The schizoaffective phenomenon: the state of the art


Objective: Schizoaffective disorders are well established. Nevertheless, the definition in the International Classification of Diseases (ICD)-10 and the Diagnostic and Statistical Manual (DSM)-IV are insufficient.

Method: Critical review of the literature from Kahlbaum (1863) to the 21st century.

Results: Many authors have described people suddenly developing a disorder with both ‘schizophrenic’ and ‘affective’ symptoms. In DSM-IV and ICD-10, the schizoaffective disorder is defined as the concurrent occurrence of schizophrenic symptoms with a major affective disorder. However, there is no reason for a chronological distinction regarding the co-existence of schizophrenic and affective symptomatology. Moreover, longitudinal aspects are not included in the definitions.

Conclusion: Two types of schizoaffective disorder must be distinguished: the ‘concurrent’ and the ‘sequential’ type. The first includes people having only a coincidence of schizophrenic and affective symptoms. The ‘sequential’ type is defined as the schizoaffective disorder under a longitudinal aspect subsuming disorders with a symptom change between different episodes. Consequences for further research are discussed in detail.

Definition

Schizoaffective disorders are yet a controversial discussed but existing nosological category. They are also an insufficiently investigated but nevertheless a fascinating psychotic area. Many years ago (1) we called the schizoaffective disorders a ‘nosological nuisance but a clinical reality’. It is also a theoretical fascinosum in so far as the study of schizoaffective disorder (SAD) can perhaps contribute seriously to answer the question of a ‘psychotic continuum’ or ‘separate entities’ of mental disorders.

Long time before the name ‘schizo-affective’ was used by Kasanin in 1933 (2) in the USA the disorders assumed under this name had been described in Europe (see Fig. 1). In 1933 the term ‘schizoaffective psychosis’ was born. The father of this term is the American psychiatrist Kasanin, who used it in his paper ‘The schizoaffective psychoses’, in the American Journal of Psychiatry. He described nine cases of young patients in good general condition and with good social adaptation who suddenly developed a dramatic psychosis, having both ‘schizophrenic’ as well as ‘affective’ symptoms. Some of these patients had a positive family history with affective disorders. Usually a critical life event had happened before onset, the duration of the episode was not long and they had a favourable outcome.

Karl Kahlbaum can be considered as the first psychiatrist of modern times; he described them as a separate group as ‘vesania typica circularis’ (3). For his definition Kahlbaum applied cross-sectional and longitudinal aspects. Emil Kraepelin knew was also very familiar with cases between ‘dementia praecox’ and ‘manic-depressive insanity’ (4–7). These ‘cases-in-between’ were a problem for him: a nuisance but, on the other hand, an interesting problem to be solved. As is well known, Kraepelin dichotomized the so-called ‘endogenous
Kraepelin wrote: 'The cases which are not classifiable (namely to Manic-Depressive Insanity or to Dementia praecox) are unfortunately very frequent' (7, p. 26). After two pages he made the decisive and for him certainly not easy step: 'We have to live with a sort (of disorder) to whom the criteria applied by us are not sufficient enough to differentiate reliable in all cases between Schizophrenia and Manic-Depressive Insanity. And there are also many overlaps in this area' (7, p. 28). This means overlaps between schizophrenia and affective disorders.

Eugen and Manfred Bleuler (9, 10) knew and described such overlaps and named them Mischpsychosen (mixed psychosis). They allocated the ‘mixed psychosis’ to schizophrenia because of the primacy of the so-called ‘fundamental symptoms’. According to Bleuler’s concept, only the presence of the so-called fundamental symptoms, but not the course or the outcome, are decisive for making a diagnosis of schizophrenia. In 1966 Jules Angst, the scholar and colleague of Manfred Bleuler, investigated the ‘mixed psychosis’ notion as part of the affective disorders (11): a very emancipating and contrary step regarding the theories of his teacher.

It is evident that the cases described by Kasanin do not have much in common to what we define nowadays as ‘schizoaffective disorders’. Kasanin’s cases have much more similarity to the bouffé délirante of the French psychiatry (12) or partially to what we call today ‘acute and transient psychotic disorder’, especially with the polymorphous type [International Classification of Diseases (ICD), F23 (13, 14)]. What we actually call ‘schizoaffective disorders’ was described in an almost identical way by Kurt Schneider in Germany in the 1930s as ‘cases-in-between’ [Zwischen-Fälle].

However, in North America, long before Kasanin’s paper (2) had been published, similar cases were also being described and similar opinions existed: for example, by Kirby (15) or Hoch (16). Three years after Kasanin’s publication, in 1936 Hunt and Appel published their study (17) in which they investigated all patients admitted to the Pennsylvania Hospital between 1919 and 1929 with mixed, schizophrenic and affective symptomatology. They found that remission in these cases is twice as frequent as in schizophrenia, but 50% less frequent than in manic-depressive diseases. In 1963 Vaillant (18) characterized all patients with so-called ‘remitting schizophrenia’ as schizoaffective. Vaillant wrote: ‘Almost every schizophrenic patient with remission could be also diagnosed as having a “schizoaffective disorder”’.

The modern definitions of schizoaffective disorders according to the Diagnostic and Statistical Manual (DSM)-IV (17) and ICD-10 (18) are not

| KAHLBAUM: Vesania typica circularis |
| KRAEPELIN BLEULER : Mixed Psychoses |
| SCHNEIDER: Cases-in-between |
| ANGST CLAYTON: Schizoaffective Disorders |

**Modern Concepts**

| a) Concurrent |
| Concurrent and Sequential |
| Unipolar |
| Bipolar |

**Fig. 1.** Schizoaffective disorders: development of the concept.
sufficient to define all the groups and subgroups of schizoaffective disorders, nor are they sufficient to describe and define the ‘schizoaffective phenomenon’.

They defined as schizoaffective disorders the concurrent occurrence of schizophrenic symptoms with a major affective disorder. In ICD-10 (19) the schizophrenic symptoms have to be present for at least 2 weeks. In DSM-IV (20) the schizophrenic symptoms have to be present for at least 2 weeks in the absence of prominent mood symptoms.

The most important criticisms of the definitions of DSM-IV and ICD-10 are the following: first, there is no argument for the chronological distinction regarding the co-existence of schizophrenic and affective symptomatology. Secondly, both diagnostic systems do not involve the longitudinal aspect in their definitions.

**Concurrent and sequential types**

What about patients having in one year a schizophrenic episode, in the next year a major depressive episode, some months later a manic episode and again some months later a schizodepressive episode? What kind of disease does this patient have? one can say, of course, that the patient has many diseases – a disease named schizophrenia, a disease named depression, a disease named mania and at least a disease named schizoaffective disorder.

This could be named the ‘one day fly-theory’; but this would be definitely wrong. Longitudinal comparative investigations have demonstrated that we must define a sequential type of schizoaffective disorder. Operational research has shown that there is no difference on all levels of investigation, for example family history, premorbid personality, premorbid social adaptation, pattern of course, frequency and type of persistent alterations and response to prophylaxis between patients having only schizodepressive episodes in their course and patients changing among schizophrenic and affective episodes.

These shortcomings in the definitions of DSM-IV and ICD-10 have been the reason that we decided to use our own definition, based on the results of operational comparative and longitudinal research. As a consequence we define two types of schizoaffective disorders: namely the ‘concurrent’ and the ‘sequential’ types.

The ‘concurrent’ and the ‘sequential’ type of schizoaffective disorders

As the concurrent type of schizoaffective disorders, we define disorders as having only schizodepressive, schizomanic or schizomanic–schizodepressive mixed episodes. This means that there is a coincidence of schizophrenic and affective symptomatology at the same time. As the sequential type, we define schizoaffective disorders under a longitudinal aspect, namely those disorders with a change of different episodes: schizophrenic, depressive, manic, schizodepressive, schizomanic, mixed bipolar episodes and so on. As mentioned above, there are no differences between the two types of schizoaffective disorders described and I do not know of any investigation or any study which could contradict this thesis.

**Unipolar, bipolar and mixed states**

It has been also well established that schizoaffective disorders must be divided into unipolar and bipolar types, in exactly the same way as the pure affective disorders. Longitudinal clinical research has shown that bipolar schizoaffective disorders must be distinguished from the unipolar type. Bipolar schizoaffective disorders have very similar premorbid and sociodemographic features and patterns to the pure affective bipolar disorders in terms of course, treatment and prophylaxis, but they differ significantly from the unipolar schizoaffective disorders, in exactly in the same way as bipolar affective disorders differ from unipolar affective disorders.

Another important point is that, corresponding to the mixed bipolar states of pure affective disorders, there are also mixed bipolar schizoaffective episodes. We described such episodes in our Cologne Study 15 years ago (21). At present we are carrying out a longitudinal prospective investigation on mixed states. One of the subjects of these studies is the comparison of affective and schizoaffective mixed states. Mixed schizoaffective disorders are almost equally as frequent as the affective mixed ones (index episode c. 20% lifetime more than 40% of bipolar affective and schizoaffective);
but mixed schizoaffective patients became ill earlier than mixed affective patients; they have longer episodes, and patients with mixed schizoaffective episodes seem to be impaired more heavily than patients with mixed affective episodes, and they have a more unfavourable outcome. Such a schizomanic–depressive mixed episode is an indicator of higher severity of the illness, as in pure affective mixed bipolar episodes (Fig. 2).

What are schizoaffective disorders?

What is the nosological position of schizoaffective disorders? The history of schizoaffective disorders and attempts to answer the above question is also the history of the theories on schizophrenia and on affective disorders. Some of us, especially in earlier descriptions, allocated the schizoaffective disorders to schizophrenia, but research during recent decades have shown increasingly that schizoaffective disorders are more similar to affective than to schizophrenic disorders (Fig. 3).

Particularly following the dichotomization of unipolar and bipolar schizoaffective disorders, evidence of the strong relation between schizoaffective and affective disorders has been documented. However, affective and schizoaffective disorders are not identical. It seems that schizoaffective disorders are inhomogeneous. Some of them have a strong relation to schizophrenia, the so called ‘schizo-dominant type’, with a higher incidence of schizophrenia in the family history. However, the majority of them have a stronger relation to the affective disorders. In this sense, SAD occupy a position between schizophrenia and affective disorders. Thus, schizoaffective disorders are of enormous theoretical interest, because they are building a bridge between different disorders and stimulate the basis for research and discussion on a psychotic continuum and an independent nosological entity.

References


Fig. 3. Theory of continuity of mood disorders.