Difficulties in Diagnosing Schizoaffective Disorder

A Paper Presented to The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for the Degree of Master of Arts

in Adlerian Counseling and Psychotherapy

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April 2008
Abstract

This limited-scope literature review focuses on the difficulties of diagnosing schizoaffective disorder. The difficulties are predominantly manifest in differentiating schizoaffective disorder from schizophrenia and mood disorders.

The history of schizoaffective diagnosis is first reviewed. The literature reviewed reflects a wide range of conclusions regarding the diagnosis and differentiation of schizoaffective disorder, including conclusions challenging the value in having a diagnostic category of schizoaffective disorder.

The articles do little to clarify how schizoaffective disorder can be reliably diagnosed. However, the articles also indicate that the differential diagnosis of schizoaffective disorder requires an especially thorough examination current symptoms, as well as historical and longitudinal information. Therefore, while the diagnosis of schizoaffective disorder appears very ethereal, the diagnostic process itself has significant value.
Difficulties in Diagnosing Schizoaffective Disorder

Diagnosing mental disorders is never as black and white as might be surmised by reading the content of the DSM-IV-TR. While the DSM-IV-TR is most useful in getting a therapist in the diagnostic ball park, it is another matter to deal with the gray shades and multiple symptoms presented by actual human beings. There is very little that is black and white. Some diagnoses are particularly hard to establish, and schizoaffective disorder has been and remains one of the most difficult. This literature review has been undertaken with the hope of gaining a better understanding of the diagnostic criteria.

An editorial (Maier, 2006) included the results of a PubMed search for the terms schizoaffective disorder (230 hits), schizophrenia (13,297 hits), and bipolar disorder (2,355 hits) during a 10-year period 1995 – 2005. A similar search, conducted by the writer of this integrative paper on January 3, 2008, for the same period of time using a Medline search, reflected similar results. For the two-year period 2006 – 2007, the respective Medline results were schizoaffective disorder (67 hits), schizophrenia (3,791 hits), and bipolar disorder (1,121 hits). The editorial notes that schizoaffective disorder most typically appeared to have become a research topic during 1995 - 2005 only because of its association with schizophrenia and/or affective disorders. This was also true for 2006 – 2007; however, for 2006 – 2007, it is also noted that of the 67 articles with schizoaffective disorder in the title, 34 (51%) pertained primarily to medication efficacy. The diagnostic difficulties of the DSM-IV-TR criteria for schizoaffective disorder are not a popular subject, even though the articles presented in this literature review suggest that the difficulties are significant.

A review of historical and current literature about schizoaffective disorder suggests that, diagnostically, it is necessary to play one diagnostic game in two or three, or more, ball parks.
That is, there is a significant overlap of symptoms, as well as the symptoms changing often. This brief literature review reflects some of the history of the schizoaffective descriptor, and then summarizes some articles that give evidence of the difficulties of making a valid diagnosis of schizoaffective disorder.

**Reason for Choosing a Literature Review on Schizoaffective Disorder.** Schizoaffective disorder is one of the diagnoses for an individual well known to the writer. This individual is age 38 and has resided at the Regional Treatment Center, St. Peter, Minnesota, for the past 15 years (i.e. since 1993). Furthermore, the symptom overlap of schizoaffective disorder with those of other psychoses and mood disorders believed to have been experienced by the writer in his anger and abuse management internship is relevant to decisions regarding whether individuals are appropriate members for inclusion in the anger and abuse management group.

**History of the Schizoaffective Disorder Diagnosis.** The history of the development of the schizoaffective disorder diagnosis deepens the appreciation of the difficulties associated with defining schizoaffective disorder as currently contained in DSM-IV-R.

Pre-DSM discussions seem to inevitably begin with Emil Kraepelin’s dichotomous classification of psychoses into two parts: dementia praecox (termed schizophrenia today) and manic depressive insanity (termed affective/mood disorders today) (Fox, 1981; Korn, 2001; Marneros, 2003; Nardi et al., 2005; Vollmer-Larsen, Jacobsen, Hemmingsen, & Parnas, 2006). The purpose of beginning with Kraepelin’s classification system, which was acknowledged as a very positive step at the time Kraepelin created the system, was to point out it’s inadequacy in light of the many “cases-in-between”.
The schizoaffective disorder “case in-between” was first termed as such by J. Kasanin in a 1933 paper discussing nine case studies (Kasanin, 1933). Kasanin refers to the need for more differential criteria to arrive at more homogeneous classification groupings.

