ISSN: 2573-9514

Research Article

Journal of Addiction Research

Schizoaffective Disorder - The Middle Point between Schizophrenia and Psychotic Bipolar

Charmee Patadia[1], Dev Desai[2] and Maria Eleni Malafi[3*]

[1]*B J Medical College, Ahmedabad, India*

[2]*Smt NHLMMC, Ahmedabad, India*

[3]*Medical School, Democritus University of Thrace, Greece*

[*]Corresponding Author
Maria Eleni Malafi, Medical School, Democritus University of Thrace, Greece.

Submitted: 2024, Jan 11; **Accepted**: 2025, May 19; **Published**: 2025, May 28

citation: Patadia, C., Desai, D., Malafi, M. E. (2025). Schizoaffective Disorder - The Middle Point between Schizophrenia and Psychotic Bipolar. *J Addict Res, 9*(2), 01-03.

Abstract

Schizoaffective disorder and its classification have always been a topic of discrepancy among researchers. The overlapping presentations of schizoaffective disorder, schizophrenia and psychotic bipolar disorder makes it difficult to classify and diagnose. This study is a narrative review of literatures and genetic and epidemiological research evidences, done to determine the similarities and differences between schizoaffective and psychotic bipolar disorder. Beginning from the introduction of schizoaffective disorder as "schizoaffective psychosis" by Kasanin in 1933, various researchers have proposed different views regarding the diagnosis and classifications for schizoaffective disorder. DSM-III considered schizoaffective disorder as a diagnosis of exclusion as it fails to fit the definite diagnostic criteria of schizophrenia, major affective disorders, or schizophreniform disorder. DSM-V updated the criteria of schizoaffective disorder and stated it as a life time illness rather than being an episodic disorder as in DSM-IV and hence is more reliable. However, some studies show that schizoaffective disorder patients are more like schizophrenia than mood disorder. It still remains unclear whether schizoaffective disorder is a heterogenous disease, a form of schizophrenia, a form of mood disorder or a midpoint in the continuation spectrum of schizophrenia and psychotic bipolar disease.

Keywords: Schizoaffective Disorder, Schizophrenia, Bipolar Disorder with Psychotic Features, Duration of Symptoms

1. Introduction

Schizoaffective disorder, according to DSM-V, is a psychotic condition which includes at least a two-week period of psychosis without prominent mood symptoms. It is often misdiagnosed or a diagnosis of exclusion due to its overlapping symptoms with schizophrenia and mood disorder [1]. Some researchers propose it as part of schizophrenia or mood disorder others as heterogenous disease. It has always been the topic of debate for researchers and hence the purpose of this study is to determine the position of schizoaffective disorder on the schizophrenia and bipolar disorder continuum by critically assessing various findings and integrating those with some recommendations [2,3].

1.1. Aetiology

The aetiology of the disorder is not clear. However, studies schizophrenia and bipolar disorders have also led to the increased interest in schizoaffective disorder. Though there are no conclusive studies available, various genetic factors, life events, trauma and stress are considered as risk factors for mood and psychotic disorders and hence schizoaffective disorder [4]. The risk of developing schizoaffective disorder is also found to be increased in first degree relatives of patients having schizophrenia or bipolar disorder and same way there is also increased risk of developing schizophrenia or bipolar disorder in first degree relatives of patients having schizoaffective disorder [5,6]. It is observed that identical twins have 40 percent risk of developing schizoaffective disorder in the co-twin. Whereas in non-identical twins, the risk is just 5 percent. This denotes that development of schizoaffective disorder depends on genetics and other factors as well [7].

1.2. Pathophysiology

Similar to aetiology, the pathophysiology of schizoaffective disorders is also unclear. However, there might be a possible involvement of neurotransmitters like dopamine, norepinephrine and serotonin [8]. Multiple degradation areas of white and grey matter are found in the lentiform nucleus, superior temporal gyrus, precuneus, thalamus and hippocampus as compared to normal brain [9,10].

1.3. Epidemiology

Due to the changes in the criteria of schizoaffective disorder in the DSM, its diagnosis has been difficult and less common as compared

to schizophrenia, psychotic bipolar disorder and other affect disorders. This has also led to lack of large-scale epidemiological studies on its incidence and prevalence. It is observed that the incidence and prevalence of schizoaffective disorder is more common in females than in males. schizoaffective disorder has an earlier onset of around 25 to 35 years of age and patients experience more positive, delusional and thought disorder symptoms with fewer risk of developing mania and lower premorbid IQ scores than bipolar disorders [11].

