When psychosis clouds mood symptoms, mismatched medication can worsen patients’ course
Does schizophrenia = psychotic bipolar disorder?

When a patient presents with psychotic symptoms, you might not recognize or pursue hints of bipolarity if you assume psychosis means schizophrenia. Yet psychotic bipolar disorder can explain every sign, symptom, course, and other characteristic traditionally assumed to indicate schizophrenia (Table 1, page 44). The literature, including recent genetic data,1-6 marshals a persuasive argument that patients diagnosed with schizophrenia usually suffer from a psychotic bipolar disorder.

Consider here how a cascade of changing signs and symptoms, initially unrecognized, caused five sequential re-evaluations of one psychotic patient’s primary Axis I diagnosis. His case highlights why the correct initial diagnosis of the disease causing psychosis is essential to effective treatment.4,7-9

CASE: CARVED IN STONE

Police officers carry Mr. C, age 30, into the emergency department (ED). He is mentally disorganized and arrives in a rigid, catatonic posture. According to a neighbor, Mr. C was kneeling motionless on his
Psychosis

Table 1

<table>
<thead>
<tr>
<th>DSM-IV-TR criteria for schizophrenia vs. psychotic mood disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schizophrenia diagnosis</strong></td>
</tr>
<tr>
<td><strong>Criterion A</strong></td>
</tr>
<tr>
<td>Hallucinations and delusions</td>
</tr>
<tr>
<td>Paranoia</td>
</tr>
<tr>
<td>Catatonia</td>
</tr>
<tr>
<td>Disorganized speech and behavior</td>
</tr>
<tr>
<td>Negative symptoms</td>
</tr>
<tr>
<td><strong>Criterion B</strong></td>
</tr>
<tr>
<td>Social and job dysfunction</td>
</tr>
<tr>
<td><strong>Criterion C</strong></td>
</tr>
<tr>
<td>Chronic continuous symptoms</td>
</tr>
</tbody>
</table>

mother’s front lawn, alternating between mutism and inappropriately loud, disorganized religious preaching. When his arm is lifted, it remains as placed. He is admitted to the acute care inpatient unit.

Mr. C’s most striking symptoms are catatonia and psychosis. Postural rigidity, waxy flexibility, and automatic obedience are characteristics of catatonia.\textsuperscript{6,9} An organic cause is first considered, such as hyperthyroidism, cerebrovascular accident, cerebral neoplasm, head trauma, seizure disorder, dementia, neuroleptic malignant syndrome, pheochromocytoma, or—especially—intoxication from illegal drugs.\textsuperscript{7}

While awaiting results from physical, mental status, and lab exams and imaging studies, staff assign him two admitting diagnoses: catatonic disorder due to a general medical condition and psychotic disorder not otherwise specified.\textsuperscript{8}

**CASE: INCONCLUSIVE WORKUP**

Mr. C denies using illegal substances or alcohol, which his mother confirms. He has no history of seizures or other medical conditions. His distractibility prevents him from focusing on a formal mental status exam. Physical exam, urine drug screen, lab results, and imaging studies are unremarkable except for an admitting blood pressure of 145/95 mm Hg and pulse of 115 beats per minute. These readings normalize within 1 hour. IM haloperidol and lorazepam are given as needed for agitation, but physicians withhold scheduled medications to allow staff to observe his symptoms.

Organic causes of catatonia now seem less likely, though past use of drugs such as phencyclidine that can cause chronic psychosis cannot be ruled out. Schizophrenia is considered likely because catatonia is one of schizophrenia’s five core diagnostic symptoms.\textsuperscript{9} Catatonia can also be a symptom of bipolar disorder.\textsuperscript{5,8} Staff make a preliminary diagnosis of schizophrenia, catatonic type.

**CASE: ‘HIT MEN ARE AFTER ME’**

Staff observe Mr. C responding to threatening auditory hallucinations. His affect is “fearful to terrified.” He

continued on page 47
Continued brief summary of prescribing information from previous page.

