The Catatonia Foundation

How did you become interested in catatonia?

Dr. McCall:
My first exposure to catatonia was marked by my lack of knowledge of what I was looking at and the problem the patient was experiencing. But I was a psychiatry intern in my first year of training. My teaching hospital had received a lady from our sister state psychiatric hospital. This lady had a seizure while she was at the state hospital and, after the seizure, seemed very confused and somewhat combative and not directable. So she was sent to the teaching hospital, and the initial thought was that she was still having seizures. And so she still came to psychiatry because her behavior was so problematic.

We treated her at the direction of my attending physician. I was just a junior trainee. We treated her as if she was having seizures causing all these behavioral problems and emotional distress. To give you a picture of what she looked like, she was always in distress. She couldn't communicate in any effective manner as a conversation and simply repeated the same self-derogatory statements over and over again — such things as “I'm a cigarette butt,” “I'm a piece of shit,” to use her language verbatim. And she would, left to her own devices, run around randomly and excitedly through the unit and sometimes knock into people, almost knocking them down. Sadly, because of this, she ended up being put in her own room, and sometimes she was in restraint. This went on actually for about two or three weeks.

As a junior trainee, I was instructed to try to treat seizures. So I was infusing her with intravenous phenytoin or dilantin, which just didn't do a thing. She just seemed so miserable. I told my senior attending, I said, “I think this lady should have ECT,” which was purely intuitive, and my attending said, “You have to have a diagnosis. What's the indication for ECT?” And I said, “I don't know, but she seems like she's had a serious problem and we need to pull out a serious treatment.”

With some reluctance, I was allowed to proceed with my recommended plan. She had two or three treatments, and by the end of two or three treatments, she was fully normal and conversant and didn't need to be in restraints, and she was given a release from the psychiatry unit to go play tennis. Interestingly, she had no recollection of this — maybe partially related to the form of ECT we were using at the time, of course.

ECT has been improved upon since then, but it really wasn't until I continue to study catatonia over the next number of years, I thought I had this “aha” moment. I thought, this lady we were treating, who had a provisional diagnosis of bipolar disorder as well, what she was experiencing was excited catatonia, which can often be seen in people with underlying bipolar disorder diagnoses. And that easily explained her presentation, as well as her robust and rapid response to ECT.

So that was my retrospective reconstruction of what I had been through. It's too bad I had to do it that way, but that was my first real encounter with someone having excited catatonia, and really the satisfaction of seeing the patient get so much better.