Letters

Drs. Lake and Hurwitz respond

Dr. Henry Nasrallah is correct that the "2 names, 1 disease" concept is polarizing (Commentary, CURRENT PSYCHIATRY, March 2006, p. 67-8). Schizophrenia, conceived almost 100 years ago, has been so widely accepted and has accumulated such a "massive body of evidence" that we keep endorsing it without question.

Schizophrenia is defined by hallucinations, delusions, and a chronic, deteriorating course, but these supposedly disease-specific features readily occur in psychotic mood disorders.[1,2] Classic bipolar patients can suffer chronic, deteriorating courses without remission, and severe psychotic symptoms can obscure mood symptoms.[1,2] The idea that "interepisode phenomenology," "chronic persistent psychosis," and "between-episode interpersonal skills" differentiate schizophrenia from severe mood disorder is obsolete.[1,2]

More-recent phenotypic and genotypic similarities—and overlap from basic science, neuroradiologic, epidemiologic, and genetic studies—support the "one disease" hypothesis.[3,4] Moreover, 8 of 11 susceptibility loci identified for schizophrenia and bipolar overlap.[4]

In his table, Dr. Nasrallah presents the traditional justifications for considering schizophrenia a separate disorder: that auditory hallucinations, negative symptoms, and the most bizarre delusions are "more common" in schizophrenia, and that paranoia is "more systematized."

However, nearly **all** severely manic patients have these features as well as "disorganized and derailed thoughts." **All** patients with severe depression have "negative symptoms" that can lack "affective cyclicity." The "racing thoughts and flight of ideas," specific to mania, actually derail and disorganize thoughts and behavior.

Continuing to consider schizophrenia a separate disease based on "a massive body of evidence," and on certain symptoms being "more common" or "more severe" in schizophrenia than in bipolar

disorder, puts psychiatry in the category of "art," not science, and opens us for criticism from antipsychiatry groups such as the Scientologists.

The broad spectrum of symptoms and chronicity of course, initially unrecognized in psychotic mood, might account for differences in comparative studies. This spectrum likely encompasses other variances across mood disorders that have been cited as evidence for a separate disorder. Further, the longstanding tradition of separating bipolar disorder and schizophrenia may influence interpretation of comparative studies.

Concerning Dr. Skirchak's remarks, psychotic major depressive disorder misdiagnosed as schizophrenia and treated only with neuroleptics explains "a risk of suicide with neuroleptics." Also, continued use of neuroleptics in remitted, misdiagnosed manic patients can increase cycling, typically to a depressed episode.[5]

Regarding the queries of Drs. Green and Skirchak, our sample patient presented "without evident current or past mood symptoms." No mood symptoms were obvious or elicited at presentation because attention focused on psychotic symptoms and not mood symptoms, leading to misdiagnosis and mistreatment. A temporary diagnosis of psychotic disorder NOS is appropriate in some cases while obscure mood and organic causes are explored.

Should the "one disease" concept prevail,

Kraepelin would rest easily because his later concept was accurate; Bleuler—who could have renamed and promoted manic-depressive insanity instead of dementia praecox—and those invested in schizophrenia—clinicians, professors, researchers, grantees, editors, and some in the pharmaceutical industry—would incur discomfort.

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