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Гипердиагностика шизофрении как когнитивное искажение процесса познания клинической реальности

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АННОТАЦИЯ

Статья посвящена анализу причин гипердиагностики и ошибочной диагностики шизофрении с позиции когнитивных искажений процесса познания клинической реальности. На примере диагноза «вялотекущей шизофрении» сделан вывод о том, что гипердиагностика основана на эффекте ложного консенсуса. В психиатрии этот консенсус отражает солидаризацию диагноста с позицией научной школы, к которой он принадлежит, и с невозможностью противостоять давлению авторитетов. Приведён клинический пример ошибочной диагностики у пациента Г. 30 лет. В заключение констатируется, что гипердиагностика шизофрении и необоснованное назначение пациентам антипсихотической терапии приводит к дискредитации психиатрии и стигматизации психически больных. Данная тенденция должна быть пересмотрена, и диагностику шизофрении следует проводить исключительно с опорой на очевидные, а не косвенные клинические феномены, с развёрнутой системой доказательств наличия психического расстройства.

Ключевые слова: *шизофрения, гипердиагностика, ошибочная диагностика, вялотекущая шизофрения, Снежневский*.

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Overdiagnosis of schizophrenia as a cognitive distortion of the process of knowledge of clinical reality

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ABSTRACT

The article is devoted to the analysis of the causes of overdiagnosis and misdiagnosis of schizophrenia from the standpoint of cognitive distortions in the process of cognition of clinical reality. Using the diagnosis of "sluggish schizophrenia" as an example, it is concluded that overdiagnosis is based on the false consensus effect, which in psychiatry reflects the diagnostician's solidarity with the position of the scientific school to which he belongs, and with the inability to resist the pressure of authorities. A clinical example of an erroneous diagnosis is given. In conclusion, it is stated that the overdiagnosis of schizophrenia and the unjustified prescription of antipsychotic therapy to patients leads to the discrediting of psychiatry and the stigmatization of the mentally ill. This trend should be reconsidered and the diagnosis of schizophrenia should be made solely on the basis of obvious, and not indirect, clinical phenomena.

Keywords: *schizophrenia, overdiagnosis, misdiagnosis, sluggish schizophrenia, Snezhnevsky*.

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Diagnosis of schizophrenia refers to recognizing and identifying specific (pathognomonic) symptoms of a particular mental disorder. It includes assessing the psychological impact of the diagnosis established on the patient. It is believed that any medical diagnosis should contribute to the patient's positive attitude toward active interaction with the doctor, reassuring the patient, promoting compliance, and adherence to therapy. Hope is a construct that includes a positive outlook, energy, planning, and action to achieve a goal. To maintain a reassuring approach, clinicians must better understand that people with schizophrenia are interested in recovery and symptom management, as well as control over their lives and relief from hopelessness [1]. Simultaneously, the diagnosis of schizophrenia is seen by the population as incurable and unpromising, increasing the need for accurate diagnostics.

There is no doubt that, unlike the diagnosis of bipolar affective disorder, the diagnosis of schizophrenia can become a psycho-traumatic factor that blocks the patient's desire to collaborate with the doctor and follow his prescriptions. The stigmatizing impact of the diagnosis may increase the risk of inadequate responses and suicide in patients [2]. As a result, misdiagnosis of schizophrenia has been identified as a significant factor in patients' social functioning, and this diagnosis should not be given in diagnostically unclear cases.

Accurate diagnosis of schizophrenia spectrum disorders is based on identifying apparent core psychopathological symptoms and syndromes in accordance with the classification of mental and behavioral disorders (International Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders [DSM]). However, many psychiatrists (particularly Russians) believe that the formalization of diagnosing schizophrenia using classification systems is inadequate for understanding clinical reality.

According to one study, 48% of psychiatrists reported that "it is impossible or hardly possible to create an accurate and convenient list of diagnostic criteria for schizophrenia." Another 44% of respondents argued that "this can be done, but it is necessary to improve the lists of diagnostic criteria" [3]. The results of this study demonstrated the skepticism of specialists regarding the accuracy of their diagnostic conclusions, but this did not affect the practice of diagnosing schizophrenia, even in cases of uncertain diagnosis. Psychiatrists still often present schizophrenia rather than other psychotic disorders, believing that this may contribute to the efficiency of early therapeutic interventions.

