

Analysis

'Shock tactics', ethics and fear: an academic and personal perspective on the case against electroconvulsive therapy

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Despite extensive evidence for its effectiveness, electroconvulsive therapy remains the subject of fierce opposition from those contesting its benefits and claiming extreme harms. Alongside some reflections on my experiences of this treatment, I examine the case against electroconvulsive therapy and find that it appears to rest primarily on unsubstantiated claims about major ethical violations, rather than clinical factors such as effectiveness and risk.

Keywords

electroconvulsive therapy; depressive disorders; bipolar affective disorders; ethics; psychiatry and law.

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A recent review discussing the efficacy and safety of modern electroconvulsive therapy (ECT) finds that it is still the 'most effective treatment for severe, psychotic or treatment-resistant depression'.¹ Although ECT is viewed by many clinicians and recipients as indispensable in treating debilitating and life-threatening severe mental illness,^{2,3} it remains arguably the most stigmatised, misunderstood, contested and feared psychiatric or perhaps even medical treatment. A few days after publication of the review, a short and sensationalist newspaper article, 'Shock Tactics',⁴ directed anyone 'considering having a big electric shock passed through your brain' toward a *Psychology Today* article by an influential academic ECT opponent, disputing efficacy and calling for urgent review of a treatment with 'risks of brain damage and death'.⁵ As a researcher focusing on medical ethics and law, and as someone with considerable lived experience of receiving ECT, my aim here is to examine the nature and validity of the extreme and often vitriolic opposition to this treatment.

Probably the strongest feeling engendered by the notion of ECT is fear. ECT involves an electrical charge being passed through the brain to induce a seizure and cause a radical shift in mental state. Perhaps unsurprisingly, this description might sound alien, scientific and frightening. Added to this are multiple cultural and media representations situating ECT firmly within the 'dark side' of psychiatry.^{6,7} Most well-known is the iconic 1975 film, *One Flew Over the Cuckoo's Nest*, portraying psychiatry as a misused tool of repressive social control. Jack Nicholson's character, who is not mentally unwell, forcibly receives ECT, without anaesthetic, as punishment for insubordinate behaviour. The effects of this treatment can become easily conflated with the gruelling final scene showing Nicholson's near-vegetative state, resulting from a psycho-surgical procedure not shown and no longer practised. The takeaway impression of ECT is as a sadistic and illegitimate process, punitive rather than therapeutic, and capable of, effectively, destroying the brain. No famous depictions of ECT within contemporary psychiatric practice exist to counter these images, demonstrating the severity of the conditions it treats and its potential benefits. It is no wonder that ECT remains an object of fear. Yet, for myself, as for many others for whom ECT has been a life-saving treatment, the greatest fear surrounding ECT is that it might one day be inaccessible or abolished.

Before examining the anti-ECT position, I present some potential 'conflict of interests' alongside some credentials for my ability to offer a balanced view about psychiatric practice, ethics and law. For me, the benefits of ECT have been immeasurable in treating a severe

and dangerous mixed-affective presentation of bipolar disorder, which remained, until very recently, steadfastly resistant to any acute or maintenance psychopharmacological treatment or psychotherapeutic intervention. I first received ECT at 21 years of age, after over a year of failed treatments and hospital stays. Eight bi-weekly ECT treatments were, for myself and my family, the 'miracle cure' allowing me to reengage with life and return to university to complete my degree. Treatment was not frightening, and I experienced no significant side-effects. Despite receiving over 150 ECT treatments over the years, I have noticed no deterioration of intellectual ability or capacity to build new memories, and have been able successfully to resume my academic career. I was also on the Royal College of Psychiatrists' ECT Accreditation Service Advisory Committee for 6 years.

However, my experience and views of ECT and psychiatry are not universally positive. I have sustained considerable autobiographical memory loss from later treatments, causing both psychological and practical difficulties, and would never minimise or deny the views of those for whom side-effects have been severe and debilitating. Although I, when well, condone and accept the need for a treatment I often resist when unwell, among my many experiences of ECT were instances where treatment and enforcement were mismanaged. More generally, my own academic work often involves critique of contemporary psychiatry and mental health law.

