to the outpatient clinic who would not otherwise be discovered and who are even now not considered incapable of functioning adequately.

16. "If other plant and animal pairs of traits had not forced the Mendelian theory upon us, we would never have considered any explanation for dementia praecox other than intermediate inheritance with infinite gradations in the intensity of the illness."

17. "Social unfitness, which must be defined differently in different environments, is no criterion for the biological boundaries of a sickness."

18. He states: "It appears most probable to me that a considerable part of the 'other psychoses' are genetically identical to dementia praecox." This view is a forerunner of the schizophrenia spectrum concept employed by Kety, Wender, and Rosenthal, but Bleuler's view is much broader.

19. He says: "For the present, the delineation of the different forms within the group schizophrenia presents unsurmountable difficulties."

20. "The basis of every genetic study on schizophrenia rests on very shaky ground."

21. "No one denies that an inherited predisposition plays an important role, although that has not at all been proven with the desired certainty."

22. "Does the addition of certain destructive forces to an existent predisposition first develop the sickness?"

- "Is it only the reaction of a psyche predisposed to sickness to various destructive forces?"

- "Generally, that which I have labeled secondary symptoms, peculiar ideas, hallucinations, etc., is not inherited."

- It is most probable that the primary symptoms do not correspond to the inherited anomaly itself.

References


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The diagnostic ambiguity of postpsychotic depression

The clinical and prognostic significance of severe depression in the aftermath of acute psychotic episodes has been pointed out recently by McGlashan and Carpenter (1976b). On the basis of case studies and clinical observations, they estimated that a clearly differentiated episode of depression follows acute psychoses in approximately 25 percent of all patients hospitalized with an acute schizophrenic reaction, although this incidence may be an underestimation due to the scarcity of detailed posthospitalization followup studies and confounding effects of medication. The syndrome appears to be associated with a good prognosis for recovery (although not from further episodic relapse) and occurs infrequently in chronic schizophrenic patients with acute exacerbations of their illnesses or in patients with poor premorbid psychosocial functioning (McGlashan and Carpenter 1976b; Roth 1970). Rather, the syndrome is typically observed in younger patients (in their twenties) who have a good premorbid level of functioning (McGlashan and Carpenter 1976b; Roth 1970).¹

While postpsychotic depressive (PPD) may be a valuable prognostic sign, we disagree with McGlashan and Carpenter's (1976b, p. 234) conclusion that PPD is a phase in the course of schizophrenia. The level of premorbid adjustment, symptomatology, and clinical course of patients exhibiting PPD strongly suggest an alternative hypothesis—that many of these patients may be bipolar depressives who were misdiagnosed schizophrenic while in the acute manic phase of their disorder. Such cases of misdiagnosis are not infrequent, as evidenced by the recent findings that 50 to 92 percent of good prognosis schizophrenics studied fulfill research criteria for bipolar depressive disorder (McCabe et al. 1971, 1972; Taylor and Abrams 1973, 1975; Taylor, Gaz-
Symptomatically, PPD is quite similar to the depressed phase of bipolar patients. The depression is unlike the symptoms of blunted or inappropriate affect more commonly reported during a schizophrenic episode. Rather, PPD is characterized by the following symptoms: daytime hypersomnia and difficulty in arising in the morning; difficulty socializing; anorexia; weight loss; constipation; lack of gratification and interest; thoughts of guilt, worthlessness, suicide, and hopelessness about the future; self-denigration; suicidal attempts; somatic complaints unrelated to drug effects; impaired concentration; profound passivity; and a classic pattern of akinesia, including psychomotor retardation, thought and speech retardation, muscular rigidity, a reduced frequency of blinking, and unchanging facial patterns (Kayton 1973; McGlashan and Carpenter 1976b; Roth 1970).

Not only are these symptoms typically associated with the depressive disorders (Beck 1967; Winokur, Clayton, and Reich 1969), but, more specifically, certain of these symptoms are highly characteristic of the depressed phase in bipolar depression (as compared to unipolar depression, in which only depressive episodes occur). In particular, the akinetic psychomotor pattern (retardation) has been found to characterize the depression of bipolar disorder, whereas psychomotor agitation is found more commonly in unipolar depressed patients (Beigel and Murphy 1971b; Bunney and Murphy 1973; Kotin and Goodwin 1972; Kupfer et al. 1974). Psychomotor agitation is not commonly found in PPD (McGlashan and Carpenter 1976b). Similarly, hypersomnia is found most frequently in bipolar depression, while hyposomnia is more typically found in unipolar depressive patients (Bunney and Murphy 1973; Detre et al. 1972; Hartmann 1968; Kupfer et al. 1972).

