

ELECTROCONVULSIVE THERAPY (ECT):
AN EXPLORATORY STUDY OF THE PSYCHODYNAMIC TREATMENT OF
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Abstract

Background: Electroconvulsive therapy (ECT) is widely used as a treatment for severe depression, mania, and chronic suicidality. An estimated 100,000 people in the United States receive ECT annually and its popularity within psychiatry is increasing. In recent years, scholars have focused their attention on investigating the neurobiology and electrochemistry of ECT. This has led to advances in technique and reduced side-effects. However, ECT has more than a discrete impact on mood and cognition; recipients must cope with treatment and assimilate the experience into their lives. **Aims:** The purpose of this study was to explore the unique impact of ECT on the psychodynamic treatment of recipients. The study was designed to help develop recommendations and strategies for working with patients to process the impact of ECT on their lives. **Method:** Case study methods were used to examine the experiences of five psychotherapists who had each treated a patient who received ECT while in treatment. **Conclusions:** Findings revealed that the decision, procedure, and outcome of ECT impacted the psychotherapist's treatment of the patient, the therapist's attitudes toward ECT, and the patient's experience of himself. Preliminary suggestions for psychotherapists working with patients who are considering or are receiving ECT are included.

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Electroconvulsive Therapy (ECT):

An Exploratory Study of the Psychodynamic Treatment of Recipients

Electroconvulsive therapy (ECT) is a reasonably safe and remarkably effective treatment for severe depression, mania, and chronic suicidality (Shorter & Healy, 2012). Its use is supported by over seventy years of research and is endorsed by the American Psychiatric Association (APA), National Institute of Mental Health (NIMH), National Institute of Health (NIH), U.S. Surgeon General, and World Health Organization (WHO) (John Hopkins Medicine, 2014). ECT is a somatic treatment in which an electric current is passed through the brain to induce a seizure. The therapeutic impact tends to be rapid though short-lived, with people often requiring repeated treatments to maintain symptom reduction. In the United States, an estimated 100,000 people receive ECT annually (Hermann, Dorwart, Hoover, & Brody, 1995; Shorter & Healy, 2012). However, ECT continues to be controversial and the mechanism of action remains largely unknown (Andre, 2009; Breggin, 1991; Fink, 2001, 2009; Read, 2010).

A Brief History of ECT

The story of convulsive therapy begins in early twentieth century Europe with Hungarian neuropathologist, Ladislaus Meduna (1896-1964). Meduna studied alterations in the neuroanatomy of people diagnosed with epilepsy as well as in people diagnosed with schizophrenia. Microscopic examination of brain tissue led Meduna to hypothesize that epilepsy is associated with an abundance of glia cells, whereas schizophrenia is associated with a scarcity of glia cells. Epidemiological research and clinical experience bolstered this hypothesis – epilepsy was uncommon in those with schizophrenia. Consequently, Meduna reasoned that epilepsy and schizophrenia were antagonistic disorders. This antagonism was the basis for convulsive therapy.

On January 24, 1934, Zoltan became the first person treated with convulsive therapy. Zoltan was diagnosed with a catatonic form of psychotic illness and had hardly spoken or cared for himself in four years. Meduna used a camphor injection to induce the seizure (Fink, 1984). After forty-five minutes of waiting for the camphor to take effect, Zoltan had a grand mal seizure lasting sixty seconds. Sadly, his symptoms persisted unchanged. Additional treatments were given in three- to four-day intervals. After the fifth treatment, Zoltan awoke and asked where he was. He slipped back into a catatonic state later that day. Zoltan's periods of lucidity grew longer with each additional treatment. After the eighth treatment, he returned home to work and to care for himself. Zoltan maintained his gains for many months, but eventually relapsed and required further treatment (Baran, 2008, as cited in Fink, 2009). (Abrams, 1992; Fink, 2001; Glen & Weiner, 1985; Kneeland & Warren, 2008; Shorter & Healy, 2007)

Metrazol (pentylentetrazol) soon replaced camphor as the induction agent; it was more water-soluble and acted more quickly. Regrettably, both Metrazol and camphor produced feelings of intense anxiety before the convulsion and frequently triggered spontaneous seizures for up to a week after treatment. Meduna reported (1937) that of 62 patients treated with Metrazol convulsive therapy – all of whom had schizophrenia and a poor prognosis – eighty percent experienced a remission. Other physicians employing Meduna's method reported remission rates of around fifty percent. Discrepancies aside, Metrazol convulsive therapy was effective. It was also safer and produced results more quickly than insulin coma therapy (ICT), the prevailing treatment for schizophrenia at that time. (Shorter & Healy, 2007)

Concurrent with the development of chemical convulsive therapy, electricity was being used to induce seizures in dogs for research purposes. Ugo Cerletti (1877-1963) and Lucio Bini (1908-1964) used electrically-induced seizures in dogs to study the involvement of the

hippocampus in epilepsy. When Cerletti learned of Meduna's success treating schizophrenia with convulsions, he realized that his electrical method of inducing seizures was applicable to the treatment of schizophrenia. To establish parameters for the safe use of electricity to induce therapeutic convulsions in humans, Cerletti and Bini experimented with pigs. In Italy on April 11, 1938, Cerletti and Bini administered electroconvulsive treatment to a human patient for the first time. Enrico X was a thirty-nine year old man with delirious mania. The first two applications of electricity failed to produce a convulsion. A third treatment successfully induced a grand mal seizure. Enrico X recovered from delirious mania and was discharged from the hospital on June 17, 1938, having received approximately eleven treatments (Fink, 2009). He was readmitted to the hospital after almost two years in remission (Shorter & Healy, 2007). In 1940, psychiatrists administered the first ECT treatment in the United States. ECT's popularity eventually surpassed that of Metrazol convulsive therapy due to the ease of administration and negligible lag time between application and seizure.

Convulsive therapies were practiced in an "unmodified" form: no muscle relaxant and no general anesthesia. Patients risked fracture and dislocation of the long bones, spine, and chin, as well as biting the tongue and lips (these risks were less pronounced with electrically-induced convulsive therapy than with Metrazol-induced convulsive therapy). Shortly after its discovery in 1952, the muscle relaxant, Succinylcholine, was put into use to minimize risk of physical injury. Administration of a general anesthetic (barbiturate) was added to this procedure to block the transitory sensation of being unable to breathe, which resulted from use of the muscle relaxant. These modifications changed ECT from a relatively inexpensive procedure that required only a psychiatrist and a simple treatment room, to a costly one that required a psychiatrist, an anesthesiologist, and a well-equipped surgery suite. For many state hospitals and

public sanatoriums, ECT became financially out-of-reach. A 1979 study conducted by the Department of Mental Hygiene of New York State concluded that “ECT is administered largely in non-public facilities to a relatively advantaged population of white, middle-class females whose treatment is covered by private insurance” (as cited in Shorter & Healy, 2007). (Abrams, 1992; Fink, 2001; Glen & Weiner, 1985; Kneeland & Warren, 2008; Shorter & Healy, 2007)

Development of the first effective antipsychotic drug (chlorpromazine) and its approval by the U.S. Federal Drug Administration in 1954 signaled the rapid ascendancy of psychopharmacology, dominance of biological psychiatry, and precipitous decline of ECT. By 1969, more than nineteen important drugs for schizophrenia were on the American market including, haloperidol (Haldol), perphenazine (Trilafon), and thioridazine (Mellaril) (Shorter & Healy, 2007). The first drugs to treat depression – tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) – were introduced to American psychiatry in 1959 (Shorter & Healy, 2007). Selective serotonin re-uptake inhibitors (SSRIs) – drugs like fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) – became available in the 1980s.

The decline of ECT within psychiatry coincided with increased public disapproval of ECT. Hollywood’s portrayal of ECT promoted an extremely negative view of the procedure. ECT became tremendously stigmatized (McDonald and Walter, 2001). The movie *The Snake Pit*, based on Mary Jane Ward’s 1946 novel, was released in 1948 (Litvak, 1948). The movie is essentially a case history of a woman who receives ECT during her stay at an insane asylum. The shock treatments are depicted as reducing her symptoms, though the procedure is portrayed as painful and a means of control by the staff of the asylum. The 1975 movie, *One Flew Over the Cuckoo’s Nest*, is probably the best known of the anti-psychiatry movies (Forman, 1975). It is based on Ken Kesey’s 1962 novel of the same name. In this movie, ECT is presented as “a

barbaric and unjustified tool for social control, but it is also totally impotent” (McDonald & Walter, 2001).

Until the 1990s, it seemed the combination of increased procedural costs, effective psychopharmaceuticals, and negative depictions in the popular media would prove the death knell of ECT. This conclusion appeared unequivocal – Bellevue Hospital in New York City cancelled its ECT program in 1962 (as cited in Short & Healy, 2007); ECT use in the U.S. decreased by 54 percent between 1975 and 1980 (Thompson, James, Blaine, & Jack, 1987); and ECT use at the Maudsley Hospital in London declined from 34 percent of all admissions in 1956, to 21 percent in 1968, to 5 percent in 1987 (Eranti & McLoughlin, 2003, as cited in Shorter & Healy, 2007). However, in time it became clear that a significant minority of individuals with mental illness did not respond to pharmaceutical treatment (Smith, 2001). This led to renewed interest in ECT (Kalinowsky, 1986). In 1985 the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH) held a conference on electroconvulsive therapy which concluded that “whilst ECT is the most controversial treatment in psychiatry and has significant side-effects, it has been shown to be effective for a narrow range of severe psychiatric disorders” (Abrams, 1992; Glen & Weiner, 1985; Kneeland & Warren, 2008). In 2003, Bernard Lerer, director of the biological laboratory of Hadassah University Hospital in Israel, gave voice to what is progressively becoming the conventional attitude within the field of psychiatry:

Have you ever asked yourself how it is that a treatment with such a terrible stigma, a treatment that the public is afraid of and is said to be primitive and unhelpful – has, despite all this, survived into the twenty-first century, and not in obscure little places but in the world’s most advanced medical centers? The answer is simple. Because it works. (as cited in Shorter & Healy, 2007)

Today, electroconvulsive therapy remains a controversial treatment. Some researchers uphold that “ECT is an effective and safe treatment for those with severe mental illness” (Fink, 2009), while others challenge the claim that ECT prevents suicide and find that the “cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified” (Read & Bentall, 2010). Commonly acknowledged side-effects include headache, backache, nausea, vomiting, memory loss, and impaired memory (Fink, 2009). Patients report different amounts of cognitive deficits and memory loss: some hardly notice an effect while others describe lasting cognitive deficits and up to eighteen years of retrograde memory loss (Donahue, 2000; Froede, & Baldwin, 1999; Sackheim, 2001). Dr. Harold Sackheim, a supporter of ECT, reported on a study he conducted in 2007:

When the dosage is too great or too frequent, patients can have grave memory loss and acute confusion. But if you do it properly, two or three weeks later patients have no sign of any cognitive problems except for an inability to remember the several hours before the treatment. (Sackheim, 2007)

Despite many years of research into the behavioral and biological sequelae of ECT, relatively few studies have looked into the subjective psychological impact of receiving ECT (Lindow, 1992; Myers, 2007). An extensive search of the professional literature revealed three qualitative studies that directly examined the psychological impact of ECT (Froede & Baldwin, 1999; Johnstone, 1999; Koopowitz, Chur-Hansen, Reid, & Blashki, 2003). A number of studies exploring patient and clinician attitudes and satisfaction, using qualitative and quantitative research approaches, were also discovered, but these were found to be of limited help in exploring the psychological impact of ECT on the recipient (Pettinati, Tamburello, Ruetsch, & Kaplan, 1994). One of the three qualitative studies mentioned above took a neutral approach to

participant recruitment, utilizing a convenience sample from a clinic database (Koopowitz, et al., 2003). The remaining two studies recruited individuals who had experienced adverse reactions to ECT such as feelings of fear, shame and humiliation, worthlessness and helplessness, and a sense of having been abused and assaulted (Froede & Baldwin, 1999; Johnstone, 1999).