According to Lake [4], psychotic patients with a psychotic mood disorder are often misdiagnosed with schizophrenia. Another study, "Does Misdiagnosis Explain the Epidemic of Schizophrenia among Immigrants from Developing Countries to Western Europe?" [5], the topic of the association between the increase in the incidence of schizophrenia and the erroneous diagnosis of cultural beliefs, acute psychotic reactions, or nonaffective relapsing psychoses with a good prognosis is being discussed.

According to Ayano et al. [6], more than a third of patients with severe mental disorders were misdiagnosed (39.16%), with schizophrenia misdiagnosis accounting for 23.71%. Another study revealed that schizophrenia had become a "trigger diagnosis," with a retrospective analysis of patients referred to a psychiatric consultation clinic with an initial diagnosis of schizophrenia, telling that about half of all such diagnoses were inaccurate upon further study [7]. Schizophrenia is more likely to be diagnosed among African Americans than in American Europeans, whereas mood disorders are diagnosed less often [8]. This phenomenon was called the "implicit bias phenomenon" because it reflected the attitudes of diagnosticians.

According to several authors [9], one of the causes of diagnostic problems in psychiatry is psychiatrists' inadequate attention to neurophysiology and its integration with psychiatry. In this regard, factors, such as the conservatism of experienced doctors in the perception of the new, a preference for "psychologizing" over a neurobiological approach, an impression of the static nature of treatment methods, and skepticism regarding the appropriateness of studies focused on neuroimaging, are noted.

Misdiagnosis and overdiagnosis are distinguished in the schizophrenia diagnostic process, with many scientific articles focusing on the former issue and isolated studies discussing the latter in the PubMed database. Misdiagnosis is commonly defined as the diagnosis of schizophrenia rather than another psychotic disorder (e.g., schizophrenia-like syndromes

within bipolar affective disorder or associated with the use of psychoactive substances, organic brain damage, and neuroinfections). Overdiagnosis is defined as the diagnosis of schizophrenia in people who do not have psychosis but have personality disorders, such as obsessive–compulsive, somatoform, or hypochondriacal disorder [10, 11].

The diagnosis of "sluggish schizophrenia," or the use of a scientific euphemism in the form of "schizotypal disorder," is a common example of schizophrenia overdiagnosis, and it is often given to patients with personality disorders (typically borderline), as well as to people with gender identity disorder (transsexualism) [12].

The term "sluggish schizophrenia" first appeared in Soviet psychiatry in the 1970s and 1980s. It was based on the idea that schizophrenia can manifest as "poor in symptoms," latent, or "schizophrenia without schizophrenia." Snezhnevsky defined "sluggish schizophrenia" as a type of schizophrenia wherein the disease progresses slowly. There are no productive symptoms characteristic of schizophrenic psychoses, and most often, only indirect clinical manifestations (neurosis-like, psychopathy-like, affective, predominant, and hypochondriacal) and minor personality changes are observed [13, 14]. The focus in diagnosis on "indirect clinical manifestations" is noteworthy, and the inability to confirm their presence significantly hampered assessment objectivity.

The concept of "sluggish schizophrenia," like any other, is undeniably viable. The problem is the broad interpretation of this type of disease's symptoms and the unproven attribution of psychopathological symptoms, which can be interpreted as a manifestation of personal pathology. Rejection is caused by the lack of apparent, verifiable symptoms of "sluggish schizophrenia," the stigmatizing nature and negative impact on the patient's fate, and the excessive frequency with which this disorder is diagnosed. According to Russian scientists, the prevalence of the sluggish form of schizophrenia ranges from 16.9% to 20.4% [15–17], which cannot be considered consistent with clinical reality, scientifically proven, and ethically correct.

