Gin S. Mali: A Critical Analysis of Concepts in Psychiatry

Gin S. Malhi and Erica Bell: Fake Views: Schizoaffective Disorder is not "SAD," just bad*

Who makes this diagnosis?

Schizoaffective disorder, nay the "illness" SAD, is seemingly ubiquitous. Hospital-based public psychiatric services and associated community care programs across the country are positively brimming with patients that are supposedly "schizoaffective." Of patients diagnosed with a psychotic illness that had contact with public specialised mental health services, 17.5% were diagnosed with SAD using the ICD-10, the same prevalence as bipolar disorder (Australian Government Department of Health 2011). Many of these patients have been assigned this label as a differential diagnosis, but remarkably, many have SAD as their primary "illness." This is of critical importance because one of the key functions of any diagnosis is to inform treatment, but as we shall see, although the diagnosis of SAD seemingly serves many purposes, meaningfully informing management is arguably not one of them.

Anecdotally, most consultant psychiatrists deny making the diagnosis of SAD, explaining that most patients they see have already been diagnosed with the disorder. The few that admit to making the diagnosis themselves, usually go to great lengths to justify their actions. However, privately, many clinicians (even those that make the diagnosis) are not convinced that it is a valid disorder. They use it because it *"provides an explanation for what they have before them"* and that even though the symptoms don't quite fit they are *"unable to make an alternative diagnosis with any greater confidence."* Part of the problem is that in clinical practice the diagnostic criteria for SAD are difficult to apply. Even the fundamental criterion of an overlap of mood and psychotic symptoms along with periods when each of these groups of symptoms manifest separately, can be difficult to identify – especially retrospectively. Thus, in practice, the timing criteria and degree of overlap necessary for a diagnosis of SAD are often applied loosely. Added to this, it is generally acknowledged that the criteria as set out in taxonomies such as the DSM and ICD do not have a scientific basis, making their utility in clinical practice largely empirical.

Why is the diagnosis made?

Clinically, the diagnosis comes about because of two sets of factors. The first is a function of time and the second concerns phenomenology.

Severe mood disorders at either pole (depression and mania) can, and do, feature definitive psychotic symptoms. And conversely, psychotic syndromes often manifest in significant and sustained changes of mood, in particular depression. Furthermore, the processes by which these disorders (depression, mania, schizophrenia) develop are unpredictable and, because of this the clinical picture early in the course of these disorders is often highly variable. In other words, most diagnoses at this time are indeterminate, and though symptoms can be condensed into a variety of syndromes, these are often ephemeral groupings that are prone to change over time (Santelmann, Franklin, Bußhoff and Baethge 2015). It is usually at this juncture, in a milieu of diagnostic nebulousness, that the term schizoaffective is introduced. Part of the reason is to provide an interim "working diagnosis," one which can be revised when more information comes to light. However, in practice, once the diagnosis of SAD is conferred, it is seldom supplanted. Hence, diagnoses such as schizophrenia or bipolar disorder may later be *added*, but the label of schizoaffective remains firmly ensconced.

Other reasons for the use of SAD include a desire to avoid more stigmatizing labels. Schizoaffective disorder is seemingly more acceptable than schizophrenia, which has dire connotations akin to the diagnosis of cancer (Malaspina, Owen, Heckers et al. 2013). This is particularly relevant early in the course of the illness or in young individuals where it is felt that acceptance of the diagnosis either by the individual or their family is likely to be poor. Cloaking an emerging psychotic syndrome in a "schizoaffective cape" allows the true diagnosis (e.g., schizophrenia) to be revealed gradually, giving everyone time to adjust to the reality of a severe and disabling chronic mental illness.

A diagnosis of SAD is also sometimes made at the point of prescribing medication, and this expedient practice occurs more so in the USA, where some medications can only be prescribed if the individual has a diagnosis that is specified in the DSM. For example, diagnosing SAD allows the prescription and cost of antipsychotics to be paid for through medical insurance. The problem with this, apart from the obvious clinical and ethical issues of knowingly misdiagnosing an illness, is that SAD epidemiological and treatment data derived from insurance company databases contains inaccurate information that is potentially misleading.

