

Barbaric age of electric shock 'cure' must vanish

MICHAEL CORRY

Wed, Jun 25, 2008

The Seanad will tonight debate a private member's Bill seeking a partial ban on ECT - electroconvulsive therapy. This "therapy" must be done away with, writes Michael Corry.

A YOUNG WOMAN called Sarah lies strapped to a table. Without the general anaesthetic just administered to her, she would still be resisting. The procedure taking place is against her will.

Electrodes are attached to Sarah's head. A switch is thrown. Up to 400 volts of electricity surge through Sarah's brain. They cause an electrical brainstorm of such magnitude that its exponential energy is released in a series of spasmodic outbursts involving her entire nervous system. Sarah's breathing is interrupted, her blood pressure rises, stress hormones are released and her muscles go into a rhythmic series of violent contractions.

The psychiatrist overseeing this session of ECT keeps the current on until he sees her toe twitching. This is a sign that his patient, despite muscle relaxants, is convulsing, and a grand mal seizure is taking place. The desired outcome has occurred. The session is over.

Sarah was prescribed ECT for psychotic post-natal depression. After treatment, while she no longer exhibits psychotic behaviour, large tracts of her memory - including the experience of holding her newborn baby for the first time - have been permanently lost.

Lacking her previous "memory map", Sarah finds herself confused about her identity and personal history, and plunges into a state of fear and vulnerability. Her family notice that since ECT, Sarah has shut down emotionally and lost her ability to empathise. She gets disorientated in once-familiar surroundings. Worst, since the treatment Sarah has suffered two epileptic fits.

In my psychiatric practice, I come across individuals of all ages who, like Sarah, have been damaged intellectually and emotionally by ECT. Memory loss is the first obvious result. Other factors compromised include problem-solving ability, processing of new information, concentration, planning, decision-making, self-awareness, imagination, creativity, abstraction and reflection.

The damage is similar to that resulting from a violent head trauma, with one notable difference: after head injury, brain damage would be expected; but after a "healing" session such as ECT, it comes as an unpleasant surprise. Unfortunately, the effects are permanent, because brain cells, once damaged, cannot be replaced.

There is a particular "deadness" about people hurt by ECT: a tiredness, as if they are living in a twilight zone. Their spirits seem broken. Some of the younger people I have encountered are unable to complete second-level education or engage in further studies, so compromised are their cognitive abilities. Many of the elderly frequently report becoming disorientated in their own homes.

Many survivors of ECT, in particular the elderly, are left docile, with brainwave recordings showing a predominance of delta wave activity, usually sleep-associated. Notably absent are normal levels of beta waves seen when a person is alert.

Electric shocks to the brain induce epileptic fits that are much more violent than those experienced in the medical disorder itself. In this way a double impact is administered to the brain - the destructive force of electric shock and the secondary grand mal seizure. It has been demonstrated that successive electric shocks create an excitability in the brain that increases the potential for future grand mal seizures to occur after ECT.

It is broadly accepted that the apparent effectiveness of ECT results from the long-term brain damage it causes. In a 1941 paper entitled *Brain-Damaging Therapeutics*, Dr Walter Freeman - the psychiatrist who introduced ECT to America - wrote: "The greater the damage, the more likely the remission of psychotic symptoms . . . Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in operation."

In 1942 another US psychiatrist, Dr J Stainbrook, wrote: "[It] may be true that these people have . . . more intelligence than they can handle and that the reduction in intelligence is an important factor in the curative process . . . Some of the best cures one gets are in those individuals who one reduces almost to amentia."

Before the use of muscle relaxants and general anaesthesia in ECT, evidence abounds that bones were broken, teeth cracked, and damage rendered to muscles and ligaments due to the convulsions. If the heart's system is overwhelmed by the electric storm nearby, abnormal rhythms lead to cardiac arrest and death, particularly in the elderly. Some elderly people die from strokes and pneumonia in the days and weeks following ECT.

Many individuals have been administered hundreds of electric shocks and thus have experienced hundreds of seizures during treatment. It must be understood that the grand mal seizure in the brain is believed by psychiatrists to be the mechanism of cure.

