

## SHOCK AND DISBELIEF

*Electroconvulsive therapy was once psychiatry's most terrifying tool—blunt, painful, and widely abused. It is now a safe and effective treatment for a wide range of mental illnesses. But an unlikely trio of activist groups stands against it*

BY DANIEL SMITH

On the cover of a pamphlet I was sent recently appears a photograph of an elderly man with bright bolts of electricity shooting outward from his temples. His teeth are clenched. His eyes are squeezed shut. His hair is standing on end. Holding the man's head secure is a leather strap that resembles the restraint on a prisoner in the electric chair.

This is electroconvulsive therapy (ECT)—the psychiatric use of an electric current to stimulate a grand mal seizure—as seen through the eyes of the [Citizens Commission on Human Rights](#), a lobbying group founded by the [Church of Scientology](#) and the most active and well-organized anti-ECT group in existence. It is a grim view, invoking coercion, barbarity, anguish—everything negative that has ever been associated with psychiatry. It is also the common view.

Last fall I saw a patient receive ECT at [McLean Hospital](#), a private psychiatric facility in Belmont, Massachusetts. There, in a well-lit treatment room, attended by a nurse, a psychiatrist, and an anesthesiologist, a middle-aged man suffering from hallucinations and depression lay unconscious on his back while two electrode paddles were placed on his head. A button was pressed, and the patient's right foot twitched lightly. Shortly afterward the patient awoke and was given a snack before being escorted back to his room.

The contrast between image and reality is surprising. The procedure I saw at McLean reflects the way ECT has been administered for years, as cautiously and as formally as any other medical procedure—perhaps even more so, because of the awareness psychiatrists have of ECT's reputation as savage. Yet the popular image of ECT has persisted, sustained almost single-handedly, it sometimes seems, by the 1975 movie *One Flew Over the Cuckoo's Nest*, the release of which coincided with a decline in the use of ECT. In 1980 less than three percent of all psychiatric inpatients were being treated with the procedure, and by 1983, thirty-three states were in some way regulating it.

Although the public seemed willing to let ECT fall into obsolescence, many psychiatrists felt that they were losing a valuable and irreplaceable treatment. In 1985 the National Institutes of Health, in Bethesda, Maryland, called a three-day conference on electroconvulsive therapy. The first day of the conference passed without incident, as experts delivered lectures. On the second day, however, during an open discussion period, anger erupted on the floor of the conference hall. Former patients and even a few clinicians began protesting loudly. One of those present was Max Fink, then a professor of psychiatry at the State University of New York at Stony Brook and a pioneer in modern ECT research. As Fink remembers it, "They were shouting, 'How dare you even consider electroshock as a possibility! It has no place in the world! Everybody who does electroshock should be in jail!'"

When the conference resumed, a panel of "nonadvocate" experts forged a consensus statement in which they observed, with standoffish delicacy,

Electroconvulsive therapy is the most controversial treatment in psychiatry. The nature of the treatment itself, its history of abuse, unfavorable media presentations, compelling testimony of former patients, special attention by the legal system, uneven distribution of ECT use among practitioners and facilities, and uneven access by patients all contribute to the controversial context in which the consensus panel has approached its task.

Today ECT has strengthened its position in the profession. Many psychiatrists, whether or not they actively administer the treatment, have come to appreciate its ability to ameliorate a range of mental illnesses, from depression to some forms of schizophrenia and catatonia. [A 1993 commentary](#) in *The New England Journal of Medicine* stated, "Electroconvulsive therapy is more firmly established than ever as an important method of treating certain severe forms of depression." The first phase of a National Institute of Mental Health-supported study, to be published this spring, found that ECT produced a greater than 95 percent remission rate in psychotically depressed patients—vastly higher than the rate for any drug on the market. When I talked with Fink recently, he told me, "ECT is the most effective antidepressant, antipsychotic, anticatatonic we have today." Other psychiatrists have been even more enthusiastic. One, T. George Bidder, has written that ECT is "one of the most effective treatments in all of medicine—with a therapeutic efficacy, in properly selected cases, comparable to some of the most potent and specific treatments available, such as penicillin in pneumococcal pneumonia." Such endorsements have led to what looks like a renaissance for ECT: it is estimated that 100,000 patients are treated with it each year—nearly triple the number cited for 1980 by the NIMH.

Yet the attacks on the treatment are as virulent as ever. Activists continue to push for prohibitive legislation. In 1997 a bill that would effectively have made administering ECT a criminal act, punishable by a fine of up to \$10,000 and/or up to six months in jail, was narrowly defeated in Texas. ECT has virtually disappeared from state-run psychiatric facilities, owing in large part to government regulation. To be treated, patients must almost always gain access to a private or academic hospital. This means that ECT is very rarely an option for poor patients—those without adequate insurance or access to information, or without the means to travel, for example, to a distant, well-equipped university hospital. A 1995 article in the *American Journal of Psychiatry* found that ECT was unavailable in more than a third of the 317 metropolitan areas nationwide that it surveyed. "The situation has reversed itself from where it was decades ago," says Richard Weiner, a professor of psychiatry at Duke University and the head of the American Psychiatric Association's Committee on ECT. "Many ECT patients used to be asylum patients. Now it's very hard to get ECT in such places, and its use has shifted to general hospitals and private psychiatric hospitals."

