Case Reports and Reviews

Mini Review

Recognizing Catatonia Beyond Psychiatry: From Underdiagnosis to Routine Screening

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Abstract

Background: *Catatonia is a potentially life-threatening but highly treatable neuropsychiatric syndrome that remains frequently underrecognized across clinical settings. Although historically linked to schizophrenia, it is now understood as a transdiagnostic condition that may occur in psychiatric, neurological, autoimmune, infectious, metabolic, systemic, and critical care contexts.* ***Objective:*** *This mini review discusses why catatonia continues to be missed in contemporary practice and highlights routine bedside screening as a practical strategy to improve recognition.* ***Methods:*** *A narrative mini review was developed from recent clinical reviews, consensus resources, diagnostic frameworks, and studies addressing catatonia prevalence, diagnostic criteria, screening instruments, and medical complications.* ***Discussion:*** *Detection rates vary substantially according to clinical setting and assessment method. Structured instruments such as the Bush-Francis Catatonia Screening Instrument identify more cases than routine clinical assessment or DSM-based criteria alone. Underdiagnosis is sustained by historical misconceptions, heterogeneous clinical presentations, overlap with delirium and encephalopathy, and limited routine screening outside psychiatric services.Delayed recognition may lead to severe complications, prolonged hospitalization, and increased mortality, whereas timely treatment with benzodiazepines and electroconvulsive therapy is often highly effective.* ***Conclusion:*** *Catatonia should be considered a treatable neuropsychiatric emergency across hospital medicine. Clinician education and systematic bedside screening may reduce preventable morbidity and mortality.*

Introduction

Catatonia remains one of the most underrecognized neuropsychiatric syndromes in contemporary clinical practice [1], despite being a potentially life-threatening yet highly treatable condition [2-5]. Although it was traditionally associated with schizophrenia, catatonia is now recognized across a broad spectrum of psychiatric disorders, neurological diseases, autoimmune conditions, infectious and metabolic illnesses, and critical care contexts [1-10]. Nevertheless, this paradigm shift has not been fully translated into routine clinical practice [2,3]. In psychiatric and general medical settings, catatonia continues to be overlooked, resulting in delayed diagnosis, inappropriate management, and increased but potentially preventable morbidity and mortality [1-3]. The central challenge is therefore no longer the absence of effective treatments, but the persistent failure to recognize the syndrome systematically across different clinical settings. This mini review examines the major factors contributing to the underdiagnosis of catatonia and advocates for systematic screening as a practical strategy to improve clinical recognition and outcomes.

Mini-Review Approach

This article was prepared as a narrative mini review focused on clinically relevant literature regarding catatonia recognition, diagnostic criteria, bedside screening, and medical complications. The discussion emphasizes recent consensus documents, contemporary reviews, diagnostic classifications, and studies comparing structured instruments with routine clinical assessment. Because the aim is to provide a concise clinical synthesis rather than a systematic review, the literature was organized thematically around underdiagnosis, diagnostic barriers, overlap with delirium, complications of delayed treatment, and practical screening strategies.

Discussion

Variation in Detection Across Clinical Settings

The reported prevalence of catatonia varies considerably according to the clinical setting and, perhaps more importantly, the method used for its identification [1-3,11]. Among patients admitted to acute psychiatric units, prevalence estimates generally range from 9% to 20% [1,5], whereas studies employing systematic bedside screening have reported

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rates approaching 30% (3,9). In contrast, consultation-liaison psychiatry services and general medical wards consistently report substantially lower detection rates, typically below 10% [1-3]. Rather than reflecting true differences in disease frequency, these discrepancies likely illustrate how often catatonia remains underrecognized when clinicians rely solely on unsystematic clinical suspicion instead of structured assessment tools [1-11].

Limitations of Diagnostic Criteria and Routine Assessment

One of the most compelling demonstrations of this diagnostic gap comes from prospective studies comparing DSM-5 diagnostic criteria with standardized screening instruments [1,7,8]. In a cohort of patients admitted to an acute psychiatric unit, the Bush-Francis Catatonia Screening Instrument identified nearly three times as many patients as DSM-5 criteria [2]. Approximately two-thirds of individuals with clinically significant catatonic symptoms would have remained undiagnosed had DSM-5 criteria been used alone [2]. Notably, staring, the most common catatonic sign observed in that cohort, is not included among DSM-5 diagnostic criteria, highlighting how current diagnostic frameworks may fail to capture common yet clinically meaningful manifestations of the syndrome [1-5].

