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Schizoaffective Disorder: An overview

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Abstract This paper reviews the definition of schizoaffective disorder which is not well understood or defined as other mental health conditions. This is largely because schizoaffective disorder is a mix of multiple mental health conditions that may run a unique course in each affected person. Individuals who have a family history of schizoaffective disorder and women are significantly higher at risk. Diagnostic and Statistical Manual on Mental Disorder-5 is used as a guideline to characterize the disorder as well as to differentiate it from schizophrenia and other mood/affective disorders. The symptom depends on the two subtypes of schizoaffective disorder which includes the manic and depressive type. This paper also discusses the treatment needed to help patients cope with daily basis and improve their social skills. At the current situation there is no cure for schizoaffective patients, however treatments such as pharmacologic and non-pharmacologic which includes group counselling can help reduce worsening of symptoms in patients. Hence, an earlier detection enhances a better outcome.

Keywords Schizoaffective, Schizophrenia, Affective

1. Introduction

According to Saddock, schizoaffective disorder has features of both schizophrenia and affective disorder. In current diagnostic systems, patients can receive the diagnosis of schizoaffective disorder if they fit into one of the following six categories. First, patients with schizophrenia who have mood symptoms; second, patients with mood disorder who have symptoms of schizophrenia; third, patients with both mood disorder and schizophrenia; fourth, patients with a third psychosis unrelated to schizophrenia mood disorder; fifth, patients whose disorder is on a continuum between schizophrenia and mood disorder; and finally, patients with combination of the above [1].

Generally, schizoaffective disorder has been differentiated in several ways. It can be differentiated as an affective disorder with schizophrenic symptoms, schizophrenia with affective symptoms, a transitional step between schizophrenia and affective disorder in a continuum psychosis, a genetic intermediate form with a combination of schizophrenic and affective symptoms, a possible episode of schizophrenia and affective disorder in a continuum psychosis, a genetic intermediate form with a combination of schizophrenic and affective symptoms, a possible episode of schizophrenia and affective disorder in the same patient at the same time, and as an independent illness with its individual symptoms [2].

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Research Diagnostic Criteria (RSD) defines schizoaffective disorder as the acute occurrence of a full mood syndrome (depression and/ or mania) and one of a set of "core schizophrenic" symptoms such as bizarre delusions, first-rank symptoms or nearly continuous hallucinations at the same time [3].

According to International Statistical Classification of Disease and Related Health Problems (ICD-10), schizoaffective disorder is a separate unit and can be used to patients who have co-occurring mood symptoms and schizophrenic-like mood-incongruent psychosis (Table 1) [1].

There are two subtypes of schizoaffective disorder. First is the schizoaffective bipolar type, where symptoms consist of manic episodes or manic and depressive episodes. Secondly there is the depressive type, and the symptoms are merely depressive episodes. In the year 1933 Jacob Kasanin introduced the term schizoaffective disorder. The disorder is regarded as a group of schizophrenia and affective (mood) disorder symptoms. It is clinically presented with clear-cut affective and schizophrenic symptoms that coexist in the same episode. There is disagreement on whether it is a type of mood disorder or schizophrenia. However, experts hardly agreed on treating it as a distinct disorder [1].

George H. Kirby, in 1913, and August Hoch, in 1912, both described patients with mixed features of schizophrenia and affective disorders. Their patients did not have the deteriorating course of dementia praecox (premature dementia), therefore, Kirby and Hoch classified them in Emil Kreplin's manic depressive psychosis group.

Around 1970, two sets of data shifted the view of schizoaffective disorder from a schizophrenic illness to a

mood disorder. First lithium carbonate was shown to be an effective and specific treatment for both bipolar disorder and some cases of schizoaffective disorder. Second, the United States and United Kingdom study published in 1968 by John Cooper and his colleagues, showed that the variation in the number of patients classified as schizophrenic in both states resulted from an overemphasis in The United States on the presence of psychotic symptoms as a diagnostic criterion for schizophrenia [1].

Table 1. Diagnostic Criteria for Schizoaffective Disorder According to ICD-10

ICD-10 Diagnoastic Criteria for Schizoaffective Disorder

Note: This diagnosis depends upon an approximate balance between the number, severity, and duration of the schizophrenic and affective symptoms.

G1. The disorder meets the criteria for one of the affective disorders of moderate or severe degree, as specified for each category.

