

Chapter 2

The Basic Data

Psychosis is prevalent in bipolar disorder.... When differentiating from schizophrenia and schizoaffective disorder, presenting signs and symptoms are usually not helpful....

(Dieperink and Sands 1996)

... the validity of the diagnostic distinction between schizophrenia and bipolar disorder is increasingly challenged.... The diagnostic split between schizophrenia and bipolar disorder is unable to define distinct etiological and/or pathophysiological entities.

(Maier et al. 2006)

2.1 Introduction

Definitions and explanations of the terms and diseases referred to in this book are derived from various sources including the American Psychiatric Association's (APA) current DSM and the American Psychiatric Glossary as well as Wikipedia and other sources. Examples include the definitions of the functional or primary versus the organic or secondary psychoses, insanity, dementia, dementia praecox, schizophrenia, manic-depressive insanity, bipolar disorder, major depressive disorder, and the Kraepelinian dichotomy.

2.2 Dementia, Insanity, and Psychosis

Clarification of such terms is relevant because dementia praecox/schizophrenia and manic-depressive insanity/bipolar disorder were considered by some in the nineteenth century as overlapping psychoses that both could lead to dementia (Morel 1851; Berrios & Beer 1994; Angst 2002; Conrad 1958). According to Wikipedia (2011),

Dementia (taken from Latin, originally meaning “madness”, from *de*-“without” + *ment*, the root of *mens* “mind”) is a serious loss of cognitive ability in a previously unimpaired person, beyond what might be expected from normal aging. ... Although dementia is far more common in the geriatric population, it may occur in any stage of adulthood. Dementia is a non-specific illness syndrome (set of signs and symptoms) in which affected areas of cognition may be memory, attention, language, and problem solving. It is normally required to be present for at least 6 months to be diagnosed;... In all types of general cognitive dysfunction, higher mental functions are affected first in the process. Especially in the later stages of the condition, affected persons may be disoriented in time (not knowing what day of the week, day of the month, or even what year it is), in place (not knowing where they are), and in person (not knowing who they are or others around them). Dementia, ..., is usually due to causes that are progressive and incurable.

(Wikipedia 2011)

According to the APA’s Psychiatric Glossary (2003), dementia is

A cognitive disorder characterized by deficits in memory, aphasia, apraxia, agnosia, and deficits in executive functioning.

The concept of dementia as it is known today evolved during the twentieth century. Prior to the early 1900s, dementia was broadly defined as mental dysfunctionality. The terms madness, dementia, insanity, and psychosis might have been used interchangeably before and even into the early years of the twentieth century. Dementia praecox or dementia of the young (a precursor to what was later labeled as schizophrenia) was initially confused with dementia of old age. The distinctions between secondary/organic and primary/functional psychoses were not recognized before the twentieth century (see below).

Psychosis is the modern term for insanity. According to the American Psychiatric Glossary, eighth edition (2003), “psychosis” is defined by,

A severe mental disorder characterized by gross impairment in reality testing, typically manifested by delusions, hallucinations, disorganized speech, or disorganized or catatonic behavior.

Note that this definition of a primary or functional psychosis is identical to the DSM core diagnostic symptoms of schizophrenia (Chap. 2; Table 2.5), and for almost a century, primary/functional psychosis was erroneously equated with schizophrenia due in large measure to the substantial influence of Eugene Bleuler (1911) and Kurt Schneider (1959) on academic psychiatry in the USA. Their ideas are described in detail in Chaps. 6 and 8, respectively. The misconception of schizophrenia as isomorphic with primary/functional psychosis has gradually waned in acceptance as psychosis has been recognized as common to severe mood disordered patients.

A state of psychosis is

... often characterized by aggressive behavior, inappropriate mood, diminished impulse control, ... and delusions and hallucinations.