What *are* the criteria for SAD?

The lack of a clear consensus on the core features of SAD is evident in the stark differences between ICD-10 and DSM-5. Both classification manuals stipulate that in SAD schizophrenia symptoms and those of a mood episode occur conterminously, however, this is where the similarities more or less end. The duration of the dysfunction, the degree to which the mood and psychotic symptoms cooccur, and even *which* symptoms are necessary in order to satisfy the requirements for the diagnosis, differ between the two manuals (see Table 1).

The general diagnostic criteria for SAD have remained almost identical for over 30 years (DSM III-R (1987), see Figure 1). After initially morphing from being a subtype of schizophrenia, to being considered an additional psychotic disorder this criterion and has largely remained unchanged thereafter.

Figure 1

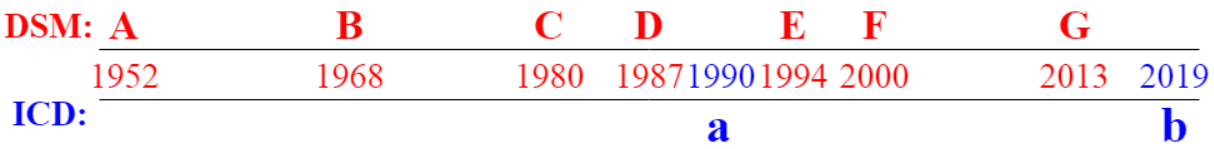

Figure 1. ***Timeline of SAD diagnostic criteria in DSM and ICD***. Dates and letters for each edition of DSM (red) and ICD (blue) correspond to letters shown in Table 1.

Table 1

Table 1. Timeline of diagnostic criteria for SAD

A	DSM I	Schizophrenic reaction, Schizo-affective type
B	DSM II	Schizophrenia, Schizo-affective type, excited, Schizophrenia, schizo-affective type, depressed
C	DSM III	Schizo-affective disorder (no operational diagnostic criteria)
D	DSM III-R	Introduces Bipolar type and Depressive type and the 4 diagnostic criteria: A) An uninterrupted period of illness occurs during which a major depressive episode or a manic episode occurs with symptoms that meet criterion A for schizophrenia

		B) During the same period of illness, delusions or hallucinations occur for at least 2 weeks, in the *absence* of prominent mood symptoms. C) Symptoms that meet the criteria for mood episodes are present for a *substantial* portion of the *total active and residual periods* of illness. D) Symptoms not due to effects of substances or other medical conditions
E	DSM-IV	Mixed episode subtype added to Bipolar subtype. No change to diagnostic criteria
F	DSM-IV-TR	No change to diagnostic criteria
G	DSM-5	Change to Criterion C: Symptoms that meet criteria for a major mood episode are present for the *majority* of the *total duration of the active and residual portions* of the illness.
a	ICD-10	Episodic disorder in which both affective and schizophrenia symptoms are prominent, but which do not justify a diagnosis of either schizophrenia or depressive or manic episodes. Specifiers: Manic type, Depressive type or Mixed type
b	ICD-11 (In Press)	Episodic disorder in which the diagnostic requirements of schizophrenia and a mood episode are met within the same episode of illness, either simultaneously or within a few days of each other. Prominent symptoms of schizophrenia are accompanied by typical symptoms of a mood episode. Specifiers: First episode, Multiple episodes, Continuous

What is needed for a diagnosis?

The diagnostic criteria for SAD detailed in DSM-5 are presented schematically in Figure 2 below.

