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

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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5); 68% (6%) are mute, and 62% (3%) are negativistic or withdrawn.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 rapidly beneficial. Every prospective study confirms that catatonia syndrome exists, occasionally becomes malignant, and requires prompt treatment.

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) renders 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.

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TABLE 1

Prospective Studies of the Incidence of Catatonia

Authors	Year	Patients Screened	Percent With Catatonia Syndrome	Percent With Mutism	Percent With Negativism or Withdrawal
Rosebush et al ¹	1990	140	9	85	78
Ungvari et al ²	1994	212	8	94	67
Bush et al ^{3,4}	1996	215	7	86	75
Peralta et al ⁵	1997	567	3.5	55	60
Northoff et al ⁶	1999	1259	2.7	—	—
Braunig et al ⁷	2000	297	12	54	58
Lee et al ⁸	2000	160	15	54	71
Peralta and Cuesta ⁹	2001	187	17	84	69
Chalasanani et al ¹⁰	2005	208	12	63	50
Peralta et al ¹¹	2010	200	12	38	54
<i>Mean (SEM)</i>			<i>9.8 (1.4)</i>	<i>68 (6)</i>	<i>62 (3)</i>