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Schizophrenia Is a Misdiagnosis

Implications for the DSM-5 and the ICD-11

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Preface

The mental health professions, the media and the public have accepted the diagnosis of schizophrenia as *bona fide* for over a century. Some have estimated that there are as many as two million patients with the diagnosis of schizophrenia. This book was written for diagnosing psychiatrists, mental health professionals and physicians, as well as patients diagnosed with schizophrenia and their families. It aims to provide information that will change their diagnosis and ensure their optimal treatment.

I began my research career in biological psychiatry at the NIMH, Bethesda, MD and published empirical papers on patients diagnosed with schizophrenia (Lake et al. 1980). At that time, there was little doubt in academic circles, nor did I doubt, that these patients who exhibited a certain constellation of psychotic symptoms should receive the diagnosis of schizophrenia. Subsequently, however, with increased clinical experience and familiarity with the comparative literature, I began to question the validity of the diagnosis of schizophrenia. Symptoms of mood disturbances were observed in psychotic patients diagnosed with schizophrenia, and I noted that some patients with “schizophrenia” improved with mood-stabilizing medications. This led me to the idea that many patients, initially diagnosed with schizophrenia, actually suffered from a psychotic mood disorder. A review of the descriptive historical and recent comparative scientific literature from patients diagnosed with bipolar disorder and with schizophrenia revealed, somewhat to my surprise, that others shared my opinion. Several recently published articles conclude there is only one disorder, a psychotic mood disorder, that accounts for the functional psychoses (Lake 2008a, b; Lake 2010a, b).

In this book, I have examined research data from a wide array of scientific disciplines as well as historical sources. The result of this investigation is my belief that at least two million patients have been misdiagnosed with schizophrenia. The question is not whether these patients suffer from a psychotic disorder; the vast majority do. The question is: Which psychotic disorder afflicts them? A correct diagnosis is mandatory for effective treatment. Without the correct diagnosis, patients receive substandard care and their prescribing physicians may be subject to malpractice

claims. The purpose of this work is to improve the mental and emotional health of psychotic patients by discussing diagnostic strategies and appropriate treatments.

The book reviews the changing diagnostic concepts of schizophrenia and bipolar disorder within an historical perspective in order to clarify how the current conflict over diagnostic explanations for psychosis has arisen. The idea that two disorders, schizophrenia and bipolar, known as the Kraepelinian dichotomy, account for the functional psychoses has been a cornerstone of psychiatry for over 100 years, but this has recently been questioned because of substantial similarities and overlap between what for so long has been presumed to be two different disorders. One implication of the overlapping data is the question of whether to eliminate the diagnosis of schizophrenia from the psychiatric nomenclature.

Manic-depressive insanity or bipolar disorder has been consistently described in the literature for over 2,000 years. Its diagnostic criteria are disease-specific, validating bipolar disorder as a bona fide disease. Physicians through the centuries made clear that manic-depressive insanity included psychosis, chronicity of course and cycling episodes of mania and depression. It is only recently that some cases of bipolar disorder have been documented to involve deterioration through a chronic, non-cycling, persistently psychotic, treatment-resistant state. Well before the recognition of the possibility of such a chronic, non-cycling deterioration in bipolar patients, in the middle of the nineteenth century, several psychiatrists introduced a separate disease to account for such a condition of psychosis and chronicity. Critical to the establishment and maintenance of schizophrenia as a valid diagnosis has been the erroneous acceptance of two major conclusions: (1) schizophrenia is defined by chronicity and psychosis, i.e., hallucinations, delusions, disorganization and/or catatonia; (2) schizophrenia is separate from, more severe and more important than manic-depressive insanity, i.e., the Kraepelinian dichotomy. The most severe cases of manic-depressive insanity were, in retrospect, carved out and given a new name, schizophrenia. This new but redundant disease was then widely embraced, especially in the United States.

At least three famous psychiatrists initiated and promoted the concept of schizophrenia: Emil Kraepelin (1856–1926), Eugene Bleuler (1857–1939) and Kurt Schneider (1887–1967). All were prolific writers and lecturers and, as much or more than others, have influenced academic psychiatrists, mental health professionals, physicians, the press and the public with regard to schizophrenia. Because of the influence of their writings, each has been given a chapter in this book in which their most renowned publications have been extensively quoted in order to demonstrate how symptoms today considered diagnostic of a psychotic bipolar disorder were interpreted by them as diagnostic of schizophrenia. Thus, the early twentieth century concepts of schizophrenia that formed the foundation for current concepts of schizophrenia were flawed as they are explained by another disease, a psychotic mood disorder.