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Suicidal thoughts, death fantasies, and suicidal attempts are symptom patterns reported frequently in PPD patients (McGlashan and Carpenter 1976b; Roth 1970). However, the suicide risk for depressive disorders exceeds that of any other disorder and is 30 times greater in the depressive disorders than in the general population (Beck 1967; Depue and Evans, in press; Mendlewicz et al. 1972; Winokur et al. 1969). In line with our misdiagnosis argument, Cohen et al. (1964) observed patterns of psychotic behavior in 35 schizophrenic patients who later committed suicide that were markedly different from behavior patterns of matched non-suicidal schizophrenic controls. In general, approximately 65 percent of the suicidal patients had shown behavior commonly found in mania, such as hyperactivity (Carlson and Goodwin 1973; Mendels 1970; Taylor and Abrams 1973; Winokur et al. 1969), aggression, delusional thinking (Beigel and Murphy 1971a; Carlson and Goodwin 1973; Murphy and Beigel 1974; Taylor and Abrams 1973), complaining and demandingness (Taylor and Abrams 1973; Winokur et al. 1969), and some depressed affect, which, despite traditional conceptions of mania, is found in the majority of manic patients (Beigel and Murphy 1971a; Kotin and Goodwin 1972; Murphy and Beigel 1974). Only about 15 percent of the nonsuicidal schizophrenics exhibited similar behaviors (Cohen et al. 1964). This evidence suggests the possibility that suicide occurring during the PPD phase is preceded by mania and not schizophrenia.

One other important characteristic of PPD suggests a close congruence with bipolar depression. Before the onset of depression, Roth (1970) has observed a “compensated-transition” stage (lasting anywhere from a few days to several months), during which the patient no longer shows overt psychotic symptoms. Instead, there is an impressive display of health and a desire to return to regular life. Premorbid social abilities and interests are also recovered at this time. This stage may correspond to the “normal transition” phase that occurs as bipolar patients “switch” from depression to mania and from mania to depression (Bunney and Murphy 1973). The “normal transition” phase and the “compensated-transition” stage are similar in being characterized by a return of more normal mood, psychomotor activity, somatic functioning, and premorbid adjustment and interests.

Thus, the possibility strongly exists that what is referred to as PPD following a “schizophrenic” episode may, in fact, be a phase of bipolar depression following a psychotic manic episode. This sequence of episodes is common in bipolar depressive disorder, Winokur et al. (1969) having noted it in over half of their bipolar patients. The symptomatology exhibited during PPD is quite characteristic of the clinical symptomatology found in bipolar depressed
patients. Furthermore, the alternating biphasic course of acute psychotic episodes and psychomotor retarded depression, separated by a normal transition period, is highly concordant with the course of bipolar depressive disorder. The good prognostic character of patients exhibiting PPD is in keeping with the prognosis characteristic of bipolar disorder and with studies generally suggesting that depressive symptoms during a “schizophrenic” psychosis appear to have favorable prognostic implications (Huston and Pepernik 1958; Phillips 1953; Schonfeld et al. 1954; Vaillant 1962, 1964; cf. McGlashan and Carpenter 1976a). In fact, several authors have concluded on the basis of clinical analysis that PPD is a positive sign for psychosocial recovery in schizophrenia (Hoedemaker 1970; Roth 1970; Wildroe 1966).

Therefore, we are in tentative agreement with Ollerenshaw’s (1973) review, which concluded that the acute schizophrenia preceding PPD may actually represent the manic phase of bipolar depressive disorder. The tentativeness of this discussion must be stressed in that the bulk of the literature on PPD consists of case illustrations and clinical observations. While most of the more systematically obtained data are concordant with the clinical observations, further empirical work is required before complete assurance may be achieved.

Further research in this area should more carefully assess the symptomatology occurring during the psychotic episode preceding PPD in order to determine its similarity to manic or schizophrenic behavior. In addition, controlled studies of the nature of psychiatric disorder within the first degree relatives of patients experiencing PPD would provide differentiating evidence in favor of bipolar depressive disorder or schizophrenic illness as being associated with the occurrence of PPD. Finally, drug trials comparing the efficacy of lithium carbonate and the antipsychotic compounds in treating the psychotic episode preceding PPD, as well as lithium’s efficacy during the PPD phase, would also yield differentiating data to this area of diagnostic confusion.

Summary

A clearly differentiated episode of depression in the aftermath of acute psychosis reportedly occurs in approximately 25 percent of all patients hospitalized with a diagnosis of acute schizophrenia. A comparison of premorbid functioning, symptomatology, and clinical course in patients with a postpsychotic depression following acute schizophrenic episodes and patients in the depressed phase of bipolar depressive illness suggests a high congruence between the two disorders. The results support the growing evidence that bipolar depressive illness is frequently misdiagnosed as acute schizophrenia.

References


Kotin, J., and Goodwin, F.K. Depression during mania: Clinical observations and theoretical implications. American Journal of
In an otherwise valuable review article (Beck 1978), it was surprising that only a one-page note (Karon and VandenBos 1970) summarizing the preliminary findings (after 12 months of clinical work) on the Michigan State Psychotherapy Project was cited. The project was then criticized for not presenting details ("selection, prognosis, background information, etc.") although such details have been in the literature for some time. It is to be hoped that this omission reflects a lack of assiduousness on the part of Beck's research assistants, and does not merely reflect his prior conviction: "I question whether psychotherapy could account for such a large difference and . . . I speculate that there were differences between the groups at the start of the study that contributed to the result" (Beck 1978, pp. 91--