Figure 2

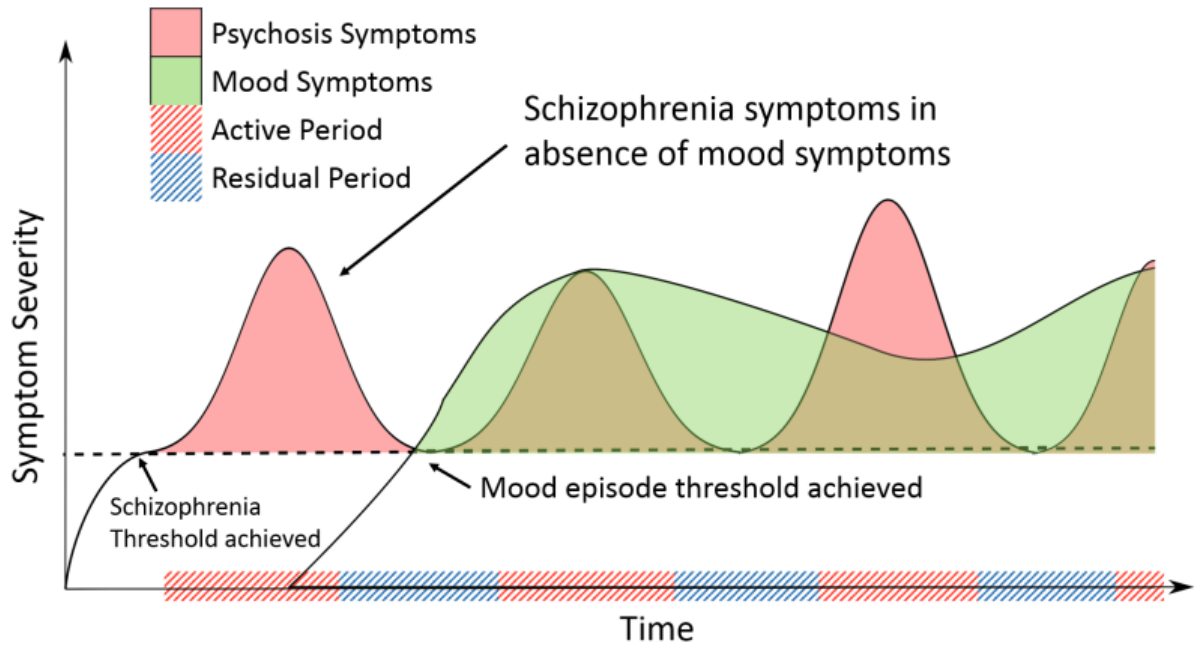

Figure 2. ***Development of SAD: specifying the diagnostic criteria as per DSM.*** Active and residual periods refer to schizophrenia symptoms. And active periods of schizophrenia symptoms must last at least 4 weeks (1 month). Mood episodes can be either depression or mania (lasting at least 2 weeks and 1 week respectively). Once both the criterion A schizophrenia threshold and mood episode threshold have been achieved SAD can be diagnosed once there is sufficient cooccurrence of the two sets of symptoms.

Criterion C (see Table 1, DSM III-R) can be especially problematic for clinicians, because attempting to retroactively map a patient's illness is difficult and subject to recall inaccuracy. Furthermore, this criterion requires that mood symptoms be present for the *majority* of the illness, meaning that technically a patient who has had a decade of psychotic symptoms (active and residual) but co-occurring mood symptoms only for the last 2 years of this period, would not qualify for the diagnosis of SAD. In addition, the criterion fails to assign sufficient weighting to recent symptoms – all of which makes it unnecessarily complicated; and coupled with the vagueness of the remaining SAD criteria, diagnostic decision-making becomes needlessly difficult.

The Conceptualisation of SAD and Barriers for Clinicians

The importance placed on psychotic symptoms within SAD in both ICD-10 and DSM-5 has meant that affective symptoms are regarded as an appurtenance. This hierarchy is completely arbitrary, and in no way reflects clinical presentations (e.g. psychotic mania and depression) and does not enhance diagnostic clarity for clinicians. This is exemplified in the test-retest reliability of SAD being consistently lower than that of schizophrenia, bipolar disorder and unipolar depression (Santelmann, Franklin, Bußhoff and Baethge 2015).

These problems concerning the conceptualisation of SAD can be illustrated by portraying psychotic symptoms and mood symptoms as two peaks reflecting separate aetiologies, which happen to co-occur at times because of overlap temporally, which gives rise to the diagnosis of SAD (Figure 3, a. Yellow triangle). However, the current diagnostic criteria for SAD could also reflect the full complement of mood symptoms nesting within a broader umbrella of psychotic symptoms (Figure 3, b. Dashed outline). Importantly, under the current conceptualisation of SAD, we have no way of determining which of these models, if any, best

capture the clinical manifestations of SAD and whether they are of research value as regards the underlying mechanisms of SAD.