In 1933, Jacob Kasanin (1897–1946) published a now famous paper that introduced the diagnosis of schizoaffective disorder and that directly questioned the dogma that psychosis mandated a diagnosis of schizophrenia. He indirectly questioned

the validity of the Kraepelinian dichotomy and schizophrenia itself. By the 1970s, several groups of psychiatrists provided support for Kasanin's position by reporting the presence of hallucinations, delusions, disorganization and catatonia in classic bipolar patients, thus discounting the specificity of the diagnostic criteria of schizophrenia. Specific diagnostic criteria are mandatory for a creditable psychiatric disease. Since the 1980s, basic and preclinical data began to steadily accumulate from laboratories around the world showing similarities and overlap between thousands of patients diagnosed with schizophrenia versus psychotic bipolar disorder. Persuasive data pointing to only one disease especially derive from the overlap recorded by comparative studies of molecular genetic and cognitive decline studies from these patients. There are also considerable data reported to be unique to either schizophrenia or bipolar disorder but if these were truly two separate diseases, there could not be such overlap. Such differences may be explained by differences between psychotic and non-psychotic mood-disordered patients. The psychotic mood-disordered patients can be misdiagnosed with schizophrenia. Currently there is a movement to return to the pre-1850s concept that severe, chronic and psychotic mood disorders can account for all of the criteria considered diagnostic of schizophrenia.

Four chapters in this book track the changing conceptualizations of the diagnosis of functionally psychotic patients from 100 BCE to the present. The impact of these conclusions, combined with the overlap and similarities in the diagnostic criteria in all of the editions of the DSM, is striking and leads to the question of how these two disorders can continue to be considered as separate entities.

The last three chapters in this book address respectively the extensive negative outcomes that can be a product of a diagnosis of schizophrenia, an explanation of how schizophrenia has survived as a clinical entity and finally what to do if you or a friend has a diagnosis of schizophrenia. The risk of murder, filicide and/or suicide is increased by a misdiagnosis of schizophrenia in psychotic bipolar or unipolar patients. Patients, families, friends, their psychiatrists and other mental health professionals are especially at an increased risk for violence.

The continuing acceptance of schizophrenia as a valid diagnosis is explained by a series of events discussed herein. These include the absence of any physical tests to rule in or out schizophrenia and a massive volume of research data published on schizophrenia. Patients and families are encouraged to use this book and to research the Internet for symptoms of a psychotic mood disorder, to question the diagnosis of schizophrenia and to seek a psychiatrist and treatment that emphasizes the first-line mood-stabilizing medications while minimizing the use of the antipsychotic drugs.

The DSM-5 proposes to eliminate the subtypes of schizophrenia. This revision, while welcome, does not go far enough. The elimination of the concept of the Kraepelinian dichotomy and the diagnoses of schizophrenia and schizoaffective disorder is necessary to achieve the proper standard of care for functionally psychotic patients. Ultimately such a change will hinge upon serious attention to the issues raised in this book by academic psychiatry. Such a discipline-altering change is warranted despite its radical nature.

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Dr. Lake graduated from Tulane University, New Orleans, LA, in 1965. He received an MS in Insect Physiology, also from Tulane, in 1966. He graduated from Duke University, School of Medicine and Duke Graduate School (Department of Physiology and Pharmacology), Durham, NC, in 1971 and 1972. He studied at Oxford University and at St. Bartholomew's Hospital, London. His residency in Psychiatry was completed at Duke and at the National Institute of Mental Health (NIMH) Bethesda, MD. He remained at the NIMH, Laboratory of Clinical Sciences as a research associate and staff psychiatrist until 1979 when he moved across the pike to take a professorship of psychiatry and pharmacology at the new Uniformed Services University of the Health Sciences (USUHS), School of Medicine. He secured two RO1s continuing his research on the regulation of the sympathetic nervous system in health and in patients with neuropsychiatric and/or cardiovascular disorders.

In 1993, he accepted the chairmanship of Psychiatry at the University of Kansas, School of Medicine for 3 years after which he continued on the full-time faculty until his recent partial retirement. As Professor Emeritus, he continues to publish, teach students and residents about mood disorders, and follow his long-term patients. He has over 250 publications and has achieved life-fellowship status in the American Psychiatric Association and the American College of Neuropsychopharmacology. His current interests are the misdiagnosis of schizophrenia and a more effective strategy for teaching medical students about Psychiatry.

