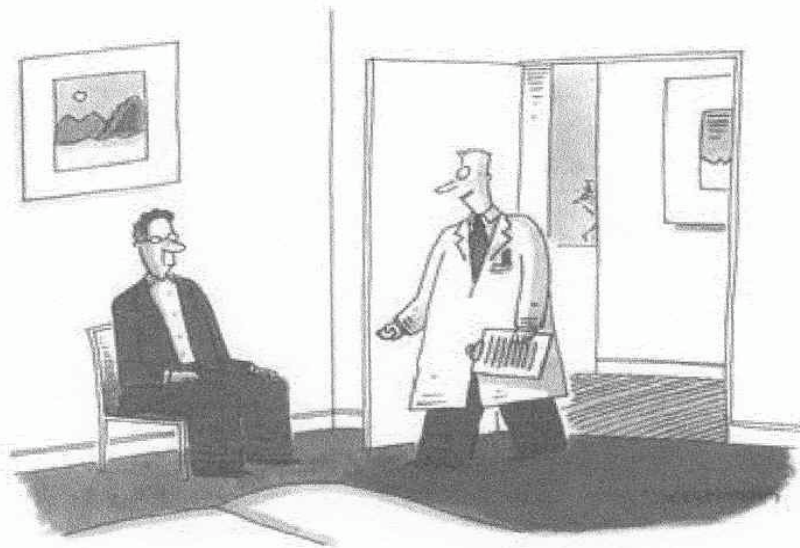


Schizoaffective Disorder: Confusion in Psychiatric Diagnosis Reaches New Heights

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While it's true that American psychiatrists can't seem to reliably diagnose *any* major mental disorders, no other illness demonstrates our muddled approach to diagnosis better than Schizoaffective disorder.

It's becoming increasingly rare to find a person with a severe mental illness who hasn't been labeled "Schizoaffective" at some point in their relationship with the psychiatric profession. Once made the diagnosis tends to follow people throughout their careers as psychiatric patients. So at the rate that things are going there will come a time, perhaps around the year 2014, that *every* patient in our public mental health system will carry the diagnosis of "Schizoaffective Disorder". At least that should make the process of diagnosing people easier.



"Hi! My name is Kevin, and I'll be your doctor today."

As our relationships with our patients have become increasingly superficial and oriented towards brief visits for "medication management" the forces pushing us towards this diagnosis have become extremely compelling. Many of these forces are outlined in the chapter on "**Problems with Psychiatric Diagnosis**" but the reasons that they converge to favor this Schizoaffective diagnosis are very interesting. Our tendency to let all of our patients eventually fall into this diagnostic box has far-reaching implications.

The diagnosis of Schizoaffective Disorder almost always leads to an array of medications that have rarely, if ever, been studied together. Medication regimens of five drugs or more - sometimes even into the teens - are becoming increasingly common. It often becomes difficult to tell if a drug is actually adding any benefit or whether it might even be causing harm. And the diagnosis is so overused these days that some cynics are beginning to wonder if this is even a discrete disorder at all. So what is a person to do when they're told that they, a loved one, or a client have now been diagnosed with Schizoaffective Disorder?

How is the Schizoaffective Diagnosis intended to be used?

If the diagnosis of any illness is to have practical utility we need to expect certain things from it. If we put a person into a diagnostic box we should be able to show that they will have a lot of things in common with the other people that are in the same box.

We expect that our diagnostic labels for the mental illnesses should have some predictive power. They should inform us about what life might be like for the person that has the disorder. What sorts of symptoms are likely to be present? How will it affect the capacities for work and forming loving relationships? Will the disease run a progressive, downhill course or will the person get better over time? Will it run in the family? And, of course, we'd like to see that a diagnosis leads to specific treatment approaches for the particular disorder. It is pretty easy to argue that the Schizoaffective Disorder diagnosis comes up short of each of these expectations.

Schizoaffective Disorder does seem to be a specific illness for some people - a combination of features of schizophrenia and a prominent overlay of depression, mania, or both. But in actual practice, the diagnosis gets used in all sorts of situations, and for all sorts of reasons.