G2. Symptoms from at least one of the groups listed below must be clearly present for most of the time during a period of at least 2 weeks (these groups are almost the same as for schizophrenia):

1. Thought echo, thought insertion or withdrawal, thought broadcasting (Criterion G1[1]a for paranoid, hebephrenic, or catatonic schizophrenia);
2. Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations (Criterion G1[1]b for paranoid, hebephrenic, or catatonic schizophrenia);
3. Hallucinatory voices giving a running commentary on the patient's behavior or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body (Criterion G1[1]c for paranoid, hebephrenic, or catatonic schizophrenia);
4. Persistent delusions of other kinds that are culturally inappropriate and completely impossible, but not merely grandiose or persecutory (Criterion G1[1]d for paranoid, hebephrenic, or catatonic schizophrenia), e.g., has visited other worlds; can control the clouds by breathing in and out; can communicate with plants or animals without speaking;
5. Grossly irrelevant or incoherent speech, or frequent use of neologisms (a marked form of Criterion G1[2]b for paranoid, hebephrenic, or catatonic schizophrenia);
6. Intermittent but frequent appearance of some forms of catatonic behavior, such as posturing, waxy flexibility, and negativism (Criterion G1[2]c for paranoid, hebephrenic, or catatonic schizophrenia).

G3. Criteria G1 and G2 above must be met within the same episode of the disorder, and concurrently for at least part of the episode. Symptoms from both G1 and G2 must be prominent in the clinical picture.

G4. *Most commonly used exclusion clause*. The disorder is not attributable to organic mental disorder, or to psychoactive substance-related intoxication, dependence, or withdrawal.

Schizoaffective disorder, manic type

A. The general criteria for schizoaffective disorder must be met.
B. Criteria for a manic disorder must be met.

Other schizoaffective disorders

Schizoaffective disorder, unspecified

Comments

If desired, further subtypes of schizoaffective disorder may be specified, according to the longitudinal development of the disorder, as follows:

Concurrent affective and schizophrenic symptoms only

Symptoms as defined in Criterion G2 for schizoaffective disorders

Concurrent affective and schizophrenic symptoms beyond the duration of affective symptoms

Source: Saddock. B.J, 2007

The disorder is frequently misdiagnosed because people with schizoaffective disorder have symptoms of two mental illnesses. As a consequence, it is not easy to decide exactly on the number of people who are actually affected by schizoaffective disorder. Though, it is believed to be less common than both schizophrenia and affective disorder alone. Although its exact prevalence is not clear, the lifetime prevalence of schizoaffective disorder is thought to be approximately 0.32%, with a range of 0.5-0.8%. However, this rate is only estimation; no studies have been performed. The international prevalence rates are difficult to determine, because the diagnostic criteria have changed over the last few years [1, 4].

The incidence rate of schizoaffective disorder peaked in women compared to men. Studies shows that married women are more prone to schizoaffective disorder [2, 1]. Men with schizoaffective disorder tend to exhibit antisocial traits and behaviour in contrast to other personality traits. In addition, the age of onset is later for women than for men. Older individual are said to have depressive type of schizoaffective disorder more commonly compared to younger ones; whereas the bipolar type is more common in young adults than in older individuals [1].

2. Aetiology

Till date, the aetiology of schizoaffective disorder is remaining unknown. Thus, researchers believe that there are several factors involved. There are few studies designated to explore the causes that could lead to schizoaffective disorder. Those studies include role of gender, family history and so on [1].

2.1. Role of Gender

Data from studies shows that females are at significantly higher risk for schizophrenia and other affective disorders compared to males [1]. However, this data is not completely reliable since, compared to males females are more prone to depression and need more familial factor to become ill [6].

2.2. Family History

A study conducted to observe if there is any specific pattern of family history in persons with schizoaffective disorder compared with persons with bipolar disorder and schizophrenia. It was understood that there is no difference between male and female patients when impact of family history of psychiatric admission was examined. Besides, it was also found that schizoaffective disorder was equally strongly related with bipolar and schizophrenia among first-degree relatives [2, 6].

3. Signs and Symptoms

A schizoaffective patient has severe mood changes and a number of the psychotic symptoms of schizophrenia, such as,

hallucinations, delusions and disorganized thinking. Psychotic symptoms reflect the person's failure to differentiate reality and imagination. Symptoms of schizoaffective disorder may different in each person and may can range from mild to severe. Symptoms of schizoaffective disorder are a sum of symptoms that appears in depression, mania and schizophrenia.