DSM-I (American Psychiatric Association. Committee on Nomenclature and Statistics & National Conference on Medical Nomenclature (U.S.), 1952) included schizoaffective disorder diagnosis as a subtype of 000-x20 Schizophrenic Reactions, specifying 000-x27 Schizophrenic reaction, schizo-affective type. The category was described in broad terms in five sentences. The final sentence indicated that such cases usually prove to be schizophrenic. It is also noteworthy that the narrative for 000-x20 Schizophrenic Reactions flatly states that this category is synonymous with dementia praecox, as described above.

DSM-II (American Psychiatric Association. Committee on Nomenclature and Statistics, 1968) also included the schizoaffective disorder diagnosis as a subtype of 295 Schizophrenia, specifying 295.7 Schizophrenia, schizo-affective type. However, two further divisions of this subtype were added: 295.73 Schizophrenia, schizo-affective type, excited, and 295.74 Schizophrenia, schizo-affective type, depressed. The narrative for 295.7 Schizophrenia, schizo-affective type was even more economical than DSM-I, consisting of only two sentences. The first sentence indicated the category was for patients showing both schizophrenic symptoms and either elation or depression. The second sentence only referred to the two further divisions of this subtype, i.e. excited and depressed, which were apparently considered self-explanatory since there were no narrative explanation or diagnostic criteria.

DSM-III (American Psychiatric Association, 1980) was the first to separately identify 295.70 Schizoaffective Disorder, including it among Psychotic Disorders Not Elsewhere Classified. The narrative for this DSM-III disorder provides no diagnostic criteria, instead
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summarily directing its use when a differential diagnosis cannot reasonably be made between Affective Disorder and either Schizophreniform Disorder or Schizophrenia. Before use, it must also be differentiated from Schizophreniform Disorder, Major Depression or Bipolar Disorder with Psychotic Features, and Schizophrenia with a superimposed Atypical Affective Disorder. Two examples of schizoaffective disorder are included. The first example cites an episode of affective illness followed by a delusion or hallucination after the affective symptoms are no longer present, i.e. sequential symptoms. The second example cites an episode of full affective syndrome and psychotic symptoms, i.e. concurrent symptoms, when prodromal differentiating information is not available.

One book (Blashfield, 1984) includes a paragraph noting that initial drafts of DSM-III kept schizoaffective disorder as a subcategory of schizophrenia. However, a literature review (Procci, 1976, as cited in Blashfield, 1984) concluded that those with schizoaffective disorder have family histories of affective disorders and respond to drug therapies as if they had affective disorders. As a result, according to Procci, DSM-III included schizoaffective disorder as a new major category.

DSM-III-R (American Psychiatric Association. Work Group to Revise DSM-III., 1987) retained 295.70 Schizoaffective Disorder as in DSM-III, and also provided additional information regarding age at onset (saying detailed information is lacking), course (suggesting chronicity), prevalence (detailed information is again lacking), sex ratio (no information shown), and familial pattern (suggesting schizophrenia or mood disorder in first-degree relatives, but not firmly established). The narrative notes that DSM-III-R replaces the term affective disorder with the term mood disorder; however, the term Schizoaffective Disorder is retained in order to be consistent with this disorder’s history. Differential diagnosis is more specific in DSM-III-R.
The DSM-III-R Diagnostic Criteria for 296.70 Schizoaffective Disorder uses two subtypes, similar to those used in DSM-II. The first subtype is bipolar type (current or previous Manic Syndrome). The second type is depressive type (no current or previous Manic Syndrome). The second type appears poorly defined since it covers all types that are not bipolar type, even though it seems to emphasize depression.