The American Psychiatric Association's current diagnostic manual, the "DSM- IV-TR", lists specific requirements for the diagnosis of Schizoaffective Disorder. In order to use this label *all* of the following conditions must be met:

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 criteria A for Schizophrenia.

(The "A" criteria for Schizophrenia require that people have at least two of Five symptoms - delusions, hallucinations, disordered thinking or behavior, "catatonic symptoms", or "negative symptoms" for at least one month.)

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

C. Symptoms that meet criteria for a mood episode are present for a substantial period 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 Mixed Episode (or a Manic or a Mixed Episode and Major Depressive Episodes)*

Depressive Type: *if the disturbance includes only Major Depressive Episodes*

Like many of our criteria for diagnosing psychiatric disorders, this approach can be a little confusing to the uninitiated and all of the ramifications may not be immediately obvious.

The basic idea is that a person with Schizoaffective Disorder has a continuous illness (Schizophrenia) upon which are superimposed discrete periods of mania or depression. The mood symptoms have to be present for a "substantial period" of the illness. The mood symptoms cannot be secondary to drugs of abuse, medications, or physical illness.

And the person has to have "at least" a 2 week period of psychotic symptoms when they aren't manic or depressed - thus demonstrating that their delusions or hallucinations are not a result of mania or depression.

These criteria are an improvement on those found in previous versions of the Diagnostic Manuals but it's easy to see where problems might arise.

There is the usual important emphasis on the longitudinal course of the illness - how the illness has behaved since the person first became ill. That sort of information is often difficult to come by and even when available it takes time to sift through. So saying with certainty that a person's illness has been "uninterrupted" can be difficult.

At a minimum, the psychiatrist should know how old the person was when they became ill, whether they ever regained their previous level of functioning, what symptoms have been present and for how long, and whether the symptoms come and go or have been constant. But psychiatrists, because of our limited time, generally focus on what symptoms or problems are present *today*. No psychiatrist can reliably make a diagnosis of Schizoaffective Disorder based on the symptoms that are present at the time of one office visit or psychiatric hospitalization. That would be inconsistent with the way we're supposed to make the diagnosis.

The requirement about having psychotic symptoms for at least two weeks in the absence of a mood disorder makes a lot of sense, but that information is often hard to get at too. If the patient currently has depression or mania that is likely to color their recollections of

their entire life, making objective assessment of the relationship between mood and psychosis very difficult. And people that have been psychotic can have enormous difficulty recalling specific events that took place in the midst of their psychosis, much less whether they also had manic or depressive symptoms during any given two week period. They may try to provide answers to questions about this on the rare occasions that we even ask, but for many it's like trying to dig up the minute details of a distant dream.

Similarly, determining whether mood symptoms have been present for a "substantial period" of their illness can be difficult.

Depressed people are often not able to recall a time when they were not depressed. People with mania frequently deny that there is anything wrong at all. And no guidelines are given for deciding what a "substantial period" is. If a person has suffered from schizophrenia for thirty years and depression has been a problem for twenty of them everyone is likely to call that "substantial". But what if they've had schizophrenia for thirty years but have only been depressed for the last four months? Most of us wouldn't call that "substantial" relative to the course of illness but the schizoaffective label is likely to be applied in that situation nonetheless.

So without getting into even more mind-numbing details, it should be apparent that these criteria may make perfect sense in a world where psychiatrists have ready access to each piece of clinical information that they need to make a diagnosis, as well as the time to synthesize it properly. But when it comes to the real world of office or hospital practice this approach breaks down in short order.

The psychiatrist almost never has the required information so we're essentially put in a position of guessing whether Schizoaffective Disorder is truly what the person has. And once one of us has attached that label it follows the person around indefinitely. The next provider that treats the patient sees the Schizoaffective diagnosis and they don't have access to the necessary information or the time to sort it out either. So they just write down "Schizoaffective Disorder" on the line asking for a diagnosis without giving it a lot of thought.

