Catatonia in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

Andrew Francis, PhD, MD,* Max Fink, MD,* Francisco Appiani, MD,†
Aksel Bertelsen, MD;‡ Tom G. Bolwig, MD, DMSc;§ Peter Bräunig, MD,¶
Stanley N. Caroff, MD,¶ Brendan T. Carroll, MD,#
Andrea Eugenio Cavanna, MD,** David Cohen, MD,††
Oliver Cottencin, MD, PhD,‡‡ Manuel J. Cuesta, MD,‡‡ Jessica Daniels, MD,¶¶
Dirk Dhoosche, MD, PhD,¶¶ Gregory L. Fricchione, MD,##
Gabor Gazdag, MD, PhD,*** Neera Ghaziuddin, MD,††† David Healy, MD,‡‡‡
Donald Klein, MD,‡‡‡ Stephanie Kruger, MD,‡ Joseph W.Y. Lee, MBBS,¶¶¶
Stephan C. Mann, MD,¶¶¶ Michael Mazurek, MD,###
W. Vaughn McCull, MD, MS,***** William W. McDaniel, MD,††††
Georg Northoff, MD, PhD, FRCPC,***** Victor Peralta, MD, PhD,§§
Georgios Petrides, MD,§§§ Patricia Rosebush, MScN, MD,####
Teresa A. Rumans, MD,///// Edward Shorter, PhD,¶¶¶¶
Kazumasa Suzuki, MD,#### Pierre Thomas, MD, PhD,‡‡ Guillaume Vaiva, MD,‡‡
and Lee Wachtel, MD*****

As international scholars of catatonia, we are concerned that the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) proposes to delete the codes 295.2 (schizophrenia, catatonic type) and 293.89 (catatonia secondary to a medical condition) and to substitute a noncoded “catatonia specifier” as the principal identifier. We believe that these changes will badly serve clinical practice and research. We advocate a unique and broadly defined code for catatonia in DSM-V.

Catatonia is common among hospitalized psychiatric patients, including adults, adolescents, and occasionally children. In the 10 principal prospective studies from sites around the world, catatonia syndrome was identified in a mean (SEM) percentage of 9.8% (1.4%) of adult admissions (Table 1). These patients have multiple signs of catatonia (commonly 5); 68% (6%) are mute, and 62% (3%) are negativistic or withdrawn. Some are unable to eat, requiring parenteral nutrition and/or medication.

Once catatonia is recognized, first-line treatment with benzodiazepines usually brings prompt relief, although high doses may be needed. If catatonia persists, electroconvulsive therapy is often indicated and may be lifesaving. Some patients have multiple signs of catatonia (commonly 5); 68% (6%) are mute, and 62% (3%) are negativistic or withdrawn. Some are unable to eat, requiring parenteral nutrition and/or medication.

Under the proposed new guidelines for DSM-V, patients with catatonia syndrome will lack an informative diagnosis. Mutism, negativism, and withdrawal prevent assessment for mood, cognitive, and psychotic symptoms and impede proper delineation of episodes of prior illness. Without findings for a specific diagnosis, it is rational to use a provisional diagnosis of the catatonia syndrome to allow tests and treatments to proceed. Lacking recognition and treatment, catatonia may persist or worsen with adverse or life-threatening results. On the other hand, when patients with catatonia are identified...
and treated, they become verbal and interactive, allowing interviews and more definitive diagnoses, regardless of the primary pathological findings.

When patients cannot provide information, clinicians may conflate or misdiagnose catatonia with schizophrenia (as in the DSM-IV schema), impute a psychotic process, foster the unproven use of neuroleptics, and risk adverse effects, such as conversion to malignant catatonia or the neuroleptic malignant syndrome. Similarly, assignment of catatonia to “psychosis not otherwise specified” (298.9, DSM-IV and DSM-V) would be erroneous because these patients often either lack hallucinations and delusions or cannot be assessed for them.

The proposed elimination of DSM-IV “catatonia due to a general medical condition” (293.89) render the coding for catatonia arising from general medical conditions problematic. At clinical presentation, the medical/toxic factors are rarely known, as time is often needed to identify these etiologies.

We also note that noncoded specifiers are not useful for research on nosology, treatment, and outcome.

To address all these issues, we urge inclusion in DSM-V of a specific diagnostic code for catatonia. One simple option is to retain the 293.89 code but revise its formulation to broadly encompass the catatonia syndrome without imputing a link to either primary psychiatric or general medical conditions. A unique and broadly defined code would foster recognition of the catatonia syndrome and permit research on nosology, treatment, and outcome. These goals are not met with the DSM-V plan for noncoded modifiers.

**REFERENCES**


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**TABLE 1. Prospective Studies of the Incidence of Catatonia**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Patients Screened</th>
<th>Percent With Catatonia Syndrome</th>
<th>Percent With Mutism</th>
<th>Percent With Negativism or Withdrawal</th>
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<tbody>
<tr>
<td>Rosebush et al¹</td>
<td>1990</td>
<td>140</td>
<td>9</td>
<td>85</td>
<td>78</td>
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<tr>
<td>Ungvari et al²</td>
<td>1994</td>
<td>212</td>
<td>8</td>
<td>94</td>
<td>67</td>
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<tr>
<td>Bush et al³,⁴</td>
<td>1996</td>
<td>215</td>
<td>7</td>
<td>86</td>
<td>75</td>
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<tr>
<td>Peralta et al⁵</td>
<td>1997</td>
<td>567</td>
<td>3.5</td>
<td>55</td>
<td>60</td>
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<tr>
<td>Northoff et al⁶</td>
<td>1999</td>
<td>1259</td>
<td>2.7</td>
<td>—</td>
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<tr>
<td>Brüning et al⁷</td>
<td>2000</td>
<td>297</td>
<td>12</td>
<td>54</td>
<td>58</td>
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<tr>
<td>Lee et al⁸</td>
<td>2000</td>
<td>160</td>
<td>15</td>
<td>54</td>
<td>71</td>
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<tr>
<td>Peralta and Cuesta⁹</td>
<td>2001</td>
<td>187</td>
<td>17</td>
<td>84</td>
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<tr>
<td>Chalasani et al¹⁰</td>
<td>2005</td>
<td>208</td>
<td>12</td>
<td>63</td>
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<td>Peralta et al¹¹</td>
<td>2010</td>
<td>200</td>
<td>12</td>
<td>38</td>
<td>54</td>
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<tr>
<td><strong>Mean (SEM)</strong></td>
<td></td>
<td></td>
<td><strong>9.8 (1.4)</strong></td>
<td><strong>68 (6)</strong></td>
<td><strong>62 (3)</strong></td>
</tr>
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</table>

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*Note: Table data compiled from various sources as indicated.*