

# Making Sense

## of electroconvulsive therapy (ECT)





# Contents

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What do I need to know before I have ECT?	4
What is ECT and why is it controversial?	6
What is it used for?	8
Where will I have my treatment?	8
What should I expect from a treatment session?	10
What's the difference between bilateral and unilateral ECT?	11
How many treatments will I need?	12
Who should avoid having ECT?	12
How does it work?	13
Does it save lives?	15
What do users say about ECT?	16
What are the adverse effects of ECT?	17
What are the added risks for older people?	23
What are the alternatives to ECT?	23
What are the pros and cons of ECT?	27
Index	29
References	30
Useful organisations	32
Further reading and order form	34

## Making sense of electroconvulsive therapy

**This booklet is for anyone who wants to know about electroconvulsive therapy (ECT). It is one of the most controversial treatments in modern psychiatry, used for conditions, such as severe depression, which have not responded to other interventions. For some people, it has been a life-saver. But others have found it far from satisfactory, and consider the long-term side effects to be an unacceptable consequence.**

### **What do I need to know before I have ECT?**

The law states that people have the right to make an informed decision about which of a number of treatment options to choose, and whether, or not, to accept the treatment a doctor suggests. To consent properly to a particular treatment, people need information to enable them to weigh up the risks and benefits, in the light of available evidence.

### **ECT and consent to treatment**

Before any treatment begins, the doctor should provide you with full information about the treatment, any unwanted effects and what the alternatives to that treatment would be, including the alternative of having no treatment at all. Information should be given in language that you can understand. This means that technical information should be explained, using everyday terms. It also means that if your first language is not English, and your understanding of English is not adequate for you to understand fully, you should be provided with an independent interpreter. Having a relative or friend acting as a translator is not good enough.

You should be able to have the information in writing, and have someone go through it with you, face to face. The information should include the specific nature of the treatment, its purpose, the chances of its success, any side effects or risks involved, and the way of administering it.

You should also be offered similar information about any alternative treatments available, and about the consequences that may result should no treatment be provided.

You should be allowed time, afterwards, to decide whether, or not, to go ahead with the treatment. You may want to talk this through with a relative, friend or adviser, before signing a written consent form specific to the proposed treatment. It can be hard to take in a lot of new information at one go, especially if you are depressed and taking medication. The Royal College of Psychiatrists recommends that you have a friend, relative or advocate with you, when you are given the information, so that they can go over it again, with you. You should not be afraid to ask your psychiatrist, or another member of staff, to explain it to you more than once. The Royal College of Psychiatrists also recommends that, if your relatives or close friends disagree with your treatment, this should be recorded in your notes, together with the reasons for proceeding with the treatment.

When you have signed a consent form, you should be informed that you can change your mind at any stage in the treatment and that, should you do so, the treatment will be stopped. At each stage of the treatment, the doctor should confirm with you that you are continuing to consent.

*The ECT Handbook*, which has been produced by The Royal College of Psychiatrists, states:

‘You can refuse to have ECT and you may withdraw your consent at any time, even before the first treatment has been given. The consent form is not a legal document and does not commit you to have the treatment. It is a record that an explanation has been given to you, and that you understand, to your satisfaction, what is going to happen to you. Withdrawal of your consent to ECT will not in any way alter your right to continued treatment with the best alternative methods available.’

ECT can only be given without consent if you are detained in hospital under the Mental Health Act 1983, and this is authorised by a doctor appointed by the Mental Health Act Commission (a second opinion appointed doctor, or SOAD). This doctor must visit you and consult with your own doctor, a nurse, and another professional involved in your care, who is neither a doctor nor a nurse. The only exception to this is in an emergency. In such cases, treatment can begin, under section 62 of the Act, pending the arrival of the SOAD, for patients without capacity to consent, in a life-threatening situation, where the common law might be invoked. (See *Getting the Best from your Approved Social Worker*, details on p. 34.)

For more advice on your rights, ask whether there is an advocacy service or patients' council at the hospital. Mind's Legal Unit and your local Community Health Council may also be able to help. For more detailed information on the Mental Health Act, and consent to treatment, see *Mind Rights Guide 3: Consent to treatment*. For information about advocacy, see *The Mind Guide to Advocacy*. (For details of these and other booklets mentioned here, look under *Further reading* on p. 34, or consult Mind's website.)

## **What is ECT and why is it controversial?**

ECT involves sending an electric current through the brain to trigger a seizure, or fit, with the aim, in most cases, of relieving severe depression. The treatment is given under a general anaesthetic and using muscle relaxants, so that the muscles do not contract, and the body does not convulse during the fit.

No-one seems to be able to give a clear explanation of how ECT works, and this is a cause of controversy. On the one hand, its critics describe it as a crude treatment that causes brain damage; on the other hand, its supporters defend it as an effective and life-saving technique.

Mind conducted a survey, in 2001, of mental health service users who had received ECT. (*Shock Treatment: A Survey of People's Experiences of Electro-convulsive Therapy [ECT].*)

It reported that as many people found it unhelpful as helpful: 'I would happily die rather than have ECT again.'  
(Woman, Yorkshire.)

'If I had not received ECT I would be dead by now.'  
(Woman, Staffordshire.)