The case against ECT

The case for suspension or abolition of ECT is usually argued in terms of three main clinical transgressions: lack of evidence for effectiveness, minimisation or even denial of severe side-effects and treatment without informed consent. However, close examination suggests that ethical rather than clinical concerns dominate anti-ECT critiques. A pervasive *One Flew Over the Cuckoo's Nest*-type image emerges of deliberate concealment and human rights violations.

Claim 1: lack of evidence for effectiveness

A 2020 review by prominent ECT critics concludes 'There is no evidence that ECT is effective for ... its target diagnostic group—severely depressed people, or for suicidal people, people who have unsuccessfully tried other treatments first, involuntary patients, or children and adolescents'.⁸ Such claims, common within anti-ECT literature,^{9,10} seem strange and are easily challenged, given

considerable evidence and abundant patient and clinical testimonies to major benefits,^{1,3,11–15} including many calling for ECT's use not to be restricted to 'last-resort' treatment.^{1,3,11,12,15} Research on ECT's effectiveness is too extensive to summarise or assess here. The critical 2020 review only considered studies between 1956 and 1985, with many of its findings highly disputable, particularly in a modern context.¹⁵ These points aside, however, let us consider the broader implications of this anti-ECT viewpoint.

The first question must surely be motivation. Around 1.4 million people worldwide receive ECT annually.¹ In psychiatric terms, ECT is relatively costly and complex, involving general anaesthesia in most countries, with estimates of annual treatment costs that 'can exceed \$10 000'.¹⁴ If, after 80 years of ECT, there really was no evidence for effectiveness, why would healthcare providers continue funding ECT and what would psychiatrists stand to gain, especially in the face of such acrimonious criticism?

Moreover, claiming that psychiatry knowingly inflicts an invasive medical treatment with potentially serious side-effects and no evidence of substantive therapeutic benefits implies a global breach of core medical ethical principles. Not only would this violate both beneficence and nonmaleficence, but also justice, through allocating limited resources to expensive and ineffective treatments. Moreover, deliberately misleading patients about therapeutic benefits would surely negate 'informed' consent and autonomous decision-making concerning treatment. Although psychiatry may sometimes involve errors of clinical judgement, the idea that so many medical practitioners are complicit in breaching fundamental professional ethics seems implausible and devoid of apparent motivation.

Claim 2: minimisation or even denial of severe side-effects

ECT opponents claim that psychiatry fails to acknowledge the extent, severity or even existence of severe potential side-effects from ECT, including brain damage, mortality and traumatic impact on the brain.¹⁰ However, as with lack of effectiveness, claims that ECT has such side-effects, which are deliberately and collectively concealed, denied or minimised by psychiatrists, once again implies multiple seemingly implausible and unmotivated ethical violations.

It is widely acknowledged that ECT's most substantial side-effect can be retrospective autobiographical memory loss, and the substantial research exploring ways to reduce retrograde amnesia indicates, very clearly, that psychiatry is neither ignoring nor denying this issue.^{1,16,17}

Historically, this phenomenon was underacknowledged or even denied,¹⁶ and some clinicians – as I have witnessed – may still fail to attribute sufficient weight to its nature and impact. Although guidance materials and clinical decision-making now usually include consideration and information about such side-effects, a desire to emphasise potential benefits may lead to insufficient attention being devoted to issues surrounding retrograde amnesia. For example, the new Royal College of Psychiatrists ECT information leaflet mentions the possibility of 'permanent' gaps under short-term rather than long-term side-effects.¹⁸ Assessing memory issues is further complicated by the difficulties of differentiating residual cognitive impairment resulting from depression from the effects of ECT, which can help to relieve these impairments.^{19,20}

I have experienced such memory loss within two perinatal periods. For various reasons, I have twice needed multiple courses of bi-weekly and bilateral ECT within a period of 3–4 years. Such extensive treatment is unusual and may make my experience of memory loss greater than usual.¹⁶ My lasting memory loss relating to people, events and periods of my life can be difficult both emotionally and practically. I have found various ways to manage this amnesia, and am extremely fortunate to have support from multiple people who understand and help to fill in the gaps. For me and

many others,³ although not for everyone, the benefits of treatment have undoubtedly outweighed these costs. Beyond these autobiographical memory gaps, however, no clinical evidence supports common accusations of permanent 'brain damage', physical damage or major fatality risk.^{1,5,9,10,12,21,22}

Claim 3: excessive use of involuntary treatment

A final major concern is the proportion of patients receiving ECT without providing informed consent, usually described by ECT opponents using language implying physical coercion.⁸ Informed consent will, of course, always be contentious in relation to psychiatry, given common international use of legally sanctioned involuntary treatment. The United Nations Committee on the Rights of Persons with Disabilities, for example, call for abolition of all involuntary treatment (General Comment 1; see https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en). Yet, with ECT, such concerns appear to extend beyond straightforward questions about ethical validity of involuntary treatment.

