REvised ELECTRO-SHOCK THERAPY REPORT
Formulated by the
Committee on Therapy of the Group for the Advancement of Psychiatry

Report No. 15 3617 W. 6th Ave., Topeka, Kansas August, 1950

Since the publication of GAP Report No. 1* on electro-shock therapy three years ago, more clinical experience has been gained and additional scientific reports have been published. On this basis and with the assistance of consultants,† the Committee on Therapy submits a second report on electro-shock therapy.

1. Electro-shock therapy (perhaps better named electro-convulsive therapy or electro-cerebral therapy) is of unquestioned benefit in certain psychiatric conditions. When indicated it is a valuable part of the overall psychiatric treatment program and in many cases is the major therapeutic procedure. As a psychiatric procedure, it should be administered only by or under the direct supervision of a qualified psychiatrist who has been trained in this technique.

2. The best results with electro-shock therapy have been obtained in patients with depression.

   a. Involutional psychosis, melancholia. In this condition, the duration of the depression is shortened, the incidence of suicide decreased, and the recovery rate increased. In those cases where this illness is associated with pronounced agitation or delusions about eating, the management problem may be simplified or overcome.

   b. Manic-depressive psychosis, depressive type. In this psychosis the depressive episode is shortened and the danger of suicide decreased. There is no evidence that electro-shock therapy prevents subsequent attacks of depression or alters the frequency of recurrences.

   c. Psychoneurosis, reactive depression. The treatment of choice for patients with neurotic depression is psychotherapy. However, certain patients with neurotic depression respond to electro-shock therapy. Each patient must be studied with regard to depth of the depression, suicidal risk, intensity of guilt, personality resources, environmental situation, and relationship to therapist.

   The choice of therapy depends upon an evaluation of these factors. Electro-shock therapy and intensive psychotherapy may not be mutually exclusive. Both may be indicated for successful treatment. However, it is often found that electro-shock nullifies attempts at psychotherapy, particularly when inadequate attention is paid to the doctor-patient relationship before and during the shock therapy.

   d. Depression associated with certain organic brain disorders. Some authorities advocate electro-shock therapy in senility, cerebral arteriosclerosis, multiple sclerosis, Parkinsonism, general paresis, etc., where depression is present. Electro-shock therapy in these conditions is not a customary practice and this Committee considers that it is still in the investigative stage.

3. Electro-shock therapy has been advocated in conditions other than depression.

   a. Manic-depressive psychosis, manic type. There is evidence that manic attacks may be shortened by a greater number of convulsions given more frequently than to patients with depression. Manic patients who fail to have a remission under treatment may be quieted and therefore easier to manage. Electro-shock therapy does not prevent subsequent attacks of mania.

   b. Schizophrenia. Electro-shock treatment is of value in the production of remissions in certain patients ill with schizophrenia. These are usually the acute cases of short duration in which the affective components are pronounced and the assets of the pre-psychotic personality were good. Patients of this type are understood to have a relatively good prognosis in any case and other forms of treatment are equally effective as regards the production of remissions. However, psychiatrists who have devoted themselves to the psychotherapy of schizophrenic patients do not believe that all patients of this type have a relatively good prognosis with any form of treatment. On the basis of such experience, they believe that appropriate psychotherapy is productive of more lasting and sound results and in some instances is their only hope.

In hospital practice the management of chronically excited, intractable schizophrenic patients may be made easier with electro-shock therapy.

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†The Committee on Therapy is especially indebted to the following: A. E. Bennett, M.D., K. M. Bowman, M.D., P. H. Hoch, M.D., W. A. Horwitz, M.D., L. B. Kalinowsky, M.D., and R. B. McGraw, M.D. These consultants gave their opinions to the GAP Committee on Therapy, but this report should not be construed as fully representing their views or as carrying their endorsement as a whole.
c. Organic psychoses with excitement. Some authorities advocate the use of electro-shock therapy in organic psychoses with excitement, such as general paresis, epileptic clouded states, alcoholic hallucinosis, etc., to control the excitement. This Committee considers that the use of shock in such illnesses is in the investigative phase of study.

4. Psychiatric contraindications. Electro-shock therapy is contraindicated in psychosomatic conditions, psychopathic personalities, behavior problems of children, and psychoneuroses with the exception of neurotic depressions. (See above.)

5. Physical contraindications. When electro-shock therapy was introduced, many physical contraindications were suggested. Accumulated experience indicates that there are no absolute physical contraindications to electro-shock therapy. Each patient must be evaluated in terms of his overall physical status, the severity of the psychosis, and the urgency of the need for treatment.