Focalix™ XR (desmethylphenylclohexil) extended-release capsules

Adverse Events in Clinical Studies with Focalix™ XR – Adults

Adverse Events Associated with Discontinuation of Treatment

In the adult placebo-controlled study, 10.6% of the Focalix™ XR-treated patients and 7.5% of the placebo-treated patients discontinued for adverse events. Among Focalix™ XR-treated patients, nausea (14.6%, no), vomiting (10.3%, no), anorexia (7.5%, no), vomiting (1.8%, no), and anorexia (1.5%, no) were the reasons for discontinuation reported by more than 1 patient.

Adverse Events Occurring at an Incidence of 5% or More Among Focalix™ XR-Treated Patients

Table 2: Summary of treatment-emergent adverse events for the placebo-controlled, parallel-group study in adults with ADHD at fixed doses of Focalix™ XR doses of 20, 30, and 40 mg/day. The table includes only those events that occurred in 5% or more of patients in a Focalix™ XR dose group and for which the incidence in patients treated with Focalix™ XR increased to more than one level above the baseline. The table shows the proportions of patients with at least one event categorized by dose level. The results are presented for each dose level. The table is designed to present the results of the clinical studies in adults with ADHD, which were conducted from 1998 to 2000.

<table>
<thead>
<tr>
<th>Event</th>
<th>Focalix™ XR 20 mg n=26</th>
<th>Focalix™ XR 30 mg n=26</th>
<th>Focalix™ XR 40 mg n=26</th>
<th>Plasma Treatment-Emergent Event Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>12 (46)</td>
<td>15 (58)</td>
<td>14 (54)</td>
<td>7 (30)</td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (23)</td>
<td>4 (15)</td>
<td>3 (11)</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Anorexia</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Palpitations</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Mr. C's catatonic symptoms resolve overnight, but obtaining additional history is difficult because of his paranoia. He denies any history of bizarre behavior or past contact with mental health services. He claims not to be especially religious. He is unmarried and lives with his mother, is college-educated, but has held only menial jobs.

Inpatient staff shifts its diagnostic focus to functional disorders associated with auditory hallucinations, paranoid delusions, and gross disorganization. According to Schneider and the DSM-IV-TR, 6.10 hearing a voice "keeping up a running commentary on one's behavior" is especially diagnostic of schizophrenia.

CASE: A TURN FOR THE WORSE

That night, nursing staff find Mr. C naked and cowering in the fetal position in a corner of his room. He has continued from page 44.

Mr. C says God's voice is warning him and have "infiltrated" the inpatient ward.

Inpatient staff shifts its diagnostic focus to functional disorders associated with auditory hallucinations, paranoid delusions, and gross disorganization. According to Schneider and the DSM-IV-TR, 6.10 hearing a voice "keeping up a running commentary on one's behavior" is especially diagnostic of schizophrenia.

Because of the rapid resolution of his "catatonic" symptoms and prominence of paranoia, they change his diagnosis on day 2 to schizophrenia, paranoid type. Mr. C meets all diagnostic criteria for schizophrenia except one: the staff has overlooked and has not adequately excluded a psychotic mood disorder.
Psychosis

smeared his feces on his face and in his hair and mouth. While being cleaned up, he suddenly begins quoting scripture in a loud, disorganized voice. His expressed thoughts are incomprehensible. He is given haloperidol and lorazepam immediately; oral haloperidol is continued at 10 mg bid.

Both Bleuler and Kraepelin concluded “coprophilia and coprophagia are unique to children and patients with schizophrenia.”[11,12] The DSM casebook cites Kraepelin’s description of a catatonic patient who “smeared feces about” as a “classic, textbook case” of schizophrenia.[11] The casebook goes on to say: “In the absence of any known general medical condition, the combination of coprophilia, disorganized speech, and catatonic behavior clearly indicates the diagnosis of schizophrenia.”

Mr. C shows each of these. Staff changes his diagnosis again—to schizophrenia, disorganized type, which carries a poor prognosis.[11,12]

CASE: BANKING AND RAY GUNS
By day 5, Mr. C’s mental status is normalizing and his psychosis improving. He volunteers for a weekly student case conference. There, he reveals additional information that staff could have discovered at admission with more-focused questions.