1.4. History

History of schizoaffective disorders started from a dichotomous approach between the diagnoses of Schizophrenia (dementia praecox) versus psychotic Mood Disorders (manic-depressive insanity) suggested by Kraepelin in 1920. Earlier, Bleuler led to idea of conjugation of schizophrenia and manic-depressive symptoms and drew attention towards differential diagnosis of schizophrenia and manic-depressive psychosis. He proposed that presence of mood disorder symptoms along with psychosis is to be diagnosed as schizophrenia due to the presence of "fundamental" schizophrenic symptoms, irrespective of the severity of mood/ affect symptoms. Later Kasanin introduced the term "schizoaffective psychosis" in 1933 by identifying cases in his research on patients in his hospital initially diagnosed as either schizophrenic or bipolar disorder (dementia praecox) but differed from the classical presenting symptoms of both the diseases. Kasanin and Bleuler's studies concluded that a different name was needed to differentiate the atypical cases from the classical patients. This led to the creation of a diagnostic entity which was different from both schizophrenia and bipolar depression, yet shared features of both. Hence the term "schizoaffective" was coined to describe the new syndrome. The "schizo" prefix was given to describe schizophrenia specific symptoms such as hallucinations and delusions and hence it was considered to an intermediate diagnosis rather than a diagnosis of psychotic affective disorder.

The first recognition of schizoaffective disorder was established in the diagnostic and statistical manual for mental disorders (DSM)-I in 1952. DSM I and II followed the proposition of Bleuler and considered schizoaffective disorder as "schizoaffective schizophrenia" for the category of patients who presented with both schizophrenic and manic or depressive symptoms. It was classified as a subtype of schizophrenia rather than affective disorder.

Procci reviewed patients who are neither clearly schizophrenic nor clearly bipolar affective and found evidence of family history of depression and psychomotor excitation. Later, after reviewing response to lithium therapy and family studies, he concluded schizoaffective psychosis as a heterogenous group of disorder. Tsuang (1979) divided schizoaffective disorder into three subtypes namely, schizophrenic subtype, affective subtype, and undifferentiated subtype.

But in DSM-III proposed in 1980, schizoaffective disorder was denoted a diagnosis of last resort with a definition of a psychotic illness with combined symptoms of schizophrenia and affective disorder but fails to satisfy the diagnostic criteria for schizophrenia, major affective disorders, or schizophreniform disorder and was classified under "psychotic disorders not elsewhere classified." Currently, DSM-V updated the criteria of schizoaffective disorder and stated it as a life time illness rather than being an episodic disorder as in DSM-IV and hence is provides a better and more reliable criteria for diagnosis [12,13].

1.5. Schizoaffective Disorder and Schizophrenia

According to Bleuler's study schizoaffective disorder was considered as a part of schizophrenia due to the presence of symptoms considered as fundamental symptoms of psychosis and the affective symptoms were not taken into much consideration [14]. Welner et al conducted a study of family history that showed that psychosis was associated with chronic progression of illness just as seen in schizophrenia and hence supported the view of schizoaffective disorder being a part of schizophrenia [15]. Studies have found that both schizoaffective and schizophrenia patients have similar presenting pattern such as more dyskinesia and weaker family history of mood disorder. However, there were differences too, such as schizoaffective disorder has longer duration with better psychosocial functioning and more severe negative symptoms as compared to schizophrenia [16].

1.6. Schizoaffective Disorder and Mood Disorder

Some researchers had different views regarding schizoaffective disorder being a type of schizophrenia. They believed that schizoaffective disorder was just a misnomer, inappropriately labelled for a pure mood disorder due to confusion symptomatology or timeline of diagnosis. The term "schizomania" was proposed for defining symptoms of hallucinations and delusions in manic patients [17]. However further studies comparing patients of all three categories showed that the progress of schizoaffective disorder was better than that of schizophrenic patients and worse than that of mood disorder, hence it does not completely support reclassification of schizoaffective disorder as a form of mood disorder [18].

1.7. Schizoaffective Disorder as a Heterogenous Disorder

Considering age of onset, it is found that schizoaffective disorder, just like schizophrenia and mood disorder can be stated as heterogenous disease. Studies suggested presence of genetic linking between schizoaffective and schizophrenia (unexpectedly high prevalence of schizophrenia in relatives) and bipolar disorder (higher morbidity risk for manic depression in relatives of schizoaffective disorder patients) [19]. Studies by Tsuang (1979) suggested that schizoaffective disorder is genetically heterogenous and can be divided into 3 subtypes: schizophrenic, affective and undifferentiated [20].

2. Conclusion

In spite of multiple studies, there is still debate about the diagnosis

of schizoaffective disorder, from various studies stating it to be a type of schizophrenic disease to several hypothesis proposing schizoaffective disorder as an intermediate or midpoint of schizophrenic and bipolar disorders. The reason behind the controversies is the closely related range of presenting symptoms of schizoaffective disorder and schizophrenia and bipolar disorders. Further improvement in the DSM classification might make the diagnosis clearer, but according to the current classification it is suggestive that schizoaffective disorder is an intermediate with schizophrenia and bipolar/ mood disorders at poles.