DSM-IV (American Psychiatric Association. Task Force on DSM-IV., 1994) and DSM-IV-TR (American Psychiatric Association. Task Force on DSM-IV., 2000) are virtually identical, with each providing substantial additional information compared to DSM-III-R. Except for page reference changes, all narrative is the same in DSM-IV and DSM-IV-TR except for the addition of two sentences and the elaboration of one sentence. Anosognosia (i.e., poor insight) was added to DSM-IV-TR’s Associated Features and Disorders. A general statement was added to DSM-IV-TR’s Course section, indicating that precipitating events or stressors were an indicator of a better prognosis for schizoaffective disorder. The DSM-IV statement, without explanation, that the incidence of Schizoaffective Disorder has a higher incidence among women than among men was briefly explained in DSM-IV-TR’s Specific Culture, Age, and Gender Features. DSM-IV and DSM-IV-TR both provide the identical complex Differential Diagnosis narrative, which while very difficult to practically apply does provide a good discussion. The four Diagnostic Criteria are stated simplistically, and the same two specific types are carried forward from DSM-III-R. However, the poorly-defined DSM-III-R Depressive Type was redefined from its catch-all definition to DSM-IV and DSM-IV-TR’s definition that this type of Schizoaffective Disorder includes only Major Depressive Episodes.

Current Diagnostic Criteria. From DSM-IV-TR:

Diagnostic criteria for 295.70 Schizoaffective Disorder
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

Literature Summary. The following literature summary is brief, consistent with the requirements of this integrative paper. Articles were selected to reflect the more current thinking with regard to schizoaffective disorder, as well as for their level of interest to the writer. The articles are presented chronologically to better reflect the progress achieved over time in improving diagnosis and resolving difficulties regarding schizoaffective disorder.

A 1994 article (Taylor & Amir, 1994) investigated whether schizophrenia and affective disorder are related and also looked at the problem of differentiating schizoaffective disorder by using signs and symptoms. The question being asked is whether schizophrenia and affective disorder have discrete symptoms.
The 1994 Taylor article conducted research using Chicago VA Hospital patients, all males, ages 18 and up and English-speaking. The article does not specify how many total patients were in the initial group of potential subjects, but later indicates that the research process resulted in 241 subjects (167 DSM-III schizophrenic patients and 74 DSM-III affective patients). The research focused on the 167 DSM-III schizophrenic patients. Subjects with a primary diagnosis of substance abuse and/or physical brain trauma were excluded. Subjects were interviewed by two interviewers using a semi-structured instrument that incorporated parts of the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (SADS-L), Scale for the Assessment of Positive Symptoms (SAPS), and Scale for the Assessment of Negative Symptoms (SANS) modified to include additional first-rank symptom, thought disorder, and affective feature items, an emotional blunting scale (EBS), and additional items to assess specific DSM-III criteria.

The 167 schizophrenic patients were further divided into three author-defined categories: 1) core schizophrenic, i.e. more serious, 2) noncore schizophrenic, i.e. less serious, and 3) schizoaffective disorder. The interviewers classified 59 as core, 32 as noncore, and 76 as schizoaffective. It is unclear, when the authors are using DSM-III diagnostic criteria, how they arrived at the 167 schizophrenic patients grouping which was then further reduced to three subgroups, one of which was a distinctly separate DSM-III category. The authors’ process leaves the writer with the understanding that the authors assumed schizoaffective disorder was a subgroup of schizophrenia. This, of course, is not consistent with DSM-III criteria.

The 1994 Taylor article concludes that, when using the measurements described above to identify DSM-III signs and symptoms, core and noncore schizophrenia diagnoses can be differentiated from affective disorder. However, it is also concluded that patients with
schizoaffective disorder could not be discerned with any confidence when using these measures. While schizoaffective disorder appears to hold a mid-ground position between core/noncore schizophrenia and affective disorders, there is considerable overlap of symptoms. Further findings suggested that schizoaffective/unipolar patients are more like schizophrenia patients, and schizoaffective/bipolar patients are more like patients with affective disorder. It was also suggested that diagnostic reliance on hallucinations and delusions to distinguish psychoses is not reliable since these symptoms occur in all forms of psychosis.