He reports that 2 years earlier he suffered severe suicidal depression. Six months later, during a hypomanic episode, he began “toying with the idea” that he might become part owner of his local bank. He believes “the Secret Service decided to transfer ownership to me.”

His plans upon acquiring the bank include buying three houses and six cars valued at several million dollars and running for state governor. For weeks before admission, he did not need sleep, experienced an increase in energy and activities, and his mind was racing. His job seemed so “trivial” that he quit. Immediately before his hospital admission, his delusions intensified to include an “evil conspiracy” to murder him for ownership of the bank and he feared his execution was imminent.

He explains his catatonic behavior on the lawn by his belief that “hit men” hiding across the street aimed a “motion-detecting, heat-seeking ray gun” at him so that if he had “moved an inch,” he would die. He says the “feces incident” was an effort to get himself transferred to the state hospital, where he thought he would be safer because his present caretakers were “infilitrated.” He also says his mother received electroconvulsive therapy in her 20s.

These symptoms—especially the striking grandiosity, lack of need for sleep, racing thoughts, hallucinations and delusions—define a manic episode with psychotic features. Only one manic episode as described here is diagnostic of bipolar disorder, type I.[15,16] Staff changes his diagnosis to schizoaffective disorder, a compromise used to include patients with bipolar and psychotic (schizophrenic) features. Some authors contend schizoaffective disorder is psychotic bipolar disorder and not a separate disease.[17,19]

CASE: FROM SSRI TO LITHIUM
After 2 weeks, Mr. C is discharged on haloperidol, 5 mg bid, but no mood stabilizer. He receives follow-up care at a community mental health center. When he develops severe depressive symptoms 6 months after discharge, the attending psychiatrist starts him on a selective serotonin reuptake inhibitor (SSRI). Within 2 weeks, Mr. C switches from depression to a mixed, dysphoric mania. After the SSRI is discontinued and lithium is added to his haloperidol, his mood gradually stabilizes to moderate depression. He develops rigidity, masked faces, and a fine tremor in his hands.

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causes and dizziess), but less to other effects (e.g., dry mouth, somnolence, and asthenia). Male and Female Sexual Dysfunction with SSRI's: Although changes in sexual desire, sexual performance, or sexual satisfaction can occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that selective serotonin reuptake inhibitors (SSRIs) might cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence.

In placebo-controlled clinical trials involving more than 1,800 patients, the ranges for the reported incidence of sexual side effects in males and females with major depressive disorder, OCD, andpanic disorder are displayed in Table 1. Table 1. Incidence of Sexual Adverse Events in Controlled Clinical Trials

During intestinal ischemia, patients may also develop thrombocytosis, leukocytosis, lymphocytosis, eosinophilia, basophilia, neutrophilia, monocytosis, basophilia, and eosinophilia. During spontaneous recovery from drug-induced toxicity, patients presented with chills, fever, rash, malaise, nausea, vomiting, abdominal pain, fever, and diarrhea. In those patients, the occurrence of these signs and symptoms is associated with the use of SSRIs. Physicians should routinely inquire about such possible side effects. Weight and Vital Sign Changes: Significant weight loss may be an undesirable result of treatment withparoxetine for some patients, but an average, patients in controlled trials had minimal (about 1 pound weight loss mostly during the first few weeks of placebo and active control). No significant changes in vital signs (systolic and diastolic blood pressure, pulse and temperature) were observed in patients treated with paroxetine in controlled clinical trials.

Other Events Observed During the Premarketing Evaluation: In clinical studies conducted during premarketing evaluation in major depressive disorder, multiple doses of paroxetine were administered to 6,149 patients. During treatment with paroxetine, some adverse effects were associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standard categories. In the tabulations that follow, reported adverse events are classified using a standard COSTART dictionary terminology. The frequencies presented, therefore, represent the proportion of the 6,149 patients (N=6,149) who experienced an event of the type cited at least once while receiving paroxetine. All reported adverse events are included except those already listed in Tables 1 and 2, those reported in terms so general as to be uninformative and those where a drug cause was remote. It should be noted that the following adverse events are those occurring in one or more patients in at least 1/100 patients (only those not already listed in the tabulated results). The frequencies presented are based on a post-hoc analysis of the events reported during treatment trials, they were not necessarily caused by the drug. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in one or more patients in at least 1/100 patients (only those not already listed in the tabulated results), infrequent adverse events are those occurring in 1/100 to 1/1,000 patients; rare adverse events are those occurring in fewer than 1/1,000 patients. Events of major clinical importance are also presented. In general, adverse events included in (NPN) may be associated with paroxetine.