Aggressive behavior and diminished impulse control are characteristics of psychotic mania and inconsistent with avolition attributed to schizophrenia and major depression. The psychotic behaviors of several murderers over the past decades have been consistent with manic episodes but have been called schizophrenia (Chap. 15). The APA also characterizes psychosis as “a major mental disorder of organic or

Table 2.1 DSM-IV-TR
psychoses due to secondary/
organic causes versus
the primary/functional
psychoses

<div><div>• Psychoses due to organic or secondary causes</div><div>Multiple drugs (illegal, over-the-counter, and prescription)</div><div>Toxins</div><div>Medical/surgical disorders</div></div> <div><div>• Functional or primary psychoses</div><div>Psychotic mood disorders (Bipolar or Unipolar)</div><div>Schizophrenia</div><div>Schizoaffective disorders</div><div>Delusional disorders</div><div>Psychoses, not otherwise specified (NOS)</div></div>
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emotional/functional origin” (Shahrokh and Hales 2003). The disorder must be sufficiently severe as to grossly interfere with the individual’s capacity to meet the ordinary demands of life. While there are only five primary/functional disorders in the DSM currently said to have the potential to involve psychosis (Table 2.1), there are dozens of pharmacological, medical, and surgical (secondary/organic) causes of altered brain function and psychosis (Chap. 14; Tables 14.1, 14.2, and 14.3).

2.3 The Types of Psychoses: Primary or Functional Versus Secondary or Organic

The psychoses can be artificially divided into two major subtypes: (1) primary or functional and (2) secondary or organic (Table 2.1). This work will focus primarily on the functional psychoses because it is this subtype that includes schizophrenia and psychotic mood disorders. A primary/functional psychosis is one for which no causal pathophysiology has been reliably identified, but since all valid diseases must at some level be represented by pathophysiology, there must be a neurochemical abnormality in brain function in the valid “primary/functional psychoses.” Thus, the primary/functional psychoses that can be scientifically grounded as valid, distinct diseases are actually in a fundamental sense also secondary/organic. A secondary/organic basis for dementia praecox/schizophrenia was postulated by Kraepelin and Bleuler around 1900 and even earlier for manic-depressive insanity/bipolar disorder. However, to date, no clinically reliable pathophysiology has been discovered for any psychiatric disorder despite massive efforts.

A discussion of secondary/organic causes of psychosis is presented in Chap. 14. Many of the secondary/organic psychoses are a consequence of medical/surgical disorders or drug/medication effects that can present predominately with psychotic symptoms. The typical clinical symptoms of each medical/surgical disorder can be so subtle initially, or the causative drug cleared from the body, that they are missed and the psychosis mistakenly labeled as functional. The possibly misdiagnoses include bipolar disorder, major depression, schizoaffective disorder, and schizophrenia (Chap. 14; Tables 14.1, 14.2, and 14.3). There are substantial negative consequences of such misdiagnoses (Chap. 15). For example, a patient with a brain

tumor can develop psychotic and/or mood symptoms first before neurological signs are obvious, and if the diagnosis of a functional psychosis is made, there is no early treatment of the tumor.

The DSM is the most widely accepted authority on classifications and definitions of mental disorders. The most recent edition, the DSM-IV-Text Revision (DSM-IV-TR), lists five diagnoses with potential for “functional psychosis”: (1) mood disorders, (2) schizophrenia, (3) schizoaffective disorder, (4) delusional disorders, and (5) psychotic disorders not otherwise specified (Table 2.1) (APA, DSM 2000). The latter two diagnoses have been included relatively recently in contrast to the first three disorders that date to the first century, the nineteenth century, and 1933, respectively (Chap. 3). The delusional disorders are a relatively rare group of disorders, characterized by a focused rather than generalized dysfunctionality (APA, DSM 2000). These patients display various nonbizarre delusions of paranoia, such as having an imaginary illness, of being loved by another at a distance, of the replacement of a significant other, etc. The relevance of the delusional disorders to the present work is that they may account for a small percent of patients misdiagnosed with schizophrenia, especially paranoid schizophrenia. The erotomanic type of delusional disorder involves the delusion that another person, typically of a higher social and economic status, is in love with the individual. Such grandiosity also fulfills one of the criteria for mania and thus indicates a consideration of a diagnosis of bipolar disorder. However, to qualify for a diagnosis of bipolar disorder, the other DSM diagnostic criteria must be present (Tables 2.3 and 2.4).

