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Electroconvulsive Therapy Can Be Effective
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Article Commentary

Val Flint, "The Place of ECT in Mental Health Care," *Kai Tiaki: Nursing New Zealand*, vol. 11, no. 9, October 2005, pp. 18-19. Copyright © 2005 New Zealand Nurses Organisation. Reproduced by permission.

"[Electroconvulsive therapy] can be a very effective treatment for a potentially life-threatening condition."

In the following viewpoint Val Flint asserts that electroconvulsive therapy (ECT)—in which electricity is sent through electrodes that have been placed on a patient's head—is an effective treatment for people suffering from serious mental disturbances. Flint discusses the case of a patient suffering from catatonia, a motionless, apathetic, and uncommunicative state that can result from severe depression. After eight sessions of ECT, the patient had greatly improved and was able to return home to a relatively normal life. Flint concludes that ECT is re-emerging as a safe treatment for certain disorders. Flint is a registered nurse who specializes in mental health services.

As you read, consider the following questions:

1. How does popular culture tend to portray ECT, according to Flint?
2. How was the patient Trevor treated during his first ECT treatment?
3. How did Trevor score on the Montgomery and Asberg Depression Rating Scale after his three-week series of ECT treatments?

Electroconvulsive therapy (ECT) is one of the most controversial treatments in medicine. It has a chequered history of misuse and abuse. Some of those who recall having had unmodified ECT, i.e. without anaesthetic or muscle relaxant, retain nightmare memories of the treatment. Some people remember being given ECT as a punishment for perceived poor behaviour, or to coerce them to conform to acceptable "normal" behaviours. In 2001, 95 people who had been patients in Lake Alice Hospital near Wanganui, [New Zealand,] received \$6.5 million in compensation for the abuse they suffered. Many who received compensation had been given unmodified shock treatment, and when describing their experiences today, they use the term "torture" in relation to ECT. Popular culture has tended to portray the procedure and outcomes of ECT negatively. Many people's understanding of the treatment is based on the 1975 film, *One Flew over the Cuckoo's Nest*. Seldom does one read or hear of the positive effects of ECT for those who present with a life-threatening mental disorder. An exception was an article published in the *New Zealand Listener* in 2003. This presented evidence and views from experts both in favour of, and against ECT.

An Effective Treatment for Catatonia

Electroconvulsive therapy is no longer used indiscriminately, as was the case in the 1950s and 1960s. It has proven to be an effective treatment for catatonia and catatonic states. [According to eMedicine.com,] "Catatonia is a state of apparent unresponsiveness to external stimuli in a person who is apparently awake, and is difficult to differentiate from diffuse encephalopathy [brain disease] and non-convulsive status epilepticus [continuous seizures].... Diagnostic criteria for catatonia include motoric immobility, excessive motor activity, extreme negativism or mutism, peculiarities of voluntary movement, and echolalia or echopraxia [repeating the words or actions of others, respectively]." Two of these symptoms are required to diagnose catatonia in schizophrenia and mood disorder. Only one is required to diagnose catatonia in general medical conditions. Catatonia can present in an immobile state (apparently stuporose) and is potentially life-threatening, unless nutrition is administered parenterally [non-orally].

Extreme excitability in a catatonic state presents a risk of injuring self and/or others, with ensuing autonomic disturbances, such as tachycardia [fast heart rate] and hypertension [high blood pressure], and can result in collapse. Catatonia is not related to any specific age group or gender. Children as young as eight have received ECT to relieve them of this condition when all other treatments have failed.

A Case Study in ECT Use

I was closely involved in caring for a client for whom ECT treatment for catatonia was successful. Trevor (not his real name) had no previous-known psychiatric disorder and there was no family history of mental ill health. Trevor had experienced a traumatic incident at work. During the following four weeks his mood progressively deteriorated, with a decrease in responsiveness and activity. He presented to a medical ward in a severe catatonic state, resistive to physical examination, adamantly but mutely refusing to open his eyes or mouth, and combative when nurses

attempted to reposition him.

