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EDITORIAL

Problems of Schizo-affective Disorders

In ICD-9 schizo-affective type (295.7) is one of the major types of schizophrenia, and the definition is that it is a psychosis in which pronounced manic or depressive features are intermingled with schizophrenic features and which tends towards remission without permanent effects but which is prone to recur. The diagnosis should be made only when both the affective and the schizophrenic symptoms are pronounced.

Types in ICD-9 related to this category are cyclic schizophrenia; mixed schizophrenic and affective psychosis; schizo-affective psychosis; schizophreniform psychosis, affective type.

In DSM-3 schizo-affective disorder is not included under schizophrenic disorders nor under paranoid disorders but under a separate category called psychotic disorders not elsewhere classified. Underneath this category, there is the schizophreniform disorder, brief reactive psychosis, schizo-affective disorder and atypical psychosis. In DSM-3 the term schizo-affective disorder is vague and has been used in many different ways since it was first introduced and at the present time there is no consensus on how this category should be defined, some of the cases that in the past were diagnosed as schizo-affective disorder would in DSM-3 be diagnosed as schizophreniform disorder, major depression or bipolar disorder with mood congruent or mood incongruent psychotic features, or schizophrenia with superimposed atypical affective disorder. Future research is needed to determine whether there is a need for this category and if so how it should be defined and what its relationship is to schizophrenia and affective disorder.

The term schizo-affective disorder in DSM-3 is retained to cases in which the clinician is unable to make a differential diagnosis with any degree of certainty between affective disorder and either schizophreniform disorder or schizophrenia.

After reviewing these two definitions in ICD-9 and DSM-3 it seems logic that its use is a waste basket declaring our failure to diagnose neither pure schizophrenia nor pure major affective disorder in many cases. Several recent reviews regarding the nosological and genetic nature of schizo-affective illness indicate a considerable divergence of opinion. This disorder has been hypothesized as either a variant of affective disorder, a variant of schizophrenia, a transitional form between the two disorders or a separate diagnostic entity. Unlike affective disoders and schizophrenia that appear to be genetically distinct, an assortment of psychiatric disorders including affective illness, schizophrenia and schizo-affective disorder has been found to exist with greater than expected frequency among the relatives of schizo-affective probands. It has been found recently by Angst et al. (1979) that the relative morbidity risks for affective disorder, schizophrenia and schizo-affective illness are 3.4 – 35.5 %, 0.9 – 11 % and 0 – 3.8 % depending on the data cited. The conflicting results have been attributed to variations in clinical typologies of schizo-affective disorder and to genetic differences among the population. Most family studies suggest that schizo-affective illness is genetically heterogeneous, some genetic forms may be related to affective disorder while others may be related to schizophrenia.

The mode of genetic transmission is unclear although preliminary data suggest that a subset of schizo-affective disorders may be transmitted in an x – linked fashion and that these disorders are genetically related to bipolar affective illness. Other genetic hypothesis for schizo-affective disorder include interaction between mutative genes for schizophrenia, and for affective disorder " a polygenic transmission. "

Recent investigation by Baron et al. (1982) showed that schizo-affective disorder, bipolar and unipolar affective disorders are assumed to produce different degrees of genetic liability on a single genetic – environmental continuum. Although the current data are not compatible with this hypothesis, the use of diagnostic subtyping of schizo-affective disorder is proposed as a promising avenue in clinical and genetic research of schizo-affective illness, subdividing schizo-affective illness into affective and schizophrenic types on one hand and schizo-affective, affective disorder into manic, or schizo-affective bipolar, and depressive, or schizo-affective, unipolar on the other hand may prove useful in future application of multiple threshold and other genetic models to large data sets of schizo-affective and related psychosis.

The syndrome known as schizo-affective psychosis has not been clinically validated. In discussing how psychopathologies can be validated Feighner et al. (1972) described five common phases : clinical description, differentiation from other disorders, follow-up study, family history and laboratory studies. The first four phases have been used among schizo-affectives without resolving nosological uncertainties. Few investigations have applied laboratory testing, however, principally because suitable pathophysiological markers have been unavailable until recently. With the introduction of promising biological markers for melancholia a new research strategy is available for adressing the question of whether depressed type of schizo-affective can be delimited from depressives and schizophrenics. The dexamethazone suppression test (DST) is a neuro-endocrinal challenge test for melancholia, and in many cases this test shows no suppression in primary affective disorders or what we call endogenous depression. The study of Greden et al. (1981) showed that depressed types of schizo-affectives appear to be a heterogeneous group of patients and a clinically significant portion have abnormal DST, this finding suggests that selected depressed type schizo-affective has limbic-hypothalamic-pituitary- adrenal pathophysiology comparable to that observed among many melancholics. These results do not resolve nosological disputes about the schizo-affeative syndrome but they do support the belief that the neuro-endocrine strategy may be

useful in clarifying this perplexing entity and in identifying a homogeneous collection of schizo-affective patients. The authors hypothesize that schizo-affectives with abnormal DST will be shown to be a relatively homogeneous subgroup different from those with normal DST and most closely resembling melancholics in clinical features with more prominent family histories of affective disorders, a tendency towards recurrent clinical courses and better response to antidepressant treatment but again this remains to be tested.

The classification should be based on etiology and pathogenesis, and if not known, as in our case, on symptomatology. Taking the previous history into account we can only describe the psychopathological syndromes and their changes in the course of time. Based on a descriptive psychopathological classification schizo-affective psychosis must consist of psychosis with both syndromes; schizophrenic and affective. The syndromes can occur simultaneously or subsequently and they must fulfill diagnostic criteria for both schizophrenia and manic - depressive disorders. Accepting the existence of a third group of patients between schizophrenia and affective psychosis does not answer the controversial question whether this third group belongs to the two groups or whether it forms an independent entity.

