What are some misconceptions about catatonia?

Dr. Northoff:
They say it's just motor schizophrenia. They don't know that they can use lorazepam because it hasn't really entered textbooks yet. And it's also a gross neglect of the psychological dimension of it. As paradoxically as it sounds, current psychiatry teaches these psychiatric symptoms in a very objective way. You have cognitive deficits, you have emotional deficits, but yes, you have them, but it's important how you subjectively experience it. Catatonia is all about that. And I think that's a key. So first, I think, more awareness. It needs to enter textbooks. It needs to be said it can be treated in 60 to 80 percent very well immediately with lorazepam.

One of the few disorders in the mental realm where you can do this. It's unique. Maybe ketamine in acute suicidal depression, but otherwise, I don't know of any other psychiatric disorder with such an immediate therapeutic benefit, and the psychological side of things.

Also, what is often neglected is the motor component, or let's better say the psychomotor component. In depression, you can see when a depressed patient — the spouse already knows two or three weeks before the onset of cognitive and affective symptoms. The facial mimic becomes a little less, they walk like this, they make themselves small, the speech is a little lower and slower. So it's all there already. That could be a marker for early detection.

So the psychomotor component is grossly neglected in psychiatry because the background — also the historical background and also the current background — that these are higher order disorders of higher order cognitive or emotional functions. No. All functions in the brain are affected by mental disorders: motor, sensory, affective, cognitive, social, yeah? And you can see that. I think that's important.