His wife has a Ph.D. in Psychology and was a member of the Clinical Psychology faculty at the University of Kansas for 10 years. She recently received her J.D. from Georgetown Law Center in Washington, DC. They have three wonderful children. Dr. Lake is competitive in tennis.

Contents

- 1 Overview 1**
 - 1.1 Introduction..... 1
 - 1.2 The Impact of the Misdiagnosis of Schizophrenia..... 12
 - 1.3 Chapter Summaries..... 12
 - 1.4 Conclusions..... 19

- 2 The Basic Data..... 21**
 - 2.1 Introduction..... 21
 - 2.2 Dementia, Insanity, and Psychosis..... 21
 - 2.3 The Types of Psychoses: Primary or Functional
Versus Secondary or Organic..... 23
 - 2.4 Manic-Depressive Insanity and Bipolar Disorder..... 24
 - 2.5 Dementia Praecox and Schizophrenia 26
 - 2.6 The Controversy of the Kraepelinian Dichotomy
Undermines the Diagnosis of Schizophrenia..... 30
 - 2.7 Conclusions..... 31

- 3 A History of the Diagnoses of Psychotic Patients**
 - Before 1950 33**
 - 3.1 Introduction..... 33
 - 3.2 A History of Manic Depressive Insanity or Bipolar
Disorder Is Long and Consistent..... 38
 - 3.3 Early “Unitary” Hypotheses for the Psychoses
(i.e., One Disorder Accounts for Bipolar Disorder
and Schizophrenia)..... 41
 - 3.4 Dementia and Dementia Praecox (Schizophrenia) 48
 - 3.5 Dementia Praecox or Schizophrenia: Defined a Dichotomy
with Manic-Depressive Insanity or Bipolar Disorder..... 49
 - 3.6 Kraepelin, Bleuler, Kasanin, and Schneider 53
 - 3.7 Conclusions..... 54

4	Psychiatric Disease and Diagnoses: The Scientific Basis for Establishing Validity	55
4.1	Introduction	55
4.2	Diagnostic Symptoms Must Be Unique and Consistent over Time	56
4.3	Patients with Such Unique Symptoms Must Have Other Consistent Findings	58
4.4	Conclusions	60
5	Emil Kraepelin (1856–1926) Established the Kraepelinian Dichotomy and Schizophrenia but Then Reneged	63
5.1	Introduction: A Dichotomy Meant Dementia Praecox/Schizophrenia Is a Real Disease	63
5.2	Selected Quotes from <i>Dementia Praecox and Paraphrenia</i> , by E. Kraepelin 1919/2002	70
5.3	Selected Quotes from <i>Manic-Depressive Insanity and Paranoia</i> , by E. Kraepelin 1921/1976	85
5.4	Kraepelin's Reversal of the Dichotomy: Implications for a Single Disease	90
5.5	Conclusions	90
6	Eugen Bleuler (1857–1939) Named and Dedicated Himself to Schizophrenia	93
6.1	Introduction	93
6.2	Bleuler's Fundamental Symptoms of Schizophrenia (1911/1950); Not Pathognomonic, Capture Eccentrics and Normals, and Suggest a Bipolar Disorder	95
6.3	Selected Quotes from Bleuler's Textbook, <i>Dementia Praecox or the Group of the Schizophrenias</i> (1911/1950)	101
6.4	Bleuler's Accessory Symptoms: Hallucinations and Delusions Embraced as Diagnostic of Schizophrenia	110
6.5	Functional Psychosis Does Not Equal Schizophrenia	120
6.6	Conclusions	120
7	Jacob Kasanin (1897–1946) and Schizoaffective Disorder	123
7.1	Introduction	123
7.2	Schizoaffective Disorder Contradicts the Concepts of Kraepelin and Bleuler About Schizophrenia	124
7.3	Schizoaffective Disorder Merges Schizophrenia and Psychotic Mood Disorders	125
7.4	Examples of Psychotic Mood Symptoms from Kasanin's Cases	126
7.5	Schizoaffective Disorder Ignored for 30 Years But Then Flourished	127
7.6	Schizoaffective Disorder Is a Compromise Diagnosis	132
7.7	Flawed Diagnostic Criteria for Schizoaffective Disorder	132
7.8	Conclusions	135