Modifications in the Delivery of ECT

When ECT was first practiced, electrodes were placed on opposite sides of a patient's head and the energy level or voltage used was seemingly chosen at random. According to Sherwin Nuland (2001), who spoke with an individual present at the first use of ECT on a patient, the amount of electrical current and duration of application were chosen as follows:

They thought, "Well, we'll try 55 volts, two-tenths of a second. That's not going to do anything terrible to him." So they did that.... This fellow – remember, he wasn't even put to sleep – after this major grand mal convulsion, sat right up, looked at these three fellows and said, "What the fuck are you assholes trying to do?" Well, they were happy as could be, because he hadn't said a rational word in the weeks of observation. (Nuland, 2001)

Since its initial use, numerous methods of administering ECT have been tested – each modification applied with the goal of maximizing symptom reduction and minimizing adverse side effects. These modifications include variations in: electrode placement, stimulus intensity (charge), waveform (sine wave to square wave), pulse width (duration of stimulus), and frequency of administration (usually measured in number of administrations per week) (Waite & Easton, 2013). In the 1940s brief pulse replaced sinusoidal current in an attempt to reduce cognitive impairment and confusion. Unilateral, non-dominant electrode placement – one electrode is placed on the right temple and the other is placed on the top of the head – versus

bilateral electrode placement – electrodes are placed on opposite temples – was developed to further reduce cognitive impairment and confusion. Bifrontal electrode placement – both electrodes are placed on the forehead – was introduced as a method for further reducing cognitive impairment and confusion. Unfortunately, a broad trend seen with ECT delivery modifications is that a reduction in adverse side-effects corresponds to a reduction in treatment efficacy. (Abrams, 1992; Fink, 2001; Glen & Weiner, 1985; Kneeland & Warren, 2008; Shorter & Healy, 2007)

The Use of ECT in the Treatment of Mental Disorders

Use in Depression

I want to die. I can't believe I feel like this. But it's the strongest feeling I know right now, stronger than hope, or faith, or even love. The aching relentlessness of this depression is becoming unbearable. The thoughts of suicide are becoming intrusive. It's not that I want to die. It's that I'm not sure I can live like this anymore. (Manning, 1995)

ECT is often used to treat severe and drug resistant unipolar depression. Kellner, Pritchett, Beale, and Coffey (1997) write that “ECT remains the most reliably effective treatment for serious depression.” Most studies have found a response rate of 80-90% for major depression treated with ECT (Kellner et al., 1997). However, naturalistic studies show that the relapse rate during the six to twelve months following ECT exceeds 50% (Committee on Mental Health, 2002; Whitaker, 2010). West (1981) studied twenty-two patients with unipolar depression who had received either six treatments of genuine ECT or six treatments of “sham ECT.” Sham ECT included patient preparation, general anesthesia, and after care procedures. Depression was rated using the Beck self-rating scale and was also rated by doctors and nurses blind to treatment

groups. There was a statistically significant improvement in the genuine ECT group compared to the sham group.

ECT has also been found to be superior to antidepressants in the treatment of severe depression. Pagnin, de Queiroz, Pini, Cassano, and Battista (2004) found ECT to be significantly superior to simulated ECT, placebo, antidepressants in general, TCA's, and MAOIs. Additionally, in Janicak, Davis, Gibbons, Ericksen, Chang, and Gallagher (1985), the authors analyzed several rigorously controlled studies that compared the efficacy of ECT with that of simulated ECT, placebo, and antidepressants. In each of these instances ECT showed clear superiority over all these other forms of treatment for severe depression.

Studies looking at continuation ECT and antidepressants versus antidepressants alone have also been conducted. Gagne, Furman, Carpenter, and Price (2000) found that the outcome was significantly better in patients treated with antidepressants and continuation ECT than in patients treated with antidepressants alone. The cumulative probability of living without relapse or recurrence at two years was 93% for continuation ECT, and 52% for patients treated with antidepressants alone. Additionally, the cumulative probability of living without relapse or recurrence at five years was 73% for continuation ECT and 18% for patients treated with antidepressants alone. The mean number of years lived without a depressive episode were 6.9 for continuation ECT and antidepressant treatment and 2.7 for antidepressant treatment alone.

Use in Mania

“Manic intentions are always good; manic consequences, almost never” (Cheney, 2008).

In addition to its use in treating severe depression, ECT is also used to treat mania (Fisk, 2009). Mukherjee, Sackeim, and Schnur (1994) looked at lithium treatment versus ECT. In this prospective controlled trial of ECT thirty-four patients in a manic episode and with a diagnosis

of bipolar I were randomly assigned to receive a course of bilateral brief-pulse ECT or lithium. Patients treated with ECT showed a greater reduction in symptoms than those treated with lithium. This result was statistically significant at weeks six, seven, and eight. Additionally, study results shown that 80% of the patients studied achieved either marked clinical improvement or complete remission after treatment with ECT.

Small, et al. (1988) conducted a naturalistic study of ECT versus lithium in 438 patients. This was a prospective controlled trial of lithium versus ECT. ECT was associated with significantly greater improvement in symptoms than lithium on all rating scales used (brief psychiatric rating scale, clinical global assessment scale, and Bech-Rafaelson manic rating scale).

Use in Psychosis

“Consciousness gradually loses its coherence. One’s center gives way. The center cannot hold. The ‘me’ becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal” (Saks, 2007).

The ECT Handbook (2013), published by the Royal College of Psychiatrists’ Special Committee on ECT and Related Treatments, aptly states “claims for the efficacy of ECT in treatment-resistant schizophrenia would perhaps best be described as a triumph of anecdote over empiricism.” In 1953, Miller, Clancy, and Cummings took thirty chronic, catatonic patients with schizophrenia and administered either ECT or sham ECT. After three to four weeks of treatment, no differences were noted among groups for reduction of psychotic symptoms or for improvement in social performance. Likewise, in 1964, Heath, Adams, and Wakeling studied forty-five individuals with chronic schizophrenia: after one month of ECT or sham ECT, no differences between groups were noted. Taylor and Fleminger (1980) studied twenty individuals

with paranoid schizophrenia. Those who were chronically ill were excluded. Each individual received eight to twelve genuine or sham ECT treatments and low dose chlorpromazine. Those receiving genuine ECT had lower scores on the comprehensive psychiatric rating scale (decrease in symptoms) at two, four, and eight weeks, but not at one month after the treatment course ended. Because half of the patients studied also had clinical depression, it is difficult to discern if these positive results are due to a positive effect of ECT on paranoid schizophrenia or due to ECT's known effect on depression. Additionally, a recent meta-analysis of 443 studies found evidence to support the efficacy of ECT treatment of psychosis in the short-term (up to approximately six weeks post-treatment), but no evidence to show any long-term improvement in symptoms (Tharyan & Adams, 2005). In summary, current research suggests that ECT should only be considered an option in treating schizophrenia and catatonia when pharmacotherapy has been shown to be ineffective or intolerable.

ECT Administration: A Patient's Experience

My first ECT is scheduled for tomorrow morning. I am frightened because it sets me on a course from which I cannot turn back. More than losing my memory, I am terrified that I will lose the last remnants of myself. (Manning, 1995)

The patient's experience of ECT usually begins with the process of informed consent. The informed consent process includes, at a minimum, written material explaining the procedure and possible adverse effects of the treatment. At some locations, narrative accounts of previous patients and a video detailing the procedure are included in the consent process. In addition to informed consent, the patient also requires medical clearance. After the informed consent is signed and medical clearance is granted by the supervising physician, the patient is ready to receive ECT. ECT may be given on either an in-patient or out-patient basis.

The patient is asked not to eat or drink anything the morning of treatment. An attendant greets the patient and takes them to “prep.” In “prep,” the patient is put on a gurney and an intravenous line is started by a nurse. When space in the treatment room becomes available, the patient is wheeled into a treatment alcove and hooked up to various devices used to measure heart rate and rhythm, blood pressure, oxygenation, and brain activity. A gel-like substance used for conducting electricity is placed on the patient’s head where the stimulus electrodes will be placed. A mouth guard is placed in the patient’s mouth to prevent him from biting his lips and tongue during the seizure. An anesthesiologist and the attending psychiatrist enter. The anesthesiologist gives the patient a short-acting general anesthetic and the patient quickly loses consciousness. A muscle relaxant is then given to prevent muscle contraction during the seizure. The patient stops breathing on his own and positive pressure ventilation is used to maintain the patient’s blood oxygen levels.

At this time, the psychiatrist places the stimulus electrodes on the patient’s forehead and/or temples, sets the ECT device to the desired specifications, and pushes a button which signals the transmission of a specific amount of electricity through the stimulus electrodes to the patient’s brain. If the amount of electricity is sufficient (reaches the patient’s seizure threshold), the patient experiences a therapeutic seizure as measured by brain activity on an electroencephalogram (EEG). As a result of the muscle relaxant, the patient’s muscles do not contract and the patient’s body is still throughout the procedure. Seizure activity usually stops within fifteen seconds.

Still unconscious, the patient is taken to a recovery room. When the patient first regains consciousness, he is often so disoriented as to not remember his name or where he is. Patients tend to be oriented to person, place, and time within an hour of the treatment. Analgesics (ex.

aspirin) may be provided to prevent post-ECT headaches. When they are deemed ready, the patient is either discharged to an inpatient unit or to a family member or friend, depending on whether the procedure was conducted on an inpatient or outpatient basis. The patient will often find himself slightly disoriented for the rest of the day, frequently with an extreme headache. As previously mentioned, anterograde and retrograde memory deficits, as well as cognitive deficits, may accompany treatment.

