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ECT: a patient-friendly procedure?

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Electroconvulsive therapy is widely seen by the public as a barbaric and outmoded form of treatment. Even within groups of health care professionals, ECT does not have a 'good press'. Most research into the area of patient attitudes to ECT has been retrospective and often considerably so, and is therefore unlikely to illustrate patients' feelings about a course of treatment at the time it took place (Freeman & Kendell, 1980; Kerr *et al.*, 1982). The only prospective study is that by Malcolm (1989). This showed a low level of understanding of treatment and a high level of anxiety both before treatment and afterwards, but, despite this, a high level of compliance with ECT therapy.

Our aim was to re-examine these findings in order to find a way of improving the experience of ECT.

The study

Our study took place between August 1990 and June 1991. Consecutive patients prescribed ECT in three hospitals in the Northern Region were identified

before treatment and approached for the study. Consenting patients were interviewed using a semi-structured questionnaire before treatment and approximately two months after it had been completed.

The interviewers were psychiatric registrars not involved in the patient's clinical care. An agreed interview script was used to improve inter-rater reliability. Patients were interviewed after consenting but before commencing treatment. The questionnaire included open and closed questions, and Likert attitude scales, on various aspects of the ECT 'process' such as anxieties about treatment, anticipated benefit, understanding of procedure, knowledge of side-effects and opinion of relatives' attitudes to ECT.

After treatment patients were interviewed at home or on the ward. We assessed change in attitude to treatment, perceived benefits, standard of care received, experience of side-effects, satisfaction with the consent procedure, and opinion as to who should be involved recommending ECT.

Findings

Forty-nine patients, 15 men and 34 women, were identified; 43 consented to the pre-treatment questionnaire and 40 to the post-treatment. A total of 37 consented to both questionnaires. Mean age was 53.6 years (range 19–83, s.d. 16.3); 14 were over 65. All had marked depressive symptoms but diagnoses using research criteria were not made. The mean number of treatments was 6.5 (range 1–15). Seven patients were detained under the Mental Health Act when treatment began; four of these were on Section 58. Treatment was administered twice weekly by junior psychiatrists using standard equipment such as the Ectron ECM1 machine.

Pre-treatment

Of patients, 60% believed treatment would be helpful, 18% believed it would have no effect, and 10% that it would be unhelpful.

Fifty-one per cent had a good understanding of the indication for treatment; the remainder did not know or gave vague or incorrect explanations. There was no statistically significant relation between age and understanding of indication for treatment, or between understanding and viewing the treatment positively or likely to be of benefit.

Details of treatment procedure were recalled by 57%, the most frequently recalled item being that a general anaesthetic was involved (50%); 38% recalled the use of electricity, and 10% that a fit was induced. Twelve per cent recalled all three items. Forty per cent could not recall being told of any side effect; 44% knew of memory difficulties, 44% of headaches, and 47% of confusion. Five per cent mentioned fracture risk and 5% muscle pain.

Sixty-nine per cent felt anxious about treatment. There was no statistically significant age or sex difference in incidence of anxiety. Patients receiving treatment for the first time were more anxious than those who had received it previously. Fifty-three per cent had specific worries which they mentioned spontaneously – 16% about physical side-effects, pain and death, and 16% a fear of the anaesthetic, brain damage, or change in personality.

Twenty-five per cent knew that treatment had been discussed with their family; 61% thought it had not, 7% had no family, and 7% did not know. There was a high level of perceived relative approval of treatment (83%).

Post-treatment

Fifty-six per cent viewed treatment as helpful, and 20% felt it was unhelpful. Fifteen per cent perceived no change, and the remainder did not know if it had been helpful. More than four-fifths reported at least

one mild side-effect, mainly memory difficulties (75%), headache (35%), and confusion (45%).

Sixty-seven per cent said they would accept ECT in the future if it was advised; 20% felt it unlikely and 10% were undecided. Patients were significantly more likely to consider further treatment if they found the course helpful and viewed ECT positively. Five per cent perceived benefit but were negative about further treatment. There was no statistically significant difference between the experience of side-effects and attitude to further treatment. Over one third felt they had not been given an adequate opportunity to discuss treatment. A similar proportion believed their views were not really considered.