Labeling an individual with the category of psychotic disorder, not otherwise specified, suggests diagnostic uncertainty as to the cause of the psychosis, whether primary/functional or secondary/organic, and if considered primary, which one. This label is sometimes used in forensic psychiatry with the goal of avoiding a specific diagnosis; it is not recommended and should not be used as a permanent diagnosis but may be appropriate for a brief period while a more definitive diagnosis is sought.

2.4 Manic-Depressive Insanity and Bipolar Disorder

Manic-depressive insanity was the early name for bipolar disorder, and the two are synonymous. That “insanity” was used for bipolar patients for centuries suggests that such patients are capable of exhibiting psychosis. The mood disorders, also previously called affective disorders, are common and have been subdivided into bipolar and unipolar (Table 2.2). Bipolar is defined by the occurrence of one or more manic and/or hypomanic episodes with or without depression, while unipolar patients suffer only episodes of depression, that is, they never experience a manic or hypomanic episode (Table 2.3). When only hypomanic episodes occur and not full blown mania, bipolar-II is the diagnosis, while bipolar-I requires a full manic episode. The depressions that can occur in both bipolar-I and bipolar-II disorders, as well as in recurrent unipolar or major depressive disorder, are indistinguishable with regard to severity, signs, symptoms, psychosis, and risk for suicide. Further, moderate to severely depressed patients, whether bipolar or unipolar, typically

Table 2.2 Types of mood disorders

<ul style="list-style-type: none">• Bipolar disorders<ul style="list-style-type: none">Bipolar-I^{a,b}Bipolar-II^bBipolar-III^cCyclothymia^d• Unipolar depression (major depressive disorder)^b<ul style="list-style-type: none">Single EpisodeRecurrentDysthymia^e
^a Manic episodes can be associated with psychosis, i.e., hallucinations, delusions, disorganization, catatonia, paranoia
^b Depressive episodes can be associated with psychosis, i.e., hallucinations, delusions, disorganization, catatonia, paranoia
^c Manic and/or hypomanic episodes occur only after use of antidepressant medications
^d Cycles of mild hypomania and mild depression lasting several days to a week or two, occurring continually for two years or more
^e Persistent mild depression, i.e., the glass half empty person with symptoms lasting two years or more; often also associated with the occurrence of major depressive episodes

Table 2.3 DSM-IV-TR diagnostic criteria for mania or bipolar disorder (Modified for brevity)

- A. Distinct period for at least *1 week* (or inpatient hospitalization necessary) of abnormal and persistently elevated, expansive, or irritable mood
- B. In the period, three symptoms (four if mood is only irritable) persist to a significant degree:
 - 1. Distractibility
 - 2. Insomnia with increased energy
 - 3. Grandiosity/increased self-esteem
 - 4. Flight of ideas
 - 5. Increased activities: including phoning, spending, travel, investing, gambling, sex; excessive involvement in pleasurable activities with high potential for negative outcome
 - 6. Speech: pressed to *incoherent*^a
 - 7. Thoughts: racing, *loose, tangential*^a
- C. Symptoms cause *marked impairment in functioning*^a (job, social, family) or *hospitalization*^a warranted because of severity of symptoms
- D. Symptoms not due to substance or general medical condition

Note: See Table 2.4 for specifiers that overlap with schizophrenia

^aSigns and symptoms associated or confused with schizophrenia

Table 2.4 DSM-IV-TR specifiers and features for mood disorders

- A. Presenting state: for BP: manic, depressed, mixed; for UP: single episode or recurrent
- B. Severity: mild, moderate, severe without, *severe with psychotic features*,^a partial, full remission
- C. Course/onset: *chronic (symptoms over 2 years)*,^a seasonal affective disorders, *rapid cycling*^a (at least four episodes/year), postpartum onset (within 4 weeks), with or *without full interepisode recovery*^a
- D. Features: *catatonic*,^a *melancholic*, *atypical*^a

Abbreviations: BP bipolar, UP unipolar

^aSigns and symptoms associated or confused with schizophrenia

experience the “negative symptoms” that are considered diagnostic of schizophrenia (Table 2.5) (Chap. 12).