Psychological Impact for Recipients

Over the next few weeks, my ECT treatments continue three times per week. With each treatment, I could feel myself slowly but steadily being released from the grips of the Beast...The darkness began to lift. (Kivler, 2010)

Imagine you wake up tomorrow with your past missing...Eventually you realize that years of your life have been erased, never to return. Worse, you find that your daily memory and mental abilities aren't what they were before. You are somehow slower, less sharp, less able or unable to resume your former work. With the integrity of your life destroyed, you no longer know who you are. When you say what happened, no one believes you. (Andre, 2009)

Despite many years of research into the behavioral and biological sequelae of ECT, relatively few studies have looked into the subjective psychological impact of receiving ECT (Lindow, 1992; Myers, 2007). "What is never discussed in the literature is the profoundly damaging psychological effects ECT can have" (Lindow, 1992). An extensive search of the professional literature revealed three qualitative studies that directly examined the psychological impact of ECT (Froede & Baldwin, 1999; Johnstone, 1999; Koopowitz, Chur-Hansen, Reid, & Blashki, 2003). The primary paper cited in this regard is Johnstone (1999). Johnstone looked

specifically at adverse psychological reactions of twenty people who reported having found ECT upsetting. Individuals were recruited by posters and flyers distributed through local mental health voluntary organizations asking, “Have you been given ECT? Did you find it upsetting or distressing in any way?” Twenty-two people responded and twenty were found to fit criteria. There were twelve women and eight men with an age range of twenty-seven to sixty-three years. Nine of the participants reported that they had had more than one course of ECT. Six of the participants had had at least one course of mandated ECT. The most recent course of ECT was two to five years ago for five participants; five to ten years ago for five participants; ten to twenty years ago for six participants; and twenty to thirty years ago for four participants. Two participants described themselves as mixed race. The rest described themselves as white. Semi-structured interviews were conducted with each participant and the results were transcribed and submitted to thematic analysis.

Johnstone organized the themes pulled from twenty qualitative interviews under nine main questions: (1) “What were the circumstances in which you came to have ECT?” (2) “What kind of explanation were you given?” (3) “Why did you agree to have ECT?” (4) “What was the actual experience of ECT like?” (5) “What other emotional or psychological effects has ECT had on you?” (6) “Did ECT have any beneficial effects?” (7) “Did you tell anyone how you felt about ECT?” (8) “What other forms of help would have been more appropriate instead of ECT?” (9) “What are your overall views about ECT?” For question one, “What were the circumstances in which you came to have ECT?” Johnstone notes that participants described their mental states at the time of treatment in standard psychiatric terms (“I’m diagnosed as manic-depressive”), but that as the interviews progressed, more complicated stories began to emerge (“I knew when I was growing up that I had some problem”). Under the second theme, “What kind of explanation

of ECT were you given?" the author notes that nearly everyone found the explanation they were given to be lacking or altogether non-existent ("I don't remember anything being explained"). For question three, "Why did you agree to have ECT?" Johnstone writes that the decisions of participants "[lay] in their feelings of extreme desperation and powerlessness" ("I was just looking for answers as to why I was so strange, so peculiar.") and that this powerlessness was often coupled with a feeling of 'doctor knows best' ("you didn't disagree with doctors, you did what they said" and "part of depression is losing your sense of self really, and you're so easily influenced and so easily willing to accept authority"). Under the fourth theme, "What was the actual experience of ECT like?" the author writes that six participants did not experience ECT as particularly frightening, while the remaining fourteen reported a high level of fear ("I was absolutely terrified... I imagined great big metal things being put each side of my head and, like, sparks coming out" and "sitting in the room waiting for treatment... it was almost like a pre-execution room really"). Johnstone further writes that the most commonly mentioned frightening aspects of receiving ECT were "feelings of being helpless and out of control, and worries about long-term damage." For question five, "What other emotional or psychological effects has ECT had on you?" the author writes that participants experienced a great variety of responses including feelings of shame and stigma, "humiliation, increased compliance, failure, worthlessness, betrayal, lack of confidence and degradation, and a sense of having been abused and assaulted" ("It made me feel like a cabbage, like I wasn't worth anything at all," "It made me feel like a freak," "ECT I feel is just such a betrayal," and "I was deeply, deeply ashamed of having ECT... this was real serious stuff, this was a mad person"). Regarding question six, "Did ECT have any beneficial effects?" Johnstone reports that eleven participants noted at least some temporary relief from depression ("everything had been tried... Perhaps I felt the ECT gave me

permission to get better”). Under the seventh theme, “Did you tell anyone how you felt about ECT?” the author notes that most participants felt unable to tell the psychiatrist or psychiatric staff about their strength of their psychological response to ECT (“you can’t be angry with them. People who are, get a really bad time”). For question eight, “What other forms of help would have been more appropriate instead of ECT?” Johnstone writes that nearly all participants felt “that ECT and all its disadvantages could have been avoided had the right kind of counseling and support been available instead” (“I needed someone to talk to more than anything”). Regarding the last question, “What are your overall views about ECT?” the author reports that fourteen of the participants felt that, though they would never receive ECT again, that it should be available as a last resort for people to make their own informed decisions. The six remaining participants called for a total ban on the procedure (“I suppose if users feel it might benefit them, then go ahead;” “It’s just not, in my view, an ethical way to proceed;” and “Quite barbaric, really, barbaric to put electric shocks through people’s heads”).

Johnstone (1999) concludes that “organic therapies do carry meanings, and that these meanings, filtered through the individual’s own background/context and interpretations, influence how such therapies are experienced.” Johnstone goes further and questions whether or not ECT may exacerbate some patients’ underlying psychological problems.

A second paper discussing the psychodynamic effects of ECT is Froede and Baldwin (1999). In this paper, the authors begin with the statement that a controversy exists as to “whether or not ECT is a ‘beneficial’ treatment.” Froede and Baldwin analyzed eighteen testimonies of “ECT survivors” and drew out eight main themes: fear, physical symptoms after ECT, consent, memory loss, attitudes towards ECT, degradation/dehumanization, control, and information about treatment. The eighteen testimonies were obtained from public hearings held

in Toronto (Canada) by the Ontario Coalition to Stop Electroshock (OCSE). The public hearings were intended to provide an opportunity for individuals who received ECT to voice their experiences and opinions on ECT. The hearings were held on three consecutive Saturdays and eighteen people who had received ECT testified. Nine were female, eight were male, and one was unknown. Ages were not specified, neither was the number of years since the last ECT treatment. Content analyses of the testimonies resulted in the eight themes mentioned above.

The first theme, fear, involved fear of the treatment itself and fear of the stigma resulting from having received ECT. Froede and Baldwin (1999) record quotes such as “I felt like I was dying every time one of them was administered” and “I am afraid to come out and talk about electroshock because it instantly makes [me] have a stigma.” Theme two, physical symptoms, included statements such as “I was a complete vegetable for two years.” This theme also encompassed loss of artistic abilities and artistic performance (“For artist and writer the main source of inspiration is her imagination and emotion. These important values electroshock destroyed.”) The third theme identified by Froede and Baldwin is memory loss. The authors found that all those who testified experienced memory loss, some more severe than others. One individual stated “I lost nearly 18 years of my memory.” Another said, “It’s taken me thirty years to find out what happened, because the shock erased everything that happened before and after the treatment.” Theme number four is consent. The authors note that some individuals gave consent because they thought it would be beneficial, while others objected to ECT, but had family members who consented for them (“I didn’t sign any paper, it was my husband’s signature”). Control is the fifth theme. The authors found that most people did not feel they were in control of the situation or their life (“I never felt so helpless and vulnerable in all my life”). The sixth theme identified by Froede and Baldwin is degradation and dehumanization

(“it’s degrading, it’s humiliating”; “I totally felt like an animal and a victim of a crime”). The authors identified theme seven as information about treatment. They purport that most patients did not know the process nor what would happen after ECT (“I had no idea of what ECT is about,” “They never described what would happen to my memory or how you function afterwards” and “He explained to me that electroshock treatment is supposed to be like banging on the top of a television set – when it gets out of focus, you bang on the top and it goes back into focus”). The last theme in Froede and Baldwin is attitudes towards ECT use. Out of the eighteen former patients in this study, only one saw ECT as a useful form of therapy. The other seventeen former patients viewed ECT negatively (“I would never, ever want shock treatment again”; “I wouldn’t wish it on a dog”; and “ECT makes the problem much bigger than it was”).

Froede and Baldwin (1999) discuss whether ECT should still be administered from a patient perspective versus from the more common professionals’ perspective. They posit that “ECT is not a form of healing, but instead the cause of more damage” and conclude that “ECT is invasive and destructive and should be prohibited.”

The most recent study found on the subjective experience and psychodynamic effects of ECT is an article from 2003 by Koopowitz, Chur-Hansen, Reid, and Blashki. In this study, semi-structured interviews were conducted with eight former patients. Each of these individuals had received a course of ECT between July 1997 and June 1999. The age range was twenty-five to fifty years with a mean of 35.4 years. Five individuals were female, three were male. This was a sample of convenience: ten patients were chosen from a population of fifty-five “on the basis of their contactability by telephone and letter, their willingness to communicate with the researchers, and capacity to present for interview.” Individuals were also chosen to provide a range of psychopathologies and indications for ECT, as well as variable outcomes. The

interviewers were blind to the psychiatric history of the participants and had no previous contact with them. Eight of ten individuals showed up for the interview. These interviews were then subjected to structured analyses and four prominent themes were identified. These themes are fear of ECT, attribution of cognitive decline and memory loss to ECT, positive ECT experiences, and patients' suggestions.

The first theme identified by Koopowitz, Chur-Hansen, Reid, and Blashki (2003) is fear of ECT. The authors note that the word "scary" was frequently used to describe the actual procedure of ECT. One participant stated he still had nightmares three years post ECT ("to this day I still dream about it. Bolt upright, sweating in bed"). Other reasons mentioned for fear of ECT include: fear of not waking up from the procedure, fear that it would induce personality change, and fear of brain damage. The second theme identified by the authors is the attribution of cognitive decline and memory loss to ECT. Seven of the eight participants noted some form of memory impairment. Of these, some also felt that ECT had affected overall cognitive function ("I think the ECT had an effect on my brain, I feel stupider"). Attribution of memory loss and cognitive decline to ECT did not universally lead to a negative opinion of ECT. The authors write that some patients felt that memory loss was ECT's mechanism of action ("You lose your memory so you don't know what you're unhappy about" and "I still don't know whether the treatments just made me forget how much I wanted to die"). Positive experience of ECT is the third theme identified by Koopowitz, et al.. The authors note that some patients reported feeling positive emotions directly after ECT ("I felt so good and I thought, if this can happen, it's really terrific, I can work this world out") and others reported that ECT had a positive impact on their sense of self ("I started feeling like my old self again"). The fourth and final theme identified by the authors is patients' suggestions. The authors write that the

participants reflected on what would make ECT a more positive experience for future patients. Four principle suggestions developed: (1) decrease the waiting time prior to each procedure, (2) staff should be made more aware of the discomfort of the procedure, (3) patients should not be exposed to the discomfort of other patients in the general recovery room, and (4) there should be more research into what patients actually experience. The authors of this study conclude that “there is a need for future research in order to explore and address patients’ experiences of ECT.”

