

Coverage of the banning of electroconvulsive therapy in Berkeley, Calif. (CLINICAL PSYCHIATRY NEWS, December 1982, p. 1), stresses the efforts of former psychiatric inmates in bringing the issue to a vote. One reason ECT has become a public issue is exemplified in the coverage, which wholly ignores the criticism of ECT within the profession of psychiatry itself.

The pro-ECT report of the American Psychiatric Association Task Force on Electroconvulsive Therapy (1978) [Dr. Fred H. Frankel, chairman] recognizes that "considerable controversy" surrounds the treatment, that 32% of surveyed psychiatrists "expressed some degree of opposition," and that many never use the treatment.

Finding that criticism of ECT from within the profession is largely stifled within the profession, the public naturally seeks other means of controlling the treatment.

I have reviewed a vast amount of literature that indicates that ECT frequently produces irreversible brain damage. The evidence includes: animal autopsy data, animal biochemical and behavioral studies, human autopsy data, psychological testing and follow-up questionnaires, clinical reports, and EEG studies.

Since all forms of ECT produce an acute organic brain syndrome, the question is not: "Does ECT cause brain damage and dysfunction?" The question is: "How thoroughly can the patient recover from ECT-induced brain damage and dysfunction?"

The not-unexpected conclusion must be that trauma to the brain capable of causing an acute organic brain syndrome often results in irreversible brain damage.

Arguments that ECT is an indispensable treatment fall apart with the realization that many psychiatrists and many large psychiatric facilities never use ECT.

In regard to such a dangerous treatment, the burden of proof remains with the advocates of ECT to show that psychiatrists and institutions that do not use ECT have a higher rate of suicide or other indications of therapeutic failure.

Most important is the issue of informed consent. When the profession itself refuses to recognize internal controversy about the treatment, it is unlikely that individual psychiatrists will present their patients with enough data about the controversy to permit truly informed consent.

Again, the public feels compelled to intervene on its own behalf in the absence of a responsible attitude within the profession.

Peter R. Breggin, M.D.  
Bethesda, Md.

### *Dr. Frankel replies:*

Although Dr. Breggin refers to the American Psychiatric Association Task Force Report on ECT as "pro-ECT," there are some in the psychiatric profession who considered it to be unsympathetic to ECT and, in fact, damaging to the practice of the treatment. Under such circumstances, where both extreme viewpoints disapprove of the result, we on the task force believe that we must have done something right.

Dr. Breggin's quotation from the task force report that 32% of the psychiatrists surveyed "expressed some degree of opposition" to ECT is presented out of context. Of those polled, only 2% were totally opposed to its use, as is Dr. Breggin. All others were capable, to varying degrees, of appreciating its usefulness in selected cases.

The referendum in Berkeley exemplifies an unfortunate misuse of the democratic process. It favors a total ban on ECT for all patients in that county, regardless of their clinical needs, and is a sad demonstration of how the will of the few can be imposed on the many.

### *Comment:*

The coverage was meant to be "on the issue of bringing the issue to a vote." Whatever your feeling about ECT, and whether or not you approve of the action that was taken, the story was the subjecting of a medical procedure to public referendum.

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**Letters**

## Electroshock therapy and brain damage: The acute organic brain syndrome as treatment

Peter R. Breggin

4628 Chestnut Street, Bethesda, Md. 20014

The psychiatric literature is wondrous to behold and even more wondrous to review; from that vast body of research and opinion one can cull a mass of unqualified support for the efficacy and harmlessness of every imaginable assault upon the brain: classical prefrontal lobotomy, carbon dioxide asphyxiation, insulin coma, total body freezing, and poisoning with a variety of neurotoxins, such as arsenic and cyanide (for reviews, see Breggin 1979; 1981a; 1981b; 1983). Even when the treatments begin to fall into disrepute, as with classical prefrontal lobotomy and insulin coma, the reviews that appear in the literature will be almost uniformly positive to the bitter end.