Some decades ago some professors of psychiatry were known to have the ambition of creating at least one new psychiatric disorder during their life time, this era had passed and was followed by another where every investigator, specially Anglo-Saxon, developed his own methodology, e. g. in the form of a new rating scale. More recently another trend became fashionable, the creation of new diagnostic criteria for all sorts of psychiatric disorders. This is certainly necessary to standardize diagnosis and will be highly valuable for training clinicians in countries without a long tradition in psychopathology and diagnosis. This development will hopefully terminate the psychodynamic arrogance against the classification of psychiatric patients. Schizo- affective psychosis irritates every diagnostician who believes in a clear dichotomy of endogenous psychosis into schizophrenia and affective di-

sorder. In a cross-sectional view Angst (1981) found that many of these patients may suffer from a clear cut schizophrenia or from affective disorder. In a long term perspective specially if we follow up these patients over decades we find an increasing proportion of patients who meet diagnostic criteria for both major endogenous psychoses. The half-life of researchers in this field is usually several folds shorter than the half-life of the illness they study, therefore, the problem is frequently not recognized during the short research activity. The better and the longer we know our patients the more frequently we diagnose them as schizo-affectives. Perhaps future research will show that schizo-affective psychosis may be nonexistent as a true nosological entity but we can be sure that the patients with a syndrome exist and we live further on.

Moller and Von Zerssen (1981) reported a series of 280 schizophrenics of whom 80 % had depressive symptoms on admission and 14 % at discharge. Depression alone was responsible for 70 % of the patients' morbidity measured in weeks over the two year period while only 30 % could be ascribed to schizophrenia alone or schizophrenic symptoms plus depression (Johnson, 1981). These results raise the question about our concept of schizophrenia and distinction between schizophrenia and depression, the old concept of a unitary psychosis springs to mind because of the high frequency of depressive symptoms in schizophrenia occuring whether patients are on neuroleptic medication or not, their tendency to recur and the fact that they remit rather than increase after treatment has begun, all suggest that depressive symptoms are an integral part of the schizophrenic syndrome and must therefore share common pathophysiological processes with schizophrenia.

Winokur (1974) stressed the fact that acute schizophrenia is characterised by a specific clinical picture, i. e. the presence of affective symptoms and it has a considerably better prognosis. What is perhaps most striking is the fact that the results of a blind family study indicate

that chronic schizophrenia is rarely seen in the families of acute schizophrenics but affective disorders are common occurrence in these families. Is there a third major psychosis apart from poor prognosis for schizophrenia and affective disorder ; the evidence argues against the idea that there is a third psychosis. In the families of acute schizophrenics the model psychiatric illness is of common ordinary affective disorder. In favour of a third psychosis are the distinguished studies of Mitsuda (1967) on atypical psychosis. He described atypical psychosis as having emotional disturbances similar to those seen in the manic and the depressive patients, further there is frequently some clouding of the consciousness in the background. This investigator feels that there is a high incidence of epilepsy in the families of atypical psychosis patients. In Winokur's studies, he found that muddled thoughts, perplexity, slow thinking, or disorientation was seen in 82 % of acute schizophrenics, thus his patients may be similar to those of Mitsuda. The important difference is that Mitsuda found that his patients with atypical psychosis bred true, i. e. the ill family members also had atypical psychosis. Leonhard (1934) also found that atypical psychosis appeared to be transmitted in the family as such and that there was no evidence of familial relationships to either schizophrenia or manic depressive illness. It would be important in further work to determine whether acute schizophrenia or atypical psychosis is familially related to one or many types of affective disorder. It seems clear that acute schizophrenia should be considered apart from schizophrenia and not included in subsequent biological or psychosocial studies of schizophrenia, it would appear from the previous data that acute schizophrenia is nothing more nor less than a variant of affective disorder, however, this last question deserves considerably more investigation. Our clinical impression in Egypt parallels that of Winokur and Mitsuda as almost the majority of our acute schizophrenics present with the atypical psychotic picture or what is called acute undifferentiated psychosis with perplexity, muddled thoughts, a huge affective component which may give the impression of a schizo-affective disorder or a variant of the atypical psychosis, this is completely different from the presentation of the negative symptoms in what is called process schizophrenia which carries a completely di-

fferent prognosis and a variable picture which should be differentiated from the manic depressive illness or the schizo-affective disorder or the atypical psychosis.

Ahmed OKASHA

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EDITORIAL

Schizo-affective Disorder : An Exclusive Waste Basket or a Specific Cross-road Devolutionary Phase

A Psychopathological Stand Point

After considering schizo-affective disorder as an independent category by the DSM-III (APA, 1980) it seems logic to revise its use as a waste basket declaring our failure to diagnose neither "pure" schizophrenia nor "pure" major affective disorder in a single case.

I would like to show first what such term **should not** mean rather than what it can indicate :

1 – It is not simply atypical schizophrenia where depressive symptoms or attitude seem to colour the verbal complaint of a schizophrenic patient in a nihilistic 'no object' despair.

2 – It is not atypical depression where declared depression lacks its genuinity, periodicity or vividness and where the apathy is acted out through nagging stickiness and occasional cruelty; a variety I have previously (1979) called the nagging sticky parasitic depression.

3 – It is not simple association of regressive manic-like behaviour that may be responsible for apparent pseudointegration at a lower level.

4 – Lastly, it is not simply an indication that a certain degree of emo-