8 Kurt Schneider (1887–1967): First- and Second-Rank Symptoms, Not Pathognomonic of Schizophrenia, Explained by Psychotic Mood Disorders	137
8.1 Introduction.....	137
8.2 Selected Quotes From Schneider’s Textbook <i>Clinical Psychopathology</i> (1959); Bleuler’s Concept Reinforced: Psychosis Means Schizophrenia	139
8.3 Schneider’s First- and Second-Rank Symptoms of Schizophrenia Reflect Obsolescence but Remain in the DSM and ICD	143
8.4 Conclusions.....	149
9 Concepts of Schizophrenia and Bipolar Disorder in the 1950s and 1960s	151
9.1 Introduction.....	151
9.2 The Effectiveness of New “Antipsychotic/Antischizophrenia” Medications in the 1950s Increased the Acceptance of Schizophrenia as a Bona Fide Disease	153
9.3 Electroconvulsive Therapy (ECT) Initially Used to Treat Schizophrenia	155
9.4 The National Institute of Mental Health (NIMH) and the Pharmaceutical Industry Focused on Schizophrenia Rather Than Mood Disorders.....	156
9.5 The Use of Lithium in Bipolar Patients Was Delayed in the USA.....	157
9.6 Discrepancies in Diagnostic Comparisons Between the USA and the UK	157
9.7 Overlap of Diagnostic Symptoms Between Schizophrenia and Psychotic Mood Disorders from the Diagnostic and Statistical Manual for Mental Disorders-I (DSM-I) and the DSM-II	159
9.7.1 The DSM-I (APA, DSM 1952)	160
9.7.2 The DSM-II (APA, DSM 1968).....	164
9.8 The Timing of Schneider’s Book (1959) Supported Schizophrenia	166
9.9 Conclusions.....	166
10 Changing Concepts in the 1970s and 1980s: The Overlap of Symptoms and Course Between Schizophrenia and Psychotic Mood Disorders	167
10.1 Introduction.....	167
10.2 Symptoms and Course of Schizophrenia Observed in Severe Bipolar Patients: The Early Reports.....	168
10.3 Thomas S. Szasz	178
10.4 Harrison G. Pope and Joseph F. Lipinski.....	179
10.5 I.F. Brockington	179

10.6	Martin Harrow, Linda Grossman, Marshall Silverstein, Jay Himmelhoch, and Herbert Meltzer	180
10.7	Reports from the NIMH.....	180
10.8	Richard P. Bentall.....	181
10.9	An Introduction to the Continuum Concept.....	181
10.10	Overlap and Similarities Between Schizophrenia and Mood Disorders from the DSM-III (APA, DSM 1980) and the DSM-III-R (APA, DSM 1987)	182
10.10.1	The DSM-III (APA, DSM 1980)	182
10.10.2	The DSM-III-R (APA, DSM 1987)	184
10.11	Conclusions	184
11	Changing Concepts in the 1990s, 2000s, and 2010s:	
	More Overlap and Similarities	187
11.1	Introduction	187
11.2	Additional Reviews of Clinical Overlap and Similarities.....	197
11.3	Overlap and Similarities from Basic Science and Preclinical Studies Comparing Schizophrenia and Mood Disorders.....	197
11.3.1	Brain Metabolic and Neurochemical Studies.....	200
11.3.2	Brain Imaging Studies.....	200
11.3.3	Epidemiological Studies	202
11.3.4	Psychopharmacological Studies.....	204
11.3.5	Family and Heritability Studies	208
11.3.6	Molecular Genetic Studies	211
11.3.7	Neurocognitive, Selective Attention, and Insight Studies	220
11.4	Overlap and Similarities Between Schizophrenia and Mood Disorders in the DSM from the DSM-IV (APA, DSM 1994) Through the DSM-5 (APA, DSM Proposed 2013).....	224
11.4.1	The DSM-IV (APA, DSM 1994)	224
11.4.2	The DSM-IV-TR (APA, DSM 2000)	226
11.4.3	The DSM-5 (APA, DSM Proposed 2013).....	227
11.5	Psychotic Depression Accounts for Many Patients Diagnosed with Schizophrenia	228
11.6	C.M. Swartz and E. Shorter (2007).....	230
11.7	The Development and Implications of the Continuum Concept.....	230
11.8	Conclusions	236
12	The Subtypes and the Positive and Negative Diagnostic Symptoms of Schizophrenia Are Explained by Psychotic Mood Disorders	241
12.1	Introduction: The Subtypes Are the Same as the Diagnostic Criteria.....	241
12.2	Catatonic Subtype	245

