What are some of the misconceptions in psychiatry about catatonia, and what do you think can be done to overcome these misconceptions?

Dr. McCall:
There are several misconceptions, and the first applies to psychiatry as much as it does to internal medicine or surgery. And that is catatonia is a rare phenomenon.

Again, once you have trained yourself to know what to look for, you'll be surprised at how often you see it. I've seen some literature saying that on a psychiatric floor in a hospital, as many as about 20 percent of patients will have one or more catatonic signs.

The second thing is for psychiatrists not to be deluded themselves that every person with catatonia has this dramatic, almost Hollywood-like presentation where they're stuck in some unusual statuesque pose.

If you don't diagnose catatonic stupor — I'm focusing on that for the moment — until someone is stuck in a frozen position, you're going to miss the vast majority of catatonia. It isn't always so dramatic and it can come and go. The same patient may have more catatonic signs in the morning, fewer in the afternoon, and round it comes again in the evening, so you can't expect it to always be a static presentation. It's a dynamic presentation that can change hour by hour.

The next misconception we need to help psychiatrists understand is to not think that every person with catatonia is experiencing it as part of a schizophrenia diagnosis. We know that if it's a part of any psychiatric diagnosis, it's much more likely to be derivative from a severe mood disorder — probably bipolar disorder — then from schizophrenia, as I mentioned in my other comments, but to also at least be aware that illicit drugs or medical conditions can be causing it as well.

That's a long list. So we've got a lot of education to do to increase awareness, to lower the threshold for diagnosing catatonia so we don't miss people that are treatable, and not to always conflate it with schizophrenia.