Why Catatonia Continues to Be Missed

The persistence of underdiagnosis reflects the interaction of multiple factors [2]. Historical misconceptions continue to influence medical education, leading many clinicians to associate catatonia almost exclusively with schizophrenia, despite growing evidence demonstrating that mood disorders, medical illnesses, and neurological diseases account for a substantial proportion of contemporary cases [1-3,12,13]. Catatonia is also a remarkably heterogeneous syndrome [14]. Although the classic image of a mute and immobile patient remains deeply rooted in medical practice, many individuals present with subtler manifestations, fluctuating symptoms, or predominantly excited forms characterized by severe psychomotor agitation [3,7]. During the early stages of the syndrome, partial presentations may fail to satisfy formal diagnostic criteria despite representing clinically significant and potentially progressive illness [1].

Catatonia Outside Psychiatry

Recognition becomes even more challenging outside psychiatric services. In emergency departments, general medical wards, intensive care units, and neurology services, catatonia frequently occurs in patients with complex medical conditions, in whom psychomotor abnormalities are commonly attributed to delirium, metabolic encephalopathy, medication effects, non-convulsive seizures, stroke, or severe depression [1-14]. Rather than incorporating catatonia into the differential diagnosis, clinicians often interpret motor abnormalities as nonspecific manifestations of the underlying medical illness (2,3,9). This diagnostic overshadowing contributes substantially to delayed psychiatric consultation and postpones potentially life-saving interventions [1-3].

Overlap Between Delirium and Catatonia

Delirium and catatonia should no longer be regarded as mutually exclusive diagnoses [1,2]. Emerging evidence demonstrates that both syndromes frequently coexist, particularly among critically ill patients [3,10]. Failure to recognize concomitant catatonia carries important therapeutic implications because interventions commonly used to manage delirium, particularly dopamine-blocking antipsychotics, may exacerbate catatonic symptoms in susceptible individuals [2,9,10]. This evolving understanding reinforces the need for systematic assessment of motor signs in all patients presenting with altered mental status, regardless of the presumed underlying diagnosis [1,9].

Consequences of Delayed Diagnosis

The consequences of delayed recognition extend far beyond psychiatric symptom burden. Untreated catatonia predisposes patients to aspiration pneumonia, dehydration, malnutrition, venous thromboembolism, rhabdomyolysis, pressure injuries, muscle contractures, urinary complications, and prolonged hospitalization [1,3,5,9]. Malignant catatonia remains associated with high mortality when not promptly recognized and treated [1-3,10]. Importantly, many of these complications arise not from the syndrome itself, but from prolonged immobility, autonomic instability, and delays in initiating effective therapy. Consequently, the most important determinant of prognosis is often not disease severity alone, but the timing of diagnosis [1-10].

Routine Screening as a Practical Solution

Fortunately, the diagnostic process need not be complex. Validated bedside instruments such as the Bush-Francis Catatonia Screening Instrument provide rapid, reproducible, and highly sensitive methods for identifying patients who require further evaluation [1,4,15]. The lorazepam challenge test also remains a simple and clinically informative diagnostic tool, frequently producing marked improvement within minutes of administration [1-3]. Despite their practicality and validation, neither systematic screening nor benzodiazepine challenge testing has been routinely incorporated into the assessment of patients with altered mental status in most hospitals [1,10].

Findings

This mini review highlights four clinically relevant findings. First, catatonia is not confined to schizophrenia or psychiatric wards; it is a transdiagnostic syndrome encountered across modern hospital medicine. Second, routine clinical assessment and DSM-based criteria alone may miss a substantial proportion of clinically significant cases. Third, overlap with delirium, encephalopathy, medication effects, and neurological illness is a major driver of diagnostic delay. Fourth, systematic bedside screening is a feasible intervention that may improve recognition, reduce inappropriate treatment, and prevent avoidable medical complications.

Conclusions, Limitations, and Recommendations

The greatest challenge in catatonia no longer lies in the absence of effective treatments, as well-established therapeutic options, including benzodiazepines and electroconvulsive therapy, are readily available. The true obstacle remains recognizing the syndrome before potentially fatal complications develop. This review is limited by its narrative design and does not provide a systematic assessment of all available studies. Even so, the current literature strongly supports the need to improve clinician education, implement standardized screening protocols, and reinforce the understanding that catatonia is a common and treatable neuropsychiatric emergency. Routine screening should be considered in psychiatric units, emergency departments, general medical wards, intensive care units, and neurology services, particularly when patients present with altered mental status and motor abnormalities.

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Conflicts of Interest

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