- 36 per cent of those treated in the last five years found it helpful in the short term (within the first six weeks of treatment)
- 27 per cent found it unhelpful or damaging in the short term
- 43 per cent felt that it was unhelpful or damaging in the long term.

Two-thirds of all those asked, and almost half of those who had had ECT in the last two years, would not agree to have it again.

Many psychiatrists are convinced that it is an effective treatment for seriously depressed people, when no other treatment has been effective or available. They would argue that it is a suitable treatment when it is important to have an immediate effect, for example because a person is so depressed that they are refusing to eat or drink, and are in danger of kidney failure.

Other controversial issues are also discussed later. They include:

- differences of opinion about how ECT works
- whether, or not, it is always used as a treatment of last resort
- whether, or not, it is effective in preventing suicide
- the adverse effects, including memory loss, which may be very significant in some people.

## What is it used for?

ECT has been used to treat all types of mental distress in the past. It is now most commonly used to treat severe depression and, occasionally, mania, schizophrenia and catatonia.

In treating schizophrenia, *The ECT Handbook* recommends that ECT should be limited to patients who can't take, or respond poorly to antipsychotic drugs, when psychotic symptoms (such as hallucinations) accompany a mood disorder (such as depression) or great agitation or immobility. It also states that:

'ECT is unlikely to be effective in the treatment of obsessional compulsive disorders, but may be of benefit to some patients with both obsessive-compulsive and depressive symptoms.'

Because, when it works, ECT usually works very quickly, some psychiatrists think it is the best treatment for severe postnatal depression. It can minimise the time that the new mother is not able to care for and bond well with her baby. (See *Understanding Postnatal Depression*, details under *Further reading* on p. 34.)

## Where will I have my treatment?

People usually receive ECT as inpatients in a hospital, although outpatient treatment is possible. *The ECT Handbook* recommends that the ECT treatment centre should consist of a suite of at least three rooms. The waiting area should be comfortable and provide a relaxing environment. Accessible from the waiting area should be a treatment room, with a recovery area leading off it. The suite should be organised so that patients are able to move easily from waiting room, to treatment room, to recovery room.

A nurse, who the patient knows and trusts, should escort the patient to the ECT suite and, preferably, stay with him or her during all stages of treatment. In some clinics, relatives or friends are allowed to accompany patients throughout the treatment, if both agree.

'A minimum number of trained staff must be present for a treatment session to take place. As well as the anaesthetist and psychiatrist, there must be one person to help with the anaesthesia and one person to recover each person who has not regained consciousness.'

In the treatment room, an electrocardiogram machine, to measure blood pressure and temperature, should be easily accessible. There should also be adequate resuscitation equipment, including a defibrillator (a machine to restart the heart should it stop beating). A standard box of drugs should be kept in the unit, in case of cardiac arrest or medical emergency. All staff working in the ECT unit need regular training, updating and practice in basic and advanced life support techniques. *The ECT Handbook* states:

'A senior psychiatrist, preferably a consultant, should be responsible for ECT clinics and, in particular, must advise on appropriate treatment facilities, develop a treatment policy, and train and supervise staff.'

Some psychiatric units fall short of these guidelines. A survey of the 230 sites in England and Wales that provide ECT found that:

- 20 per cent showed 'substantial departures' from best policy, practice and training
- 32 per cent did not have a dedicated ECT suite of three rooms
- 36 per cent did not have a nurse in the recovery room trained in basic life support and resuscitation techniques
- 27 per cent did not have regular visits from a named consultant psychiatrist
- 5 per cent did not have either copies of *The ECT Handbook* (the Royal College's publication) or the hospital's own policy for ECT.

## **What should I expect from a treatment session?**

ECT is carried out under a general anaesthetic and with a muscle relaxant (this is what is known as 'modified' ECT). Because of the anaesthetic, you must not eat or drink anything for at least six hours before ECT. An anaesthetist, a psychiatrist and one or more nurses should be present during the procedure. You will lie on a bed, and your jewellery, shoes and dentures (if necessary) will be removed. You should not be wearing any hair lacquer, creams, make-up or nail polish, or have any metal slides or grips in your hair.

Once you are comfortable, you will be given a general anaesthetic, via an injection. Later, while you are asleep, you will receive an injection of muscle relaxant to minimise the convulsions caused by the electric current. Because of the muscle relaxant, you will be given oxygen, and the anaesthetist will look after your breathing, using a face mask and a pressure bag. Two padded electrodes will be placed on your temples (see opposite page). A gag will be placed in your mouth, to stop you biting your tongue.

Modern ECT machines deliver a string of brief, high-voltage, direct-current pulses, about 60 to 70 pulses a second, for three to five seconds, which results in a seizure, or fit. This will cause you to stiffen slightly, and there will be twitching movements in the muscles of your face, hands and feet. The seizure should last 20 to 50 seconds.

### **The seizure threshold**

The strength of electric current needed to produce a fit is called the seizure threshold. This varies from person to person. It is higher in men than in women, and it increases with age, meaning that older people need a stronger electric current to produce the desired effect. The 'dose' of electric current given to you will be adjusted to take this into account.