To eliminate other diagnoses, the patient underwent a thorough medical and physical investigation but nothing abnormal was discovered. These investigations included a chest x-ray; an electrocardiograph; a full blood screen; lumbar puncture for cerebral-spinal fluid abnormality; a CAT brain scan; a magnetic resonance imaging brain scan; electroencephalograph; thyroid function tests; toxicology screening; and syphilis serology. He was given intravenous (IV) fluids for nutrition, as he was not taking any food or drink. He resisted oral cares, clenching his jaws tightly. A neurology review showed no evidence of any neurological disorder.

A referral was sent to the mental health team for an assessment of his mental health status. Since delirium had been ruled out, a diagnosis of a catatonic state was made. Because Trevor had no previous psychiatric history, a definitive diagnosis of catatonic schizophrenia could not be established. The mental health team advised ECT, as this has been used successfully to treat catatonia, "effectively releasing the patient from an apparent state of stupor to one of recovery and the resumption of a normal active life" [as reported on mhsources.com].

Next of kin or other family members cannot give consent for ECT and, as Trevor was not able to give informed consent for the treatment, he was placed under the Mental Health Act (MHA) Section 11. This is a five-day compulsory assessment and treatment order and ECT is prescribed and administered under section 60(b) of the MHA. A second opinion from a suitably appointed psychiatrist must be sought and assessment conducted and recorded using a particular legal form.

The ECT nurse plays a crucial role in all issues involving the administration of ECT. She is a co-ordinator, an educator, she liaises [acts as a link] with other services and families, and is a point of contact about ECT within the mental health service generally and in the ECT unit in particular.

The Family Is Informed

The nurse caring for Trevor on the medical ward contacted the ECT nurse for information regarding the treatment and the MHA. This was provided in as much detail as was required. The family had been fully informed of the proposed treatment, the risks involved, potential side-effects and the anticipated benefits. The family was given a comprehensive information booklet about ECT and was invited to ask any questions in relation to the treatment. The family was satisfied with the information and agreed that Trevor should receive ECT.

Escorted by his nurse and the ECT nurse, Trevor was taken from the medical ward in his bed to the ECT suite for his first three treatments. In the suite he was greeted warmly by the ECT team and was given step-by-step verbal information about the procedure, despite his apparent semi-comatose state. The ECT nurse remained with him, holding his hand by way of reassurance, while the anaesthetist and the psychiatrist explained to Trevor exactly what they were doing. Trevor recovered quickly from the ECT treatment, with no untoward events and was returned to the medical ward. Response after the first ECT treatment was minimal but evident. Trevor was able to specify which drink he wanted when his nurse asked him to nod or shake his head to indicate what drink he wanted. He accepted sips of water and co-operated with mouth cares; however he continued to refuse to eat or to open his eyes.

After the second ECT treatment his condition showed little improvement, although Trevor did continue to comply with oral cares and accept fluids. Naso-gastric feeding [through a tube inserted into the nose and down into the stomach] was to be considered if his nutritional intake did not improve after the third ECT treatment.

The Turning Point

The third treatment proved to be the turning point. In the recovery room, Trevor opened his eyes. He was wheeled back to the medical ward where he ate a full breakfast. He was able to respond verbally and later got up from his bed to walk quite steadily around the ward. The mental health team conducted a further assessment and agreed that Trevor could be transferred from the medical ward to the mental health unit, as he no longer required intensive medical and nursing cares.

During an interview in the mental health unit with a psychiatrist and a mental health primary nurse, Trevor denied any thoughts of self-harm or suicide and said he was feeling slightly better. Despite this, he appeared low in mood, his responses were restricted, poverty of thought and speech were evident, and he made only fleeting eye contact. He spoke in a quiet monotone and was extremely retarded [slow] in his responses to questions, appearing somewhat preoccupied and guarded throughout the interview. There was evidence of paranoia, as he intimated that people were talking about him and putting him down in relation to the incident at work. He denied any alcohol or illegal substance abuse. He indicated that his family was extremely supportive and anxious for his recovery and return home. Trevor was fully orientated to time, place and person but was hesitant in his responses, apparently unable to concentrate on the questions being asked.