12.3	Disorganized Subtype	248
12.4	Paranoid Subtype, i.e., Hallucinations and Delusions: Paranoia Hides the Grandiosity and Guilt of Psychotic Mood Disorders	248
12.5	Case Summaries of Psychotic Mood Disorders Misdiagnosed as Schizophrenia, Paranoid Subtype.....	250
12.6	Paranoid Schizophrenia Is a Psychotic Mood Disorder.....	260
12.7	Undifferentiated Subtype	262
12.8	The Positive and Negative Symptoms of Schizophrenia	262
	12.8.1 The Positive Symptoms.....	263
	12.8.2 The Negative Symptoms	264
12.9	Conclusions.....	267
13	Psychotic Mood Disorders Are Disorders of Thought and of Mood	271
13.1	Introduction.....	271
13.2	Selective Attention: The Brain's Filter-Prioritizer Mechanism.....	272
13.3	Defective Selective Attention Is Epitomized by Manic Distractibility	274
13.4	Student Case Conference: Schizophrenia Explained by Mania	275
13.5	Conclusions.....	279
14	Medical and Other Psychiatric Conditions Potentially Misdiagnosed as Schizophrenia	281
14.1	Introduction.....	281
14.2	Medical and Surgical Causes of Psychosis.....	282
	14.2.1 Autoimmune Disorders	282
	14.2.2 Chromosomal Abnormalities	282
	14.2.3 Chronic Traumatic Encephalopathy (History of Head Trauma)	284
	14.2.4 Dementias and Delirium	285
	14.2.5 Demyelinating Diseases	285
	14.2.6 Electrolyte and Fluid Imbalance	285
	14.2.7 Endocrinopathies.....	285
	14.2.8 Epilepsy.....	286
	14.2.9 Hydrocephalus.....	286
	14.2.10 Infections.....	286
	14.2.11 Metabolic Diseases.....	287
	14.2.12 Narcolepsy.....	287
	14.2.13 Neuropsychiatric Diseases	287
	14.2.14 Nutritional Deficiencies	288
	14.2.15 Space-Occupying Lesions and Structural Brain Abnormalities	288
	14.2.16 Stroke	288

14.3	Substances That Can Cause Psychosis.....	289
14.4	Tardive Psychosis Possibly Caused by Antipsychotic/“Antischizophrenia” Medications and Misdiagnosed as Schizophrenia	290
14.5	Obsessive-Compulsive Disorder and “Hallucinations and/or Delusions” in Normals Can Be Misdiagnosed as Schizophrenia	292
14.6	Conclusions.....	295
15	The Negative Impact of the Misdiagnosis of Schizophrenia upon Patients, Their Families, and Their Caretakers	297
15.1	Introduction.....	297
15.2	The Absence of Mood-Stabilizing Medications due to Misdiagnoses of Schizophrenia Allows Recurrent Mood Disorders to Worsen	299
15.3	Higher Dosages of Antipsychotic/“Antischizophrenia” Medications Are Given to Patients Diagnosed with Schizophrenia and for Longer Periods of Time	301
15.4	The Stigma of Schizophrenia.....	308
15.5	Risk for Violence, Suicide, Homicide, and Filicide Is Increased in Psychotic Mood Disorders Misdiagnosed with Schizophrenia.....	310
15.6	The Negative Impact of the Misdiagnosis of Major Depressive Disorder or Postpartum Depression in Patients Who Have Bipolar Disorder, Depressed.....	348
15.7	Conclusions.....	351
16	How Has Schizophrenia Survived?	353
16.1	Introduction.....	353
16.2	The Overemphasis on Hallucinations and Delusions by Academic Psychiatry.....	356
16.3	Media Examples of the Endorsement of Schizophrenia	358
16.4	The Neuroses Became Obsolete in 1980 with the DSM-III: Why Not Schizophrenia?	364
16.5	The DSM and the ICD Perpetuate Schizophrenia and the Dichotomy	365
16.6	The Pharmaceutical Profit Motive Promotes Schizophrenia.....	365
16.7	Conclusions.....	367
17	What to Do if You, a Family Member, or Friend Is Diagnosed with Schizophrenia or Suffers with Psychotic Symptoms.....	371
17.1	Introduction.....	371
17.2	How Do You Tell If There Is a Severe Psychiatric Problem?	374

