Journal of Affective Disorders 172 (2015) 30–37

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

A comparison of schizophrenia, schizoaffective disorder, and bipolar disorder: Results from the Second Australian national psychosis survey

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ARTICLE INFO

Article history:
Received 26 June 2014
Received in revised form
18 September 2014
Accepted 21 September 2014
Available online 30 September 2014

Keywords:
Schizophrenia
Schizoaffective disorder
Bipolar disorder
Comparison
Phenomenology

ABSTRACT

Introduction: It remains uncertain whether schizoaffective disorder (SAD) is a discrete diagnostic entity, is a variant of either a psychotic mood disorder such as bipolar disorder (BDP) or schizophrenia (SCZ), or exists on a spectral continuum between these disorders. The present study examined whether SCZ, SAD, and BDP differed qualitatively on demographic and clinical variables based on a large Australian dataset.
Methods: This study examined data from the Australian Survey of High Impact Psychosis (SHIP), in which 1469 of the 1825 participants in who had an ICD-10 diagnosis of SCZ ($n=857$), SAD ($n=293$), and BDP ($n=319$) were assessed across a broad range of variables.
Results: When compared to patients with SCZ, those with SAD reported more current delusional and thought disorder symptoms, a greater number of lifetime depression, mania, and positive symptoms, and fewer negative symptoms. Relative to the BPD group, the SAD group were younger, endorsed more current positive, delusional, and thought disorder symptoms, fewer lifetime mania symptoms, more lifetime psychotic, hallucination, and delusional symptoms, and recorded lower premorbid IQ scores. Compared to patients with BPD, those with SCZ were significantly younger, endorsed more current psychotic and hallucination symptoms, fewer lifetime depression and mania symptoms, more lifetime psychotic, hallucination, and delusional symptoms, reported more negative symptoms and had lower premorbid IQ and psychosocial functioning scores.
Limitations: Validated psychometric measures of psychotic or mood symptoms were not used.
Conclusion: This pattern of results is consistent with the conceptualisation of a spectrum of disorders, ranging from BDP at one end, to SAD in the middle, and SCZ at the other end.
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1. Introduction

There is ongoing debate in the literature about whether schizoaffective disorder (SAD) is a distinct diagnostic entity, a variant of either schizophrenia (SCZ) or psychotic mood disorders or lies on a continuum between them (Cheniaux et al., 2008; Lake, 2012). The continuum model has been conceptualised as a spectrum of psychotic disorders with mood disorders, including bipolar disorder (BD) with psychotic features (BDP), at one pole and SCZ at the other pole with SAD in the middle (Kempf et al., 2005; Lake and Hurwitz, 2007).

Reports of substantial and overlapping heritability estimates for SCZ, SAD, and BD provide support for the continuum model (Cardno et al., 2002). Lichtenstein et al. (2009) found that first-degree relatives of persons with SCZ or BD were at increased risk of these two disorders. Valles et al. (2000) showed that relatives of probands with BD have an increased risk of SCZ, whereas relatives of probands with SCZ have an increased risk of BD. The authors concluded that psychosis may be a nonspecific indicator of illness severity that is not limited to schizophrenia.

Comparable results were reported in a meta-analysis by Van Snellenberg (2009), who found that relative to first-degree relatives

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http://dx.doi.org/10.1016/j.jad.2014.09.035
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of controls, the first-degree of probands with SCZ had significantly increased rates of BD, while the first-degree of probands with BD also showed a trend towards increase rates of SCZ. The researchers suggested that the findings supported a continuum model of psychosis rather than discrete diagnostic entities for SCZ and BD. This view is commensurate with that of Craddock and Owen (2010) who contended that there is substantial sharing of genetic susceptibility between BD and SCZ. Equally, there is research evidence that the environmental risk factors for these disorders (and for that matter many other neuropsychiatric disorders) overlap substantially, and that many biological pathways including oxidative stress, inflammation, neurogenesis and apoptosis are shared between them (Anderson and Maes, 2012; Berk et al., 2011; Moylan et al., 2012).

Neuropsychological, demographic, and clinical data has also been used to examine whether the three disorders differ qualitatively. The results from neurocognitive research are mixed (Cheniaux et al., 2008; Kempf et al., 2005). Some studies have found better neurocognitive function in SAD and BDP than in SCZ (Gruber et al., 2006; Heinrichs et al., 2008; Reichenberg et al., 2009), whereas others have not (Fiszdon et al., 2007; Smith et al., 2009). Furthermore, a recent meta-analysis reported no differences in neurocognitive functioning between SCZ and SAD, and SCZ and affective psychosis, including BDP and psychotic depression (Bora et al., 2009). Simonsen et al. (2011) found that relative to controls, those with SCZ, SAD, and BDP performed worse across several neurocognitive measures, although individuals with nonpsychotic BD were impaired only on a measure of processing speed. The SCZ, SAD, and BDP groups did not differ from each other, but performed poorer than the nonpsychotic BD group. In the bipolar disorder sample, a history of psychosis explained more of the neurocognitive variance than bipolar diagnostic subtype (i.e., bipolar I versus bipolar II). This suggests that a history of psychosis may be more influential in determining neurocognitive dysfunction in SCZ, SAD, BDP, and nonpsychotic BD than diagnostic category or subtype.

