Schizoaffective Disorder

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Introduction

- Schizoaffective disorder is characterized by persistent psychosis (eg, hallucinations, delusions) and mood episodes of depressive, manic, and/or mixed types.
- Although the DSM-based classification of psychiatric disorders identifies schizoaffective disorder as a specific clinical diagnosis, there remains a lack of consensus regarding both the conceptual and clinical aspects of this condition.

History

- Kraeplin had patients with features of both dementia praecox and MDP
- Early 20th century-Lange, Bowman and Dunton- patients with features of both dementia praecox and manic-depressive illness.
- 1933- Jacob Kasanin coined the term- ‘schizoaffective psychosis’ for co-occurrence of symptoms.

History

- Ongoing debate by the 1960s about the proper classification of schizoaffective disorder.
  1. a type of schizophrenia (e.g. ‘remitting schizophrenia')
  2. a type of affective disorder
  3. a unique separate disorder
  4. an arbitrary categorization that masks a continuum of pathology between schizophrenia and affective illness i.e. categorical versus dimensional approach
  5. a heterogeneous collection of ‘interforms'

History

- 1978-The Research Diagnostic Criteria (RDC) were the first to delineate specific criteria for schizoaffective disorder.
- Schizoaffective disorder was defined as the acute co-occurrence of a full mood syndrome and one of a set of “core schizophrenic” symptoms.

History

- DSM-I: predominantly schizophrenic reaction with elation or depression
- DSM-II: subtyped into excited and depressed.
- DSM-III: mood disorders with mood-incongruent psychotic symptoms. It relegated schizoaffective disorder to the psychotic disorders not elsewhere classified
- DSM-III-R schizoaffective disorder -“there have been delusions or hallucinations for at least two weeks, but no prominent mood symptoms” and that “the duration of all episodes of a mood syndrome has not been brief relative to the total duration of the psychotic disturbance.

History

- DSM-IV incorporated the stricter time frame of 1 months duration of schizophrenia symptoms (as part of criterion A)
- Both DSM-5 and ICD-10 criteria for schizoaffective disorder require that there be a period of concurrent psychosis and disturbance of mood.

Comparative Nosology

DSM 5	ICD 10
2 weeks of psychotic symptoms without mood symptoms	Concurrent prominent symptoms of both symptoms not fulfilling criteria for both affective and schizophrenic disorder in same episode
No comment of type of psychotic symptoms	Mood congruent psychotic symptoms excluded
Mood symptoms must be present in active and residual illness	Concurrent symptoms. If otherwise consider BPAD or RDD
Bipolar and depressive subtype	Manic and depressive subtype

Epidemiology

- A general population study in Finland using DSM-IV criteria - a lifetime rate of schizoaffective disorder of 0.32 %.
- Median age of onset- 29 years
- Gender- equal prevalence of bipolar subtype, female predominance of depressive subtype.
- Individuals with schizoaffective disorder are more likely to be married or employed than individuals with schizophrenia but less likely than those with bipolar disorder.

Etiology

- Etiological analyses have typically combined individuals with schizoaffective disorder and with schizophrenia into a single category.
- As a result, distinctive etiologic factors associated with schizoaffective disorder remain poorly researched.
- Relatives of probands with schizoaffective disorder have higher rates of mood disorder than relatives of probands with schizophrenia, higher rates of schizophrenia than relatives of probands with mood disorder.

Etiology

- Recent studies of the DISC1 gene suggest its possible involvement in schizoaffective disorder as well as schizophrenia and bipolar disorder.
- Most neuroimaging and neurocognitive studies have failed to differentiate between schizophrenia and schizoaffective disorder.