The international psychiatric community unconditionally rejected the Soviet approach and the widespread diagnosis of sluggish schizophrenia in the USSR, stating that "the concept of sluggish schizophrenia is a psychiatric crime against humanity…. It should be considered unacceptable due to the significant expansion of the concept of schizophrenia" [18, 19].

Because of the prevalence of psychiatrists' overdiagnostic attitude, known as diagnostic relativism [20], the process of scientific and objective recognition of schizophrenia can be influenced by subjective factors, such as the prejudices of doctors, the traditions of the psychiatric school to which they belong, and social pressure. Factors leading to schizophrenia overdiagnosis include insufficient qualifications of a specialist, fear of "disregarding schizophrenia," prejudice, public pressure on psychiatrists regarding diagnostic criteria, and so-called cognitive distortions.

Cognitive distortions are "systematic errors in thinking or patterned deviations that emerge from dysfunctional beliefs embedded in cognitive schemes and are easily identified when analyzing automatic thoughts" [21]. In such cases, it is preferable to avoid random errors and instead focus on those that occur reliably under similar conditions.

It is important to note that cognitive distortions typically reveal themselves in cases of uncertainty when it is necessary to analyze the situation and make the best option [22]. In this regard, the diagnostic process in psychiatry should be classified as an activity in a case of uncertainty combined with a time limit [23].

Kahneman [21, 22] analyzed several types of cognitive errors, including the "hasty conclusion" error, emotional judgment errors (personalization, dichotomous thinking, selective abstraction, arbitrary conclusions, overgeneralization, and catastrophization), and socially determined distortions (majority effect, denial of probability, and false consensus effect).

Personalization is a person's tendency to interpret events based on personal considerations. Dichotomous thinking refers to a person's tendency to think in extremes in situations that hurt his feelings, such as when he is in danger. Selective abstraction is ignoring other information when concluding on insufficient evidence. Arbitrary conclusions are those that have not been proven or contradict the facts. Overgeneralization is an unjustified generalization based on a single case. Catastrophization is the

exaggeration of an event's negative consequences.

The majority effect reflects thinking characteristics associated with reliance on group thinking. The false consensus effect is based on our unconscious tendency to believe that others share our feelings, and that most people around us share our beliefs. Each of these cognitive distortions may be relevant to the psychiatric diagnostic process.

However, the effect of false consensus appears to be the most significant, which in psychiatry reflects, first, solidarity with the position of the scientific school to which the diagnostician belongs and with the diagnostic principles that he considers himself obligated to follow and, second, the inability to contradict these principles due to a "vertical system of relations" within psychiatric schools when a superior's diagnostic conclusion cannot be criticized a superior.

According to Kornetov [24], strict adherence to diagnostic traditions adopted by one or more psychiatric schools contributes to developing so-called "assimilative" psychiatric diagnoses, in which diagnostic judgments are made based on habitual fixed attitudes, prejudices, references to intuition, and authoritative opinions. Because it is commonly recognized as the ultimate truth, reliance on authority is the most prevalent technique to defend "scientific" views in the former Soviet Union [24].

Morgenstern [25] identified cognitive distortions specific to the diagnostic process, namely, the diagnosis impulse (after the diagnostic label has already been "attached" to the patient by another doctor, it is challenging to reconsider the diagnosis and interpret the symptoms with a fresh perspective) and the preconception effect (the diagnostician's thinking is formed through prior expectations, and he sees what he expects to see; for example, a homeless patient with a history of drug use found unconscious is more likely to be suspected of overdose than severe hypoglycemia).

Cognitive diagnostic distortions are systematic diagnostic errors caused by dysfunctional principles of cognition of clinical reality. That is, it should be recognized that, in general, overdiagnosis of schizophrenia is based not on a deliberate broad interpretation of the diagnostic criteria for this disorder (disease) but on erroneous ideas that diagnosticians do not realize about the interpretation of behavioral stereotypes formed within psychiatric schools (e.g., the Soviet one) and using nonscientific diagnostic principles.