A 1997 article (Ricca et al., 1997) assesses basic symptoms in schizophrenia, schizoaffective disorder, and bipolar disorder. This is an evaluation of the differences in basic symptoms. The purpose is to identify similarities and differences among the three.

The 1997 study sample consisted of 72 outpatients who had been discharged from the Department of Psychiatry, University of Florence, Florence, Italy. All subjects were diagnosed using DSM III-R, with resulting diagnoses of 28 schizophrenia, 29 bipolar disorder, and 15 schizoaffective disorder. Nine others in addition to the 72 subjects, refused to participate in the study. There were 37 males and 35 females, with an average age of 38.6. Mean age at onset for schizophrenia was 21.0, for bipolar disorder 27.2, and for schizoaffective disorder 24.3. The assessment of basic symptoms was done using Frankfurter Beschwerde-Fragebogen (FBF). FBF measures 10 subscales: loss of control (LC), simple perception (SP), complex perception (CP), receptive language disorder (LD), thought disorder (TD), memory (MM), loss of automatism (LA), anhedonia (AN), and overstimulation (OS).

Using FBF in the 1997 study, schizoaffective disorder was not diagnostically distinguishable from schizophrenia or bipolar disorder. There were no significant differences between schizoaffective disorder patients and bipolar patients, in total or on subscales. SP and
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CP were different among the three disorders, in that qualitative alterations by schizophrenia patients were more frequent and more lasting than for schizoaffective disorder or bipolar disorder patients. TD was also significantly different among the three disorders, in that TD was more representative of schizophrenia patients than of schizoaffective disorder patients. Nothing is said about the differences in TD with regard to bipolar disorder patients. The article suggests that a schizoaffective disorder diagnosis is seldom made due to the indefinite diagnostic criteria of DSM-III. The article also suggests that a more accurate clinical characterization of schizoaffective disorder might result from inclusion of premorbid variables and longitudinal follow-up.

A 2000 research report (Maj, Pirozzi, Formicola, Bartoli, & Bucci, 2000) examined the reliability and validity of the DSM-IV diagnostic category of schizoaffective disorder. The report presented preliminary data. The authors indicated that no systematic study had been published before their report.

Subjects of the 2000 research report consisted of 150 consecutive patients (68 males and 82 females, ages 18 to 64 years, mean age 38.6) who had been diagnosed with a manic, major depressive, or schizoaffective episode. (The term “schizoaffective episode” appears to mean schizoaffective disorder, since schizoaffective episode is not a typical term.) All were attending a research unit of the Department of Psychiatry of Naples University, Naples, Italy. All 150 patients were independently interviewed by two senior psychiatrists using a slightly modified version of the Composite International Diagnostic Interview (CIDI). Of the 150 patients interviewed, 15 (seven males and eight females, ages 20 to 59 years, mean age 34.4) were diagnosed with DSM-IV schizoaffective disorder.
The main sources of disagreement between the two senior diagnosing psychiatrists in the application of the DSM-IV schizoaffective disorder diagnostic criteria were:

- Criterion A, the uncertain meaning of the expression, “symptoms that meet criterion A for schizophrenia”. There is no specification in DSM-IV that to meet this criterion, delusions and hallucinations must not have an affective content, that disorganized speech or behavior must not be secondary to elation, and that alogia and avolition must not be secondary to depression. All this must be implied or not implied by the assessor. Also, the assessment of the nature of the symptoms is often difficult.

- Criterion B, the unclear meaning of the expression “absence of prominent mood symptoms”. Does this mean that the criteria for manic or major depressive episode must not be fulfilled, or that no clinically significant mood symptom is present?

- Criterion C, the ambiguity of the formula “for a substantial portion of the total duration of the active and residual periods of the illness”. What should be regarded as a “substantial portion?”

- The difficulty of assessing retrospectively the temporal relationship between mood symptoms and mood incongruent psychotic symptoms.

The two senior psychiatrists doing the assessments needed to reach their own consensus by more specifically defining the DSM-IV criteria before they could reach a consensus for the 15 patients.