Are more reasons for confusion really necessary?

Perhaps the biggest culprit in the whole mess around the diagnosis of Schizoaffective Disorder is, ironically, a prior version of our Diagnostic Manual - "The DSM III". This was the first of the American Psychiatric Association's diagnostic manuals to emphasize specific, reproducible diagnostic criteria. But Schizoaffective Disorder was handled differently in that manual than any of the other illnesses. In fact it was the only disorder in the whole book that didn't have its own criteria for diagnosis.

According to DSM III, Schizoaffective Disorder was a diagnosis *"for those instances in which the clinician is unable to make a differential diagnosis with any certainty between Affective Disorder... and Schizophrenia"*.

So there were no other specific criteria to be met for Schizoaffective Disorder except that the psychiatrist couldn't be sure whether the person suffered from schizophrenia or a mood disorder.

Of course those situations crop up for psychiatrists all the time, for a variety of reasons.

This diagnostic approach, where you could use Schizoaffective Disorder whenever you were uncertain about what the person actually had, was so wonderful for psychiatrists that a lot of us have never abandoned that older way of using Schizoaffective Disorder.

So in practice today, many people getting that diagnosis are still getting a label that actually means that the psychiatrist just doesn't know what they really suffer from.

Common situations in which Schizoaffective Disorder is misdiagnosed

Those of us who regularly review the work of other psychiatrists can quickly point to all sorts of situations where the Schizoaffective label is wrongly applied. Of course these errors are much more apparent in the work of others than in our own...

Some patients who receive the diagnosis have plain old schizophrenia and happen to have a relatively time-limited depression or manic episode that does not actually qualify for a Schizoaffective disorder diagnosis. Depression is extremely common in schizophrenia, for a host of reasons. Fully two-thirds of people with schizophrenia have at least one serious depressive episode in their life. Depressive symptoms are also among the most common signs of relapse in schizophrenia. And a surprising number have fairly typical manic episodes too, sometimes as a part of their illness and sometimes as a result of medications that we give them.

The key point here is that for someone with schizophrenia, having a manic or depressive episode does *not* mean that they now have Schizoaffective Disorder. All of those other criteria must still be met.

Some "Schizoaffective" patients will have schizophrenia with prominent negative symptoms that the psychiatrist misreads as depression.

A portion of people diagnosed with Schizoaffective disorder will actually have Bipolar Disorder and the extent and duration of the psychotic symptoms will be overemphasized. When people are in psychotic episodes they are not great historians. And Doctors can have a hard time picturing a time when the person was not psychotic. So confusion is, again, inevitable.

Some people develop a clinical picture of episodic psychosis, mania, and depression as a result of prolonged stimulant abuse. Crack cocaine and methamphetamine are common offenders. Many of these clients are relatively low functioning to begin with and when they end up in various treatment settings psychiatrists have no way of really knowing if these people would ever have had any severe psychiatric symptoms in the absence of the

substance abuse.

Because our society now demands that the clients have a diagnosis of mental illness if they are to get disability benefits, they have to say "yes" to the necessary questions about a mental illness history. So the psychiatrist is faced with drug-abusing people that clearly have some significant problems with both moods and psychosis, can't seem to take care of themselves adequately, and there is no way to provide a definitive diagnosis for them. But a major mental illness diagnosis is required or the person will likely end up homeless and deprived of benefits. This is an increasingly common situation in our hospitals and offices. Maybe we can be forgiven if we throw up our hands and, in the best tradition of DSM III, just say "Schizoaffective".

Patients with severe Borderline Personality Disorder sometimes have transient psychotic symptoms superimposed on chronic problems with mood regulation. They, too, are often put in a position where they must exaggerate the extent of their psychotic symptoms if they are to gain access to the hospitals and other supportive settings in which they feel safe. Many of these people are eventually diagnosed with Schizoaffective disorder.

Some patients with severe Obsessive Compulsive Disorder will have ongoing problems with depression and have obsessive ideas that are hard to distinguish from delusions. Occasionally they receive a Schizoaffective diagnosis too.