The symptoms of depression are such as poor appetite, weight loss or gain, change in sleeping patterns, agitation, lack of energy, loss of interest in usual activities, feeling of worthlessness or hopelessness, guilt or self-blame, inability to think or concentrate, and thoughts of death or suicide. The symptoms seen in manic patients are inclusive of increased activity, including work, social and sexual activity, increased and/or rapid talking, rapid or racing thoughts, agitation, exaggerated self esteem, distractibility, and self-destructive or dangerous behaviour. Whereas the symptoms in schizophrenia are delusions, hallucinations, disorganized thinking, odd or unusual behaviour, slow movement or total immobility, poor motivation and problem with speech and communication [5].

4. Diagnosis and Differential Diagnosis

If symptoms of schizoaffective disorder occur, a thorough physical examination and complete medical history will be performed by the doctor. A range of tests such as X-rays or blood tests will be used by the doctors to rule out a physical illness as the reason of the symptoms. If there is no physical reason for the symptoms, the patient may be referred to a psychiatrist or psychologist. Schizoaffective disorder is diagnosed if one has episodes of continuous illness and has, at some point, an episode of mania, major depression or combination of both while also having symptoms of schizophrenia [1, 7].

So far, the DSM-V criteria (Table 2) is used as a basic tool in diagnosing patients with mood disorder. To diagnose schizoaffective disorder, DSM-V criteria require a continuous period of illness during which there is a Major Mood Episode concurrent with Criterion A of Schizophrenia: hallucinations, delusions, disorganized verbal communication, grossly disorganized or catatonic behaviour, or negative symptoms such as mild emotional affect. Throughout this period, hallucinations or delusions must be present for a minimum of 2 weeks in absence of Major Mood Episodes. At some time during the illness, there must be any of Major Mood Episode meeting DSM-V criteria as stated. Symptoms should not be due to the effects of drugs or alcohol or a common medical condition [8].

Differentiating schizoaffective disorder schizophrenia and mood disorders can be difficult and confusing. The symptoms related to mood in schizoaffective disorder are unclear and persist longer than the symptoms in schizophrenia. Schizoaffective disorder maybe distinguished from a mood disorder by the fact that delusion and hallucination must be present in persons with schizoaffective disorder for at least two weeks in the absence of obvious mood symptoms. The diagnosis of a person with schizophrenia or mood disorder may change later to that of shizoaffective disorder, or vice versa [2].

Table 2. Diagnostic criteria for schizoaffective disorder according to Diagnostic and Statistical Manual of Mental Disorders (DSM-V)

DSM-V Diagnostic criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which there is a Major Mood Episode (Major Depressive or Manic) concurrent with Criterion A of schizophrenia.
B. Depressed mood. Delusions or hallucinations for 2 weeks or more in the abscence of a Major Mood Episode (Depressive oor Manic) during the lifetime duration of the illness.
C. Symptoms that meet criteria for a Major Mood Episode are present for the majority of the total duration of the active and residual portions of the illness.
D. The disturbance is not attributable to the effects of a substance or another medical condition.

Specify whether:
Bipolar type: This subtype applies if a Manic Episode is part of the presentation. Major Depressive Episodes may also occur.

Depressive type: This subtype applies if only Major Depressive Episodes are part of the presentation.

With catatonia: This specifier, which applies to both 295.70 (F25.1) Schizoaffective Disorder, with prominent depressive symptoms, and 295.70 (F25.0) Schizoaffective Disorder, with prominent Manic symptoms, may be used to specify a current episode with at least three of the following: catalepsy, waxy flexibility, grimacing, echolalia, and echopraxia

Source: Malaspina, D., et al., Schizoaffective Disorder in the DSM-5, 2013.

5. Treatment and Prognosis

It is important for a clinician to distinguish between schizoaffective disorder and schizophrenia or affective disorder to avoid misdiagnosis of patients. It is equally important to differentiate between the two types of schizoaffective disorder as the treatment varies. The issue that matters is not only about treating the patient but treating the patient with the most effective treatment plan. There is no cure for schizoaffective disorder, but treatment has been revealed to be effective in minimizing the symptoms and in helping the person better cope with the disorder and improve social functioning. Drug treatments, along with more psychosocial therapies, are often necessary to successfully treat schizoaffective disorder. Drug therapy usually can stop the patient's psychosis, but often only social and occupational rehabilitation therapies can overcome any associated problems such as unemployment, poverty and homelessness. The prognosis for schizoaffective patients

mainly depends on the type of the disorder and the existence of a trigger. Improved treatment responds are seen in the bipolar type of the disorder than in the depressive type. Commonly, earlier detection of the disorder and total compliance of the medication gives more positive outcome. Treatment for schizoaffective patients can be categorized into two: pharmacologic and non-pharmacologic [1].

