At Issue

Abstract

In a recent article in the Schizophrenia Bulletin, Goplerud and Depue (1978) discuss our writings on postpsychotic depression (McGlashan and Carpenter 1976a and 1976b). They argue that postpsychotic depression is the depressed phase of bipolar affective illness and thus join many workers who now challenge the diagnosis of schizophrenia in patients in whom affective disturbance is a significant part of the manifest psychopathology. In our response, we place special emphasis on the fallacy of using nondiscriminating similarities between groups (e.g., suicidal ideation) as a basis for positing disease homogeneity. Contrariwise, we argue the value of emphasizing nosologically discriminating features of individual patients in reaching diagnostic decisions.

Concern is expressed with the current trend of defining diagnostic criteria such that acute and episodic psychoses are increasingly classified as affective disorders. We present arguments in favor of maintaining such cases within an ambiguous or uncertain category and reassert the time-honored (but recently forgotten) observation that schizophrenic patients can be affectively disturbed and still be schizophrenic.

In their recent article in the Schizophrenia Bulletin, Goplerud and Depue (1978) discuss our writings on postpsychotic depression (McGlashan and Carpenter 1976a and 1976b) at some length. They argue that postpsychotic depression (PPD) is the depressed phase of bipolar affective illness rather than a phase of schizophrenic illness. They conclude that many such patients are misdiagnosed as schizophrenic when they actually suffer from affective disorder.

Goplerud and Depue thus join many others who have questioned the diagnosis of schizophrenia in patients in whom affective disturbance is a significant part of the manifest psychopathology.

Critique of a Critique

Goplerud and Depue have misunderstood our contributions on PPD in several respects. First, their footnote (p. 447) indicates that we specifically excluded patients with good prognostic features. Exactly the opposite was the case. On our clinical research unit at the National Institutes of Health, we attempted to recruit patients from the middle to good prognostic range and specifically restricted admission of patients with established chronic illness. As we wrote (McGlashan and Carpenter 1976a, pp. 14–15), patients with “adequate previous social and work functioning” were selected for study and admitted to the research unit “early in a psychotic episode.” Screening criteria are never as precise as those used in a final assessment, and our group of patients ultimately proved to be more heterogeneous than expected. Nonetheless, there was a decided skew toward good prognosis in the patient population. On the Phillips Scale, for example, two thirds of our patients would be judged reactive and one third process. The most frequently used DSM-II (American Psychiatric Association 1968) diagnosis on admission was acute schizophrenic reaction, a diagnosis compatible with good prognosis and a phasic or episodic course of illness.

Second, Goplerud and Depue state: “They [McGlashan and Car-
penter] concluded that depression in schizophrenia did not predict recovery in their sample" (p. 477). That, too, is a misreading of our findings. The presence or absence of depression or PPD at discharge in those patients had nothing to do with recovery since the sample was selected on the basis of recovery from psychosis. Our findings indicated that the presence or absence of PPD at discharge did not predict a better or more persistent recovery at 1-year followup.

Third, Goplerud and Depue suggest that our patients with PPD were, in fact, patients with bipolar affective disorder entering a depressive phase following a manic episode rather than following a schizophrenic episode. If their assertion is correct, then the many published reports on the biochemistry, psychophysiology, phenomenology, treatment, course, and outcome in that patient cohort are not relevant to acute schizophrenia as purported. We owe it to ourselves and our colleagues, then, to examine the nature of the evidence we used to support a diagnosis of schizophrenia.

