentions. Such is far from the case. Instead, we wish to stress again that *the very nature of the treatment itself can produce the attitudes described.*

The success of EST principally in depressions is thus associated with hostile or punishing attitudes on the part of the therapist which correspond with the impressions received by the patients. It seems probable therefore that even the most organically minded shock therapist unconsciously allies himself with the punitive super-ego of the depressed patient.

In insulin therapy, we can be sure that the schizophrenic's well-known sensitivity to the attitudes of others makes him aware of the element of tender loving care to which the treatment lends itself.

A statement uttered by Freud in 1904 (10) is worth repeating here: "All physicians, therefore, yourselves included, are continually practising psychotherapy, even when you have no intention of doing so and are not aware of it; it is disadvantageous, however, to leave entirely in the hands of the patient what the mental factor in your treatment of him shall be. In this way it is uncontrollable; it can neither be measured nor intensified. Is it not then a justifiable endeavor on the part of a physician to seek to control this factor, to use it with a purpose, and to direct and strengthen it?"

This is a suitable place to suggest our need also to examine the psychological implications of the latest type of somatic therapy—the use of the drugs called tranquilizing agents. Undoubtedly these drugs have turned attention and interest toward the chronic psychiatric patient. Many thousands of "back ward" patients in state hospitals can now feel that

"something is being done." In many instances these patients are being observed as never before. The enthusiastic drug therapist looks for signs of improvement in his patients and, in so doing, offers an interpersonal relationship that has often been lacking. Nurses and physicians react in a more positive and loving way towards the "tranquilized" patient. These and many other such factors must be kept in mind because we cannot investigate such therapeutic tools from a purely pharmacological viewpoint.

The whole question of countertransference in medicine generally has been considered by Lewin (15). The medical student's first "patient" is a cadaver. "His relationship to the cadaver is an outlet for many sublimated, active, libidinal drives, as well as those of mastery and power. Intended to be a prototype of all future patients in certain rational respects, the cadaver easily comes to be the student's ideal of a patient in all respects." Lewin goes on to point out the unconscious knowledge of doctors that sick people are aggressive, either to the environment or to themselves. Counter-aggression on the part of the doctor has to be sublimated. For example, the doctor will use drugs which would be poisonous in non-therapeutic doses; he may use morphine for a severe pain and thus reduce his patient to the state of a cadaver. Occasionally in years gone by, we have seen or heard of whole wards of chronic psychiatric patients being kept relatively orderly and subdued by the use of the older sedatives. Such occurrences can be understood in terms of Lewin's interpretations. It seems clear that such excessive medication is the end result of countertransference feelings in the nurses and physicians.

Lewin's original paper deserves study by all psychiatrists who are using the latest drugs which have, as yet, none of the unfortunate associations of the older sedatives such as suicides and addictions. While we investigate these drugs from pharmacological, physiological and psychological points of view, we would do well also to elucidate countertransference meanings.

Demands from relatives of patients are well known to psychiatrists in relation to shock therapies as well as to the new drugs. A study of the unconscious attitudes of relatives of shocked patients might well be revealing. Meanwhile, many of us will agree with Arieti (3) when he says, "The drastic nature of shock treatment often acts as a catalyst on the emotional attitude of the relatives toward the patient."

Summary

The mode of action of the somatic therapies can be investigated from the psychological viewpoint as well as approached through physiological studies. Psychological studies seem to be most useful when unconscious transference and countertransference reactions in the physician-patient relationship are scrutinized.

Prolonged intensive psychotherapy with patients who have had shock therapy shows that unconscious defensive reactions were aroused *vis-a-vis* the shock therapist and his assistants at the time of treatment. It is upon the arousal of such defenses as well as the support the patient feels in the total treatment configuration that the efficacy of shock therapy largely depends. It is important to realize that there are crucial psychodynamic events involved in the organic therapy of a functional psychosis; these need further elucidation through research in the psychotherapeutic process. This conclusion reached through study of patients previously treated by shock methods may well also apply to those treated by drugs.

Concerning the countertransference aspects, it is concluded that the briefer therapies lend themselves to the development of hostile, punitive attitudes, whereas a therapy such as insulin therapy engenders a more loving and caring attitude on the part of the therapist. These attitudes are displayed in the casual "off-guard" remarks made by shock therapists, some examples of which are listed. It is emphasized that there is as great a need for awareness of countertransference in the physical therapies as in psychotherapy. This awareness should lead to fuller understanding of the psychological implications of these therapies and to their more effective use.

Bibliography

1. Abse, D. W.: The psychologic implications of shock therapy. *Quart. Rev. Psychiat. & Neurol.; Internat. Rec. Med. & Gen. Practice Clinics, 166:* 287, 1955.
2. Abse, D. W.: Theory of the rationale of convulsion therapy. *Brit. J. Med. Psychol., 20:* 33, 1944.
3. Arieti, S.: *Interpretation of Schizophrenia.* New York: Robert Brunner, 1955.