17.3	Journal Daily Symptoms, Dates, History, and Family History	374
17.4	Learn About the Disorders: Study Diagnostic Symptoms and Compare to Your Symptoms	376
17.5	Preparation for Seeing a Doctor/Psychiatrist	378
17.6	Treatment Plans for Major Mood Disorders	379
17.6.1	Major Depressive Disorder	380
17.6.2	Bipolar Disorders	384
17.6.3	Psychotherapy	386
17.7	Conclusions.....	387
18	Vision for the Future: Conclusions and Solutions	389
18.1	Introduction.....	389
18.2	The Failure to Recognize Depression and the Risk for Suicide in Nonpsychiatric Clinical Settings.....	390
18.3	The Responsibility of Academic Psychiatry for Improving the Recognition of Mood Disorders in Nonpsychiatric Clinical Settings	392
18.4	Simplify and Consolidate the Functional Psychoses for DSM-5 and/or DSM-6.....	393
18.5	Potential Judicial Sources for Change to Psychiatric Diagnostics.....	395
18.6	Conclusions.....	396
	References.....	397
	Index.....	419

List of Tables

Chapter 1

Table 1.1	Selected quotes from reviews and books in support of no dichotomy	3
Table 1.2	Kraepelin, Bleuler, Kasanin, and Schneider: what they are remembered for and what they actually said	14

Chapter 2

Table 2.1	DSM-IV-TR psychoses due to secondary/organic causes versus the primary/functional psychoses	23
Table 2.2	Types of mood disorders.....	25
Table 2.3	DSM-IV-TR diagnostic criteria for mania or bipolar disorder	25
Table 2.4	DSM-IV-TR specifiers and features for mood disorders	25
Table 2.5	DSM-IV-TR diagnostic criteria for schizophrenia	28
Table 2.6	Definition and symptom overlap of psychotic mood disorders and schizophrenia from current sources.....	29
Table 2.7	The Kraepelinian dichotomy; two disorders explain severe mental illness	30

Chapter 3

Table 3.1	Bipolar disorder has a long and consistent history	35
Table 3.2	Historical links of paranoia with mood disorders not schizophrenia	39
Table 3.3	A history of the unitary or one disease hypothesis for the functional psychoses	43
Table 3.4	DSM-IV-TR subtypes of schizophrenia defined.....	51
Table 3.5	Diagnoses of 236 consecutive admissions with functional psychoses (hallucinations and/or delusions).....	54

Chapter 4

Table 4.1	Concordance of monozygotic (MZ) and dizygotic (DZ) twins in the mood disorders.....	58
Table 4.2	Genetic loci associated with psychotic and nonpsychotic bipolar disorders (and schizophrenia).....	59

Table 4.3	Characteristics initially attributed to schizophrenia are accounted for by psychotic mood disorders	59
Chapter 5		
Table 5.1	A selection of publications of E. Kraepelin translated to English	64
Table 5.2	Selected quotes of symptoms Kraepelin assigned to schizophrenia that are diagnostic of mania and depression (Kraepelin 1919)	66
Table 5.3	Overlap of signs and symptoms between schizophrenia and psychotic mood disorders from two of Kraepelin's books	71
Chapter 6		
Table 6.1	Bleuler's "pathognomonic" fundamental and accessory symptoms for schizophrenia.....	94
Table 6.2	Selected quotes from <i>Dementia Praecox or the Group of Schizophrenias</i> (E. Bleuler 1911/1950) raise questions as to the validity of schizophrenia	96
Table 6.3	Bleuler's subtypes of schizophrenia	100
Table 6.4	Additional characteristics Bleuler and others associated with schizophrenia.....	101
Table 6.5	Selected quotes from <i>Dementia Praecox or the Group of Schizophrenias</i> attributed to schizophrenia but diagnostic of a psychotic mood disorder	107
Chapter 7		
Table 7.1	DSM-IV-TR diagnostic criteria for schizoaffective disorder	125
Table 7.2	PubMed literature cites of schizoaffective disorder	128
Table 7.3	Selected quotes discounting the validity of schizoaffective disorder: schizoaffective disorder is a psychotic mood disorder; there is no schizoaffective disorder	130
Chapter 8		
Table 8.1	K. Schneider's "pathognomonic" first- and second-rank symptoms of schizophrenia.....	138
Table 8.2	Schneider's dichotomy	139
Table 8.3	Relevant quotes from <i>Clinical Psychopathology</i> (K. Schneider 1959).....	140
Chapter 9		
Table 9.1	Events in the 1950s and 1960s that promoted schizophrenia and demoted bipolar disorders.....	152
Table 9.2	PubMed literature cites of schizophrenia/schizophrenic	156
Table 9.3	DSM-I (APA, DSM 1952) classifications of the primary/functional psychotic reactions.....	162

