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The History of Electroconvulsive Therapy in the United States and Its Place in American Psychiatry: A Personal Memoir

Zigmond M. Lebensohn

The history of electroconvulsive therapy (ECT) in the United States is traced from its crude beginnings in 1940 to its emergence as a highly sophisticated and effective treatment for many severe psychiatric disorders. The general distrust of all somatic therapies in the 1930s and 1940s expressed by many prominent psychiatrists (both analysts and nonanalysts) contributed to an ambivalent relationship between ECT and the rest of American psychiatry. The media coverage of ECT is reviewed, and suggestions for dealing with the antipsychiatry movement and anti-ECT prejudice are discussed.

AMERICAN PSYCHIATRY BEFORE ECT

THE HISTORY OF electroconvulsive therapy (ECT) in the United States cannot be completely understood without knowing something about the history and character of American Psychiatry from its European roots to the evolution of its uniquely American style.

In colonial days and for many years thereafter, the only psychiatry known in the United States was mental hospital psychiatry. We borrowed heavily from the Tukes and the Quaker retreats in England, but in the early 1800s, American psychiatrists developed a system of "moral treatment" that elicited praise and admiration from many including the famous novelist Charles Dickens,[1] who described his visit to the Boston Psychopathic Hospital in 1842 in glowing prose. Shortly thereafter, the flood of immigration to our shores plus the increase in our population overburdened and overwhelmed the state hospital systems and the quality of care deteriorated.

In April 1938, when ECT was first used in Italy, the state hospitals in this country were still overcrowded and grossly understaffed. The only medications available were sedatives, chiefly in the form of barbiturates, bromides, paraldehyde, and chloral hydrate. Theelin injection was occasionally used (with equivocal results) for menopausal depressions. Hydrotherapy with cold packs, continuous tub baths, and Scotch douches were a mainstay of most state hospital treatment. However, the major approach to treatment was psychological, supportive or custodial. There was general distrust of somatic therapies for the functional disorders.

The chief exception was the Sodium Amytal Interview introduced in the 1920s, which often enabled mute catatonics to speak under its influence. Unfortunately, the long-term results were disappointing. Equally disappointing had been the introduction of "*Dauerschlaf*" (1922) by the Swiss psychiatrist Klaesi,[2] which consisted of administering large amounts of barbiturates over a long period, thus placing the patient in a state of mild barbiturate intoxication until such time as he was permitted to awaken and presumably resume his more normal activities. Because of the frequency of pneumonia and the poor success rate, this treatment never gained acceptance and was soon abandoned.

The first of the somatic therapies used to treat a then-major mental disorder was the malarial therapy for general paresis (1918) for which Professor Wagner von Jauregg[3] of Vienna was awarded the Nobel Prize in Medicine in 1927. However, the general distrust and dislike of somatic therapies by

Dr Lebensohn is Chief-Emeritus, Department of Psychiatry, Sibley Memorial Hospital, Washington; and Clinical Professor of Psychiatry, Georgetown University School of Medicine, Washington, DC.

Address reprint requests to Zigmond M. Lebensohn, MD, 4840 Hutchins Pl, NW Washington, DC 20007.

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many psychiatrists in the United States extended even to such a clearly organic disorder.

An excellent example of this attitude was given to me by Joseph Wortis of New York (personal communication, July 1984), who (in 1937) invited Professor Adolf Meyer, then Psychiatrist-in-Chief at Johns Hopkins University Hospital and one of the great leaders of American Psychiatry, to participate in a major meeting on insulin shock therapy sponsored by the New York Academy of Medicine. Dr. Meyer finally accepted the invitation but with marked ambivalence, as indicated by the following excerpt from his acceptance letter:

> Dear Dr. Wortis:
> There are two extremes in the attempts to play the savior role in psychiatry; work at the root—which is evidently not Insulin work—and importations which have next to nothing specific to do with psychiatry but exploit the patient and resources through and for imported interests; and this is the case of Insulin. I am always sorry to see the latter get on top. Whenever it does my interest wanes. I have allowed the paresis problem to pass into the domain of the Lues department because Paresis is a 'dirty' experiment of nature without localizing or any other control being possible. I am willing to leave it to the spirochaetist [sic]. And with Insulin we deal with even more of an importation apt to divert the attention completely from the illness by absorbing the attention in the direction of something pharmaceutical.

