24 The Conundrum of Schizoaffective Disorder

Essential Concepts

- Schizoaffective disorder is often loosely diagnosed.
- When carefully assessed, patients can be assigned to three major groupings.
- A group with more bipolar than psychotic symptoms probably represents a severe variant of bipolar disorder and requires aggressive mood stabilizer treatment.
- A group with more psychotic than affective symptoms probably represents a milder variant of schizophrenia and requires aggressive treatment with antipsychotics.
- A group with similar amounts of psychosis and affective symptoms probably represents a true comorbidity of schizophrenia and affective disorders and requires aggressive treatment with both antipsychotics and mood stabilizers or antidepressants.

FIVE MODELS OF SCHIZOAFFECTIVE DISORDER

Our understanding of schizoaffective disorder can be organized in five different theories (Table 24.1). One approach holds that schizoaffective disorder is its own illness, separate from others, as appears to be the case superficially by its separate diagnostic criteria in DSM-IV. A second model holds that schizoaffective disorder represents a middle clinical picture on a psychotic continuum that extends from bipolar disorder to schizophrenia; in other words, this model rejects the Kraepelinian dichotomy of bipolar disorder and schizophrenia. A third model argues that schizoaffective disorder represents the comorbidity of affective disorders and schizophrenia, thereby maintaining the Kraepelinian dichotomy and explaining overlap symptoms as chance co-occurrence. A fourth theory views schizoaffective disorder as basically a variant of bipolar disorder, and a fifth sees schizoaffective disorder as a variant of schizophrenia.

TABLE 24.1. Five Models of Schizoaffective Disorder

1. A separate illness
2. An intermediate form on the continuum of psychosis
3. Comorbidity of schizophrenia and affective disorders
4. A more severe variant of bipolar disorder
5. A less severe variant of schizophrenia

PHENOMENOLOGY OF SCHIZOAFFECTIVE DISORDER

This is the aspect of diagnosis that receives the most attention from clinicians. From this perspective, the term *schizoaffective* simply applies to individuals with continuous psychotic and mood symptoms. Unlike mood disorders, psychotic symptoms are not brief. And unlike schizophrenia, mood symptoms are not absent. Clinically, many patients seem to fall into this overlap region. In fact, the original paper describing the occurrence of such patients with such overlap was published in 1933. Indeed, Kraepelin himself observed that a good number of patients had such overlap of manic-depressive and dementia praecox symptoms. Hence the fact that such overlap occurs is almost universally accepted, even by Kraepelin, who originated the idea that mood and psychotic disorders differ.

By itself, the presence of overlap does not invalidate the diagnoses of schizophrenia and mood disorders. This is partly because phenomenology is only one of four diagnostic validators. This is also partly because a difference in symptoms is not an all-or-nothing phenomenon. In other words, to say that schizophrenia and mood disorders differ in symptoms is not to say that they never overlap. It only means that they usually do not overlap. And indeed, some well-done symptom prevalence studies have shown that patients with mood and psychotic symptoms tend to differentiate into two big groups—one with mainly mood symptoms and one with mainly psychotic symptoms, although there is some overlap (Figure 24.1).

It is sometimes argued that the mere existence of schizoaffective disorder is a counterexample to the Kraepelinian dichotomy of schizophrenia and mood disorders. As should be clear from the preceding considerations, this is not the case. Some overlap is expected, and symptoms are only one

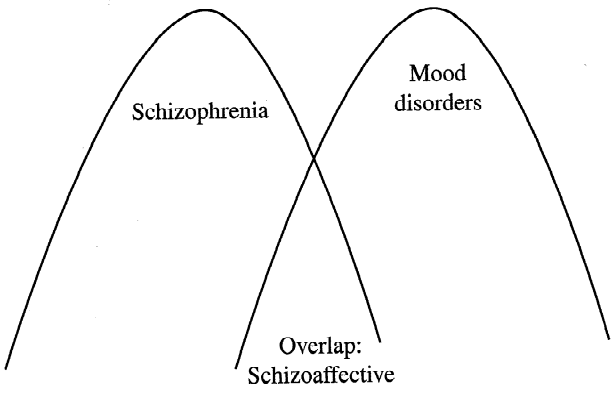

FIG. 24.1. Symptom differentiation between schizophrenia and mood disorders.

aspect of diagnostic validation. To refute the Kraepelinian diagnostic schema, one also would need to look at genetic, course, and treatment-response data.