Table 9.4	DSM-II (APA, DSM 1968): The neuroses and the psychoses not attributed to physical conditions listed previously	165
Chapter 10		
Table 10.1	Selected quotes showing overlap and similarity of symptoms and course between schizophrenia and psychotic mood disorders from the 1970s and 1980s and before	169
Table 10.2	Classical and “atypical” symptoms in 20 manic patients	177
Chapter 11		
Table 11.1	Summary of areas of overlap between schizophrenia and mood disorders	188
Table 11.2	Selected quotes from clinical studies showing overlap of signs and symptoms comparing schizophrenia and psychotic mood disorders from the 1990s and 2000s	189
Table 11.3	Selected brain metabolic and neurochemical studies comparing schizophrenia and psychotic mood disorders	198
Table 11.4	Selected brain imagining studies comparing schizophrenia and psychotic mood disorders	201
Table 11.5	Selected epidemiological studies comparing schizophrenia and psychotic mood disorders	203
Table 11.6	Selected psychopharmacological studies comparing schizophrenia and psychotic mood disorders	206
Table 11.7	Selected heritability and family studies comparing schizophrenia and psychotic mood disorders	209
Table 11.8	Selected molecular genetic studies comparing schizophrenia and psychotic mood disorders	214
Table 11.9	Selected cognitive function, selective attention, and insight studies comparing schizophrenia and psychotic mood disorders	221
Table 11.10	Overlap and similarities in the DSM-IV-TR (2000) diagnostic criteria between schizophrenia and psychotic mood disorders	225
Table 11.11	Proposed for DSM-5 (2013): the subtypes eliminated as subtypes but retained as diagnostic criteria	226
Table 11.12	Proposed for DSM-5: nine dimensions of “schizophrenia” are more applicable to psychotic mood disorders	228
Table 11.13	Selected quotes supporting the continuum theory of a single disease encompassing schizophrenia and mood disorders	231
Table 11.14	Differences between schizophrenia and psychotic mood disorders resolved by one disorder	237
Chapter 12		
Table 12.1	Changes and lack thereof of the subtypes and the positive and negative diagnostic symptoms of schizophrenia from the DSM-IV-TR to the DSM-5 (proposed)	242

Table 12.2	Redundant descriptions of catatonia from the DSM-IV-TR chapters on schizophrenia versus the mood disorders.....	246
Table 12.3	Selected quotes discounting the validity of catatonia as diagnostic or even characteristic of schizophrenia	247
Table 12.4	Case summaries of psychotic mood disorders misdiagnosed as schizophrenia.....	257
Table 12.5	Symptoms indicating a psychotic mood disorder not schizophrenia in functionally psychotic patients.....	260
Table 12.6	Sources of paranoid delusional threats that suggest grandiosity of mania	261
Table 12.7	Take home messages for the diagnosis of psychotic patients.....	262
Table 12.8	A history of the negative symptoms of schizophrenia from Bleuler's accessory symptoms to the DSM-5	265
Table 12.9	The subtypes of schizophrenia explained by mood disorders; are a prerequisite for schizophrenia's existence	267
Table 12.10	Suggested initial screening questions for psychotic or paranoid patients (or their significant others)	268
Chapter 13		
Table 13.1	Symptoms of disordered thought and speech traditionally indicative of schizophrenia or mania	272
Table 13.2	Psychotic mood disorders are disorders of mood and disorders of thought	279
Chapter 14		
Table 14.1	Medical disorders with potential psychotic presentations	283
Table 14.2	Substances that can cause psychoses.....	289
Table 14.3	Suggested medical work-up for the rule out of secondary/organic psychoses.....	295
Chapter 15		
Table 15.1	Department of Justice National Crime Victimization Survey for 1993-1999; Annual rate for nonfatal violent crime.....	298
Table 15.2	First-line mood-stabilizing medications	299
Table 15.3	Adverse effects of the first-line mood-stabilizing medications	300
Table 15.4	Antipsychotic/antischizophrenia medications; typical vs atypical	302
Table 15.5	Adverse effects of antipsychotic/antischizophrenia medications	304
Table 15.6	Movement disorders caused by the antipsychotic/antischizophrenia medications	305

