

## **Educating patients and relatives about electroconvulsive therapy: the use of an information leaflet**

ALISON JENAWAY, Registrar in Psychiatry, Fulbourn Hospital Cambridge CB1 5EF

Several studies in the United Kingdom have highlighted the lack of knowledge that patients show about electroconvulsive therapy (ECT), both before treatment starts (Malcolm, 1989) and after it is completed (Freeman & Kendell, 1980; Hughes *et al*, 1981), with only 10 to 15% of patients having a full understanding of the treatment. In an American study (Baxter *et al*, 1986) patients seemed slightly better informed; this might be because they were given written information. However, subjects who watched a videotape of someone having the treatment did not score higher on a knowledge questionnaire than a control group and the authors postulated a 'ceiling effect'. Bird (1979) demonstrated that access to media coverage about ECT improved patients' knowledge without increasing anxiety about the treatment.

The present study is a comparison between patients who received only verbal information about ECT from their doctor and those who also got a written information leaflet about the treatment. Outcome measures include satisfaction with the information given, knowledge about ECT and anxiety about the treatment. I also interviewed relatives of the subjects using a similar questionnaire.

### *The study*

I recruited 60 consecutive in-patients suffering from a major depressive illness (as defined by DSM-III-R criteria) who had consented to a course of ECT at two hospitals over eight months.

I used a crossover design. During the first half of the study, consecutive patients recruited from the adult wards at Fulbourn Hospital and the psychogeriatric ward at the West Suffolk Hospital received the leaflet, while patients recruited from the adult ward at the West Suffolk Hospital and the psychogeriatric ward at Fulbourn Hospital acted as controls. This policy was reversed during the second half of the study, following a ten day period when leaflets were removed from all the wards and no new patients recruited.

I interviewed patients after they had signed the consent form but before the treatment. Subjects in the leaflet group were given the leaflet by a member of the nursing staff following the consent procedure and were interviewed between two and four hours later.

Control patients were interviewed between two and four hours after consenting to treatment. I did not attempt to alter the usual consent procedure of the ward doctor.

The leaflet consisted of basic information about the reasons why ECT is given and about the treatment itself. In order to give information about when and where the treatment was given the leaflet was customised according to the individual hospital.

The interview consisted of the 17 point Hamilton Depression Rating Scale and a standardised interview about ECT based on the one used by Freeman & Kendell (1980) with some alterations as it was being used for patients prior to starting treatment. Questions asked about the consent procedure, anxiety and knowledge about the treatment. Patients' responses to the knowledge question were coded according to the number of items mentioned out of a total of 11 items.

I repeated the interview one week after completion of a course of ECT, with the addition of three questions concerning changes noticed following treatment and the patient's attitude to the possibility of ECT in the future. At the second interview, I also asked patients if they had a close relative who had visited them during their treatment and who might agree to be interviewed about ECT. The relatives did not receive a leaflet directly but the leaflet was clearly marked, "Information for patients and relatives" and it was hoped that patients would show it to their relatives. The interview carried out with the relatives contained the same questions as the post-treatment interview described above.

### *Findings*

Of 60 patients recruited, three refused the second interview. These patients' responses have not been included in the results.

Of the remaining 57 patients, 38 (67%) were women, and the average age 57 years. Forty-nine had previously had a course of ECT. The mean Hamilton score before treatment was 21, and after treatment 6. There were no significant differences between the control group and the experimental group on demographic or clinical features, the number of treatments received, the social class distribution or the educational levels of the two groups.

Fifty patients (88%) were satisfied with the consent procedure before treatment and 49 patients (86%) afterwards. Forty-eight patients (84.2%) were aware that they could have refused treatment if they had wanted and this increased to 53 patients (93%) after treatment. There were no significant differences in the responses of the two groups to these questions.

Patients in the control group were more likely to say yes when asked before treatment if they would like more information about ECT, but this finding failed to reach significance following Yates' correction (control = 10/29, leaflet = 3/28,  $\chi^2 = 3.647$ ,  $P = 0.056$ ). The difference was less marked after treatment.

The mean number of knowledge items mentioned by the experimental group was significantly greater than that of the control group both before treatment (control = 2.3, leaflet = 3.1,  $t$  value = 2.21,  $P = 0.03$ ) and after treatment (control = 1.9, leaflet = 3.0,  $t$  value = 3.23,  $P = 0.002$ ).

Knowledge scores were not significantly affected by patients' sex, social class, level of education or previous experience of ECT, nor by the status of the doctor who obtained their consent. Subjects under 65 scored higher than those over 65 although this was statistically significant only before treatment (under 65 yrs = 3.1, over 65 yrs = 2.1,  $t$  value = 2.54,  $P = 0.014$ ).

The only significant differences in individual knowledge items were that subjects in the experimental group were more likely to mention "muscle relaxant" before treatment ( $P < 0.03$ ) and "electrodes" after treatment ( $P < 0.02$ ).

Patients were asked to choose which word on a 5 point scale of increasing anxiety best described their feelings about having ECT. Before treatment subjects in the experimental group described themselves as significantly less anxious about ECT than those in the control group (Mann-Whitney U test, 2 tailed probability = 0.045). After treatment there were no differences in the two groups' description of how they felt about the possibility of having ECT again in the future.

Thirty-two relatives (53.5% of a possible total of 60) were interviewed, of whom one was the spouse of a patient who refused follow up. Seventeen patients did not have a close relative visiting them, six did not want a relative to be interviewed and three relatives agreed to be interviewed but could not be contacted.