Other things that affect it are the exact position of the electrodes on your head, the amount of anaesthetic you have been given, and other medication you may be taking. If the dose is too low (below the threshold), there will be no benefit from the ECT. But the higher the dose, the greater the risk of unpleasant side effects, so it's important to get the dose as close to the threshold as possible.

### **Immediate after effects**

After the convulsion, the gag is removed and you will be turned on your side. The anaesthetist will provide oxygen until the muscle relaxant wears off (after a few minutes), and you start breathing on your own again. You will slowly come round, although you may feel very groggy. You may sleep for up to an hour, after treatment.

The immediate effects of ECT include headache, confusion, nausea, disorientation, loss of memory, apathy, aching muscles and physical weakness (see p. 17). If you are an outpatient, you will need to have someone with you to accompany you home. You should not drive, and you should not return alone to an empty house.

### **What's the difference between bilateral and unilateral ECT?**

ECT may be given by placing one electrode on each temple (bilateral) or by placing both electrodes on one temple (unilateral), and this makes a difference to the effect ECT will have. The National Institute for Clinical Excellence (NICE) says there is evidence of cognitive impairment after ECT. This is greater when electrodes are applied bilaterally. In unilateral ECT, electrodes placed on the dominant side of the brain cause more harm than if they are placed on the non-dominant side (see p. 19 for more information). But reducing the risks involved also reduces the effectiveness of the treatment.

*The ECT Handbook* recommends unilateral ECT when:

- a very rapid response to treatment is less important
- you have responded well to unilateral ECT in the past, and
- it's thought particularly important to minimise memory loss.

It recommends bilateral ECT when:

- a very rapid response to treatment is desirable
- previous bilateral ECT has been effective, and
- it has not caused significant loss of memory.

## **How many treatments will I need?**

*The ECT Handbook* says there should not be a pre-set number of treatments, but that you should be assessed after each treatment to see if another one is necessary. Most people respond to a course of between four to eight treatments, although older people and men may need more. It's usual to stop after eight, or so, treatments, if there has been no change at all in the patient's symptoms. The treatments should take place two or three times a week, not daily.

*The Code of Practice to the Mental Health Act 1983* states that the proposed maximum number of applications of ECT should be written down on form 38, when the patient consents to treatment.

## **Who should avoid having ECT?**

Before a course of ECT treatments, you will need a full medical examination. You will be asked about your medical history, any medicine you are taking, any drug allergies, and whether you are pregnant. If you have any physical problems, these should be treated, as far as possible, before you have ECT.

*The ECT Handbook* emphasises that the risks and benefits of the treatment must be carefully assessed, and that you and your family should be involved in the discussion. (See p. 28 for a checklist of questions to ask.)

## Cardiovascular problems

When assessing whether to give you ECT, it's important that doctors take into account any heart and related problems you may have. It may be hazardous to give you an anaesthetic if you have a serious chest disease.

## Pregnancy

ECT is occasionally used in pregnancy. However, an anaesthetist may not be happy about giving a general anaesthetic to a pregnant woman, except in a medical emergency.

## Medication

The *British National Formulary* (BNF) advises caution in using ECT if the patient is taking SSRI antidepressants (selective serotonin re-uptake inhibitors), because these drugs may prolong the seizures. Drugs that raise the seizure threshold (so that a higher dose of electric current has to be used) should also be avoided. This includes benzodiazepine tranquillisers. (See Cause for concern, on p. 22)

## How does it work?

No theory provides a clear explanation. Some give very little information. *The ECT Handbook* says:

'[ECT] produces a seizure which affects the entire brain, including the centres which control thinking, mood, appetite and sleep. Repeated treatments alter chemical messages in the brain and bring them back to normal.'

NICE says that it changes the way brain cells respond to their chemical messengers:

'Although ECT has been used since the 1930s, there is still no generally accepted theory that explains its mechanism of action. The most prevalent hypothesis is that it causes an alteration in the post-synaptic response to central nervous system neurotransmitters.'

Psychiatric opinion about how it works is divided. Dr Brian Harris, a consultant psychiatrist and senior lecturer, is quoted as saying: 'No-one knows how it works, but it does; quicker than medication'.

The author, Dr Anthony Clare, has said:

'Interest centres on the possibility that ECT acts on the neurotransmitters believed to hold the cause of severe depression. ECT certainly affects these monoamines, but in complicated ways, and it has not hitherto been possible to produce a coherent explanation.'

Dr Simon Green, a psychologist, comments:

'It does work through changes in brain chemistry, but comparing this favourably with the current generation of pharmacologically specific drugs would be similar to the assumption that a broken television could be mended as readily with a sledgehammer as with a screwdriver: you might jog the right bit.'

The electrical activity in the brain that ECT causes is accompanied by increases in blood flow, oxygen levels and use of glucose in the brain. The blood-brain barrier also becomes more permeable during ECT. (The blood-brain barrier is a physiological mechanism, which acts to prevent a large number of substances from crossing the protective cell membranes and entering the brain cells. It also becomes more permeable as a result of stress.)

### **Brain damage**

Other psychiatrists believe that ECT works through causing brain damage. People may experience a temporary lifting of mood after ECT, but this can be explained by post-traumatic euphoria, which typically follows head injury. This causes amnesia, denial, euphoria, wide and unpredictable mood swings, helplessness, submissiveness, confusion and disorientation.