Although psychotic mood disorders are called “primary or functional,” which means that no consistent pathophysiology has been identified, data from patients with bipolar disorder, such as that from genetic studies, show differences between patients diagnosed with bipolar disorder and a nonaffected population; the limitation is that the specific brain pathophysiology remains elusive. Heritability and molecular genetic evidence substantiating bipolar as a bona fide disease is discussed in Chaps. 3, 4, and 11.

Another definition is found in Wikipedia (2011):

Bipolar Disorder and Manic-Depressive Disorder [or originally manic-depressive insanity], which is also referred to as Bipolar Affective Disorder or Manic Depression, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy level, cognition, and mood with or without one or more depressive episodes. The elevated moods are clinically referred to as mania or, if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or mixed episodes in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of “normal” mood; but, in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling. Extreme manic episodes can sometimes lead to such psychotic symptoms as delusions and hallucinations. The disorder has been subdivided into Bipolar I, Bipolar II, cyclothymia, and other types, based on the nature and severity of mood episodes experienced; the range is often described as the bipolar spectrum....

Bipolar-III is designated for patients with episodes of mania or hypomania that occur only after use of an antidepressant.

Data from the United States on lifetime prevalence varies; but it indicates a rate of around 1% for Bipolar-I, 0.5%–1% for Bipolar-II or cyclothymia,... The onset of full symptoms generally occurs in late adolescence or young adulthood. Diagnosis is based on the person’s self-reported experiences, as well as observed behavior. Episodes of abnormality are associated with distress and disruption and an elevated risk of suicide, especially during depressive episodes. In some cases, it can be a devastating long-lasting disorder. In others, it has also been associated with creativity, goal striving, and positive achievements. There is significant evidence to suggest that many people with creative talents have also suffered from some form of Bipolar Disorder. ... People with Bipolar Disorder exhibiting psychotic symptoms can sometimes be misdiagnosed as having Schizophrenia, another serious mental illness.

(Wikipedia 2011)

As a general reference, this Wikipedia description of the signs and symptoms of the bipolar disorders is accurate and reasonably comprehensive.

2.5 Dementia Praecox and Schizophrenia

Emil Kraepelin (1856–1926) in his 1919 textbook defined dementia praecox as

... a series of clinical states which have as their common characteristic a peculiar destruction of the internal connections of the psychic personality with the most marked damage of the emotional life and of volition.

(Kraepelin 1919)

Kraepelin wrote that a chronic, downhill course of intellectual or cognitive deterioration was the defining common feature to all of the subtypes and thus to dementia praecox overall. The references to "... damage of the emotional life and volition ..." are striking in this definition of dementia praecox by Kraepelin, a disease supposedly separate from mood disorders, when these characteristics are so closely associated with mood. Avolition, universal in severe depression, has survived for a century as a diagnostic "negative symptom" of schizophrenia in the DSM-IV-TR (APA, DSM 2000).

Eugene Bleuler (1857–1939) renamed dementia praecox, schizophrenia and defined schizophrenia as

... a group of psychoses whose course is at times chronic, at times marked by intermittent attacks and which can stop or retrograde at any stage, but does not permit a full "restituto ad integrum."

(Bleuler 1911/1950)

Thus, Bleuler said, once one has a diagnosis of schizophrenia, they can never get back to their prediagnosis functional baseline. This concept added substantial stigma and hopelessness to a diagnosis of schizophrenia. Thus, dementia praecox and schizophrenia were synonymous, and with time, the former label fell into disuse. Not reflected in these early and influential definitions was the prevalence of mood symptoms in many of the psychotic patients who Kraepelin and Bleuler depended on to develop their concepts of dementia praecox and schizophrenia. Mood symptoms were actually interpreted as symptoms of schizophrenia in psychotic patients (Chaps. 3, 5, and 6).

