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Classification of Catatonia

TO THE EDITOR: The provocative argument of Michael Alan Taylor, M.D., and Max Fink, M.D., that catatonia should be classified as an independent syndrome (1) confuses the distinction between catatonia and delirium. In particular, there is a prominent overlap between delirious and malignant catatonia with delirium due to medical condition, as defined by DSM-IV-TR.

As consultation-liaison psychiatrists, we see delirium daily. Delirium may be characterized by acute psychomotor hypoactivity or hyperactivity (2) and a "disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to sustain focus or shift attention" (DSM-IV-TR). Delusions and hallucinations are common, and symptoms classically wax and wane. In catatonia, consciousness and alertness are not typically impaired (3).

Clearly, it is difficult to distinguish delirium from Drs. Taylor and Fink's view of malignant catatonia: "acute onset of excitement, delirium, fever, autonomic instability, and catalepsy" (1, p. 1236). There is also considerable overlap between their definition of regular catatonia, "motor abnormalities that occur in association with changes in thought, mood, and vigilance" (p. 1234), and delirium, as described. Drs. Taylor and Fink expound on malignant catatonia and its significant mortality by saying that "most patients died" in pre-ECT days. However, fever, confusion, and psychomotor abnormalities may simply have been manifestations of an underlying illness that was not diagnosed. Many of the references quoted are from the 1970s, before sophisticated diagnostic imagery was available, and do not include a comprehensive delirium workup that we would expect as standard in 2003. In our opinion, fever, confusion, psychomotor abnormalities, and autonomic instability in the presence or absence of delusions and hallucinations should be viewed as delirium and worked up and treated as such.

We note, as did Drs. Taylor and Fink, that there have been no controlled treatment trials of catatonia. Therefore, to state that benzodiazepines, barbiturates, and ECT relieve or resolve catatonic episodes is an expert opinion that lacks objective validity. There is evidence from the double-blind controlled study by Breitbart et al. (4) that lorazepam may not be effective as a single agent in the treatment of delirium. To view neuroleptic malignant syndrome and serotonin syndrome as variants of catatonia and to state that the treatment is the same is, in our opinion as consultation-liaison psychiatrists, premature and flies in the face of current practice.

Finally, their subheading, "Common Causes of Catatonia," is misleading. Drs. Taylor and Fink use "causes" and "associations" of catatonia interchangeably. Mood disorders, general medical and neurological conditions, and genetic abnormalities may be associated with catatonia, but there is no strong evidence that they are causal. The etiology of "catatonia" remains unknown, and we lack biological (endophenotypical) markers that could provide further evidence to support the existence of catatonia as a separate disorder.

It is our opinion that the expanded meaning of catatonia offered in this article is problematic and confusing. Catatonia is best left to its association with schizophrenia and bipolar disorder, as Kaplan and Sadock (3) have clearly done. It should be clearly distinguished from the hypoactive and hyperactive delirium that we see daily on medical wards.

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Drs. Taylor and Fink Reply

TO THE EDITOR: Drs. Levin and Martin miss the point of our argument. We did not claim that catatonia is a delirious process but cited the DSM-IV-TR category of delirium (293.0) as an analogy for the location of catatonia. We could also have cited dementia (290.0) as our analogy.

We presented catatonia as a distinct syndrome that is identifiable by its psychopathology, occurs in a wide range of psychiatric disorders, and is responsive to defined interventions. We suggested that catatonia deserves a class of its own in psychiatric classifications, much as delirium and dementia are individually defined. We presented extensive evidence that catatonia is not limited to a subtype of schizophrenia (295.2) or secondary to a medical condition (293.89), as formulated in DSM-IV-TR.

Classifying catatonia as a distinct psychopathological entity encourages its diagnosis, application of its unique treatments, and its research study. The textbook formulation of catatonia based on the DSM classification is no longer useful in psychiatric practice.

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