

SCHIZO-AFFECTIVE PSYCHOSIS: IS IT AN ENTITY?

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SUMMARY

The nature of schizo-affective psychosis remains elusive even nearly 5 decades after its recognition. A brief review of the controversies in the nosological status of schizo-affective psychosis is presented and the observations made by the authors in 9 cases of schizo-affective psychosis are discussed.

Kraepelinian classification of psychoses into two major mutually exclusive entities has undoubtedly enriched the understanding of manic depressive psychoses and schizophrenia. However the presence in clinical populations of patients who suffer from a combination of manic-depressive and schizophrenia like abnormalities have rendered the traditional dichotomy difficult. The term schizo-affective was first introduced by Kasanin in 1933 to refer to cases of acute psychoses, characterised by mixture of schizophrenic and affective symptoms, primarily depressive, who had good premorbid adjustment and who recovered fully within a few months. Of late the frequency of use of this term has increased considerably but still there is no consensus regarding the nature of schizo-affective psychosis.

A survey of literature reveals a variety of conflicting views.

That schizo-affective psychosis is a subtype of schizophrenia (Detre and Jarecki, 1971; Kolb, 1973; Lehman, 1975; Angst and Perris, quoted by Dempsey et al., 1975; DSM-II, 1968; ICD-9, 1975), or it is a part of those illnesses which are schizophreniform or 'atypical' in character (Lengfeldt, 1956). It is also considered closely allied to manic depressive psychosis (Clayton et al., 1968; Klein and Davis, 1969; Cohen et al., 1972; Sovner and McHugh, 1976; Tsuang

et al., 1976; Tsuang et al., 1977, Pope and Lipiniski, 1978), and that it is a hybrid state or border state (Redlich and Freedman, 1966) or intermediary state (Beck, 1967) or midzone (Cobb, 1948) or transitory group (Astrup and Noreik, 1966) between schizophrenia and manic-depressive psychosis. Schizo-affective patients exhibit typical schizophrenic symptoms while ill; but once well, they have a remitting clinical course such as seen in affective disorder (Valliant, 1964). It is considered a misnomer as well since depression is a frequent feature of schizophrenia (Batchelor, 1969) and a careful diagnostic evaluation in the supposed schizo-affective illness will lead to a rediagnosis either of schizophrenia or of affective disorder (Slater and Roth, 1969). Some have considered it as a separate entity (Kajj, 1967; Wallinder, 1972; Olleranshaw, 1973).

In view of the above it is the intention of this paper to present a study of some schizo-affective psychotics.

MATERIAL AND METHOD

All the adult new cases seen from January 1977 to June 1978 at the psychiatric out-patient department of Kasturba Medical College Hospital, Manipal, Karnataka constituted the material. ICD-9 (1975) criteria have been employed to identify

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schizo-affective illness. During this period there were 12 such cases with pronounced schizophrenic and affective symptoms, where a diagnosis of schizo-affective psychosis was entertained by either of the consultants in the out-patient department. All these cases were admitted and after a thorough examination and observation were discussed between the two consultants. In the ICD-9 criteria, it is not specified, what pronounced schizophrenic and affective symptoms mean, and hence it could lead to overinclusion or underinclusion of cases in this appellation. Hence we have applied the criteria described by Welner et al. (1974) which specify the nature of schizophrenic and affective symptoms that should be satisfied to include under the group of schizo-affective and related psychoses. When these criteria were used, we reached unanimity of opinion regarding the diagnosis of schizo-affective psychosis in 9 cases. The remaining 3 cases, that failed to fulfill these criteria were discarded from the study.

OBSERVATIONS

Frequency : There were 1152 new adult cases seen in Psychiatry O.P.D. during a

period of 1½ yrs. from Jan. 1977 to June 1978. Out of these only 9 were cases of schizo-affective psychosis (0.78%), which indicates it is rather infrequent as compared to schizophrenia (excluding schizo-affective) 268 cases (23.26%); M.D.P. (mania & depression combined) 123 cases (10.67%); and mania 24 cases (2.08%).

Sex ratio and marital status: There appears to be a female preponderance. Out of 9,7 were females. Six of the nine were married, two were separated (due to the illness) and one was widowed (see table).

Age of onset : (Age when the patient first manifested psychiatric symptoms whether followed by remission or not, Welner et al., 1974) : Age of onset ranged from 17 to 30 years, mean being 23.4 years. Mean age at first visit (to our clinic) was 36.3 years which indicates that there is a considerable gap between the age of onset and age at first visit (see Table).