Genetics

KEY POINT

If schizoaffective disorder is a separate illness in its own right, one would expect that it would breed true in families. However, almost all genetic studies are consistent in demonstrating that it does not breed true.

Schizoaffective disorder is not found mainly in the families of persons with schizoaffective disorder. Rather, various studies suggest a unique pattern. In some studies of families of persons with bipolar disorder, there is an increased prevalence of schizoaffective disorder, bipolar type. In some studies of families of persons with schizophrenia, there is an increased prevalence of schizoaffective disorder, depressed type. And in a number of well-executed studies comparing both major groups, schizoaffective disorder is more prevalent in families of persons with schizophrenia or bipolar disorder than in control populations or families of persons with schizoaffective disorder.

These results are consistent with a number of possibilities. In some persons, schizoaffective disorder, bipolar type, appears to be a more severe variant of bipolar disorder. In others, schizoaffective disorder, depressed type, appears to be a less severe variant of schizophrenia. In still others, since it seems to run in families of persons with both schizophrenia and bipolar disorder, only two explanations seem possible: (1) Schizoaffective disorder indeed may be the counterexample to the Kraepelinian dichotomy between bipolar disorder and schizophrenia; no distinction between any psychotic disorders can be made, and they all should be seen as one continuum; and (2) schizoaffective disorder simply may represent the comorbidity of having, by chance, schizophrenia and bipolar disorder (or unipolar depression) *at the same time*, just as one might have diabetes and asthma at the same time. So far, then, the genetics of schizoaffective disorder mainly argues against the concept of a separate illness, but the four other possibilities remain open.

Course

KEY POINT

Studies of the course of schizoaffective disorder tend to be rather consistent: The course of the illness is more severe than in bipolar disorder but less severe than in schizophrenia. Further, schizoaffective disorder, depressed type, appears to demonstrate less recovery than schizoaffective disorder, bipolar type.

These findings again are consistent with the four remaining models. If there is only one continuum of psychotic illness, bipolar disorder may lie at the less extreme end, schizophrenia at the more extreme end, and schizoaffective disorder in between (Figure 24.2). Hence schizoaffective disorder may have an intermediate course. On the other hand, if it represents a comorbidity, it may be that the more severe outcome of schizophrenia is leavened by the coexistence of bipolar disorder so that an intermediate outcome would be observed in schizoaffective disorder. Further, if the bipolar type of

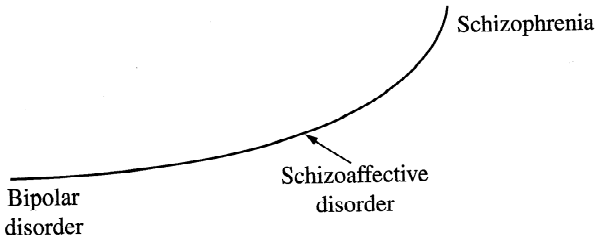

FIG. 24.2. The continuum model of psychosis.

schizoaffective disorder is a variant of bipolar disorder, it would be expected to have a worse outcome than bipolar disorder but better than schizophrenia. Also, if the unipolar depressed type of schizoaffective disorder is a variant of schizophrenia, one would expect a better outcome than schizophrenia given the more responsive affective illness factor.

In sum, the course studies are similar to the genetic studies in supporting all the models except the concept of a separate illness.