According to Wikipedia, schizophrenia is derived from the Greek roots "*schizein*," meaning "to split" and "*phren*," the "mind." Despite its etymology, schizophrenia is not associated with multiple personality disorder, "split personality," or dissociative identity disorder. It

... is a psychiatric diagnosis that describes a mental disorder characterized by abnormalities in the perception or expression of reality. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, catatonia or disorganized speech and thinking in the context of significant social or occupational dysfunction. Social problems, such as long-term unemployment, poverty and homelessness, are common and life expectancy is decreased; the average life expectancy of people with the disorder is 10–12 years less than those without, owing to increased physical health problems and a high suicide rate.

(Brown et al. 2000)

The high suicide rate quoted in patients diagnosed with schizophrenia may be explained by the high suicide rate in misdiagnosed and mismedicated patients actually suffering from psychotic depression (Swartz and Shorter 2007). "... Significant social or occupational dysfunction.... Social problems, such as long-term unemployment, poverty, and homelessness,..." are common to severe or psychotic mood disorders (APA, DSM 2000).

According to the APA Guidelines, schizophrenia is a

... chronic and debilitating mental illness in which patients often have a diminished capacity for learning, working, self-care, interpersonal relationships, and maintaining general living skills.

According to the current APA Psychiatric Glossary, eighth edition (2003), schizophrenia is defined as

Table 2.5 DSM-IV-TR diagnostic criteria for schizophrenia (modified)^a

-
- A. Characteristic symptoms: patient must have two symptoms during a 1-month (active) phase (except as noted below):
1. Delusions^b
 2. Hallucinations^b
 3. Disorganized speech (frequent derailment, incoherence)^b
 4. Grossly disorganized^b or catatonic^b behavior
 5. Negative symptoms (affective flattening, alogia, and avolition)^b

Note: Only one symptom is required if delusions are bizarre or hallucinations are a voice commenting on one's behavior/thoughts, or if two or more voices are conversing with each other^{b,c}

- B. Social/occupational dysfunction: work, interpersonal relations, or self-care have markedly deteriorated^b
- C. Duration: continuous signs for 6 months with 1-month active phase symptoms and may include prodromal or residual symptoms^b
- D. Exclude schizoaffective and mood disorders with psychotic features^d
- E. Exclude substance and general medical condition^b
- F. Exclude preexisting pervasive developmental disorder^b
- Subtypes: paranoid, disorganized, catatonic, undifferentiated, residual
-

^aAbbreviated format without change in meaning or substance

^bThese symptoms/criteria are disease nonspecific and occur frequently in mood disorders, severe with psychotic features

^cThese qualifications that allow a diagnosis of schizophrenia with only one of the characteristic symptoms in Sect. A are from K. Schneider's first-rank symptoms (Chap. 8)

^dThis criterion is often underemphasized or ignored; a diagnosis of schizophrenia is made before reaching criterion D due to the presence of psychotic features

A group of psychotic disorders characterized by both positive and negative symptoms associated with disturbance in one or more major areas of functioning, such as work, academic development or achievement, interpersonal relations, and self-care.

The positive and negative symptoms of schizophrenia are discussed in detail in Chap. 12. The “positive” of positive symptoms suggests an increased chance for improvement with antipsychotic/antischizophrenia medications compared to the negative symptoms. Positive symptoms include delusions, which may be bizarre in nature; hallucinations, especially auditory; catatonia; disorganized speech; and disorganized behavior. Negative symptoms include flat or inappropriate affect, avolition, alogia and anhedonia, and associate with a poor prognosis (Shahrokh and Hales 2003):

Duration is variable: the International Classification of Diseases, Tenth Edition (ICD-10) requires that continuous signs of the disturbance persist for at least one month; the DSM-IV-TR requires a minimum of six months.

(Shahrokh and Hales 2003)

Perhaps surprisingly, schizophrenia is defined and understood today much as it was over a century ago with some narrowing of the diagnostic criteria from Bleuler's very broad concept that occurred in 1980 with the publication of the DSM-III (Table 2.5) (APA, DSM 2000).