Figure 3

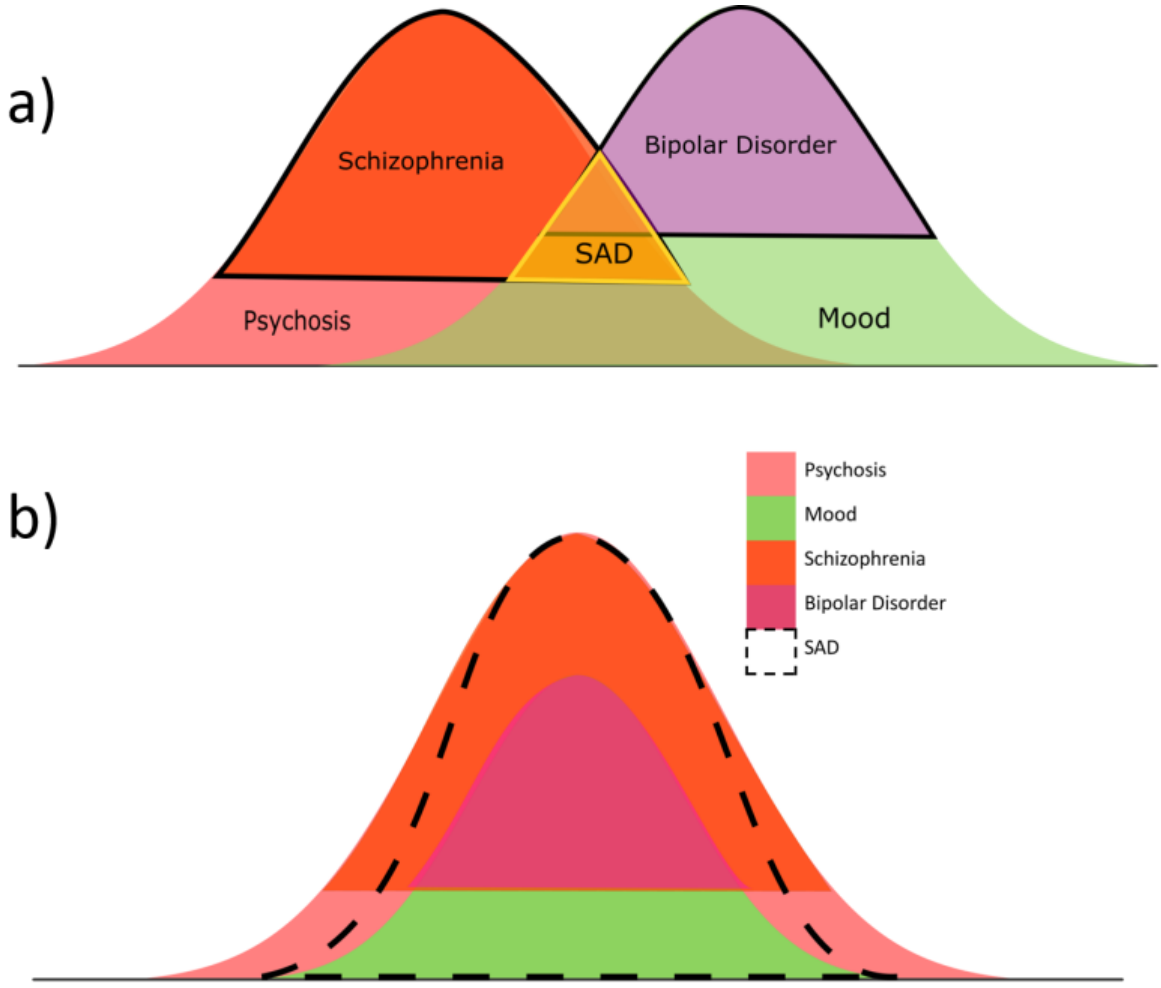

Figure 3. ***Schematic conceptualisations of SAD according to current diagnostic criteria.*** (a) shows the significant overlap of SAD with the psychosis peak, reflecting the emphasis on psychotic symptoms in the absence of mood symptoms. (b) shows SAD within

What can be improved here and now?

