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Dear Alick,

The usage of ECT early in an illness, rather than as a last resort, has become a reasonable tenet of our practice, based on the extensive evidence of the efficacy and safety of ECT. When the California legislature, in 1973-1974, enacted restrictive legislation against the use of 'intrusive treatments', including ECT, the American Psychiatric Association appointed a Task Force (1975-1978) to review the evidence of safety and efficacy of ECT, and to provide guidelines as to a proper response to restrictive rules. The Task Force reviewed the literature, carried out surveys of usage, held public hearings, and published a report (American Psychiatric Association, Task Force Report #14, 1978). The members concluded that the evidence for the efficacy of ECT in major depressive disorders and catatonia was compelling; in mania, less well defined; and for schizophrenia, poor. As for safety, the committee concluded that in its own right, ECT was remarkably safe (when properly done) and in comparison with other treatments (as tricyclic drugs and lithium, for example) as safe or safer. The Task Force also noted new evidence that ECT was more effective than tricyclic drugs in treating delusional depressions. Soon after that publication, articles appeared that indicated that ECT treated patients had a lesser incidence of successful suicides and lesser death rates from other causes when compared to depressed patients treated by other means.

In 1979, I published my book on ECT (Convulsive Therapy: Theory and Practice. Raven Press, New York, 1979) in which I documented the same information and concluded that ECT was particularly effective in severe depressions and catatonia, especially if accompanied by delusions, inanition, or suicidal drive. I suggested that the standard approach of using all other treatments first, and reserving ECT for treatment failures, was contrary to the evidence, and encouraged the earlier use of ECT.

After that publication, I became aware of the 1964 deCarolis study (Avery and Lubrano: Am. J. Psychiat. 136:559-562, 1979) which clearly showed the efficacy of ECT in patients who failed adequate courses of imipramine therapy.

Since then, others have come to similar conclusions about efficacy and safety, notably Kendell (1981), Weiner (1981), and Palmer (1981).

There have been other supports of early usage. The awareness that some elderly patients with symptoms of dementia may be suffering from severe depression (which is responsive to ECT) has encouraged the early use of ECT in elderly subjects (presumably suffering with 'pseudo-dementia'). Reports that patients with a syndrome poorly classified as neither schizophrenia nor depression, but rather 'schizo=affective disorders' are responsive to ECT is also encouraging.

We now teach that the severity of the illness is a compelling factor in our choice of treatment. For severely depressed and delusional patients, particularly those whose medical status is compromised (inanition, metabolic disorder, cardiovascular decompensation, pregnancy), who are ill enough to be hospitalized, ECT is considered among the initial treatment choices. I recommend and use ECT as a primary condition in the most severely ill patients.

For severely depressed and suicidal patients, who have recently carried out a severe threat, ECT is preferred.

In elderly patients with depressive conditions with symptoms of dementia, ECT is clearly preferred.

In psychotic pregnant women, during the first trimester, who cannot be managed by nursing care alone, ECT is preferred over antipsychotic, antidepressant, or antimanic drugs.

None of this is stated as explicitly in one location. Indeed, since publishing my book, and while on the lecture trail, the question has often been asked. Gradually, especially when I am encouraged to see patients in case conferences, I have become bolder in my statements about the indications for ECT. I have also been encouraged by a long line of successes with ECT in patients who have failed other treatments, since I accepted responsibility for the therapy unit at this hospital.

There is one other factor which operates here but may not in your country. When, in 1976, I carried out a survey of usage of ECT in New York, I was amazed to find greater usage in upper class, private pay hospitals. Clinicians in the U.S., faced with a severely depressed individual requiring hospitalization, who when well, was active in the home, office, or business, use ECT in preference to drugs because they are convinced that the resolutions are more rapid. For hospitalized patients, especially those whose insurance has a 30-day or 45-day clause, ECT is clearly the first choice. It is in our public mental hospitals, where the cost of care is borne by the state, that duration of hospitalization is not a factor, and therapists follow popular beliefs about the relative risk in ECT. (Many public hospitals also do not provide ECT since it is labor intensive and therefore very expensive, requiring psychiatrist, anesthesiologist, nurse, and aide.)

I am not sure what prompted your question, but I chose to give a detailed answer since it is an exercise which I enjoy. In September, I attended the advanced postgraduate sessions in psychiatry at the Maudsley Hospital. I was impressed with the quality of care of the patients and the extent and fine quality of their research endeavors. I was given a short tour of the ECT facility and in this fine institution, usage was similar to that we see in our public mental hospitals. I was reminded of the Pippard and Ellam report (which has had a good press in this country) and the conclusion that in about 1/3 the centers, ECT was administered poorly.

It is sad that this treatment, which has so much to offer so many, is restricted to so few. In January, it will be 50 years since the first convulsive treatment was given by Meduna in Budapest. Hopefully, our understanding of the therapeutic process will improve so that the treatment will be less feared, and soon replaced by a more acceptable treatment as our undersatanding of its mechanism grows.

My best regards.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry