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Premorbid adjustment in schizophrenia and schizoaffective disorder

Ricardo Saracco-Alvarez [a], Soledad Rodríguez-Verdugo [a], María García-Anaya [b], Ana Fresán [b,*]

[a] Schizophrenia Clinic, National Institute of Psychiatry Ramón de la Fuente, Mexico City, 14370, Mexico
[b] Clinical Research Division, National Institute of Psychiatry Ramón de la Fuente, Mexico City, 14370, Mexico

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Abstract

There is evidence that premorbid adjustment can differentiate schizophrenia from schizoaffective disorder. We recruited 41 patients with schizophrenia and 24 patients with schizoaffective disorder without substance abuse 6 months before the assessment. Diagnoses were based on the Structured Clinical Interview for DSM-IV. Psychotic symptoms were rated with the Positive and Negative Syndrome Scale, the Calgary Depression Scale was used to assess depressive symptoms, and the Global Assessment of Functioning Scale was used to rate global psychosocial functioning. Premorbid adjustment was evaluated with the Premorbid Adjustment Scale. Patients with schizophrenia showed worse premorbid adjustment compared with the patients with schizoaffective disorder. The areas of "peer relationships" and "scholastic performance" showed deficits in schizophrenia. Significant associations were found between premorbid adjustment life periods and symptom severity in both groups. Differences found between groups may be related to an earlier illness onset in the schizophrenic group. Premorbid adjustment may be a useful clinical feature to differentiate schizoaffective disorder from schizophrenia.

Keywords: Peer relationships; Scholastic performance; Schizophrenia-like psychosis

1. Introduction

Schizophrenia and schizoaffective disorder often have their onset in young adulthood, with severe negative consequences on education, social relationships, and employment. Early onset has been related to poor clinical and psychosocial outcomes.

There is consistent evidence that persons affected with schizophrenia and schizophrenia-like psychosis exhibit poor social adjustment and subtle deviations from cognitive norms before the illness is formally diagnosed (Rabinowitzm et al., 2002; Addington et al., 2003; Tuulio-Henriksson et al., 2004). Premorbid adjustment is defined as the psychosocial functioning in the educational, occupational, social and interpersonal relations areas before evidence of characteristic positive symptomatology (Cannon-Spoor et al., 1982).

Premorbid deviations observed in schizophrenia and schizoaffective disorder are related to an early and insidious onset, longer duration of untreated psychosis,

* Corresponding author. Clinical Research Division, National Institute of Psychiatry Ramón de la Fuente, Calz. México-Xochimilco No 101, Tlalpan, Mexico City, 14370, Mexico. Tel.: +52 55 56 55 28 11x204; fax: + 52 55 55 13 37 22.
E-mail address: fresan@imp.edu.mx (A. Fresán).

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poor clinical outcome, more frequent relapses, severe negative symptoms and cognitive impairment, pronounced neurological deficits, abnormal findings on computed tomography and positron emission tomography, lower quartile birth weights and height, and lower quality of life during the course of the disorder (Addington and Addington, 1993; Bailer et al., 1996; Nopoulos et al., 1998; Malla and Payne, 2005).

It has been considered that premorbid adjustment can vary considerably among individuals with psychotic disorders, and a more detailed understanding of this variance might help us to identify subtypes within the heterogeneous syndrome of schizophrenia, including schizoaffective disorder (Larsen et al., 2004). However, the specific clinical features and correlates of premorbid adjustment in schizoaffective disorder and schizophrenia are far from clear (David et al., 1997; Russell et al., 1997; Mohamed et al., 1999).

In this study, we investigated the influence of premorbid adjustment on patients with schizophrenia and schizoaffective disorder. We hypothesized that patients with schizophrenia would show a worse premorbid adjustment during all life periods before illness onset in comparison to patients with schizoaffective disorder, and that patients with schizophrenia would present more severe impairment in specific premorbid adjustment areas than patients with schizoaffective disorder.

2. Methods

2.1. Subjects

We recruited 41 consecutive patients with schizophrenia and 24 patients with schizoaffective disorder from the outpatient admission ward at the National Institute of Psychiatry (Mexico City), according to DSM-IV diagnostic criteria (American Psychiatric Association, 1994). All patients with concomitant alcohol or substance abuse in the last 6 months preceding the assessment were excluded.

2.2. Assessment procedures

Diagnoses were based on the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (First et al., 1996). All subjects were evaluated with clinical instruments validated in Mexican populations (Apiquian et al., 2002). Psychotic symptoms were rated using the dimensional model of schizophrenic symptoms, based on five-factor analysis (positive, negative, cognitive, excitement and depression/anxiety factors) of the Positive and Negative Syndrome Scale (PANSS) (each item rated from 1 to 7) in Mexican populations (Fresán et al., 2005; Lindenmayer et al., 1995), the Calgary Depression Scale for Schizophrenia (CDSS) for depressive symptoms (Addington et al., 1993; Ortega-Soto et al., 1994), and the Global Assessment of Functioning Scale (GAF) for global psychosocial functioning (American Psychiatric Association, 1994).

Premorbid adjustment was assessed with the Premorbid Adjustment Scale (PAS). This scale is designed to evaluate the level of functioning from several periods of the subject's life in the following four major areas: (1) social accessibility-isolation, (2) peer relationships, (3) ability to function outside the nuclear family, and (4) capacity to form intimate socio-sexual ties. Each area has a scoring range from 0 to 6, where "0" denotes the healthiest range and "6" the least healthy end. The life period sections are divided as follows: (1) childhood (up to 11 years), (2) early adolescence (12–15 years), (3) late adolescence (16–18 years), and (4) adulthood (19 years and beyond). The year before onset of psychosis was not taken into account in the PAS evaluation to avoid interference by functional dysfunction associated with the prodromal phase. The final section, labeled "General," contains items designed to estimate the highest level of functioning that the subject achieved before becoming ill. Each life period section has a scoring range from 0 to 1. The "0" end of the continuum denotes the healthiest end of the adjustment range, and "1" the least healthy end (Cannon-Spoor et al., 1982; López et al., 1996).

Demographic data were obtained by a personal interview with the patient's family, while psychopathology evaluation and premorbid adjustment information were obtained from both the patient and the family.

2.3. Statistical analyses

The demographic and clinical characteristics are described with frequencies and percentages for categorical variables, and with means and standard deviations (S.D.) for continuous variables. The chi-square test (χ^2) was used for categorical contrasts and *t*-test for independent samples for the comparison between patients with schizophrenia and those with schizoaffective disorder. A general linear model was used to determine the pattern of premorbid adjustment through life period sections. The Pearson correlation coefficient was used to measure linear association between the PAS categories and clinical rating scales. The significance level for tests was established at $P \leq 0.05$ (2-tailed).