

# 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.



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

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