



Review

Catatonia in DSM-5

Rajiv Tandon ^{a,*}, Stephan Heckers ^b, Juan Bustillo ^c, Deanna M. Barch ^{d,e}, Wolfgang Gaebel ^f, Raquel E. Gur ^{g,h}, Dolores Malaspina ^{i,j}, Michael J. Owen ^k, Susan Schultz ^l, Ming Tsuang ^{m,n,o}, Jim van Os ^{p,q}, William Carpenter ^{r,s}

^a Department of Psychiatry, University of Florida Medical School, Gainesville, FL, USA

^b Department of Psychiatry, Vanderbilt University, Nashville, TN, USA

^c Department of Psychiatry, University of New Mexico, Albuquerque, NM, USA

^d Department of Psychology, Washington University, St. Louis, MO, USA

^e Department of Psychiatry and Radiology, Washington University, St. Louis, MO, USA

^f Department of Psychiatry, Duesseldorf, Germany

^g Department of Psychiatry, Perlmutter School of Medicine, University of Pennsylvania, Philadelphia, PA, USA

^h Department of Neurology and Radiology, Perlmutter School of Medicine, University of Pennsylvania, Philadelphia, PA, USA

ⁱ Department of Psychiatry, New York University, New York, NY, USA

^j Creedmoor Psychiatric Center, New York State Office of Mental Health, USA

^k MRC Centre for Neuropsychiatric Genetics and Genomics and Neuroscience and Mental Health Research Institute, Cardiff University, Cardiff, Wales, United Kingdom

^l Department of Psychiatry, University of Iowa School of Medicine, Iowa City, IA, USA

^m Center for Behavioral Genomics, Department of Psychiatry and Institute of Genomic Medicine, University of California, San Diego, CA, USA

ⁿ Veterans Affairs San Diego Healthcare System, San Diego, CA, USA

^o Harvard Institute of Psychiatric Epidemiology and Genetics, Harvard School of Public Health, Boston, MA, USA

^p Maastricht University Medical Centre, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht, The Netherlands

^q King's College London, King's Health Partners, Department of Psychosis Studies, Institute of Psychiatry, London, United Kingdom

^r Department of Psychiatry, Maryland Psychiatric Research Center, Baltimore, MD, USA

^s VISN 5 MIRECC – Veterans' Healthcare System, Baltimore, MD, USA

ARTICLE INFO

Article history:

Received 15 March 2013

Received in revised form 20 April 2013

Accepted 25 April 2013

Available online 24 June 2013

Keywords:

DSM

Classification

Catatonia

DSM-5

Mood disorder

Schizophrenia

Nosology

Diagnosis

ABSTRACT

Although catatonia has historically been associated with schizophrenia and is listed as a subtype of the disorder, it can occur in patients with a primary mood disorder and in association with neurological diseases and other general medical conditions. Consequently, catatonia secondary to a general medical condition was included as a new condition and catatonia was added as an episode specifier of major mood disorders in DSM-IV. Different sets of criteria are utilized to diagnose catatonia in schizophrenia and primary mood disorders versus neurological/medical conditions in DSM-IV, however, and catatonia is a codable subtype of schizophrenia but a specifier for major mood disorders without coding. In part because of this discrepant treatment across the DSM-IV manual, catatonia is frequently not recognized by clinicians. Additionally, catatonia is known to occur in several conditions other than schizophrenia, major mood disorders, or secondary to a general medical condition. Four changes are therefore made in the treatment of catatonia in DSM-5. A single set of criteria will be utilized to diagnose catatonia across the diagnostic manual and catatonia will be a specifier for both schizophrenia and major mood disorders. Additionally, catatonia will also be a specifier for other psychotic disorders, including schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, and substance-induced psychotic disorder. A new residual category of catatonia not otherwise specified will be added to allow for the rapid diagnosis and specific treatment of catatonia in severely ill patients for whom the underlying diagnosis is not immediately available. These changes should improve the consistent recognition of catatonia across the range of psychiatric disorders and facilitate its specific treatment.