As previously stated, until now, followers of the teachings of Snezhnevsky continue to classify patients with "sluggish schizophrenia," a diagnosis that does not exist in international classifications based on indirect clinical manifestations, depending on intuition rather than scientific evidence.

In 1941, the Dutch psychiatrist Henricus Cornelius Rümke introduced the concept of "feelings of schizophrenia" ("Praecox gefühl"), and it was proposed to use it to make this diagnosis. The path to a diagnosis of schizophrenia is often reached through passive and indescribable intuition. Taken individually, the oddities in posture, facial expression, tone of voice, and motor behavior are minor, but overall, they present the patient as "definitely incomprehensible." "The "feeling of schizophrenia" can be explained by the fundamental inaccessibility of the schizophrenic patient to empathic understanding," wrote Henricus Cornelius Rümke [26]. Despite its apparent unscientific nature, this approach implicitly defines the diagnostic process of recognizing schizophrenia [27].

Modern research supports [28] that the feelings of psychiatrists toward patients with schizophrenia are still deemed diagnostically significant by doctors, necessitating a more in-depth study of the nature and diagnostic significance of these feelings. Moreover, psychiatrists worldwide support this viewpoint (Figure 1). According to the study results, 62% to 92% of psychiatrists believed that "feeling of schizophrenia" is considered a viable approach to diagnose schizophrenia and 13% to 29% of specialists believed that it is the most reliable [28].

The clinical case of Mikhail G., 30 yr old and with no fixed residence, is presented as an example of schizophrenia overdiagnosis.

The patient was taken to the emergency department of a psychiatric hospital, where he was diagnosed with "acute polymorphic mental disorder with symptoms of schizophrenia" (F23.11). Doctors were called to the grocery store when Mikhail "fell ill and felt a sudden loss of strength," forcing him to sit on the store sales floor.

With his behavior and statements, he deliberately drew the attention of a police officer passing by,

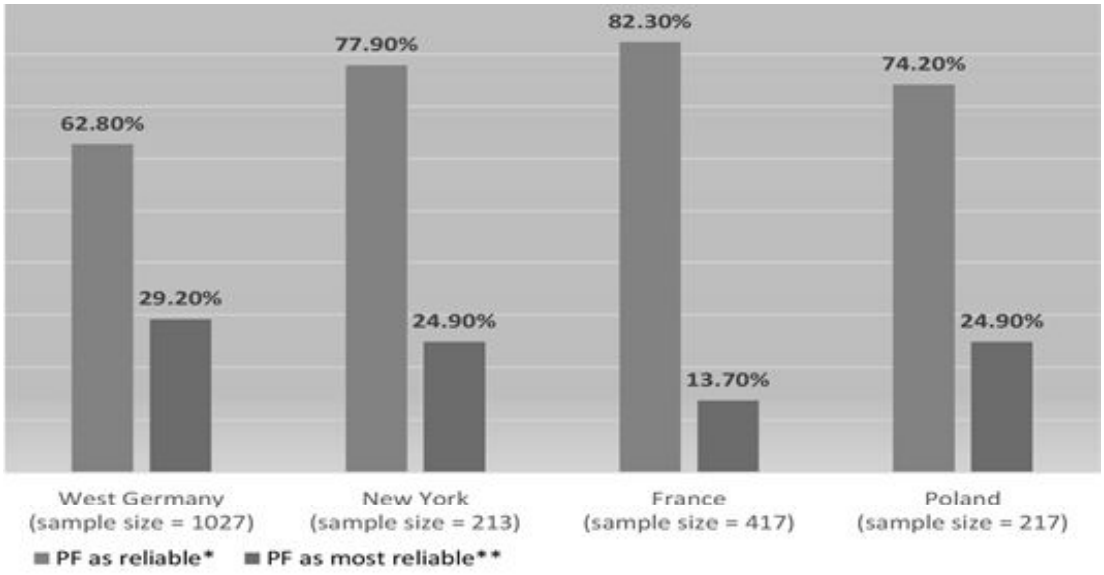

Figure 1. Evaluation of the "feeling of schizophrenia" as a reliable diagnostic method [28]

asking him, "what is the term of imprisonment for committing an extremely grievous crime?" When the police officer asked about the reason for such interest, the patient replied that several years ago, he cut off the head of an acquaintance and escaped punishment.