4. Blek, L., and Navron, L.: Somatic therapy as discussed by psychotic patients. *J. Abnorm. & Social Psychol., 50:* 394, 1955.
5. Boyer, L. B.: Fantasies concerning convulsive therapy. *Psychoanal. Rev., 39:* 252, 1952.
6. Fenichel, O.: *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton & Co., Inc., 1945, pp. 568.
7. Fisher, S., Fisher, R., and Hilkevitch, A.: The conscious and unconscious attitudes of psychotic patients toward electric shock treatment. *J. Nerv. & Ment. Dis., 118:* 144, 1953.
8. Flescher, J.: The "primary constellation" in the structure and treatment of psychoses. *Psychoanal. Rev., 40:* 197, 1953.
9. Freedman, A.: Observations on the treatment situation in carbon dioxide therapy. *J. Nerv. & Ment. Dis., 121:* 359, 1955.
10. Freud, S.: *Collected Papers,* Vol. I, pp. 251. London: The Hogarth Press, 1953.
11. Gordon, H. L.: Fifty shock therapy theories. *Mil. Surgeon, 103:* 397, 1948.
12. Hargrove, E. A., Bennett, A. E., and Steele, M.: An investigation of carbon dioxide as an adjunct to psychotherapy in some neuroses. *Am. J. Psychiat., 110:* 844, 1954.
13. Hill, D.: Psychotherapy and the physical methods of treatment in psychiatry. *J. Ment. Sc., 100:* 360, 1954.
14. Jung, C. G.: *Psychology of the Unconscious.* New York: Dodd, Mead & Co., 1952.
15. Lewin, B. D.: Countertransference in the technique of medical practice. *Psychosom. Med., 8:* 195, 1946.
16. Rees, L.: Premier Congres Mondial de Psychiatrie, Paris: 1950. Therapeutique Biologique, Paris: Hermann, 1952.
17. Spencer, H.: *Principles of Psychology.* New York: D. Appleton & Co., 1890.
18. Wayne, G. J.: Some unconscious determinants in physicians motivating the use of particular treatment methods—with special reference to electroconvulsive treatment. *Psychoanal. Rev., 42:* 83, 1955.

The International Psychiatric Association for the Advancement of Electrotherapy: A Brief History

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This paper discusses the origin, purposes, and development of the International Psychiatric Association for the Advancement of Electrotherapy. Its achievements, current activities, and possible future directions are described. It concludes that the need for such an organization within the framework of psychiatry remains imperative in light of the fact that no treatment measure has been developed that offers a suitable alternative to ECT in many cases of mental illness.

A state of ecstasy, as well as seasoned alarm, prevailed within a segment of delegates attending the 1975 American Psychiatric Association Convention in Anaheim. On one hand, electrotherapists were feeling in a congratulatory mood because word had recently been received that California's first legislation restricting in some cases, and prohibiting in still other cases, electrotherapy had been overturned.[1] On the other hand, electrotherapists knew that the battle to keep similar legislation from being reenacted in California and elsewhere was not over. Although the Fourth District Court of Appeals, San Diego, California, had affirmed the value of electroconvulsive therapy, the legislation deemed to be so onerous to patients' rights and interests had been overturned primarily because of legal imperfections in the legislation itself. The law could easily be rewritten to overcome judicial prohibitions in California.

Those who utilize electroconvulsive therapy (ECT) found themselves in the rather lonely position of having no organization to assert their right and to comfort them in their plight. Although the American Psychiatric Association had filed an *amicus curiae* brief in favor of the plaintiffs in the lawsuit to overturn the objectionable legislation, it was clear that the concerns of the APA were so multidimensional as to relegate ECT to a low priority. It was further clear that the Society of Biological Psychiatry, which had previously merged organizationally with Electroshock Research Associates, headed by David Impastato, M.D., likewise viewed the purpose of their organization as transcending the issues affecting ECT in spite of their generally friendly stance toward ECT as a treatment procedure.

Several observations were generally acknowledged: There was no vehicle available for communication devoted to electroconvulsive therapy. There was no organization devoted exclusively to the concerns of electrotherapists and patients who needed this form of treatment. There was no organization available to give legislative testimony relevant to this treatment. Finally, the literature on ECT had markedly dwindled during the 1960s and 1970s because of the rapid emergence of chemotherapy and a generally prevailing attitude that the "word was in" on ECT because of its popularity in the 1940s and 1950s.

