
**SOCIOPSYCHOLOGICAL CHARACTERISTICS OF PATIENTS WHO
REFUSE CONVULSIVE THERAPY**

MAX POLLACK, PH.D. AND MAX FINK, M.D.

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SOCIOPSYCHOLOGICAL CHARACTERISTICS OF PATIENTS WHO REFUSE CONVULSIVE THERAPY

MAX POLLACK, PH.D.¹ AND MAX FINK, M.D.

The growing recognition of the relation of social factors to referral for and response to somatotherapy in psychiatric treatment has stimulated increased study of "drop-outs"—patients who refuse to start or to continue treatment. Although the problem of "drop-outs" is a major one in somatotherapy, it has received little attention. In convulsive therapy it is considered one of the most frequent "complications" of treatment (1) yet it is infrequently discussed (3, 7) and no systematic studies have been devoted to it.

Systematic studies of "drop-outs" have been limited for the most part to patients in psychotherapy in out-patient facilities (4, 5, 9, 19, 20). These studies have consistently shown marked differences in social and psychological characteristics of patients who remain in psychotherapy and those who fail to continue. Those patients who remain in therapy have more years of education and are of higher social class than those who leave. In addition, their social attitudes, as measured by the California F Scale, show "less so-called conventionalism, stereotypy and less of an uncompromising insistence that 'right' and 'wrong' can be distinguished" (20).

In sociopsychologic studies of the patient population of Hillside Hospital (12, 13) age, education, place of birth and degree of stereotypy, as measured by the F Scale, were related to selection for, and response to, convulsive therapy. Those patients who were older, had fewer years of education, were foreign-born and who manifested high scores on the F Scale were most likely to receive convulsive therapy, be hospitalized for

a shorter period, and be rated as improved at time of discharge. In contrast, patients who were younger, better educated, native-born and who obtained low scores on the F Scale, most often received psychotherapy as their sole form of treatment, were hospitalized for a longer time, and were more likely to be discharged with a rating of unimproved. Thus, the determination of psychiatric treatment was viewed as an interactive process, and related to the background, cultural values and communicative pattern of *both* therapist and patient.

In view of this relation of psychosocial factors to selection for and response to treatment, it was postulated that in a psychotherapeutically-oriented hospital patients who refuse or fail to complete convulsive therapy would be significantly younger, better educated, and be less stereotyped and conventional than patients who completed a course of therapy. This study was undertaken to test this hypothesis.

PROCEDURE

The seventy-five consecutive in-patients (27 males and 48 females) referred for convulsive therapy at Hillside Hospital during the one year period from October 1, 1957 to September 30, 1958 were included in this study. Hillside Hospital is a non-profit institution for the treatment of voluntary patients. Psychoanalytically-oriented psychotherapy is regarded as the primary method of treatment, with various somatotherapies available when necessary. All patients are seen for individual psychotherapy three times a week, with psychotherapy continuing when other treatment, *e.g.*, convulsive therapy, is administered.

Three social (age, education and nativity) and one psychological measure (the Cali-

¹ Department of Experimental Psychiatry, Hillside Hospital, Glen Oaks, L.I., New York. Aided by grants MY-2092 and MY-2715, National Institute of Mental Health, U. S. Public Health Service.

fornia F Scale), were employed. A ten-item modification of the F Scale (6, 14) was administered to 53 referrals prior to treatment. In this task, the subject reads 10 statements and indicates whether he agrees or disagrees with each statement, and to what extent. The score given for each item ranges from one to seven and the range of total scores is ten to seventy. The greater the subject's agreement, with the statement, the higher the score obtained. The statements themselves are extreme, conventional and stereotyped expressions. For example, one statement is, "If people would talk less and work more, everybody would be better off."

Patients were referred for convulsive therapy by the psychiatric resident with the approval, frequently at the suggestion, of his supervisor. The referral form requesting treatment was sent to the psychiatrist in charge of the convulsive therapy unit for medical examination and the institution of treatment. Thus, it was possible to determine those patients who were referred for treatment but who refused to start. Convulsive therapy was generally administered three times a week, and grand mal convulsions were induced with the standard Medcraft alternating current instrument.

RESULTS

Of the 75 referrals for convulsive therapy, 13 refused treatment. Of these, seven failed to start and six refused to continue treatment. In the latter group, the number of treatments ranged from three to eight—short of the generally prescribed course of at least twelve treatments.