Another factor contributing to the bias against somatic therapies (particularly ECT) has been the dominance of psychoanalytic theory in most medical schools and psychiatric training centers. This dominance began at the end of World War II and lasted until the mid 1990s, when it began to wane. Little attention was given to teaching students the indications and contraindications for ECT. Many psychiatrists would take, and pass, specialty board examinations without having witnessed, much less administered, an ECT. The attitude toward ECT displayed by many teaching psychiatrists and psychoanalysts varied from overt antagonism to smug condescension. The psychiatrist who still administered ECT was often viewed with the same gaze that gynecologists used to reserve for their colleagues who performed abortions in the days before legalization. In some centers, a double standard seemed to exist. I have known analysts who condemn ECT in public but who have privately recommended it for individual patients and even for members of their own family. Even after the patient has made a good recovery with ECT, they often manifest a curious lack of interest in the case.

SOMATIC THERAPIES OF THE 1930s

It should be noted that all of the somatic therapies for the major mental disorders had their origins in Europe, mostly in the 1930s, and were rapidly introduced, accepted, and in many cases modified and improved in the United States. It should also be noted that the theoretical underpinnings for these treatments were often erroneous and unsophisticated in light of our present knowledge of brain physiology.

The four major somatic therapies are listed below in chronological order of discovery.

1933: Insulin Shock Therapy

This was introduced by the Austrian, Manfred Sakel,[4] who (influenced by his observation on withdrawal symptoms in drug addicts) thought that an increased level of adrenaline was responsible for many mental symptoms and that insulin could be used as a biological antagonist to adrenaline. After a wave of enthusiastic acceptance in this country (roughly 1936 to 1946), the treatment fell into disuse largely because it was so cumbersome, costly, and relatively ineffective.

The general distrust of somatic therapies for the so-called "functional" disorders was again clearly apparent when insulin therapy was first introduced in the United States by Joseph Wortis[5] and Bernard Glueck.[6]

In 1936, Dr. William A. White, then superintendent of St. Elizabeths, showed no enthusiasm for insulin, but by February 1937, he was no longer able to resist the pressure from his staff and he invited Dr. Sakel to give a speech on "Hypoglycemia Therapy." Dr. Wortis accompanied Dr. Sakel on this visit as interpreter and cicerone. Dr. Wortis' comments on what happened are revealing:

> At St. Elizabeths I remember how William Alanson White fretted while his staff besieged Sakel with questions. There was a politely hospitable but constrained luncheon, and when White then escorted us to the gate Sakel clicked his heels in Central European style, bowed, put forth his hand and said, in halting English, 'Dr. White, I wish to thank you for your hostility.' (Personal communication, July 1984.)

1934: Metrazol Convulsive Therapy

This was introduced by the Hungarian psychiatrist, Ladislaus von Meduna,[7] who thought there was a biological antagonism between schizophrenia and epilepsy. Others had observed dramatic improvements in schizophrenics who experienced

grand mal epileptic seizures. Accordingly, von Meduna treated schizophrenics by producing convulsions at first with camphor-in-oil injections and then with Metrazol. Later, it was observed that Metrazol was much more effective in treating psychotic depressions. Because of the frightening preconvulsive aura and other complications, this treatment rapidly fell into disuse after the introduction of ECT in the United States, 1940 to 1942.

1935: Psychosurgery (prefrontal lobotomy)

This was introduced by Egas Moniz[8] of Portugal. Dr. Moniz received the Nobel Prize in Medicine for his work in 1949. Psychosurgery in its original form has been almost completely abandoned. However, recent advances in functional neuroimaging have led to more sophisticated studies of major psychiatric disorders in some research centers.

1938: ECT

This was originally called electro-shock therapy by Ugo Cerletti[9] and Lucio Bini of Italy. This treatment, despite attacks from the lay and medical communities, is the only one of the four therapies that remains in use today.

Since 1938, the technique of administration has been greatly refined, so that today it remains, without a doubt, the single most dramatically effective treatment for major depressions in psychiatry.

WHO ADMINISTERED THE FIRST ECT IN THE UNITED STATES?

Of course, we know with certainty that Cerletti and Bini administered the first ECT in Rome in 1938. Endler[10] has described this event in meticulous detail in 1958. The bronze plaque on the hospital wall recording the event reads simply, "In this place in the month of April 1938, Ugo Cerletti and Lucio Bini effected the first Electroshock." However, it is curious that the precise date in April on which this historic event took place is not recorded. There is a similar lack of precision in the records of the American psychiatrists, including Dr. Impastato, who first used ECT in this country. We know, for example, that Lothar Kalinowsky (who shares with Cerletti and Bini the honor of being a co-dedicatee of the 50th Anniversary Volume of *Convulsive Therapy*) became the foremost exponent of ECT in America in the early days. But the date of the first ECT in the United States and the person who administered it have remained undocumented until recently.