Current Study

The purpose of this study was to explore the unique impact of electroconvulsive therapy (ECT) on the psychodynamic treatment of recipients. This study was designed to help develop recommendations and strategies for working with patients to process the impact of ECT and assimilate the experience into their lives. This line of inquiry is founded on the belief that, as Abse and Ewing wrote (1956), “there are crucial psychodynamic events involved in...organic therapy.” Unlike other studies, this study did not specifically recruit participants with a negative view or experience of ECT.

Methods

This study uses a multiple case, holistic design (Yin, 1989). Qualitative data gathered from semi-structured interviews were analyzed using content analysis methodology in order to identify common and unique themes (Fishman, 1999).

Participants

Five participants were recruited through advertisements on state psychological association and psychoanalytic institute listservs. Advertisements were neutral with regard to recruiting participants with a particular view or experience of ECT. Participants were three

licensed, doctoral-level psychologists and two licensed, master's-level therapists, all currently in private practice, who defined their primary therapeutic approach as psychodynamic or psychoanalytic. This group consisted of four males and one female, with an average age of 52.2 years-old (range 36 to 68 years-old). The five participants averaged 23.4 years in practice with a range of 12 to 38 years. All six psychotherapists had post-graduate training from a psychoanalytic training institute. Four of the five had more than six years of post-graduate training at a psychoanalytic institute; one participant had two years of post-graduate training and was in the process of completing a psychodynamic psychotherapy training program at an institute for psychoanalysis. Regarding previous experience or exposure to ECT, three of five participants reported no previous experience or exposure to ECT. Two of five participants reported prior experience of ECT: one participant described a volunteer experience during college at a psychiatric hospital that provided ECT; the other participant noted having a close family member who had received ECT many years ago. Three of the five therapists treated the patient of interest before, during, and after the patient received ECT; the fourth therapist treated the patient of interest during ECT; the fifth therapist began treating the patient of interest within a week of the patient completing ECT.

Measures and Data Collection

Participants were interviewed using a semi-structured qualitative interview (see Appendix C). This protocol included a series of open-ended questions and prompts related to four primary areas: 1) the therapist's understanding of and training in ECT, 2) the therapist's conceptualization of the impact of ECT in treatment, 3) the therapist's reflection on the patient's experience of ECT, and 4) the therapist's reflection on their own experience of treating patients who received ECT. Each interview lasted approximately seventy-five minutes and was

audiotaped and transcribed for subsequent analysis. Additionally, a demographics questionnaire (see Appendix B) was administered at the beginning of each interview to gather information regarding participant demographics and professional experience, as well as patient demographics and ECT experience.

Data Analysis

Data collected through semi-structured interviews were analyzed qualitatively using content analysis methodology. The first phase of data analysis involved scrutinizing the interviews for emerging ideas and concepts. General categories and common themes were extracted from the interviews in order to categorize interview data into smaller subsets of data (McCracken, 1988). Related categories were then grouped into sub-categories of a larger group. Subsequently, the interviews were compared to each other to identify common and unique themes. The ideas and concepts found to occur most frequently across interviews are highlighted in the results section.

Results

The main focus of this study was to discern the unique impact of ECT on the psychodynamic treatment of recipients. This study was designed to help develop recommendations and strategies for working with patients to process the impact of ECT on their lives. ECT has more than a discrete impact on mood and cognition; recipients must cope with treatment and assimilate the experience into their lives.

The therapists who participated in this study had extensive experience in psychodynamic psychotherapy and were currently, or had recently, treated a patient who had ECT at the time of treatment. The patients discussed (one male; four females) had an average age at ECT treatment

of 31 years-old (range of 20 to 54 years-old) and had received an average of 13.2 ECT treatments (range of 2 to 30 treatments). Four of the patients received ECT as outpatients, while one received ECT as an inpatient. For each of the five patients discussed, ECT had been prescribed to treat severe depression and unremitting suicidality. The patients discussed had been in treatment with the participant/psychotherapist for an average of 5.4 years at the time of the interview (range of 1 month to 15 years). Occupations of the patients included professional dancer, college student, two Ph.D. candidates, and unemployed. Four of the five patients reported a history of physical, sexual, or emotional abuse.

All participants/therapists described how the decision, procedure, and outcome of ECT impacted their treatment of the patient, their attitudes toward ECT, and the patient's experience of himself. Content analyses of the interviews identified six major themes. These themes were: deciding on ECT, experience of ECT administration, beneficial effects of ECT, negative effects of ECT, implications for psychotherapy, and guidance for other therapists. Each major theme was broken down into several sub-categories for clarity.

Deciding on ECT

Participants described how they and their patients thought about the decision to receive ECT. This theme is divided into four sub-categories are presented below. These sub-categories are: prior knowledge of ECT, desperation as a motivating factor, trust in the psychiatrists' recommendation, and informed consent.

Prior Knowledge of ECT

I'm sure I read a paragraph or two in some book.

The only thing I knew about ECT was in my undergraduate abnormal psychology course where they mentioned it briefly.

One of my very close friends in graduate school was writing his dissertation on ECT specifically....It was over 20 years ago....I've also had a few patients who've had [ECT] in the past,...but it was something that they had reported to me. I didn't (try to learn about ECT on my own), I hate to say....At that time I was seeing too many patients.

It's so hard to know and I hadn't had any other experiences with it and [the patient] hadn't so we were sort of together in trying to just hang-in through the education process as she made her ultimate decision. And then see how it went....It was a combination of inadequate information or scary overabundance of information.

My father had ECT when I was a teenager. He had major depression.... I don't know if a whole lot was explained to me. It was very strange for me. I certainly know that he got better, it worked, but at that time I didn't really learn anything about it. I became aware of it as a thing, I guess as a psychiatric treatment, but I didn't know anything about it and probably didn't want to know anything about the details.

Desperation as a Motivating Factor

She knew she needed help and she had to get it....You don't do it unless you're driven to that last resort.

She was sort of desperate for a while....She had a hospitalization and she was feeling like suicide was a possibility and she just felt like she had to do something....I don't know that there was any option that we didn't try.

She agreed to the procedures... because her depression and suicidal ideation was feeling overwhelming and she did not see any way out of it. We had been working together for two and half years and she had tried many medications not only in this treatment, but in the past and she really just seemed to be intent on killing herself....Her suicidal ideation was becoming more severe and concrete and she had a plan and had means by that time.

I think ECT made a lot of sense for him because he'd been on every medication in the book. The only thing I might have wanted to do with him, if it were possible, would be more intensive psychotherapy, but I'm not sure that that would have been transformative....There didn't seem to be other alternatives...It was a product of desperation.

Trusting the Psychiatrist

I asked [the patient] what made him more hopeful about treatment the second time. He said, "I liked and trusted the ECT doctor."

The psychiatrist at her university counseling center...suggested it, which was shocking to me and the patient at first, but I certainly kept an open mind, especially liking her and the psychiatrist....The psychiatrist was really progressive and was good about keeping in touch with me, was responsive.

I trusted the psychiatrist.

I had been in, in close communication with the psychiatrist who was prescribing to her and we talked about the specifics of his opinion. He had a lot more experience with ECT than I did and he was very strongly positive about ECT for her and basically said to me, if she were his family member he would absolutely 100% recommend ECT and that made an impact on me.

Informed Consent

Yes, [the patient gave fully informed consent] because she had had ECT in the past and knew what the potential risks were....Now after the fact I would say that I don't think that she does feel that way. I think because her memory impairment was so severe that if she had known beforehand she may not have agreed to the procedures.

[The patient] said that the procedure was explained to him, but the environment in which it took place wasn't described to him before he began treatment. He said that, had he known how it would be given, or the environment in which it would be given, he might have changed his mind.

Absolutely, yeah, when all was said and done [she gave fully informed consent]. It was a big decision....We really struggled together with that.

Experience of ECT Administration

Participants described how they and their patients reacted to the actual experience of ECT administration. This theme is divided into four sub-categories presented below. These sub-categories are: feelings of fear and re-traumatization, symbolic suicide, impersonal treatment, and relationship with treatment providers.

Fear, Terror, and Trauma

At this first hospital...he said it was so horrific he didn't go back to that hospital. The room was the size of a gym; there were beds all over the place....He said it was a room with fifteen beds lined up, with little curtains, and they went from bed to bed anesthetizing patients. He could hear people crying, nervous, waking up feeling awful. He said it was terrifying.

(Describing patient's experience at a second hospital...) So you don't break bones, you're given anesthesia, but if it wears off first before you wake up, then you feel you're suffocating. He said that was not explained to him the first time, and so that's what happened, apparently. It wore off before he woke up, and so, when he woke up, he thought he was going to die and he wasn't able to say anything because he was having difficulty breathing.

I did not know what was coming. This was really existentially terrifying for her and for me.

I think that I was feeling worried about this treatment as well. I didn't know anything about it. I didn't know what she was going to have to go through. I wanted to meet the psychiatrist who was administering the ECT or the one who was the director of the program. I wanted to get my own reassurance from them that this wouldn't be harmful to her. I wanted to see what it was going to be like for her, so I guess you could say for my own comfort with recommending or going along with the recommendation.

You could think of it as a re-traumatization.

When she [became] more alert the following sessions, she was shocked at how unaware she was when she first saw me. I think that because she was a victim of sexual assault, that she was vulnerable and realized that she was vulnerable when she was having those cognitive deficits...[She described it like a] sexual trauma: "I was laying on the gurney, the bed, and just being poked and prodded."

Symbolic Suicide

The loss of control that goes into when the general anesthesia is applied – the symbolism to that. [It was symbolic to] the patient of dying; a little bit of hitting death each time.... She had very mixed feeling about going under – the anesthesia part to the ECT. In one respect it represented the death that she was longing for at the time and in another respect it scared her because of the death that it represented.