The stigma attached to ECT is in some ways a holdover from less scrupulous days of psychiatry. But one of the main reasons many people still consider ECT to be archaic and even destructive is that it continues to be painted as such by an unlikely trio of activist groups: a handful of former ECT patients, some dissenting psychiatrists, and the Church of Scientology. These groups have agitated for the complete elimination of ECT. They have pushed legislative attempts to limit or ban ECT. They have initiated and supported lawsuits against psychiatrists, hospitals, and ECT-device manufacturers. They claim that ECT is authoritarian, violent, and representative of everything that is wrong with the profession of psychiatry. And despite all medical evidence to the contrary, people are listening to them.

### "A CRACK OF ELECTRICITY"

**E**lectroconvulsive therapy emerged during a bleak period for psychiatry. In the first third of the twentieth century not much could be done for the mentally ill. Psychoanalysis, the dominant method of treatment, proved helpful to some wealthy patients complaining of the so-called "minor illnesses": melancholy and neurosis. But it didn't do much for patients with more-systemic afflictions, such as schizophrenia and manic-depressive illness. These patients were merely warehoused in vast state asylums, where conditions were appalling. Patients were abused, shackled, even surgically sterilized. Psychiatry's job seemed to be no more than brutal custodianship; psychiatrists could do no more than hope that their patients would recover spontaneously from their illnesses. Under these desperate circumstances some psychiatrists began experimenting with radical treatments: insulin coma, transorbital lobotomy, malarial fever.

One of these "somatic therapies"—Metrazol shock—seemed particularly promising, given the theory (now known to be untrue) that a "biological antagonism" existed between epilepsy and schizophrenia. A schizophrenic patient was injected with Metrazol, a drug similar to camphor. After a few minutes the patient would undergo a full-blown seizure: all the muscles in his body would convulse violently, his back would arch, his limbs would flail, his breathing would become shallow. Often he would vomit. It was a gruesome ordeal. The historian Edward Shorter, in *A History of Psychiatry* (1997), reported that a Swiss psychiatrist stopped using the treatment because it caused "agonizing fears of dying and crumbling away," and that a British doctor spoke of "the unseemly and tragic farce of an unwilling patient being pursued by a posse of nurses with me, a fully charged syringe in my hand, bringing up the rear." And yet, strangely, Metrazol shock worked pretty well. "Convulsive therapy," as it came to be called, opened wide vistas of possibility.

But no one really understood why inducing seizures made patients better. Even today there are only educated guesses. Some subscribe to the neuroendocrine hypothesis, which states that seizures cause a shift in the body's hormonal system. Others subscribe to what has been called the anticonvulsant view, which holds that, paradoxically, the whole purpose of causing a seizure is to tap into the brain's ability to stop that seizure naturally. In other words, the brain's anticonvulsant mechanism may alter the brain's neurochemistry, acting as a built-in antidepressant. Still others believe that it is the seizures themselves that change the level of chemicals in the brain. In 1990 a group of articles in the journal *Neuropsychopharmacology* examined all three possibilities without drawing any conclusions.

Regardless, from the beginning convulsive therapy proved promising. Ugo Cerletti, in the 1930s the chief of the Clinic for Nervous and Mental Diseases at the University of Rome, was among those who were impressed. But he considered that electricity might cause seizures more quickly, and thus in a less harrowing manner, than Metrazol. Earlier Cerletti had tested the neurological effects of electricity by conducting experiments on dogs. His first attempts were inauspicious: because he put one electrode in the dog's mouth and one in its anus, the bulk of the current passed through the dog's heart; half the dogs died of cardiac arrest. Lucio Bini, one of Cerletti's assistants, solved this problem by transferring the electrodes to the dogs' temples. Cerletti and his staff worked tirelessly, experimenting on animals that were brought to them each week by dog catchers. The results supported their hopes: it seemed that using electricity was an effective way to produce an epileptic fit. Before applying it to a human being, Cerletti's assistants visited a Rome slaughterhouse to observe an electrical device that was being used to incapacitate pigs prior to slaughter. They discovered that there was a wide margin between the amount of electricity that would create a seizure and the amount that would kill.

In the spring of 1938 "electroshock," as Cerletti called it, was ready to be tested on a human being. The subject was a Milanese man the Roman police had found wandering in the train station without a ticket, mumbling gibberish to himself. Shorter described the inaugural treatment.

The patient, his head shaved, seemed quite indifferent to what was going on. A nurse placed the electrodes on his temples while an orderly put a rubber tube between his teeth to prevent him from biting his tongue ... There was a crack of electricity. The patient's muscles jolted once ...

"Let's step it up to 90," said Cerletti.

Another electrical crack. Another spasm. The patient lay motionless for a minute, then began to sing.

"We'll try it one last time at a higher voltage," said Cerletti, "*poi basta* [and then enough]."

At this point, the patient said, in a perfectly calm and reasonable voice, as though answering an exam question,

"Look out! The first is pestiferous, the second mortiferous." The residents looked at each other puzzled.