There is an increasing trend among American authors writing on diagnosis to regard the presence of affective symptoms during or following a psychotic break as sufficient to challenge the diagnosis of schizophrenia. Our critics followed this trend, ignoring the everyday clinical observation that disturbed affect is ubiquitous in acutely psychotic patients, regardless of etiology or classification. Most importantly, they failed to note that our patients had undergone detailed diagnostic evaluations using ordinary clinical and systematic assessment techniques. The following clinical and research data relevant to diagnosis were available in our report on PPD:

- Information on family history of mental illness, past psychiatric history, premorbid functioning, and cross-sectional signs and symptoms was provided.
- A diagnosis of schizophrenia was made by consensus of the project's senior psychiatrist (WTC) and the patient's treating psychiatrist based on all information available 3 weeks after admission. DSM-II guidelines and categories were used. Systematic reassessments at discharge and 12-month followup (including the Present State Examination) were conducted, and the diagnosis of schizophrenia remained unchanged in all 30 patients reported. Hence, diagnostic judgments were made by at least two clinicians at three different times.
- The question of specified criteria was also discussed:

To further clarify diagnosis, we used criteria other than consensus clinical assessments based on the categories of DSM-II... In a previous study from the IPSS, Carpenter and associates [1973] identified 12 signs and symptoms noted at admission that most clearly discriminated schizophrenic patients from those in other diagnostic categories. Our group of 30 patients demonstrated an average of 6.2 of these 12 signs and symptoms, giving a probability of more than 90% that, on the basis of international criteria, we were dealing with a schizophrenic class of patients. [McGlashan and Carpenter 1976a, p. 15]

- To accept our critics' assertion and treat depressive disturbance following psychosis as evidence of manic-depressive disorder would further belie our data. We reported no significant difference between our diagnosed schizophrenics with PPD and those without PPD on the 12-point system, Schneiderian first rank symptoms, prognostic status, age, socioeconomic class, and a number of other variables often purported to discriminate schizophrenic from affective disorders. Our report contained the following relevant information:

Chi-square analysis of sex, race, marital status, social class, and diagnosis revealed no significant differences between the two groups for these variables. A one-way analysis of variance (ANOVA) on the 50 continuous variables from our data set shown in appendix 1 produced no significant differences between the depressed and nondepressed groups. We conclude that this analysis demonstrates an essential similarity between these groups historically, symptomatically, and prognostically. [McGlashan and Carpenter 1976a, p. 16]

Further data for the diagnostic argument (not included in our PPD report) derives from a consistency in diagnosis among several clinicians involved with our clinical research unit. That is, the diagnosis by the referring source was schizophrenia in all instances, and the project clinician screening the patients concurred. Past history suggestive of manic-depressive illness or recurrent depression was sufficient to exclude the patient from admission.

We mention those data in some detail so that the reader can contrast them to the arguments now popular in challenging the diagnosis of schizophrenia. For example, Goplerud and Depue note that hyperactivity, aggression, delusional thinking, some depressed affect, complaining, and demandingness are characteristic of manic psychoses. We have no quarrel with that assertion but find it surprising that Goplerud and Depue believe such descriptors to be highly discriminating of any diagnosis. Similarly, suicidal thoughts, death fantasies, and suicide attempts were reported in PPD patients, and Goplerud and Depue note that sui-
cide risk for depressive disorders exceeds that of any other disorder. Again we agree but seriously question the assumption that suicidal ideation is sufficiently discriminating of one diagnostic category to challenge a diagnostic assignment to other psychotic classes. It is well known that schizophrenic patients often have suicidal ideation and that young male schizophrenics are particularly prone to successful suicide.

In our particular study sample, there is substantial evidence (cross-sectional, past history, and follow-up) for a diagnosis of schizophrenia against a diagnosis of manic-depressive illness. We are surprised that Goplerud and Depue ignored this extensive discriminating diagnostic data while they challenged the classification on the basis of several general descriptivesimilarities with other psychotic classes. It is well known that schizophrenic patients often have suicidal ideation and that young male schizophrenics are particularly prone to successful suicide.