Although the question of who first used ECT in this country might be of little moment to some, it is of considerable importance to others. Fortunately, I was able to discover a most thorough discussion of this subject in documents that are now in the Archives of the American Psychiatric Association (APA). On January 27, 1969, Walter Barton,[11] then Medical Director of the APA, wrote to Dr. David Impastato, asking him to clarify the first use of ECT in the United States. On June 24, 1969, after considerable research, Dr. Impastato[12,13] sent Dr. Barton a 13-page report on "The Beginnings of ECT in the United States," including a complete bibliography and a two-page cover letter. Although Dr. Impastato refers to Dr. Kalinowsky of New York, Dr. Joseph Hughes of Philadelphia, Drs. Green, Feldman, Meyerson, and Alexander of Boston, Dr. Goldman of Cincinnati, and Drs. Gonda and Neymann of Chicago, it seems very clear that the first documented treatment of ECT in this country was administered by Dr. David Impastato on January 7, 1940.

Details of the first treatment were made available to me by David Impastato Jr. (personal communication, July 1989), who provided me with copies of the original manuscripts that verify this matter. The first patient was a 29-year-old woman of Italian descent suffering from severe schizophrenia. The apparatus used by Dr. Impastato was made in Italy and brought to the United States in 1939 by Dr. Renato Almansi, who had been associated with Dr. Ugo Cerletti in Rome. Perhaps we should let Dr. Impastato describe what happened in his own words, although the date given in this report conflicts with the actual entry in the chart:

> In the summer of 1939, Almansi was unsuccessful in interesting the heads of the psychiatric departments in the Philadelphia, New York and Boston areas in the method. In the fall of 1939, he was referred to me. Soon thereafter, using a copy of the Cerletti-Bini machine which he had brought with him from Rome, we began to convulse dogs experimentally. Using the same machine, we treated our first patient, a female schizophrenic, on 8 February 1940 at our office at 27 West 55th Street, New York City. This is the earliest recorded ECT given in America as I have in my possession the patient's record with notation of this first treatment. It is most probably the first treatment ever given in the United States. We subsequently treated her at the Columbus Hospital, New York City, which is probably the first hospital in the United States to allow ECT.

However, this account is not exactly correct; Dr. Impastato's records reveal the following handwritten entry for January 7, 1940: "Volts 70, T-.1 sec MA 400. Had delayed (15 sec?) reaction during apnea, face flushed, eyes opened, normal expression—looking forward, no breathing." This treatment was administered by Dr. Impastato on a Sunday morning in his office. Further confirmation comes from Dr. Almansi, who called me from New York (personal communication, September 14, 1992) after reading an earlier draft of this article and stated that ". . . the treatment given on January 7, 1940, was given by Dr. Impastato alone. He used 70 volts . . . I would never have used such low voltage. As a result, the patient had a petit mal reaction." Subsequent treatments were administered by both Drs. Impastato and Almansi at Columbus Hospital in February 1940, but the hospital records for this period are no longer available. A more detailed description of this first treatment appeared in *Psychiatric News* on August 6, 1993, written by Lucy Ozarin, M.D., M.P.H.,[14] with the help of David Impastato Jr.

FIRST ECT IN WASHINGTON, DC

Some time in December 1940, Dr. Walter Freeman invited Drs. Impastato and Almansi to come to Washington with their Italian ECT machine to demonstrate ECT on one of Dr. Freeman's patients, a 30-year-old man with schizoid depression. Dr. Freeman was then Professor of Neurology at the George Washington University School of Medicine and a pioneer in treating psychiatric patients in general hospitals. I was Dr. Freeman's associate in his practice of Neurology and Psychiatry. Dr. Freeman was then Secretary of the American Board of Psychiatry and Neurology and America's foremost exponent of prefrontal lobotomy. He was deeply involved in all aspects of somatic therapies that were introduced in the 1930s.

In January 1941, Dr. Freeman obtained an ECT machine from Dr. Joseph Hughes of Philadelphia. The origins of this electroshock apparatus are best described by Dr. Impastato:

> According to Dr. Hughes (personal communication) in the fall of 1939 an assistant of Dr. Lucio Bini was passing through Philadelphia. Dr. Earl Bond, Chief of the Psychiatric Department of the Institute of the Pennsylvania Hospital, who had read an abstract on Electroshock Therapy, invited him to visit the institute. There Dr. Bini's assistant discussed ECT with Dr. Joseph Hughes, who was then electrophysiologist to the hospital. Subsequent to this discussion, Hughes designed an ECT machine which was constructed by Mr. Fritz Schindler.

