

Schizoaffective Disorder Fact Sheet

Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder. There has been a controversy about whether schizoaffective disorder is a type of schizophrenia or a type of mood disorder. Today, most clinicians and researchers agree that it is primarily a form of schizophrenia. Although its exact prevalence is not clear, it may range from two to five in a thousand people (- i.e., 0.2% to 0.5%).

Schizoaffective disorder may account for one-fourth or even one-third of all persons with schizophrenia.

To diagnose schizoaffective disorder, a person needs to have primary symptoms of schizophrenia (such as delusions, hallucinations, disorganized speech, disorganized behavior) along with a period of time when he or she also has symptoms of major depression or a manic episode. (Please see the section on Mood Disorders for a detailed description of symptoms of major depression or manic episode). Accordingly, there may be two subtypes of schizoaffective disorder:

- (a) Depressive subtype, characterized by major depressive episodes only, and
- (b) Bipolar subtype, characterized by manic episodes with or without depressive symptoms or depressive episodes.

Differentiating schizoaffective disorder from schizophrenia and from mood disorder can be difficult. The mood symptoms in schizoaffective disorder are more prominent, and last for a substantially longer time than those in schizophrenia. Schizoaffective disorder may be distinguished from a mood disorder by the fact that delusions or hallucinations must be present in persons with schizoaffective disorder for at least two weeks in the absence of prominent mood symptoms. The diagnosis of a person with schizophrenia or mood disorder may change later to that of schizoaffective disorder, or *vice versa*.

The most effective treatment for schizoaffective disorder is a combination of drug treatment and psychosocial interventions. The medications include antipsychotics along with antidepressants or mood stabilizers. The newer atypical antipsychotics such as clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole are safer than the older typical or conventional antipsychotics such as haloperidol and fluphenazine in terms of parkinsonism and tardive dyskinesia. The newer drugs may also have better effects on mood symptoms. Nonetheless, these medications do have some side effects, especially at higher doses. The side effects may include excessive sleepiness, weight gain, and sometimes diabetes. Different antipsychotic drugs have somewhat different side effect profiles. Changing from one antipsychotic to another one may help if a person with schizoaffective disorder does not respond well or develops distressing side effects with the first medication. The same principle applies to the use of antidepressants or mood stabilizers (- please see the section on Mood Disorders for details).

There has been much less research on psychosocial treatments for schizoaffective disorder than there has been in schizophrenia or depression. However, the available evidence suggests that cognitive behavior therapy, brief psychotherapy, and social skills training are likely to have a beneficial effect. Most people with schizoaffective disorder require long-term therapy with a combination of medications and psychosocial interventions in order to avoid relapses, and maintain an appropriate level of functioning and quality of life.

*Reviewed by Dilip Jeste, MD November 2003
Information from NAMI's website (www.nami.org)*