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We have focused on Goplerud and Depue’s critique of our articles on PPD, but we believe that their conceptual approach is representative of a good deal of discussion about diagnosis in contemporary American psychiatry. We wish to comment further on the general topic because, in our opinion, the classification of the acute and episodic psychoses is an unsettled issue whose resolution will require the generation of much new information. Careful diagnostic studies have already delineated some forms of acute schizophrenia and acute schizophrenia-like conditions from the chronic schizophrenias. We applaud further efforts to study and reconceptualize patients comparable to those we designated as acute schizophrenics between 1971 and 1974. Such work will gradually increase the validity of psychiatric nosology. However, the exercise of shifting patients from class to class based on superficial similarities can only impede progress by substituting additial fads for clinical acumen and research.

Differential Diagnosis of Psychosis

The whole topic of affect during a psychotic break has never failed to raise lively issues of differential diagnosis. Does a “schizophrenic” parent who shows grandiose delusions and flight of ideas or psychomotor retardation and hopelessness really belong in the diagnostic category of schizophrenia? That old debate is far from moribund, and recent psychiatric research and the development of DSM-III are keeping the controversy very much alive.

The first recorded observation of affective symptoms as part of a schizophrenic process is over 100 years old. In his classic monograph on catatonia, Kahlbaum stated:

In most cases the disease manifests itself in the first stages with an easily recognized clinical picture of melancholia; very often the stage of melancholia is preceded by true manic states. [Kahlbaum 1973]

Kraepelin (1917), while classifying catatonia as a form of dementia praecox, noted in 1919 that roughly half his cases began with a depressive phase. Eugen Bleuler (1950) also classified catatonia as a schizophrenic disorder, but he too noted the frequent presence of manic and melancholic symptomatology. In some patients such symptomatology was so pronounced that he wrote, “One can speak of a manic or melancholic catatonia” (p. 26).

Thus, clinicians have known for many years that a single patient can present simultaneously with symptoms suggestive of a schizophrenic disorder and symptoms suggestive of manic-depressive disorder. Many diagnostic scholars have tenaciously insisted, however, that patients manifesting such symptomatic mixtures must be classified as either schizophrenic or manic-depressive. Is such tenacity justified? Even though process schizophrenia and manic-depressive psychoses are separate disease entities with different pathogenesis and treatment, there is considerable overlap in manifest psychopathology (e.g., paranoid delusions), course of illness, and some overlap in treatment (e.g., neuroleptic drugs and lithium decrease symptoms in some patients from both classes). Such ambiguities are only a small part of the diagnostic problem. The critical issue is conceptual: How many classes of illness can be defined usefully and validly, and how should patients who do not fit one class to the exclusion of others be categorized?

Over the years, many classes have been suggested for the mixed or ambiguous cases (Taylor, Gatzanaga, and Abrams 1974; Welner, Croughan, and Robins 1974) including schizoaffective schizophrenia, reactive schizophrenia, acute schizophrenia, schizophreniform psychosis, oneirophrenia, pseudoneurotic schizophrenia, acute exhaustive psychosis, remitting schizophrenia, cycloid psychosis, atypical psychosis, third psychosis, nonprocess schizophrenia, periodic catatonia, good prognosis schizophrenia, confusion psychosis, affect-laden paraphrenia, thymophrenia, schizomania, benign stupor, and about 10 other labels. These categories often enjoy only temporary or provincial acceptance, in part because of the traditional adherence to dichotomizing the psychotic disturbances and in part because, with time, some of these mixed symptom pictures differentiate into more classical schizophrenia or manic-depressive syndromes.

Recently, there has been a strong movement in the American psychi-
atric literature toward classifying such mixed syndromes into the manic-depressive or affective spectrum of disorders. This may have been precipitated by international studies in the late 1960s showing that clinicians in the United States (New York) attach the label of schizophrenia to patients with significantly greater frequency than clinicians in the United Kingdom (London) (Professional Staff of the U.S.-U.K. Cross-National Project 1974).

