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ECT in the treatment of the ‘blues’: taking a page from the playbook of blues musicians

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Mozart said “The music is not in the notes, but in the silence between.” Similarly, John Ruskin, an English art critic of the Victorian era, said: “There is no music in a rest, but there is the making of music in it.” The premise that ‘musical rests’ make for great music also found a place in the playing of 20th century blues icon B.B. King, who sang and played blues guitar with simplicity, sparseness and restraint. (Check out his recordings of “Sweet Sixteen” or “The Thrill is Gone”).

In medicine, including psychiatry and electroconvulsive therapy (ECT), we take notice of case reports of the successful delivery of services to patients that initially had seemed at high risk of complications. We spend less time considering the circumstances of when withholding services is the better part of valor. Are there times in our treatment of the ‘blues’ (depression) when we should take a page from the playbook of blues musicians like B.B. King?

The Journal of ECT has and will continue to publish case reports of the successful delivery of ECT to patients with high risk medical conditions but who desperately need ECT for a psychiatric disorder. But the Journal has had little to say about clinical vignettes that ended with a conscious withholding of ECT. Here we share outlines of two cases.

An ECT referral was made for a well-educated man in his 60s with no prior history of psychiatric disorder. He had advanced liver involvement from Hepatitis B, and had been admitted to the psychiatry unit for suspected severe depression. On exam, he was listless, apathetic, socially withdrawn, and lying in bed in mid-day. Although he was not grossly disoriented, he showed left-right confusion. The indications for ECT were not crystal-clear, and the decision was made to defer ECT. The patient died three days later of complications of hepatic failure.

The pressure to rapidly intervene on behalf of patients who might need ECT can be hard to resist, but when the clinical presentation is complicated a deep breath is sometimes the most important next action. A 41 year old woman presented for an outpatient evaluation in a work week shortened by holiday vacation. She evinced a history of bipolar 1 disorder, panic and attention deficit disorder. Current symptoms were consistent with a mixed state but the history also revealed longstanding interpersonal difficulties and challenging life

circumstances. She endorsed all major depressive symptoms as well as passive suicidal ideation: “I would never do it because I would never leave my children to feel the way I feel.” The patient made a number of disparaging remarks about prior treating clinicians and hospitals. Medications included divalproex, lamotrigine, clonazepam, pregabalin, clonazepam, venlafaxine, and dextroamphetamine. In this case the sheer volume of uncertainties combined with the pending limited holiday schedule, patient’s lack of acute suicidal ideation and unwillingness to be hospitalized to taper multiple anticonvulsants led us to the decision to simply defer ECT pending reevaluation. She ultimately consented for treatment as an outpatient but pulled out her IV and left AMA prior to the first procedure.

The decision to pursue ECT (hopefully) is evidence-based in most circumstances. Approximately 4% of ECT referrals result in a recommendation against ECT in our experience.¹ In these instances, instincts or intuition seem to take over, and things ‘just don’t feel right.’ We believe these two cases illustrate this point. Response inhibition is a major element of executive control, illustrated by the classic “Go/No-go” task². As clinicians dedicated to improving the lives of our patients, our prepotent tendency is to “Go” with ECT or any number of other powerful interventions. Experience teaches us the value of “No-go”, but what of our trainees? Can the ‘instinct’ for restraint be taught in residency? There are ample opportunities to *model* this behavior, but often we may lack the empirical basis to fully justify our decision making, which we know is easily corrupted by the availability bias³. Nonetheless, we stand at the crossroads between beneficence and non-maleficence. This is a choice and a responsibility not to be taken lightly. Robert Johnson would surely understand.

Reference List

1. McCall WV, Dickerson LA. The outcome of 369 ECT consultations. *J ECT*. 2001; 17:50–52. [PubMed: 11281516]
2. Donders FC. On the speed of mental processes. *Acta Psychologica*. 1969; 30:412, e431. [PubMed: 5811531]
3. Saposnik G, Redelmeier D, Ruff CC, et al. Cognitive biases associated with medical decisions: a systematic review. *BMC Med Inform Decis Mak*. 2016; 16(1):138. [PubMed: 27809908]