Schizoaffective Disorder: Is the News of Its Nonexistence Premature? 

Editor’s Introduction

by Herbert Y. Meltzer

Abstract

Because of the continued controversy about the nature of the schizoaffective disorders and their relationships to schizophrenia and the affective disorders, a thorough review of the concept, genetics, treatment, outcome, and biological aspects of the schizoaffective disorders in relationship to schizophrenia and the affective disorders appears timely. The use of explicit criteria for schizoaffective disorders, such as those provided by the Research Diagnostic Criteria, permits clinical investigators to continue the inquiry into these disorders. Current evidence appears most consistent with the idea that schizoaffective disorder is usually a variant of affective psychosis and sometimes a variant of schizophrenia. However, the possibility that an interacting group of biological vulnerabilities, environmental insults, and ensuing psychological reactions produces the spectrum of clinical states from “pure” schizophrenia to “pure” affective psychosis with schizoaffective disorder as a genuine mixed state needs further investigation. Dimensional diagnostic systems rather than categorical ones may be of value for many clinical and research purposes.

For those readers who have already decided that the schizoaffective disorders are really affective disorders, lacking significant difference in etiology, family history, treatment response, course or long-term outcome, it may seem strange for an issue of the Schizophrenia Bulletin to be largely devoted to reviews of the topics just listed as well as to a theoretical model considering the relationship of the schizoaffective disorders to schizophrenia and the affective disorders.

The nihilistic view concerning the distinctiveness of the schizoaffective disorders was accepted by the framers of DSM-III (American Psychiatric Association 1980). Though they decided to retain the category, no diagnostic criteria were provided and it was intended to be used rarely, only in those instances in which a differential diagnosis between affective disorder, schizophrenia, or schizophreniform disorders could not be made with any degree of certainty. That it was retained at all is some indication of the uneasiness aroused in all nosologists by this boundary-blurring diagnostic category.

However, the concept of the schizoaffective disorders has survived the disdain of the drafters of DSM-III for a variety of reasons, not the least of which is that another diagnostic system, the Research Diagnostic Criteria (RDC; Spitzer, Endicott, and Robins 1978), provides usable criteria for various subtypes of schizoaffective disorder. Moreover, many researchers continue to find it advantageous to use these categories rather than to restrict their diagnoses of patients with major psychoses to affective disorders and schizophrenia. Because most American investigators, and to an increasing extent, European investigators, use the RDC, it is not uncommon for studies of even medium size samples of psychotic patients to include 10–30 percent schizoaffective patients. These studies usually mention the schizoaffective patients only in passing and rarely attempt to compare them both to affective and schizophrenic patients.

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Studies of treatment response, outcome, and inheritance more often have as their goal the explicit comparison of these three groups of patients than do biological studies. The reviews prepared for the Bulletin, written by individuals who have devoted very considerable effort to this question, present a diverse array of arguments for discarding, retaining, or modifying the concept of schizoaffective disorders for clinical and research purposes, at least for the current time. Treatment response and short-term outcome, reviewed by Goodnick and Meltzer and by Harrow and Grossman, respectively, suggest schizoaffective patients may, as a group, fare less well than affective patients but better than schizophrenic patients. Tsuang and Simpson argue that the mixed phenomenology and the intermediate nature of the long-term outcome of these patients (paralleling the short-term outcome findings of Harrow and Grossman) argue for a unitary concept of psychosis as opposed to a two-psychosis Kraepelinean model into which schizoaffective illness must be apportioned. Genetic studies, reviewed by Abrams, seem to indicate both a schizophrenic and affective genetic contribution to schizoaffective disorders, which differentiate it from either schizophrenia or affective disorder. Biological studies, reviewed by Meltzer, Arora, and Metz, show a complex pattern of overlap among the three syndromes and suggest a unitary psychosis model should be considered. Finally, Braden begins with the assumption that the biological basis of the phenomenology of affective and cognitive disturbances must be understood before a nosological issue such as the nature of schizoaffective illness can be resolved. He then considers several possible models to explain the coexistence of affective and cognitive abnormalities.

Elsewhere, Brockington and Meltzer (1983) have considered in detail six hypotheses concerning the nature of schizoaffective disorder: (1) that it occurs when both schizophrenia and affective disorder are present; (2) that all such cases are variants of schizophrenia; (3) that all such cases are variants of affective psychosis; (4) that schizoaffective illness may be an expression of either schizophrenia or affective psychosis; (5) that at least some such cases represent a unique type of psychosis; and (6) that an interacting group of biological vulnerabilities, environmental insults, or ensuing psychological reactions produces the spectrum of clinical states from "pure" schizophrenia to "pure" affective psychosis.

The evidence offered for and against these hypotheses will not be reviewed here. It is, in fact, often found in the articles reviewed in this issue. Some of the conclusions of Brockington and Meltzer (1983) are, however, worth noting. The precondition for effective research of biological abnormalities, treatment response, and genetic data which bear upon the relationship between the psychoses is the collection of reliable and comprehensive information about symptoms and course in probands and relatives. These data must then be used to test various existing models of the psychoses and, as these are rejected, to develop new ones. Current evidence appears most consistent with the idea that schizoaffective disorder is usually a variant of affective psychosis and sometimes a variant of schizophrenia. However, this author believes that the most interesting hypothesis is the last one mentioned in the preceding paragraph: that an overlapping group of biological vulnerabilities interacting with environmental stresses may produce the spectrum of psychoses. This hypothesis provokes research aimed at identifying the full range of biological and psychosocial disturbances in psychotic patients and their first and second degree relatives and their integration into a comprehensive model with probable hierarchical relationships. The overlap between the psychoses in regard to biological abnormalities, treatment response and course, if not inheritance patterns, would seem to argue for the interactive model. In keeping with this view, Caine and Shoulson (1983) reported that 24 patients with Huntington's disease manifested seven well-defined DSM-III syndromes, including schizophrenia and affective disorder, as well as some less well-defined disorders. They suggested that this heterogeneity in a "disorder with a known unitary pathogenic mechanism" challenges the current nosological efforts to "demarcate homogeneous behavioral syndromes."

If this model is correct, the basis for deciding what diagnostic categories to use becomes very different. Whether the mixed phenomenological state, schizoaffective disorders, should be retained as a unique category, along with the phenomenological ends of the continuum, affective disorders and schizophrenia, would depend upon a variety of clinical considerations as much as anything. It might, for example, lead to groups of patients diagnosed as affective disorder or schizophrenia who are more homogeneous in regard to a specific biological marker or treatment response. However, the impetus to develop and use a dimensional system that would permit a description of observed phenomena would be strengthened
and categorical systems might become of secondary importance.

References

American Psychiatric Association. 

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Spitzer, R.L.; Endicott, J.; and Robins, E. 
Research Diagnostic Criteria: Rationale and reliability. 

Acknowledgment

The preparation of this article was supported, in part, by USPHS MH-25116, MH-29206, MH-30938, MH-30059, and by the State of Illinois Department of Mental Health. Dr. Meltzer is recipient of USPHS Research Career Scientist Award MH-47808.

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Announcement

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