

# Feminism & Psychology

<http://fap.sagepub.com>

---

## Choosing ECT

Rachel Perkins

*Feminism Psychology* 1994; 4; 623

DOI: 10.1177/0959353594044023

The online version of this article can be found at:

<http://fap.sagepub.com>

---

Published by:



<http://www.sagepublications.com>

**Additional services and information for *Feminism & Psychology* can be found at:**

**Email Alerts:** <http://fap.sagepub.com/cgi/alerts>

**Subscriptions:** <http://fap.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.co.uk/journalsPermissions.nav>

**Citations** <http://fap.sagepub.com/cgi/content/refs/4/4/623>

---

### Choosing ECT

Rachel PERKINS

---

I don't think I have ever heard the word 'choice' associated with electroconvulsive therapy (ECT) on the lips of a lesbian feminist or psychologist. Almost universally construed in *One Flew Over the Cuckoo's Nest* terms, ECT is seen (along with psychosurgery) as the ultimate in barbaric 'treatments' used to punish or control those who will not conform, especially women. There is no question in my mind that it can and has been abused: I worked at Broadmoor — a high security hospital for 'forensic patients' — in 1980, when ECT was still given without anaesthetics or muscle relaxants (MIND, u.d.: 2). Although, as the Royal College of Psychiatrists (1993a) admits 'there is no case at all for prescribing ECT to alleviate violent or offending behaviour *per se*', I remember well the psychiatrist talking of the need for 'emergency ECT' when someone was behaving in a violent fashion. How could someone like me, a radical lesbian feminist and a psychologist, choose to submit themselves to such torture?

Numerous women have asked me this question. I am writing now to address this question, as well as to outline some of the things that I wish I had known at the time, and some of the help that I would like to have received from my friends/allies, but which they were unable to provide because of their ignorance and my own.

At the outset, I would like to say that there are many ways in which readers can ignore what I say here, can reframe my situation in their own psychotherapeutic terms and construct wonderful explanations for my decision based on a panoply of psychological processes. It is always easy to tell someone, especially someone who is mad, that they do not know what they are talking about. However, as one who occupies the roles of both mental-health-service practitioner and user, I believe that our views as users must be taken seriously, even when they are discordant with our perspective as professionals.

#### THE DECISION

I was two months into my second bout of severe depression. The first had prevented

---

*Feminism & Psychology* © 1994 SAGE (London, Thousand Oaks and New Delhi), Vol. 4(4): 623–627.

me from working (or doing anything very much) for about six months, and now I was back in the same situation. Although I was profoundly miserable, this misery that characterizes popular uses of the term 'depression' is not what bothers me most. More important to me is being unable to think properly. Although I was receiving medication, I was still unable to work, read, drive my car, make even the simplest decisions or look after myself. I had all the classic symptoms: early morning wakening, loss of appetite, diurnal variation and amenorrhea. And I was terrified. Could I, like last time, face months of this?

One option available was ECT — and if it worked, it would at least be quick. I had seen its effects numerous times over the years: it hadn't 'worked' for everyone (neither has anything that I've seen) but it had for some. My primary interest in the possibility of ECT was its speed. Apart from a vague recollection of a literature review I had once done on its side effects (memory loss is often cited as a problem but I should say that memory can be affected by depression just as it can by ECT), I wasn't really able to make decisions at this time. What I wanted was someone who I trusted (someone who knew me, my values, my situation and the options available) to tell me what to do and make sure that I didn't do anything too stupid.

When I asked friends, I received several long letters outlining the evils of ECT — not very helpful as I really wasn't able to read what they said. Several telephoned and went on at length about how I would lose my memory and never be able to do anything again (at least that's what I think they were saying) — calls that generally left me in a flood of tears of indecision and hopelessness. Then there were the stunned silences at the other end of the phone, followed by some comment along the lines of 'Oh ... Well ... You must do what you think best' — again not very helpful: I didn't know what to think; I wasn't really *able* to think.

Fortunately, my family and a couple of friends (both mental-health professionals) knew me well enough to provide what I needed. I am very grateful to them. First, they knew me and just how intolerable I found the inability to work, read, drive and the like. Second, they summarized 'pros' and 'cons' in a way I could grapple with. Third, they told me what they would do if they were me. Fourth, they made it clear they would help me whatever I decided.

I had ECT — the standard six treatments. Two a week for three weeks and within a week of the sixth I was back at work.

#### WHAT IS IT LIKE?

Nothing really. I had an injection (anaesthetic and muscle relaxant), went to sleep and then woke up again a few minutes later. That's all I knew of the process. Some people get headaches: I didn't, although I did have some memory problems during the three-week course (could not remember who had visited, etc.). I think my friends found this more distressing than I did — if I wanted to remember something I simply wrote it down. These effects were not long lasting: my job places heavy demands on my memory and I was able to resume it shortly after my final treatment. Now, some three months on, no-one has complained about my having forgotten anything.

I tried having ECT on an outpatient basis, but having to cope with the demands of ordinary life as well as the effects of ECT made me rather agitated and confused. So

for most of the course I was an inpatient: I left hospital the day after my last treatment. I did not notice any positive effects until I had received my fourth ECT and then all of a sudden I could recognize me again. It may be difficult for anyone who has not experienced depression (or something similar) to understand what this means but there is definitely a point at which I wake up knowing I am 'me' again. It's an absolutely wonderful feeling that on both occasions has been mistaken for hypomania by my consultant psychiatrist ('How many sports cars have you bought Rachel?!'). No, it is not hypomania — simply delight at being 'me' again.