Table 15.7	Violence, homicide, and suicide committed by patients misdiagnosed with schizophrenia	312
Table 15.8	Epidemiology of psychotic murderers and their victims	334
Table 15.9	Risk for filicide is increased in psychotic bipolar disordered patients misdiagnosed with schizophrenia, major depressive disorder, or postpartum depression	340
Chapter 16		
Table 16.1	Factors prolonging the recognition of schizophrenia as valid	354
Table 16.2	Core beliefs of E. Kraepelin, E. Bleuler, and K. Schneider promoted schizophrenia	357
Table 16.3	Media emphasis on schizophrenia	361
Chapter 17		
Table 17.1	Outline of what to do if you or a significant other has a diagnosis of schizophrenia	372
Table 17.2	Differentiating a bipolar disorder in a depression from a major depressive disorder	378
Table 17.3	Differentiating a bipolar disorder from the diagnosis of schizophrenia	378
Table 17.4	Second-generation antidepressive medications	381
Chapter 18		
Table 18.1	Suggested changes for the DSM-5 and/or the DSM-6	394
Table 18.2	Proposed additions to the DSM specifiers for mood disorders	395

List of Figures

Chapter 3

Fig. 3.1	Changing diagnostic concepts of the psychoses from 19th century (a) to 1933 (b) to 1986 (c) to current (d).....	42
Fig. 3.2	Hypothesized history of diagnoses for the functional psychoses	50

Chapter 4

Fig. 4.1	Relationship between mean cycle length and episode number in recurrent mood disorders.....	57
-----------------	---	----

Chapter 7

Fig. 7.1	PubMed literature cites of schizoaffective disorder	129
-----------------	---	-----

Chapter 9

Fig. 9.1	PubMed literature cites of schizophrenia/schizophrenic	153
-----------------	--	-----

Chapter 11

Fig. 11.1	Bipolar responsivity to lithium and antipsychotics along two axes	204
Fig. 11.2	Estimated diagnoses of functionally psychotic patients over 2000 years.....	212
Fig. 11.3	Continuum/dimensional concept explained by mood disorders: the original versus the current concept	236

Chapter 12

Fig. 12.1	Estimated diagnostic weight given to the positive and the negative symptoms and chronic course for the diagnosis of schizophrenia over time	244
Fig. 12.2	Paranoia hides guilt and grandiosity: Psychotic mood disorders cause paranoid delusions.....	249
Fig. 12.3	PubMed cites of the negative symptoms of schizophrenia.....	266

Chapter 13

Fig. 13.1	Psychotic mood disorders are disorders of thought: euthymia	273
Fig. 13.2	Psychotic mood disorders are disorders of thought: mania.....	277
Fig. 13.3	Psychotic mood disorders are disorders of thought: depression...	278

Chapter 16

Fig. 16.1	Feedback loop enhancing the promotion of the concept of schizophrenia.	355
Fig. 16.2	Schizophrenia: a covered wagon	368

Chapter 17

Fig. 17.1	Get the diagnosis right.....	373
Fig. 17.2	Daily mood, energy level, and sleep flow sheet for recurrent mood-disordered patients	375
Fig. 17.3	Medication treatment plan for unipolar depression (major depressive disorder, MDD).	382
Fig. 17.4	Medication treatment plan for bipolar disorder, manic or depressed.....	385

Chapter 1

Overview

It must be assumed that these diseases [schizophrenia and affective illnesses] are genetically related. ... that the psychoses represent a continuum of variation at a single genetic locus.

(Crow 1990a)

There is a whole concept of major psychiatric illness as a single disease process, suggesting that schizophrenia might be the chronic untreated form of psychotic depression and of psychotic mixed manic-depressive states.

(Swartz and Shorter 2007, pp. 19)

1.1 Introduction

In 1976, Professor Tom Szasz, a noted psychiatrist, published a controversial, if not heretical, article in the *British Journal of Psychiatry* in which he said, “There is, in short, no such thing as schizophrenia.” In 1976, the current author was a resident in psychiatry and was appalled at Szasz’s ideas because the esteemed professors at Duke thoroughly embraced the validity of schizophrenia and so, at that time, did this author. The curriculum, governed by the teachings of Kraepelin, Bleuler, and Schneider, fully accepted the Kraepelinian dichotomy, that is, the idea that schizophrenia is a disease distinct from mood disorders. Schizophrenia was taught as the “disorder of thought,” while the affective or mood disorders were “disorders of the emotions,” and there was no overlap. Schizophrenia was to be diagnosed in the presence of primary or functional psychosis and/or chronic dysfunctionality regardless of the presence of mood symptoms. Considerably more diagnostic weight was placed on psychotic than mood symptoms. While initially a strong proponent of schizophrenia and the Kraepelinian dichotomy for some 15 years between medical school and a fellowship, as this author coauthored a paper based on results from patients diagnosed with schizophrenia, there are now doubts about the validity of the diagnoses of schizophrenia in the patients from the 1980 publication (Lake et al. 1980).