Despite the primitive application, the patient responded quite well. He had ten more treatments and was released, "in good condition and well-oriented." After a year he had not relapsed significantly. This was no small feat; no one could remember any experiment that had shown nearly such promising results. Thereafter ECT spread quickly to European hospitals. By 1940 it had appeared in the United States. Psychiatrists were enthusiastic. One, whom Shorter quoted, wrote in the *British Journal of Psychiatry*, "Without ECT I would not have lasted out in psychiatry, as I would not have been able to tolerate the sadness and hopelessness of most mental illnesses."

ECT was a great step up. Patients did not vomit, as they did in the course of Metrazol shock, and they did not experience as much psychological trauma. But they did still have to suffer the effects of muscular convulsions, which were frequently excruciating, and which have contributed to the persistent image of ECT as a brutal form of treatment. Thrashing around on the treatment table, many patients bit their tongues and cheeks. Many suffered broken bones or serious spinal injuries. Sometimes a gang of orderlies and nurses was needed to prevent the patient from tossing himself off the table altogether. In addition, patients suffered memory loss. They would awake confused, unsure of where they were or what had happened, often forgetting events of the preceding weeks or months.

ECT was also drastically overused. Doctors in some hospitals would treat dozens of patients in one giant room, wheeling the device on a cart from bed to bed; patients were forced to watch the ordeal of those who came before them. One doctor in England treated some of his patients more than a thousand times each. In the 1950s Ewen Cameron, a psychiatrist at McGill University, in Montreal, "depatterned" his patients by giving them twelve treatments daily. [Milledgeville State Hospital](#), in Georgia, for a time the largest asylum in the United States, had perhaps the worst history of abuse: it used what was known as the Georgia Power Cocktail to punish uncooperative patients.

The publicized experiences of famous patients treated privately with ECT bolstered the evidence against the treatment. The poet Sylvia Plath was subjected to ECT and wrote about it in her autobiographical novel *The Bell Jar*: "Then something bent down and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant." (Later in the novel the narrator had a less unpleasant ECT experience.) Ernest Hemingway underwent a course of ECT at the Mayo Clinic, in Rochester, Minnesota, and wrote to his biographer, A. E. Hotchner: "What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure, but we lost the patient." Soon afterward Hemingway shot himself. In 1972 Senator Thomas Eagleton had to withdraw as the presidential candidate George McGovern's running mate after it was revealed that he had been treated with ECT. And, of course, *One Flew Over the Cuckoo's Nest* bundled all the public's negative associations into the disturbing image of Jack Nicholson, mocking and playful one moment, writhing on a table the next, and finally catatonic—the result, in actuality, not of the ECT he received but of an off-camera lobotomy.

ECT all but disappeared in the 1970s, eclipsed by psychiatric drugs, which brought about, as Shorter called it, the "triumph of the biological." More and more drugs came on the market, offering a sophisticated biochemical arsenal for treating mental illness. In the 1980s, owing to more-advanced neuro-imaging techniques, physiological sources were found for schizophrenia and manic-depressive illness. As is by now well known, psychiatry and neurology edged toward a permanent intimacy. Electroconvulsive therapy seemed more than a little outmoded.

But drugs have not been the complete answer to mental illness. They were and still are a frustratingly inexact method of treatment—with a long wait between the first pill and any sign of relief. Often they don't work at all. This can be fatal for a patient who is suicidally depressed. Moreover, some patients prove resistant to medication.

The psychiatric community set out to modernize ECT and improve its image. Researchers worked with manufacturers to modernize ECT devices, outfitting them with equipment to monitor heart rate and brain activity and upgrading the electricity used. The 1985 NIH conference was followed by a 1990 report by the American Psychiatric Association committee charged with introducing better standards for treatment. The problem of physical injuries had been solved by the administration of fast-acting anesthesia and muscle

relaxants, which confine the effects of a seizure to the brain. Clinicians implemented an informed-consent procedure that detailed every aspect of ECT along with its benefits and risks—including the (slim) possibility of death. (According to the most recent report of the APA Committee on ECT, published this year, one death occurs for every 80,000 treatments.) ECT became safer and more exact, and psychiatrists used it more selectively. Today ECT is frequently used to treat the elderly, a population highly susceptible to mental illness and sensitive to the side effects of medication. Because drugs can cause birth defects, ECT is also often the preferred psychiatric treatment for women during the early stages of pregnancy.

Some side effects do remain. Memory loss is the most prevalent and is the primary reason that ECT is not used more often. Patients may have gaps in their memory affecting several months preceding treatment, and may also have trouble "laying down" new memories for a couple of weeks following treatment. In a small number of patients these problems can persist for a much longer period of time. But to some people, the fact that ECT causes any memory loss at all is unacceptable. ECT's detractors focus their objections on this side effect.