It is speculated that a seizure triggers a compensatory surge of "well-being" neurotransmitters and hormones, and that this chemical cascade soothes the symptoms of the distresses being targeted - such as depression, schizophrenia, mania, obsessive compulsive disorders and anorexia. A chemically-induced transient euphoria can occur, particularly in the depressed population, immediately after ECT, creating the illusion of a breakthrough. This can occur after any head injury or physical trauma, even a natural one such as prolonged labour.

When the target is eradication of symptoms, treatment can involve shocks stretched over months at a time, at the rate of two to three per week. If symptoms diminish, and return later, further treatment is prescribed, and to prevent any further relapse, maintenance ECT is administered each month. These "top-ups" are deemed necessary when treatment does not "take" sufficiently. This is particularly so in the elderly. The classical "revolving door" patient is created. Left floundering, many feel estranged, a burden, riddled with fear, panic, shame and guilt - needing an ECT machine to sustain their equilibrium.

The brain is shielded from injury by a thick bony skull within which it floats in a buffering fluid. A protective blood-brain barrier, functioning as does the placenta in relation to the foetus, screens off toxic materials from entering the brain's fragile organisation. Post-ECT brain autopsies have revealed micro haemorrhages and rupturing of the protective barrier. It is inconceivable that anyone in their right mind would sanction such a procedure for a developing foetus as it floats in fluid within the uterus, with the goal of improving its "well-being". Is the brain any less fragile?

IT IS universally agreed in medicine that occurrence of seizures is always harmful to the brain. Within neurology, every effort is made to prevent seizures. Psychiatry is the only branch of medicine that specialises in deliberately causing them. Psychiatry seems blind to the possibility that after an electric shock to the brain, it is the state of confusion, sometimes tinged with a mild euphoria, that obscures the

individual's original symptoms. This temporary obscuration is classified by psychiatrists as an "improvement".

In this way a powerful physical intervention is used to jolt dysfunctional metaphysical thoughts and feelings into alignment, as if they were cogs in a machine requiring a kick-start. Such interventions lack scientific rigour. Mental distress does not emanate from a malfunctioning, diseased brain, but from problems of living: family breakdown, school and work pressure, bullying, financial difficulties, relationship dilemmas, fear, loss, a broken heart, grief, sexual abuse, violence, trauma, drug abuse, physical illness, loneliness, abandonment, lack of meaning, ageing and that titanic sense of being overwhelmed that sensitive children and teenagers experience. Using ECT is the equivalent of sending the TV or computer for repair if programmes are not to one's liking.

ECT is frequently given involuntarily, forced against patients' wills, and repeatedly so. Those receiving it are emotionally vulnerable, and may have already suffered bullying, coercion and violence. ECT retraumatises them, with the additional burden of brain damage.

No branch of medicine except psychiatry has prompted such terror, stress and condemnation from those at the receiving end. The literature and the internet tell story after story of lost personal histories and ruined lives. Anti-psychiatry movements abound, populated by survivors who want their opinions respected and to protect those who may come after them.

How has psychiatry been allowed to place itself beyond accountability? Where is the logic? The truth is that there is no logic when it comes to mental distress. There appears to be a collective denial of its validity, its rightful place in the human condition. Mental distress is considered something to be feared, denied, condemned and driven out like a demon, at any cost. People suffering from mental distress are not taken seriously, and are rarely given the luxury of being understood. Their objections to ECT, and their reporting of its side effects, often go unheeded, rationalised away as a manifestation of the disease process itself, a possible side effect of medication, delirium or paranoia, or a coincidental relapse rendering them non compos mentis.

Psychiatric patients historically have been segregated in dehumanising, unhealthy environments. Many have been detained against their wills, warehoused, forgotten by relatives and friends, and left without advocates, professional or otherwise. No other minority group, and certainly no patients in any other medical speciality, continue to suffer such ordeals - utterly abandoned by the normal societal impulses towards reason, dignity and compassion.

A psychological apartheid towards the mentally distressed exists, with stigmatisation and the collective blind eye central to the process of denial. This lack of vision also allows worldwide use of lobotomy, a surgical procedure that involves the severing of nerve pathways in the frontal lobe of the brain in order to cure "intractable mental disorders".