The ideal solution would be to expunge SAD altogether from both the DSM and ICD – as it is not a separate entity and because the clinical diagnosis lacks reliability and validity (Cheniaux, Landeira-Fernandez and Versiani 2009). However, until any such revision takes

place, it is important to recognise the many shortcomings of the SAD label and attempt to make pragmatic use of it noting that this does not reflect any deep understanding.

A pragmatic solution that would aide clinicians in navigating prescription legislation, would be to replace the term "disorder" with a more accurate specifier – "dysfunction." This would allow the acronym SAD to remain, and the new label of "schizoaffective *dysfunction*" could continue to fulfil some of its current roles. However, critically, the fact that it is not a disorder would ensure ongoing re-evaluation until a definitive diagnosis can be assigned. Clinically, the key benefit of using schizoaffective dysfunction to describe the overlap of mood and psychotic symptoms is that it does not reify the clinical syndrome as a separate illness or disease. Furthermore, this new label allows for re-evaluation and modification of the label itself and provides clinicians the necessary flexibility to reclassify patients as the illness progresses and evolves.

Figure 4

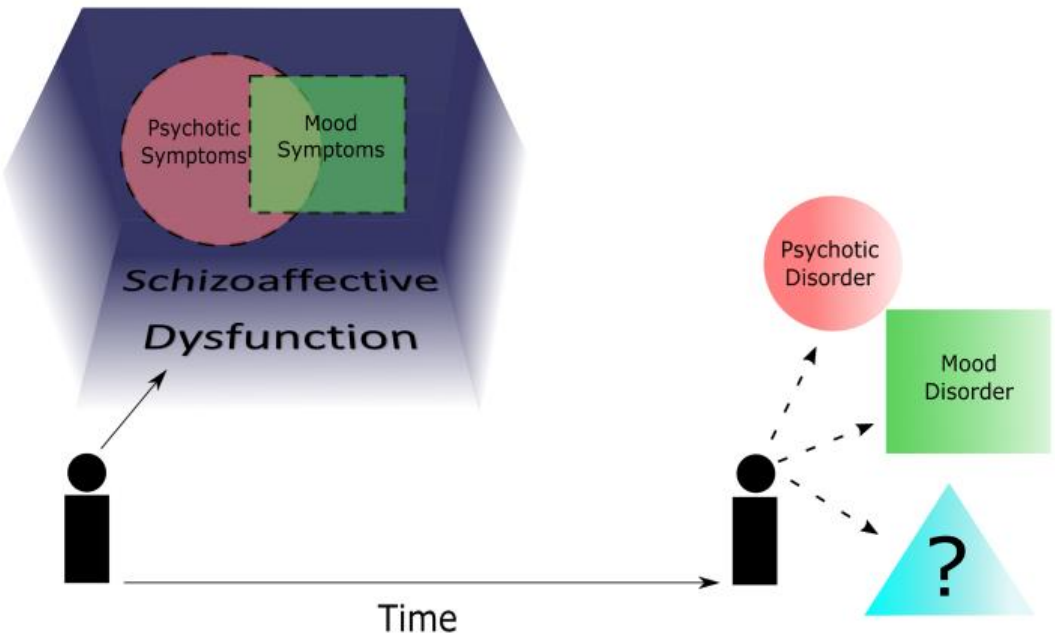

Figure 4. ***Schizoaffective Dysfunction.*** A new pragmatic conceptualisation of overlapping symptoms of psychosis and mood.

Research into schizoaffective dysfunction needs to be stepwise. This is because the definition is still partly based on the diagnostic criteria for schizophrenia. Therefore, initially, the underlying neurobiological mechanisms of schizophrenia need to be better understood before schizoaffective dysfunction can be meaningfully explored. But as new developments in the understanding of schizophrenia and mood disorders come to light, the label schizoaffective dysfunction can be refined, and ultimately better defined.

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