

FACTS ABOUT SCHIZOAFFECTIVE DISORDER

What Is 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 different symptoms, including having unusual perceptual experiences (hallucinations) or beliefs others do not share (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 consumers to go to the hospital to get care. 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. More hospital beds are occupied by persons with these disorders than any other psychiatric disorder. However, as with other types of mental illness, individuals with schizoaffective disorder can engage in treatment and other mental health recovery efforts that have the potential to dramatically improve the well being of the individual.

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 person 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 the person 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, X-ray, 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 person 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 must be 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 usually 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 persons who are not diagnosed with schizophrenia or schizoaffective disorder, but are **present** in persons with schizoaffective disorder. These symptoms often vary over time in their severity, and may be absent for long periods in some persons.

Hallucinations. Hallucinations are "false perceptions"; that is, hearing, seeing, feeling, or smelling things that are not actually there. The most common type of hallucinations is auditory hallucinations. Individuals 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 which the person holds, but which others do not share. Some individuals have paranoid delusions, believing that they are not safe or others want to hurt them. Delusions of reference are common, in which the individual believes that something in the environment is referring to him or her when it is not (such as the television talking to the person). Delusions of control are beliefs that others can control one's actions. Individuals may hold these beliefs strongly and cannot usually be "talked out" of them.

Thinking Disturbances. This problem is reflected in a difficulty in communication. The individual talks in a manner that is difficult to follow. For example, the individual 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 who are not diagnosed with schizophrenia or schizoaffective disorder. These symptoms can often persist for a long period of time, though with effort on the individual's part they can often be improved. Many professionals think these symptoms reflect a sense of hopelessness about the future.

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

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

Anhedonia. The individual 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.

Poverty of Speech or Content of Speech. The individual says very little, or when he or she talks, there does not seem to be much information being conveyed. Sometimes conversing with the person with schizoaffective disorder can be very difficult.

Inattention. The individual has difficulty paying attention 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 individual's mood is abnormally elevated, such as extremely happy or excited (euphoria). The person may tend to talk more and with greater enthusiasm or emphasis on certain topics (expansiveness).

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

Inflated Self-Esteem or Grandiosity. The individual is extremely self-confident and may be unrealistic about his or her abilities (grandiosity). For example, the individual may believe he or she is a brilliant artist or inventor, a wealthy person, a shrewd businessperson, or a healer when he or she has 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 individual to feel rested.

Talkativeness. The individual talks excessively and may be difficult to interrupt. The individual 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 individual finds it hard to keep up with them or express them.

Distractibility. The individual'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. Often these behaviors put the person at risk.

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 person or significant others.

Diminished Interest or Pleasure. The individual 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 individual may have difficulty falling asleep, staying asleep, or wake early in the morning and not be able to get back to sleep. Alternatively, the person 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, both in terms of the individual's behavior and thought processes. Alternatively, the individual may feel agitated, "on edge," and restless.

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

Feelings of Worthlessness, Hopelessness, Helplessness. Individuals may feel they are worthless as people, that there is no hope for improving their lives, or that there is no point in trying to improve their unhappy situation.

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

Recurrent Thoughts about Death. The individual 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 individual to pay attention to others or complete simple tasks. The individual may be quite indecisive about even minor things.

Other Symptoms

Individuals with schizoaffective disorder are prone to alcohol or drug abuse. Some individuals may use alcohol and drugs excessively either because of their 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 schizophrenia or bipolar disorder. Frequently, this previous diagnosis is revised to schizoaffective disorder when it becomes clear, over time, that the person experiences symptoms of mania or depression much of the time, but on other occasions has experienced psychotic symptoms such as hallucinations or delusions even when his or her mood is stable.

What Is the Course of Schizoaffective Disorder?

The disorder usually begins in late adolescence or early adulthood, often between the ages of sixteen and thirty. The severity of symptoms usually varies over time, at times requiring hospitalization for treatment. The disorder is often life-long, although the symptoms tend to improve gradually over the person's life and many individuals who were diagnosed with the disorder when they were younger appear to have few or no symptoms from middle age on. With schizoaffective disorder, as with other major psychiatric illnesses, individuals can work to achieve their goals and live very full lives.

What Causes Schizoaffective Disorder?

The cause of schizoaffective disorder is not known, although many scientists believe it is a variant of the disorder of 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 the baby in the womb before and during birth).

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, but not all, persons with the disorder. These drugs are not a "cure" for the disorder, but they can reduce symptoms and prevent relapses among the majority of people 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 include social skills training, vocational rehabilitation and supported employment, peer support, 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. Individuals with schizoaffective disorder who work actively toward mental health recovery can positively affect the course of their illness and improve the quality of their lives. Family support for the individual's recovery efforts can lend meaningful benefits.

Summary

1. Schizoaffective Disorder is a biological disorder which likely results from an imbalance in brain chemicals.
2. Schizoaffective Disorder develops in about 1 in 200 people.
3. Common symptoms of Schizoaffective Disorder include positive symptoms (hearing voices, unusual beliefs), negative symptoms (apathy, little emotion, poor attention and concentration) and other symptoms such as depression or mania.
4. Medications can reduce symptoms of schizoaffective disorder.
5. There is hope for individuals with schizoaffective disorder. Symptoms tend to improve through the lifetime.
6. Effective treatments are available that may reduce symptoms. Individuals and their loved ones who work actively toward mental health recovery can positively improve the course of the illness and the quality of the individual's life.

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