Patients Who Break Their Fast Before ECT

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Of 81 patients receiving ECT during a period of 24 months, 21 ate or drank something, against medical advice, shortly before ECT was due. Compared with controls, the fast-breakers were less often married; were more likely to be detained under a section of the Mental Health Act; had an unfavourable view of ECT; and had often not given consent for ECT. Fast-breaking was more likely to occur after four or more ECTs. Amongst the fast-breakers there was a significant correlation between age and (a) number of previous ECTs; (b) treatment at which the fast-break occurred. The more drugs the patient was taking the more likely it was that the fast would be broken early in the course of ECT.

Little is known of the clinical characteristics of patients who refuse ECT or those who, while not overtly refusing, avoid receiving it by breaking their fast. One may speculate that the latter group may be constituted of at least two sub-groups: patients who forget that they must not eat and patients who wilfully eat as a form of passive resistance. However, this distinction is based on the ascertainment of motives and so is difficult to make in clinical practice. This paper reports on a prospective study into the more objective clinical characteristics of a cohort of fast-breakers.

**Method**

The study was carried out in a 30-bed acute unit (Friends Ward) in Fulbourn Hospital, Cambridge. All patients receiving ECT during the period of 24 months starting on 13 July 1983 were included. There were 617 admissions during the period in question: 76 patients received ECT, of whom 21 broke their fast at some time.

Fast-breaking was defined as eating or drinking, against clear medical advice, during the 8 hours prior to ECT. Due to a ruling by the consultant anaesthetist in charge, such fast-breaking led automatically to a cancellation of that particular treatment. In emergency cases the patient was kept fasting from the time of the incident and the treatment was postponed until the afternoon.

Information was collected by means of specially formatted data sheets which were completed immediately after the incident. These requested data on the patient's age, sex, civil status and legal status under the Mental Health Act; whether he gave consent to ECT; the treatment at which the fast was broken; the patient's and family's attitude to ECT; the patient's previous experience with ECT, medication, and ICD-9 diagnosis; the psychosocial state of the ward; the number of nurses working on the particular shift; and the number of empty beds (an indirect index of overcrowding).

The fast-breakers (n = 21) constituted the index sample. There were 55 other patients who received ECT and these constituted the control sample. Five control subjects received ECT twice during the period in question: in each case only the first course was included in our analysis.

In the first stage of our analysis the index sample was considered separately and the correlations between all its variables were examined. In the second stage the index and control samples were compared on those variables for which they were not matched. Statistical analysis was carried out by means of the Minitab Statistical Package (available in the Computer Laboratory of the University of Cambridge).

**Results**

There was a predominance of females amongst the fast-breakers (18 out of 21) but this reflected a bias in the hospital population. Significant correlations (Pearson correlation coefficient) were found in the index sample between age and (a) the number of previous ECTs ($r = 0.43; P<0.02$); (b) the ECT at which the fast was broken ($r = -0.51; P<0.008$); and (c) the drug score ($r = -0.53; P<0.006$). There was a tendency for the fast to be broken after four or more ECTs, and the ECT at which the fast was broken was significantly correlated with the drug score ($r = -0.61; P<0.01$). No other correlations were found between any of the following variables: number of previous courses of ECT; the number of nurses on the ward; the number of empty beds; drug score; psychosocial climate of the ward.

The index and the control groups were not different in terms of age, sex, diagnosis, drug score, number of previous ECTs or family attitude towards ECT (Table I). There were however some statistically significant differences: the fast-breakers included more subjects who (a) were divorced, single or widowed; (b) were detained under a section of the Mental Health Act; (c) held an unfavourable view of ECT; and (d) had not given consent for ECT.

**Discussion**

The identification of potential fast-breakers is of some clinical importance. This form of behaviour interrupts treatment; it may prolong the hospital...
stay and so increase costs; and it may damage the relationship between the patient and the staff.

This paper has identified a cluster of features which may help the clinician to identify such patients. The fast-breaker can be male or female and of any age but is likely to be single, divorced or widowed rather than married; to be detained under a section of the Mental Health Act; not to have given consent to ECT (even if able to do so); and to hold unfavourable views on ECT. The fast tends to be broken after four or more ECTs. Confusion, memory impairment and the total amount of medication taken by the patient while receiving ECT do not seem to be important factors. Indeed, in our study only one patient claimed to have forgotten the instruction.

Tea- and coffee-drinking were the most common method of fast-breaking and the action tended to occur within the three hours prior to ECT. The subjects were very rarely willing to provide an account of their motives.

Our initial hypothesis was that environmental factors such as the psychosocial state of the ward, the number of nurses working on the particular shift, and the number of empty beds might be important. This was not borne out by our findings.

The fact that there were more fast-breakers than controls detained under the sections of the MHA suggests that the condition of the fast-breakers was more severe, or their behaviour more disordered. In fact there was a tendency for fast-breakers to stay in hospital longer than controls, but the difference did not reach statistical significance. There was no difference in outcome between the two groups, nor did the index sample receive more psychotropic medication than the controls. Since we did not include specific measures of severity, this issue remains unresolved.

We conclude that wilful fast-breaking was more common than forgetfulness or confusion in our sample. It is hypothesised that this represents some form of passive resistance which may be related to increased experience of side-effects as the course of ECT progresses, since fast-breaking tends to occur during the later stages of the course. The more drugs the patient was taking the earlier he tended to break his/her fast, which suggests that medication may amplify any unpleasant side-effects of ECT. Another hypothesis is that ECT produces increased arousal and psychomotor reactivation, leading to disinhibition and increased self-assertion.

It is recommended that patients meeting the criteria mentioned above are subject to special observation and given special counselling before and during any course of ECT.

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