Eighty per cent felt the nursing care on the ward had been either good or adequate; 83% were satisfied with the level of reassurance given by ward staff; 90% recalled being accompanied by a familiar nurse for their treatment; 20% could recall an explanation of what was happening during the treatment procedure; 45% said they had no explanation. Fifty-five per cent said they had received good care in recovery, 18% adequate care, and 5% poor care. In all the above the remainder could not remember.

Twenty-five per cent felt their family's attitude was more positive after treatment, 55% that their attitude was unchanged, and 8% that it was more negative. The remainder did not know or had no family. In the families who were more negative the patients themselves had perceived treatment as unhelpful and were more negative about it.

Comment

Our small sample excluded urgent cases where a last minute decision about treatment was made, and those who may have initially declined treatment but then consented – important groups whose opinions would have been valuable.

Depression can lead to a negative view of many things, including treatment, which may have influenced responses.

Our results confirm that patients usually have a positive or neutral attitude to ECT (Freeman & Kendell, 1980; Baxter *et al.*, 1986), with a significant minority viewing it negatively. The likelihood of accepting a further course of treatment was influenced by how beneficial they had found this course. Experience of side-effects was not related to the likelihood of having further treatment. This may reflect a willingness to tolerate side-effects for beneficial treatment. Denial of possible further illness may account for some who perceived benefit from treatment, but said they would not have it again.

Only 56% reported benefit from treatment, lower than in previous studies. It would have been interesting to have an objective report of outcome of

treatment. This may have indicated more benefit than that reported. The effect of ECT does not always persist (Hughes *et al*, 1981) – we aimed to allow for this by seeing people an average of two months after treatment, but some may have forgotten in this time any benefit which had not been sustained, or be minimising the severity of their illness prior to treatment. Since perceived benefit influences attitude to treatment, this is an important group to identify. They would benefit from more feedback from professionals.

We confirmed previous studies (Freeman & Kendell, 1980; Hughes *et al*, 1981; Malcolm, 1989) showing that patients have a low level of understanding of indications for treatment, procedure and side-effects, as well as a low level of satisfaction with consent. Only 50% of our sample recalled the use of a general anaesthetic, compared to 89% of Malcolm's sample. Thirty-eight per cent knew that electricity was used (42% in Malcolm's) and only 10% of our study and 16% of Malcolm's knew a fit was induced. It is unclear whether this is because the items are being inadequately discussed, or whether the patients' mental state makes them unable to retain the information. There was a suggestion that people could recall aspects of the consent procedure however, and that these items had not been clearly discussed. We did not find that having a good understanding had any influence on attitude to treatment. This is an important area for further work, perhaps evaluating the use of tapes and written information, to ensure that patients have a clear understanding of what treatment involves.

We confirm Malcolm's finding (1989) that although patients had a low understanding of treatment, they were still compliant, with most rating highly the doctor's role in decision making. This may reflect a high level of trust, or a resigned lethargy, in part reflecting mental state, but also a feeling of lack of involvement in their own management. Professionals

must work hard to ensure this is not the case. The range of side-effects was similar to previous studies (Freeman & Kendell, 1980; Malcolm, 1989), but our group was more anxious. This anxiety was not related to age and sex. It may reflect lack of understanding of what treatment involved, or a feeling that this decision had been made on their behalf by others. Those who had had previous treatment were less anxious, which may be because they knew what to expect, or because they had been instrumental in initiating this course of treatment, which gave them a greater sense of control. Specific worries similar to those previously reported were found (Freeman & Kendell, 1980; Malcolm, 1989), notably brain damage, personality change and fear of anaesthesia.

There appears to be a need for more explanation of ECT by doctors, perhaps augmented by explanatory leaflets or even videotapes. In the language of commerce which appears with increasing frequency in the NHS today, a lot more could be done to 'sell' ECT more effectively.

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