There are some psychiatrists that simply use the Schizoaffective disorder label for just about any severe mental illness that they encounter. It seems that the idea is that since they can't really determine whether a person has schizophrenia or a mood disorder, if they diagnose Schizoaffective disorder they will be at least half right (or can't be more than half wrong).



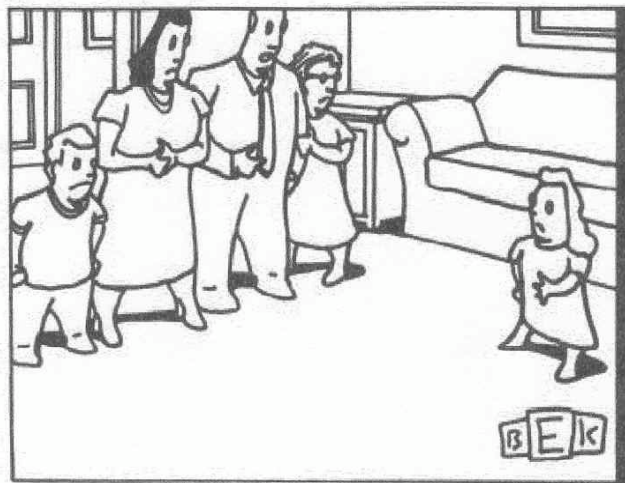
"While it's not a cure, it does mean a guaranteed income for me."

Sometimes the Schizoaffective diagnosis is used essentially to justify the fact that the patient is being prescribed a combination of antipsychotic drugs, mood stabilizers, and antidepressants.

A more ominous possibility is that some patients suffering from conditions in which psychotic symptoms would ordinarily be temporary become psychotic whenever antipsychotic medications are quickly withdrawn. So the psychiatrist naturally assumes that the person has a chronic psychotic condition.

As we have discussed elsewhere, the possibility exists that some of these patients experience psychotic symptoms because of the way their brain has changed in response to the antipsychotic medicines. Abrupt withdrawal of antipsychotics may predispose them to psychosis and perpetuate the idea that they will always be psychotic if they don't have antipsychotic medicines on board. They may have originally been diagnosed with Bipolar illness or severe depression with psychotic symptoms but when they are seen as requiring antipsychotics indefinitely their diagnosis shifts to Schizoaffective Disorder.

Does Schizoaffective Disorder run in families?



"Bad news—we're all out of our minds. You're going to have to be the lone healthy person in this family."

The idea that there are two types of Schizoaffective Disorder comes from some research that took place back in the 1980's. The general finding was that people with the Bipolar type of Schizoaffective Disorder had more Bipolar illness in their families while the people with depressed type had more straight forward schizophrenia in their families.

The family studies are certainly a good way to understand a complicated disorder like Schizoaffective illness but the approach has its limitations. It's hard to find a large enough sample of people with classic, unquestioned Schizoaffective disorder to study. It also turns out that people with Schizoaffective Disorder have an increased incidence of schizophrenia in their families. But they also have more affective illness in their families too, both depression and bipolar illness.

People with strong family histories of mood disorders may have more schizophrenia in their families relative to the general population too. So, if anything, the family studies seem to support the idea that Schizoaffective Disorder may be part of a *spectrum* of problems that can be inherited.

One factor that isn't so intuitively obvious is that if these major mental disorders do exist on a spectrum, with schizophrenia representing the most severely ill people on the spectrum, one would expect that the people with schizophrenia would have an increased incidence of *all* of the less severe problems on the spectrum too. Another way to put this is, since people with schizophrenia have global problems with brain functioning it would be unrealistic to expect that the parts of the brain involved with mood regulation would work normally.

What are the implications of a misdiagnosis of Schizoaffective Disorder?

