

OPINION

SCHIZOAFFECTIVE DISORDER – AN ISSUE OF DIAGNOSIS

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Abstract

Objective: To highlight the diagnostic challenges in diagnosing a patient with schizoaffective disorder under DSM-IV-TR and to evaluate the effectiveness of changes in DSM-V in addressing these issues. **Methods:** We present the evolution of the diagnosis from its inception, outline its complex nosology, review the diagnostic difficulties under DSM-IV-TR and critique the proposed changes made in DSM-V. **Results:** A complex nosology, varied thresholds of diagnosis under DSM-IV-TR, and the inherent difficulty in obtaining a detailed longitudinal history from a patient contribute to the challenge of diagnosing a patient with schizoaffective disorder. Changes in DSM-V attempt to increase the reliability of the diagnosis by specifying and raising temporal thresholds, moving the time of disease observation away from a single episode but towards the lifetime of illness. **Conclusion:** Changes made in DSM-V only address a small part of the difficulties raised and clinicians will continue to face challenges in diagnosing schizoaffective disorder under DSM-V. However, there might still be value in the proposed changes under DSM-V. *ASEAN Journal of Psychiatry, Vol. 14 (1): January – June 2013: XX XX.*

Introduction

The term ‘schizoaffective disorder’ is commonly used to refer to the patient who exhibits psychotic symptoms as well as mood symptoms. When vaguely defined, it can seem to be an easy way to pigeonhole patients who have a mixture of both mood and psychotic symptoms but cannot be easily categorized into either schizophrenia or major mood disorders. However, under stringent criteria, there is a challenge for diagnosing patients with schizoaffective disorder. This can be, in part, attributed to the confusing and diverse nosology of schizoaffective disorder; the similarities between schizoaffective disorder and schizophrenia with mood symptoms or major mood disorder with psychotic symptoms; and

the poor clinical reliability of the DSM-IV criteria, which can be ambiguously vague.

In this commentary, we explore these challenges by tracing the history and evolution of the diagnosis, its nosology, and the clinical challenges in utilizing DSM-IV to diagnose schizoaffective disorder and how the proposed changes for the DSM-V criteria for schizoaffective disorder would aide the challenge of diagnosis.

Evolution of the Diagnosis

Kasanin proposed the term ‘schizoaffective disorder’ in 1933 on the basis of 9 detailed case histories (republished in 1994) [1]. In his lecture he described nine cases of acutely psychotic

patients who were diagnosed to suffer from dementia praecox (now known as schizophrenia) but did not quite fit the traditional Kraepelinian two-entity diagnosis of schizophrenia (dementia praecox) or manic-depressive psychosis (affective psychosis) [2]. The term “schizoaffective” did not appear in the text. However, it was mentioned that Claude [3] had described cases of “schizomania” (pre-dating Kasanin’s “schizoaffective” psychoses) that developed into schizophrenia and finally ended in dementia. Kasanin’s accounts of the nine cases were descriptive, narrative and psychodynamic; he summarised the features common to the group as follows: (i) blending of schizophrenic and affective symptoms; (ii) ages 20-39; (iii) usually a history of a previous attack in late adolescence; (iv) normal pre-morbid personality; (v) good social and work adjustment; (vi) very sudden onset in a setting of marked emotional turmoil with a distortion of the outside world and presence of false sensory impression in some cases; (vii) definite and specific environmental stress; (viii) absence of any passivity or withdrawal; (ix) duration of a few weeks or months and followed by recovery.

Kasanin acknowledged that Bleuler had recognised such cases many years earlier. If the established major psychoses of schizophrenia (with a deteriorating course) and manic-depressive psychosis (recurring and recovering) are considered “typical”, then other psychotic conditions would form an “atypical” category. Some of these atypical psychoses have a number of common characteristics such as acute onset, polymorphic symptomatology and good prognosis.

Vaillant [4] identified in a selected list of 16 studies of remitting schizophrenics common salient features that could be found in most, detailed as follows: (i) picture resembling schizophrenia but with symptoms of psychotic depression; (ii) acute onset; (iii) confusion or disorientation during acute onset; (iv) good pre-morbid adjustment; (v) clear precipitating event; and (vi) remission to the best pre-morbid level of adjustment. Notably, there was a close correspondence of Kasanin’s description of

“schizoaffective” psychoses to Vaillant’s observations of these atypical psychoses.