This apparatus, although therapeutically effective, was crude by present-day standards. The machine was so faulty that occasionally the person administering the treatment would feel a tingle of electricity in his fingers as he flipped the metal switch. Later, a piece of rubber tubing was slipped over the switch to prevent such a complication. Despite the crudeness of the early machines, they were effective in producing a grand mal convulsion, which soon became recognized as the single most important factor in successful therapy.

EARLY TECHNIQUES

Most treatment methods in medicine that are relatively easy to administer are often overused at first. As new information accumulates, the treatment is refined and made safer and finds its proper place. The history of medicine is replete with once-lauded but now discarded therapies. Think of the thousands of needless tonsillectomies, hysterectomies, and sympathectomies performed by well-intentioned surgeons who were once convinced of their usefulness. Even more to the point, think of the countless removals of so-called "foci of infection" including the removal of all of the teeth, several feet of bowel, etc., because of an unsound theory spawned by a psychiatrist, Dr. Henry A. Cotton[15] of New Jersey, in the 1920s.

In the early days, ECT was given without the benefit of anesthesia or muscle relaxants. In most hospitals, the treatment was given in a special treatment room. The patient was treated in the early morning on an empty stomach. The patient would lay on a bed in the reverse position, that is, with his head at the foot of the bed. This served several purposes. First, it enabled the doctor to stand directly behind the patient and adjust the electrodes without being blocked by the high headboard. Second, it permitted the mattress to be cranked upward so that the patient's back was arched over the part of the mattress normally used to flex the legs. The patient was fully awake. A heavily padded double tongue depressor was inserted on one side of the mouth between the upper and lower molars and the treatment was given. Two or more nurses or attendants were usually present to hold the patient's shoulders and extremities during the unmodified convulsion. Following the treatment,

the mattress was lowered to a flat position and the patient turned on his side for recovery.

In some hospitals during the early days of ECT, the patients were lined up in a large dormitory and treated en masse. With their heads at the foot of the bed, the ECT apparatus was wheeled from patient to patient, accompanied by the doctor and his assistants. This permitted a large number of treatments to be administered in a very short period. It should be pointed out that this insensitive wholesale method of administration, which did indeed occur in some of the larger state hospitals, was doubtlessly one of the factors responsible for the horror stories that emerged from patients during this period.

During the 1940s and 1950s, ECT was frequently given in the office of the psychiatrist without the benefit of anesthesia, muscle relaxants, or emergency equipment. In certain cases, the psychiatrist would make a "house call" with his ECT machine, accompanied by a nurse or an assistant, and the treatment would be administered in the patient's own bed. Responsible members of the patient's family were instructed to remain with the patient until recovery was complete. ECT was also given to suitable patients in their beds in medical wards of general hospitals or in the outpatient clinics of these hospitals. In the case of outpatient treatments, the responsible relatives who accompanied the patient to the clinic would be asked to stay with the patient following the treatment, until recovery was complete.

LAY PRESS REACTION TO THE EARLY CRUDE TECHNIQUES

In a sensational article in *The Washington Post* for December 1972 entitled "The Fury of Shock Treatment—A Patient's View" by Elizabeth Wertz,[16] a patient describes in her own words an experience that occurred in the 1950s. She writes:

> We are turned around in the bed so that our heads are at the wrong end, the foot. Then the shock machine and a table with needles and tubes are wheeled up. First there is a shot of insulin [sic]. Then, the shock to your head. You are terrified. You are clammy and cold with fear. When it is too much, your feelings shut off although your mind goes on recording events around you. The last thing you remember is the sharp noise, a peculiar sound of the electric shock machine. Your head, your brain, complete the circuit. You have a convulsion, you moan in an unnatural animal way and after the seizure you go into a coma. You know this because it happens to the others.