One might justifiably ask “what difference does a label make for severely mentally ill people if they're all going to get the same mixture of antipsychotics, antidepressants, mood stabilizers, tranquilizers, and side effect medications anyway?” Just the sort of question that we psychiatrists don't like to hear. Specific diagnoses should ideally lead to specific treatments but this is clearly not the case in modern psychiatry. And there is still that small matter of the principle that is supposed to guide physicians in all that we do: “First do no harm”.

None of these groups of medications that we routinely give to people diagnosed as Schizoaffective is without its problems and side effects. Antidepressants can lead to manic symptoms or even increase psychotic symptoms in some individuals. Mood stabilizers can cause mental sluggishness, weight gain, and a host of other problems. Antipsychotic medications can cause sedation, neurological problems, weight gain, and increase the likelihood of diabetes. None of these medications are pills that a person would want to take unless it was absolutely necessary. And the costs of these medication regimens can be truly staggering. So giving someone a diagnosis that nearly always leads to taking a dizzying collection of medications has enormous implications.

We also shouldn't overlook the fact that people who are given these combinations of medications based on the mistaken diagnosis of Schizoaffective Disorder are also deprived of the slim chance that they'd receive specific treatment for the disease that they actually *do* have. If that disease is Major Depression, for example, they might be best treated with a combination of psychotherapy, exercise, lifestyle changes, and periods of

time in which they take modest doses of a single antidepressant. People with true Bipolar Disorder may do well with a single mood stabilizer, omega III fatty acids, therapy, and rigorous attention to their sleep patterns. For some people prolonged abstinence from stimulant drugs will be an essential part of any psychiatric stability. The list goes on. But as soon as people get that Schizoaffective label it is likely to cut them off from simple approaches like this. And that label is really sticky.

What can the individual do when they or someone that they care about is diagnosed with Schizoaffective Disorder?

Mistakes are usually easier to deal with if you catch them early. A new Schizoaffective Disorder diagnosis should prompt some of the 20 questions that were listed in the “**New models of psychiatrist-patient relationships**” chapter.

What symptoms led to the diagnosis? Was there adequate historical information available to support the diagnosis? What other information would have been helpful? What other diagnoses were considered? Reviewing the diagnostic criteria oneself or even using a computerized diagnostic program like that available at www.mentalhealth.com can help reduce diagnostic confusion. This is also a situation where getting a second opinion from another psychiatrist can be very helpful.

When treating a complex condition like Schizoaffective Disorder it is always easy to justify using a variety of medications from each of the available classes. But monotherapy -using one medication alone - is still a solid option for many people who truly have this disorder.

Clozaril and Zyprexa are antipsychotic medications that have a nice track record in Schizoaffective Disorder. They both can help to stabilize moods and may even help with reducing depression. Side effects of weight gain and diabetes are a problem for some people that take these medications. Some emerging data is suggesting that many of the newer antipsychotic medications have mood stabilizing and/or antidepressant properties too, so using them as single agents for Schizoaffective Disorder has potential as well.

The common sense rules for prescribing psychotropic medications, as listed in the “**Treating Mental Illnesses with Medications**” section, are especially important in the treatment of Schizoaffective Disorder. Both psychiatrist and patient should have a clear idea of what any proposed medication is intended to help with. The length of an adequate medication trial, and ways to tell if medicines are helping, should be agreed upon beforehand. Changes or additions should be performed gradually, with ample time to determine the result of each change before making another. Medications that aren’t offering clear benefits should be tapered off under appropriate supervision.

It’s clearly in the best interests of the psychiatric profession itself for us to take the issues embodied in the diagnosis and treatment of Schizoaffective Disorder very seriously.

Using a catch-all diagnosis for so many severely ill people and treating them all with idiosyncratic and experimental combinations of medications has harmed our already sagging reputations with other mental health providers, as well as the general public.

Taking the sorts of shortcuts that we often do with Schizoaffective Disorder may be easy and quick for the busy practitioner but it would be hard to argue that this is in the best interests of our patients. If our diagnostic labels do not fit the clinical situations in which we must use them - or if they don't provide good information about matters like course of illness and treatment response - perhaps we should rethink them.