Facts about Schizoaffective Disorder

Schizoaffective disorder is a major psychiatric disorder that is quite similar to schizophrenia. The disorder can affect all aspects of daily living including work, social relationships and self care skills (such as grooming and hygiene). People with schizoaffective disorder can have a wide variety of symptoms including problems with their contact with reality (hallucinations and delusions), mood (such as marked depression), low motivation, inability to experience pleasure and poor attention. The serious nature of the symptoms of schizoaffective disorder sometimes requires clients to be hospitalized at times for treatment. The experience of schizoaffective disorder can be described as similar to "dreaming when you are wide awake"; that is, it can be hard for the person with the disorder to distinguish between reality and fantasy.

How Common is Schizoaffective Disorder?

About one in every two hundred people (1/2 percent) develops schizoaffective disorder at some time during his or her life. Schizoaffective disorder, along with schizophrenia is one of the most common serious psychiatric disorders.

How is the Disorder Diagnosed?

Schizoaffective disorder can only be diagnosed by a clinical interview. The purpose of the interview is to determine whether the client has experienced specific "symptoms" of the disorder, and whether these symptoms have been present long enough to merit the diagnosis. In addition to conducting the interview, the diagnostician must also check to make sure that the client is not experiencing any physical problems that could cause symptoms similar to schizoaffective disorder, such as a brain tumor or alcohol or drug abuse.

Schizoaffective disorder *cannot* be diagnosed with a blood test, an X ray, a CAT scan, or any other laboratory test. An interview is necessary to establish the diagnosis.

The Characteristic Symptoms of Schizoaffective Disorder

The diagnosis of schizoaffective disorder requires that the client experience some decline in social functioning for at least a six-month period, such as problems with school or work, social relationships or self-care. In addition, some other symptoms are commonly present. The symptoms of schizoaffective disorder can be divided into five broad classes: *positive symptoms, negative symptoms, symptoms of mania, symptoms of depression and other symptoms.* A person with schizoaffective disorder will have some (but not all) of the symptoms described below.

Positive Symptoms

Positive symptoms refer to thoughts; perceptions and behaviors that are ordinarily absent in people in the general population, but are present in person with schizoaffective disorder. These symptoms often vary over time in their severity, and may be absent for long periods in some clients.

Hallucinations. Hallucinations are false perceptions; that is hearing, seeing, feeling or smelling things that are not actually there. The most common type of hallucinations are *auditory hallucinations.* Clients sometimes report hearing voices talking to them or about them, often saying insulting things, such as calling them names. These voices are usually heard through the ears and sound like other human voices.

Delusions. Delusions are false beliefs; that is, a belief that the client holds but that others clearly see is not true. Some clients have paranoid delusions, believing that others want to hurt them. *Delusions of reference* are common, in which the client believes that something in the environment is referring to him or her when it is not (such as the television talking to the client). *Delusions of contro*l are beliefs that others can control one's actions. Clients hold these beliefs strongly and cannot usually be "talked out" of them.

Thinking Disturbances. The client talks in a manner that is difficult to follow, an indication that he or she has a disturbance in thinking. For example, the client may jump from one topic to the next, stop in the middle of the sentence, make up new words, or simply be difficult to understand.

Negative Symptoms

Negative symptoms are the opposite of positive symptoms. They are the absence of thoughts, perceptions, or behaviors that are ordinarily present in people in the general population. These symptoms are often stable throughout much of the client's life.

Blunted Affect. The expressiveness of the client's face, voice tone, and gestures is diminished or restricted. However, this does not mean that the person is not reacting to his or her environment or having feelings.

Apathy. The client does not feel motivated to pursue goals and activities. The client may feel lethargic or sleepy and have trouble following through on even simple plans. Clients with apathy often have little sense of purpose in their lives and have few interests.

Poverty of Speech or Content of Speech. The client says very little, or when he or she talks, it does not amount to much. Sometimes conversing with the client can be unrewarding.

Anhedonia. The client experiences little or no pleasure from activities that he or she used to enjoy or that others enjoy. For example, the person may not enjoy watching a sunset, going to the movies, or a close relationship with another person.

Inattention. The client has difficult attending and is easily distracted. This can interfere with activities such as work, interacting with others and personal-care skills.

Symptoms of Mania

In general, the symptoms of mania involve an excess in behavioral activity, mood states in particular, irritability or positive feelings), and self-esteem and confidence.

Euphoric or Expansive Mood. The client's mood is abnormally elevated; for example, he or she is extremely happy or excited (euphoria). The person may tend to talk more and with greater enthusiasm or emphasis on certain topics (expansiveness).

Irritability. The client is easily angered or persistently irritable, especially when others seem to interfere with his or her plans or goals, however unrealistic they may be.

Inflated Self-Esteem or Grandiosity. The client is extremely self-confident and may be unrealistic about his or her abilities (grandiosity). For example, the client may believe he or she is a brilliant artist or inventor, a wealthy person, a shrewd businessperson, or a healer when he or she had no special competence in these areas.