ECT and lobotomy both use a traumatic physical intervention to dislodge non-physical phenomena. This might be compared to applying a defibrillator to interrupt cardiac electrical rhythm in the hope of easing the pain of a broken heart. Trained proponents of ECT believe they are doing the best for patients, and rigorously defend this position. Most endorse it in the belief that the relief of symptoms in the short term is worth whatever secondary disabilities occur as a "side effect".

In this modern era of psychiatry - with its access to such a vast array of medications claiming to treat patients safely, a reasonable person would exclaim: "How can an outdated procedure like ECT still be in use?"

Where repeated use of medication has failed, and with their arsenal now depleted, an attitude of "things

can't get any worse" develops in the psychiatrist's mind. ECT is therefore often seen as the the last stop. The risk of secondary disabilities is thought to be worth the possible benefit.

It can be argued that if psychiatrists were to do an about-turn and condemn ECT, they would be opening the door to loss of power, possible litigation and moral indignation. The fact that ECT is common practice does not make it right, or the best therapy for patients.

Proponents of ECT write about "modified" ECT, devised to "minimise" brain damage. Instead of giving a shock to both brain hemispheres, a shock is given exclusively to the non-dominant hemisphere. But a serious question has to be raised about this: what is the difference between one or two fast or slow moving bullets travelling through the brain?

There is little information on use of ECT in Ireland. Research is badly needed. Most recent figures reveal that in 2003, 859 persons had treatments in the South, and 628 in the North of Ireland. Among other problems, there is no information on gender breakdown, age distribution, numbers to whom ECT was forcibly applied, and, most importantly, numbers of fatalities.

It is very difficult for psychiatrists who have given ECT to acknowledge the true risk of death and the real extent of brain damage caused. The magnitude of their error is too great and the consequences so enormous and far-reaching that most find it impossible to admit they may be wrong. The imperative to believe in the efficacy of their treatment appears to negate objective judgment.

We can no longer sit on the fence. Use of ECT is archaic, irrational and barbaric. It is a Holocaust of the brain: a brutal Final Solution. We must abolish it, and close doors on the psychiatric dark ages it represents.

Dr Michael Corry is a consultant psychiatrist at the Institute of Psychosocial Medicine in Dún Laoghaire, Co Dublin. He is co-author, with Dr Aine Tubridy, of *Going Mad?* (Gill Macmillan) and *Depression: an Emotion, not a Disease* (Mercier Press). Drs Corry and Tubridy are creators, with Basil Miller, of the websites www.depressiondialogues.ie and www.wellbeingfoundation.com, dedicated to ECT abolition. If you would like to share your experience of ECT as part of a research study, please contact the Institute via 01-2800084 or ipmed@eircom.net

Best practice urged in review of therapy

JIMMY WALSH

Thu, Jun 26, 2008

SEANAD REPORT: ANY REVIEW of the rules governing the administration of Electro Convulsive Therapy (ECT) should ensure that international best practice continued to be taken into account, Minister of State for Health John Moloney said.

He was responding to a Bill in the names of Green Party members Deirdre de Burca and Dan Boyle and Independent member David Norris seeking to prohibit the involuntary administration of ECT to patients without their informed consent.

Ms de Burca said this was a highly controversial treatment and while it was supported by many practitioners in the psychiatric profession, it was bitterly opposed by many patients and their families and by some mental health professionals.

The issue of informed consent was central to the legal change being proposed. The Mental Health Commission rules governing the use of ECT stated that a patient must be considered capable of giving informed consent for ECT, including anaesthesia, unless there was evidence to the contrary. The involuntary use of this procedure could no longer be justified. Advance directives would allow patients to give consent or otherwise in advance, or to empower a named individual to do so on their behalf.

Mr Moloney said there were diverging views within and outside the psychiatric profession on the necessity and efficacy of ECT.

"However, it remains a recognised treatment for severe mental illness and is sometimes used to treat persons with severe depression who do not respond to drug treatment. A review and meta-analysis which was published in the highly respected medical journal the Lancet in 2003, concluded that ECT is probably more effective than drug therapy.