### A PATIENT'S COMPLAINT

Linda Andre, a tall, attractive woman in her early forties, is the director of the [Committee for Truth in Psychiatry](#), a loose-knit organization of 500 former ECT patients. I was directed to CTIP by Max Fink, who has had numerous run-ins with Andre. At a talk Fink gave some years ago in New York, Andre stood up in the audience and loudly protested his association with [Somatics](#), one of the two largest U.S. manufacturers of ECT devices. (Fink says he has no financial links with any ECT-device manufacturer.) Andre has been to many psychiatric conferences. She is hardly ever afforded official time to speak. More often she simply rises from the crowd.

When Andre and I met recently, I mentioned Fink, and she shook her head. "Ah, Max Fink, my dear friend. Oh, that man. That man. Not an honest and ethical individual, shall we say? I cannot believe that the scientific press lets the stuff he says get through. I'm sure he told you that no one ever had memory loss from ECT, except maybe around the time of ECT itself, and that they don't want to remember. He probably told you that we're just exaggerating. And everybody has some memory loss. He keeps these positions because he can. Shock is his baby. He's been associated with it longer than anyone." Fink, it became clear, represents for Andre the epitome of psychiatric deception. In an unpublished article on ECT, Andre has written,

After 50 years of giving electroshock, I can't believe Fink knows any less about the extent of permanent memory loss and disability than I do. I believe he and his fellow apologists are making a value judgment about the worth of their patients' memories and lives, and deciding on that basis to essentially trade brain damage for temporary relief of depression.

Andre has been the director of CTIP since 1992. She told me she first became involved in the organization in 1985, several months after she received fifteen "shock" treatments at the Payne Whitney Psychiatric Clinic, in New York City. Andre takes exception to the term "ECT," dismissing "electroconvulsive therapy" as "the elegant new PR-conscious name for 'electroshock.'" She says that she doesn't remember anything about her treatments, and that she was committed to the clinic against her will.

"Everything I know about getting electroshock is what I've been told," she says. "I don't remember anything about it. From what I understand, my brother basically tricked me into going into the hospital at a time when I was going through a lot of problems and had become a pain in the ass to him." Andre says she escaped from the hospital several times before her treatment began, and that each time her brother recommitted her. When she was finally released, she says, she had both retrograde and anterograde amnesia: she couldn't remember much of the previous four years, and she had difficulty creating memories of new events. One day, at home, she heard a woman named Marilyn Rice talking on the radio about ECT.

Rice is something of a legend in the world of ECT. In 1974 the distinguished medical writer Berton Roueché published an article about her in *The New Yorker*, disguising Rice, who had received ECT to treat a serious bout of depression, as "Natalie Parker." The article, titled "As Empty as Eve," depicted Rice's experience as a nightmarish erasure of memory. "There is a harrowing sense of confusion," Roueché wrote, "and then a full awakening in the midnight dark of total amnesia." Her sense of purpose bolstered by the article, Rice formed CTIP and began accumulating documentation that ECT causes, as she put it, "psychiatrically-induced brain damage." She wrote letters to psychiatrists, government officials, newspapers and magazines, and other potential allies, and created a small network of ECT "survivors," as she called them. To one doctor she wrote, "I could easily set up a psychiatric hospital as good as yours. I would just put the patients down on the sidewalk and interfere with their cerebral function by dropping flower pots on their heads."

Andre got Rice's phone number from the radio station and called her. The two became very close, and when Rice died, of heart failure, in 1992, Andre took over as director.

Can ECT cause a complete erasure of memory, as Andre claims? Most psychiatrists insist that it can't, and that side effects are usually slight. Roland Kohloff, the principal tympanist for the New York Philharmonic, was treated several times with ECT after slipping into severe depression. Each time he quickly rebounded and went back to work. "After you get a series," he told me recently, "there will be for a while some short-term-memory problems. I might not remember something I had done a couple of weeks before, or somebody called and I don't remember that they called. But nothing major; and then, as time goes on, it gets better. Look at Vladimir Horowitz"—the concert pianist, who has also been treated with ECT. "He was able to play billions of notes: Chopin, Tchaikovsky. The worst for me was that I'd forget something and my wife would say, 'Oh, I told you a couple of weeks ago but you didn't remember: you had the ECT.'"

What patients like Andre are complaining about is something more serious. They argue that ECT can result in wholesale amnesia, along with a steep decline in IQ. At the age of twenty, Andre says, her IQ was 156. Three years after her ECT it was around 112, and it does not appear to have increased since. Whether or not this is a result of ECT is hard to determine. Norman Endler, a psychologist who was himself treated with ECT, and Emmanuel Persad, a psychiatrist, wrote in their book *Electroconvulsive Therapy: The Myths and the Realities* (1988), "There is no conclusive proof that ECT causes permanent brain damage." What muddies the issue is that mental illness itself can cause cognitive defects, including a drop in IQ and in the ability to retain new memories. The informed-consent document for ECT used by Charles Kellner, a professor of psychiatry at the Medical University of South Carolina and the editor of *The Journal of ECT*, although scrupulous in its delineation of even the most severe side effects, states, "In part because psychiatric conditions themselves produce impairments in learning and memory, many patients actually report that their learning and memory functioning is improved after ECT."

In some cases a profound deterioration of cognitive ability is clearly the result of mental illness. Harold Sackeim, the chief of [biological psychiatry at the New York State Psychiatric Institute](#), in New York City, and probably the most prolific ECT researcher in the world, told me about a colleague whose son had a psychotic break while a student at Harvard and now can't hold down a job at a fast-food restaurant.