This sensational article demanded a prompt reply to correct its distortions. The following excerpt from my response (*Washington Post*, March 4, 1973) should suffice to indicate the tone and content of the complete reply, which had a positive reaction from many readers:

> "The Fury of Shock Treatment—A Patient's View" gives a greatly distorted and highly emotional view of an important treatment method which has been used successfully by psychiatrists all over the world since its discovery in 1938. In doing so, Ms. Wertz has done a great disservice to the countless thousands of patients who have benefited from this treatment and to the untold thousands of patients who may require it in the future as a health saving measure.
>
> It is true that electro-convulsive therapy has sometimes been used injudiciously as has any new and powerful instrument in medicine . . . but I do not know of any reputable psychiatric institution now in operation which resembles the horror chamber described by Ms. Wertz. If what she relates truly occurred some twenty years ago, then it cannot be condoned and should have been reported to responsible medical authorities. However, there have been many advances in the intervening years. What Ms. Wertz describes is totally incompatible with the present day practice of electro-convulsive therapy in a good hospital by well trained psychiatrists. In such a hospital the patient is carefully selected, must give informed consent and is properly prepared. Each treatment is similar to a minor surgical procedure in which the patient is put to sleep by intravenous anesthesia, given muscle relaxants in a specially equipped treatment room and the treatment administered by a skilled psychiatrist with all modern safeguards. Recovery is monitored carefully and the patient is usually eating breakfast within 30 to 40 minutes of this treatment with no memory whatsoever of the procedure.[17]

THE IMPORTANCE OF EMOTIONAL REACTIONS OF THE STAFF

It must be conceded that convulsive therapy in the 1930s and early 1940s unmodified by anesthetics or muscle relaxants was frightening to behold and a severe ordeal for both patients and staff. In recent years, the sensitivity to staff reactions has reached such proportions that one leading authority in the field advised the use of so much succinylcholine that all convulsive movements were suppressed. It was thus necessary to ligate an upper extremity to determine whether a grand mal seizure had occurred. The primary reason for the excessive use of muscle relaxants, he admitted, was to placate the nurses, who might recoil from viewing an unmodified grand mal seizure.

I think it is important for all psychiatrists who adhere to the medical model in the treatment of psychiatric disorders to view such procedures with

professional objectivity and encourage other members of the staff to do likewise.

Although the early use of ECT was crude by current standards, the practice in America did not descend to the primitive levels sometimes seen in Third World countries. In 1959, I vividly remember visiting a psychiatric hospital in Indonesia where ECT was administered without the use of any special apparatus. In this hospital, they used only the cord from the electric outlet to two electrodes strapped to the patient's temples. At the time of the treatment, a nurse was stationed at the electrical outlet holding the plug in her hand. At a nod from the doctor, the nurse inserted the plug into the outlet and an immediate grand mal seizure ensued. With the next nod, the plug was withdrawn, and the patient had his convulsion and recovered uneventfully. The doctors in charge of the clinic admitted that their technique was primitive, but there were no funds to purchase equipment and many patients who might otherwise destroy themselves needed the treatment.

ECT has been enormously refined and improved in every way. The introduction of muscle relaxants eliminated the fractures and dislocations that occurred with unmodified ECT in the early days. The first muscle relaxant to be used was curare, which was introduced in 1946 by A.E. Bennett,[18] a pioneer in the field of ECT. For a while, curare was standardized and marketed by Squibb (now part of Bristol-Myers Squibb, Princeton, NJ) under the trade name Intocostrin. It was very effective but often unpredictable. The advent of succinylcholine in the 1960s made muscle relaxation predictable and safe. It should be noted that many of the new advances in ECT were accompanied by resistance from the "old-timers." Some of them even objected to the use of anesthetics or muscle relaxants on the mistaken grounds that they complicated and added risks to the procedure. This turned out to be nothing but self-serving pseudologic, and no practitioner today would think of administering ECT without preanesthesia and a sufficient amount of muscle relaxant to prevent skeletal complications.

The greatly improved equipment and techniques for administering ECT together with physiologic monitoring and excellent training programs have all helped ECT reemerge in recent years as a safe and effective treatment for a variety of severe psychiatric disorders.

MEDIA COVERAGE OF ECT IN RECENT YEARS

When it was first introduced, ECT was accepted with almost unprecedented enthusiasm. Prior to the advent of the somatic therapies, our expectations regarding severe mental disorders were very low indeed. Thus, any treatment that offered almost "miraculous" cures in mental patients who had been given up for lost was eagerly welcomed by the profession and the public at large. As invariably happens with any new treatment method, unsuccessful cases accumulated and some of the persons treated unsuccessfully reached the news media and told their stories. Many gifted and articulate authors who had the experience of being in a psychiatric hospital or who had friends with unfortunate experiences wrote about them. Most readers have already seen or heard of the most famous of these, namely "One Flew Over the Cuckoo's Nest" by Ken Kesey, which was made into a play and later into a movie seen by millions. ECT is often presented as a form of punishment for deviant behavior and not as a treatment for serious psychiatric disorder.