Decreased Need for Sleep. Only a few hours of sleep are needed each night (such as less than four hours) for the client to feel rested.

Talkativeness. The client talks excessively and may be difficult to interrupt. The client may jump quickly from one topic to another (called flight of ideas), making it hard for others to understand.

Racing Thoughts. Thoughts come so rapidly that the client finds it hard to keep up with them or express them.

Distractibility. The client's attention is easily drawn to irrelevant stimuli, such as the sound of a car honking, outside on the street.

Increased Goal-Directed Activity. A great deal of time is spent pursuing specific goals, at work, school, or sexually.

Excessive Involvement in Pleasurable Activities with High Potential for Negative Consequences. Common problem areas include spending sprees, sexual indiscretions, increased substance abuse, or making foolish business investments.

Symptoms of Depression

Depressive symptoms reflect the opposite end of the continuum of mood from manic symptoms, with a low mood and behavioral inactivity as the major features.

Depressed Mood. Mood is low most of the time, according to the client for significant others.

Diminished Interest or Pleasure. The client has few interests and gets little pleasure from anything, including activities previously found enjoyable.

Change in Appetite and/or Weight. Loss of appetite (and weight), when not dieting, or increased appetite (and weight gain) are evident.

Change in Sleep Pattern. The client may have difficult falling asleep or staying asleep, or may wake early in the morning and not be able to get back to sleep. Alternatively, the client may sleep excessively (such as over twelve hours per night), spending much of the day in bed.

Change in Activity Level. Decreased activity level is reflected by slowness and lethargy, in terms of both the client's behavior and his or her thought processes. Alternatively, the client may feel agitated, "on edge," and restless.

Fatigue or Loss of Energy. The client experiences fatigue throughout the day, or there is a chronic feeling of loss of energy.

Feelings of Worthlessness, Hopelessness, Helplessness. Clients may feel they are worthless as people, that there is not hope for improving their life, or that they are helpless to improve their unhappy situation.

Inappropriate Guilt. Feelings of guilt may be present about events that the client did not even cause, such as a catastrophe, a crime or an illness.

Recurrent Thoughts about Death. The client thinks about death a great deal and may contemplate (or even attempt) suicide.

Decreased Concentration or Ability to Make Decisions. Significant decreases in the ability to concentrate make it difficult for the client to pay attention to others or complete rudimentary tasks. The client may be quite indecisive about even minor things.

Other Symptoms

Clients with schizoaffective disorder are prone to *alcohol or drug abuse*. Clients may use alcohol and drugs excessively either because of the disturbing symptoms, to experience pleasure, or when socializing with others.

How Is Schizoaffective Disorder Distinguished from Schizophrenia and Affective (Mood) Disorders?

Many persons with a diagnosis of schizoaffective disorder have had, at a prior time, diagnoses of bipolar disorder or schizophrenia. Frequently, this previous diagnosis is revised to schizoaffective disorder when it becomes clear, over time, that the person has sometimes experienced symptoms of mania or depression but on other occasions has experienced symptoms such as hallucinations or delusions even when his or her mood is stable.

What is the Course of Schizoaffective Disorder?

The disorder usually beings in late adolescence or early adulthood often between the ages of sixteen and thirty. The disorder is lifelong, although the symptoms gradually tend to improve over the person's life. The severity of symptoms usually varies overtime, at times requiring hospitalization for treatment. However, most clients have at least some symptoms throughout their lives.

What Causes Schizoaffective Disorder?

The cause of schizoaffective disorder is not known although may scientists believe it is a variant of the disorder schizophrenia. Schizoaffective disorder and schizophrenia may actually be several disorders. Current theories suggest that an imbalance in brain chemicals (specifically, dopamine) may be at the root of these two disorders. Vulnerability to developing schizoaffective disorder appears to be partly determined by genetic factors and partly by early environmental factors (such as subtle insults to the brain of a baby while still in the womb or during birth).

Are There Factors That Might Increase the Likelihood of Relapse?

Factors that tend to increase the likelihood of a psychotic episode include a significant life change (good or bad), use of stimulant drugs such as amphetamines or cocaine, and stopping prescribed medications against the doctor's advice.

How is Schizoaffective Disorder Treated?

Many of the same methods used to treat schizophrenia are also effective for schizoaffective disorder. Antipsychotic medications are an effective treatment for schizoaffective disorder for most persons, but not all, persons with the disorder. These drugs are not a "cure" for the disorder, but the can reduce symptoms and prevent relapses among the majority of persons with the disorder. Antidepressant medications and mood stabilizing medications (such as

lithium) are occasionally used to treat affective symptoms (depressive or manic symptoms) in schizoaffective disorder. Other important treatments included social-skills training, vocational rehabilitation and supported employment, and intensive case management. Family therapy helps reduce stress in the family and teaches family members how to monitor the disorder. In addition, individual supportive counseling can help the person with the disorder learn to manage the disorder more successfully and obtain emotional support in coping with the distress resulting from the disorder.

Consult mental health professionals (such as a psychiatrist, psychologist, social worker or psychiatric nurse) about any questions you have concerning this handout.