There were no significant differences between the patients whose relatives were seen and those whose relatives were not seen on demographic or clinical measures. Relatives of the experimental and control groups did not differ significantly from each other.

Twenty-three relatives (72%) were aware that the patient had signed a form for ECT and 27 (84%) that the patient could have refused the treatment. The majority of relatives were quite satisfied with the

consent procedure; only six (19%) were not and this was generally because they felt the patient had been too ill to make an informed decision. There were no differences between the two groups on these three aspects of treatment.

Relatives of the control patients were significantly more likely to say that they would have liked more information about ECT than relatives of the experimental group (control = 11/15, leaflet = 4/17,  $\chi^2 = 6.06$ ,  $P = 0.02$ ).

Although the experimental group relatives had a slightly higher mean knowledge score than control relatives (2.7 and 2.2, respectively) this finding was not significant. There were no differences in the relatives' anxiety about the possibility of the patients having future treatment.

### Comment

Patients were highly satisfied with the consent procedure used in this study as in previous studies. However, they were more likely to believe that they could have refused treatment than previous authors have found. This may reflect changes in the Mental Health Act which emphasise patients' right to refuse treatment.

Only 34.5% of the control group and 10.7% of the experimental group would have liked more information. Several patients made comments such as, "It's better not to know too much, I might worry more." However, when asked if the information they had been given had affected their anxiety about treatment, only one experimental patient and three control patients said it had made them more anxious.

The experimental group, having seen the leaflet, were significantly less anxious about ECT than the control group prior to treatment. Patients appear to find the notion of ECT less frightening after a course of treatment; no difference between the two groups was found at the second interview. This may be due to the effect of ECT on patients' mood, or the result of their having actually experienced the treatment.

The difference in knowledge scores due to the leaflet was small but significant. It seems to be a general effect rather than an increase in knowledge about particular items. This study does not distinguish between direct effects of reading the leaflet and possible indirect effects, for example, asking more questions of the nursing staff.

The effect of the leaflet on relatives is less impressive, although they were not given their own copy and probably only saw it for a short time when visiting. Nevertheless, relatives appeared to feel better informed when the patient had been given a leaflet and this may make them more confident about the use of ECT.

In summary, my impression is that the leaflet was welcomed by both patients and staff, no-one

complained of feeling upset by it and no experimental patients withdrew their consent to ECT after receiving it. Some patients will not benefit directly from being given written information, but it may act as a basis upon which nursing staff can build in order to increase patient knowledge and reduce anxiety.

### Acknowledgements

I am grateful to Dr C. P. L. Freeman for supplying me with his questionnaire and to Dr C. N. Mayer and Professor E. Paykel for their advice and encouragement.

This study was carried out while the author was the Research Registrar on the Cambridge Psychiatric Training Scheme.

### References

- BAXTER, L. R., ROY-BYRNE, P., LISTON, E. H. & FAIRBANKS, L. (1986) Informing patients about electroconvulsive therapy: effects of a videotape presentation. *Convulsive Therapy*, **2**, 25–29.
- BIRD, J. M. (1979) Effects of the media on attitudes to electric convulsion therapy. *British Medical Journal*, **3**, 526–527.
- FREEMAN C. P. L. & KENDELL, R. E. (1980) ECT: I. Patients' experiences and attitudes. *British Journal of Psychiatry*, **137**, 8–16.
- HUGHES, J., BARRACLOUGH, B. M. & REEVE, W. (1981) Are patients shocked by ECT? *Journal of the Royal Society of Medicine*, **74**, 283–285.
- MALCOLM, K. (1989) Patients' perceptions and knowledge of electroconvulsive therapy. *Psychiatric Bulletin*, **13**, 161–165.

---

*Psychiatric Bulletin* (1993), **17**, 12–13

## Attitudes of child psychiatrists to electroconvulsive therapy

RANJANA PARMAR, Senior Registrar, Child And Adolescent Psychiatry, West Midlands Regional Health Authority

Electroconvulsive therapy (ECT) has long been recognised as an important method of treatment in adult psychiatric disorders, especially severe depression. However, in spite of increasing concern about the occurrence of depressive disorders among the young (Klerman, 1988), very little is known about the use of ECT in children and adolescents. Indeed the published literature on ECT in this age group consists almost entirely of case reports (Bertagnoli & Borchardt, 1990). This paper is concerned with an important determinant of such practice, the attitudes of child and adolescent psychiatrists.

The concept of depressive disorder in children and adolescents has itself involved some controversial issues. Accordingly, before considering attitudes to ECT it was first necessary to establish whether or not the concept of depressive disorder was felt to be useful, as this is after all the main indication for use of ECT in adults. Since national surveys of psychiatrists can have unacceptably low response rates, this study focused on five health regions: West Midlands,

Trent, Northern Western, South West Thames, and three Health Boards in Scotland.

### The study

All consultants in child and adolescent psychiatry who were working in these five regions were sent a questionnaire that enquired about the usefulness of various forms of therapy in three categories of depression (psychotic, severe, moderate/mild). Respondents were also asked to rate usefulness according to the age of the patient (under 12 years, 12–17 years, over 17 years). Of the 125 consultants then in post, 99 (79%) returned completed questionnaires.

### Findings

The majority of respondents reported that the concept of depression was useful/very useful (60% in children and 85% in adolescents).