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Transdiagnostic conceptualization: Giving psychosis and mood a personality

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1. It's not all negative?

As delved into incisively by Moritz and colleagues, the current lexicon within psychiatry is in desperate need of refinement (Moritz et al., 2019). This is revealed by their discussion of the term 'negative', which is used to describe specific schizophrenia symptomatology such as flattened affect, avolition and poverty of speech. The authors note that *"in the context of schizophrenia, depressive symptoms usually mean productive features such as depressive mood, feelings of worthlessness, feelings of guilt and suicidality"*, but that other typical features of depression such as social withdrawal and lack of drive are described as 'negative' symptoms of schizophrenia. In effect, the descriptor 'negative' is used to disassociate and distance these symptoms of schizophrenia from those of depression even though there is little to distinguish them in theory; and in practice there is an obvious overlap if not complete synonymity. This is because this distinction in classification and clinical use of symptoms is not based upon recent empirical evidence, but instead is derived from theories first developed in the 19th century that persuaded researchers to overlook the similarity between symptoms of schizophrenia and depression and regard the disorders as separate entities with divergent illness courses (Kraepelin, 1899). However, their phenomenological similarities remain conspicuous, and should not be ignored – not only for reasons of taxonomic correctness, but because these commonalities in symptoms may hold important clues that point to the mechanisms underpinning these disorders.

2. Schizoaffective disorder

The arbitrariness of the manner in which 'negative' symptoms of schizophrenia and these 'same symptoms' in the context of depression are assigned taxonomic significance, is not only evident within the diagnostic criteria for schizophrenia, but is also apparent within the classificatory criteria for the contentious diagnosis of schizoaffective disorder (SAD) (Malhi and Bell, 2019a). In general, this disorder is conceptualised as a co-occurrence of both psychotic and mood symptoms. But, the diagnostic criteria do not fit the empirical evidence, nor the clinical observations of mixed mood and psychotic presentations, and are unnecessarily convoluted and impractical to implement (Malhi and Bell, 2019b). It is within these criteria for SAD that DSM-5 stipulates that *"because loss of interest or pleasure is common in schizophrenia"* if the mood episode experienced is depressive in nature, it must include the major depressive episode criterion A1 of depressed mood (American Psychiatric Association, 2013). Consequently, depression in the context of schizophrenia is classified fundamentally differently. Admittedly the difference is subtle and based on logic, but it nevertheless means that there is a nuanced variance in definition. In practice, this is often forgotten, but the distinction is important because it may have both clinical and research significance – for example, for disentangling and defining the complex intersection of mood and psychosis (Keshavan et al., 2011). It also means the threshold for diagnosing depression in the context of psychotic symptoms is higher than that used to diagnose depression routinely, and as mentioned above, this threshold is already raised as it is dependent more so on the productive symptoms of depression.

In sum, at the very least, it suggests that the presence of depression in schizophrenia is underestimated both in severity and prevalence and that the manifestations of depression that are detected and recognised as such, are necessarily different to those of straight forward major depressive disorder.

3. Adding psychosis to the ACE model and giving it some personality

Akin to psychosis in psychotic disorders, another domain in which the current taxonomy is in urgent need of revision is that of mood and

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its associated principal disorders, namely major depressive disorder and bipolar disorder. The current conceptualisation of mood disorders as a continuum of symptoms polarising into mania and/or depression, which then form opposite ends of a single dimension of mood, is demonstrably inadequate (Vieta and Valentí, 2013). The shortcomings of this framework have been explored in depth – and prompted the development of the Activity Cognition and Emotion (ACE) model, which attempts to explicate the sophisticated manifestations of mood disorders, such as mixed states, that are frequently encountered clinically, but are unaccounted for in diagnostic taxonomies (Malhi et al., 2018). The ACE model provides an explanation for the symptom variability both within and between patients with mood disorders as variation in the combinations of symptoms from the activity, cognition and emotion domains.