Reference

1. Malaspina, D., Owen, M. J., Heckers, S., Tandon, R., Bustillo, J., Schultz, S., ... & Carpenter, W. (2013). Schizoaffective disorder in the DSM-5. *Schizophrenia research, 150*(1), 21-25.
2. Wilson, J. E., Nian, H., & Heckers, S. (2014). The schizoaffective disorder diagnosis: a conundrum in the clinical setting. *European archives of psychiatry and clinical neuroscience, 264*, 29-34.
3. Parker, G. (2019). How well does the DSM-5 capture schizoaffective disorder? *The Canadian Journal of Psychiatry, 64*(9), 607-610.
4. Robinson, N., & Bergen, S. E. (2021). Environmental risk factors for schizophrenia and bipolar disorder and their relationship to genetic risk: current knowledge and future directions. *Frontiers in genetics, 12*, 686666.
5. Cardno, A. G., & Owen, M. J. (2014). Genetic relationships between schizophrenia, bipolar disorder, and schizoaffective disorder. *Schizophrenia bulletin, 40*(3), 504-515.
6. Laursen, T. M., Munk-Olsen, T., Nordentoft, M., & Mortensen, P. B. (2007). A comparison of selected risk factors for unipolar depressive disorder, bipolar affective disorder, schizoaffective disorder, and schizophrenia from a danish population-based cohort. *Journal of Clinical Psychiatry, 68*(11), 1673.
7. Gejman, P. V., Sanders, A. R., & Duan, J. (2010). The role of genetics in the etiology of schizophrenia. *Psychiatric Clinics, 33*(1), 35-66.
8. Meltzer, H. Y., Arora, R. C., & Metz, J. (1984). Biological studies of schizoaffective disorders. *Schizophrenia bulletin, 10*(1), 49-70.
9. Antonius, D., Prudent, V., Rebani, Y., D'Angelo, D., Ardekani, B. A., Malaspina, D., & Hoptman, M. J. (2011). White matter integrity and lack of insight in schizophrenia and schizoaffective disorder. *Schizophrenia Research, 128*(1-3), 76-82.
10. Radonić, E., Radoš, M., Kalember, P., Bajs-Janović, M., Folnegović-Šmalc, V., & Henigsberg, N. (2011). Comparison of hippocampal volumes in schizophrenia, schizoaffective and bipolar disorder. *Collegium antropologicum, 35*(1), 249-252.
11. Abrams, D. J., Rojas, D. C., & Arciniegas, D. B. (2008). Is schizoaffective disorder a distinct categorical diagnosis? A critical review of the literature. *Neuropsychiatric Disease and Treatment, 4*(6), 1089-1109.
12. Jablensky, A. (2010). The diagnostic concept of schizophrenia: its history, evolution, and future prospects. *Dialogues in clinical neuroscience, 12*(3), 271-287.
13. Lake, C. R., & Hurwitz, N. (2006). Schizoaffective disorders are psychotic mood disorders; there are no schizoaffective disorders. *Psychiatry Research, 143*(2-3), 255-287.
14. Arantes-Gonçalves, F., Gama Marques, J., & Telles-Correia, D. (2018). Bleuler's psychopathological perspective on schizophrenia delusions: towards new tools in psychotherapy treatment. *Frontiers in psychiatry, 9*, 306.
15. Welner, A., Welner, Z., & Fishman, R. (1979). The group of schizoaffective and related psychoses: IV. A family studies. Comprehensive psychiatry.
16. Evans, J. D., Heaton, R. K., Paulsen, J. S., McAdams, L. A., & Jeste, D. V. (1999). Schizoaffective disorder: a form of schizophrenia or affective disorder? *The Journal of clinical psychiatry, 60*(12), 18895.
17. Spijker, J., & Claes, S. (2014). Mood disorders in the DSM-5.
18. Jorge, R. E. (2015). Mood disorders. *Handbook of clinical neurology, 128*, 613-631.
19. Husted, J., Greenwood, C. M., & Bassett, A. S. (2006). Heritability of schizophrenia and major affective disorder as a function of age, in the presence of strong cohort effects. *European archives of psychiatry and clinical neuroscience, 256,* 222-229.
20. Tsuang, M. T., Woolson, R. F., & Fleming, J. A. (1979). Long-term outcome of major psychoses: I. Schizophrenia and affective disorders compared with psychiatrically symptom-free surgical conditions. *Archives of General Psychiatry, 36*(12), 1295-1301.