## AFTERWARDS

One of the most irritating after-effects of having had ECT is the behaviour of those people who are so convinced that it causes irreparable damage that they 'test' my memory with their questions, or quiz me and/or my friends concerning my state: 'Are you/Is Rachel *really* all right?', they ask in hushed and ominous tones, and apparently seem unpersuaded by the answer 'yes'.

Now I am able to think back on the experience, I do not for one moment regret having had ECT. I would choose it again if I became depressed. But there are things that I wish I had known or, more importantly, that my friends and allies had known, to assist me in the process.

The classic feminist line of regarding ECT as a single, awful entity is inadequate. Ironically, this was brought home to me when the consultant psychiatrist with whom I work asked me questions like 'What equipment did they use?', 'How many volts?', 'What anaesthetic?', 'What was the seizure length?'. My rather pathetic answer — 'I don't know' — was greeted with the response: 'Why ever not? I bet you know the name of the medication you're taking, the dosage, the side-effects; you really ought to know the same for ECT.' I was ashamed: I have worked in mental-health services for years and I did not know these things. It transpires that they are important questions, particularly for women.

## THINGS I SHOULD HAVE KNOWN

I knew that ECT 'works' by passing electricity through the brain and inducing a brief fit/seizure, but that was about all. I did not know, for example, the optimal seizure length is 20–50 seconds: anything over this is more likely to result in cognitive problems. Or that the aim is to use the minimum amount of electricity to obtain such a seizure: 'the unwanted cognitive side effects of ECT are directly related to the amount of electricity used to induce therapeutic seizures' (Lock et al., 1993). Or that different people have different 'seizure thresholds' (i.e. they require different amounts of electrical stimulation to produce a seizure).

Most notably (Lock et al., 1993), seizure threshold is about twice as high for men as for women and higher in older people than in younger people. The typical recommended starting 'dose' is 150 mC for women under 40, 200 mC for those aged 40–70, and 275 mC for those aged over 70. It is important to minimize the amount of electricity used in order to reduce cognitive side-effects. It is also important that nothing is done to

increase the seizure threshold. For example, I was given a 'pre-med' before receiving the ECT anaesthetic when I was hospitalized. I was not really 'with it' enough to ask what this was at the time but I should have done. Benzodiazepines (often used as a pre-med) increase seizure threshold. I should also have known what type of anaesthetic was being used: some, especially Propofol, increase seizure threshold.

Other important aspects include the type of ECT machine and current employed. If a sinusoidal wave form is used then more electrical stimulation is needed to produce a seizure — a brief-pulse current is preferable. Five out of every six British ECT clinics are equipped with ECTRON models of ECT machine: 'It is important to note that none of the ECTRON models presently in clinical use meet the requirements of a good ECT machine outlined in the 1993 edition of the Royal College ECT Handbook' (Lock et al., 1993: 8). The same document (Royal College of Psychiatrists, 1993b: 7) outlines how 'the problem with most ECT machines currently in use in Britain is that they have a narrow range of electrical output. The minimal output may be too high for individuals with low seizure thresholds, and these individuals will be at increased risk of cognitive side effects'. As I have already said, these 'individuals with low seizure thresholds' are likely to be women, especially young women, whose seizure threshold is half that of men.

There are numerous other guidelines concerning the layout and practices of ECT clinics and the safety equipment they should contain (Royal College of Psychiatrists, 1993a). The Royal College of Psychiatrists' survey carried out in 1991 revealed that although anaesthetic practice was good, general patient care and facilities were deficient in 20 percent of ECT clinics surveyed, and psychiatric practice was deficient in two-thirds — failing to meet even the minimum standards laid down in 10 percent of clinics (Pippard, 1992).

Unfortunately, this sort of information is not generally given to patients or to their friends and relatives (Royal College of Psychiatrists, 1993b), and although more of the debate is available in the MIND report of the area (MIND, u.d.) there are still important areas missing. At the time I had ECT I could not have understood or dealt with information of the type outlined here, but I would have liked those who were with me to have known what to look for on my behalf.

I have no doubt that ECT has the potential for abuse and has been abused; it has the potential to cause harm and has been harmful. I would hate to think that my writing about ECT in this way might be used to coerce people into having ECT against their will. I also know from my own experiences, and those related to me by others, that it can be beneficial. I reject the assertion that the potential for abuse renders anything, by definition, unacceptable. Most psychological therapies and most medications (both physical and psychotropic) can be harmful and can be abused. That harm and abuse can only be reduced if we are fully aware of the facts. Had my friends and allies been better informed about the details of the ECT I chose to have, I would have been in safer hands.

## REFERENCES

- Lock, T., Freeman, C., Benbow, S., Scott, A., McClelland, R. and Pippard, J. (1993) *Electroconvulsive Therapy (ECT)*, Transcript of the official video of the Royal

- College of Psychiatrists' Special Committee on ECT. London: Royal College of Psychiatrists.
- Pippard, J. (1992) 'Audit of Electroconvulsive Treatment in Two NHS Regions', *British Journal of Psychiatry* 160: 621–37.
- MIND (undated) *ECT Pros, Cons and Consequences*. London: MIND.
- Royal College of Psychiatrists (1993a) *ECT Handbook*. London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (1993b) *Electroconvulsive Therapy, Patient Factsheet*. London: Royal College of Psychiatrists.
- 

Rachel PERKINS is a lesbian feminist, consultant clinical psychologist, and co-author (with Celia Kitzinger) of *Changing Our Minds: Lesbian Feminism and Psychology* (New York: New York University Press and London: Onlywomen Press, 1993). She is Head of Psychology Services to Rehabilitation and Continuing Care, Pathfinder Community and Specialist Mental Health Services, Springfield University Hospital, Tooting, London SW17 9RP, UK.