Syndromes and Concepts

However, these similar clinical syndromes have been given different names by different people, in different cultures and during different periods of time. Thus Kendell [5] remarked, “... as a result we do not know to what extent, for example, the French term *bouffée délirante*, the Scandinavian term *psychogenic psychosis*, the Anglo-American term *schizoaffective illness* and Leonhard’s term *cycloid psychoses* all refer to the same group of patients.” And one may add to the list the Japanese Mitsuda’s “atypical psychoses” linking to epilepsy as well. On the other hand, the same term may undergo changes in usage over time or apply to different conditions. A study by Brockington and Leff [6] looked into 8 alternative definitions of schizoaffective psychosis in a sample of psychotic first admissions and found their mutual concordance to be very low indicating very poor agreement about the meaning of the term “schizoaffective”.

There is also a hierarchical approach in which a dominant disorder is diagnosed even though contaminated with symptoms from another disorder. To Bleuler [7], Fould’s and Bedford’s [8] and Welner [9] presence of distinct schizophrenic symptoms takes precedence over affective symptoms and patients with mixed symptoms should be diagnosed schizophrenic rather than schizoaffective. Others, Stephens, Astrup and Mangrum [10]; McCabe, Fowler et al. [11] thought schizoaffective disorder was a misdiagnosed or variant of affective disorder.

Another hypothesis is the continuum model in which schizoaffective disorder occupies a midway position between schizophrenia and affective disorder. Robin Murray is of the opinion that the Kraepelinian dichotomy of distinct schizophrenia and bipolar disorders are actually part of the same continuum in which bipolar patients experience psychosis and schizophrenic patients experience depression or manic episodes [12].

Nosology of Schizoaffective Disorder/Psychosis

For decades, researches and reviews have been carried out on the nosological entity of schizoaffective psychosis or disorder. Studies have been conducted on its concepts; its definitions and criteria; its incidence; its environmental factors and onset; its course; its outcome or prognosis; its follow up and treatment response; its genetic and family studies; its boundary with and differentiation from related disorders, etc. However, there have been no conclusive findings or common agreement on its distinct entity. This is not surprising when the two major categories of “typical” psychoses *viz.* schizophrenic disorders and affective psychoses are themselves not universal and static in its definitions, criteria and classifications.

Under current diagnostic systems, a patient may be diagnosed with schizoaffective disorder if he

or she falls into one of the following categories: (i) A form of schizophrenia with some incidental affective symptoms, (ii) A form of affective disorder with some incidental schizophrenic symptoms, (iii) A co-morbid disorder with both schizophrenia and affective psychosis, (iv) A third unrelated psychosis, (v) A genuine inter-form between schizophrenia and manic-depressive illness, and (vi) A heterogeneous illness with some combination of the above.

Diagnosis and Clinical Difficulties under DSM-IV-TR

Under the DSM-IV-TR criteria, a person is diagnosed with schizoaffective disorder if he or she has prominent psychotic and affective symptoms during the same period of illness, fulfilling the following 4 criteria (A-D):

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.

Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Bipolar Type: if the disturbance includes a Manic or a Mixed Episode (or a Manic or a Mixed Episode and Major Depressive Episodes)

Depressive Type: if the disturbance only includes Major Depressive Episodes

There is some difficulty in distinguishing between schizoaffective disorder and a severe psychotic bipolar disorder or a schizophrenic illness with a mood episode. The DSM-IV-TR attempts to address these issues by the inclusion of criterion B and C. To differentiate between a psychotic bipolar disorder and schizoaffective disorder, Criterion B states that there has to be a

period of at least 2 weeks whereby the patient is acutely psychotic but not displaying any affective symptoms. If this can be identified in a patient, it rules out the diagnosis of a psychotic bipolar disorder.

Criterion C requires that mood symptoms are present for a substantial portion of the duration

of the illness. This is in attempt to exclude a brief mood episode that the patient may present with together with an underlying schizophrenia. For example, a patient with a 10-year history of schizophrenia may present with a new onset of manic symptoms lasting for 3 weeks. At the time of observation, the patient would have fulfilled criterion A (having both psychotic episode and manic episode) and criterion B but would not be diagnosed with schizoaffective disorder because he failed to fulfil criterion C.

In order for a diagnosis of schizoaffective disorder to be made, a detailed temporal history of the onset and offset of mood and psychotic symptoms has to be taken. The clinician must not only ensure that the criteria for either a manic or depressive episode are met, but also delineate the exact length of each episode. This is critical in order to assess whether there are psychotic symptoms in the absence of mood symptoms (criterion B) and to assess the relative distribution of mood symptoms over time (criterion C). There is a difficulty in obtaining this longitudinal information from either the patient or from direct clinical observation because both psychotic and mood symptoms can

begin and end rather insidiously. One would have to rely on multiple sources of information such as the patient's own memory, previous medical and mental health records and from friends or relatives of the patient. This can be particularly challenging when trying to obtain a history from a patient who has suffered from a long-standing psychotic illness [13].

