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Depression, Psychiatry and the use of ECT

by Pat Bracken

When I was training in psychiatry in the 1980s I was taught that depression was an illness like any other. Like appendicitis or disorders of the gall-bladder it could be investigated, diagnosed, measured and treated through different sorts of medical intervention. It had sub-types, a described course and with the right expertise, a prognosis could be given to the patient. While there was debate about the causes, there was no uncertainty that the symptoms were, in the end, due to a disorder of the neurotransmitters in the patient's brain. There was an acknowledgement that social factors could be important (we had to study Brown and Harris) but these were understood to operate 'from outside'. They could precipitate an episode of the illness and could impact on its course, but depression was, in the end, an independent pathology of the patient's brain, like epilepsy, Parkinson's disease or motor-neurone disease.

Depression was something we should be on the look out for, something our GP colleagues regularly 'missed'. We were encouraged to be more scientific in our management of patients with depression, to use the latest diagnostic groupings, the latest screening instruments and questionnaires. We were also encouraged to educate patients and their relatives, medical students and other doctors about the true nature of this disorder. Patients were to be told that they suffered from a 'chemical imbalance' in the brain. When it came to treatment, it was quite clear : that because depression was ultimately a disorder of the brain it required a brain intervention to cure it. While psychotherapy or social interventions might be useful for 'mild' forms of the disorder and as an adjunct to medical treatment, as a doctor I was expected to do something to the patient's brain with drugs or ECT. Furthermore, the logic of this approach dictated that if the first drug used did not work I should try another, and sooner or later use ECT. Again, there was little room for debate: if the first course of ECT did not work, I was expected to use another, and if necessary another.

Nearly twenty years later little has changed. In fact, psychiatry has become more focused on the brain. Biological psychiatry is the dominant ideology within university departments of psychiatry and trainees are taught that depression is due to an abnormality of brain neurotransmitters. In addition, through the 'Defeat Depression' campaign and clever use of the media by the pharmaceutical industry the public have been tutored to explain periods of anxiety, sadness and despair in biological terms. I have many friends who are now happy to think of themselves as 'lacking serotonin' when their mood is low and look to a course of Prozac as a solution. While ECT has never had a 'designer' image like Prozac, understanding depression as a biological disorder keeps it on the agenda. As anti-depressants have a low success rate (their efficacy is only marginally superior to placebo), there continues to be regular recourse to ECT in hospital psychiatry. In my experience, the continued use of ECT is largely driven by a background framing of depression as a biological disorder, and the more committed the psychiatrist is to a biological understanding of depression the more readily he/she will turn to the use of ECT. This is

supported by the variable use of ECT in different regions and even in different hospitals in the same region.

I began work in psychiatry in 1983. I have worked as a psychiatrist in Ireland, Uganda and in a number of cities in Britain. I have worked with men and women, urban and rural, black and white. Over the years I have seen countless people with feelings of anxiety, depression and despair, some of whom were 'stuck' and felt overwhelmed. However, in my opinion very few had a primary disorder located in their nervous systems. This is not to deny that our moods and feelings have a biological dimension. It is obvious that certain chemicals like alcohol and LSD can have profound effects on our mental states. However, just as most of our experiences of happiness and joy are clearly associated with our relationships and the events of our lives (and it would sound ridiculous to explain these emotions by way of neurotransmitters), it is my belief that most of our feelings of depression and states of despair are best understood as occurring in the particular context of our lives. Most of the people I have encountered as patients have had complicated stories with varying mixtures of problems involving their physical health, relationships and occupations. Many people with experiences of depression had very low self-esteem which often stemmed from childhood. Some had complex social difficulties involving poverty, housing issues, racism and unemployment. Some had experienced bereavement which continued to weigh heavy and most continued to carry hurt caused by other people at some stage of their lives. I have come to believe that framing the sadness and misery associated with all these problems as being primarily due to a problem with neurotransmitters is simply inadequate. For most people, attempting to deal with depression by changing brain chemistry is akin to someone trying to change the storyline of Eastenders by interfering with the wiring of their television set. The storyline is something generated outside the set and no amount of manipulation of wires and connections will change it. As human beings our thoughts, our emotions and our behaviours are always related to the context of our lives. How we see ourselves, the words we use to describe our experiences, our concerns and our priorities are all bound up with the social world in which we live. Contrary to the ideology of biological psychiatry, the lived experience of human beings will never be explained by way of reference to the make-up of the brain alone.

In my work as a psychiatrist I have come to believe that approaching the problems of depression and despair (and mental illness more generally) from a narrow medical perspective is fraught with dangers. Framing problems with our thoughts, emotions, behaviours and relationships in a medical idiom can be helpful at times but it can also prove limiting and destructive. In recent years, not only service users but historians, anthropologists and philosophers have been at pains to point out that psychiatric classification systems do not hold some universal truth about madness or distress. In reality, most psychiatric diagnoses are nothing more than a particular way of formulating and naming a person's problems. I accept that this is sometimes helpful. It can be a means whereby a person in chaos is given a framework which helps order what is going on for him/her. It can also allow the individual to shed some responsibility for his/her suffering and behaviour. It gets health professionals and others involved and offers a set of therapeutic options.