Dr Peter Breggin, a well-known critic of modern psychiatry, has reviewed the research conducted on ECT and concluded that it was the brain damage caused by ECT which explained its so-called 'effectiveness'. Ironically, a leading supporter of ECT in the USA, Dr Max Fink, has also blatantly stated that where there is no evidence of brain damage, there is no improvement: 'Where there is no evidence of impaired mental function and no electroencephalographic alteration [changes in recorded brain waves] clinical improvement does not occur.'

### **Does it save lives?**

'It was a life-saver to me, as I was very depressed and highly suicidal.' (Woman, Wiltshire, ECT six or more years ago).

ECT does sometimes prevent death when someone is profoundly depressed, no longer eating or drinking, and in a critical state. But there is no good evidence that ECT prevents suicide.

Even a paper (by David Avery and George Winokur) often cited in support of the view that ECT prevents suicide, had to conclude that, in their study, treatment was not shown to affect the suicide rate. Other studies have shown that psychiatric hospital admission can increase the risk of suicide.

(If you know someone who is feeling suicidal, you can help by just being there and listening in an accepting way. Discuss strategies for seeking help when suicidal thoughts occur. Creating a personal support list is a useful way of reviewing every conceivable option. Persuade the person to keep, by the phone, a list of individuals, helplines, organisations and professionals they can call when they are feeling suicidal. See *Useful organisations*, on p. 30, and Mind's booklet, *How to Help Someone Who is Suicidal*, details under *Further reading* on p. 34.)

## What do users say about ECT?

'The effect of the treatment was amazing. All psychotic thoughts diminished, and I started to feel as if I was finally being lifted from the big, black hole I had been in. I honestly believe that, had I not received ECT, I would not be living the full, happy and healthy life that I am living today.'

(Woman, Hertfordshire, ECT in the last two years.)

'Under no circumstances would I choose to have ECT. I would rather go down fighting than submit to that abomination.'

(Woman, no area given, ECT six or more years ago.)

'It just seems to help me out of my depressed state of mind very quickly.'

(Man, no area given, ECT three to five years ago.)

'It was hell on earth.'

(Woman, Dorset, ECT three to five years ago.)

There is a wide split among people who have had ECT about how helpful it is. In Mind's 2001 survey, of all those asked:

- 29 per cent found the treatment helpful or very helpful in the short term (within the first six weeks)
- 36 per cent found it unhelpful, damaging or severely damaging.

Among those who had received ECT more recently, the results were the opposite:

- 36 per cent found the treatment helpful or very helpful in the short term
- 27 per cent found it unhelpful, damaging or severely damaging.

Over the longer term, a much higher percentage rated the treatment as unhelpful, damaging or severely damaging:

- 63.5 per cent of all those asked
- 43 per cent of those who had treatment in the last two years.

## **What are the adverse effects of ECT?**

Psychiatry recognises the following risks of ECT:

'Each application inevitably leads to a variable period of drowsiness, confusion and anterograde amnesia [forgetting new information], commonly causes headache and nausea, and may lead to the occasional loss of personal memories; moreover each application inevitably requires a brief anaesthetic that involves additional risks of morbidity and mortality [illness or death] that are slight, but never negligible.'

In its appraisal document on ECT, NICE says that cognitive impairment happens immediately after each session, as well as following a course of treatment. (NICE is due to publish its Final Appraisal Determination on ECT in January 2003.)

Both critics and supporters have suggested that ECT works through causing brain damage, or 'acute organic brain syndrome' (see p.14). Some of the symptoms listed above may subside quickly, but memory loss, apathy (emotional blunting), learning difficulties, and loss of creativity, drive and energy, may last for weeks, months, or even permanently.

### **Loss of memory**

Memory loss can mean losing both good and bad personal memories, and having difficulty remembering new information. (It is, perhaps, worth noting that people with epilepsy experience memory loss after a fit.)

Comments recorded in Mind's 2001 survey suggested that psychiatrists seriously underestimate the potential extent and devastating effects of memory loss in some people:

'Permanent loss of reading and numeracy skills.'

(Man, West Midlands.)

'I don't play the piano, organ or violin any more, as I can't remember how to. It seems my long-term memory has gone forever. Memories from my past five years, and more, have become either vague or have gone.'  
(Man, Berkshire.)

'I qualified as a maths teacher. Following all this ECT, I have no understanding of the maths concepts used in my further education courses, or even O-level standard.'  
(Woman, Cleveland.)

'I can remember hardly anything about my past life, only very little bits. As for bringing up my three daughters, I can't remember a thing.'  
(Woman, Yorkshire).

According to *The ECT Handbook*:

'The evidence suggests that neither new learning, nor memory for information from the past, are permanently impaired. Objective memory impairment (on specific memory tests) is reversible. Some patients may, however, be left with discrete memory gaps for specific autobiographical events, the explanation for which is unclear.'

However, psychiatric research reflects users' reports that memory loss can persist, and that this is different from the memory loss caused by depression. In one study, more than half of the patients (55 per cent) felt that they had not regained normal memory function, three years after receiving ECT.