Andre, Sackeim says, has shown him her medical records; he says that she may have experienced a similar breakdown. But there is no way to know for sure whether ECT was the culprit in Andre's loss of IQ and memory. "In very rare cases," Sackeim acknowledges, "there will be profound memory loss. People can lose years of their lives."

Jeremy Coplan, a professor of psychiatry at suny Downstate Medical Center, in Brooklyn, who, like many other psychiatrists, doesn't actively treat with ECT but does refer patients for it, told me that the issue of memory loss is, unfortunately, often downplayed by psychiatrists. "For instance, someone may forget where the bathroom is in their house—at least temporarily," he said. "There can be a profound disruption of memory—not a minor thing if you put yourself in the patient's shoes." But, he said, it's a matter of risk versus benefit. "It's better that the patient is temporarily disoriented than seriously depressed for years."

The effect that ECT has on memory has been notoriously hard for ECT practitioners to concede. "The field has been under attack for such a long period of time," Sackeim says, "that a defensive posture was developed where limitations of the treatment were not acknowledged. So people complained of profound cognitive effects, and [those effects] were attributed to an ongoing psychopathology and essentially dismissed. I think that hurt the field of ECT."

Lately doctors have been taking special pains to spell out the risks that patients face. "I tell all my patients that they are going to have memory loss," Sackeim says. "In the vast, vast majority of patients that will be limited to a few months surrounding the course of treatment. There will not be a blank slate. But there will be gaps in memory. And the vast majority of patients say that's a small price to pay for getting well. It's not really a big deal to them. But I also tell them that in very rare instances it can be more extensive, and that no one can tell for certain who is going to experience that and who is not."

It has taken some time for a full disclosure to seep into the official literature. The report published this year by the APA Committee on ECT contains that organization's first substantial discussion of the possibility of serious memory problems.

### **A DOCTOR'S COMPLAINT**

**T**here was a moment at the 1985 NIH conference, [Peter Breggin](#) recalls, when patients who had had positive experiences with ECT were asked to step up to the lectern and tell about their illness and recovery. Breggin, who is the director of the International Center for the Study of Psychiatry and Psychology, in Bethesda, Maryland, had already delivered a lecture titled "Neuro-pathology and Cognitive Dysfunction From ECT," and he listened intently as the patients spoke. Afterward one of them pressed a note into his hand, thanking him for speaking out about the side effects of ECT. "This was one of the *pro*-ECT people," Breggin told me when we spoke recently. "They were up there to tell people that ECT works, and here this person was thanking me for providing a dissenting opinion."

For Breggin, the experience epitomized ECT's ability to reduce patients to docility—to the point where they are willing to praise a treatment they feel has done them harm. In his view, ECT is a purposeful assault on the brain. He has been publicizing this opinion since 1979, when his first book, *Electroshock: Its Brain-Disabling Effects*, was published. Since then Breggin, a psychiatrist by training, has made a career out of attacking psychiatry and its methods. He has written several books arguing against the use of medication to treat mental illness, and he claims to be responsible for quashing the resurgence of lobotomy. His most recent efforts have been directed at establishing a link between antidepressants and the Columbine massacre. When Breggin discusses psychiatry, it is in the brusque manner of an aggressive debater.

Though Breggin has waged many campaigns, he has attacked ECT particularly vehemently, arguing that it causes "severe brain dysfunction" and that it creates in patients profound feelings of apathy or delirium. Psychiatrists welcome either outcome, he told me, because they can note with satisfaction on their charts that the patient is "complaining less" or has "an elevated mood." In this way, he says, psychiatrists fool themselves into believing that they are helping a patient when they are really doing harm. In his book *Toxic Psychiatry* (1991), Breggin wrote,

If a woman received an accidental shock in her kitchen, perhaps from touching her forehead against a short-circuited refrigerator, and fell to the floor convulsing, she'd be rushed to the local ER and treated as an acute medical emergency. If she awoke the way a shock patient does—dazed, confused, disoriented, and suffering from a headache, stiff neck, and nausea—she'd be hospitalized for careful observation and probably put on anticonvulsants for months to prevent another convulsion. But on a psychiatric ward she'd be told she was doing fine and "not to worry," while the electrical closed-head injury was inflicted again and again.

Breggin first encountered ECT in the 1950s, when, as an undergraduate at Harvard, he volunteered at a state psychiatric hospital. He was horrified, he recalls, at the conditions on the hospital's "back wards." Schizophrenic patients were left mumbling and rocking back and forth, without any human contact. They were led, zombie-like, to be treated with insulin coma or ECT. Breggin believed that if the patients were exposed to a more empathic environment, and one that provided for their basic needs, they would get better, so he persuaded the hospital administration to start a program of "love and care." He contends that plain old kindness worked. Later, as a resident in psychiatry and a teaching fellow at Harvard Medical School, Breggin observed firsthand the trend in psychiatry away from psychotherapy and toward physiological treatment, and he found it very disturbing.