Multiple factors might justify administering ECT via statutory measures, to allow treatment without informed consent. ECT is increasingly used for severe, life-threatening depression and treatment-resistant illness often including psychotic features, catatonia or prolonged mania. Given probable severity of symptoms and concomitant likelihood of impaired decision-making abilities or extreme risk, informed consent may well not be possible.^{23,24} In such cases, failure to use statutory provision authorising substitute decision-making would be unethical, and safeguards surrounding involuntary use of ECT within mental health legislation are typically more stringent than for other forms of treatment. Although the type of physical coercion suggested by ECT critics is not typically involved, such cases would be classified as 'involuntary', and a recent data-set from UK clinics reported that 46.7% of patients were formally detained when starting acute ECT treatment, with 41% lacking decision-making capacity to consent to treatment.²⁵ However, there has been a well-documented and alarming rise in the use of formal detention in England and Wales, with a national report showing that, by 2016–2017, 80% of adult psychiatric in-patients and 100% of older in-patients (aged ≥65 years) were formally detained in some areas.²⁶ By comparison, figures for ECT might even be seen as relatively low, given that detention figures among acute ECT recipients suggest that over half of ECT recipients received treatment having provided informed consent, although it is likely that the majority were in-patients.¹⁸ Moreover, evidence suggests that patients often regain capacity to consent during a course of ECT and consent to further treatment,^{23,25} with many involuntary patients retrospectively assessing treatment as helpful^{23,27} – an experience that I have shared.

Cost-benefit analysis: which factors are often omitted by the anti-ECT lobby?

Accusations of ethical violations through ineffective treatment, concealed side-effects and excessive involuntary treatment seem unconvincing. Moreover, although treatment decisions involve informed cost-benefit analysis,^{1,3,16} ECT opponents often de-emphasise, omit or even misrepresent details about the treatment process and conditions treated, despite their frequent accusations of obfuscation and concealment among ECT practitioners.

In almost all countries, ECT now involves general anaesthesia and a muscle relaxant to prevent major physical convulsion.^{1,3} In the UK, for example, ECT staff are trained to answer any questions or concerns, provide calming environments both pre- and post-treatment,

and conduct physical and cognitive checks.²⁸ For me, when severely unwell, my fears concerning ECT have stemmed entirely from persecutory delusions about ‘brain control’, rather than fear of the physical process. Most importantly, perhaps, ECT opponents rarely describe the realities of conditions treated by ECT. Unfortunately, terminology used to defend ECT, such as ‘debilitating’, ‘depression’ or even ‘life-threatening’, barely evokes the experience of severe affective disorders or their potential consequences.

Although hard to articulate, I offer some personal examples to try to demonstrate the lived experience and dangers of such conditions, and reasons for prescribing ECT. When becoming severely unwell, I suddenly enter an internal world utterly detached from everything and everyone around me. The American psychiatrist Kay Redfield Jamison’s description of her own mixed-affective state before attempting suicide has always resonated deeply with me – her mind a ‘murderous cauldron’, her body ‘uninhabitable’, ‘raging and weeping and full of destruction and wild energy gone amok’.²⁹ For me, ‘tortuous energy’ is underpinned by manic grandiosity and invincibility, with intermittent euphoria pushing me toward enlightenment, but accompanied by terrifying paranoia. This lethal combination is all the more dangerous because it is usually veiled under a deceptive presentation of calm lucidity.

During the final trimester of my second pregnancy, I descended rapidly into these familiar patterns. I clearly needed ECT, although I did not want this or any other treatment. Why was this? I was bombarded by thoughts, voices and signs telling me that my psychiatrist, whom I deeply trust and respect, was masterminding a conspiracy to control my mind and prevent me from fulfilling my destiny, making any treatment adherence an act of cowardly capitulation. Nevertheless, like Jamison,²⁹ I had written advance documentation requesting ECT, administered involuntarily if necessary, if I became severely unwell. In fact, the perinatal risks associated with bipolar disorder and my reliance on ECT are so great that my decision to try for a second child had been heavily contingent on the availability of ECT in the perinatal period.