Upon admission to a psychiatric hospital he complained of a lack of strength, laziness, which he considered an incurable disease, and a lack of will ("there is no spirit in me…like a soulless body"). He appeared careless in his appearance, exuding the smell of an unwashed body. The hair was greasy and disheveled. He often smiled ridiculously, giggled for no reason, and muttered something under his breath. He claimed that he invented the story of cutting off his head deliberately because he was "afraid to stay on the street" due to a lack of a permanent place of work and residence.

He showed no symptoms of himself in the psychiatric hospital department. He didn't care about his appearance; he often walked around with his pants lowered and his T-shirt half-tucked in. The facial expression was hypomimic. His range of interests was extremely limited. He was uninterested in anything; he was inconspicuous and conflict-free. He stayed in bed most of the day, only getting up to eat and go to the restroom. He avoided communicating with other patients and kept himself apart.

In conjunction with the diagnosis of paranoid schizophrenia with emotional–volitional defect, haloperidol (up to 15 mg/day), chlorpromazine (up to 100 mg/day), and quetiapine (up to 600 mg/day) were prescribed. After 1 month, the idea of changing therapy and prescribing atypical antipsychotics was addressed "due to the predominance of negative disorders."

Three months later, after the patient was informed about the need to be discharged from the hospital, Mikhail provided new information about himself. In particular, he described a "settler" in him ("he occasionally coughs, sometimes confuses my thoughts" and "doesn't interfere with life, but he just sits inside me...and sometimes I feel him"). The "settler" first appeared several years ago while watching a TV show about paranormal phenomena. At this point, "unpleasant feelings erupted in the chest," and Mikhail realized that "the devil invaded him." He sought assistance from the church, but the priest said he needed an exorcist. The attending physician diagnosed schizotypal personality disorder (Verschroben variant)."

Mental status. The patient is obese and overweight. He sighs and breathes deeply as he sits in a chair. He is dressed scruffily. He freely engages in conversation, answers questions, and shows interest and emotional involvement. During a clinical evaluation, he is not embarrassed by the large number of doctors in the audience. When asked if it is worthwhile to consider discharge after being in a psychiatric hospital for several months, he responds calmly, agreeing to discharge. However, he requests that the discharge be postponed until spring when it will be warmer outside.

He raises no concerns about his health; he believes that the therapy did not help but did not worsen his mental condition. He repeats what he told his doctor about himself.

His reasoning is consistent, and he speaks clearly. When discussing the presence of a "settler" in him, he becomes more interested. He is confident that this is possible because many people around him discussed such possibilities when he was in his childhood. As a matter of fact, his attitude toward the "settler" is neutral. He explains that the "settler" never did anything terrible to him and did not contribute to his success.

He speaks with an apparent interest in paranormal phenomena that he learned from newspapers and saw on TV. Despite his exceptional experiences, he does not consider himself extraordinary. Thus, while he reported two episodes wherein the "third eye" opened, allowing him to "penetrate thoughts, read them telepathically, and see the hidden desires of his mother, grandmother, and brother," he did not argue that this was something extraordinary. He learned about the "third eye" from a TV show about paranormalists, which reported that "it was opened in Vanga, Wolf Messing, Nostradamus"; however, it opened in him for a short time (5–6 d) precisely after watching the TV show, when he "saw everything differently, green biofields, and walked like a blind man." He never told anyone about it. He was syntonic in the conversation, with an even temper.

Because the psychopathological symptoms discovered in Mikhail aligned with the traditional beliefs of people, particularly the possibility of a "settler" inside a person, the above clinical case represents a complex diagnostic case. Despite this, the attending physicians diagnosed schizophrenia with an emotional–volitional defect, followed by schizotypal personality disorder, and prescribed antipsychotics. The barrier to accurate diagnosis was Mikhail's objectively difficult life situation, namely, his lack of maintenance of life and place of residence. The patient repeatedly stated that he invented many complaints to solve his daily problems, such as finding shelter and food.