TABLE 1

Mean Age, Education and F Score by Group

Group	N	Age (Years)	Educa- tion (Years)	F Score
Acceptance	62	40.3	11.6	48.7
Refusal	13	29.7	13.7	37.7
Mean Difference (One-tailed <i>t</i> test)		-10.6	+2.1	-10.0
<i>p</i> <		2.5	1.9	2.2
		.01	.025	.025

Social and Psychologic Factors: The group of patients who accepted a full course of convulsive therapy was significantly older, less educated and manifested a higher mean F score than the group that refused treatment (Table 1). Furthermore, 37 per cent of the acceptance group were foreign-born as compared to eight per cent of the refusal group. While there was considerable overlap between groups with respect to these factors, the refusal group was more homogeneous than the acceptance group. Thus, there were no patients in the refusal group who had less than ten years of education (69 per cent of the group had attended college) and none were over fifty years of age. In contrast, 27 per cent of the acceptance group never went beyond grade school (eight years or less) and 31 per cent were fifty years or older.

Differences in occupation between groups paralleled the differences in education. Thus, none of the patients in the refusal group were unskilled or manual workers. They were in clerical, professional and business vocations, whereas ten subjects in the acceptance group were unskilled workers. Housewives were excluded from this tabulation.

Relation to Diagnosis: The discharge diagnoses of seventy-three patients fell into four major categories: psychoneurosis, schizophrenia, manic-depressive, or involuntional psychoses. Two patients were classified as "psychotic depression" without further specification. Although there was no statistically significant difference in diagnostic composition between the group accepting and those refusing treatment, the groups were dissimilar with respect to the incidence of the involuntional psychoses (Table 2). No patient in the refusal group was discharged with a diagnosis of involuntional psychosis, whereas 24 per cent of the acceptance group were so diagnosed. There was also a high positive correlation between this diagnosis and the sociopsychological factors studied. Thus, the mean age (56.7 years) and F score (61.4) were higher while the years of educa-

tion (9.2 years) was lower than that for the total refusal group (Table 1).

Relation to Improvement Ratings: At the discharge conference held by the Medical Director each patient is assigned one of four improvement ratings: recovered, much improved, improved or unimproved. The incidence of recovered and much improved ratings was significantly lower in the refusal group (Table 3). Six patients, all in the acceptance group, were rated as recovered. The hospital discharges were more closely associated with refusal or discontinuation of treatment in the refusal group.

DISCUSSION

The present study confirms and extends previous findings in this laboratory (2, 12, 13) in demonstrating the importance of social factors and their psychological correlates in the selection for and response to psychiatric treatment. It supports the hypothesis that in a psychoanalytically-oriented hospital patients who refuse convulsive therapy would more closely resemble those who remain in psychotherapy and differ from those who are selected for and treated with convulsive therapy.

The lower F scores in the refusal group than in the acceptance group are correlated with a less compliant attitude toward authority and a more analytic approach in interpersonal activities. Review of the patients' hospital records revealed that negativism, belligerence, uncooperativeness and attempts to manipulate the staff were more common in the refusal group. For example, 38 per cent of the refusal group as compared with only 17 per cent of the acceptance group formally petitioned the Medical Director for discharge from the hospital. (Almost all these patients withdrew their request for discharge shortly after the initial request). Referral for convulsive treatment was more often associated with problems of management, *e.g.*, disturbing the ward or eloping from the hospital, than for depressive or confused thinking. In contrast, a higher

TABLE 2
Discharge Diagnosis by Group

Group	Psycho- neurosis	Schizo- phrenia	Manic Depressive Psychosis	Invol- tional Psychosis
Acceptance	7 (11%)	25 (40%)	13 (21%)	15 (24%)
Refusal	2 (15%)	7 (54%)	4 (31%)	0 (0)

$$\chi^2 = 2.28, p = \text{n.s.}$$

TABLE 3
Discharge Improvement Ratings by Group

Group	Recovered— Much Improved	Improved	Unimproved
Acceptance	34 (55%)	19 (31%)	9 (15%)
Refusal	3 (23%)	5 (38%)	5 (38%)

$$\chi^2 = 6.41, p = .05$$

percentage of the acceptance group were referred for convulsive therapy for alleviation of depressive symptoms.

There is increasing evidence that acceptance or rejection of psychiatric treatment is related to learned attitudes toward treatment by both patients and therapist (8, 9, 16, 17, 21). Most often these attitudes which correlate with socio-economic status are formed far in advance of treatment, and are most likely an intrinsic part of the person's repertoire of behavior. Thus, patients from lower class backgrounds more frequently view psychiatric treatment as nonverbal and in physical terms whereas typically "the middle class patient is predisposed toward the acceptance of psychotherapy even before he arrives at the clinic" (9).

