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Patient attitudes to electroconvulsive therapy

AIMS AND METHODS

To investigate patients' subjective attitudes to electroconvulsive therapy (ECT) a questionnaire was posted to 89 consecutive patients who had received treatment in an ECT department.

RESULTS

Fifty-one responses were obtained (57%). Results indicated a high satisfaction with the department and the treatment itself; 44 respondents would or might have ECT again and 35 reported at least a modest improvement with ECT. However, a high rate (60%) of subjective cognitive impairment was reported.

CLINICAL IMPLICATIONS

Electroconvulsive therapy can be an acceptable treatment option for patients when administered in an accredited clinic. More research is urgently required to investigate the exact nature of ECT-associated cognitive impairment, in terms of functional deficits, severity and practical importance to patients' lives.

Despite concerns, electroconvulsive therapy (ECT) continues to play a role in modern psychiatry. The National Institute for Clinical Excellence (2003) recommends that ECT

'is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered potentially life-threatening in individuals with severe depressive illness, catatonia or a prolonged or severe manic episode'.

The advice contained within these guidelines has been criticised by professional groups as inappropriately limiting practice (Royal College of Psychiatrists, 2005), but has been welcomed by several patient support groups. One of the main causes of concern is the unresolved issue of the severity and significance of cognitive impairment post-ECT.

In Ireland, the 2001 Mental Health Act established the Mental Health Commission which is currently working on guidelines regarding the use of ECT in Ireland and aims to produce the first published guidelines specific to Irish psychiatric services. We are unaware of any published studies pertaining to the subjective experiences of Irish patients receiving ECT.

In 2003, 141 patients received ECT in St Patrick's Hospital out of a total of 2910 admissions (of which 40 were involuntary; Department of Health and Children (Ireland), 2004). This figure has been falling, with 149 patients receiving ECT in 2002 and 292 in 2001 (Department of Health and Children (Ireland), 2002, 2003).

An audit, carried out in the department in 2003, of 170 ECT sessions, revealed that the average age of a patient was 53.1 years (s.d.=16.8); 87% of patients received ECT for depression, 5% for mania, and 8% for a psychotic illness (including affective psychosis); 68% of patients were female and 32% male; bilateral ECT was administered in 99% of cases.

At the time of the survey ECT was administered using a MECTA SR 2 machine, which uses a biphasic brief pulse waveform. Dosing was by the estimated dose technique according to age and gender. Therapy was given as a standard bilateral treatment unless the treating team requested unilateral treatment.

Method

This study was conducted at St Patrick's Hospital, Dublin, an independent 300-bed psychiatric facility affiliated to the University of Dublin, Trinity College.

A postal questionnaire was developed with 38 questions, some of which allowed dichotomous answers and others a more complex choice. Two further sections allowed the patient to comment on the service and give suggestions for improvement, and to document any other side-effects or problems that they would like to mention. The questions relating to this study were divided into the following sections:

- background information
- the ECT procedure
- a typical day in the ECT suite
- after ECT treatment.

We posted the survey to 89 consecutively treated patients who had completed a course of ECT over a 7-month period; 5 of these 89 patients were involuntarily treated under the Mental Health Act 1945 (Ireland).

Ethical approval was sought and obtained from the research ethics committee at St Patrick's Hospital.

Results

There were 51 responses obtained (57%) from two mail shots. The ages of the respondents ranged from 20 to 82 years (mean 53.4, s.d.=15.5); 17 were male (34%) and 33 female (66%). Of those who responded to this question, 16 were undergoing their first course of ECT (33%). Two patients were treated involuntarily under the Mental Health Act 1945 (Ireland). The average length of time since treatment was 17 weeks (range 5–40, s.d.=9.9).

The 51 respondents did not differ from the 89 patients approached to enter the study in a statistically significant way in terms of age, gender or diagnosis. We were unable to comment on the specific experiences of those patients receiving ECT involuntarily due to the low numbers involved (2 responses out of 5 patients treated involuntarily).

**Table 1. The ECT procedure**

| Question | Response n (%) |
|--|-------------------|
| Did you find the procedure stressful? | |
| No | 21 (44.7) |
| Yes, a little but it was what I expected | 23 (48.9) |
| Yes very | 3 (6.4) |
| The most stressful thing imaginable | 0 (0) |
| Was the information leaflet helpful in explaining what happens in the ECT suite? | |
| No | 6 (13.6) |
| Yes | 29 (65.8) |
| Partly | 9 (20.5) |
| Did the staff in the ECT suite explain what would happen to you when you were there? | |
| No | 8 (17) |
| Yes | 39 (83) |

Table 2. On a typical ECT treatment day

| Question | Response n (%) |
|--|-------------------|
| Were you accompanied to the ECT clinic by a member of staff? | |
| No | 0 (0) |
| Yes | 47 (98) |
| Unsure | 1 (2) |
| Did the accompanying member of staff stay with you throughout the treatment? | |
| No | 7 (14.6) |
| Yes | 21 (43.8) |
| Unsure | 20 (41.6) |
| Did you know the member of staff accompanying you? | |
| No | 8 (17) |
| Yes | 39 (83) |
| Were you introduced to all those who would be present during treatment? | |
| No | 6 (12.5) |
| Yes | 34 (70) |
| Unsure | 8 (16.7) |
| Were the staff friendly and reassuring? | |
| No | 0 (0) |
| Yes | 48 (100) |
| Was the clinic clean and comfortable? | |
| No | 0 (0) |
| Yes | 47 (100) |

The results of the survey are presented in Tables 1–3. Overall results showed a high satisfaction with the clinic and the staff, with all respondents giving positive response. Of those responding to this question, there were 44 (88%) who would or might have ECT again and 35 (71%) reported at least a modest improvement with ECT. At an average of 17 weeks post-ECT, 60% of respondents report ongoing memory impairment.