About 10% of patients on paroxetine have been reported to have experienced a mild to moderate increase in weight. In mild to moderate increases in weight continued from page 48

What do you think?
CASE: A DIAGNOSTIC STEP BACK

Two years later, Mr. C is working and continues to take lithium and haloperidol prescribed at the mental health center. His intermittent depressive episodes persist, but—apparently because he has not had another manic episode—the staff switches his diagnosis back to schizoaffective disorder.

We disagree with this change. A diagnosis of schizoaffective disorder precludes ideal pharmacotherapy for Mr. C’s rapid-cycling bipolar disorder and increases the risk of adverse drug effects and stigma. Persuasive evidence shows that schizoaffective disorder is psychotic bipolar disorder; there is no schizoaffective disorder (Box). 3,14-18

MISDIAGNOSIS OF PSYCHOSIS

Bipolar disorder can be missed when patients present with psychotic symptoms, but clinicians could have initially recognized Mr. C’s bipolar disorder. His diagnostic trail illustrates important points about psychotic presentations:

- Predominant psychotic symptoms can obscure mood disturbances.
- Mistakenly believing that psychosis means schizophrenia can jeopardize patient care.
- When paranoia and fear hide grandiosity, then mania—not schizophrenia—is likely.
- Psychotic mood disorders—not schizophrenia—cause functional psychosis; there is no schizophrenia (Box).
- Pursuing mood symptoms in psychotic presentations is critical in an initial diagnostic interview.

Questioning the concept that hallucinations, delusions, catatonia, and disorganization are specific to and diagnostic of schizophrenia is not new. In 1978, Pope and Lipinski compared symptoms, course, outcome, family history, and responses to lithium in bipolar disorder and schizophrenia. They and others find no symptom, group of symptoms, or course that differentiates schizophrenia from psychotic bipolar disorder. 3,5,16,18,19 They conclude that most cases diagnosed as schizophrenia or schizoaffective disorder are misdiagnosed cases of bipolar illness, whereas others question the validity of schizophrenia. 20

Bipolar disorder has a broad spectrum of severity and course; it frequently reaches psychotic levels that can become chronic. 2,5,21 Psychotic symptoms of rigorously diagnosed bipolar patients can deteriorate until their overwhelming psychosis obscures bipolar symptoms. 3,4,13,21 Like most, if not all, acutely psychotic bipolar patients, Mr. C shows all diagnostic criteria for schizophrenia. 1,6,21

Patients with severe, psychotic bipolar disorder can stop responding to medication and suffer chronic deterioration without remission. 22 They
can lose their jobs, families, friends, and health until they are homeless, hungry, sick, and psychotic. A deteriorating course such as this has typically defined the schizophrenic process, but this concept has been reassessed.¹⁴,¹¹,¹³,¹⁴

Most, but not all, bipolar type I patients experience psychosis. Mr. C’s bipolar symptoms were not initially obvious because of predominant psychosis and were revealed only with specific, focused questions. Without the student case conference, his diagnosis might have remained schizophrenia. His treatment would have remained substandard because of the conventional belief that schizophrenia requires lifelong antipsychotics, usually without mood stabilizers.

Our patient satisfied all DSM-IV-TR criteria for both schizophrenia and psychotic bipolar. Bleuler and Schneider would have diagnosed him as having schizophrenia because they thought all psychotic disorders were schizophrenic.¹⁰,¹² They were incorrect, as psychotic symptoms are common in patients with severe bipolar disorder.¹⁰,¹¹,¹³,¹²

**CLINICAL IMPLICATIONS**

Our observations about this case suggest four important clinical questions:

- Do data justify diagnosing patients such as Mr. C with bipolar disorder and not schizophrenia?
- Do data substantiate either diagnosis as valid?

