



## Can you describe the rating scale you developed?

### **Dr. Northoff:**

Clinically I observed psychomotor — the close relation of your movements when you move to the emotional and cognitive events, experiences. So that's why I said, "Okay, it's not just motor and behavior." That's why I included the affective dimension as a third dimension into my rating scale. So in our Northoff Catatonia Rating Scale, we have three dimensions: motor, behavior, and affective. And that distinguishes our scale, for instance, from the Bush-Francis scale, which has only motor and behavior.

And historically, that also goes with the original descriptions by Karl Kahlbaum of catatonia. He also included all three: affective, motor, and behavior. Then the affective were somewhat forgotten, actually, in the European tradition, with Kraepelin and Bleuler, and it was reduced to a motor and maybe behavioral symptom of schizophrenia. Whereas in the American tradition, which was quite interesting, Kirby in 1913 already emphasised the affective damage, and also the occurrence of catatonia in bipolar.

Parallel to this Northoff Catatonia Rating Scale, we also developed sort of an instrument for subjective experiences of catatonia, which was recently put into an operationalized, quantified, standardized scale: subjective experience scale of catatonia by the Mannheim group in Germany. And that really tries to account that the role of subjective experience for me is very important in understanding the symptoms. That also gives you an idea for brain research, because in your brain research, you need to account for the subjective experiences. That also bridges the gap to the client because the client comes to you not because of the symptoms. The client comes to you because of the subjective experiences.

First, the rating scale really tries to account for the complexity of catatonia and tries not to reduce it. So that's where reducing it to motor behavior really gives strong aspect to the emotional component, and of course, to what you subjectively experience. Because there's a certain tradition in psychiatry, which really tries to understand the patient from the first-person perspective of the client. And that's what I'm trying to do in mine, and then we parallel developed the subjective scale.

Now the argument is it's too long. It has 40 items. Yes. Yes and no. From a clinical perspective, I can understand that. And maybe it would be good if we established a short version of the rating scale — it's actually a very good idea. If somebody is interested in that, we can basically look at the current studies: what are the most highlighted items in each of the three dimensions — affective, motor, behavior — and then make a short version of that.

I can understand if you're in an emergency, you don't have time for 40 items. If you're in an emergency, you want something quick. Maybe we can, indeed, it's a good idea that we make a short, quick, applicable version, maybe with 10-15. That's indeed actually a very good idea and could be a very good research project for the future.