To gain perspective on this situation, Drs. Leonard Cammer, Gary C. Aden, Howard A. Winkler, Laurence McKeever, Shervert H. Frazier, Lewis T. Ray, and H.C. Tien informally met over coffee and decided to form an organization dedicated to providing a forum for the exchange of experiences in the use of electroconvulsive therapy, while at the same time supplying an effective voice in combatting the emotional and unjustified attacks on ECT. Two other immediate purposes of the organization were developed. As it was noted at the time and later documented[2] that the training in many psychiatric programs relevant to the use of electrotherapy was deficient, it was hoped that the organization could provide an impetus toward enlarging the teaching of skills and indications for the use of electrotherapy within the curricula of medical schools and residency training programs. Finally, it

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was noted that the organization must make a concerted effort to counter immediately political and legislative encroachment on the integrity of psychiatric practice in general, but more specifically, ECT.

By the 1976 organizational meeting in Miami, Florida, the original seven founders* had been joined by another 200 charter members. After a stormy session in which matters such as whether the organization would be composed of both professionals and laity, as well as questions of the leadership of the organization, were discussed, 90 charter members met and adopted the name of the International Psychiatric Association for the Advancement of Electrotherapy along with accompanying by-laws. The organization was incorporated as a nonprofit organization under the laws of the State of California. The regional incorporators were Gary C. Aden, M.D., David W. Barron, M.D., and Donald E. Gleason, M.D. The organization adopted the sign of electrical resistance, the ohm, as its logo because electroconvulsive therapy is often effective in patients whose illnesses render them unresponsive to other modalities of treatment.

Dr. Leonard Cammer, the organization's first president, and Dr. Gary C. Aden, its executive secretary and director until recently, combined to start the publication of bi-monthly to quarterly updates relevant to issues of concern to electrotherapists. These updates were not intended to be scientific publications, but generally dealt with newsworthy items. They were subsequently joined in their publication efforts by the late Paul Blachly, M.D., who had already started publishing *Convulsive Therapy Bulletin and Tardive Dyskinesia Notes*. *Convulsive Therapy and Tardive Dyskinesia Notes* became the official scientific publication of the association until 1978, when Dr. Blachly's untimely death proved to be a crucial blow for psychiatry in general, and ECT in particular.

The organization was able to provide members to testify in public forums relevant to the value of ECT. Dr. Leonard Cammer's perseverance resulted in the ECT malpractice surcharge being reduced by nearly 50%. Dr. Shervert Frazier personally was influential within the American Psychiatric Association to garner more of that organization's attention toward the vital issues concerning accessibility of ECT for the patient. The organization had attained professional standing and recognition by 1979 when it co-sponsored an extremely successful symposium on ECT with the American Psychiatric Association at the annual meeting in Chicago. Concurrently, efforts were underway to influence the Accreditation Council on Residency Training Programs to evaluate more carefully whether psychiatrists in training were receiving adequate exposure to the indications and skills required for the use of ECT. Members of the organization provided important input to the American Psychiatric Association Task Force on ECT. Two of the organization's members were on the Task Force: Iver F. Small, M.D., and George J. Wayne, M.D. The sober analysis provided by the Task Force Report was invaluable in bringing into perspective the issues involved in ECT.[3]

Dr. Zigmond Lebensohn succeeded Dr. Cammer as President of the organization when Dr. Cammer died in 1979. Dr. Lebensohn continued the stalwart leadership of Dr. Cammer while paying special attention to professional public relations. He, in turn, was succeeded by John E. Nardini, M.D., who performed an invaluable service by presenting an actual ECT treatment in favorable light on a nationally televised program on the subject on CBS.

The organization made research grants available to those patients who were compelled by legislative or judicial actions to prove the meritorious value of ECT to the satisfaction of those circles.

The succession of Irvin H. Cohen, M.D., to the presidency was associated with improvement in the format of the *Update* and in causing the organization to reassess its goals and objectives. The organization would continue to be vigilant in attempting to preserve the patient's right to free access to ECT without judicial or legislative interference. However, the organization would also encourage new research regarding the effects and side-effects of ECT as well as continue to gather data on its therapeutic value and safety. Dr. Arthur W. Gabriel, Irvin Cohen's successor, has reinitiated the scientific mission of the organization's bulletin.

At this point, the organization has become truly international in scope with members in Canada, Mexico, the Far East, and Europe. Psychiatrists who did not regularly employ ECT in their practice have joined the organization in the belief that an attack on ECT is an attack on psychiatry in general. Although many of its original goals have already been met, a recent survey among the membership suggests that a substantial number remain ready and able to continue initiatives on behalf of ECT and to extend the organization's life in order to defend ECT from unwarranted attacks.

REFERENCES

1. Aden vs. Younger, 57 Cal App 3rd 622 (1976); Decision modified in 58 Cal App 3rd 990 (a); and 59 Cal App 3rd 174 (a).
2. Fink M. Lack of training limits ECT, speaker claims. *Daily Bull*, New York, Sandoz, May 3, 1983.
3. *Task Force Report 14, Electroconvulsive therapy*. Washington, D.C., American Psychiatric Association, September 1978.

*Dr. H.C. Tien chose to continue the development of the predecessor organization, American Society for Electrotherapy (in organization).