The most forceful proponents of the "affective shift" in classification have been Taylor, Abrams, and their colleagues. Taylor, Gaztanaga, and Abrams (1974) studied a sample of 247 consecutive admissions to an acute treatment inpatient psychiatric unit of a New York City municipal hospital over a 7-month period. The investigators compared their diagnoses, arrived at using research criteria, to the diagnostic labels assigned to patients by the hospital clinicians. Their research criteria for schizophrenia and for mania are shown in Table 1 and Table 2, respectively.

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<th>Table 1. Research diagnostic criteria for schizophrenia</th>
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<td>1. The presence of formal thought disorder (e.g., blocking, non sequiturs, neologisms, word approximations, verbigeration).</td>
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<td>2. The presence of emotional blunting (restricted affective range and intensity with absence of emotional responsivity, warmth, finer ethical and moral notions, or feelings of love for friends and family).</td>
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<td>3. The presence of incomplete auditory hallucinations or autochthonous (sudden, fully formed) delusional ideas, except for grandiose delusions of wealth or high birth or depressive ones of sin, poverty, or guilt.</td>
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<th>Table 2. Research criteria for mania</th>
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<td>1. The presence of hyperactivity.</td>
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<td>2. The presence of rapid and/or pressured speech.</td>
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<tr>
<td>3. The presence of euphoric, expansive, or irritable mood.</td>
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The prevalence of affective disorder, alcoholism, or both in the primary relatives was comparable between the subgroup of 13 and the manic group. The prevalence in both of these groups was significantly greater than in the group of schizophrenic patients. Also, the prevalence of affective disorder, alcoholism, or both in the primary relatives was comparable between the subgroup of 13 and the manic group. The prevalence in both of these groups was significantly greater than in the group of schizophrenic patients. Thus, Taylor, Gaztanaga, and Abrams suggest "that many individuals receiving the diagnosis of acute schizophrenia are actually suffering from mania and rarely satisfy rigorous criteria for schizophrenia" (p. 680).

In subsequent reports arising from the same study, Taylor, Abrams, and their associates found essentially similar results for patients with an index or hospital diagnosis of paranoid schizophrenia (Abrams, Taylor, and Gaztanaga 1974), catatonia (Abrams and Taylor 1976a), good prognosis schizophrenia (Taylor and Abrams 1975), and schizoaffective schizophrenia (Abrams and Taylor 1976b). Their often stated or implied conclusion from those studies is that many patients in the various schizophrenic subtype categories actually suffer from affective disorder.

That message has been echoed by McCabe (1976; see also McCabe and Stromgren 1975), who compared 40 patients from Denmark with a diagnosis of reactive psychosis with 28 patients from St. Louis with a diagnosis of good prognosis schizophrenia. McCabe interviewed both groups using the Present State Examination and found that most of the St. Louis group of patients could more appropriately be diagnosed as either affective disorder or reactive psychosis. Based on that and other studies, he concluded that aside from hallucinations and delusions, the
symptom picture, family history, and treatment response of patients labeled schizoaffective, acute schizophrenic, or schizophrenic with good prognosis differed "little from [those] noted in typical manic-depressive illness" (McCabe 1976, p. 571).

These studies have value insofar as they call into question diagnostic practices based upon selective observations or habit, particularly the habit of maintaining the same diagnosis from previous admissions even in the face of a changing clinical picture. On the other hand, workers such as Taylor and Abrams and, more recently, Pope and Lipinski (1978) and Goplerud and Depue (1978) seem to insist upon removing patients from the diagnostic procrustean bed of schizophrenia only to replace them into yet another procrustean bed of affective disorder. Changing diagnostic slots is relatively easy, depending upon the criteria established to make the assignments. Taylor and Abrams' criteria for schizophrenia, for example, are really quite stringent compared to their criteria for mania, as a quick perusal of tables 1 and 2 will show. Their criterion for emotional blunting, for example, requires "restricted affective range and intensity with absence of emotional responsivity, warmth, finer ethical and moral notions, or feelings of love for friends and family" (Taylor, Gaztanaga, and Abrams 1974, p. 678). Contrast that with their criteria for mania, which are broad, nonspecific, and compatible with the early stages of any psychosis.