Impersonal and Dehumanizing

She felt like she was dealing with people who didn't even remember who she was. They didn't know the course of treatment. They couldn't even respond to her individual case and it really pissed her off...She's sitting down with someone who truly doesn't, they weren't even aware of what the current frequency was or when she started...a major frustration.

She didn't imagine that she was important to the staff on the unit....It further made her feel dehumanized.

He was uncomfortable and he was treated so impersonally and made to wait for hours for treatment. He arrived at 7:00 and went in at 10:00, and he sat there with his IV and shaking while people were groaning and vomiting.

Relationship with Treatment Providers

I assumed that they knew what they were doing and that there were able to gauge [ECT] and discuss it themselves. I didn't know anything about what they were doing....If I had called the psychiatrist and said, my god, do you know what you're doing to this poor girl?

I just don't think they would have paid any... "oh, what does he know, he's just a mental health person."

[The patient] explained how sensitive he was to the treatment. This is before he got the treatment, I guess, in talking to the doctor. He told them that one second was sufficient to product a seizure, because that's what they had done at the other hospital. The guy at this hospital did four seconds in spite of what my patient told him....It was hard to hear that his experience was so awful....It made me feel angry at the psychiatrist who hadn't properly prepared him.

I actually did have calls with the staff to give them feedback about how she was doing. I felt that it really went quite well, better than I expected, in fact. They were very respectful of me. They were very accessible; at least the staff people were accessible. You did not necessarily get the psychiatrist always, but I was always able to give him feedback through one of the nurses about how she was doing. They always took my feedback. My patient's spouse and I were very careful to also communicate about her cognitive functioning and the level of impairment. When we felt that the impairment was too severe, I would call the center and they would cut back on the concentration of sessions of ECT.

It felt like a little bit of a relief...that there was another team of professionals working to help her.

Beneficial Effects of ECT

Four of five participants discussed the beneficial effects of ECT for their patient. This theme is divided into three sub-categories presented below. These sub-categories are: impact on symptoms, validation and care, and hope.

Validation and Care

It confirmed for her that nothing was working and she was in a lot of pain and maybe her parents weren't taking it seriously until she needed shock treatment.

It definitely was validating to her sense of her feelings of depression and her wishes to die; it validated the fact that she was really, really depressed.

He found it validating, in contrast with...his family's idea that he was just grumpy...It was validating for him, but apparently his family, it didn't really affect their perception.

One impact [of ECT] was that she then really required more care and attention from her spouse, who was also stressed by a lot of things as well, but she really did come through and she did provide the care and attention that my patient needed including taking time off from work to drive her to and from the sessions and being there to take care of her when she returned home.

Impact on Symptoms

It's hard to attribute [the decrease in symptoms] to anything else...it was just so drastic.

He did feel better the first time for a very short time....He noticed a real difference, but it only lasted for a day or two.

She did a really good course [of ECT] and got a lot out of it. It's been an incredible amelioration of the depression...unbelievable, I mean really pretty quick...and it far exceeded my patient's expectations. I mean who would have expected for this long without any meds to be really depression free and going through some pretty tough times.

[ECT] was worth it because he found out that it wasn't for him. Otherwise, he would have wondered, "might I benefit from ECT?"

Hope

I think I reacted with hope that this could, that this could potentially really be helpful to her. I was hopeful.

I think it made her feel that we were going to try anything to help her and that it could be tried again – that she wasn't a hopeless case.

I think she feels more of a sense of resilience just sort of in her own right and that she could have it again if she needed it because it was so effective.

Negative Effects of ECT

All participants identified negative effects ECT had for their patients, regardless of the efficacy of the treatment in reducing symptoms. There was a wide range in the severity and permanence of these negative effects. The theme of negative effects of ECT is divided into three sub-categories presented below. These sub-categories are: cognitive impact, hopelessness, and shame and stigma.

Cognitive Impact

There was a little bit of headache and maybe tiredness....She was also a little bit fuzzy, maybe slowed down.

The side effects were less than either of us were expecting.

The patient told me in the course of her treatments that she was becoming more and more confused as a result of her ECT treatments and it was all she could do to find the office driving herself there. She just could hardly drive herself to the office; and she was getting more and more confused and I could see it.

She's the one that has had to live with the memory impairment. It's been incredibly painful for her to not have access to the memories that she lost during the treatment and I think that she might even say, and she would certainly be able to convince me, that there are other ways to achieve the same goal [symptom reduction]. She lost a couple of years of memories that she had accrued prior to the ECT and then about six months after the ECT... I think mostly historical memory. She lost also what she had learned in graduate school, though that seemed to have come back a little bit better than the events that she can't remember of her life. Some of the significant ones are the birth of her child. I would say two or three years of memory that she doesn't have.

He temporarily felt better from both treatments, but he felt that with both treatments... he ended up with brain damage....The brain damage he's talking about is he feels his memory hasn't been the same and it's harder for him to be coherent. I haven't really noticed that myself, but he feels pretty sure about it.

Hopelessness

She didn't feel it had any longstanding effect on her. It only added to her feeling of hopelessness and helplessness and that nothing was going to help her. She was really lost in her own internal world and unable to connect and really see that somebody else can offer her something.

She felt like it was just destroying her....The ECT treatments...they were deleterious in their effects....I was dismayed....I was hoping that it would lead to progress and she was going the other way. It was retrograde in its effect.

Shame and Stigma

It did feel somewhat distressing [to the patient] to have to be a recipient of ECT yet again. Just that nothing else was working or helping and that she had to have such an extreme kind of treatment in order to even be able to maintain her life.

She took that in stride because her symptoms were so serious, I don't think she worried about the label.

It was hard for her to tell her current partner that she had had ECT. Eventually she did. But it was a while. There was a lot of shame and it was a while before she really went into the details of her depression and also the ECT....She didn't even communicate with her own parents about much of it. They found out by accident. She was pissed. She wanted that independence. She didn't want to worry her parents and they...were freaked out...she didn't want that kind of contact and got it anyway.

She was so confused for a week. She was embarrassed that her friends and family were like, “what’s wrong with you? Why are you so confused?”...She was ashamed. I think she felt vulnerable. I think that it made it more difficult for her to connect.

Implications for Psychotherapy

Participants were asked to consider how their patient’s ECT interacted with the treatment process. Each participant identified specific implications of ECT to psychotherapy. The theme, implications for psychotherapy, is divided into five sub-categories presented below. These sub-categories are: ECT as a topic in therapy, effect of ECT on therapy process, ECT and patient dynamics, ECT and countertransference, and changing attitudes about ECT.

ECT as a Topic in Therapy

He had a lot of life issues to address. The patient's ECT was seen as an adjunct treatment. It became an issue only because of how problematic it was and because it didn't work.

I said, “I understand you’ve been having some ECT treatments,” and she said, “yeah.” And I asked her how it was going and she told me. Then we just talked about the depression mostly....We were focusing on the depression and her symptoms and so forth and how the [therapy] was helping or not.

ECT quickly receded as a major topic of therapy pretty soon after she stopped.

It’s kind of like dispensing medication. You say, “how are your meds doing,” and we talk a little bit about it. Then we go on with the therapy. So it’s not the focus because I’m not the person who administers the ECT and evaluates the result.

Impact on Therapy Process

I couldn’t do an initial assessment because she was so confused and she didn’t really have much of a memory of anything past the last few days...I was more compassionate and more reserved with my questions so as to not make her feel more confused.

I think at that point it was more a matter of providing support, empathy. I don’t think he was in a place where he could do more analytic work.

We talked about how scared she was and I think my decision [to accompany her to ECT] was mainly based on trying to help her get through it the best way I could.... There are times when I break the frame for extenuating circumstances and this was definitely one.

ECT and Patient Dynamics

She might've kept me more at a distance because she might've seen herself as just a, that I wasn't really a, I was one of the doctors that was just seeing her as a patient and not a person.

As there is with a lot of people who've been traumatized and abused,...it's hard for him to trust that others are going to have his best interests at stake and heart and are going to take care of him. I think when something does go wrong he is very reactive because it does activate old feelings. It lands on that part of him that's scared.

It also, I think, helped me understand ... just how vulnerable he is and the conditions that he needed to feel treated well. You have to be exactly right....and when he has those few exceptions he is very powerfully ... he's very grateful and very ... even moved.

About the ECT, well then the next challenge was how to work with the fact that she had so much memory lost and also cognitive deficits....So just the practical issue of how to help her not feel discouraged about those things and not falling into a deep depression about that.... [There were] a lot of things that I would have to remind her of or ask her if she remembered and then I would just come right out and tell her the things that she didn't remember. There was a lot more talked about, about memory loss as a real loss for her in her life.

ECT and Countertransference

What first comes to mind for me is that the ECT contributed to making this patient extremely unique and special to me in a lot of ways and maybe even took the place, in her mind, of having to be special by threatening suicide... everything is always multi-determined, multi-layered, but there certainly is that part of [her decision to have ECT that is related to] getting care, getting extra care, becoming truly unique and special in some real life ways, having me demonstrate that to her. Those are all certainly wishes that she had and they certainly did come true.

There was a sense a frustration and powerlessness because I wanted to be able to do more. I wanted to be able to help him transform himself, and feel a lot better....He's been through many medicines, and nothing had done a whole lot, so this was, in some sense, a last hope. I think that the ECT might have intensified some of that feeling for me, and I may have done some work...both my own and with him....I think those feelings ... led me to question how helpful treatment was, the therapy, and talk to him about it. I also got some consultation and tried different things based on the consultation.

It's really an honor to be involved in somebody's existential dilemma whether it's just being really depressed and deciding whether you should live or die, or taking a risky treatment that seems really scary because you haven't had this positive experience that we both had. So there is something really intimate about being in that space with

somebody and it's really kind of an honor to be in there with somebody. It's intense in a way that's also fulfilling.

Change in Therapists' Attitudes toward ECT

For me, all I have is *One Flew Over the Cuckoo's Nest* and I just hoped that this would be something positive. ...I mean I went from as terrified as she felt, to relieved and really positive. I wrote to a national listserv; somebody asked a question and I might have been the first who responded to the question. I was happy to say, I just had someone go through this and not only was it not *One Flew Over the Cuckoo's Nest*, but that's where people go. To say that it was so far from that. She actually went as far as to irresponsibly teach classes in the afternoon on the same day of an ECT treatment. It was just incredible.

My general impression was that it was barbaric. ...The only reason it helped people with depression was that if they were so depressed that they needed to punish themselves. If you gave them ECT, you punished them. That removed their need to punish themselves so they came out of their depression. Of course that was just my own personal opinion.

I had negative, very negative opinion of ECT early, early in my career. Over the years I just have become much more flexible and open to other types of treatment that I may not understand. (Currently,) I think that anyone who is responsive to any other form of intervention, I don't think that the benefits will outweigh the risks.