However, my point is that there is also a downside to diagnosis and the medical framing of distress. It can cover up as well as illuminate the reasons for our pain and suffering. It is often presented to patients as 'the truth' of their condition and serves to silence other possibilities. Psychiatric diagnosis is often little more than a simplification of a complex reality and by formulating an individual's experiences in terms of pathology it can be profoundly disempowering and stigmatising.

Why does psychiatry have such a narrow view of depression, a view which sustains the use of ECT? This is partly because most psychiatric encounters occur in hospitals and clinics, with a therapeutic focus on the individual in isolation from the context of his/her life. When an individual is seen in a distressed state on a hospital ward or in an out-patient clinic the whole environment pushes the doctor or nurse towards a medical understanding. The individual becomes a patient and there is a focus on symptoms and signs as both patient and doctor search for a diagnosis. It is also because biological, behavioural, cognitive and psychodynamic approaches in psychiatry share a conceptual and therapeutic focus on the individual self.

I believe that if we are to be successful in limiting the use of ECT we will need to engage with both of these issues. We need to relocate mental health work away from hospitals and clinics but we also need to develop a critical perspective on psychiatric theory. We need to base our practice on an alternative philosophy. Both elements work together. Community mental health work should mean this: working with people where they live and work in the community. If we allow it, this can mean that the difficulties faced by users 'show up' for us professionals in a different way. Distress and despair can be understood in terms of the person's life, their struggles and their relationships, rather than as symptoms of an

illness.

I am currently working with the Bradford Home Treatment Service. We offer care and support to individuals in crisis, who would otherwise be admitted to hospital. Most of our encounters with users of the service take place in their own homes. The home treatment service attempts to work with a 'needs led' approach and does not, for the most part, seek to diagnose the service user's problems in a medical way. At times, a medical diagnosis is necessary and important, as when there is a suspicion that organic factors might be affecting the person's condition. The medical members have no compunction in arranging various medical tests if these are indicated and everyone who is admitted to the service has a medical examination to rule out a physical disturbance which might be affecting the person's mental state. The point is that the teams's interventions are not guided by psychiatric diagnoses and theories. Psychotropic drugs are used and occasionally the administration of medication becomes a priority. However, these drugs are generally used on a symptomatic basis and not with the belief that they are curing a psychiatric 'disease' of some sort. Just as paracetamol sometimes relieves a headache brought on by worry and stress but does not eliminate the cause of the headache, so too it is our belief that some psychiatric drugs can offer a reduction in anguish and distress. However, we also believe that the benefits of these drugs have been exaggerated in the psychiatric literature and in the claims made by the pharmaceutical industry. (There is now an emerging mainstream literature which would question previous claims about the efficacy of antidepressant drugs; for example, see: Moncrieff et al, 1998). Over 20% of users actually reduce the amount of medication they are taking while on home treatment. The home treatment team is also concerned with the down-side of psychiatric interventions and treatments and is particularly wary of the longer term effects of these drugs. In 5 years practice, we have never seen ECT as the answer to a client's problems. This is despite the fact that, in terms of level of agitation or distress, there is no great difference between the clients on home treatment and those from the same area admitted to hospital. Admissions are more often driven by social problems and poor housing than by the nature of the psychiatric disturbance as such. Working outside the hospital and with an alternative perspective on the nature of depression and despair means that different ways of engaging with individuals in distress become available. We attempt to encounter depression as a 'site of struggle' rather than as an illness, and offer to struggle for a solution alongside the individual in question. It is my belief that this opens up different ways of understanding the reasons behind depression and different ways of going forward.

In summary : I believe that the use of ECT in psychiatric hospitals and clinics is the result of a very narrow framing of the problem of depression. If despair is nothing more than a disorder of the patient's neurotransmitters then doing something to his/her brain becomes a medical necessity and the central focus of the professionals involved. Recourse to ECT is the outcome of medical domination of mental health care. Challenging the use of ECT involves challenging this domination.

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Notes

1In a classic study in Camberwell in south-east London, the researchers Brown and Harris found a community prevalence of depression in working class women three times that of their middle-class group. As well as class differences in prevalence they also found a clear association of depression with 'vulnerability factors' such as having three or more children under age 14 living at home, lack of an intimate confiding relationship, lack of either full-time or part-time employment and having lost a mother before age 11 years. See Brown, G.W. and Harris, T.O. (1978) Social Origins of Depression: A Study of Psychiatric Disorder in Women. Tavistock, London.

2For an excellent discussion of how the pharmaceutical industry has been involved in the 'selling' of depression with a view to maximising the profits gained from anti-depressants, see: Healy, D. (1998) 'Gloomy days and sunshine pills'. Open Mind, 90, March/April, 8-9.

3Moncreiff, J., Wessely, S. and Hardy, R. (1998) 'Meta-analysis of trials comparing antidepressants with active placebos.' British Journal of Psychiatry, 172, 227-231.

4Two patients who had positive results from ECT in the past did insist on having the treatment while on home treatment.

5Cohen, B. (1999) Evaluation of the Bradford Home Treatment Service: Final Report. University of Bradford.

6Bracken, P and Cohen, B. (1999) 'Home treatment in Bradford.' Psychiatric Bulletin, 23, 349-352.

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