Different criteria, of course, produce different results. Welner, Croughan, and Robins (1974), for example, divided 266 patients admitted with a diagnosis of schizophrenia into two groups based on carefully specified research criteria. The first group (N = 149) had two or more qualitatively different thought and behavior disorders (delusions, hallucinations, formal thought disorders, other thought disorders, bizarre behavior) and depression or mania. Those patients were labeled schizoaffective. The second group (N = 117) had two or more qualitatively different thought and behavior disorders and no symptoms of depression or mania. That was the "straight" schizophrenic group. Comparing the groups on symptomatology, demography, and course of illness (which was not looked at by the other workers), Welner, Croughan, and Robins found no differences. They concluded that the schizoaffective group could be considered schizophrenic by most criteria. Welner et al. (1977) more recently published a long-term followup of 128 of the schizoaffective patients from the original study who lived within 20 miles of the St. Louis Study Center. They concluded that the chronic course and marked deterioration evident in this group was more characteristic of schizophrenia than of affective disorder.

**Comment**

Based in part on the material reviewed above, we believe the following comments are justified.

- There is a paucity of unequivocal information regarding the etiology and pathogenesis of psychotic disorders (excluding organic psychosyndromes). What is known (e.g., greater than expected incidence of the same illness in biologic relatives of primary affective disorders, chronic schizophrenia, and probably reactive psychoses) is not readily applicable in diagnosing the individual patient. Recent systematic investigations all point to the fact that pathognomonic signs and symptoms (in the absolute sense) are yet to be associated with discrete psychotic diseases. Hence, modesty concerning the validity of all extant diagnostic approaches is in order. The continued search for the most discriminating factors of these psychoses is to be encouraged. The investigation should include past history, family illness, course of illness including treatment response, and special attributes of the sign and symptom picture (e.g., passivity delusions, while not pathognomonic, are more useful in differential diagnosis than anxiety). That approach is likely to prevent the use of "predicate logic" whereby superficial or nondiscriminating characteristics are used to equate patient and illness (e.g., manics are excited; this patient is excited; therefore this patient is manic).

- During the 1950s and 1960s, inadequate attention was given to diagnosis by American psychiatrists. That led, at least in some locales, to overdiagnosis of schizophrenia and underdiagnosis of manic and depressive illness. Because of the diagnostic skew, one would expect careful diagnostic reassessment of casually defined schizophrenic patients to result in a substantial number of reassignments to the affective disorders. Furthermore, those cases are usually found in subtypes such as acute schizophrenia and schizoaffective schizophrenia. Thus, one will find many similarities between the acute or good prognosis schizophrenias and affective disorders. The similarities are based on two attributes of loosely defined acute schizophrenic groups—the inclusion of cases who actually have affective disease and the many descriptive similarities among all the acute, episodic psychotic disorders.

The tendency to overdiagnose schizophrenia has sharply dimin-
ished in the United States for two reasons. First, the widely accepted therapeutic efficacy of antidepressant medication and lithium in affective disorders has increased the importance of correctly identifying such cases. Second, a very significant increase in attention to diagnostic criteria occurred in the mid-1970s, and is being formalized in the development of DSM-III (American Psychiatric Association, in preparation). Studies of carefully diagnosed populations may now give very different results from those of the recent past. Validating criteria (e.g., loading of illness in biologic relatives) have helped establish the good prognosis schizophrenias as relatively distinct from process schizophrenia in studies from several countries, but studies linking acute schizophrenias genetically to affective disorders are peculiarly American. We are suggesting that such findings may be an artifact of our past liberal definition of schizophrenia and may diminish with the application of increasingly stringent criteria. It is clear, however, that sets of stringent criteria do not eliminate the acute schizophrenias unless established chronicity is required to diagnose schizophrenia.