Perhaps I'm not as sanguine about ECT because of both his experience and my other patient's experience. He also didn't benefit from ECT. I certainly would not discourage anyone from ... where there seems to be a good reason to do it, I wouldn't discourage them from trying it.

Guidance for Other Therapists

At the close of the interview, participants were asked to reflect on their own experiences and share any guidance or advice that they would have found helpful in understanding and working with patients who had received or were receiving ECT. The theme of guidance is divided into three sub-categories presented below. These sub-categories are: education, collaboration, and therapy.

Education

Take a course in [ECT] – a CEU on-line for your license.

You've got to just ask people what are the pop culture references they have to this whether it's *One Flew Over the Cuckoo's Nest* or something else. I think that's worthy

of asking....1950s black and white films, what real exposure have they had through any media at all, what it's like and contrast that with how much it's changed, how different it is and I think it's a big thing, the stigma and the fear whether it's from pop culture, just generally being shocked.

If there's a way to get peers together, maybe people who have been through it and people who haven't...peer to peer kind of learning could really help so people won't feel so alone and know someone who went through it...It could really allay somebody's fears.

For somebody, a therapist whose patient is considering it, I'd probably share with them something about my understanding that it can be an awful experience, depending on the conditions, the doctor, the patient, and that I'd encourage the therapist to get as involved as possible in making sure that the patient is in good hands, trusts the psychiatrist whom they're working with who's going to be performing the ECT. I would probably encourage them to ... if the patient can see the place where it's going to be done, and go there, and be walked through the procedure. Avoid the internet, the horror stories, probably. If you take all that seriously, you probably wouldn't do it at all. Do your homework, in other words.

Collaboration

I probably would have gotten more involved in certain ways. I probably would have tried to speak to the psychiatrist more. I would have probably talked to my patient more about the importance of making sure in advance that the things that are going to make a difference for him are taken care of. I might have done more exploration myself about places that would be best for him to get treated. I didn't know anything about that....I'd take a more hands-on approach. I'd talk to the psychiatrist about what a vulnerable guy this is and that he has a history of trauma, and we need to do whatever we can to make sure that he's well treated and feels safe and secure.

I think that there should be more collaboration with the family and so forth.

Therapy

I think [therapists] should probably monitor them more, pretty closely in terms of watching for any decline in cognitive functioning and decline in memory and any confusion and so perhaps there could be some kind of assessment instruments used for that to monitor them.

I would say to, to really prepare, help the patient to really prepare for the memory loss beforehand....I would recommend that the patient write a journal, just simple journaling, especially writing about things that she currently remembered just so that she could read it in her own words,...[memories] she may not want to forget.

Much more focused on the relational piece, and the personal piece of her, and that the ECT was going to be as helpful as maybe a medication to maybe flatten her a bit, calm her a bit but not to really help her to gain self-awareness and self-love.

To be mindful of their trauma history, to realize that in some way the transference might be sped up in some kind of respect in that they're really fragile at that time, and then they kind of have to submit themselves in a more childlike way to a therapist. Because of their confusion and they know that they're not able to answer these questions. They know that they're questions they should be able to answer. That kind of vulnerability in front of a stranger is scary. They don't have the ability to defend themselves as well.

Certainly exploring the patient's wishes and fears and fantasies associated with the ECT, exploring those ... trying to understand as best as possible all of what comes up around that, feelings about it in relationship to the transference and the countertransference, and the relationship with the therapist. Certainly to explore as deeply as possible the experience both as the patient is going through it and in retrospect. How they felt. What it was like. Certainly if there's anything aversive or painful, traumatic, to really make sure to go into that and not to ignore it. To make it part of the therapy...I'd look at it thoroughly, and I'd want to explore their relationship with the psychiatrist. I'd encourage the therapist to be aware of the dynamics as best as possible, what's going on between the patient and the psychiatrist.

Discussion

The purpose of this study was to explore the unique impact of electroconvulsive therapy (ECT) on the psychodynamic treatment of recipients. This study was designed to help develop recommendations and strategies for working with patients to process the impact of ECT and assimilate the experience into their lives. This line of inquiry is founded on the belief that, as Abse and Ewing wrote (1956), "there are crucial psychodynamic events involved in...organic therapy." Unlike other studies, this study did not specifically recruit participants with a negative view or experience of ECT. Although the study is too small to be truly representative, it does confirm that unique themes and therapeutic experiences are common across ECT recipients and the therapists treating them. Case studies of five psychodynamic psychotherapists, each of whom treated a patient who received ECT, revealed important details about the impact of ECT on the recipients, the therapists, and the therapy. Content analysis revealed six major themes about working with a recipient of ECT from the therapists' perspective. These were: deciding on

ECT, experience of ECT administration, beneficial effects of ECT, negative effects of ECT, implications for psychotherapy, and guidance for other therapists. All six themes were well represented across participants.

A distinct focus and notable study contribution is the detailed reflection of therapists treating recipients of ECT. The guidance offered by these therapists provided a unique opportunity to understand what would be helpful for a clinician to consider in working with this exceptional patient population.

Deciding on ECT

The first theme that emerged from the data was how the decision to receive ECT was present within the treatment. Participants shared about their marked lack of knowledge about ECT as a treatment option for severe depression. Even the two participants who had had prior exposure to ECT – one professionally, one through family – remarked on their naivety about the treatment. Although these results are not surprising, they are concerning. Medication, ECT, and other brain stimulating therapies can all be adjuncts to psychotherapy. Therapists treating patients with severe psychopathology and unrelenting suicidality have a duty to be aware of potentially effective treatments. Decisions and in-depth knowledge about these biologically-based therapies rest with psychiatry, but this should not be a reason for ignorance. All participants described ECT as the treatment of “last resort.” They confirmed that these opinions were shared by their patients and that “desperation” was the primary motivating factor in their patient’s decision to receive ECT. Results also highlight how important it is for both the participant and the patient to trust and respect the psychiatrist who suggests ECT. Close communication with the psychiatrist was also identified by participants as an essential component in developing an open and hopeful outlook about ECT. Three of five participants

explicitly stated that they felt their patients gave fully informed consent to ECT. Two of the three clarified that if their patients had known about the environment in which ECT would be given or the memory impairment that would result, they would likely have changed their minds.

Experience of ECT Administration

A second theme that emerged from the data was reflections on anticipated and actual experiences related to receiving ECT. Present study findings confirmed that fear and terror can be a reaction to: the hospital environment (“He could hear people crying, nervous, waking up feeling awful. He said it was terrifying.”); the procedure of ECT itself (“She described it like a sexual trauma: ‘I was laying on the gurney, the bed, and just being poked and prodded.’”); and a lack of knowledge about ECT (“I did not know what was coming. This was really existentially terrifying for her and for me.”). One participant noted that receiving general anesthesia during ECT “represented the death that [the patient] was longing for” but that it also “scared her because of the death that it represented.” This connection of ECT to death is echoed in Fisher et al. (2011) by two participants who reported consenting to ECT as a form of deliberate self-harm or in the belief it might kill them. It is particularly noteworthy to learn from participants that they shared their patient’s experience of fear and terror from not knowing what would happen during and after ECT. Participants’ stories of their patient’s experience of feeling not “important to the staff,” “dehumanized,” and treated “impersonally” during the ECT procedure further highlight the importance of modifying the treatment environment to improve the patient experience of ECT. In addition, all of the participants reported on the relationships with ECT providers that developed over the course of treatment. Experiences of these relationships varied greatly across participants and included feelings of powerlessness, anger, relief, and agency.

Beneficial Effects of ECT

A third unique theme about ECT that emerged from the data was the participants' perspective of the beneficial effects of considering and receiving ECT for the recipients. Validation of the patient's feelings of severe depression and unrelenting suicidality was repeatedly identified as an important benefit of considering ECT. Unsurprisingly, decrease in the severity of the patient's depressive symptoms and suicidal ideation, though not always lasting, was reported to be one of the positive outcomes of ECT. One participant noted that even though ECT did not result in a reduction of symptoms for his patient, the patient still felt it "was worth it because he found out that it wasn't for him." Study results also shown that for a subset of both participants and patients the psychiatrist's recommendation that the patient receive ECT instilled hope for recovery.

Negative Effects of ECT

Another theme that emerged from the data was the participants' perspective of the negative impact of ECT on the recipients. Negative reactions to ECT have been widely considered in the professional literature and popular media. There is strong disagreement among individuals invested in ECT about the nature, severity, and permanence of these side-effects. Our study findings confirm that a meaningful proportion of recipients report experiencing profound confusion, permanent memory loss, and decreased intelligence ("brain damage") as a direct result of ECT. Data analysis revealed that some participants did not notice these side-effects or did not concur with the extent of side-effects reported by their patient. Present study findings also confirm that shame and stigma are common, though not universal, experiences of ECT recipients. The majority of participants in this study spoke about their patients feeling "embarrassed, vulnerable, and ashamed" of being a recipient of ECT. Notably, one participant

shared, “She took [identifying as a recipient of ECT] in stride because her symptoms were so serious; I don’t think she worried about the label.” An additional negative effect of ECT mentioned by a minority of participants in this study was the deepening of the patient’s sense of hopelessness in their recovery. One participant conjectured that her patient’s strengthened belief that no one and nothing was going to help her, led the patient to distance herself from the therapist and lessened the patient’s investment in the therapy.

Implications for Psychotherapy

A fifth theme that emerged from the data was the implication of ECT to psychotherapy. Three of the five participants noted that ECT was not a topic in treatment. Reasons given included: “we were focusing on the depression;” “ECT was seen as an adjunct treatment;” and “I’m not the person who administers the ECT and evaluates the result.” One participant related ECT’s presence as a topic in therapy to talking about medication. He explained, “you say, ‘how are your meds doing,’ and we talk a little bit about it; then we go on with the therapy.” Two of the five participants shared that ECT became a topic in treatment only when the ECT itself became problematic for the patient. It was particularly noteworthy to learn from participants that regardless of whether ECT was a topic in treatment, it did have an impact on therapy process. The short-term cognitive impact of ECT (e.g. confusion and temporary memory loss) interfered with participants’ ability to conduct initial and ongoing assessments with their patients and curtailed engagement in “analytic work.” One participant reported being “more compassionate and more reserved in [her] questions so as to not make [the patient] feel more confused.” Another participant shared about her decision to accompany her patient to an ECT treatment: “It was mainly based on trying to help her get through it the best way I could.... There are times when I break the frame for extenuating circumstances and this was definitely one.”