5.1. Pharmacologic

5.1.1. Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) are ideal over the other types of antidepressants. The adverse-effect profiles of SSRIs are lesser compared to other drugs' profiles, therefore it promotes improved compliance [1]. However, it is suggested that antidepressants to be discontinued if psychosis worsens or if no improvements observed. Although there are side effects caused by the antidepressants, the risk seems to be minimal compared with the possible benefits of reducing distressing mood symptoms [3, 4]. It is also important for the clinicians to take into account previous antidepressant success or failure.

5.1.2. Antipsychotics

A number of studies were performed to examine the effects of atypical antipsychotics on both type of schizoaffective disorder. Antipsychotics are said to be the best available treatment for patients with acute exacerbation schizoaffective disorder or schizophrenia with depressive symptoms. Results from three studies which were done to evaluate the effect of clozapine shows that patients with bipolar type improve better than the depressive type. Another open study proved that patients treated with clozapine also showed reduced suicidal behaviour [1, 3]. On the other hand, schizoaffective patients of depressive type show better progress to risperidone than those of bipolar type [3]. Antipsychotic medications, which has thymoleptic effects are said to be insufficient in overcoming mood disturbance in the disorder.

5.1.3. Mood Stabilizers

This is also considered as an important treatment for schizoaffective patients. Lithium and carbamazepine are the examples of widely used mood stabilizers. When compared lithium with carbamazepine, it was found that carbamazepine was more effective in treatment of schizoaffective disorder, the depressive type [1].

5.2. Non-Pharmacologic Treatment

5.2.1. Psychotherapy and Counselling

Building a trusting relationship in therapy can help individuals with schizoaffective disorder better understand their condition and feel hopeful about their future [1]. Effective sessions focus on real-life plans, problems and relationships. New skills and behaviours specific to settings such as home or workplace may also be introduced.

5.2.2. Family or Group Therapy

Helping patients through education on illness, creating goals and dealing with daily problems associated with the disorder are the main purpose of the therapy. Families could deal better with loved ones through family therapy. Treatment can be more effective when schizoaffective patients are able to discuss their real-life problems with others. Supportive group settings can also help decrease social isolation and provide a reality check during periods of psychosis [4].

6. Suggestion

Patients who are considered as threat for themselves as well as to the society should be hospitalised immediately. Community services plays vital role in helping patients to overcome the stigma after discharged from hospital. Specialised services might be required which include services such as community psychiatric nursing, occupational therapy, pharmacy delivery services and guidance in managing financial affairs.

7. Conclusions

After discussing the points of view, it can be concluded that schizoaffective disorder is a combination of two illnesses which are schizophrenia and mood or affective disorder. Besides, schizoaffective disorder is a variation of schizophrenia but the exact cause still remains unknown. The symptoms of schizoaffective disorder are a sum of symptoms that emerges in schizophrenia. This disorder can be categorized into manic and depression type. However, since the symptoms of schizoaffective disorder are similar to schizophrenia and bipolar, this makes it difficult to be diagnosed. The diagnosis may take some time as it is difficult to tell the differences between schizoaffective disorder, schizophrenia and mood disorders. Usually, schizoaffective disorder can be diagnosed when the symptoms of mood disorder and schizophrenia are present simultaneously for a minimum of two weeks. Treatment for schizoaffective patients can be categorized into two: pharmacologic and non-pharmacologic. Antipsychotics, mood stabilizers and antidepressant are used in pharmacologic treatment. The effect of each drug varies according to the type of schizoaffective disorder. Apart from the pharmacologic treatment, non pharmacologic also plays an important role as an effective treatment such as psychotherapy and counselling which includes family or group therapy to help patients feel more confident in performing their daily basis routine. Besides, the goal of counselling is to help support individuals with schizoaffective disorder to understand their condition better and manage everyday problems related to this disorder.

Patients who are considered as threat for themselves as well as to the society should be hospitalised immediately. Specialised services such as community psychiatric nursing, occupational therapy, pharmacy delivery services and guidance is required in managing financial affairs. The prognosis of schizoaffective patients is mainly dependent on the type of the disorder and the occurrence of trigger. Therefore, it is important that a schizoaffective patient is treated and diagnosed as early as possible in order to have a better outcome. However, more studies should be performed with big sample sizes to explore the disease efficiently.

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