Symptom Complex : In all these cases pronounced schizophrenic and affective symptoms were evident. These cases showed a 'sufficient' number of severe affective manifestations to make the diagnosis of schizophrenia unlikely, i.e., enough symp-

TABLE I

Sl. no.	Diagnosis	Sex	Marital Status	Age of Onset (Yrs)	Age at First visit (Yrs)	Past Episodes	Length of illness (Age of onset to Follow-up)		Course
							Yrs.	Mths.	
1.	S.D.D.	F	Married	30	48	8	21	6	Remitting
2.	S.M.D.	F	Widowed	25	45	6	23	5	"
3.	S.M.D.	M	Married	26	35	1	12	4	"
4.	S.D.D.	F	Married	26	48	7	25	3	"
5.	S.M.D.	M	Married	24	28	1	7	0	"
6.	S.M.D.	F	Married	17	36	2	21	11	"
7.	S.M.D.	F	Separated	20	30	2	12	7	"
8.	S.D.D.	F	Separated	23	28	1	7	4	"
9.	S.M.D.	F	Married	24	28	1	6	4	"

toms to meet the criteria for depression or mania and a 'sufficient' number of qualitatively different severe thought and behaviour disorders to make the diagnosis of affective disorder unlikely as per the criteria described by Welner *et al.* (1974). We have divided schizo-affective disorder (S.A.D., to be pronounced separately and not as 'sad'—we prefer using the term 'disorder' to psychosis) into schizo-manic disorder (S.M.D.) and schizo-depressive disorder (S.D.D). Out of 9, 6 were cases of schizo-manic disorder and 3 belonged to schizo-depressive disorder.

All the 9 cases showed two or more symptoms of schizophrenia, as required by Walner's criteria : (1) delusion, any type (persecutory delusions were present in 100% cases) ; (2) hallucination, any type (auditory hallucinations were present in 78% cases, visual hallucinations in 22% cases, some had both auditory & visual hallucinations) ; (3) formal thought disorder (tangential speech, loose associations, blocking, neologisms, word salad, ecolalia or clang associations—noticed in 67% cases) ; (4) abnormal thought disorder (Welner *et al.*, 1974—inability to communicate in a logical manner—was present in 78% cases) ; and (5) bizarre or strikingly inappropriate behaviour (noticed in 100% of the cases).

6 of the cases (67%) in addition showed three or more of the following features and satisfied Welner's criteria for Mania ; (1) hyperactivity (includes motor and social and sexual activity) ; (2) elation or euphoria ; (3) pressure of speech ; (4) flight of ideas ; (5) grandiosity ; (6) easy distractibility ; and (7) decreased need for sleep. Irritability (which could be nonspecific) was present in all these 6 cases.

3 cases (about 33%) in addition to symptoms of schizophrenic nature, showed five or more of the following manifestations and satisfied Welner's criteria for depression ; (1) sadness or dysphoric mood ; (2) loss of energy and easy fatigability ;

(3) poor appetite ; (4) psychomotor retardation ; (5) loss of interest in usual activities or decreased sexual drive ; (6) complaints of actually diminished ability to think or concentrate ; (7) sleep difficulty ; (8) feelings of self reproach or guilt ; and (9) suicidal ideas including thoughts of wishing to be dead.

It was noticed that establishing rapport in these cases in the acute phase is not as difficult as in cases of nuclear schizophrenia but more difficult than in cases of M.D.P. But in the recovery phase rapport can be established with considerable ease.

Mode of onset : For this study, mode of onset was defined as acute if the full blown symptoms have developed within a fortnight ; subacute, if the symptoms turned full blown within 3 months time ; and insidious, where symptoms have gradually developed over a length of time, amounting to more than 3 months. In all the cases, the onset of present episode was acute.

Precipitating factors : Stressful factors regarded (by the examiner) as correlated to the onset of illness were divided into : (A). Environmental/Situational viz. (1) setback, educational or occupational ; (2) loss, financial or property related ; (3) departures, quarrels or accidents (not amounting to bereavement) involving close relatives or emotionally close individuals ; (4) bereavement ; (5) divorce or separation ; (6) retirement ; (7) legal problems and (B) Physical/Exhaustional viz. (1) prolonged strenuous work ; (2) post-infection ; (3) postpartum ; (4) trauma.

Only in 3 cases situational stressful factors were evident just prior to the onset of the present episode.

Premorbid Personality : It has been labelled 'normal' or balanced if the patient, as per the information obtained from close relatives, satisfied at least three of the following criteria, 4th factor being imperative : (1) good social relations ; (2) satisfactory work adjustment ; (3) successful

marriage ; and (4) absence of 'abnormal' traits. It has been described as 'abnormal' if he had the personality traits of any of the personality disorders described in ICD-9 (paranoid, affective, schizoid, explosive, anankastic, hysterical, asthenic, antisocial & other).

It was found that some of them had abnormal traits. We have specially enquired about cyclothymic and schizoid temperaments and found them wanting. Out of 9, 7 had met all the four criteria under 'normal' personality, while 2 satisfied only 3 criteria owing to unsuccessful marriage.

Treatment and response : Mean duration of admission was 22 days. Out of 6 schizophrenic cases, 3 were given phenothiazines (chlorpromazine + thioproperazine) ; 1 was given haloperidol ; 1 case phenothiazines + haloperidol and 1 case was given phenothiazines and E.C.T. (When high doses of oral and injectible phenothiazines failed to contain violent behaviour, a course of E.C.T. was given, which quickly brought down the psychomotor excitement). In all cases psychotic symptoms were well under control within 2-3 weeks time.