Clinical features

- Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms
- Concurrent depressive or manic symptoms
- To differentiate depression from negative symptoms, low mood must be present
- Temporal history of onset and cessation of mood and psychotic symptoms

Differential diagnoses

- Organic cause or substance induced disorder
  - clinical and historical and laboratory evidence
  - Neurological disorders, infectious diseases, metabolic abnormalities, and endocrinopathies
  - Prescription drugs, alcohol, cannabis, cocaine

Differential diagnoses

- Distinguishing between schizoaffective disorder and mood disorder with psychotic features
  - Difficult to assess the relative persistence of psychotic and mood symptoms between acute episodes
  - difficult to disentangle negative symptoms from depressive symptoms by history alone.
  - Retrospectively assessed manic episodes may be viewed as episodes of acute psychosis
  - Chronic psychosis with a few prominent mood symptoms as well as mood disorders with an acute, severely psychotic presentation may be misdiagnosed

Course and Prognosis

- Variable, outcome better than schizophrenia but poorer than mood disorders
- Levels of neurocognitive impairment and deficits in social and occupational functioning are greater than those of individuals with bipolar disorder

Course and Prognosis

- Poor outcomes factors include:
  - Poor inter episode recoveries,
  - persistent psychotic symptoms in the absence of affective features,
  - poor premorbid social adjustment,
  - chronicity,
  - higher number of schizophrenia-like symptoms

Course and Prognosis

- One European study showed that individuals with schizoaffective disorder have comparable rates of death from unnatural causes to individuals with bipolar disorder and greater rates of death from unnatural causes than individuals with schizophrenia.
- Low diagnostic stability can impact study on outcome and prognosis

Course and Prognosis

- Rates of death, due mainly to suicide or accident, show elevations in this disorder similar to those observed in schizophrenia and in major affective disorders.

Research study

- In the Suffolk County, New York, first-admission series,
- 75 % of patients with this disorder did not remit fully over the first 2 years of follow-up, compared to 87 % of patients with schizophrenia and 22 and 40 % of those with bipolar disorder with psychotic features and major depressive disorder with psychotic features, respectively.

Case studies

- Higher level of premorbid functioning as compared to schizophrenia
- One of the most common features of the disorder is a precipitating event, such as a life stressor.
- Tsuang et al. found a higher percentage of such events in schizoaffective disorder (60 %) than they did in either schizophrenia (11%) mania (27 %) or depression (39 %)

Case studies

- Marneros et al also found a higher percentage of precipitating events in schizoaffective disorder (51%) than in schizophrenia (24%) but did not detect a difference between schizoaffective disorder and affective disorder.

Management

- Treatment of affective type schizoaffective disorder will include antipsychotic medication (e.g. clozapine, risperidone or olanzapine), particularly if psychotic symptoms are present.
- In addition, antidepressants, mood stabilizers (e.g. lithium), or anticonvulsants (e.g. valproate or carbamazepine) may be useful with this group.
- It will be necessary in such cases to weigh the potential risks of such medications, such as elevated toxicity, against the potential benefits.

Management

- In schizophrenic type schizoaffective disorder, combination treatments may also be more effective than a single treatment.
- Some studies find, however, that antipsychotic treatments alone may be more efficient in many cases.
- This is particularly true if affective symptoms (i.e. depression) are largely secondary to the experience of having a psychotic condition, and its attendant interpersonal, social, and financial difficulties.

Management

- In these cases, remediation of the psychotic symptoms may also have the effect of easing the affective problems.
- For other cases, which include more of a treatment-refractory depression, antipsychotic medication may be augmented with lithium or antidepressant medication.
- Electroconvulsive therapy may reduce mortality rates in schizoaffective patients

Management

- Clinically difficult to distinguish the affective subtype from the schizophrenic subtype.
- In these cases treatment decisions must rest on the presenting symptoms of the patient.

Management

- Treatment during inter morbid periods is in part dependent on the presence or absence of psychotic symptoms.
- Psychotic episodes in this period are associated with relatively poorer outcomes, and are likely to require chronic antipsychotic therapy.

Summary

- Diagnostic dilemma
- Categorical versus dimensional approach
- Co-occurrence of symptoms simultaneously with concurrent onset.
- No specific treatment guidelines
- Prognostically falls between schizophrenia and BPAD

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