Perhaps one of the most important articles about ECT appeared in *The New Yorker* magazine on September 9, 1974, written by Burton Roueché[19] in his series, "Annals of Medicine." The title of this piece was "As Empty as Eve" and described a 53-year-old government economist working in Washington who claimed she had lost her memory following a course of ECT. After she filed suit in open court, it became apparent that the person was Marilyn Rice. Following a bad experience with her orthodontist, she had become seriously depressed and was treated with ECT. Eventually, the depression cleared but the patient sued her dentist, her psychiatrist, and the hospital in which she was treated for one million dollars each for malpractice. She claimed that the dentist had disfigured her jaw and that the psychiatrist had destroyed her memory. Dr. Peter Breggin and Dr. Larry Squires testified on her behalf, but eventually the case was dismissed. After losing her case, she became an ardent crusader against ECT until her death in November 1992. Her obituary in *The Washington Post* included the following paragraph: "She founded the Committee for Truth in Psychiatry in 1976. It publicized the health dangers of electroshock therapy."

Mr. Roueché had spent a great deal of time with Ms. Rice, and his story was clearly sympathetic to

her complaint. Following publication of the article, one of the leaders in our field (Max Fink) wrote a carefully detailed letter of protest to *The New Yorker* in an attempt to set the record straight. This letter was never published (M. Fink, personal communication, December 1974).

To illustrate the great changes in viewpoint and editorial policy that have taken place in the intervening years, one need only refer to the January 12, 1998, issue of *The New Yorker.* This issue carries a remarkable autobiographical article on the nature and current treatment of depression entitled, "Anatomy of Melancholy" by Anthony Solomon.[20] This writer, obviously suffering from a severe depression, describes in a very sensitive manner his own experience in obtaining treatment. He had tried psychoanalysts, which had failed to relieve his depression. Despite warnings and discouragement from his analyst, he consulted a psychopharmacologist, who placed him on medication which helped him and which he is still taking. He also described his sessions with a Manic Depressive Support Group during which various other types of treatment were discussed. He writes about one of the participants who had an excellent experience with ECT and was described as being "enthusiastic" about the results. In the 24 years that elapsed since the original article about Marilyn Rice, there have been great advances in ECT, and it is gratifying to note that *The New Yorker,* a journal that has a highly sophisticated audience, is now adopting a much more enlightened view of the somatic therapies for depression.

Movie and television coverage of ECT has also changed over the years. In the early days, ECT was shown in a negative light in such films as "Snake Pit." In recent years, there have been several programs demonstrating an actual ECT treatment on national television. The current policy of most of the major networks is to give equal time to the proponents and opponents of ECT. A recent example of this appeared on "World News Tonight" on July 30, 1996. Forrest Sawyer, sitting in for Peter Jennings, introduced the section of the program dealing with ECT with the following words: "One of the treatments for elderly patients and for others who are suicidal may come as a surprise to you. It is shock therapy, which is now 60 years old. And we have put shock therapy on the American Agenda tonight because it is used more and more. But despite generally good results, it is also increasingly under attack." This introduction was followed by interviews with two persons who had benefited greatly from ECT, as well as a description and demonstration of the procedure by Dr. Harold Sackeim.[21] Also present was the chairman of a group leading the fight against ECT that was founded by the Church of Scientology. Despite his hostile comments, the overall impact of the program was clearly positive.

ORIGINS OF THE ANTIPSYCHIATRY MOVEMENT

Although ECT and most other somatic therapies have been attacked by the antipsychiatry movement, it must be remembered that vigorous opponents of psychiatry existed in Europe and America for hundreds of years. The causes for such antagonisms are many. They include the ignorance, prejudice, and emotional bias of single-minded individuals obsessed with the idea of attacking psychiatry. The spokesmen for the antipsychiatry groups include writers, former patients (not all of whom have fully recovered), physicians, legislators, and several prominent antipsychiatry psychiatrists, most notably Thomas Szasz[22] and R.D. Laing.[23]

In the 19th century, a series of cases alleging illegal commitments were brought to the attention of the American public. The series began with the Josiah Oakes case in 1845 and the Hinchman case in 1849. But the most famous case was that of Mrs. E.W. Packard, the psychotic wife of a clergyman, who was committed in 1860 and kept her case before the public for 7 years by claiming that she was "railroaded" into the Jacksonville, Illinois State Hospital by her husband. Following her discharge in 1866, she wrote several books and crusaded for jury trials in cases of alleged "insanity." We owe our dubious thanks to Mrs. Packard for the barbaric system of mandatory jury trials that became the law in many of the states as a result of her efforts.

