Schizoaffective disorder

What is schizoaffective disorder?

Schizoaffective disorder was first described in the 1930s. This psychiatric condition has features of both schizophrenia and mood disorders - eg, depression or mania. There is a degree of heterogeneity in the term as it is used by psychiatrists and this hampers both diagnosis and research.[1] [2]

As many as 50% of patients with schizophrenia are estimated to also have depression and the aetiology for both conditions is similar: genetics, social factors, trauma and stress.[3]

How common is schizoaffective disorder? (Epidemiology)

Schizoaffective disorder is less common than schizophrenia (which is thought to have a lifetime prevalence of about 1%) but has been estimated anywhere between 0.3-1.1%.[4] [5] There are no figures on the incidence and prevalence of schizoaffective disorder in the UK but the prevalence of severe mental disorder - with psychosis within the last year - is 1.1%.[6]

The condition commonly presents in early adulthood and women are more often affected.[3]

Diagnosis[7]

DSM-5 describes four criteria for the diagnosis of schizoaffective disorder:

- Criterion A: there is an uninterrupted period of illness during which there is an episode of either major depression or mania.
- Criterion B: there is a period of at least two weeks or more where hallucinations or delusions are present in the absence of major depression or manic episodes during the lifetime of the illness.

- Criterion C: the major mood symptoms must be present for the majority of the illness.
- Criterion D: the above-mentioned features are not caused by another disorder or by substance use.

ICD-11 describes schizoaffective disorder as having an illness which has diagnostic features both of schizophrenia and of a major affective disorder (manic, mixed or moderate/severe depression) occurring simultaneously. The symptoms need to persist for one month.[8]

The schizoaffective illness can be described as:

- Bipolar type - when a manic or a mixed episode occurs.
- Depressive type - the illness has mainly depressive episodes.

Schizoaffective disorder symptoms[9]

These can be divided into major depressive episode, manic episode, mixed episode and schizophrenia type symptoms.[10]

Major depressive episode

Five of the following symptoms should be present for at least two weeks to diagnose a major depressive episode. One symptom must be either depressed mood or loss of interest or pleasure:

- Depressed mood.
- Decreased pleasure in activities.
- Weight loss or weight gain or appetite change.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation.
- Fatigue.
- Feelings of guilt or worthlessness.
- Decreased concentration.
- Recurrent thoughts of death or suicidal notions.

Manic episode

Persistently elevated or irritable mood for at least one week. Three of the following need to be present (or four if the patient has an irritable mood):

- Inflated self-esteem or grandiosity.
- Reduced need for sleep.
- Pressure of speech.
- Flight of ideas and racing thoughts.
- Easily distracted.
- Increase in goal-directed activity with psychomotor agitation.
- Excessive involvement in high-risk activities - eg, shopping sprees.

Mixed episode

Features of both manic episode and major depressive episode are present - but only for one week.

Schizophrenia symptoms

Two or more of the following are present during one month of the illness:

- Delusions - if bizarre, no other symptoms are required to make the diagnosis.

- Hallucinations - if in the form of a running commentary or two voices, no other symptoms are necessary to make the diagnosis.
- Speech abnormalities - eg, incoherent speech and/or speech derailment.
- Behavioural abnormalities - eg, disorganised or catatonia.
- Negative symptoms - eg, apathy or lack of emotions.

Differential diagnosis[3]

It is important to ascertain that the disorder is not caused by any underlying process. Main groups of differentials include:

- Substance misuse - eg, cannabis, alcohol.
- Organic illness - eg, hypothyroidism, delirium, HIV.
- Medication side-effects.
- For a depressive episode, it is necessary to ensure that it cannot be explained by recent life events - eg, recent bereavement or loss of employment.
- Other psychiatric illness - eg, dementia, delusional disorder.

Investigations

These are tailored to the presentation of the individual and are mainly used to rule out underlying causes or differential diagnoses. They may not always be necessary but when they are may include:

- Baseline bloods: FBC, renal and liver function, TFTs, HIV test.
- Urine or plasma toxicology.
- Syphilis serology.
- CXR to exclude pneumonia in the elderly.
- Other imaging if clinically indicated - eg, patients with abnormal neurology may require CT or MRI scanning.

Associated problems

Patients affected by schizoaffective disorder can also have a number of other problems. These can include:

- Learning difficulties.
- Abnormal personality - eg, antisocial or dependent.
- Psychosis.
- Substance misuse disorders.

Complications

- Poor social integration and function.
- Self-neglect.
- Difficulties with relationships.
- Substance misuse - eg, alcohol.
- Suicidal behaviour.

Schizoaffective disorder treatment and management[11]

Urgent hospital admission should be arranged for patients who are thought to be a threat to themselves or others, or who are too disabled to care for themselves. If the patient lacks capacity, compulsory admission under the Mental Health Act may be required.

Community services may be vital in keeping patients out of hospital or in managing the step-down into the community after hospital discharge. Specialist services which may be required include community psychiatric nursing and occupational therapy as well as more pragmatic support such as transport to and from hospital appointments, pharmacy delivery services and help in managing domestic and financial affairs. Early intervention services after diagnosis of psychosis are associated with better outcomes.[12]

Treatment is based largely on the treatment of schizophrenia.[13] Antipsychotics are the mainstay of treatment, sometimes combined with psychological therapies.

Pharmacological treatments can be divided into:

- Treatment of an acute exacerbation of schizoaffective disorder - antipsychotics are useful and it may be that atypical antipsychotics have some qualities superior to typical antipsychotics - eg, risperidone or olanzapine.[14]
- Paliperidone, and risperidone have proven efficacy for and are licensed for use in the long-term treatment of schizoaffective disorder.[9] [15] Clozapine may be used in treatment-resistant cases.[16]
- Treatment of ongoing depressive symptoms in schizoaffective disorder - in this situation a trial of antidepressants is warranted and these may need to continue for longer periods of time. Sertraline or fluoxetine are often used. Occasionally, electroconvulsive therapy may be required.
- There is evidence from observational studies that mood stabilisers such as lithium and carbamazepine may be useful in the treatment maintenance phase.[13]

Psychological treatments involve cognitive remediation therapy, cognitive behavioural therapy, family interventions, counselling, art therapy and supportive psychotherapy.[11] [17] [18]

Prognosis

Research on prognosis has been difficult to conduct as diagnostic difficulties and criteria have changed over time. There is evidence that schizoaffective disorder in some populations has a better prognosis than schizophrenia .[19]

Further reading

- Arndtzen M, Sandlund M; To live with a Schizoaffective disorder. J Psychiatr Ment Health Nurs. 2022 Feb;29(1):4-8. doi: 10.1111/jpm.12708. Epub 2020 Nov 15.

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