"Of course, it can be a feature of severe mental illness that a person's judgment may be so impaired that they lack insight into their own condition. Where a person is involuntarily admitted under the provisions of the 2001 Act, for treatment that they might not otherwise receive, it is I believe, incumbent on the State and treating clinicians to provide them with the most effective treatment for their condition," he said.

ECT still a valuable psychiatric treatment

Sat, Jun 28, 2008

Madam, - The article on ECT - electroconvulsive therapy - in your edition of June 25th is factually incorrect, misleading and alarmist ("Barbaric age of electric shock 'cure' must vanish").

Despite the best efforts of the author to downgrade the immense value of ECT we wish to stress that it is widely regarded by the psychiatric profession as a valuable treatment, recognised by all international psychiatric organisations, academic bodies and the World Health Organisation.

In Ireland, ECT treatment is rigorously overseen and regulated by the Mental Health Commission. The Mental Health Act 2001 enshrines the basis for this regulation in law.

We, as doctors, consider it unethical and unprofessional to withhold from our patients, as a potential option, any treatment which can be effective, and indeed life-saving in some instances.

We also believe that the illustration accompanying the article was highly inappropriate, stigmatising and distressing for patients who have received and mostly benefited from ECT - and for their families. - Yours etc,

Dr M.C. WALSH, Chairman, Irish College of Psychiatrists; Dr SIOBHAN BARRY, Chairman, Irish Psychiatric Association, St Stephen's Green, Dublin 2.

Madam, - Dr Michael Corry's extreme views on ECT, if heeded, (Opinion Analysis, June 25th) could lead to preventable deaths.

I urge anyone who wants to be better informed on this complex and vital subject to watch the film Shock, released in 2006. In it, 12 people tell their personal stories of treatment with ECT. One of them is the former first lady of Massachusetts, Kitty Dukakis.

Theirs is a courageous testimony of suffering and recovery with ECT. As a balanced documentary, individual accounts of side-effects are also presented and the debate includes testimony from those who campaigned to ban the treatment in the United States, such as Leonard Frank, who was forced to have ECT against his will.

As for the tens of thousands of Irish men and women who have depression, their families and those who care for them, I urge them to disregard Dr Corry's opinion.

ECT must remain a therapeutic option for those who have found treatment with antidepressants and/or psychotherapy ineffective, and for those whose illness becomes so severe that emergency treatment is called for. - Yours, etc,

Dr PAUL O'CONNELL, Central Mental Hospital, Dundrum, Dublin 14.

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Patients' rights and ECT

Wed, Jul 02, 2008

Madam, - In their letter of June 28th, Drs M.C. Walsh, Siobhan Barry and Paul O'Connell note the therapeutic benefits of electroconvulsive therapy (ECT) in response to Dr Michael Corry's article of June 25th.

However, even accepting these views, an important question still arises: is it appropriate for the law to permit the provision of ECT to a legally competent, resistant adult? While some patients with mental disorders may not have the competence to make treatment decisions, many do. Section 59 of the Mental Health Act 2001 currently allows ECT to be administered to "unwilling" patients regardless of their legal competence.

In recent years, mental health legislation in other countries has moved towards a position where ECT may be provided to a legally competent patient only with her or his consent. This now applies in England, Wales and Scotland, as well as in most states in the United States and Australia. Even if one does not regard ECT as "barbaric", it is, by any standards, an invasive treatment, especially for an "unwilling" patient.

The protections afforded to patients under the Mental Health Act 2001 in this respect are inadequate. While the imposition of ECT on an "unwilling" or "incapable" patient requires a second opinion, the Act specifies that the second opinion must be obtained from a consultant psychiatrist to whom the matter has been referred by the patient's own consultant psychiatrist (who prescribed the treatment in the first place). At a very minimum, an independent review of the treatment decision should be guaranteed.

Mental health legislation has a fundamental impact on individual rights and it is important that this legislation be kept under close scrutiny. What was considered acceptable in 2001 may not remain appropriate in 2008. It is time for the Government to follow the lead set in the recent Private Member's Bill on involuntary treatment and revisit the treatment provision aspects of the Mental Health Act 2001. - Yours, etc,

Dr MARY DONNELLY,

Law Faculty,

University College Cork.