Table 2.6 Definition and symptom overlap of psychotic mood disorders and schizophrenia from current sources

Source	Schizophrenia	Bipolar disorder
DSM-IV-TR (APA, DSM 2000)	<p>(A) Characteristic symptoms: (1) delusions, (2) hallucinations, (3) disorganized speech (e.g., frequent derailment or incoherence), (4) grossly disorganized or catatonic behavior, (5) negative symptoms, that is, affective flattening, alogia, or avolition.</p> <p>(B) Social/occupational dysfunction.</p> <p>(C) Duration: continuous signs for at least six months.</p>	<p>According to the DSM-IV-TR, episodes of mania and depression can display, "Mood-incongruent psychotic features; delusions or hallucinations ... persecutory delusions ... thought insertion, thought broadcasting, and delusions of control or being controlled." Episodes can be "... continuous for at least the past two years." Major depressive and manic episodes can display "catatonic features" that are identical to the definition of catatonia in the chapter on schizophrenia in the DSM-IV-TR. The three "negative symptoms of schizophrenia" are readily accounted for by moderate to severe unipolar or bipolar depression. Note: Thus, according to the current DSM, psychotic mania or depression can explain all of the supposedly disease-specific diagnostic criteria for schizophrenia including symptom severity, chronicity, and catatonia.</p>
ICD-10 (2007)	<p>"... characterized ... by fundamental and characteristic distortions of thinking and perception, and affect that are inappropriate or blunted.</p> <p>The most important psychopathological phenomenon includes thought echo: thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control, influence or passivity; hallucinatory voices commenting or discussing the patient in the third person..."</p>	<p>"... delusions ... or hallucinations are present ... flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication. [also] Mania with: mood congruent [or] mood incongruent psychotic symptoms ... manic stupor. ... [For] Severe depressive episode with psychotic symptoms ... hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; ... danger to life from suicide, dehydration or starvation." Note: Psychotic mood disorders explain any, and all of the "... fundamental and characteristic distortions of thinking and perception..." held in the ICD-10 (2007) as specific for schizophrenia.</p>
Wikipedia (2011)	<p>"F20.4: Post schizophrenia depression... with an increased risk of suicide..."</p> <p>"... most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking, and it is accompanied by significant social or occupational dysfunction.... [such as] social withdrawal, sloppiness of dress and hygiene, and loss of motivation and judgment... social isolation commonly occurs.... the person may be largely mute, remain motionless... Negative symptoms are deficits of normal emotional responses... They commonly include flat or blunted affect and emotion, poverty of speech (alogia), inability to experience pleasure (anhedonia), lack of desire to form relationships (asociality), and lack of motivation (avolition).... [Disorganization] may range from loss of train of thought, to sentences only loosely connected in meaning, to incoherence known as word salad... The onset ... occurs in young adulthood with a global lifetime prevalence of about 0.3 to 0.7%.... People with schizophrenia are likely to have additional (comorbid) conditions, including major depression... the lifetime occurrence of substance abuse is almost 50%.... suicide rate is about 5%."</p>	<p>Postschizophrenic depression is likely psychotic depression, not schizophrenia.</p> <p>"... psychotic symptoms as delusions and hallucinations...," "onset ... in late adolescence or young adulthood...," "lifetime prevalence ... of around 1% for Bipolar-I ...," "episodes ... associated with distress and disruption [of life] and an increased rate of suicide..." "... can be misdiagnosed as schizophrenia..."</p> <p>Note: Psychotic mood disorders can suffer each and every sign and symptom given under schizophrenia. The negative symptoms (of schizophrenia) are common to moderate to severe depression, both bipolar and unipolar, specifically flat or blunted affect and emotion, alogia, anhedonia, asociality, avolition.</p>

The “group” of schizophrenias refers to the subtypes canonized by Kraepelin, Bleuler, and academic psychiatry. These early concepts of Kraepelin and Bleuler directly influenced the definitions in textbooks and in all DSM editions. Also of note, the current DSM diagnostic signs and symptoms for schizophrenia, that were once considered disease specific, are now recognized in the same DSM to occur in severe mood disorders as well (compare Tables 2.3, 2.4, 2.5, and 2.6).