In the sample studied there were many expressions of a negative attitude toward convulsive therapy long before the referral for convulsive therapy had been made. One patient, in treatment for several years prior to her current hospital admission, terminated treatment and transferred to another psychiatrist on each occasion when convulsive therapy was recommended. Another patient asked to sign the voluntary certification form on admission, appended the following note. "P.S., If I am given shock treatment

I'll either kill myself or leave the hospital." Other patients, particularly those who have been in individual psychotherapy prior to hospital admission, state that their previous therapists instructed them not to submit to convulsive therapy in that it would be harmful.

Perhaps more important than either attitude of the patient or the psychiatrist is the factor of consistency of attitudes. Klerman *et al.*, (17) have reported that young resident psychiatrists with psychoanalytic orientations frequently have unfavorable attitudes toward somatic therapy and are ambivalent about prescribing such treatment. In the present study there were many indications that referral for convulsive therapy was not the "free" choice of the resident physician but was made only after considerable pressure by administrative and nursing personnel.

A recent study by Kaplan and Lefkowitz (15) of staff and environmental factors associated with referral for drug therapy in this hospital demonstrated that the psychiatrist's tolerance for disturbed behavior was much higher than that of nurses and other personnel. Frequently the resident physician placed a premium on helping the patient modify his behavior without resort to somatotherapy. A similar observation was made by Sabshin and Ramot (21) and by Klerman (17) who found that "psychiatrists treating a patient with psychotherapy were unusually reluctant to add drug therapy." Such attitudes may be conveyed to patients either overtly or covertly. Such observations reinforce the findings of Pasamanick, Dinitz and Lefton (18) that "despite protestations by clinicians that their reference is always the individual patient, clinicians, in fact may be so overly committed to a particular psychiatric school of thought, that the patient's diagnosis and treatment is largely predetermined."

The studies here would suggest that the psychiatrist's ambivalent attitude toward

treatment is not a general attitude but is related to the "social distance" of the patient to himself. The psychiatric resident frequently has less difficulty in recommending somatotherapy for a lower class patient but is indecisive when it comes to making a similar treatment referral for a patient who is culturally more like himself.

The findings that objectors to convulsive therapy were more often discharged from the hospital as clinically unimproved is consistent with previous observations (7). Gordon (7) classified objectors into two categories—poorly oriented catatonic subjects who offered resistance to the treatment and responded with clinical improvement; and a better oriented group who objected to treatment on an attitudinal basis claiming they were "not in need of them." This latter group were refractory to the clinical benefits of the treatment. Almost all of the patients in the refusal group of the present study could be classified in the latter group.

It is of interest that most of the patients who refused convulsive treatment were prognostically poor selectees for convulsive treatment. In previous studies (2, 10, 11) we have shown that the incidence of ratings of improvement at discharge in young, well-educated, low F score patients was significantly lower than in the older, less educated, more stereotyped patients. The refusal group is part of that group of patients who are neither "ideal" patients for convulsive treatment nor are they very responsive to milieu treatment and psychotherapy.

While referral for convulsive therapy in this and other hospitals has been markedly reduced within the past few years, the problems associated with attitude toward treatment, of which treatment refusal is but one aspect, are of persistent importance. In the absence of specific therapies for the majority of psychiatric disorders the further study of decision-making in psychiatric treatment may help delineate the forces associated with selection of therapy.

SUMMARY

As part of a continuing investigation of the relation of sociopsychological factors to psychiatric treatment, the present study was concerned with the sociopsychological characteristics of patients who refused to start or to continue convulsive therapy. Thirteen of the 75 consecutive voluntary patients referred for convulsive therapy refused treatment during a one year period in a psychoanalytically-oriented institution.

These patients were younger, better educated and had lower scores on the California-F Scale than the group that accepted convulsive therapy. The diagnosis of involuntional psychosis was absent in the refusal group, and patients in the refusal group were more often discharged as unimproved.

The acceptance or rejection of psychiatric treatment is discussed in terms of learned attitudes toward psychiatric treatment by both patient and doctor.

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Max Pollack Ph.D. and Max Fink M.D.

**From the Department of Experimental Psychiatry, Hillside Hospital,
Glen Oaks, L.I., N.Y.**

**Aided by grant NY-2092 and NY-2715, National Institute of Mental
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TABLE I

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TABLE II

Discharge Diagnosis by Group

<u>Group</u>	<u>Psychoneurosis</u>	<u>Schizophrenia</u>	<u>Manic Depressive Psychosis</u>	<u>Involitional Psychosis</u>
Acceptance	7 (11%)	25 (40%)	13 (21%)	15 (24%)
Refusal	2 (15%)	7 (54%)	4 (31%)	0 (0)

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TABLE III

Discharge Improvement Ratings by Group

<u>Group</u>	<u>Recovered - Much Improved</u>	<u>Improved</u>	<u>Unimproved</u>
Acceptance	34 (55%)	19 (31%)	9 (15%)
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