Discussion

The Service User Research Enterprise (Rose et al, 2003) performed a systematic review of patients' attitudes to

Table 3. After ECT

| Question | Response n (%) |
|--|-------------------|
| Had you a headache after electroconvulsive therapy (ECT)? | |
| No | 23 (46) |
| Yes | 27 (54) |
| Did you have pains in your muscles afterwards? | |
| No | 3 (6) |
| Yes | 47 (94) |
| Was your memory affected? | |
| No | 3 (6) |
| Yes | 47 (94) |
| Is your memory still affected? | |
| No | 16 (35.6) |
| Yes | 27 (60) |
| Unsure | 2 (4.4) |
| Was ECT helpful? | |
| Very | 23 (46.9) |
| Modest improvement | 12 (24.5) |
| A little | 6 (12.3) |
| Not at all | 8 (16.3) |
| Would you have ECT again if you became unwell and your doctor felt that it would be appropriate? | |
| No | 6 (12) |
| Yes | 36 (72) |
| Maybe | 8 (16) |

ECT, which was sponsored by the UK Department of Health. They concluded that the method used to elicit the views of patients unduly influences the reporting of perceived benefit and willingness to repeat treatment. Most notably they reported that studies sponsored by patient advocacy groups such as the UK Advocacy Network reported lower rates of perceived benefit than studies performed by clinical teams.

We hope to have addressed some of the concerns raised by Rose et al (2003) in assessing the attitudes to ECT in an Irish population. The interval between treatment and questionnaire completion averaged 17 weeks. As noted by Rose et al, clinical studies tend to occur soon after treatment (e.g. Benbow & Crensil, 2004). The number of questions required to receive maximum marks on the rating scale used by Rose et al for their systematic review was 15 or more. Our questionnaire had 38 questions and therefore would score full points for this item on the rating scale. Our survey used a mix of dichotomous scales and simple Likert scales, with space for open comments at the end of the survey. The postal survey allowed for anonymity, and a research registrar conducted the research. The treating teams and staff attached to the ECT clinic were not involved in the collection or analysis of data.

Although the response rate of 57% is low, the results from the department's 2003 audit, in terms of age and gender ratios, almost mirror those of the respondents.

These data suggest that ECT can be seen as an acceptable treatment for some patients. Overall, most

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respondents would or might have ECT again and the majority stated that ECT gave at least a 'modest improvement'. It is worth noting that these high rates of subjective improvement occur in a treatment-resistant population and that the rates mirror previously reported levels of efficacy.

The therapy was not perceived by the majority of patients to be a stressful experience. As reported above, there were high rates of satisfaction with the clinic staff and procedure. This work was conducted in a clinic approved by the ECT Accreditation Service (approved with excellence for 3 years in 2004). The accreditation process allows for greater comparisons with other units, as standards are set for the administration and setting of treatment (Caird et al, 2004).

The high rates of subjective memory impairment seen post-ECT are a cause of clinical concern. The significance and importance of this are unclear, but the issue needs to be addressed urgently in future research. However, despite this, and perhaps surprisingly, given the extent of the problem, support is high for the possibility of future episodes of ECT. These results indicate that, as Rose et al (2003) state, patients make decisions about ECT by weighing the risks and benefits of treatment. However, at variance with Rose et al, substantial numbers of our patients appear to favour ECT, despite the cognitive deficits reported, which highlights the complexity of individual decisions and perhaps the differences that may exist between clinics (as evidenced in the national audits conducted in the UK (e.g. Duffett & Lelliott, 1997, 1998).

At the time of this study, the department continued to use a set guide, based on age and gender, for administering the electrical impulse. We aim to repeat this study after the introduction of a protocol of stimulus dosing. Also, in line with recent College guidelines (Royal College of Psychiatrists, 2005), an active policy of promoting the use of unilateral ECT will be introduced in our department. We will explore the effects of these changes on the high rates of reported cognitive impairment and subjective improvements in mood and satisfaction with the department.

If ECT is to remain as a component of psychiatric service delivery, the experience of patients must be recognised and understood. The efficacy of ECT has been established for some time now (UK ECT Review Group,

2003). Evidence is accumulating regarding an increase in quality of life after ECT (McCall et al, 2006), and in the reduction of suicide risk (Kellner et al, 2005). If we are to continue to administer ECT, it is imperative that we clarify the extent of the risk of cognitive impairment to our patients and understand the reasons for the large variations in subjective experience.

Declaration of interest

None.

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