Hence, because of the continuity of symptoms between schizophrenia and depression, which we have argued above, we suggest that these symptoms are best regarded as transdiagnostic, and as such the ACE model may be able to accommodate an additional psychosis domain to holistically capture the symptom presentations of both schizophrenia and mood disorders. This additional dimension would assist in explaining the presence of psychotic symptoms in mood disorders such as psychotic depression and mania, and the presence of mood episodes within psychotic disorders, such as 'schizoaffective disorder'. By positioning the ACE model as a dimension perpendicular to a dimension of psychosis, mood symptoms can be charted concurrently with psychosis symptoms. Within the mood domain, symptoms can be compartmentalised into those of activity, cognition and emotion to inform treatment of the mood symptoms as they present.

This proposed hybrid model of psychosis and mood symptoms, can be enriched further with the inclusion of a third dimension of personality dysfunction, (see Fig. 1), which would range from normalcy through to dysfunctional personality – capturing those personality traits that are exacerbated by various disorders including mood and psychotic illnesses. Neuroticism, extraversion and obsessionality are examples of features of one's personality which can be potentially advantageous in moderation and in certain contexts. However, at their extremes, these features become dysfunctional (Ohi et al., 2016). Conceptually, this dimension of personality dysfunction could be weighted on par with symptoms of psychosis and ACE, thus reducing the possibility of diagnostic overshadowing.

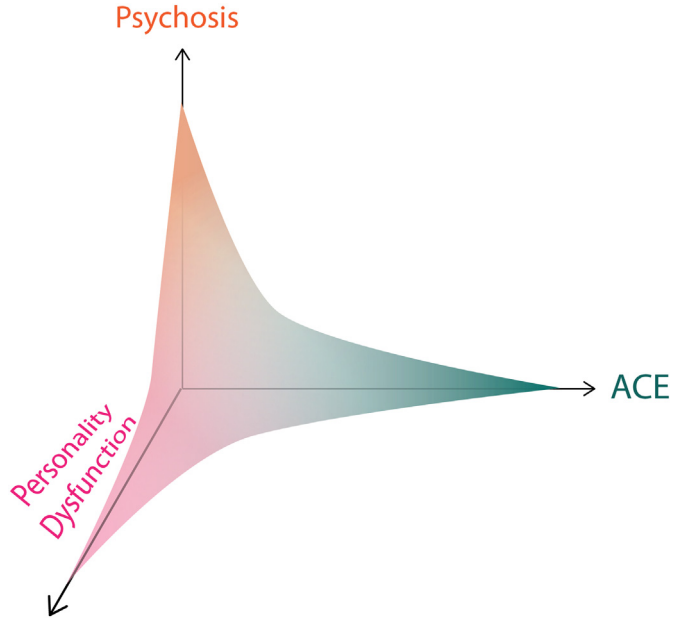

Fig. 1. Schematic of the composite dimensional model of psychotic and affective disorders. The ACE dimension consists of sub-dimensions of activity, cognition and emotion, with the ACE axis increasing with the severity of these symptoms. The psychosis and personality dysfunction axes increase with severity of respective symptoms.

4. Conclusion

Returning to the proposal by Moritz and colleagues, we echo the message that transdiagnostic measurement of negative symptoms and consistency in descriptive labels are necessary improvements, which can and should be implemented in psychiatry research and practice. Furthermore, we posit that in addition to addressing these inconsistencies, both psychotic and personality dysfunction symptoms should also be accommodated in order to facilitate the investigation and understanding of a broader scope of presentations.

If we are to truly re-conceptualise psychiatry, then it needs to be enacted ambitiously and comprehensively. By improving the consistency of the diagnostic lexicon and opening the possibility of symptoms being genuinely transdiagnostic, investigation of the mechanistic underpinnings of affective and psychotic disorders can be strengthened. And by utilising a multifaceted model, comprising psychosis, ACE and personality dysfunction, a more accurate and nuanced model of reality can be created and perhaps a deeper understanding can be achieved – one which then lends itself to meaningful advances in treatment.

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