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# This Week's Citation Classic®

**Pope H G & Lipinski J F.** Diagnosis in schizophrenia and manic-depressive illness: a reassessment of the specificity of "schizophrenic" symptoms in the light of current research. *Arch. Gen. Psychiat.* 35:811-28, 1978.
[Labs. Psychiatric Research, Mailman Research Ctr., McLean Hosp., Belmont, MA and Dept. Psychiatry, Harvard Medical Sch., Boston, MA]

Our review of phenomenologic, prognostic, family-history, and treatment-response studies indicated that putative "schizophrenic" symptoms were nonspecific and occurred commonly in manic-depressive illness as well as in schizophrenia. We suggested that schizophrenia was therefore overdiagnosed and manic-depressive illness underdiagnosed among American psychiatric patients. [The *SCI*® and *SSCI*® indicate that this paper has been cited in over 335 publications.]

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In January 1974 Joseph F. Lipinski was placed in charge of a new research ward at McLean Hospital that had been set up specifically to study patients with schizophrenia. Harrison G. Pope, a first-year psychiatric resident, joined him there in July 1974. While treating patients on this ward, we grew skeptical that patients admitted with that diagnosis were actually schizophrenic. Many were admitted with psychotic symptoms, to be sure—but they also displayed prominent affective (mood) symptoms, had first-degree relatives with major affective disorder (depressive illness or manic-depressive illness), and in many cases responded to lithium, a drug primarily effective in manic-depressive illness. In the face of these observations, was it correct to call these patients "schizophrenic"?

Prompted by this experience, we reviewed studies of the phenomenology of manic-depressive illness, studies of prognosis in acute psychotic disorders, studies of family history in acute vs. chronic schizophrenia, and studies of lithium treatment of psychotic disorders. All of these bodies of research seemed to suggest that symptoms that were regarded as occurring only in schizophrenia instead were nonspecific: "schizophrenic" symptoms occurred commonly in patients with well-documented cases of mania and depression, they did not predict prognosis, they did not "predict" family history, and, in patients with manic symptoms, the presence of concomitant "schizophrenic" symptoms did not predict response to lithium either. We concluded that the putative "schizophrenic" symptoms were thus far less useful diagnostically than was previously believed, and we suggested that large numbers of manic patients were being misdiagnosed as schizophrenic as a result of unwarranted faith in the "schizophrenic" symptoms.

Exactly a decade has now passed since our paper appeared, and our findings, which initially proved unexpectedly controversial, have been widely supported by subsequent research. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, DSM-III* in 1980[1] and *DSM-III-R* in 1987,[2] has widened the diagnosis of manic-depressive illness (now renamed bipolar disorder) and narrowed the domain of schizophrenia. Patients in American hospitals are now much less frequently diagnosed as schizophrenic and more frequently as bipolar: a valuable trend, considering the potentially grave consequences of being mislabeled as "schizophrenic."[3]

However, some of the consequences of our research have continued to stir controversy. In a small study published in 1982, we suggested that with the newer "narrow" criteria for schizophrenia, the disorder might display little or no hereditary component.[4] This study triggered a storm of protest from many more senior researchers, who perceived our finding as a radical contradiction of earlier studies that had generally found a robust hereditary component in schizophrenia as defined by older "broad" criteria. But now in 1988, even our findings on heredity in schizophrenia seem less controversial: among the nine family-interview studies of schizophrenia published in the last five years, the median morbid risk for definite schizophrenia among the first-degree relatives of schizophrenic probands has been only 1.8 percent[5]—a figure little greater than the expected rate of schizophrenia in the general population.

In conclusion, we are tempted to speculate—at the risk of stirring controversy for a third time—that, over the next few decades, the term "schizophrenia" may come to have less and less meaning, and far less significance, as it describes an ever-smaller residual group of patients with various unrelated idiopathic chronic psychotic disorders. Only time can tell whether this third impression—an unpopular one, we fear, in many circles—will be justified.

1. **American Psychiatric Association.** *Diagnostic and statistical manual of mental disorders (third edition).* Washington, DC: American Psychiatric Association, 1980. 494 p. (Cited 2,055 times.)
2. ————. *Diagnostic and statistical manual of mental disorders (third edition-revised).* Washington, DC: American Psychiatric Association, 1987. 337 p.
3. **Pope H G.** Distinguishing bipolar disorder from schizophrenia in clinical practice: guidelines and case reports. *Hosp. Community Psychiat.* 34:322-8, 1983.
4. **Pope H G, Jonas J M, Cohen B M & Lipinski J F.** Failure to find evidence of schizophrenia in the first-degree relatives of schizophrenics. *Amer. J. Psychiat.* 139:826-8, 1982.
5. **Pope H G, Cohen B M, Lipinski J F & Yurgelun-Todd D.** DSM-III criteria for affective disorders and schizophrenia: a preliminary appraisal using family interview findings. *Psychiat. Psychobiol.* (In press.)