An American psychologist conducted detailed autobiographical interviews with 19 people who were about to have ECT, and with a control group who did not have ECT. He then questioned both groups about the same information afterwards. He found that all the 19 patients showed a number of instances of forgetting their former memories, unlike the control group whose memories were unchanged. He followed up half of the ECT patients a year later, and there had been no return of the lost memories.

In another study, it was reported that memory complaints are common six to nine months after bilateral ECT, and were reported by 60 to 70 per cent of patients interviewed.

### **Bilateral versus unilateral ECT**

Research indicates that the two ECT techniques carry different risks of memory impairment. It seems that bilateral ECT causes more severe memory loss than unilateral. In unilateral ECT, the electrodes are applied to the non-dominant side of the brain, to focus energy away from the speech centre. (The speech centre is usually on the left-hand side in right-handed people, but not always.)

Peter Breggin has criticised the theory that unilateral ECT is a less harmful procedure. He points out that non-dominant brain functions include:

‘the creative faculties, such as imagination, and the use of metaphor; visual and spatial capacities, as well as musical and motor abilities, such as co-ordination, dance and athletics; the quality or vibrancy of personality; initiative and autonomy; and insight.’

Other critics have commented that unilateral ECT:

‘assumes that one side of the brain is less valuable than the other. Humanistic psychologists would not agree. Instead, they might argue that the non-dominant side is essential to creativity. The placing of the electrodes unilaterally increases the concentration of current in one part of the brain, and the damage to this part is more severe than in bilateral ECT. EEG results one month after unilateral ECT confirm that it is possible to detect which side of the brain is damaged.’

### **The emotional impact**

The emotional and psychological effects of ECT are under-estimated and under-researched. A report from the USA points out that studies measure successful outcome in terms of symptom-reduction, rather than quality of life and social functioning.

Many people feel abused by the treatment:  
'I felt very much that I was being punished for not coping and being out of work. I still feel this. I felt empty and numb.'  
(Woman, Birmingham.)

'I was an outgoing, fairly confident person, and now I feel worthless and scared.'  
(Woman, England.)

'ECT was done to me, not done for me. That's the total sense of how it felt. It paralleled sexual abuse, which I experienced as a child. Someone doing something to my body against my will.'  
(Woman, Surrey.)'

In depression, some people may feel guilt-ridden, and believe they are evil or harmful to others. They may see ECT as being a deserved punishment, and it can confirm the very feelings of worthlessness that characterise depression. In Mind's 2001 survey, 22 per cent of recent recipients felt that they were being punished.

### **Physical injury**

Injuries to teeth and mouth are risks associated with ECT, because the electrical stimulus contracts the jaw muscles, bypassing the muscle relaxant. High stresses are produced during the forceful closure of the jaws, and tooth damage or loss may result, in spite of the use of mouth guards.

Spontaneous seizures following a course of ECT are rare, and not more common than in the general population. They were reported by one per cent of the respondents to Mind's 2001 survey.

Death following ECT is relatively uncommon, but does happen. It's been estimated that the risk is about 4.5 deaths per 100,000 treatments, or four or five among 16,700 patients. This is no higher than the risk associated with having a general anaesthetic.

## **Side effects mentioned in Mind's 2001 survey**

Not everyone feels damaged by ECT, but for those who do, the feelings can be devastating. Mind's 2001 survey was not scientific research, but does reflect the experiences of 418 people, one third of whom found ECT helpful.

The following short-term side effects (lasting up to six weeks) were reported. (They are listed, here, in order of frequency, with the most frequent first):

- headaches
- drowsiness
- confusion
- loss of past memories
- dizziness
- disorientation in time or space
- difficulty concentrating
- inability to remember new information
- suicidal tendencies after the treatment
- apathy
- inability to recognise people
- loss of reasoning ability
- fear and anxiety
- feelings of helplessness
- sense of betrayal
- visual problems
- loss of previous skills (reading, music, languages)
- sleep problems
- feelings of worthlessness
- neck or back pain
- loss of creativity
- epileptic seizures
- sexual difficulties.

Permanent side effects, again in order of frequency, were:

- loss of past memories
- difficulty concentrating
- fear or anxiety
- inability to remember new information
- feelings of worthlessness
- feelings of helplessness
- sense of betrayal
- loss of previous skills
- loss of creativity
- suicidal tendencies after the treatment
- loss of reasoning ability
- sleep problems
- confusion
- apathy
- headaches
- inability to recognise people
- disorientation in time and space
- personality changes
- neck or back pain
- visual problems
- sexual difficulties
- drowsiness
- muscle ache
- dizziness
- nausea
- epilepsy

### **Cause for concern**

Giving a muscle relaxant helps prevent broken bones and dislocations during the convulsions. It also sedates the brain, making it more difficult to induce a seizure. The voltage has to be increased to reach the threshold necessary to produce a seizure. Patients are often taking psychiatric drugs, which also raise the threshold. The Royal College of Psychiatrists has expressed concern about the effect of such drugs on the safety and success of ECT. They stress more research is needed.

## **What are the added risks for older people?**

There are additional concerns in using ECT for older people, as there are with many medical procedures. The risks of treatment include an increased chance of heart problems, stroke and falls. The effect on an ageing brain is also recognised as potentially more damaging, with a greater possibility of memory loss.