Data analysis revealed that ECT impacted which patient dynamics were available to work with in the treatment. Two of the five participants shared how their patient's previous experiences of trauma and abuse reemerged as a theme in the treatment after ECT. In addition, a third participant remarked that a particular challenge to treatment post-ECT was how to "work with the fact that [the patient] had so much memory lost and also cognitive deficits...just the practical issue of how to help her not feel discouraged about those things and not falling into a deep depression about that." Another participant noted how ECT may have affected the transference: "she might've kept me more at a distance because she might've seen herself as just a, that I wasn't really a, I was one of the doctors that was just seeing her as a patient and not a person." Analysis of participants' stories revealed that the impact of ECT was not limited to the patient and the therapy, but extended to the therapist and the countertransference. One participant reflected on a sense of "frustration and powerlessness...that the ECT might have intensified." He noted, "I think those feelings ... led me to question how helpful treatment was, the therapy, and talk to [the patient] about it. I also got some consultation and tried different things based on the consultation." A second participant reflected on the impact of being "involved in somebody's existential dilemma." This participant described how his patient's contemplation of ECT impacted him: "There is something really intimate about being in that space with somebody and it's really kind of an honor to be in there with somebody. It's intense in a way that's also fulfilling." Similarly, one participant noted that "the ECT contributed to making this patient extremely unique and special to me in a lot of ways....Those are all certainly wishes that she had and they certainly did come true."

Guidance for Other Therapists

The sixth theme that emerged from the data was guidance for other therapists. Participants reflected on their experience of treating a patient who received ECT and shared what they wished they had known at the time of treatment. Although some of the recommendations are commonsense, they underscore the rudimentary nature of our current understanding of the interaction of ECT and psychotherapy. Guidance offered by participants' during the present study emphasized education, collaboration, and therapy. Regarding education for self and patient, participants advised: "ask people what are the pop culture references they have [for ECT]...and contrast that with how much it's changed;" "get peers together – people who have been through [ECT] and people who haven't;" "take a course in it – a CEU on-line for your license;" "see the place where it's going to be done...and be walked through the procedure;" "avoid the internet;" and quite simply, "do your homework."

In addition to education, participants strongly recommended taking "a more hands-on approach" regarding ECT providers and settings and getting "as involved as possible in making sure that the patient is in good hands." One participant reflected, "I probably would have tried to speak to the psychiatrist more...I might have done more exploration myself about places that would be best for him to get treated." Regarding the procedure of ECT, the same participant stated, "I'd talk to the psychiatrist about what a vulnerable guy this is and that he has a history of trauma, and we need to do whatever we can to make sure that he's well treated and feels safe and secure." Participants were also surveyed for what additional tips or suggestions they would offer to a therapist treating his first patient to receive ECT. Two participants addressed the memory loss and cognitive decline associated with ECT. One participant recommended helping "the patient to really prepare for the memory loss beforehand" and suggested journaling as a way for

the patient to record her memories in her own words. The second participant encouraged therapists to carefully monitor patients' cognitive abilities as they receive ECT and suggested using a standardized assessment instrument.

The collective advice for other therapists from the participants in the present study was well articulated in the following statement by an individual participant:

Explor[e] the patient's wishes and fears and fantasies associated with the ECT...Explore as deeply as possible the experience both as the patient is going through it and in retrospect. How they felt. What it was like. Certainly, if there's anything aversive or painful, traumatic, to really make sure to go into that and not to ignore it.

Limitations of the Current Study

Study findings must be considered in the light of certain limitations. First, the data is based on a small convenience sample that is not representative of the larger group of psychotherapists who treat recipients of ECT. Nor is it representative of the larger group of ECT recipients. Second, the decision to limit participation to psychotherapists who self-identify as practicing from a psychodynamic perspective and have post-graduate training in psychodynamic psychotherapy may have resulted in neglecting information that would be helpful for clinicians to understand in working with recipients of ECT. It may also have resulted in the development of clinical recommendations that are primarily applicable to those working within a psychodynamic framework. Third, the author was the sole person who analyzed the qualitative data. The author was also the only individual responsible for coding and identifying themes in the data. Care was taken to minimize the impact of bias to the greatest extent possible. Involvement of additional independent coders would have increased the reliability of these study results. Finally, another limitation that applies to all qualitative research is the generalizability of

results. Despite the limitations noted above, this study represents a first step toward identifying what is helpful for a clinician to understand in order to engage patients who are receiving or have received ECT in maximally effective therapy.

Conclusions and Future Directions

The purpose of this study was to explore the unique impact of ECT on the psychodynamic treatment of recipients and to begin to develop recommendations and strategies for working with patients who are considering or are receiving ECT. Although the current study is too small to be truly representative, the results of this study do reveal important details about the impact of ECT on the recipients, the therapists, and the therapy. Data analysis suggests that the decision, procedure, and outcome of ECT impact a psychotherapist's treatment of their patient, the therapist's attitudes toward ECT, and the patient's experience of himself. The guidance offered by these therapists provides a unique opportunity to understand what would be helpful for a clinician to consider in working with this exceptional patient population.

Future research should seek to expand our understanding of the psychological impact of ECT on recipients, psychotherapists, therapy, and family and friends. Recommendations and strategies for working with patients who are considering or are receiving ECT should be considered and evaluated. Additionally, future research exploring strategies for disseminating information about ECT to mental health clinicians – especially those in the community with little exposure to psychiatric hospitals – will be necessary to advance clinical practice in this area. Based on the results from this exploratory study, it is highly recommended that psychotherapists pursue education to increase their familiarity and knowledge regarding ECT. Psychotherapists currently treating a patient who is considering, receiving, or has received ECT, are urged to seek consultation both with an experienced psychotherapist and a trusted psychiatrist.

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Appendices

Appendix AInformed Consent Agreement

Electroconvulsive Therapy (ECT):

An Exploratory Study of Its Impact on the Psychoanalytic Treatment of Recipients
You are invited to participate in a research study. Before you agree to participate it is important that you know enough about the study in order to make an informed decision. If you have any questions about the nature of this study, please ask Rikki Pashen, Psy.M., the principal investigator (PI). You should be satisfied with the answers you receive from the principal investigator before you agree to participate in this study.

Purpose of the Study

This study examines the experiences of psychoanalytic psychotherapists working with patients who have received or are receiving electroconvulsive therapy (ECT). The study seeks to understand the impact of ECT treatment on the psychoanalytic treatment of recipients. Of interest are your reflections regarding the unique characteristics of the treatment process, treatment relationship, and the content of treatment sessions that develop when working with someone who has received or is receiving ECT, as well as how these issues have affected the goals, interventions, and course of treatment.

The principal investigator is a doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers, the State University of New Jersey, and is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that 6-10 individuals will participate in this study. If you wish to be provided with the general results of this study, you should notify the PI and this information will be shared with you at the completion of the study.

Study Procedures: You will be interviewed about your experiences working with patients who have received or are receiving ECT and how you have understood, addressed and worked with the impact of ECT in therapy. The interview will take between 50 and 90 minutes and will be conducted by the principle investigator.

Interviews will be audiotaped in order to ensure accurate transcription and authenticity of the data obtained. Interviews will be transcribed and audiotapes will be destroyed after transcription. You do not have to agree to be audiotaped in order to participate in this study. Should you choose not to be audiotaped, the principle investigator will take detailed notes during the interview. The principal investigator will maintain any audiotape recordings, hand-written notes, transcripts of interviews, or other data collected from you in confidence in a locked file cabinet. The study data will be retained until the project is completed and the dissertation has been successfully defended. It is expected that the data will be destroyed within four years of your interview.

Risks: The interview focuses on your experiences working in individual therapy with patients who have received or are receiving ECT. It is the principal investigator's belief that this will be a positive and thought-provoking experience for you. If however, in reflecting on issues of treating those who have received or are receiving ECT, you experience discomfort or distress recalling unpleasant memories or discussing matters of a personal nature, it is important that you notify the principal investigator immediately so that she can discuss these feelings with you and provide you with referrals to local counseling services if necessary. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services.

Benefits: Your experience and knowledge have tremendous value in helping the field of psychoanalytic psychotherapy better understand how to work with patients who have received or are receiving ECT. The information shared has the potential to help both psychotherapists and patients who are working together in a treatment setting. Results obtained could also be used to better inform the training and practice of future psychoanalytic practitioners who are interested in or find themselves working with this population. Additionally, the opportunity to share your own clinical experiences on this topic may be valuable to your own reflection and practice. However, you may not receive any direct benefit by participating in this study. There is no compensation for participating in this study.

Confidentiality: This research is confidential. Confidential means that the research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes age, gender, professional degree(s) and year(s) attained, years in practice, and theoretical orientation. Please note that we will keep this information confidential by limiting individual's access to the research data and keeping it in a secure location. Any data kept in an electronic data file will be stored in the principal investigator's password protected personal computer in order to keep it confidential. Audiotapes (if collected) and other paper work will be assigned a case number. Your responses will be grouped with other participants' responses and analyzed collectively. All common identifying information will be disguised to protect your confidentiality. This will include changing your name and other demographic information (i.e. age, professional degree).

The research team and the Institutional Review Board at Rutgers, the State University of New Jersey, are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. The study data will be retained until the project is completed and the dissertation has been successfully defended. It is expected that the data will be destroyed within four years of your interview.

Research Standards and Rights of Participants: Your participation in this research is **VOLUNTARY**. If you decide not to participate, or if you decide later to stop participating at any time during the interview, you will not lose any benefits to which you are otherwise entitled. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission.

I understand that I may contact the principal investigator or the investigator’s dissertation chairperson at any time at the addresses, telephone numbers or emails listed below if I have any questions, concerns or comments regarding my participation in this study.

Rikki Pashen, Psy.M. (Investigator)
 Rutgers, the State University of New Jersey
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 Psychology (GSAPP)
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 Psychology (GSAPP)
 152 Frelinghuysen Rd
 Piscataway, NJ 08854-8085
 Telephone: 848.445.3899
 Email: dmorgan@rutgers.edu

If you have any questions about your rights as a research subject, you may contact the Institutional Review Board Administrator at Rutgers University at:

Rutgers, the State University of New Jersey
 Institutional Review Board for the Protection of Human Subjects
 Office of Research and Sponsored Programs
 3 Rutgers Plaza
 New Brunswick, NJ 08901-8559
 Tel: 848.932.4058
 Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. I consent to participate in this research project.

Participant Name (Print) _____ Date _____

Preferred Contact (Phone/Email) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Informed Consent Agreement

Audiotape Addendum

You have already agreed to participate in a research study entitled *Electroconvulsive Therapy (ECT): An Exploratory Study of Its Impact on the Psychoanalytic Treatment of Recipients* conducted by Rikki Pashen, Psy.M. This form requests your permission to allow the principle investigator (Rikki Pashen) to make a sound recording (audiotape) of your interview as a part of this research study.