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Debate on electric shock therapy

Fri, Jul 04, 2008

Madam, - I was less than three years old when my mother, a paranoid schizophrenic, took her own life by burning herself to death. For many years prior to this she had been given an annual course of ECT. She did not like it, but it prevented the wilder excesses of her symptoms. She stayed alive and was the mother to two adoring boys.

In the last year of her life, however, she was treated by a new breed of Laingian psychiatrists, who argued that she was not "ill", and who were vehemently against ECT. It took only a few months of this new style of care before she doused herself in petrol and struck a match.

I do not doubt the idealism of those who argue against ECT. But perhaps they should appreciate that the choice is often this: either occasionally administer a treatment which is unpleasant, or allow extremely vulnerable people to kill themselves (or others).

Medicine is riven with difficult choices in which a view must be taken on the lesser of two evils. Nobody wants to have their leg cut off, yet a doctor would not hesitate to amputate a gangrenous limb if it threatened a patient's life. Someone suffering an infectious disease might not choose to isolate themselves, yet that is what must be done to try to safeguard the community.

I would not have wanted to inflict the obvious suffering involved in ECT on my mother; yet knowing what I do, I would have kept her on an annual involuntary course of it for her whole life if it spared her a death of almost unimaginable agony - and allowed us to be a family. - Yours, etc,

S. HAMILTON,

Longboat Quay,

Dublin 2.

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Should electric shock treatment be banned?

Mon, Jul 07, 2008

HEAD TO HEAD:ECT is a human rights issue: no one should be forced to undergo such a treatment and informed consent should be the minimum legal standard, writes Basil Miller. But Consilia Walsh argues that ECT has come a long way from the old media caricature. Properly targeted and responsibly administered, it has been shown to treat severe depression and save lives.

PSYCHIATRY IS a very divided profession. The medical argument on electroconvulsive therapy (ECT) has continued since its introduction, and will continue as long as it is permitted. What is at issue in the private member's Bill currently before the Seanad is not treatments, but the legal protection afforded to users of our mental health services. As Dr Mary Donnelly stated in her letter to The Irish Times of July 2nd: "The protections afforded to patients under the Mental Health Act 2001 . . . are inadequate" because "section 59 of the Mental Health Act 2001 allows ECT to be administered to 'unwilling' patients regardless of their legal competence."

The Bill proposes replacing subsections of section 59 with the following:

- (1) A programme of electroconvulsive therapy shall not be administered to a patient unless the patient gives his or her informed consent in writing to the administration of the programme of therapy.
- (2) The [Mental Health] Commission shall make rules providing for the use of electroconvulsive therapy and a programme of electroconvulsive therapy shall not be administered to a patient except in accordance with such rules.

This constitutes a minimum level of protection for the human rights of patients in relation to ECT, which they do not have at present.

The World Health Organisation, in its 2005 publication *Human Rights and Legislation: WHO Resource Book on Mental Health*, states that "ECT should be administered only after obtaining informed consent". The doctrine of informed consent should place a legal obligation on a doctor, as in the US, to make a patient aware of the reason for treatment, the risks and benefits of a proposed treatment, the risks and benefits of alternative treatment, and the risks and benefits of receiving no treatment. The patient then has the opportunity to accept or reject the treatment. ECT or other psychiatric treatments are no exception.

Such protection does not exist in Ireland, thus allowing the use of any form of treatment, including ECT and psychosurgery, on the say-so of two psychiatrists.

On a human rights issue such as this, action is the prime requirement. The minimum standards of observance of human rights, as set out by the WHO and the UN and enacted in other jurisdictions, do not apply here. To accept this Bill and support its enactment would be the courageous and correct course for the State. It would bring Ireland into line not with best practice, but with minimal practice in the developed world. As it is, we rank with less observant countries - a matter for considerable shame, surely, even among psychiatrists who favour the use of invasive treatments.

In the US a judicial proceeding is required, with patients represented by legal counsel, before involuntary ECT. The US surgeon-general's report states: "As a rule, the law requires that such petitions are granted

only where the prompt institution of ECT is regarded as potentially life-saving, as in the case of a person in grave danger because of lack of food or fluid intake caused by catatonia." In Britain, amendments to the Mental Health Act will introduce a capacity threshold for the imposition of ECT, which may not then be given to a patient who has "capacity" to refuse consent, whether detention is voluntary or involuntary.