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**Table 2**

Characteristics indicating a mood disorder, not schizophrenia*

<table>
<thead>
<tr>
<th><strong>History</strong></th>
<th>Past diagnosis or symptoms of a mood disorder; family history of mood disorder or alcoholism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past medications</strong></td>
<td>Lithium, valproic acid, or other mood stabilizers</td>
</tr>
<tr>
<td><strong>Periods of uncharacteristic and excessive goal-directed activities</strong></td>
<td>Political, religious, legal, sexual, business, criminal, medical, physical, spending, calling, writing, preaching, cleaning, planning, exercise</td>
</tr>
<tr>
<td><strong>Presence of uncharacteristic emotions or conflict</strong></td>
<td>Irritability, anger, violence, conflict with law enforcement, elation, grandiosity (paranoia), sadness, hopelessness, crying, suicidal ideation</td>
</tr>
<tr>
<td><strong>Periods of appropriate affect</strong></td>
<td>Smiles, laughs, cries, irritable, angry</td>
</tr>
<tr>
<td><strong>Mood-congruent delusions and/or hallucinations</strong></td>
<td>Consider grandiosity when there is paranoia and fear</td>
</tr>
<tr>
<td><strong>Episodes of relatively normal function/remission; premorbid personality positive</strong></td>
<td>Friends, dating, team sports, group activities, election to an office/title, club or gang memberships</td>
</tr>
<tr>
<td><strong>Current social interactions</strong></td>
<td>Enjoys a friendship, active interactions with spouse and own children, regular interactions with others</td>
</tr>
</tbody>
</table>

* Absence of any or all does not rule out mood disorder.
• Does the diagnosis matter?
• What is standard-of-care treatment for these patients?

Which diagnosis? No psychiatric disorder can be validated as rigorously as Koch’s postulates did for infectious diseases. To be considered scientifically grounded, a psychiatric illness must show one or more symptoms not found in any other disorder. Bipolar disorder meets this criterion; schizophrenia does not because the psychotic symptoms and chronic course used to diagnose it are not disease-specific. Psychotic symptoms are not diagnostic of bipolar disorder but define its severity.6

Evidence for validity? Bipolar disorder’s two extremes in mood and behavior are so different from those in persons without bipolar disorder or with any other condition that homogeneous bipolar populations can be identified and studied with confidence.2,5,13,21 DSM-IV-TR diagnostic symptoms for bipolar disorder are unique (Table 2, page 54).

For a psychiatric disorder to be considered valid, patients must share other characteristics. Bipolar disorder has been validated as a specific disease by consistent genetic,1,13,23,25 pharmacologic,1,13,15 and epidemiologic1 data accumulated across 30 years. The concordance for bipolar disorder in monozygotic twins is approximately 75%, and susceptibility loci for bipolar disorder are established.15,24

Does the diagnosis matter? Failing to make an accurate initial diagnosis can worsen the course of patients who present with psychosis (Table 3):
• Bipolar illness not treated with mood stabilizers progresses, with episodes becoming more frequent and severe.13,15
• Antipsychotics are given longer and in higher dosages for schizophrenia than for psychotic bipolar disorder and tend to have more common, chronic, and disabling adverse effects than do antidepressants and mood stabilizers.14,16
• Mr. C was given an antidepressant without mood stabilization, which is contraindicated in bipolar I disorder (especially mixed type) because the cycling rate increases.2,14,35

Paranoia and fear often hide grandiosity that is diagnostic of bipolar disorder, but patients such as Mr. C focus on perceived threats to their lives, not their grandiose delusions. Admitting physicians listening to their paranoid complaints may overlook the grandiose source and the possibility of psychotic bipolar disorder. Mr. C’s manic grandiosity explains the motivation for each of his psychotic behaviors: paranoid delusions, catatonia, and coprophilia.