You do not have to agree to be audiotaped in order to participate in this study. Should you choose not to be audiotaped, the principle investigator will take detailed notes during the interview.

If you do agree to audio-taping, the recording(s) will be used for analysis by the principle investigator.

The recording(s) will be distinguished from one another by an identifying case number. Your name will not be used or linked in any way to the recording except through a case number held by the principle investigator.

The recording(s) will be stored in a locked file cabinet by identifying number not by name or other information that might disclose your identity. The tapes will be retained until the project is completed and the dissertation has been successfully defended. It is expected that the recording(s) will be destroyed within four years of your interview.

Your signature on this form grants the principle investigator permission to record you during your participation in the above-referenced study. The principle investigator will not use the recording(s) for any other reason than those stated in the consent form without your written permission.

Participant Name (Print) _____ Date _____

Preferred Contact (Phone/Email) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix BDemographic Questionnaire – Participant

The following Demographic Questionnaire is a *self-report* regarding you as the psychotherapist.

Age: _____

Gender: _____

Ethnicity: _____

Professional degree(s) & year(s) attained: _____

Additional certifications or specialty areas: _____

Post-graduate psychoanalytic training (seminars/institute/self-study): _____

Years in practice: _____

Treatment specialty/focus: _____

Professional settings worked in throughout career: _____

Number of patients on your current caseloads who have received or are receiving electroconvulsive therapy (ECT): _____

Approx. number of patients treated over your career that have received ECT: _____

Three most common diagnoses on your individual adult caseloads: _____

Have you gained any familiarity or experience with ECT from outside of your professional life (e.g. ECT treatment of friends, family, self)? Yes No (please circle one)

DSM IV: Multiaxial Assessment

Please complete the following to the best of your ability. If there is information that you do not know, please write 'DK.'

Upon Intake

Upon Termination (if different)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

ECT Treatment(s)

Reason given for initiating ECT: _____

Number of ECT treatments received (approximate): _____

Total duration of ECT treatments received (approximate dates): _____

Electrode placement, if known (circle all that apply): unilateral bilateral bifrontal

ECT received as: inpatient outpatient both

ECT received: voluntarily under-section (mandated)

Side effects following ECT as reported by patient (circle all that apply and place an asterisk next to symptoms that persisted for more than 6 months post-ECT):

cognitive deficits memory impairment anterograde amnesia retrograde amnesia

confusion loss of intelligence personality change nausea

vomiting headache jaw pain muscle ache/spasms

other (please list): _____

Any additional side effects following ECT observed by psychotherapist (please list and place an asterisk next to symptoms that persisted for more than 6 months post-ECT): _____

Patient on maintenance ECT (please circle): Yes No

Any previous treatments with ECT (previous rounds): Yes No If yes, how many?___

Prior to receiving ECT, did the patient know anyone personally who had received ECT (please circle): Yes No If yes, what was their relationship? _____

Appendix C

Semi-Structured Interview

ECT: Understanding and Training Experiences

1. Please describe any exposure you have had to ECT, if any, during your graduate education, post-graduate education, ongoing training, or through self-directed study.
 - a. Prompt: Didactic/classes? Supervision? Externship/Internship? Continuing education/seminars? Articles/books/memoirs?
 - b. Follow-up for each experience: Please tell me more about this experience.
 - i. Prompt: Who/what organization presented the material? What was the occasion? What information did you receive regarding the indications for ECT? Outcomes of ECT? Mechanism of action? Side-effects of ECT? Impact on patients beyond symptom reduction and minor cognitive side-effects?
2. Given your current knowledge and experiences, do you feel that ECT is a worthwhile or valuable treatment for some patients?
 - a. [Yes] For whom is it worthwhile and why? For whom is it not worthwhile and why not?
 - b. [No] Please explain further.
 - c. Follow-up: Has your opinion on this changed since working with your patient? How?
3. In general, do you believe that ECT treatment has an impact on recipients beyond symptom reduction?
 - a. [Yes] Please describe.
 - b. [No] Please explain.

Working with patients who had previously received or were receiving ECT

The following questions are in regards to the specific patient you referred to on the *Demographic Questionnaire – Recipient of ECT*. (If more than one patient, complete this section of the Semi-Structured Interview separately for each patient.) If answers are not known, just state “don’t know.”

1. When, in relation to the ECT treatments, did you begin therapy with this patient?
 - a. Prompt: How many weeks/months/years before/during/after ECT?
2. Did your patient feel they were given adequate explanations about the procedure and potential outcomes of ECT prior to receiving it?
 - a. [No] Please explain.
3. In the patient's opinion, did they give fully informed consent to treatment with ECT?
 - a. [Yes] Why did patient agree to undergo ECT?
 - b. [No] Please explain.
4. Did patient complete the prescribed course of ECT or terminate early? What went into this decision?
5. [If applicable] In the *Demographic Questionnaire* you confirmed that prior to receiving ECT the patient had known someone personally who had received ECT. Would you tell me more about that?
 - a. Prompt: What do you think the patient learned about ECT from this experience? How did this affect their expectations or the experience of their own ECT?
6. How was the subject of ECT brought up in your treatment with the patient? By whom? When did this happen?
 - a. Follow-up: How was this handled by you, the therapist? What did you consider in making that decision? Why do you feel it occurred when it did/Was the timing significant?
7. Was the topic of ECT a major component of the treatment?
 - a. [Yes] Please say more. What were the major themes regarding ECT that came up in treatment?
 - b. [No] What is your understanding of why it was not a major component of the treatment?
8. Did your patient find any aspect of receiving ECT or its sequelae – including being labeled as a recipient of ECT – to be distressing, upsetting, frightening, or otherwise negative?
 - a. [Yes] Please explain.
9. Did your patient find any aspect of receiving ECT or its sequelae – including being labeled as a recipient of ECT – to be beneficial, freeing, validating, or otherwise positive?

- a. [Yes] Please explain.
10. Did your treatment of this patient differ from normal with respect to contact with significant others, family members, or other mental health professionals?
 - a. [Yes] How did it differ? What is your understanding of the reasons for this difference?
11. Did the frame of this particular treatment deviate from that which you usually employ?
 - a. [Yes] How did it deviate? What is your understanding of the reasons for these differences?
12. What do you suppose was the impact of ECT on the patient's interpersonal relationships? Were there any unresolved issues from your patient's past that came to the forefront as a result of the experience of ECT and its after-effects, including being labeled as a recipient of ECT?
 - a. [Yes] Please explain.
13. What was your experience of issues related to ECT playing out in the transference/countertransference?
14. What was your experience of issues related to ECT playing out in the unconscious?
 - a. Prompt: Consider patient or therapist fantasies, dreams, etc.
15. Other than a reduction in symptomology, physiological side-effects, and what we just discussed, how do you think the experience of ECT and its after-effects – including being labeled as a recipient of ECT – impacted this patient?
16. Did the results of ECT meet the patient's expectations? Your expectations?
 - a. [Yes] Please explain.
 - b. [No] Please explain.
17. On a scale of 1 to 10, 1 being not at all successful and 10 being completely successful, how would **you** rate the overall success of psychotherapy?
 - a. Follow-up: Please tell me what went into your rating it a *X*?
18. On a scale of 1 to 10, 1 being not at all successful and 10 being completely successful, how do you think **your patient** would rate the overall success of psychotherapy?
 - a. Follow-up: Please tell me what went into your rating it a *X*?
19. What do you think you could have done, if anything, to improve the psychotherapy outcome with this patient?

20. After reflecting on this case, what is your conceptualization of the impact of the experience of ECT and its after-effects – including being labeled as a recipient of ECT – in the treatment of this patient?
21. In your mind, given everything you know about your patient and everything we have spoken about, was ECT “worth it” for this patient?
 - a. Prompt: Would you recommend a second round of ECT if this patient returns to his pre-ECT state?
 - i. [No] Please explain.
22. Do you think the patient would feel the same way?
 - a. [No] Please explain.
23. Do you think other forms of help may have been more appropriate than ECT for this patient?
 - a. [Yes] Please expand.

Closing Questions

1. What did you enjoy about working with a patient who had received or was receiving ECT?
2. What was challenging about that work for you?
3. How did your thoughts, feelings, and approach to working with a patient who had received or was receiving ECT change over the course of your work with them?
4. Did your personal opinions about the value of ECT as an effective treatment affect your therapeutic work with this patient?
 - a. [Yes] Please explain.
5. If you were to write an article or guide about working from a psychoanalytic mindset with a patient who had previously received or was receiving ECT at the time of treatment, what tips, suggestions, concerns, etc., other than what you have already mentioned, would you include?
6. Is there anything I did not ask you about your experience with treating an individual who had received or was receiving ECT that would be helpful for me to know or consider?
7. [If applicable] In the Demographic Questionnaire you confirmed that you had gained some familiarity or had some experience with ECT from outside of your professional life

(e.g. ECT treatment of friends, family, self). Would you tell me more about that?

(Emphasize confidential nature of current study if warranted.)

- a. Prompt: What did you learn about ECT from this experience?
 - b. Prompt: Was this experience helpful when treating a patient who had received or was receiving ECT?
 - i. [Yes] How?
 - ii. [No] Why not?
8. What has been your experience of participating in this interview?

[End Audio Recording]

1. When this research is complete, would you like to receive a copy of the manuscript?
 - a. [Yes] Would you prefer e-mail or regular mail? What address should I use?

Appendix D

Recruitment Notice

Email subject: Seeking therapists working with patients treated with ECT for a study of its impact on psychoanalytic treatment.

This study is designed to help develop recommendations and strategies for working with patients to process the impact of electroconvulsive therapy (ECT) on their lives. Its focus is the impact of ECT on the psychoanalytic process and therapist's psychoanalytic understanding of the recipient. Results obtained are anticipated to reveal common themes that arise or are increasingly prominent following ECT treatment. These results are also expected to be useful in evaluating the costs-benefit ratio of ECT on an individual and social level.

Are you a therapist who, in the last four years, has worked with a patient treated with ECT? If so, please consider participating in this study. Licensed psychotherapists (counselors, social workers, psychologists, and psychiatrists) with at least five years of professional experience and who identify primarily as psychoanalytic are being recruited for a doctoral dissertation study at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

Participants will be interviewed about their experiences working with patients who were receiving ECT at the time of treatment or who had previously received ECT. Interviews will last approximately 60 to 90 minutes and will be conducted in person or via telephone or Skype. All interviews will be audiotaped to ensure accuracy in transcription. Confidentiality of all data obtained is ensured. Participants will not be compensated for this study.

If you are interested in participating or learning more about the study please contact Rikki Pashen, Psy.M., at 732.801.0014 or at rikki.pashen@gmail.com for more information.

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