A Course of ECT

The plan was for Trevor to continue with a course of ECT and to commence antidepressants. His primary nurse was responsible for gathering information from other members of the team, including occupational and art therapists, and for recording and reporting these and her findings to the multi-disciplinary team. Trevor was to be observed for any psychotic features; his food and fluid intake and his ability with activities of daily living (ADL) were to be monitored. Participation in ward social activities was to be encouraged and family contact maintained.

Over the next three weeks, Trevor received a total of eight ECT treatments and improved with each treatment. On the ward Trevor continued to look preoccupied at times but stated he was "thinking" when asked about this by his nurse. His family had described Trevor as a shy, introspective young man, who had no special relationships outside the family circle, so he was assessed as being naturally quiet. However, he gradually became less isolated, joined others in spontaneous group activities, as well as organised group work, and his appetite improved to the point where he looked forward to meals and wanted snacks in between. Trevor went home to his family on leave twice and on his return to the ward reported that all had gone well.

Just before his discharge, the ECT nurse made an appointment with Trevor and his primary nurse to conduct an assessment of his level of depression, using the revised version of the Montgomery and Asberg Depression Rating Scale (MADRAS). This is a ten-point questionnaire with ratings of 0-6 on nine questions and 0-5 on one question, with the higher number indicating the most severe depression. Trevor scored five out of a potential 59, which signified minimal depression. During the assessment he appeared a little sad and made little eye contact. He reported occasional feelings of anxiety; poor sleep at times; occasional difficulties with concentrating; and some sluggishness when having to embark on his ADLs. Due to Trevor's initial catatonic state it had not been possible to conduct a baseline assessment before ECT started, therefore there was no way of comparing the severity of his depression pre- and post-treatment. Trevor was discharged home with a minor depression which did not interfere with his normal functioning and he was showing signs of enjoying [life] once again.

An Accepted Practice

Despite the adverse publicity ECT has received, in the past decade it has re-emerged as a safe and effective treatment for major depressive disorders, with the greatest interest in research and use being in the United States (US). It is an accepted part of psychiatric practice in the Scandinavian countries, Great Britain, Ireland, Australia and New Zealand, and use is similar to that in the US.

As the case study of Trevor demonstrates, ECT can be a very effective treatment for a potentially life-threatening condition.