"Mental illness," he says, "is a metaphor. It's not reality. When patients come into my office and say that they're depressed, I don't give them medication. I ask questions: What is their life like? What is their story? Where are they from? How did they get depressed? Why do they *call* it depression? Depression isn't caused by some mythical biochemical imbalance. It's another word for hopelessness."

This is a philosophy that Breggin absorbed from his training under Thomas Szasz, one of the forerunners of the "anti-psychiatry" movement. In the 1960s—along with Erving Goffman, R. D. Laing, and Michel Foucault—Szasz, a refugee from Nazi-era Hungary and a psychiatrist, promoted the view that mental illness is a social construct. Breggin's language is taken straight from his teacher. In the revised edition of his 1961 book *The Myth of Mental Illness*, Szasz wrote, "'Mental illness' is a metaphor. Minds can be 'sick' only in the sense that jokes are 'sick' or economies are 'sick.'"

Breggin is scorned by mainstream psychiatrists for his links to Szasz and for his contemptuous attitude toward physiological psychiatry. "Lots of fields have splinter groups," Harold Sackeim says. "Increasingly the dominant perspective in psychiatry is a biochemical one. There are people who, on ideological grounds, feel that this shouldn't be the case. They think psychotherapy should be the first line of treatment." But, he says, this opinion isn't necessarily benign. "Breggin will argue that a cup of tea, chicken soup, and a lot of hugging will get a psychotically depressed patient well. And he'll kill a lot of patients that way. That's why he doesn't have hospital privileges."

Still, Breggin has hit a nerve. Patients who have had negative experiences with ECT restate his arguments almost verbatim. By demonizing psychiatrists, by "exposing" their claims, Breggin has suggested answers to patients seeking to understand why they continue to suffer.

### SCIENTOLOGY VERSUS PSYCHIATRY

If practitioners of ECT tolerate "survivor" groups and disdain dissenting psychiatrists, they actively loathe the Citizens Commission on Human Rights. The inside of the pamphlet I have—one of many published and disseminated by CCHR—is an indication of why. A quick sampling of chapter headings: "Perpetuating Cruelty," "Therapy or Torture?," "The Nazi Heritage" ("electroshock's development ... traces back to a dark alliance between psychiatry and the Nazi concentration camps"), "Apartheid and ECT," "ECT Promotes Breast Cancer," "Shock From Birth to Grave." Bolts of electricity in vivid neon colors provide visual unity here, emanating from the heads of pregnant women, fetuses, piglets. CCHR does not believe in subtlety.

The commission maintains offices in forty states and chapters in thirty other countries. It has used its branches in part to lobby for legislation against ECT. In 1974 it worked to get the California legislature to prohibit ECT for patients under the age of twelve. It has several times been instrumental in introducing legislation in Texas to ban ECT altogether. Although the legislation has failed, Texas is now, owing in large part to CCHR's efforts, the state in which it is the most difficult to get the treatment. Recently CCHR supported a bill in the Italian region of Piedmont which succeeded in banning ECT for children, the elderly, and, in most cases, pregnant women. That CCHR has effectively and perhaps permanently damaged the public image of ECT is one of the few things about which the commission and psychiatrists agree.

CCHR was founded in 1969 by the Church of Scientology, which by now has a fashionable Hollywood aura— John Travolta, Tom Cruise, and Nicole Kidman are all members. Scientology, "an applied religious philosophy," seeks to change the world through a system known as Dianetics, a term made familiar by a series of TV commercials for a book of the same name by the late L. Ron Hubbard, Scientology's founder and a science-fiction writer. Through Dianetics, Scientologists hope, according to the church's Web site, to create a utopia "without insanity, without criminals and without war, where the able can prosper and honest beings can have rights, and where man is free to rise to greater heights." In CCHR's view, one of the greatest threats to this vision is abuses inherent in psychiatry, which damages the mind instead of soothing the soul. "For more than 115 years, psychiatrists have treated man as an animal," CCHR's Web site states. "They have assaulted, sexually abused, irreversibly damaged, drugged or killed, all under the guise of 'mental healing.'"

CCHR was co-founded by Thomas Szasz, and its members take pains to emphasize this fact. Their connection to "the Church," as they call it, is spoken of less frequently. CCHR is separately incorporated, and although virtually every CCHR member worldwide also happens to be a member of the Church of Scientology, this is by choice, the organization says, not by compulsion. Rather than promote Scientology, CCHR seeks to lay out the evidence of psychiatry's misdeeds through the use of statistics, anecdotes, journal articles, news accounts, and hospital records.

The most voluminous resource for anti-ECT information within CCHR is Jerry Boswell, the director of the commission's Texas branch and the man most responsible for the state's stringent ECT laws. Boswell is patient and even-tempered, and his voice—soft and deep, with a heavy drawl—conjures the image of a large man in boots and a cowboy hat. At one point in a recent phone conversation with him I mentioned the TV personality Dick Cavett, who has very publicly and very positively spoken about how ECT helped him out of a terrible depression. "With ECT you have to ask the question of how much electricity was used," Boswell said. "Let's say you have Dick Cavett on your couch. Are you going to shock him at three hundred percent above the seizure threshold, or are you going to give him less electricity? You're going to give him less, because he's a public figure."