A study in the British Journal of Psychiatry in 2005 described patients' perspectives on electroshock. "About half (45-55 per cent) reported they were given an adequate explanation of ECT, implying a similar percentage felt they were not . . . One-third did not feel they had freely consented to ECT even when they had signed a consent form . . . Neither current nor proposed safeguards are sufficient to ensure informed consent with respect to ECT in England and Wales."

Involuntary electroshock contravenes the principle of autonomy in medical ethics, which states that the will of the patient is supreme and that a patient has the right to refuse a treatment such as ECT. As our mental health services employ psychiatrists who, apparently, ignore their own ethics and prescribe ECT against their patients' will, the State is obliged to step in and protect them.

A debate confined to whether ECT is a "good" or "bad" treatment would be sterile and unproductive. The crucial issue is this: those suffering from psychological distress and disturbance are the only group in our society who can be deprived of their liberty without a judicial process, and who can then be forced to undergo "treatments" that they do not want on the word of two members of the very flawed profession of psychiatry.

Let us not have years of delay in implementing simple human rights measures to protect this group. Let the Government accept this Bill and put it to a vote of both Houses at the start of the next term.

- Basil Miller is Head of Communications with the Wellbeing Foundation websites (wellbeingfoundation.com) and a campaigner for reform in the field of mental health.

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ECT has come a long way from the old media caricature. Properly targeted and responsibly administered, it has been shown to treat severe depression and save lives, writes Consilia Walsh.

It is important that ECT is not banned, as recent research shows that 70 per of patients who received the treatment showed significant clinical benefits. It should continue to be available for selected patients suffering from depressive illness. ECT (electroconvulsive therapy) is recognised as an effective intervention by the World Health Organisation and by medical authorities and clinical experts worldwide.

Depression is a serious illness that affects at least one in four of us at some time in our lives. It brings with it distress and suffering for the individual and their family. It takes its toll on relationships, work and achievement in life. It is associated with a significant mortality and suicide risk. Treatments for depression include counselling, psychotherapy, antidepressant medication and mood stabilisers.

However, a number of patients are not fortunate enough to respond to these treatments or combinations of them. A small number of patients experience depression of such severity that risk is increased by waiting for the standard treatments to possibly work, which can be weeks to months.

These are two groups of patients for whom ECT might be recommended. There is a strong evidence base from scientific research that ECT is not only effective in these groups but also that it is life-saving in some cases. Treatment with ECT has been shown to have a profound effect in reducing suicide in the short term, and as treating doctors with responsibility for our patients, we must never lose sight of this.

When ECT was first introduced, it was used for a wider range of mental illnesses and disorders. Clinical research and audit have allowed us to identify the patients whose clinical condition responds well to ECT. The increase in the availability and sophistication of other treatments for depression, including cognitive behaviour therapy and other forms of psychotherapy, along with greater choice of antidepressant medications, has meant that more patients recover without the need to consider ECT. Other patients, when they have ECT and respond, wonder why they have had to wait so long to be offered this treatment.

The administration of ECT has changed remarkably in recent years and bears little resemblance to the caricatured presentation sometimes seen in the media. Patients have a full medical assessment to ensure their suitability for a general anaesthetic.

All patients have a full general anaesthetic and a muscle relaxant before a short controlled seizure of about 30 seconds is induced. The patient is closely monitored throughout by specially trained staff. A consultant anaesthetist monitors their anaesthesia and recovery. The entire process is supervised by a consultant psychiatrist.

ECT in Ireland is closely regulated by the Mental Health Commission, which has written rules for its administration and a detailed code of practice. This ensures the prescription and administration of ECT is of a very high standard of practice. Many centres in Ireland who administer ECT also participate voluntarily in an accreditation programme run by the Royal College of Psychiatrists in the UK to ensure their service is at the cutting edge.

So what is the evidence that ECT works? An audit in Scotland of all patients receiving ECT, published in 2000, showed that over 70 per cent made significant clinical improvement. Many of these patients had failed to respond to antidepressant medication and made a significant recovery after treatment with ECT. The UK review group on ECT published an article in the Lancet in 2003, concluding that ECT remained an important treatment option for the treatment of severe depressive illness.