Published by Elsevier B.V.

1. Introduction

The current status of catatonia in the fourth edition of the Diagnostic and Statistical Manual for mental disorders (DSM-IV, [American Psychiatric Association, 1994](#)) is best understood from a historical perspective. It was first introduced as a distinct psychiatric syndrome by [Karl Kahlbaum \(1873\)](#) in the 1870s. Subsequently in the early 1900s,

* Corresponding author at: Department of Psychiatry and Neuroscience, University of New Mexico, Albuquerque, NM 87111, USA.

E-mail address: jbustillo@salud.unm.edu (J. Bustillo).

it was combined with hebephrenia and dementia paranoides into a single entity (dementia praecox) by Emil Kraepelin (1971) and the presence of catatonia became synonymous with dementia praecox or schizophrenia (Bleuler, 1950). The Kraepelin–Bleuler view of catatonia as a subtype of schizophrenia became prevalent and was reflected in the first three editions of DSM (American Psychiatric Association, 1952, 1968, 1980) where the only mention of catatonia was as a subtype of schizophrenia. Findings in the 1970s and 1980s, however, revealed the presence of catatonia in a number of neurological and other medical disorders (Gelenberg, 1976), and “organic catatonia” or “catatonia secondary to a general medical condition” was added as a new category in DSM-IV. Additional findings in the 1970s and 1980s revealed that a significant proportion of catatonia occurred in the context of major mood disorders (Abrams and Taylor, 1976; Taylor and Abrams, 1977) and catatonia was also added as an episode specifier of major mood disorders in DSM-IV (American Psychiatric Association, 1994).

1.1. Catatonia in DSM-IV

Currently, the presence of catatonia is recognized in three contexts in DSM-IV:

1. Catatonic Disorder due to a General Medical Condition (ICD-9 code 293.89)
2. Schizophrenia — Catatonic Subtype (295.20)
3. Episode specifier for Major Mood Disorders (296.xx) without specific numerical code:
 - a. Bipolar 1 Disorder — Single manic episode (296.00)
 - b. Bipolar 1 Disorder — Most recent episode manic (296.40)
 - c. Bipolar 1 Disorder — Most recent episode depressed (296.50)
 - d. Bipolar 1 Disorder — Most recent episode mixed (296.60)
 - e. Major Depressive Disorder, Single episode (296.20)
 - f. Major Depressive Disorder, Recurrent (296.30).

Some experts consider neuroleptic malignant syndrome (333.92), an adverse effect of antipsychotic medications, as a form of malignant catatonia (Fink, 1997; Lee, 2007).

A diagnosis of catatonia in DSM-IV requires that the clinical picture be dominated by:

- a. Motoric immobility, as evidenced by catalepsy or stupor
- b. Excessive motor activity
- c. Extreme negativism or mutism
- d. Peculiarities of voluntary movement as evidenced by posturing, stereotyped movements, prominent mannerisms, or prominent grimacing
- e. Echolalia or echopraxia.

Whereas the DSM-IV definition of catatonia as a subtype of schizophrenia or episode specifier for major mood disorders explicitly requires the presence of at least two of these five sets of symptoms, there is no such requirement for its definition in “Catatonic disorder due to a general medical condition”. Of interest, the current edition of the International Classification of Disease (ICD-10, World Health Organization, 1992) recognizes catatonia only in two contexts, i.e., Organic Catatonic Disorder (ICD-10 code F06.1) and catatonic schizophrenia (F20.2).