It should be noted that the antipsychiatry psychiatrists view so-called "mental illness" not as a distinct medical disease but as a label invented by society to control deviant behavior. In other words, it is not the patient who needs treatment but the society against which he is struggling. The theoretical gyrations of the antipsychiatry movement reveal an overly simplistic way of thinking and a refusal to accept the reality of the many complex causes of mental illness.

Networks of former patients such as NAPA (Network Against Psychiatric Abuse) have aligned themselves with various antipsychiatry organizations and cults and have staged protests at the annual APA meetings. The Scientologists have also staged similar protests, accompanied by lurid banners announcing "Psychiatry Kills." These groups have also lobbied at various state legislatures. At one time in the state of California, it was so difficult to get permission to administer ECT that patients were languishing without adequate treatment. Many patients were forced to travel outside of the state to obtain prompt therapy. At one time, ECT was actually banned for a while in Berkeley. Fortunately, the ban was eventually lifted.

WHAT TO DO ABOUT THE ANTIPSYCHIATRY MOVEMENT AND ANTI-ECT PREJUDICES

It is unrealistic to expect that the antipsychiatry movement or the opposition to ECT will ever be totally eliminated. We should remember that there are still large and vocal groups in this pluralistic society who vigorously oppose water fluoridation, vaccination, blood transfusion, and many other generally accepted medical procedures. Some of these opponents are members of religious groups or cults; other oppose ECT because of fear fueled by the vehement and distorted attacks on an empirical but dramatically effective treatment whose mechanism of action is still being elucidated. All we can hope for is that ECT, which has indeed withstood the test of more than a half-century, will continue to be used and that its good results will speak eloquently for themselves.

Psychiatrists who use ECT have nothing to hide and should continue the practice for which they have been trained. Psychiatrists who recognize its great value must now be far more articulate and less defensive than they have been in the past. But they must no longer blithely assume that ECT is here to stay because of their own favorable experience with it. They must collect their data, publish their findings, and spend as much time as possible with patients and their families to explain carefully what is currently known and useful regarding ECT. Psychiatrists who administer ECT should always remember that they are doctors of medicine first, psychiatrists second, and technicians third. They should never permit themselves to neglect the human and psychological aspects of this important treatment method.

Unfortunately, ECT is of such a nature that we do not receive testimonial support from well-known figures who have had ECT with good results. Most of us remember that Senator Thomas Eagleton, a candidate for the US Vice Presidency in the summer of 1972, had his name withdrawn from the ticket when it was discovered that he had been successfully treated for depression with ECT. Although Senator Eagleton has remained in excellent health and was reelected to two terms in the Senate, he has not given any testimonials regarding the efficacy of ECT, nor should he be expected to do so. I look upon Senator Eagleton's behavior in this regard as an indication of an excellent recovery. Any person who has suffered through a miserable depression for which he has been successfully treated does not want to be reminded of his depression or of the treatment he received, any more than a person who has recovered from colon surgery would like to go on the stump recommending colon resections.

In our efforts to change public attitudes about ECT, we must begin first with our most immediate and important "public"; namely our patients and their families. In this regard, I have found it most useful to have them read (in addition to the usual description of the procedure) one or two of the following articles on ECT:

"The Experience of Electroconvulsive Therapy by a Practicing Psychiatrist"[24]

This was written by a British psychiatrist and published anonymously. He received two courses of ECT 3 years apart. There were three treatments in the first series and five in the second, which was completed just 5 days before he wrote this excellent article. He ends by stating, "The technique is now so refined that the patient suffers a minimum of discomfort and the therapeutic benefits are so great in those cases where it is indicated that it is a great pity to withhold it from mistaken ideas of kindness to the patient."

"Depression: Schism in Contemporary Psychiatry"[25]

Written by Anthony D'Agostino, M.D., this article recounts the saga of a 52-year-old man deep in the throes of a severe depression. It is written by his son, who was a medical school graduate when his father's illness began and a psychiatric resident when his father (after failing to respond to psychotherapy and chemotherapy on an outpatient basis

plus three successive hospitalizations) was finally treated successfully with ECT.