Treatment Response

This is the least specific diagnostic validator, but it still can be useful. There are few studies of treatment of schizoaffective disorder, but it is generally thought that these patients require long-term treatment with antipsychotic agents, as in schizophrenia, and long-term treatment with either mood stabilizers (bipolar type) or antidepressants (unipolar depressed type), as in the corresponding affective disorders. Again, this treatment-response pattern is consistent with all four models except the separate illness model.

The Judgment

What are we to conclude? What appears most clear is that its appearance in DSM-IV notwithstanding, there is no evidence that schizoaffective disorder represents a separate illness distinct from schizophrenia and bipolar disorder. Studies of symptomatology vary, but some important and well-done studies tend to find a difference in symptoms in psychotic and affective populations that more or less falls along the lines of Kraepelin's dichotomy of schizophrenia and affective

disorders. While there are overlap areas, such overlap is empirically expected in a real-world population of persons (or animals or any other grouping). Therefore, studies of phenomenology can be interpreted as leaning against the single-psychosis continuum model.

If schizoaffective disorder represents a comorbidity of schizophrenia and bipolar disorder, one would expect an epidemiologic prevalence that is significantly lower than the other two. In other words, schizoaffective disorder should be very infrequent because comorbidity should not be overly frequent by chance. Clinical impressions to the contrary notwithstanding, epidemiologic prevalence studies indeed demonstrate that schizoaffective disorder appears to be very infrequently diagnosable in the general community, at a level of less than 0.5%, which is much lower than accepted prevalence rates for schizophrenia (1%) and bipolar disorder (2% to 4%).

These considerations suggest that the remaining three models are consistent with the available diagnostic research. I will summarize a final model that integrates these theories with my own clinical experience (Figure 24.3):

1. Some persons experience mainly bipolar mood symptoms, with only some excess of psychosis. These persons are diagnosable with schizoaffective disorder, bipolar type, seen as a severe variant of bipolar disorder. By and large, they need aggressive mood stabilizer treatment and perhaps somewhat less aggressive antipsychotic treatment. They have a relatively good prognosis.

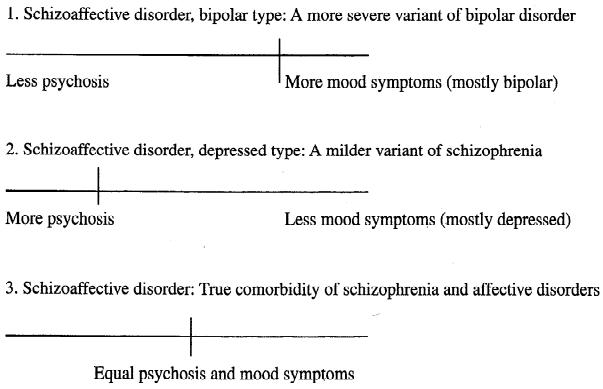

FIG. 24.3. Three varieties of schizoaffective disorder.

2. Some persons experience mainly psychotic symptoms, with only some excess of unipolar depressive symptoms. These persons are diagnosable with schizoaffective disorder, depressed type, seen as a somewhat less severe variant of schizophrenia. By and large, they need aggressive antipsychotic treatment and perhaps somewhat less aggressive antidepressant treatment. Their prognosis, though better than in schizophrenia, is usually only fair. This group is to be distinguished from schizophrenia with comorbid major depressive episodes; in the latter case, a patient may experience one or two or only a few depressive episodes that are brief, spaced apart, and often psychosocially triggered. In schizoaffective disorder, depressed type, depressive symptoms are more frequent and more persistent, although still often less so than psychotic symptoms.
3. Some persons appear to be truly schizoaffective. They experience psychotic and affective symptoms in more or less equal amounts. This group represents the true comorbidity of schizophrenia and affective disorders, has an intermediate outcome, and requires aggressive, persistent, long-term treatment with both antipsychotic agents and either mood stabilizers or antidepressants.

If clinicians try to differentiate apparently schizoaffective patients in this manner, they will encounter three groupings. By thinking about these patients according to the group that best describes them, they will be able to better target treatments.

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FOR FAMILIES AND CLINICIANS