The 15 subjects were assessed two years later using the Strauss-Carpenter Outcome Scale. The same follow-up assessment was also performed on two random samples of patients, attending the same psychiatric unit, who had previously been diagnosed with schizophrenia or
schizophreniform disorder. The follow-up assessments were made by a psychiatrist who was not aware of the patients’ initial diagnosis. The follow-up assessments showed that schizoaffective disorder patients scored significantly higher than schizophrenia patients and slightly lower than schizophreniform disorder patients.

The 2000 research report also concludes that the overlap of symptoms of schizoaffective disorder and schizophrenia does not seem to be qualitatively different than schizophrenia. Differentiation based on family history does not seem to be valid. Clinical implications of the problematic diagnosis of schizoaffective disorder appear modest. Further studies are suggested that evaluate schizoaffective disorder’s diagnostic stability over time.

A 2004 article (Averill et al., 2004) presents a study focusing on whether clear boundaries can be drawn between schizoaffective disorder, schizophrenia, and bipolar disorder. This literature review is not encouraging when looking for clarity of boundaries. Prior research has shown significant levels of mania and depression accompanying schizophrenia (Sands, 1999, as cited in Averill et al., 2004), with estimates of occurrence between 6% and 50%. Some have suggested that eventually schizoaffective disorder becomes schizophrenia or bipolar disorder (Lapierre, 1994, as cited in Averill et al., 2004). A study of diagnostic stability and usefulness lends support to this claim, with only 18.6% of initially-diagnosed schizoaffective disorder participants still being diagnosed as such after repeated admissions over a seven-year period (Chen, 1998, as cited in Averill et al., 2004). Inter-rater reliability has documented unreliable agreement between raters regarding schizoaffective disorder (Maj, 2000, as cited in Averill et al., 2004). Other articles highlighted the lack of significant differences between schizoaffective disorder and schizophrenia with regard to family history, age of onset, duration of illness, or prior number of hospitalizations (Evans, 1999, as cited in Averill et al., 2004).
The study discussed in the 2004 article used 544 subjects who had been admitted to the University of Texas-Houston Harris County Psychiatric Center, Houston, Texas from February 1, 2000, through January 31, 2001. This facility is an acute-care psychiatric facility. Diagnoses for the 544 subjects were: 245 schizophrenia, 96 schizoaffective disorder, and 203 bipolar disorder. The ages of the study groups averaged 39.9 years schizoaffective disorder, 37.9 years schizophrenic, 35.8 years bipolar disorder. Schizophrenia patients were predominantly male (69%), while the other groups were about evenly divided. The groups were predominantly African-American and admitted involuntarily. The study retrospectively used a multitude of standardized rating scales and self-report measures.

The authors of the 2004 article indicate that it is not surprising that there is a controversy about the stability of diagnosing schizoaffective disorder. While the schizoaffective disorder group had scores intermediate between the other two groups, the schizoaffective disorder group’s scores were more associated with schizophrenia in some areas and more associated with bipolar disorder in other areas. The bipolar disorder group was most likely to be voluntary, with the authors expressing surprise that more patients in the schizoaffective disorder group were not voluntary. This was apparently because the schizoaffective disorder group reported greater psychological distress and, hence, a greater motivation to volunteer than for the bipolar disorder group. The authors’ surprise implies that having greater psychological distress is more likely to motivate an individual to volunteer. This seems quite speculative since having psychological distress might just as likely promote a sense of paranoia and the decision not to volunteer.

In the 2004 article, patients in the group diagnosed with schizoaffective disorder were on average older than the schizophrenia patient group, which was older than the bipolar disorder patient group. The article speculates that the age findings suggest the possibility that, for some
patients, psychotic and mood disorders change over time to include both psychotic and mood disorders. African Americans were more likely to be diagnosed with schizophrenia or schizoaffective disorder, and Caucasians more likely to be diagnosed with bipolar disorder.

The article concludes that schizoaffective disorder is more heterogeneous, which supports the finding that schizoaffective disorder is an intermediate disorder within the spectrum of schizophrenia and affective disorders. However, it is also posited that the affective symptoms documented in the study’s schizoaffective disorder group might be a periodic occurrence rather than a stable characteristic. The article’s authors recommend that future research be done to clarify patterns of course and outcome for the three diagnostic groups over time. Longitudinal designs of future research have important implications for the reliability of diagnosing schizoaffective disorder.