2. Summary of new data and limitations in DSM-IV treatment of catatonia

Studies over the past two decades confirm the occurrence of catatonia in the context of schizophrenia, major mood disorders, and due to a range of general medical conditions (Peralta et al., 1997; Brauning et al., 1998; Ungvari et al., 2005; Weder et al., 2008). The continued importance of identifying the presence of catatonia in these different contexts is supported by its familial aggregation and co-aggregation with schizophrenia and major mood disorders (Peralta and Cuesta, 2007), clear

etiological attribution to a range of specific general medical conditions (Weder et al., 2008), and most importantly its relatively specific response to treatment with benzodiazepines and electroconvulsive therapy (Rohland et al., 1993; Hawkins et al., 1995; Bush et al., 1996; Caroff et al., 2007). Relative proportions of mood, primary psychotic, and neurological/medical disorders in samples of patients with catatonia vary across studies (Rosebush and Mazurek, 2010; Kleinhaus et al., 2012).

Whereas recent data provide clear support for the changes in the approach to catatonia made in DSM-IV, they also point to several limitations in its current definition and treatment. These include:

1. *Under-recognition.* The presence of catatonia is frequently missed by clinicians and this under-recognition has been noted in the context of schizophrenia, major mood disorders, and general medical conditions (Starkstein et al., 1996; Brauning et al., 1998; Ungvari et al., 2005; van der Heijden et al., 2005). Additionally, catatonia has been found to be significantly under-recognized in a range of other clinical populations and settings (Caroff et al., 2004; Dhossche and Wachtel, 2010; Rizos et al., 2011). One significant factor contributing to the under-recognition of catatonia is its inconsistent definition in DSM-IV.
2. *Prevalence in several psychotic disorders other than schizophrenia and psychotic mood disorders.* Currently, catatonia can be diagnosed only in the context of schizophrenia (subtype) and major mood disorders (episode specifier). It is, however, frequently observed in other psychotic disorders such as schizoaffective disorder, brief psychotic disorder, schizophreniform disorder, and substance-induced psychotic disorder (Rohland et al., 1993; Peralta et al., 1997, 2010; Tuerlings et al., 2010).
3. *Low frequency of use as schizophrenia subtype.* Although catatonic symptoms are prominent in a significant proportion of schizophrenia patients (Peralta et al., 1997; Ungvari et al., 2005), their presence is frequently not noted or diagnosed. This is significantly attributable to the fact that the only method to document the presence of catatonic symptoms in schizophrenia is as a diagnostic subtype. Despite the fact that catatonic schizophrenia is at the top of the diagnostic hierarchy of schizophrenia subtypes (in DSM-IV, prominent catatonic symptoms have to be absent before any other subtype can be diagnosed), catatonic schizophrenia is rarely diagnosed (0.2–3% of all schizophrenia; Stompe et al., 2002; Xu, 2011). In addition to rarity of use, catatonic schizophrenia as a subtype has low diagnostic stability and poor reliability (Carpenter et al., 1976; Helmes and Landmark, 2003; Tandon and Maj, 2008).
4. *Presence of catatonia in other psychiatric conditions and undiagnosed general medical conditions.* There have been several hundred reports of catatonia in a range of other psychiatric conditions such as autism and other disorders in the pediatric setting (Wing and Shah, 2000; Takaoka and Takata, 2003; Hare and Malone, 2004; Cornic et al., 2007; Dhossche and Wachtel, 2010). Additionally, the link between catatonia and a causal general medical condition may not be clear in the initial stages of clinical assessment/treatment and/or the general medical condition putatively causing catatonia may not be initially evident. There is a broad consensus among catatonia experts (Francis et al., 2011) that there needs to be an ability to diagnose catatonia in these circumstances because of its clinical importance (Fink, 2012; Shorter, 2012). Catatonia in such settings does respond to treatment with benzodiazepines and electroconvulsive therapy. Clinicians use a term of idiopathic catatonia (Benegal et al., 1993; Krishna et al., 2011), but this is unrecognized in ICD-10 and DSM-IV.

3. Changes for DSM-5

Following an extensive review of the literature and consultation with several experts, a series of changes have been made in the DSM-5 formulation of catatonia to address the identified gaps in the

Download English Version:

<https://daneshyari.com/en/article/10309175>

Download Persian Version:

<https://daneshyari.com/article/10309175>

[Daneshyari.com](https://daneshyari.com)