6. Prevention of injury to muscle, bone, and joints. Some authorities advocate the routine use of drugs such as curare, its derivatives, and synthetic compounds of similar action in conjunction with electro-shock therapy to prevent injury to muscle, bone and joints. Other authorities consider the use of these drugs dangerous to life. The Committee feels that this topic requires further study.

7. Electro-shock therapy of non-hospitalized patients. Evidence is available to indicate that electro-shock treatment of non-hospitalized patients is satisfactory in selected patients under adequate safeguards. The following safeguards are recommended by those who practice outpatient electro-shock therapy:

- a. That the office be equipped for the control of respiratory and other complications.
- b. That trained personnel attend the patient during treatment and until he is ready to leave the office.
- c. That the patient remain in the office until it is certain that there are no untoward after-effects.
- d. That the office provide recovery rooms for the patients.
- e. That patients and relatives in the waiting and recovery rooms be shielded from seeing or hearing treatment procedures.
- f. That the patient be accompanied from the office by a reliable person who is specifically instructed about the post-convulsive care of the patient.
- g. That no patient be treated on an ambulatory basis unless there are reliable and instructed persons to supervise him at home on a twenty-four hour basis if necessary, during the entire course of treatment.
- h. That there be available hospital facilities for the immediate admission of the patient if necessary.

8. Abuses of electro-shock therapy. The Committee finds that there are widespread abuses of this treatment:

- b. Its administration to patients without due regard to an adequate evaluation of the patient's personality, his problems and the potentialities of other forms of therapy.
- c. Its routine immediate use to the exclusion of adequate psychotherapy.
- d. Its use as a sole therapeutic agent to the neglect of a complete psychiatric program.

9. Research in electro-shock therapy. There is a continuing need for research in electro-shock therapy. Important areas for research are:

- a. The mode of action of electro-shock therapy, which is unknown. Combined physiologic and psychodynamic studies may be necessary to solve this basic problem.
- b. The evaluation of prophylactic shock in recurring psychiatric illnesses and of maintenance shock in chronic psychiatric illnesses.
- c. Evaluation of electro-shock therapy in organic psychoses with either excitement or depression.
- d. The use of electro-shock therapy to stop or alter cycling in manic-depressive psychosis, circular type.
- e. Clarification of the physical contraindications to electro-shock therapy.
- f. Clarification of the practice of using drugs to prevent injury to muscle, bone and joints.
- g. The use of non-convulsive electro-therapy as a means of minimizing confusion and memory loss following convulsive shock therapy.
- h. Evaluation of electro-narcosis and of the various wave-forms, pulses and frequencies used.
- i. Evaluation of electro-shock therapy when combined with other physiological methods such as insulin coma.

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4 The word “psychosomatic” is still used loosely and in this connotation does not apply to the physical symptoms that often accompany a depression.
ADDENDUM NO. 1
There are a number of reservations entertained about the content of this report by some of the members of G.A.P. They feel that under good psychiatric management electro-shock treatment is not often necessary as a life-saving measure, and that familiarity with a wide range of psychiatric theory and practice reduces the need for its use in general. They doubt the advisability of the use of electro-shock on an ambulatory basis except in an outpatient clinic connected with a psychiatric hospital. Finally, in considering the prognosis in the treatment of neurotic depressions which are held to require electro-shock treatment, they call attention to the fact that these affective disturbances occur in persons who are unsuitable for psychotherapy for reasons other than the depression. Thus, many such patients who have been treated with electro-shock as an easy means of overcoming the depression soon relapse. Since the real situational factors and their attendant emotional problems are not affected by this treatment, these patients continue to live unhappy, maladjusted lives.

ADDENDUM NO 2
There are also some reservations entertained about the content of this report by some of the consultants. Some of them do not feel that they can give all passages in it their wholehearted support. One holds the opinion that shock therapy might conceivably be given by a well qualified neurologist, physiologist, or someone in internal medicine if he had had suitable training. The term “psychosomatic conditions” is too ambiguous to have helpful meaning in the paragraph dealing with contraindications. One recommended that the statement that “Electro-shock therapy and intensive psychotherapy may not be mutually exclusive,” should read, “Electro-shock therapy and intensive psychotherapy should not be mutually exclusive.” Another consultant made the suggestion that the reader might be interested in the information that there is an Electro-Shock Research Association.

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1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

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