The literature on ECT in pregnancy is, understandably, limited, but points toward its safety and effectiveness.^{11,12,30} I received 12 bi-weekly treatments during the final trimester of pregnancy. Treatment took place in the main operating theatres, with a midwife and obstetric team present, along with full foetal monitoring and provision for emergency delivery. The ECT team were incredible and took me through the process with great compassion, acknowledging and doing everything possible to help me manage my fear. After the 10th treatment, during the 36th week of pregnancy, there was a sudden and dramatic remission of the severe symptoms and psychosis. Just as rapidly as reality had vanished, it returned. The last treatment was at 38 weeks, and I gave birth to a healthy child 2 weeks later, who started school this year.

Conclusions

On examination, academic opposition to ECT appears generally to rest on unsubstantiated claims of ethical violations, some of which its opponents may even perpetrate. Opposition comprises a small but vocal cohort, mainly subscribing to an ideological agenda rarely mentioned within specifically anti-ECT literature,^{11,15} rejecting any medical understanding of mental illness and frequently questioning psychiatric motives. The critical 2020 review appears within the official journal of an international society centred on the premise that mental illnesses ‘should not be considered medical problems and traditional medical treatment is not a solution’ (<https://psychintegrity.org/isepp-mission-statement/>).⁸ Very similar views are espoused, for example, on other sites hosting anti-ECT literature, such as ‘Behaviourism and Mental


Health’ (<https://www.behaviorismandmentalhealth.com/>) and the ‘Council for Evidence-based Psychiatry’ (<http://cepu.org/>).

Based on prejudicial and unjustified assumptions about the intrinsic illegitimacy and immorality of psychiatry, many anti-ECT academics simply assume a lack of credibility in the evidence and testimonies presented by psychiatrists. Similar assumptions about intrinsic vulnerabilities or credulity lead to dismissal or even discrimination against ECT advocates who, like myself, claim to have benefited from the treatment. As Dukakis writes in a thoughtful collection of testimonies from those who have benefited from ECT, including her own: ‘I fully expect to be attacked. I feel like I am putting a target on my back for ECT’s many critics’.³ Moreover, the views and utter intransigence of calls for suspension or abolition of ECT do not take into account the potential harms of depriving those helped by ECT treatment and deterring those who are severely unwell from considering treatment that could help to relieve their suffering.

Public perceptions of ECT may well still be dominated by a *One Flew Over the Cuckoo’s Nest* image. Currently, the sensationalist and flawed views of the academic anti-ECT lobby continue to bolster such damaging and unjustified public perceptions and media discussion, rendering it unlikely that any supporting evidence for ECT will ever receive balanced consideration. No matter how much evidence is presented in journals, unless psychiatry is proactive in educating people about ECT and is helped, rather than hindered, by the media, ECT’s ‘image problem’ will persist. The stigma surrounding ECT means ‘that its use is severely limited, and its merits are neglected or even denied’,¹¹ with even those psychiatrists who recognise its effectiveness deterred from prescribing ECT and training others.³

My arguments are in no way intended to deny any historic or even contemporary instances of misuse,¹¹ or to negate the views of those who have experienced harm from ECT, either from a lack of benefit or from benefits not outweighing the damage. However, any rights-based approach must surely recognise the rights of individuals to conduct their own cost–benefit analysis, and to have available to them a treatment with the potential to alleviate severely debilitating and dangerous symptoms.^{3,11}

From a personal perspective, ECT does not cure bipolar disorder and the condition is for me, as for so many others, an ongoing challenge. I am incredibly lucky to have levels of social, clinical and material support unavailable to many. I am aware of the high probability that I may one day become severely unwell again. I am also aware that, if I do, I will need ECT and, when I receive the first treatments, there may well be some element of coercion, whether formal or informal. Almost certainly, I will experience some degree of memory loss. But today I am alive. I have two happy and healthy daughters and am able to perform a job that is both deeply stimulating and rewarding. Only a few years ago many, if not all, of these things would have seemed highly improbable. Without ECT, it is almost certain that they would not have happened.

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None.

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