Older people will be at much higher risk of dying than younger ones, but this age group is seen as more likely to be at risk of dying from the inability to eat or drink during severe depression, and so the benefits are seen as outweighing the risks.

ECT is sometimes considered less risky for the elderly than taking tricyclic antidepressants, which can have an adverse effect on the cardiovascular system. Opinion is divided about whether the newer SSRI drugs are any better. A survey of psychiatrists working with elderly people found that those who did choose the newer drugs often did so because of cardiovascular risk. Some psychiatrists believe that, since these antidepressants are so much safer, there is now no reason to choose ECT rather than drug treatment for elderly patients.

Antidepressants and ECT are not the only possible responses to depression. There is a body of knowledge and expertise in counselling and psychotherapy with elderly people, but these approaches are under-used. (See Talking treatments, overleaf.)

## **What are the alternatives to ECT?**

There are many possible causes of depression, including life events, and psychological, social, biochemical and genetic factors. All of these interact to some degree. There are, consequently, various approaches to treatment. If the guidelines of the Royal College of Psychiatrists are being followed, you will only be offered ECT (in most cases) if you have tried other treatments and found them unsuccessful, unhelpful or unacceptable, in some way.

Most psychiatrists take a primarily biochemical approach to treatment, and offer antidepressant drugs. If these do not work, they then suggest ECT. They will not always try all the available types of drugs, nor will they always consider other approaches, such as talking treatments, arts therapies, and other alternatives or additions to medication.

The problem with treating depression in this way, as an illness with a biological basis, is that it often follows a stressful life event, such as bereavement, divorce or redundancy. People need time and space to make sense of their pain, and come to terms with loss. ECT seems inappropriate in such situations, unless the person has become morbidly preoccupied with the traumatic event, and buried in depression that looks unlikely to lift.

### **Antidepressant drugs**

People have very varied responses to medication. But there are different types of antidepressant available, and you may need to try several before finding one that works. Information about all of the different antidepressants currently prescribed in the UK is available in Mind's booklet, *Making Sense of Antidepressants* (see p. 34).

### **Talking treatments**

Your GP is a good starting point for exploring psychotherapy and counselling, which can help you to deal with the problems underlying and surrounding your depression. The treatment works by providing an opportunity for you to talk, in a way that assists you to understand yourself better. It can then help you to work out a more positive and constructive way of living. Increasing numbers of GPs are employing counsellors in their practices, but if not, they should be able to refer you to other sources of psychotherapy or counselling. Your local Mind associations may offer free, or low-cost, talking treatments. The organisations listed on p. 32 can provide details of psychotherapists and counsellors. Some will operate a sliding scale of fees, which takes into account people's financial situation.

Cognitive behaviour therapy (CBT) is a practical, short-term aid to helping someone to cope with depression. A person's thoughts have a powerful impact on their feelings and behaviour, and it's possible for someone to think themselves into a state of extreme distress.

But it's also possible to do the opposite, and challenge negative thought patterns that feed depression. If you think you might be interested in CBT, talk to your GP about getting a referral to a clinical psychologist. (See Mind's booklet, *Understanding Talking Treatments, Understanding Depression and Making Sense of Cognitive Behaviour Therapy*, details under *Further reading*, on p. 34.)

### **Arts therapies**

Therapies using art, music, drama, dance or creative writing may be very powerful in helping to lift depression. Even someone who is so profoundly depressed they can't speak may be moved by music or poetry, which then begins a process of recovery. These therapies are available in some psychiatric units and community mental health facilities (see *Useful organisations*, on p. 32).

### **Complementary therapies**

Complementary and alternative therapies have proved to be particularly helpful when people are experiencing stress-related symptoms, anxiety and depression. They can help people relax and feel better. Complementary therapists emphasise the connection between mind and body, and are not concerned with merely treating symptoms. There are many different therapies, including homeopathy, herbal medicine, acupuncture, aromatherapy, meditation, reflexology, neurolinguistic programming, and various types of massage. (For further information, see Mind's *A-Z of Complementary and Alternative Therapies, The Mind Guide to Relaxation, The Mind Guide to Managing Stress, Making Sense of Herbal Remedies, Making Sense of Homeopathy* and *Making Sense of Traditional Chinese Medicine*, details under *Further reading* on p. 34.)

## **Physical activity**

Physical activity has proved to be very beneficial when tackling problems like depression. It works by changing levels of chemicals in the body that influence mood. For more information, see *The Mind Guide to Physical Activity*, details on p. 34.

## **Self-help groups**

Many people experiencing emotional distress find it helpful to share their feelings with others going through similar difficulties. There are self-help organisations for people suffering from depression. See Mind's booklet *Understanding Depression*, details on p. 34, and *Useful organisations*, on p. 32. Or ask at your local Mind group.

## **Transcranial magnetic stimulation (TMS)**

In the last 10 to 15 years, interest has grown in this new technique. Neurologists have been using TMS as a research tool for some time, and it seems clear that it may be useful for treating depression. Some researchers feel that it may be an alternative to ECT.