A 2005 article (Nardi et al., 2005) discusses a five-year retrospective study. The study hypothesis was that schizoaffective disorder belongs to the bipolar spectrum disorder, and this would be indicated by schizobipolar (schizoaffective, bipolar type) patients having demographic, clinical course, and therapeutic characteristics similar to bipolar I patients.

The participants in the study were men and women, ages 18 to 60, who sought treatment at the Institute of Psychiatry, Federal University of Rio de Janeiro, Brazil. The patients were assigned to receive naturalistic treatment (undefined, but apparently this refers to talk therapy) in the institute’s outpatient clinic, along with medications. DSM-IV criteria were used to identify schizobipolar, schizophrenia, or bipolar I patients on their first visit to the institute. After at least five years of treatment, 173 patients (61 schizobipolar, 57 bipolar I, and 55 schizophrenic) were selected to participate in the study from among 329 total patients. The Structured Clinical
Interview was applied by an independent clinician, along with reviews of each patient’s hospital file, an interview with each patient, and an interview with a first-degree relative.

Age and gender demographics were similar among the groups. There was no difference among the three groups in family history of suicide. Education, marital status, and occupation for schizobipolar and bipolar I patients differed significantly from schizophrenia patients, i.e. schizophrenia patients had, on average, achieved a lower level of education, a lower marriage rate, and a lower employment rate. The schizophrenia patients also differed significantly from the schizobipolar and bipolar I patients in the areas of drug and alcohol abuse episodes, depressive episodes, manic episodes, mixed episodes, use of antidepressants, and use of mood stabilizers, whereas the schizobipolar and bipolar I patients had an equivalent pattern. The family histories of schizophrenia patients showed a higher incidence of schizophrenia. The family histories of schizobipolar and bipolar I patients showed a higher incidence of mood disorders. Family histories of schizobipolar and bipolar I patients had corresponding diagnoses of mood disorder, depressive episode, and bipolar I.

Perhaps the most interesting result of the study was that for the five-year period studied, the initial diagnosis of schizobipolar disorder was changed to bipolar I disorder in 60.6% of the initially diagnosed schizobipolar patients. Initially diagnosed schizophrenia and bipolar I patients had their diagnoses changed much less frequently – 21.8% and 5.3%, respectively.

The study concludes that schizobipolar disorder can be considered a severe subgroup of mood disorder. The data support the original hypothesis that schizobipolar disorder is more appropriately included in the bipolar spectrum group.
The hypothesis of another 2005 article (Stip et al., 2005) was that schizophrenia could be differentiated from schizoaffective disorder on the basis of neurocognitive function over time, i.e. schizoaffective disorder patients would perform better.

The small sample used for this study consisted of 57 subjects (40 male, 17 female) with a mean age of 34 and an age range of 19 – 65. All were diagnosed with either schizophrenia or schizoaffective disorder according to DSM-IV. While the authors of the Stip et al. 2005 article are from a Canadian psychiatric hospital, it can only be presumed that the patients were also Canadian since this factor is omitted from the article. Diagnoses were verified by using the Positive and Negative Syndrome Scale (PANSS) and the Structured Clinical Interview for SDM-IV Axis II disorders (SCID-II). All were taking part in a group rehabilitation program. There were no differences in the groups insofar as symptom severity. Most of the subjects were under antipsychotic medication. Since the diagnosis of schizoaffective disorder changes over time, diagnostic assessments were made four times (baseline, 8 months, 15 months, and 19 months), again using the PANSS and SCID-II. Neurocognitive function was assessed using four tasks (Motor Screening, Reaction Time, Paired Associates Learning, and Stockings of Cambridge) from the computerized CANTAB cognitive battery.