Among the psychopathological symptoms used to diagnose schizophrenia in Mikhail were passivity, asthenia, apathy, immersion in his own experiences, and the idea that a "settler" occasionally occupies him. The importance of this disorder was emphasized because, from adolescence, behavior typically changes in the form of an increase in mental deficiency, a decrease in initiative, mental activity combined with an impairment of adaptation, a reduction in school performance, and even a complete refusal to study.

According to psychiatrists who monitored Mikhail several years before the present examination, the clinical presentation of his illness manifested negative symptoms, such as eccentricity, strange appearance, straightforwardness, emotional coldness, detachment from relatives and friends, paradoxical feelings, and hostility and aggressiveness toward his brother. Psychiatrists interpreted Mikhail's statements regarding the "settler" as signs of delirium.

Further analysis of the patient's mental state indicated that the listed symptoms of astheno-apathetic syndrome could be caused by severe somatic disorders, namely, grade three obesity. Psychopathological symptoms should have been regarded as anergy rather than an apathetic syndrome in this case. Anergy has traditionally been defined in psychiatry as a decrease in mental, verbal, and motor activity. One of the primary causes of anergy is endocrine diseases.

During the clinical–psychopathological examination of Mikhail, we found no evidence of a decrease in the level of emotional response, apathy, or other symptoms indicative of an emotional–volitional defect. He was syntonic when recalling his life events and became upset when the topic of discharge from the psychiatric hospital arose.

The analysis of Mikhail's "pathological ideas and false beliefs" about being possessed by a "settler" and having his "third eye opened" twice in his life was examined. Therefore, psychiatrists diagnosed him with paranoid schizophrenia, which we regarded as a manifestation of traditional beliefs. It is well-known that there is a strong belief among various ethnic and cultural groups that "ethereal entities (settlers) invade easily into the human biofield and parasitize on its energy." The most renowned "settlers" include demons, dead people, and larvae[1].

Mikhail's statements about the presence of a "settler" could not be interpreted as a manifestation

[1]E. Velikaya https://vk.com/@elenagreatrich-podselency-v-cheloveke-lyarvy-besy-pokoiniki.

of delusional ideas because: first, they were within the cultural traditions of the micro-society wherein Mikhail grew up; second, they were not characterized by an unshakable conviction that this is reality; and third, the criticism directed at them was not sustainable (Mikhail claimed that he came up with this to find shelter and food for a while). Furthermore, the patient stated that he experienced such ideas after watching television programs about paranormal phenomena.

The clinical manifestation of Mikhail's mental disorder was characterized by social maladjustment and an inability to adapt to the real world. There were also not entirely adequate solutions to the patient's problematic life situation, namely, the fiction that he could kill someone and avoid punishment, a demonstrative fall in the hospital corridor with shouts that it was "the devil writhing" after he was informed about the need for discharge from the hospital.

Thus, according to the case analysis, Mikhail's clinical presentation lacked the main diagnostic criteria characteristic of schizophrenia. There were no psychotic symptoms, delusions, hallucinations, or other manifestations. Neither clinically nor pathophysiologically, "schizophrenic thinking disorders" (amorphia, diverseness, and noncontinuous thinking) were detected. In addition, no signs of organic brain damage were recorded.

It could be assumed with a high probability that Mikhail's case meets the criteria for a mixed personality disorder with a predominance of hysterical and emotionally labile traits, implying that this clinical case should be viewed as an overdiagnosis of schizophrenia.

The analysis of schizophrenia overdiagnosis suggests that its widespread distribution is due to cognitive diagnostic distortions in the process of clinical reality cognition associated with doctor attitudes, reflecting "pseudo-scientific traditions." From our perspective, overdiagnosis of schizophrenia and unjustified prescription of antipsychotic therapy to patients lead to the discreditation of psychiatry and stigmatization of mentally disabled patients. This approach should be reconsidered, and schizophrenia should be diagnosed only on apparent clinical rather than indirect clinical phenomena.

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