CCHR continually alleges that ECT uses "too high" a level of electricity. This has been difficult for psychiatrists to counter, because the very concept of "too high" leads immediately into contentious terrain. Dozens of studies have been done to determine how much electricity produces the most-therapeutic seizures. On the basis of these studies some researchers have recommended that ECT devices be equipped to deliver *more* electricity. A 1991 paper by Harold Sackeim, "Are ECT Devices Underpowered?," published in *The Journal of ECT* (then called *Convulsive Therapy*), questioned the ability of contemporary devices to stimulate an ideally therapeutic seizure.

Whatever damage CCHR may have done to ECT, the organization has unquestionably improved the gathering of statistics regarding the treatment. The results, however, have not been advantageous to CCHR's cause. Several years ago CCHR lobbied successfully for compulsory reporting of ECT cases in Texas. William Reid, a clinical professor of psychiatry at the University of Texas Health Science Center, in San Antonio, and three other authors recently published in the *Journal of Clinical Psychiatry* all of the center's available data from September of 1993 to April of 1995. The article reported that 97.5 percent of all admissions were wholly voluntary; that the percentage of patients exhibiting "severe" symptoms was reduced from 70.7 prior to ECT to 2.4 afterward; that the percentage of patients with "moderate," "severe," or "extreme" memory dysfunction decreased after ECT; and that no bone fractures, heart attacks, or deaths occurred during treatment. Of the 2,583 patients described by the data, eight died within two weeks of their last treatment, but only two of these deaths may have been related in any way to ECT. The authors write,

We are aware that anti-ECT groups have used the publicly available ... data to support their contentions that ECT is dangerous and unnecessary and to campaign in the Texas legislature to ban the treatment altogether. We believe that those groups have often misinterpreted and/or misused the ... data. We hope that this paper promotes objective discussion among clinicians, patients, families, and those who influence patients' access to this important treatment modality.

### **KEEPING IT BORING**

**M**cLean Hospital has the sprawling lawns and architectural mien of a small New England college. Its forty-two buildings, almost all made of brick, are spread out over 242 acres. Adirondack chairs grace the lawns. Even early in the morning people

are strolling about, and it is impossible to tell which are patients and which are staff members.

As at most hospitals, ECT at McLean is administered early on Monday, Wednesday, and Friday mornings—a cycle that allows patients to spend at least two days resting between treatments. In a typical year doctors at McLean give about 2,000 ECT treatments to about 200 patients. The diagnosis for almost all of them is some form of acute depression. Most have experienced what psychiatrists gently call "suicidal ideation." On the April morning that I visited to watch a treatment, Michael Henry, the head of McLean's ECT programs, was scheduled to treat sixteen patients, all of whom fit into those two categories. Henry seems to display all the qualities one hopes for in a psychiatrist. He has soft, comforting features; indomitable patience; and a voice that remains calm even when the situation calls for some emotion.

I arrived at the hospital before 8:00 a.m. and was met in the reception area by a staff member in the hospital's public-affairs office. (This was the first time that a reporter was to be allowed to watch an ECT procedure at McLean.) A few minutes later I was shown into the treatment room, which looked like a small operating room but was less intimidating. With the middle of the room dominated by the table on which the patient lay, there was little space for the small crowd that had assembled: Henry, the anesthesiologist, a nurse, a third-year medical student, another staff member, and me.

The patient appeared to be in his late fifties, with gray hair and a touch of stubble. He was wearing jeans, a purple long-sleeved shirt, and white tennis shoes. He seemed unalarmed by the treatment that was to come, but his countenance betrayed the anguish of what Henry had told me was a depression whose manifestations included somatic hallucinations—illusions of movement and disease in different parts of the man's body. A year earlier the patient had gone through a course of ECT for similar episodes. That course had shown positive results, but the patient had recently relapsed and opted for more ECT. The treatment he was receiving that morning was his sixth in this course. I later asked Henry how many the man was to have. "That depends on him," he said. "We let the patient decide. We are very reluctant to push ECT."

The treatment began when the anesthesiologist injected a muscle relaxant and a general anesthetic into the patient's arm. The nurse inflated a blood-pressure cuff around his right ankle, which would prevent the relaxant from reaching his right foot and thus would provide a place where Henry could observe muscle contractions. She gently rubbed his hand as he went under. The anesthesiologist fit a plastic mask attached to a turnip-shaped bag over the patient's mouth and proceeded to squeeze oxygen into his lungs. Manually aided respiration has become standard procedure in ECT; it helps the patient not only to breathe once the muscle relaxants have paralyzed his diaphragm but also to rise from the anesthesia with a minimum of discomfort and memory loss.

Henry rubbed conductive jelly on two electrodes and placed both on the left side of the patient's head. Unilateral ECT, as this is called, is now the most common form. For years researchers debated whether this method was less effective than bilateral ECT, which involves placing one electrode on either side of the head, thus causing the seizure to affect both hemispheres of the brain. It has recently become clear that the difference in effectiveness is negligible but that unilateral ECT causes much less serious aftereffects.