The study concludes that it has demonstrated there are differences over time in cognitive performance between schizoaffective disorder patients and schizophrenia patients, with schizoaffective disorder patients performing better. Although this is a very small sample size, the article nevertheless indicates that neurocognitive batteries of tests may be relevant for differentiating schizophrenia patients from schizoaffective disorder patients. The performance of schizoaffective disorder patients also suggests a better prognosis due to their ability to participate in rehabilitation programs. Schizoaffective disorder patients may also, therefore, have a better
chance to socially integrate and succeed in daily living. The authors acknowledge the very small sample size as a limitation and confounding variable. The authors also suggest that using multiple tests, with verbal and non-verbal responses, would be beneficial. However, the authors are not clear what is meant by multiple tests. That is, are multiple tests 1) tests other than those used in the authors’ study, 2) the same tests, but administered more times, 3) both 1) and 2), or 4) something else.

A 2006 article (Vollmer-Larsen et al., 2006) presents the results of a study about the reliability of the clinical diagnostic use of the schizoaffective disorder category in two separate hospitals. The study examined the extent to which the schizoaffective disorder diagnosis met the operational criteria of ICD-10 and DSM-IV-TR. The authors’ bias or tendency, whether developed pre- or post-study, is reflected in their statement that the progression of the schizoaffective designation has developed from a very broad concept to the current “convoluted” criteria contained in both DSM-IV-TR and ICD-10. The ICD-10 is required in Denmark, the location of the study.

Using the data bases from two Copenhagen University Hospitals serving most of the Copenhagen area, 59 patients were identified in 2002 as having been discharged with diagnoses of schizoaffective disorder, lifetime or episode. Diagnoses had been made by the senior clinicians at the hospitals.

The two authors of the 2006 article read and rated all relevant chart material for the 59 patients. The raters prepared lifetime narrative illness summaries for the patients, and independently developed diagnoses. Where there was disagreement, additional review was done and consensus diagnoses were assigned. In addition, the Operational Criteria (OPCRIT) checklist generated computerized diagnoses. Demographic data was developed for the patients.
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at each hospital, and these data were compared between the two hospitals to see if the schizoaffective disorder diagnosis had been given to the same types of patients.

There were no significant demographic differences between the two hospitals. However, only 6 of the 59 patients were re-rated with diagnoses of schizoaffective disorder, lifetime, according to ICD-10. No re-rated patients were diagnosed with schizoaffective disorder, lifetime, according to DSM-IV-TR. Furthermore, of 543 single discharges of the 59 patients with a diagnosis of schizoaffective disorder, the 59 patients were re-rated with schizoaffective disorder 19 times (ICD-10) and two times (DSM-IV-TR), respectively.

The 53 patients who were not re-rated with schizoaffective disorder were so rated because:

- Affective and schizophrenic symptoms did not occur at the same time (6)
- Lifetime diagnoses of affective disorder (6)
- Criteria for schizophrenia were fulfilled (22)
- Criterion B. of schizoaffective disorder were not met (21)
- Other (11)

The computerized OPCRIT results agreed with the re-raters diagnoses on 39 of the 59 lifetime assessments. OPCRIT diagnosed 13 patients with other psychoses, with three of these being schizoaffective disorder. Four of the 39 concordantly-diagnosed patients were diagnosed with schizoaffective disorder by the re-raters, with only one patient identically diagnosed with schizoaffective disorder. OPCRIT was unable to make a diagnosis for three patients.

Making a diagnosis of schizoaffective disorder in a clinical setting is not easy. The study indicates that diagnosticians, in the psychiatric university setting, nearly always used the schizoaffective disorder diagnosis incorrectly. Based on the results of this study and the study’s
demonstrated lack of validity of the current schizoaffective disorder concept, the authors recommend a moratorium on the use of the schizoaffective disorder diagnosis.

Current Thinking. Current thinking is, to a large extent, reflected by the articles summarized above. However, while the articles used for this literature review express a great deal of frustration and difficulty with the DSM-IV-TR diagnostic criteria for schizoaffective disorder, there is likely a silent majority which more readily embraces the DSM-IV-TR diagnostic criteria. Otherwise, why would schizoaffective disorder diagnostic criteria have been created and included in DSM-IV-TR. However, in the process of identifying potential articles and scanning them for relevance, only one letter to the editor (Marneros, 2007) expressed a supportive stance by critiquing an earlier editorial (Maier, 2006) that was unfavorable regarding the schizoaffective disorder diagnosis.

