CATATONIA IS NOT ALL SCHIZOPHRENIA

Saeed Farooq

Catatonia is characterized by mutism, stupor, posturing, and excitement amongst many other manifestations. It is one of the commonest presentations in psychiatric settings in developing countries. Although catatonia is one of the most florid and dramatic presentations of the psychiatric disorders and is highly treatable, it is one of the least studied. This state of neglect for a severe psychiatric condition is perhaps a manifestation of overall neglect of phenomenology in psychiatric literature which is evident these days in rare glimpse of papers on phenomenology in well known psychiatric journals. This article will attempt to highlight the apparent reasons for decreasing diagnosis of catatonia, its relationship with schizophrenia and the classification.

The prevalence of the diagnosis of catatonic symptoms and diagnosis of catatonic schizophrenia appears to have decreased considerably over the last century[1]. Several explanations for this apparent reduction have been put forward. In an important study, Van der Heijdena et al (2005) showed that the application of a systematic catatonia rating scale in patients admitted with acute psychosis identified a substantial proportion of patients presenting with catatonic symptoms. At least 18% of patients fulfilled the criteria for catatonia. They also challenged another myth i.e. the prevalence of catatonia has decreased with the use of atypical antipsychotics and found that the catatonic subgroup used atypical antipsychotic compounds more frequently ($p < 0.05$). They concluded that changes in diagnostic criteria and the diagnostic practices are responsible for the under-recognition of catatonia[2].

One of the reasons for apparently diminishing diagnosis of catatonia could be its historical association with schizophrenia. Original concept of catatonia, introduced by Karl Kahlbaum in 1874, was subsumed under dementia praecox and, subsequently, schizophrenia. This historical tradition meant that catatonia is not seen separately from schizophrenia. This is not supported by research and catatonia is it is most often caused by disorders other than schizophrenia.

The catatonic signs and symptoms occur most commonly in patients with mood disorders. It is reported that 28%-31% of catatonic patients had mixed mania or mania in three studies conducted since 1977 and only 10%-15% of catatonic patients were reported to have an underlying diagnosis of schizophrenia[3]. Catatonia is also caused by a medical conditions and it is important to bear that in mind as this may result in serious consequences. There is plethora of case reports describing the catatonia in wide variety of conditions, ranging from multiple sclerosis to subdural haematoma[4].

Another reason for not observing catatonia more frequently could be the early use of benzodiazepines in patients presenting with psychiatric problems. It is well known that benzodiazepines are one of the most commonly used drugs in psychiatric practice especially in developing countries and may even be available over the counter. Lorazepam is the most commonly reported agent, used in the treatment of catatonia, but other benzodiazepines have also been reported in treatment of this condition[1]. The early and common use of benzodiazepines especially in those patients presenting with any form of agitation may be responsible for the apparent reduction in the presentation of catatonia in psychiatric practice.

Catatonia is often not recognized for the simple reason that eyes cannot see what is not in the mind. The current teaching of the mental state examination often de-emphasizes psychomotor behaviour. The traditional teachings equate catatonia with extreme signs such as such as, catalepsy, stereotypy, mannerisms, verbigeration, rigidity, negativism, waxy flexibility, echolalia and echopraxia. However, catatonia has many other varied manifestations such as excitement, withdrawal, impulsivity, perseveration and combativeness. If we carefully record these manifestations in our practice, the prevalence of catatonia may be quite high.

Commonly used rating scales to assess mood disorders or other psychotic disorders rarely address catatonic symptoms. Not surprisingly we do not see catatonia mentioned in studies on mood or psychotic disorders. A number of rating scales are available to assess the catatonic signs and symptoms[5,6]. The Bush-Francis Catatonia Rating Scale (BFCRS) is one of the most widely used in research studies and case reports. However, these scales are rarely used to assess a patient for catatonia in routine practice.

Better recognition of catatonia is essential for effective treatment as it often requires early treatment. Supportive care is essential in early stages to reduce the risk of morbidity and mortality caused by immobility, infection, aspiration pneumonia, rhabdomyolysis, deep venous thrombi, and poor nutrition[7-9]. Benzodiazepines and ECT have been the first-line treatments for almost all types of catatonia. Available studies and case reports suggest that ECT has a high success rate in treating all

Correspondence:
Prof. Saeed Farooq, PhD, MCPS(Psych), FCPS (Psych).
Visiting Professor, Staffordshire University & Postgraduate Medical Institute, Peshawar, Pakistan.
E-mail: sfarooqlrh@yahoo.com

types of catatonia[10]. A literature review found that lorazepam was the most commonly used treatment, resolving symptoms in 70% of reported cases. ECT alone resulted in resolution of symptoms in 85%, whereas antipsychotics alone were effective in only 7.5% of cases. In malignant catatonia, the response to ECT was 89% and response to benzodiazepines was 40%[1].

The present classification of catatonia predominantly as manifestation of schizophrenia dates back to the historical tradition mentioned earlier and has hindered the research and diagnosis in clinical practice. For example in ICD-10, only stupor which is one of the most extreme manifestations of catatonic signs is recognised as feature of depression or mania. However, in case of schizophrenia a broader range of catatonic signs are considered relevant. There is some indication that the situation is changing. In the current version of proposed DSM-5, catatonia is treated both as an independent diagnostic entity and as a specifier for other disorders. DSM-5 suggests a rating system for the severity of psychomotor symptoms in its optional dimensional assessments:11-13. The propsed draft of ICD-11 suugests changes along similar line.

It is important that catatonic symptoms are considered separately from schizophrenia. These symptoms are important part of the schizophrenic symptomatology but just like other symptoms such as delusions and hallucinations can occur in affective as well as other psychiatric disorders. This needs a paradigm shift in our clinical practice, research and classification.

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