Systematic review of patients who have had ECT shows that they have a positive view of their experience of ECT.

What about the potential side effects? There is some evidence of memory impairment after ECT, a retrograde amnesia, more associated with bilateral treatment than unilateral treatment. In 2007, a leading researcher in ECT reported that 10 per cent of patients were still experiencing some memory difficulties after six months. We expect that this number will fall significantly with contemporary ECT practice - and this aspect is currently undergoing further research in Dublin. Another area of current research showing promise concerns the mode of action of ECT. Recent work has shown growth of new nerve cells in the part of the brain regulating emotion following ECT.

ECT has a long-established proven efficacy in the treatment of depression. It is not a first-line treatment but a vitally important intervention option. Standards of administration and regulation must be kept high so that our patients and families are informed and aware of the potential benefits and possible side effects - and this of course applies to many medical interventions. This important treatment must not be evaluated on the view of individuals, but on the well-recognised and evidence-based positive outcomes experienced by patients.

- Dr Consilia Walsh is chairman of the Irish College of Psychiatrists

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Debate on electric shock therapy

Mon, Jul 07, 2008

Madam, - The letter of June 28th from spokespersons for the Irish College of Psychiatrists and the Irish Psychiatric Association is headlined "ECT still a valuable psychiatric treatment". I beg to differ.

Nearly three years after I commenced training in psychiatry, towards the end of 1968, as I stated in my book, Music and Madness, "I began to have deep reservations about the efficacy of ECT and the long term damage which can ensue from this procedure. I was becoming increasingly uneasy about these crude forms of physical intervention; my feeling was growing that there must be a more humane way to work in psychiatry."

As I gradually reached the "use of reason" as to the true nature of mental health, I decided that I would only countenance giving ECT to a patient if I could find no better alternative and if their very survival was at stake.

Since then, I have never had to give anyone ECT, though over all those years I have dealt with the full range of psychiatric disturbance. There were occasionally very difficult situations where, for example, someone was refusing food and in danger of dying, but I always managed to find an alternative.

Back in those days I was not yet fully aware of the extent to which punitive procedures have been meted out to psychiatric patients over several centuries, frequently without their consent. I knew of the purging, the bleedings, the swinging chairs, freezing baths, the beatings and so on which were perpetrated during the 18th and 19th centuries. But I didn't realise that such abuses continued in different forms throughout the 20th century right up to the present day.

We have had the debacle of lobotomies, deep insulin coma therapy, and ECT - all, one after the other, being shown to be highly damaging and therapeutically ineffective.

Even worse, by 1939 the plan to murder most mental patients in Germany was put into operation with the support of most of the professors of psychiatry and senior psychiatrists. "By September 1941, over 70,000 mental patients had been killed with carbon monoxide. . .the total figure for Germany alone is well over a quarter of a million." (Models of Madness, Ed. John Read, Loren R. Mosher, et al.) The entire procedure, which was later used in the Holocaust, was developed by psychiatrists.

In Canada, Dr Ewen Cameron, at McGill University's Allen Memorial Institute, instituted a method of "complete depatterning" of the personality of his patients (frequently without their consent), to return their minds to a state of "tabula rasa". He then intended to recreate an entirely new personality - which was absurd and of course a total failure. To achieve this he used continuous electroshock, giving a terrifying 360 shocks to each patient, combined with an array of drug therapies and sensory deprivation.

At this time he was at the pinnacle of his profession, being at various times president of the American Psychiatric Association, the Canadian Psychiatric Association and the World Psychiatric Association. This vicious programme was funded by the CIA and the methods he pioneered have formed the basis of the interrogation, rendition and torture being carried out by American intelligence to this day.

Over many years studies of ECT have shown no long-term benefit, only a temporary relief of symptoms due to confusion and brain damage.

When will psychiatrists finally accept that we are dealing with sensitive, delicately poised human beings, not machines to be tinkered with; that the very definition of life is one of self-organisation and self-management.

The only real, lasting change comes when we help a person to bring about the painful work of change within themselves. - Yours, etc,

IVOR BROWNE, Professor Emeritus, UCD, Ranelagh, Dublin 6.

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