In this light, it is certainly no surprise that a proponent of electroshock, Dr. Richard Weiner, should be able to use the literature in defense of ECT. More surprising, perhaps, this same strongly promotional ECT literature can be reviewed by a critic of the treatment who finds ample evidence for the dangerousness and destructiveness of the treatment (Breggin 1979; 1981a). The evidence consists of human and animal autopsy studies, animal behavioral and biochemical studies, human brain-wave research, psychological testing, and multiple clinical reports. In many instances, such as the animal autopsy literature, the studies reviewed may be the same, but the analyses and deductions are diametrically opposed. Short of reading the entire literature for themselves how, then, are intelligent, scientifically minded individuals to make up their own minds? They can start with common sense, an elementary knowledge of psychology and neurology, and most important, a genuine interest and concern for the actual experiences of the patient undergoing the treatment.

From the viewpoint of the patient undergoing the treatment, there is one overriding fact about every form of convulsive therapy: *the production of an acute organic brain syndrome*. A series of artificially induced convulsions produces to one degree or another a generalized dysfunction of the brain and mind, characterized by disorientation, disruption of memory functions, impairment of intellectual functions and judgment, and emotional lability, varying from apathy to euphoria. Curiously enough, even attempts to alleviate depression by self-medication, such as sniffing glue (toluene intoxication) or drinking alcohol can produce symptoms of generalized central nervous system dysfunction.

It is therefore wrong and misleading to ask whether ECT can produce serious brain damage. It *always* produces serious brain damage as manifested in the acute organic brain syndrome. The question should be, Is it safe to assume that many or most patients experience a complete recovery from this trauma? Similarly, it is misleading to seek a subtle biochemical mechanism to explain the action of ECT (or any other trauma to the brain). We should ask ourselves more directly, How does an acute organic brain syndrome give the appearance of an improvement?

In regard to recovery from damage, my review of the literature suggests that the electrical current is the main culprit in producing the damage. It follows the path of least resistance throughout the brain, the vascular tree, producing vasospasm,

blanching, breakdown of the blood-brain barrier with the extravasation of toxic substances, petechial hemorrhages around the small blood vessels, glial reactions, and cell death (see Breggin 1979 for a detailed review).

That patients frequently complain about memory dysfunction long after ECT is well known. Weiner confirms that testing also demonstrates a loss of personal memories. That psychological tests for memory and other intellectual functions are frequently negative is irrelevant, since the tests are not used anywhere else in medicine or neurology to prove an absence of pathology. Rudimentary neurology tells us that a negative psychological test cannot rule out even a gross lesion in the brain, let alone subtle but widespread damage, such as that found in chronic drug intoxication or ECT.

What is the improvement seen following ECT? It is the direct effect of the acute organic brain syndrome, which not only blunts patients' memory and awareness of their problems, but produces a corresponding artificial apathy or euphoria. In so-called retarded patients, the euphoria will be taken as an improvement, and in agitated patients, the apathy will be seen as an improvement. The nurses' or occupational therapists' notes on the ward, however, will show that the patient is no longer able to focus attention, remember everyday details, or carry out complex tasks. Why doesn't the "cure" last? Because the gross effects gradually subside, and as the patients' brain function approximates normal again, their problems again become apparent.

Is there hope for newer variations in the technology of the treatment? No, because the treatment "works" by means of the trauma. If unilateral ECT causes less trauma, as some proponents advocate, then it will often be given in longer courses to produce the equivalent trauma. In reality, the most important modern modification, the use of anesthesia, raises the seizure threshold, requiring more intense or more prolonged doses of the offending electrical current. A review of the literature confirms that modern clinical ECT uses a larger dose of electrical energy than the premodified era (Breggin 1979). Furthermore, the appearance of reduced damage in unilateral or nondominant ECT is misleading. Damage to the nondominant side produces less verbal memory disability, but more visual memory disability. More ironically, nondominant damage, as any textbook of neurology will confirm, tends to produce a greater degree of denial of symptoms on the part of the patient (this particular form of confabulation is called anosognosia). Nondominant ECT may even be more damaging, since it focuses the energy in a more localized area, producing more severe local trauma as manifested in transient neurological signs on the opposite side and focal brain-wave abnormalities on the same side (Breggin 1979).

ECT is an irrational and often brutal treatment. The psychiatric and medical professions ought to place a self-imposed ban on the therapy. Lacking such self-restraint, the public will continue to protest and even to take action to halt the treatment.