It involves creating magnetic fields through an insulated coil conducting an electric current, which is placed on the surface of the scalp. Rapidly changing magnetic fields cause electrical currents to flow within the brain. This affects the nerve function, without causing an epileptic fit. The technique has been investigated in various ways, by using different positions of the coil, by stimulating different areas of the brain, and by changing the signal frequencies, for example. The first trials of TMS for depression used only small, selected groups of patients, with no control group for comparison. As a result, it was not clear whether this was really an effective treatment for depression. More recent research continues to suggest that it may become an alternative to ECT.

It is considered to be a safe procedure. The most important safety concern is the risk of seizures, but no seizures have been reported since the introduction of guidelines for safe use of the technique.

This may seem a strange concern, given that ECT is considered to have failed if it does not cause a seizure. But, if similar results can be achieved without seizure, it would be a great advantage. There may be some local scalp pain or headache at the time of treatment, but, so far, there have been no reports of harmful effects.

The technique is still being researched, and is not yet available as a treatment. In 2001, the Health Technology Assessment Programme of the Department of Health decided to commission a study comparing TMS with ECT.

### **Vagus nerve stimulation (VNS)**

VNS was initially developed for treating epilepsy, but has been tried for depression in the last few years. It involves placing an electronic device under the skin in the left chest wall, with an electrode connecting it to the left vagus nerve in the neck. Putting the device in place takes about an hour. Once working, it sends mild, electrical pulses to the nerve, at intervals.

Side effects can occur, but usually only when the stimulation is on. They include voice alteration, shortness of breath, neck discomfort, and coughing, all of which apparently diminish over time. It's reported to lift depression, and is available in various centres throughout Europe, including the UK.

### **What are the pros and cons of ECT?**

People's experience of ECT varies enormously. It's a short-term treatment, which can't directly address underlying despair or practical problems, and does not prevent future depression. Memory problems are widely reported, though for some people they are only temporary. Some people also feel violated by ECT.

However, ECT can lift depression, and the speed of response may be an important consideration, for instance in preventing kidney failure in someone who is not eating or drinking.

ECT may help people enough for them to begin looking for a different solution. Some people feel that after ECT they are better able to make use of other forms of treatment and support. One service user, who has commented favourably on his ECT treatment, makes the point that ECT, on its own, is not enough: 'On more than one occasion in my life, the intervention of ECT has been beneficial and not damaging. The initial help given, it's been all the more possible to gain from the skills and the patience of a clinical psychologist. It is true that ECT should not be used to excess, and it is also true that usually more than ECT is needed. But the different therapies and treatments can, and should, be seen as complementary, rather than in competition.'

### **Questions to ask your doctor**

If ECT is recommended, you should ask the following questions:

- What is the reason for suggesting ECT?
- What are the risks associated with ECT?
- How could ECT help me?
- What are the side effects?
- Are there any long-term effects?
- Has every alternative treatment been tried, including different drug treatments, or talking treatments?
- What treatment will be offered in addition to, and after, ECT?
- What is the risk of physical deterioration or suicide?
- How many treatments are proposed?
- Is unilateral or bilateral ECT proposed?
- How will the dosage be decided?

# Index

abuse, sense of	20	memory loss	7, 11, 12, 14, 17-18, 23
advocate	6	Mental Health Act 1983	6
alternative treatments	23-25	modified ECT	10
anaesthetic	6, 10, 13, 20	muscle relaxant	6, 10, 11, 22
anaesthetist	9, 10	obsessive-compulsive disorder	8
antidepressants	13, 23, 24	old people	12, 23
antipsychotic drugs	8	oxygen	10-11, 14
arts therapies	25	physical activity	26
bilateral ECT	11, 19	postnatal depression	8
blood-brain barrier	14	pregnancy	13
brain		preparation for treatment	10, 12
- damage	6, 14, 15, 17, 19	psychiatrist(s)	5, 7, 9, 10, 14, 17, 22, 23, 24
- dominant /non-dominant side	19	psychotic symptoms	8, 16
- functions	13	schizophrenia	8
cardiovascular system	13, 23	seizure (fit)	6, 10, 13, 20, 22, 26
catatonia	8	seizure threshold	10, 11, 13, 22
chemical messages	13	self-help groups	26
cognitive impairment	11, 17	shortfalls in practice	9
complementary therapies	25	side effects	
consent/refusal of treatment	4-6	- adverse	17-23
death	15, 17, 20, 23	- emotional	19
depression	6-7, 8, 15, 18, 20, 23, 24, 25, 26, 27	- immediate	11
ECT		- long-term	22
- helpfulness/harm	7, 11	- physical	20-22
- effectiveness	15-23, 27, 28	- short-term	21
electric current	6, 10, 13, 19, 26	SOAD	6
electrodes	10, 11, 19, 27	speech centres	19
emergency treatment	6, 13	staffing requirements	8-9
epilepsy	17, 22, 27	suicide	15
equipment	9	survey	7, 9, 16, 20, 21-22
frequency of sessions	12	talking treatments	24-25
mania	8	transcranial magnetic stimulation (TMS)	26
medical examination	12	treatment rooms	8-9
medical history	12	unilateral ECT	11, 19
medication	11, 13	vagus nerve stimulation (VNS)	27

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*Vagus nerve stimulation (VNS) therapy for patients with depression now available in Europe* Porter Novelli (web: [www.immedia.it](http://www.immedia.it))