• Nosology of the episodic psychoses is (and should be) uncertain. It is clear that a number of disease entities exist in this ambiguous group. Some cases belong to chronic schizophrenia, as subsequent course has revealed (M. Bleuler 1968). Some cases belong to affective disorders as has been repeatedly demonstrated. What remains is a large population of psychotic patients who tend to become psychotic rather abruptly, who usually recover, and who may have repeated episodes with good or somewhat impaired interepisodic functioning. To a greater or lesser extent they share symptomatology and therapeutic response profiles with the two major psychoses, but are not genetically linked with either (so far as we now know). Multiple nosologic classes will no doubt be established eventually for the differential diagnosis of episodic psychoses, but present data are insufficient to establish a firm typology. The reactive psychoses of Scandinavia and the episodic dyscontrol syndrome (Monroe 1970) are in the process of being firmly delineated, and more will follow. Meanwhile, we believe it essential to maintain this ambiguous category rather than prematurely assigning cases to already established classes (i.e., schizophrenia or affective disorders). Further study will not be enhanced by relegating uncertain disorders to “certain” status.

• Schizophrenic patients are often affectively disturbed and the diagnosis of schizophrenia should not immediately be questioned every time such a patient is noted to be upset. More investigation needs to be made of the type and nature of the affective disturbance in both schizophrenia and manic-depressive psychoses. A relevant question is not whether affect is present or absent, but what kind of affect, how well differentiated, how well tolerated, and so on. For differential diagnosis, it is critical to determine on phenomenologic grounds whether affective disturbance can account for psychosis can account for affective disturbance.

Present data are insufficient for us to conclude that the application of increasingly stringent criteria to the diagnosis of schizophrenia will be associated with greater validity of the syndrome so identified. It is possible by ever increasing reliability of diagnostic judgments to reduce validity by excluding ever increasing numbers of patients who belong in that nosologic niche. Nonetheless, for purposes of communication and investigation, the use of more stringent operationalized criteria in the diagnosis of schizophrenia is necessary. That many patients previously considered schizophrenic might now be placed in an ambiguous diagnostic category is not troublesome, so long as that category clearly signals the limits of our knowledge. It is here that the problem has emerged. Patients with ambiguous illnesses have heretofore often been considered schizophrenic. We have learned a lesson from this history and now attempt to provide more rigorous criteria for the diagnosis of schizophrenia. There appear to be many, however, who are prepared to ignore the lessons of history and glibly assign a diagnosis of affective disorder to these ambiguous cases. In short, we are concerned that episodic and phasic illnesses, with presenting psychopathology simultaneously suggestive of affective disorder and schizophrenia, are not being clearly identified for future study. Submerging them into affective disorders curbs the potential for rigorous study of the diagnostically ambiguous. It also ignores the most ordinary of clinical observations, i.e., that all illnesses manifest as acute psychotic episodes are frequently associated with severe disturbances in affect.

Summary

We, along with many others, believe acute and episodic psychotic conditions comprise multiple illnesses and perhaps even some nonillness syndromes. In our response to the critique of Goplerud and Depue (1978), we defend the diagnosis of acute schizophrenia in our patient cohort at the National Institutes of Health. By so doing, we mean to argue against casual reassignment of such
patients to a carefully delineated syndrome (affective disorders). We are not suggesting that acute schizophrenics are a special subcomponent of chronic or process schizophrenia, or even that schizophrenia is the best diagnostic term for the acute psychoses. We go to some length, however, to argue that affective disorder is not the best label for acute patients and to debate the issue because of our concern with current trends in classification and diagnostic attitudes. Another reason for our response is that we have joined with many colleagues in investigating the psychophysiology, neuropsychology, biochemistry, psychotherapy, milieu dynamics, treatment response, and course of illness in the same patient cohort. The suggestion that those investigations should be reclassified as studies of affective disorders rather than studies of acute psychoses requires a response beyond that appropriate for the criticism directed at our report of postpsychotic depressive phenomena.

References


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