Although differences in demographic and clinical variables have been noted between SCZ, SAD, and BDP, these findings have also been conflicting (Cheniaux et al., 2008; Kempf et al., 2005). There are mixed findings as to whether positive and negative symptoms are similar in SCZ and SAD or occur with greater severity in SCZ (Evans et al., 1999; Peralta and Cuesta, 2008; Simonsen et al., 2011; Wilson et al., 2013). Pagel et al. (2013) recent meta-analysis of studies comparing SCZ, SAD, and BDP may clarify these discordant results. Individuals with SAD were found to have a longer duration of illness, better psychosocial functioning, and more severe depressive and negative symptoms than those with SCZ. Persons with SAD also had younger age of illness onset, longer duration of illness, a greater number of psychiatric symptoms, more severe depressive and negative symptoms, and lower IQ scores relative to those with BDP. However, the majority of studies showed that individuals with SAD were more similar to individuals with SCZ than to individuals with BDP. Furthermore, the diagnostic system used (i.e., DSM-III-R versus DSM-IV) did not generally affect this pattern of results. These findings suggest that SAD more strongly resembles a schizophrenia-like disorder rather than an affective disorder.

Treatment data suggests that antipsychotics demonstrate no specificity as a diagnostic marker, showing efficacy across SCZ, SAD, and BDP. However, lithium response appears to parse affective symptomatology in that, amongst people with psychotic disorders, only those with prominent affective features seem to respond (Leucht et al., 2004).

The familial, epidemiological, neuropsychological, and the clinical literature suggests that SAD shares more similarities with SCZ than with BDP. However, few studies have examined whether these three disorders differ qualitatively using large representative samples of broadly-defined patients with a psychotic disorder. The present study addressed this gap by comparing SCZ, SAD, and BDP on demographic and clinical variables in a large Australian dataset.

2. Method

2.1. Participants

We included data from 1469 of the 1825 participants in the Australian Survey of High Impact Psychosis (SHIP) who had an ICD-10 diagnosis of SCZ ($n=857$), SAD ($n=293$), or BDP ($n=319$). Individuals with BDP needed to have experienced formal psychotic symptoms for inclusion in the SHIP study. The ICD-10 diagnosis of SAD comprises manic and depressive subtypes (World Health Organization, 1992). The former diagnosis is indicated if schizophrenic and manic symptoms are prominent in the same episode of illness, while the latter is indicated if schizophrenic and depressive symptoms are prominent in the same episode of illness.

The SHIP is the second Australian national survey of psychosis, covering seven catchment areas with a total area of 62,000 square kilometres and a population of 1.5 million people aged between 18 and 64 years. A two-phase design was used. In Phase I, potential participants were screened for psychosis during March 2010. In Phase 2, 1825 individuals aged 18–64 years were randomly selected for interview from those who screened positive for psychosis. The study was approved by institutional human research ethics committees at each of the seven study sites and all participants provided written, informed consent. While a detailed description of the sample, methods and aims of the SHIP survey can be found elsewhere (Morgan et al., 2013, 2012). Table 1 presents the demographic characteristics of the sample.

2.2. Measures

2.2.1. Diagnostic interview for psychosis

The Diagnostic Interview for Psychosis (DIP) (Diagnostic Module) is a semi-structured clinical interview used to generate both DSM-IV and ICD-10 diagnoses (Castle et al., 2006). The DIP assesses family history of schizophrenia, current and lifetime prevalence of positive symptoms (i.e., hallucinations, delusions, and subjective thought disorder), negative symptoms, duration and course of illness, and mood symptoms (i.e., depression and mania). The survey interview schedule also assessed sociodemographic details, childhood experiences (including occurrence of distressing or traumatic events), social participation and functioning, physical health (including family history of illness), quality of life, other psychopathology not fully covered in the DIP (i.e., worry, panic, anxiety, and obsessions), cognitive profile, service use and perceived need for services.

In the present study, the binary responses (i.e., present/not present) of depression symptoms (range=0–20), mania symptoms (range=0–9), hallucination symptoms (range=0–5), delusion symptoms (range=0–7), subjective thought disorder symptoms (range=0–4), respectively, were summed to produce symptom severity scores, with higher scores representing more severe symptoms. Furthermore, all positive symptoms (i.e., hallucinations, delusions, and thought disorder symptoms) were summed to create a positive symptom severity score ranging from 0 to 16, with higher scores reflecting more severe positive symptoms.

2.2.2. Negative syndrome score

Six symptoms over the past 12 months were identified based on the items classified by Kirkpatrick et al. (1989) as

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