

F. letters

September 24, 1974

Mr. Berton Roueche
The New Yorker
24 West 43rd Street
New York, N. Y.

Dear Mr. Roueche:

Many are sure to write about your article, "As Empty as Eve", to sympathize with Mrs. Parker and to praise your presentation. Some will write to criticize the errors of fact and of experience. I am writing to express my sadness that you have chosen the public press to air a single medical case report, without the leavening of clinical experience, which would permit this case to be seen in the context of the goals, successess and failures of this therapy. I do not understand what service you were attempting to offer, but surely you have added your powerful voice to the many who fear that which they do not understand, thus making it more difficult for patients who may be helped to receive treatment. You are encouraging many patients to weeks and months of the unnecessary hell of a severe depression; and even some to a suicide that may have been prevented.

I am sad that the New Yorker and particularly you, with your record of fine writing, have chosen this topic to attack. It is easy to find the single case which has not done well; it is easy to damn with innuendo, error, misquotation, and selective quotation; it is hard to stay one's voice when we are ignorant, and to speak with balance when we have an urge to speak.

Some specifics. From the record given, it is probable that Mrs. Parker was a poor choice for this therapy. I anticipate that she is a person who is critical in her perception of her environment -- in psychological terms, she has a low California F-Scale, makes few errors on figure-ground tests, and is unusually accurate in the perception of the visual upright. Such individuals, when they become depressed, do so gradually, and characterize their depression not in mood or affective terms, but in body symptoms (often termed hypochondriacal) and are

generally poor therapeutic risks. The outcome you describe with convulsive therapy is rare, since patients who have her background are infrequently treated with this therapy. One of the limitations in getting therapists to have adequate experience with convulsive therapy is the prevailing social attitude that the therapy has less success than the psychotherapies, that it is less elegant, and that it represents (in some minds) a failure of a 'better' therapy. Indeed, one would guess that the consulting psychiatrist was reluctant to recommend this candidate for this therapy. Regretfully, had he chosen a form of the therapy called "unilateral convulsion^{v2} therapy" in which the application of the electrodes is not to both temple^s, but to the scalp overlying the non-dominant cerebral hemisphere, the complaints would surely have been less, for this therapy yields almost equivalent therapeutic change with decreased effects on memory and recall. ✓

There are also many errors of fact. The historical origins of convulsive therapy are not usually related to the experiences of Reil, but rather to the interest aroused in the biological causes of insanity by the successful treatment of general paresis by fever therapy by Wagner von Jauregg. This observation was universally hailed as a step forward in the treatment of the insane (von Jauregg received the Nobel Prize for medicine for this observation) and led many scientists in Europe to seek other biological ways to relieve the symptoms of the mentally ill. Convulsive therapy is usually described as originating in the laboratories of the Hungarian, Ladislas von Meduna, who observed that schizophrenia was rare among epileptics and that epilepsy was rare among those with schizophrenia. Seeking a way to relieve the plight of severe psychotics, he tried to simulate epilepsy by intravenous administrations first of camphor, then of pentelenetetrazol (Metrazole). The first patients improved markedly and it was following his early reports that the Italians, Cerletti and Bini, tried electrical inductions of seizures. ✓

Electro-convulsive therapy has gone through many modifications in the past 38 years. The techniques of administration have improved (succinylcholine is the latest of the muscle relaxants; the use of a sedative, usually Brevital, is not to improve breathing, but to provide relaxation for the patient before treatment and to reduce the excitement which occasionally is seen after a seizure, unilateral seizures and flurothyl seizures are used in selected cases, etc.). Our understanding has gone from ideas that the treatment is a punishment for sins, or to frighten the patient to health, through the stage where the therapy was related to amnesia, to present views which ascribe

improvement to the biochemical changes which result from the seizures. Indeed, the therapy is seen to produce long-lasting biochemical changes in the central nervous system which are remedial to depressive mood and psychotic ideation, in appropriately selected patients.

To carp about a few specific errors. Insulin coma therapy is not in widespread use. For example, there is no insulin coma therapy unit in a community hospital in New York. It is far from the inspirational prototype of electroconvulsive therapy since Sakel clearly separated insulin coma from the convulsive therapies, as did many of his followers.

ECT was not the first convulsive therapy - metrazole and camphor were used earlier.

I am surprised by the quotations from Noyes and Kolb, Hope and Adams, and Aubrey Lewis for none of these authors have written on the subject within the past two decades. The quotations from Squires and Ottosson are appropriate. Ottosson is one of the most experienced observers of convulsive therapy and it may have served him better to quote from his more recent studies, and those of his co-workers, Laurell and d'Elia, than to use an older study. Squires is a young experimental psychologist who has done only one experiment. The quotation from the "New Home Medical Encyclopedia" is probably accurate, but one would wonder why you have selected this lay volume as an authority to quote in the New Yorker.

In sum, I am disappointed that the New Yorker, known and read for its accuracy and fine reporting, saw fit to publish a single case report, with many errors of fact in discussion - thereby doing a disservice to the many patients who will undoubtedly read or be given this article, and who will be scared out of their wits if a physician recommends this therapy. The harm that has been done will never be known by you, but the many therapists who will find it more difficult to use this therapy when it is useful will have reason to remember you, as will the families that will have lost a member by suicide.

Should you wish to reach other scientists who may find your report a disservice, I suggest you call Dr. Martin Katz, head of the Clinical Research Branch of the National Institute of Mental Health, or such consultants to the NIMH as Dr. Seymour Kety, Harvard Medical School, Dr. Lothar Kalinowsky of the New York Medical College, or Dr. Charles Shagass, of Temple University (also this year's President of the Society of Biological Psychiatry and the American Psychopathological Association).

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You may also wish to read some of the more recent volumes on the subject, and to assist you, I am appending citations that are well known.

Lastly, I would suggest that you spend a week studying a ward of chronic mentally ill (in any State mental hospital) and a week visiting laboratories researching the newer therapies of the mentally ill. Perhaps then you may be able to write a more balanced response to yourself. ✓

Sincerely yours,

Max Fink, M. D.
Professor of Psychiatry

MF:ed

cc: Peter F. Fleischmann, President
The New Yorker Magazine, Inc.

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