Table 3
Consequences of misdiagnosing psychotic mood disorder as schizophrenia

For patient
• Less likely to receive a mood stabilizer or antidepressant
• Without a mood stabilizer, cycles increase and occur more rapidly; symptoms worsen
• More likely to receive neuroleptics for life, increasing risk for severe and permanent side effects
• Greater stigma with schizophrenia
• Less likely to be employed
• More likely to receive disability for life
• More likely to “give up”

For clinician
• Increased risk of liability if patient given long-term neuroleptics instead of mood stabilizers develops tardive dyskinesia or commits suicide

continued from page 54
Several initial signs could have raised suspicion that Mr. C had psychotic bipolar disorder (Table 4). Standard-of-care treatment in psychotic patients is predicated on early and correct diagnosis. On the basis of the evidence and our experience, we recommend that you look for bipolar symptoms when a patient:

- presents for the first time with psychosis, and you rule out an organic cause
- is readmitted for treatment of psychotic symptoms after having been diagnosed with schizophrenia.

**What is standard of care?** Patients with psychotic mania warrant polypharmacy:

- an antipsychotic, with or without a benzodiazepine for sedation, to enhance ward safety and treat acute psychotic symptoms
- and a first-line mood stabilizer such as valproate, carbamazepine, lithium, or lamotrigine, followed by atypical antipsychotics. Antidepressants appear to be contraindicated, even in psychotic bipolar depressed patients.\(^{14,15}\) We suggest that you taper and discontinue the initial antipsychotic when psychotic symptoms resolve. Some data indicate that continuing antipsychotics in psychotic bipolar patients is detrimental after the psychosis has resolved.\(^{17}\) Medication-resistant cases may require two or three mood stabilizers and possibly an atypical antipsychotic.

The idea that “symptoms should be treated, not the diagnosis” is inaccurate and provides substandard care. When psychotic symptoms overwhelm and obscure bipolar symptoms, giving only antipsychotics is beyond standard of care.

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**Table 4**

**Mr. C’s symptoms that indicated bipolar disorder**

<table>
<thead>
<tr>
<th>Religiosity</th>
<th>Loud preaching and no past special interest in religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catatonia</td>
<td>Most frequently associated with bipolar disorder</td>
</tr>
<tr>
<td>Paranoia; fear</td>
<td>Usually hides grandiosity, which is diagnostic of mania</td>
</tr>
<tr>
<td>Distractibility</td>
<td>Could not stay focused in the diagnostic interview; showed ‘flight of ideas’</td>
</tr>
<tr>
<td>Pressured speech</td>
<td>Rapid, disorganized thoughts</td>
</tr>
<tr>
<td>Disorganization</td>
<td>Hallmark of mania; present in all patients with severe mania</td>
</tr>
<tr>
<td>Functional psychosis</td>
<td>If an organic cause is ruled out, a psychotic mood disorder is the most likely diagnosis</td>
</tr>
<tr>
<td>Trouble with the law</td>
<td>Police found patient disturbing neighborhood and escorted him to hospital</td>
</tr>
<tr>
<td>Patient history</td>
<td>Severe depression</td>
</tr>
<tr>
<td>Family history</td>
<td>Mother was treated for depression with ECT</td>
</tr>
</tbody>
</table>

ECT: electroconvulsive therapy

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\(^{14,15}\)
Psychosis

continued from page 58

References
4. Lake CR, Hurwitz N. Schizoaffective disorders are psychotic mood disorders; there are no schizoaffective disorders. Psychiatry Res 2006 (in press).

Evidence supports the idea that functional psychoses are predominantly—if not entirely—caused by psychotic mood disorders. Misdiagnosing bipolar patients as schizophrenic and treating them with chronic antipsychotics worsens their course. Vigorously pursuing mood symptoms in patients with psychosis increases the likelihood of accurate initial diagnosis and effective treatment.

Bottom Line

Related resources
- Lake CR, Hurwitz N. Schizoaffective disorders are psychotic mood disorders; there are no schizoaffective disorders. Psychiatry Res 2006 (in press).

DRUG BRAND NAMES
- Haloperidol • Haldol
- Lamotrigine • Lamictal
- Lithium • Lithobid
- Lorazepam • Ativan
- Valproate • Depakote

DISCLOSURE
The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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