What are your thoughts in terms of continuation and maintenance ECT?

Dr. McCall:
Continuation ECT is often required after the resolution of the acute presentation of catatonia. The most unfortunate situation, which I've seen and had been involved with myself, is when nothing seems to work but ECT for catatonia, or lorazepam is not particularly helpful. And you do get a short-term response.

There have been in my 36 years of independent practice, maybe three cases I've seen where someone had ECT almost every week, and it went on for years, and they accumulated hundreds of exposures to ECT, and it always worked. And there didn't appear to be any negative consequences of any sort, other than the loss of time and the inefficiency of the patient and the family having to build their lives around repeating ECT so often.

I'm hopeful that one day we will have substitutes for continuation ECT so that people's lives are not interrupted as much by the treatment itself. But I would say probably about half the time a person with a catatonic stupor — I use that example — can get a course of ECT, is essentially well within six to eight treatments, if not sooner, and then can walk out of the hospital with medications alone to help manage relapse. And they may or may not relapse. If they do relapse, more often than not, it's measured in months to years, as opposed to days to weeks. But the reality is severe psychiatric illnesses essentially, by definition, are prone towards relapse, and to give someone a course of ECT for catatonia and then send them home with no further treatment is typically not going to work. You're going to have to do something. You're hopeful the medications will be sufficient, but not necessarily in every case.