DSM-IV-TR criteria for schizoaffective disorder are a fact and are apparently readily used. While the diagnostic criteria are difficult to apply, this diagnostic category does at least allow a more specific way to say, “Not quite schizophrenia” or “Not quite mood/affective disorder”. The schizoaffective disorder diagnosis becomes a catch-all for “cases in-between”.

Conclusions. This brief literature review reflects the broad, complex, and dynamic nature of DSM-IV-TR schizoaffective disorder diagnosis.

Schizoaffective disorder appears to be viewed by most diagnosticians as a middle ground diagnosis, occupying a large portion of the continuum between schizophrenia and mood disorders. However, it is far from a clear diagnostic area since schizoaffective disorder may be concurrent (simultaneously exhibiting symptoms of both schizophrenia and mood disorders) or sequential (exhibiting symptoms of schizophrenia, which then changes to symptoms of mood
diagnosis). Based on the literature reviewed, if schizoaffective disorder is not a middle-ground diagnosis, it appears to be closer to a sub-type of mood disorder than to schizophrenia.

Having a schizoaffective disorder diagnostic category is certainly a convenience. The schizoaffective diagnosis allows diagnosticians additional latitude, i.e. to be more cautious about diagnosing schizophrenia and to not diagnostically understate by choosing a mood disorder. The complex diagnostic criteria logically support this, as well as the apparent change of schizoaffective disorder diagnoses over time to either schizophrenia or a mood disorder.

The studies themselves are very difficult to evaluate since none of them are identical, or even close to identical. Each one, while using some of the same testing protocols, seems to make some adjustment or adjustments to the tests to accomplish some unexplained but important objective of the researcher. Each researcher customizes the research program in some way, and thereby makes replication impossible. It almost seems that each researcher has some underlying belief about schizoaffective disorder that the research program is constructed to support. It would have been more helpful if the authors had explained why the adjustments were made.

While not a focus of this literature review, it was noted that a number of articles indicated the schizoaffective disorder diagnosis had great importance in order to allow development of a more effective treatment plan. However, while this was stated or alluded to by several authors, little was specifically stated about what the different treatment plans should include and how they differed from treatment plans for schizophrenia or mood disorder.

Perhaps the clearest diagnostic imperative is that knowing the patient’s history and course of disorder are essential to accurately identifying schizoaffective disorder. There seems to be quite strong evidence that the DSM-IV-TR operational criteria, by themselves, are too broad and often misused in a short-term clinical setting. Diagnosticians seem to use the schizoaffective
disorder category almost as a holding pattern, i.e. to more scientifically say, “I’m not sure” until sufficient observation pushes the diagnosis to either schizophrenia or mood disorder.

All of the articles reviewed were intent on fine-tuning the schizoaffective disorder diagnostic criteria to thereby result in a higher confidence level of diagnosis. While this would seem to be an admirable goal, it is probably not practical given the broad and dynamic nature of cases-in-between.

The most important thing learned from this literature review is that, insofar as schizoaffective disorder diagnosis is concerned, the diagnostic “process” is probably more important than arriving at an exact diagnosis. The diagnostic process for schizoaffective disorder makes it clear that lack of clarity and the symptom changes are the rule rather than the exception. The schizoaffective diagnosis category does seem to force a more careful diagnosis, however, which can result in a more intentional and customized treatment plan. The process also highlights the need to change the treatment plan when symptoms change. The schizoaffective disorder treatment plan must be as quick to change and as dynamic as the disorder. Based on the literature reviewed, it is not clear that treatment plans are actually as dynamic as the disorder itself.

The most interesting future research would be a more exacting comparison of treatment plans for schizophrenia, schizoaffective disorder, and mood disorder. While the literature reviewed provided substantial rhetoric about creating treatment plans customized to the disorder, it would be beneficial to know more about what is actually done with treatment plans when schizoaffective disorder is in the mix. Also, it is not clear whether the apparent substantial changes in symptoms over time are the result of the natural course of the disorder or whether the changes are a result of the different types of treatment applied over the same period of time.
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