# THE SHAME OF MY LIFE

by Peter R. Breggin

Leonard Frank has been heroic in confronting the damage done to him by shock treatment and I'm delighted to see his fine criticism of the treatment in *AHP Perspective*. AHP in general should give more attention to the damage being done in the name of psychiatry.

As I look back on my career as a psychiatrist, one shame seems unforgivable — my involvement with electroshock treatment. As a resident in psychiatry, I prescribed electroshock, I supervised a ward on which patients were given the treatment, and for a time I personally administered it. I was involved in damaging innumerable patients — many of them for the rest of their lives.

Why did I do it, even when I knew it was wrong? Because then, as now, advocates of electroshock will go to any extreme to stifle opposition from within the profession. One of my fellow psychiatric residents refused to give the treatment, and he was summarily fired from the training program, his career ruined. This pattern has been repeated into modern times when anyone, from professor to reporter, risks his career if he takes on the shockers.

When I finished my training, I resolved never again to use the treatment. Soon after I found that this was not enough. I had to do something more about it. In 1979 my book, *Electroshock: Its Brain-Disabling Effects*, was published. For the first time it gave hard evidence to back up what common sense has always told us — that electroshock damages the brain.

Now we are in the midst of a resurgence of electroshock treatment. Proponents of the treatment claim that they have a "new" method called "modified electroshock" in which the patient is anesthetized, paralyzed, and then breathed with oxygen during the treatment. This allegedly new treatment is promoted as safer than the old methods. But in truth modified shock is not new and is not safe. I personally administered this allegedly "new" treatment in 1962. Indeed, as early as 1957, autopsy reports were already demonstrating brain damage from modified shock. The only thing "new" about modified shock is the recent national campaign to clean up its image. Most shock is done exactly as it was done 20 and more years ago, and it produces exactly the same devastating effects as it always did.

As Director of the Center for the Study of Psychiatry in Bethesda, Maryland, nearly every week I receive phone calls, letters or have personal interviews with patients who have suffered brain damage and permanent mental dysfunction from shock treatment. The story is typically uniform. First, the patient was not told the truth about the treatment before submitting to it — that it is controversial and dangerous. Second, the patient tried to stop

the treatment once the devastating results were experienced, but the doctor and staff ignored the agonized appeals for mercy. Third, the patient continues to suffer, often years later, from memory and learning defects.

Typically the period of several months around the treatment is almost entirely obliterated. Worse still, the patient may experience massive memory losses that reach back years into the past, often obliterating entire professional and educational capacities. And worst of all, too often the ability to concentrate upon and to learn new material is severely impaired. The result is enormous anguish, humiliation, and wasted human capacity.

Only last week I saw a fine young woman in my practice whose abilities to learn have never returned to normal — years after shock treatment. She suffers continuing psychological devastation that is made worse by physicians who invalidate her by claiming that the treatment is harmless. I describe several more such cases in my book.

The reports of damage given to us by patients are confirmed by animal experiments and human autopsy reports which show brain damage, and by permanent damage in patients demonstrated on psychological testing, brain waves, and brain X-rays.

Nor is there any good evidence that the treatment actually helps people. The most frequently made claim is that shock treatment saves lives, especially by preventing suicide, but a review of the literature shows the opposite — that there is no evidence that shock prevents suicide.

Many hospitals and many psychiatrists never use it, rendering absurd the claim that the treatment is needed as a last resort. If it is needed, why do so many hospitals and doctors do without it?

But does it work? Yes, it works, exactly as all brain damaging treatments work, including insulin coma and lobotomy. It works by destroying brain function and temporarily rendering the patient unable to think and feel in any coherent manner. During this time the patient may not seem depressed because in his or her damaged state, the patient is either apathetic or artificially high. But as the worst of the damage begins to clear, the original mental state returns, now compounded and worsened by brain damage.

Electroshock has no place in a humanistic approach to helping human beings. It is too damaging and there are better human service alternatives available including the broad panoply of services that we include in humanistic psychology. Many psychiatrists like myself see a broad spectrum of patients, including those who are severely depressed, and we never resort to shock treatment. It's time to give up this antiquated, barbaric therapy.

Peter R. Breggin is Director of the Center for the Study of Psychiatry, Inc., of Bethesda, Maryland.