2.6 The Controversy of the Kraepelinian Dichotomy Undermines the Diagnosis of Schizophrenia

From 100 CE to about 1850, some psychotic patients were consistently described with behaviors meeting criteria for manic-depressive insanity; dementia praecox/schizophrenia had yet to be named. Throughout the eighteenth and nineteenth centuries, several prominent psychiatrists believed that only one disease explained all the psychoses (Sect. 3.3). The concept of the Kraepelinian dichotomy emerged in the last half of the nineteenth century with the idea that manic-depressive insanity could not encompass young, functionally psychotic patients with a chronic course.

A dichotomy, credited to Kraepelin (1856–1926), was entertained by others including Kahlbaum (1828–1899) and Griesinger (1817–1868). Kahlbaum was,

Initially taken by the idea that all insanities were stages of one disease, [but] he progressed on to offer a classification which included many.

(Berrios and Beer 1994)

Angst (2002) notes that Kahlbaum’s classification system was not successful because it was too complex. Griesinger’s later publications indicate that he believed that there were two groups of insanities: the affective ones and then the primary disturbances of perception and will. This idea seems a precursor of the Kraepelinian dichotomy. A new disease, dementia praecox or schizophrenia was named, and “the dichotomy” was born (Table 2.7). The Kraepelinian dichotomy was simple and widely embraced and has been a cornerstone of the mental health professions for over a century. Its acceptance guaranteed the acceptance of schizophrenia as a bona fide disease.

Modern skepticism as to the validity of the Kraepelinian dichotomy was actually initiated by Kraepelin himself in 1920 when he said:

It is becoming increasingly clear that we cannot distinguish satisfactorily between these two illnesses [dementia praecox/schizophrenia and manic-depressive insanity/bipolar] and this brings home the suspicion that our formulation of the problem may be incorrect.

(Kraepelin 1920)

Table 2.7 The Kraepelinian dichotomy; two disorders explain severe mental illness

- Dementia praecox or schizophrenia
- Manic depressive insanity or bipolar disorder

The 1933 introduction of schizoaffective disorder (Kasanin 1933) recognized the diagnostic relevance of mood symptoms in psychotic patients, linked schizophrenia (psychosis) and mood disorders, and eroded the concept of the Kraepelinian dichotomy and the dogma that psychosis was schizophrenia (Procci 1976; Brockington and Leff 1979; Brockington et al. 1979; Pope et al. 1980; Lake and Hurwitz 2006a, b). The concept of schizoaffective disorder facilitated a narrowing of zones of rarity between schizophrenia and psychotic mood disorders, but further closure did not progress for another 50 years (Figs. 3.1 and 3.2) (Schwartz et al. 2000; Swartz 2002a, b; Averill et al. 2004; Maier 2006; Vollmer-Larsen et al. 2006; Lake and Hurwitz 2007a, b). Pope and Lipinski (1978) raised the idea that many psychotic patients were misdiagnosed with schizophrenia and actually suffered from bipolar disorder. More recently, persuasive overlap and similarities across a wide spectrum of clinical and basic science fields have led to the idea that the disease we have called schizophrenia, since the time of Bleuler (1911), may actually be a severe, psychotic mood disorder. Craddock and Owen (2005) have recently predicted “The Beginning of the End of the Kraepelinian Dichotomy” (article title) in the *British Journal of Psychiatry*.

2.7 Conclusions

Before the early 1900s, there was not a clear distinction between primary and secondary psychoses as many of the surgical, medical, and drug causes of secondary psychoses were unknown. Before the twentieth century, dementia was considered the end stage for many diseases including schizophrenia and manic-depressive insanity suggesting overlap in course and symptom severity.

From the inception of schizophrenia in the 1850s through the present DSM, the definitions of bipolar disorder and schizophrenia contain striking clinical similarities and overlap. It is surprising to this author that there has not been earlier doubt about the Kraepelinian dichotomy and the validity of schizophrenia as separate from psychotic bipolar disorders (Table 2.6). The Kraepelinian dichotomy has been questioned if not discounted; having been a cornerstone of psychiatry for over a century, it now seems best represented by a tombstone.

Schizophrenia Is a Misdiagnosis
Implications for the DSM-5 and the ICD-11

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2012, XXVIII, 428 p., Hardcover

ISBN: 978-1-4614-1869-6