Even if such data can be accurately obtained, there is no quantitative measure to allow clinicians to judge if a mood symptom is present for a "substantial proportion" of the duration of illness. The term "substantial portion" is poorly defined and is open to interpretation by clinicians. It is found that clinicians and researchers often use different thresholds when applying the diagnostic criteria for schizoaffective disorder [14]. This leads to poor clinical reliability and limited clinical utility for the diagnosis [15].

Proposed Changes in DSM-V

Under the proposed DSM-V [16], the criteria for schizoaffective disorder has been modified to:

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A. An uninterrupted period of illness during which, at some time, Criterion A symptoms of Schizophrenia are present, and there is also either a Major Depressive Episode or a Manic Episode.

Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the lifetime duration of the illness, delusions and/or hallucinations are present at least for 2 weeks in the absence of a major mood episode (depressive or manic).

C. A major mood episode is present for the majority ($\geq 50\%$) of the total duration of the time after Criterion A has been met. (Note: periods of successfully treated mood symptoms count towards the cumulative duration of the major mood episode).

D. Disturbance is not due to direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition.

Some of the changes are highlighted as the following: (1) Under Criterion B, "during the same period of illness" (DSM-IV) has been replaced with "during the lifetime duration of the illness" (DSM-V). Under DSM-IV, the term "period of illness" was an episodic designator, which could refer to a single episode of illness that lasted a minimum of 1-month duration up to the lifetime duration of the illness. This can result in a patient, over time, being diagnosed

with multiple conditions such as schizoaffective disorder, schizophreniform disorder, schizophrenia, or psychotic mood episodes. In the study conducted by Schartz et al. [17], he reported that in a follow-up of patients diagnosed with schizoaffective disorder at initial psychiatric assessment, only 36% of these patients had a stable diagnosis after a 24-month period. Thus, the change to using "lifetime duration of the illness" as the timeframe for a

diagnostic criterion would increase the reliability of the diagnosis, (2) Under Criterion B, “major mood symptoms” (DSM-IV) has been replaced with “major mood episode” (DSM-V). The change helps to clarify that instead of requiring an absence of any mood symptoms whatsoever, what is required to meet criterion B rather, is the absence of psychopathology that would cross the threshold of a diagnosis of a depressive or manic episode (under DSM-V), (3) Under Criterion C, the term “substantial portion of the total duration of the active and residual portion of the illness” (DSM-IV) has been replaced with “majority (> 50%) of the total duration of the illness” (DSM-V).

As mentioned previously, the use of the term “substantial portion” in the DSM-IV criteria has been fraught with much difficulty, partly due to the use of different thresholds by clinicians and researchers to define “substantial” [18]. There is some common consensus that a “substantial portion” of the illness would mean mood symptoms to being present during 15 to 20 percent of the total illness duration [19]. The change in DSM-V overcomes this variation of thresholds used by different observers by stating a fixed value (> 50%) for which mood symptoms have to be present. However, this is also an increase from the previous definition of the duration of mood symptoms that need to be present in order for criterion C to be met. This means that patients previously diagnosed as having schizoaffective disorder might now, under this new criteria, fall outside of the diagnostic range hence resulting in a decreased prevalence of schizoaffective disorder. Also, the change will probably cause patients with a more temporally unstable course of schizoaffective disorder to be excluded from the new diagnosis until sufficient historical data can be obtained and a detailed timeline of both psychotic and mood symptoms can be clearly outlined. However, whether this change will improve the clinical reliability of the diagnosis remains to be seen.

Conclusion

By tracing the history and evolution of schizoaffective disorder, we can see that there is

a real need for this category of illness to define a distinct group of patients who lie somewhere between the psychotic and affective spectrum. However, there is insufficient data to accurately pinpoint the nosology of schizoaffective disorder, with many different theories held by different clinicians with regards to the entity of schizoaffective disorder. Furthermore, the challenges of obtaining an accurate longitudinal history and the variability of thresholds used by clinicians to diagnose schizoaffective disorder all culminate in a real diagnostic challenge for clinicians. The changes made in DSM-V aim to increase the reliability and clinical utility of the diagnosis by giving clinicians firm handles on which to make their diagnosis and by changing the schizoaffective diagnosis from a more episodic approach to a more longitudinal one. However, this increased emphasis on a longitudinal history can in itself be a difficult task for clinicians. Only time will tell if the changes made will ultimately lead to an increase in reliability, clinical utility and validity of the diagnosis of schizoaffective disorder.

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