Amongst schizo-depressives, 2 cases were given phenothiazines and antidepressants (amitriptyline) and 1 case phenothiazines and E.C.T. All 3 cases had shown marked improvement within 3 weeks time.

Outcome-Immediate : Based on the assessment made by both of us at the time of discharge, outcome was graded as : (1) Recovery (asymptomatic) ; (2) Good (much improved) & (3) Poor (slightly improved, no change or worse). 3 had recovered fully. The rest 6 cases had good outcome. None had poor outcome.

Subsequent outcome (after index admission) : All the 9 patients had fully recovered. Mean length of time taken for complete recovery was 3.7 months, from the onset of present episode of illness.

Final outcome (Follow up Oct. '79) : 6 cases remained well through out without drugs. (In all these cases medication was stopped by the relatives when they found the patient entirely normal and the patient getting drowsy even with small doses of drugs advised by us). 1 case remained well throughout while on medication. 2 cases had relapses without drugs, symptoms subsided when medication was restarted, they are much improved and drug treatment is continuing.

Thus 7 cases had full recovery. 2 patients had good outcome. At the time of final follow-up all but one have attained pre-morbid functioning. None had poor outcome.

DEVIATION AND COURSE OF ILLNESS

The definitions given by Welner *et al.* (1974) have been used to describe length and course of illness. Duration of illness was defined as the period of time from the onset of symptoms to the time of follow-up interview after discharge from the most recent hospitalisation. The illness was considered "too brief" for evaluation of a continuous Vs. remitting course if its length was less than 2 years. The course of the illness was considered 'unknown' if its duration was at least two years but there was a period of six months or more when there was no satisfactory information concerning the patient's symptoms. The course of the illness was considered 'episodic' (remitting) if its duration was at least 2 years, the patient was asymptomatic for a period of at least six months and not receiving major psychiatric drugs, electro shock therapy or any other local therapy for symptoms. The course of the illness was considered chronic (nonremitting) if the duration was at least two years and patient was continuously symptomatic with either affective symptoms or thought and behaviour disorders or a combination of both. The mean duration of illness in these cases was 14

yrs. and 11 months. In all the 9 cases, the course of the illness was episodic or remitting.

FAMILY HISTORY

Family history of mental illness was obtained by (1) interviewing the spouse, parent, sibling or children (above 15 yrs.) of the affected members ; (2) interviewing the affected member when accessible ; and (3) the records of the relatives treated by us.

Amongst 56 first degree relatives, 5 had affective illness (9%) ; 3 had schizo-affective illness (5.4% ; two of these cases are currently under our treatment and satisfy Welner's criteria) and 1 had schizophrenia (1.8%). Amongst 114 second degree relatives, 2 had affective illness (1.7%) and 2 had schizophrenia (1.7%).

DISCUSSION

Undoubtedly there are cases of psychoses where both schizophrenic and affective symptoms are so marked that they cannot be conveniently pigeonholed into either schizophrenia or M.D.P. Quite often we encounter cases of 'pure' or nuclear schizophrenia and 'pure' M.D.P. But not uncommonly we do encounter cases of schizophrenia with affective symptoms, and affective illness with a little schizophrenic colouring. If that is so, cases where both affective and schizophrenic symptoms are pronounced cannot be regarded as entirely unfathomable.

In our study, the schizo-affectives often seem to have a more or less normal pre-morbid adjustment. The illness has, usually an acute onset, at times preceding stressful factors may be evident. They exhibit pronounced schizophrenic and affective symptoms. They show good therapeutic response. In schizo-manics usually a properly adjusted dose of antipsychotics might suffice. However when they fail or even otherwise lithium may be tried. It appears that

schizo-manics need much higher doses of antipsychotics than do schizo-depressives. And the schizo-depressives seem to respond only to a combination of adequate doses of major tranquillizers and antidepressant drugs and not to either of the drugs alone, which calls for a closer look at the diagnosis. Anti-depressants in these cases apparently do not aggravate schizophrenic symptoms, in the way it might occur in a schizophrenic with depressive symptoms or with post psychotic depression. Schizo-affectives may have a unipolar course, i.e., a schizo-depressive has relapses of schizo-depressive episodes, or a bipolar course can occur, that is, a schizo-depressive may later present as a schizo-manic and vice versa. The available history suggests that all these 9 cases had unipolar course. However, we submit that the exact nature (whether schizo-manic or schizo-depressive) of previous episodes in S.A.D. cannot be ascertained by the description given by relatives or the patient, with the same ease as in the case of M.D.P. and only a prospective follow-up would further offer information in this report.

We suggest that it should be regarded as a separate entity with 2 subtypes : (1) schizo-manic disorder (S.M.D.) and (2) schizo-depressive disorder (S.D.D.). Schizo-affective disorder can be further described as unipolar or bipolar depending on the nature of the previous or further attacks of the illness.

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