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Schizoaffective disorder: Time to refine our thinking not the criteria?

Gin S. Malhi *, Erica Bell

Discipline of Psychiatry, Northern Clinical School, University of Sydney, Sydney, NSW, Australia
Department of Academic Psychiatry, Northern Sydney Local Health District, St Leonards, NSW, Australia
CADE Clinic, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, NSW, Australia

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Peterson et al. (2019) have to be applauded, not only for their valiant efforts to test the diagnostic accuracy of the new ICD-11 criteria for schizoaffective disorder (SAD), but also, for taking an interest in this issue. Their approach of comparing the diagnostic abilities of clinicians from around the world using case vignettes is methodologically sound and makes their study clinically relevant, but their findings are unsurprising, and sadly are unlikely to produce any significant change. Hence why perhaps they themselves conclude, *"that further research is needed"*.

Their study showed that by making the guidelines more explicit and providing specific information regarding differential diagnosis, ICD-11 improved upon ICD-10 in terms of diagnostic accuracy, but only marginally, and such a modest improvement is unlikely to increase the diagnostic reliability of SAD in clinical practice. The authors furnish us with several plausible reasons as to why clinicians found the task of making an accurate diagnosis difficult. For example, they point to the possibility of *"diagnostic overshadowing"* – where for instance, psychotic symptoms are accorded greater salience as compared to those pertaining to mood, and *"confirmatory bias"* where clinicians begin to formulate a diagnosis prematurely and, as a consequence, disregard symptoms that subsequently come to light.

These explanations probably apply to some extent. But the authors fail to address the fundamental problem with diagnosing SAD, which, put simply, is that schizoaffective disorder is a total fabrication. In this regard SAD is not unique amongst psychiatric syndromes, many of which have been reified as disease equivalents by repeatedly being referred to as disorders, which have then over time graduated to the status of specific illnesses. However, this is not the only level at which SAD is fictive. It's certainly not a disease and not a disorder, but even as a syndrome SAD is extremely problematic. The authors subtly hint at these issues when they say, *"the concept of SAD itself may be problematic"*, but don't expand upon this any further, and instead conclude "*the concept (referring to SAD) itself warrants re-examination*".

The diagnosis of SAD is indeed problematic. In practice it does not inform prognosis or treatment and is often simply used to avoid making a diagnosis of schizophrenia. And whilst the term SAD clearly contains two main phenomenological components (psychosis and mood), the term totally fails to capture the true complexity that occurs at the intersection of these domains (Malhi and Bell, 2019).

Comparing ICD and DSM and considering the evolution of the definition of SAD it is evident that the differences in these taxonomies and their reasons for change cannot be fully explained. For example, in ICD-10, the diagnosis of SAD could entail either sub-threshold clinical symptoms of both schizophrenia and a mood episode, *or* both schizophrenia and mood episode symptoms if they had developed together (World Health Organization, 1992). Peterson et al. (2019) suggest that in order to "resolve such ambiguities and inconsistencies", the ICD-11 SAD criteria now stipulate that *all* the requirements of schizophrenia and a mood episode be met. But this profound reconceptualization of SAD from a disorder that may or may not entail full schizophrenia symptomatology, to one that must do so *always*, has not come about as a consequence of deep understanding but rather, is a reaction to its poor reliability in clinical populations. In other words, the modification is arbitrary.

Critically, this change in the ICD diagnostic criteria for SAD increases *both* the likelihood of diagnostic overshadowing by psychotic symptoms and the perception of mood symptoms as less significant. Peterson and colleagues suggest that confusion surrounds SAD diagnosis partly because, *"psychotic disorders appear to exist upon a continuum of symptom severity"*. But this view is still an open question, as the evidence remains inconclusive as to which model, if any, of the many that have been posited to date, best explains the clinical admixture of psychosis and mood. What is clear however, is that by emphasising psychotic symptoms within the diagnosis itself, the treatment of SAD is skewed towards schizophrenia. Furthermore, diagnostic distortion such as this does not improve upon previous classificatory criteria, and nor does it inform future research into the underlying mechanisms of clinical presentations.

* Corresponding author at: CADE Clinic Level 3, Main Hospital Building, Royal North Shore Hospital, NSW 2065, Australia.
E-mail address: gin.malhi@sydney.edu.au (G.S. Malhi).

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Notably, the ICD-11 criteria state that although the mood episode and schizophrenia symptoms must co-occur for 4 weeks, the onset of psychotic and mood symptoms may happen simultaneously or *"within a few days"* of each other. This is remarkably imprecise and needlessly so, even for ICD criteria, and such inexact guidance is of little use to clinicians trying to distinguish mood disorders with psychotic symptoms from schizophrenia with co-occurring mood symptoms. Such obvious definitional ambiguity perhaps reflects a broader unwillingness within the field, to engage the much needed but much more demanding task of reconceptualising mood and psychotic disorders.

In order to clinically differentiate psychosis from mood it is useful to know the order in which these sets of symptoms emerge. For this a longitudinal approach to mapping the symptoms is best and is what DSM advocates (American Psychiatric Association, 2013). In contrast, ICD favours cross-sectional appraisal as it regards having to recall reports to be unreliable. But again, the bigger problem is not how a diagnosis of SAD is made, but that it is made at all. Therefore, rather than examining differences in diagnostic reliability and accuracy which result in "modest" improvements upon criteria that have remained unchanged for 27 years, perhaps the focus should shift to examining the differences these changes make to the treatment of the illness.

In sum, although the authors did not go as far as to "consider deleting schizoaffective disorder at this time", the scant improvements in reliability and validity that have been made in light of exhaustive research should give pause for thought. The dearth of evidence to support SAD as a distinct diagnostic entity provide no justification for the continuation of the use of the diagnosis and should be reason enough to revise the taxonomy. A taxonomy that does not reflect current evidence or inform management is redundant and is no longer fit for purpose; namely, to ensure the best outcomes for patients.

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