*Vagus Nerve Stimulation Fact Sheet* Cyberonics Europe (web: [www.cyberonics.com](http://www.cyberonics.com))

## Useful organisations

### **Age Concern**

Astral House, 1268 London Road, London SW16 4ER  
helpline: 0800 009 966, tel. 020 8765 7200, fax: 020 8765 7211  
e-mail: [ace@ace.org.uk](mailto:ace@ace.org.uk) web: [www.ace.org.uk](http://www.ace.org.uk)  
Concerned with the welfare of the elderly

### **The Association for Post Natal Illness**

145 Dawes Road, London SW6 7EB  
helpline: 020 7386 0868, fax: 020 7386 8885  
e-mail: [info@apni.org](mailto:info@apni.org) web: [www.apni.org](http://www.apni.org)  
Offers advice and support to women suffering from postnatal depression

### **British Association of Art Therapists (BAAT)**

Mary Ward House, 5 Tavistock Place, London WC1H 9SN  
tel. 020 7383 3774, fax: 020 7387 5513  
e-mail: [baat@ukgateway.net](mailto:baat@ukgateway.net) web: [www.baat.org](http://www.baat.org)  
Maintains a comprehensive directory of qualified art therapists

### **British Association for Behavioural and Cognitive Psychotherapies (BABCP)**

PO Box 9, Accrington BB5 0XB  
tel. 01254 875277, fax: 01254 239114  
e-mail: [babcp@babcp.com](mailto:babcp@babcp.com) web: [www.babcp.com](http://www.babcp.com)  
Promotes the development of the theory and practice of behavioural and cognitive psychotherapies. Can provide details of accredited therapists

### **British Association for Counselling and Psychotherapy (BACP)**

1 Regent Place, Rugby, Warwickshire CV21 2PJ  
tel. 0870 443 5252, fax: 0870 443 5160, minicom: 0870 443 5162  
e-mail: [bacp@bacp.co.uk](mailto:bacp@bacp.co.uk) web: [www.bacp.co.uk](http://www.bacp.co.uk)  
Information and advice about counselling and psychotherapy.  
Send an SAE for details of practitioners in your area

### **Depression Alliance**

35 Westminster Bridge Road, London SE1 7JB

helpline: 020 8768 0123, tel. 020 7633 0557, fax: 020 7633 0559

e-mail: [information@depressionalliance.org](mailto:information@depressionalliance.org)

web: [www.depressionalliance.org](http://www.depressionalliance.org)

Information and support to people affected by depression

### **The Fellowship of Depressives Anonymous**

Box FDA Self-help Nottingham, Ormiston House, 32–36 Pelham Street, Nottingham NG1 2EG

infoline: 01702 433838, fax: 01702 433843

e-mail: [fdainfo@aol.com](mailto:fdainfo@aol.com) web: [www.depressionanon.co.uk](http://www.depressionanon.co.uk)

Self-help organisation run by people who have been or are depressed

### **Rethink Severe Mental Illness**

(formerly the National Schizophrenia Fellowship)

28 Castle Street, Kingston-upon-Thames, Surrey KT1 1SS

advice line: 020 8974 6814, fax: 020 8547 3862

e-mail: [advice@rethink.org](mailto:advice@rethink.org) web: [www.rethink.org](http://www.rethink.org)

Aims to improve the lives of everyone affected by severe mental illness

### **Samaritans**

The Upper Mill, Kingston Road, Ewell, Surrey KT17 2AF

helpline: 08457 909090, fax: 020 8394 8301

minicom: 08457 909192

e-mail: [jo@samaritans.org](mailto:jo@samaritans.org) web: [www.samaritans.org.uk](http://www.samaritans.org.uk)

24-hour emergency helpline

### **UK Council for Psychotherapy (UKCP)**

167–169 Great Portland Street, London W1W 5PF

tel. 020 7436 3002, fax: 020 7436 3013

e-mail: [ukcp@psychotherapy.org.uk](mailto:ukcp@psychotherapy.org.uk)

web: [www.psychotherapy.org.uk](http://www.psychotherapy.org.uk)

UKCP is the umbrella organisation for psychotherapy in the UK

## Further reading and order form

- A-Z of Complementary and Alternative Therapies* (Mind 2000) £3.50
- Depression: The way out of your prison* D. Rowe (Routledge 1996) £10.99
- Getting the Best from your Approved Social Worker* (Mind 2001) £1
- Going Mad? Understanding mental Illness* M. Corry, A. Tubridy (Newleaf 2001) £8.99
- How to Cope with Memory Loss* (Mind 1998) £1
- How to Help Someone who is Suicidal* (Mind 2000) £1
- Madness: A brief history* R. Porter (Oxford University Press 2002) £11.99
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- Mind Rights Guide 5: Mental health and the courts* (Mind 1995) £1
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- The Mind Guide to Physical Activity* (Mind 2001) £1
- The Mind Guide to Relaxation* (Mind 2001) £1
- The Noonday Demon: An anatomy of depression* A. Solomon (Random House 2001) £8.99
- Toxic Psychiatry: A psychiatrist speaks out* P. Breggin (HarperCollins 1993) £9.99
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