Books

- Diane R. Brown and Verna M. Keith, eds. *In and Out of Our Right Minds: The Mental Health of African American Women*. New York: Columbia University Press, 2003.
- Phyllis Chesler *Women and Madness*. New York: Palgrave Macmillan, 2005.
- Shirley Cohen *Targeting Autism: What We Know, Don't Know, and Can Do to Help Young Children with Autism Spectrum Disorder*. Berkeley and Los Angeles: University of California Press, 2006.
- Katherine Read Dunbar, ed. *At Issue: Antidepressants*. San Diego: Greenhaven, 2005.
- Penny Gray *The Madness of Our Lives: Experiences of Mental Breakdown and Recovery*. London: Jessica Kingsley, 2006.
- Joe Griffin and Ivan Tyrell *Human Givens: A New Approach to Emotional Health and Clear Thinking*. Chelvington, UK: HG Publishers, 2003.
- Gracelyn Guyol *Healing Depression and Bipolar Disorder Without Drugs*. New York: Walker, 2006.
- James Whitney Hicks *Fifty Signs of Mental Illness: A Guide to Understanding Mental Health*. New Haven, CT: Yale University Press, 2006.
- Janice Hunter Jenkins, ed. *Schizophrenia, Culture, and Subjectivity: The Edge of Experience*. New York: Cambridge University Press, 2004.
- Richard Kadison and Theresa Foy DeGeronimo *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It*. San Francisco: Jossey-Bass, 2004.
- Paul R. Kimmel with Chris E. Stout, eds. *Collateral Damage: How the U.S. War on Terrorism Is Harming American Mental Health*. Westport, CT: Praeger, 2006.
- Peter D. Kramer *Against Depression*. New York: Viking, 2005.
- Juan Jose Lopes-Ibor et al, eds. *Disasters and Mental Health*. Hoboken, NJ: Wiley, 2005.
- Michael Martin *Teen Depression*. San Diego: Lucent, 2004.
- Theodor Millon *Masters of the Mind: Exploring the Story of Mental Illness, from Ancient Times to the New Millennium*. Hoboken, NJ: Wiley, 2004.
- Francis Mark Mondimore *Depression, the Mood Disease*. Baltimore: Johns Hopkins University Press, 2006.
- Kim T. Mueser and Susan Gingerich *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*. New York: Guilford, 2006.
- Demetri Papalos and Jennifer Papalos *The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder*. New York: Broadway, 2006.
- Mark Pollard *In Small Doses: A Memoir About Accepting and Living with Bipolar Disorder*. Mill Valley, CA: Vision Books International, 2004.
- Tim Rowan *Solution-Oriented Therapy for Chronic and Severe Mental Illness*. New York: Norton, 2003.
- Sarah Russell *A Lifelong Journey: Staying Well with Manic Depression/Bipolar Disorder*. Toronto: Warwick, 2006.
- Norman Sartorius and Hugh Schulze *Reducing the Stigma of Mental Illness*. New York: Cambridge University Press, 2005.
- Jennifer A. Schaler, ed. *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics*. Chicago: Open Court, 2004.
- Timothy Scott *America Fooled: The Truth About Antidepressants, Antipsychotics, and How We've Been Deceived*. Victoria, TX: Argo, 2006.
- Susan Senator *Making Peace with Autism: One Family's Story of Struggle, Discovery, and Unexpected Gifts*. Boston: Trumpeter, 2006.
- Meredith F. Small *Culture of Our Discontent: Beyond the Medical Model of Mental Illness*. Washington, DC: National Academies Press, 2006.
- Thomas Szasz *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. Syracuse, NY: Syracuse University Press, 1997.
- Graham Thornicroft *Shunned: Discrimination Against People with Mental Illness*. New York: Oxford University Press, 2006.
- Sami Timimi *Naughty Boys: Anti-Social Behavior, ADHA, and the Role of Culture*. New York: Palgrave Macmillan, 2005.
- E. Fuller Torrey *Surviving Schizophrenia: A Manual for Families, Patients, and Providers*. New York: HarperCollins, 2006.
- Tina Zahn with Wanda Dyson *Why I Jumped: My True Story of Post-partum Depression, Dramatic Rescue, and Return to Hope*. Grand Rapids, MI: Revell, 2006.

Periodicals

- Leila Abboud "Should Family Doctors Treat Serious Mental Illness?" *Wall Street Journal*, March 24, 2004.

- Roy F. Baumeister "The Lowdown on High Self-Esteem," *Los Angeles Times*, January 25, 2005.
- Benedict Carey "Mentors of the Mind," *Los Angeles Times*, June 18, 2001.
- Paul J. Fink "Rethinking Electroconvulsive Therapy," *Clinical Psychiatry News*, October 2004.
- Bob Guldin "A Treatment for Depression, or a Pain in the Neck?" *Public Citizen News*, September/October 2005.
- Arline Kaplan "Teacher of the Year Addresses Psychiatric Education, Schizophrenia Treatment," *Psychiatric Times*, February 1, 2006.
- Katherine Lerer "Twirling in Space: My Experience with Shock Therapy," *Psychology Today*, May 2000.
- John S. March "CBT: An Important Part of Treatment," *Clinical Psychiatry News*, July 2005.
- Susan Mayor "ECT May Be Better than Drugs for Short-Term Depression," *British Medical Journal*, March 15, 2003.
- Tara Pepper "Talking to the Demons: Schizophrenia Is No Longer Seen as a Genetically Predetermined Disease," *Newsweek International*, December 12, 2005.
- Dan Seligman "It's All the Rage (Anger Management)," *Forbes*, December 8, 2003.
- Louise Sharah "A Patient's Story," *Australian Doctor*, March 31, 2006.
- Nigel Short and Mark Hardcastle "Cognitive Behavioural Therapy Explained," Clinical Section, *Independent Nurse*, March 10, 2006.
- Margaret Wehrenberg "Is Relief Just a Swallow Away?" *Psychotherapy Networker*, November/December 2003.
- Andrew Weil "Mother Nature's Little Helpers," *Time*, January 20, 2003.

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