Electroconvulsive therapy (ECT) was introduced 8 decades ago and has proven to be a durable and effective treatment for a variety of neuropsychiatric diseases, not just severe mood disorders. But even if one considers only the prevalence of severe and treatment-resistant major depressive disorder, why is it that ECT is not used more frequently—and practically speaking, becoming even less available?

It is not as a result of safety concerns, because an estimated 2.1 deaths per 100,000 treatments is comfortably safer than general anesthesia overall. For the sake of comparison, the rate of sudden cardiac death in college athletes in the United States is approximately 2.4 per 100,000 people, and the rate of death in the US from lightning strikes is approximately 2.3 per 100,000 people.

A lack of access to services is one explanation; as with many other medical services, those with limited resources are disproportionately affected in this regard, and people who are severely and persistently mentally ill are differentially likely to experience poverty at higher rates, which can result in a lack of access. Public attitude also undoubtedly has a role; persistent and pervasive stigma not only dissuades patients from considering ECT, it translates in some states to burdensome reporting and regulatory requirements that have the practical effect of limiting access as well.

It seems reasonable to suspect that this prejudice extends to hospital administrators as well, and not just because psychiatric services typically do not bring in the revenue to the hospital that highly technical, resource-intensive services do.

It may be that psychiatrists’ lack of comfort with the procedure also contributes to its underuse, failing to consider it when clinically appropriate and advocating for its wider access. Major indications for ECT are widely disseminated, and I think, generally acknowledged within the field (although less commonplace indications may not be); but in day-to-day decision-making how accurately are they balanced against perceived drawbacks?

Unfortunately, ECT training remains underemphasized in many residency programs, suggesting that many clinicians are deprived of the opportunity to become familiar with this treatment. It may be that clinical decisions are driven, at least in part, by outdated or inaccurate perceptions; it has been known for decades that attitudes toward ECT become markedly more favorable with actual exposure and experience.

Like any other medical procedure, ECT has its risks. Cognitive side effects in particular can be troubling, although fears of permanent (if unspecified) “brain damage” appear unjustified.

And ECT is, in practice, differentially offered to patients who have treatment-resistant forms of illness, so relapse is commonplace. However, advances in technique continue to make ECT safer and cognitive side effects less pronounced, and relapse rates can be substantially decreased with proper pharmacological management after treatment (or continuation of ECT). Because it remains an effective intervention, not to consider it in appropriate cases or even an inability to have access, is a failure of responsibility to our patients.

With that being said, expertise in the actual administration of ECT is unnecessary for most psychiatrists; it is a technique best left to those who have acquired the highly specialized skills necessary to safely administer it.

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the other hand, its safety and efficacy are such that a broad general understanding of the implications of treatment remains important in everyday practice so that when the subject is broached, the patient can be provided appropriate information.

Fears that ECT might somehow cause physical damage to the brain persist (even, sometimes, among professionals), so in this issue of Psychiatric Annals, in the first article “Does Electroconvulsive Therapy Injure the Brain?”, I review many of the studies that have looked for—and not found—evidence to that effect. In the second article, “The Cognitive Effects of Electroconvulsive Therapy: A Critical Review,” Drs. Caterina Mosti and Michael Brook review the nature and typical duration of the cognitive side effects associated with ECT. In the next article, “Uses of Electroconvulsive Therapy in Conditions Other than Major Depressive Episode,” Drs. Sandarsh Surya, Ram Bishnoi, Peter B. Rosenquist, and William V. McCall point out that ECT is effective and safe in the treatment of severe states of illness other than mood disorders, and thus should be considered when such conditions present. Finally, in the article, “Continuation Therapies After Successful Treatment with Electroconvulsive Therapy in Major Depressive Disorder,” Drs. Brendan J. O’Connor and Charles R. Conway provide valuable advice regarding perhaps the most challenging clinical task—maintaining response after ECT. We hope that these contributions will help the practitioner in thinking through the question of when, and for which patients, ECT should be considered.

REFERENCES