"Electroconvulsive Therapy: Psychiatry's Villain or Hero?"[26]

Written by Z.M. Lebensohn, M.D., in this article, the fears and doubts that patients and their families often express regarding ECT are addressed in nontechnical language. I have found that giving this article to ambivalent family members often enables them to make a sounder decision regarding therapy.

"Electroconvulsive Therapy: Problems and Prejudices"[27]

Written by Joyce Jackson, R.N., C.S., this is a brief but moving account of a nurse's personal experience with ECT in relieving a "debilitating" depression. She had two courses of ECT: the first in 1982 and the second in 1986. She described ECT as she experienced it as a "very humane treatment." Following her recovery, she completed graduate school with superior grades. The only significant long-lasting side effect is the stigma, which she deals with in her own way.

We who use ECT must continue to educate our colleagues who do not always share our experience and clinical judgment. It is only by making ourselves heard in a consistent and dignified way that we can educate our colleagues and the public at large to have a more realistic view of what ECT can accomplish when properly used.

REFERENCES

1. Dickens C. American Notes for General Circulation. Vol. 2. London, UK: Chapman & Hall, 1842.
2. Klaesi J. Über die therapeutische Anwendung der "Dauernarkose" mittels Somnifen bei Schizophrenen. Ztschr Ges Neurol U Psychiatr 1922;74:557-592.
3. von Jauregg W. Über die Einwirkung der Malaria auf die progressive Paralyse. Psychiatr Neurol Wochnschr 1918/1919; 20:132 and 251.
4. Sakel M. The nature and origin of the hypoglycemia treatment of psychoses. Am J Psychiatry 1938;14(Suppl):24.
5. Wortis J, Bowman KM, Orenstein LL, Rosenbaum IJ. Further experiences at Bellevue Hospital with the hypoglycemic insulin treatment of schizophrenia. Am J Psych 1937;94:153-158.
6. Glueck B. The hypoglycemic state in the treatment of schizophrenia. JAMA 1936;107:1029-1031.
7. von Meduna L. Versuche Über die biologische beeinflussung des ablaufes der schizophrenen: campher und. Kardiozolkrampfe. Ges Neurol U Psychiatr 152:235-262.
8. Moniz E. Prefrontal leucotomy in treatment of mental disorders. Am J Psychiatry 1937;93(Suppl):1379-1389.
9. Cerletti U. Old and new information about electroshock. Am J Psychiatry 1950b;107:87-94.
10. Endler NS. The origins of electroconvulsive therapy (ECT). Convuls Ther 1988;4:5-23.
11. Barton WE. The history and influence of the American Psychiatric Association. Washington, DC: American Psychiatric Press, 1987:164-165.
12. Impastato DJ. The story of the electroshock treatment. Am J Psychiatry 1960;116:1113-1114.
13. Impastato DJ. Report to W.E. Barton. Washington, DC: American Psychiatric Association Archives, January 27, 1968.
14. Ozarin L. The First Use of ECT in the United States. Washington, DC: Psychiatric News, August 6, 1993.
15. Cotton HA. The Defective Delinquent and Insane: The Relation of Focal Infections to Their Causation, Treatment and Prevention. Princeton, NJ: Princeton University Press, 1921.
16. Wertz E. The Fury of Shock Treatment—The patient's View. Washington, DC: Washington Post, December 10, 1972.
17. Lebensohn ZM. Letter to the editor. Washington, DC: Washington Post, March 4, 1973.
18. Bennett AE. Preventing traumatic complications in convulsive shock therapy by curare. JAMA 1940;114:322-324.
19. Roueché B. Annals of Medicine: As Empty as Eve. New York, NY: The New Yorker, September 9, 1974.
20. Solomon A. Anatomy of Melancholy. New York, NY: The New Yorker, January 12, 1998:46-61.
21. Sackeim H. World News Tonight With Peter Jennings, EST Edition Aired July 30, 1996. Transcript by Journal Graphics, Denver 5-6.
22. Szasz T. The Myth of Mental Illness. New York, NY: Hoeber-Harper, 1961.
23. Laing RD. Self and Others. London, UK: Tavistock, 1969.
24. Anonymous. The experience of electro-convulsive therapy. Br J Psychiatry 1965;3:365-367.
25. D'Agostino AM. Depression: schism in contemporary psychiatry. Am J Psychiatry 1975;132:629-632.
26. Lebensohn ZM. Electroconvulsive therapy: psychiatry's villain or hero? Am J Soc Psychiatry 1984;4:30-43.
27. Jackson J. Electroconvulsive therapy: problems and prejudices. Convulsive Ther 1995;11:179-181.