Henry walked over to the ECT device, which looks like a large stereo receiver, and pressed a button. The patient's right foot seized, as though experiencing a sudden itch or a slight muscle spasm, and after ten seconds that was it. The procedure was gracefully mundane—anticlimactic, I couldn't help thinking. As we walked out, Henry said, "We try to keep it as absolutely boring as possible. The less interesting the better."

He could have been speaking for nearly all his fellow practitioners of ECT. Henry understands full well that the treatment's reputation is more complicated. Despite all the improvements in patient care, despite all the subtle tweaks and the impressive monitors affixed to the devices, ECT, Henry says, is still fundamentally the same treatment it was sixty years ago. The theory has remained fixed: shock a patient with enough electricity so that he'll have a seizure, and he'll probably get better. It's a blunt idea, medically speaking, and when pills that silently alter neurochemistry are the frame of reference, it is tough to warm up to something so primitively straightforward—even if for some reason it seems to work.

A number of ECT's most dedicated practitioners express a distaste for engaging in public efforts to bolster its reputation. One reason they give is that such undertakings would require pressing patients into service as witnesses. "We are here to do good by patients," Henry told me, "not to create poster children." In any event, among ECT practitioners there is considerable apprehensiveness about the media. In 1995 *USA Today* ran a three-part story about ECT that began with the death of a seventy-two-year-old woman during treatment; understandably, the article's publication had serious repercussions for patients' willingness to undergo ECT. In 1980 *The Atlantic Monthly* ran an article titled "Electroshock: The Unkindest Therapy of All," which Max Fink likened to *Mein Kampf*.

A skeptical press is symptomatic of a larger phenomenon. Psychiatrists assume that anti-ECT activists represent a fringe viewpoint on mental illness, whereas the evidence suggests that the anti-ECT outlook is actually close to the public's. In 1999 the Office of the Surgeon General released its first ever [report on mental health](#). The report cited estimates that two thirds of all cases of mental illness in this country go unreported. One of the main reasons the report gave for this is a widespread disbelief in the biological origin of

psychiatric disorders. Despite the fact that major depression ranks second only to heart disease in the nation's "disease burden" (a measure that takes both mortality and morbidity into account), and despite the great scientific leaps that psychiatry has made, the report found the stigma associated with mental illness to be overwhelming: many people do not even accept that mental function is the work of a physical organ—a basic tenet of psychiatry. This suggests that the main obstacle ECT proponents face may be not proving its inherent usefulness but proving that the brain is an organ like any other, capable of breakdown.

When the Surgeon General's report came out, it included a statement about ECT: "First-line treatment for most people with depression today consists of antidepressant medication, psychotherapy, or the combination ... In situations where these options are not effective or too slow ... electroconvulsive therapy (ECT) may be considered." This wasn't the original wording. Two months earlier a consumer-rights activist had leaked the section dealing with ECT, which had called it a "safe and effective treatment for depression." A torrent of protests flooded the Surgeon General's office. CCHR sent a sixteen-page document denouncing what it saw as a categorical endorsement of ECT. Linda Andre held meetings with an administrator working on the report. In the end the statement was softened.

However, the central message of the report—that there exists an enduring, peculiar, and unfortunate double standard involving the "physical" and the "mental" illnesses—was not mitigated. The predominant belief in the United States, the report indicated, is that it is all right to be subject to infection, degeneration, and microscopic revolts from the neck down. But a moral culpability is attached to whatever afflicts our minds. The double standard extends to treatment. We concede that coping with diseases of the body may of necessity bring about painful, even dangerous, side effects. We concede that we must weigh risks and benefits. But with psychiatric treatments, especially ECT, any possibility of harm is deemed wanton and intolerable. The discrepancy in attitudes is a strange one. According to Joseph Coyle, the chairman of the Department of Psychiatry at Harvard University, 15 percent of severely depressed patients commit suicide. It is a lethal disease. ECT doctors often draw a parallel with cancer: the treatments for cancer can be as damaging as the disease itself, they point out, yet there are no anti-chemotherapy lobbyists.

More important than questioning why anti-ECT lobbyists persist is asking what psychiatrists might do to counter the criticism. The answer from some is that they are already doing all they need to do. ECT use seems to be on the rise, even if slowly, and psychiatry's professional organizations are continually refining treatment guidelines. Greater advocacy efforts seem not to be on anyone's agenda, perhaps for fear of luring ECT's detractors into even louder denunciations.

There is still the possibility that a more benign method will be found to produce therapeutic seizures in the brain. Clinical trials are under way at hospitals worldwide for a treatment known as transcranial magnetic stimulation, which in one of its forms uses a strong magnetic field to create a seizure that is much more precise in intensity and placement than an ECT seizure. Convulsive TMS could drastically reduce memory loss, and thus could be an advance in convulsive therapy as marked as the move from Metrazol to electricity, sixty years ago. But it is likely to be years before TMS is fully developed and finds its way into treatment rooms around the country. In the meantime, patients must continue to seek out hospitals that offer ECT. And ECT will continue to offer benefits that other treatments do not.

As for Michael Henry's patient, he underwent six more treatments and was released, in good condition and well oriented.