Schizoaffective Disorder At A Glance*

In schizoaffective disorder, there is a distinct episode of mood disturbance along with active symptoms of schizophrenia. In addition, either before or after this conjoint mood/psychosis disturbance, the person has experienced delusions or hallucinations for at least 2 weeks without any prominent mood symptoms. This disorder can be further classified as either bipolar type (the mood component can consist of manic, mixed, or depressed features) or depressive type (the mood component consists only of major depression features).

TREATMENT

There is a consensus that both medication and some type of psychotherapeutic treatment are indicated as combination treatment for schizoaffective disorder. When choosing medications, antipsychotics are the firstline medications of choice. In severe cases of psychotic thoughts/behaviors, hospitalization may be indicated.

If the bipolar sub-type is suspected then adding in a mood stabilizer (and an antidepressant if depressed) is indicated. If the depressive subtype is suspected then adding an antidepressant along with the antipsychotic is indicated. In general, all the antipsychotics (both typical and atypical) have shown some degree of efficacy with the exception of clozapine because of its potential to cause agranulocytosis. There is no evidence of superior efficacy of any one mood stabilizer, however there is some evidence supporting use of newer as opposed to older (tricyclic) antidepressants.

Adherence to Drug Treatment

Medication compliance is a frequent problem in this population. When this is an issue then long acting injectable forms of antipsychotics may be used.

Although psychotherapy is strongly recommended, there is no consensus about the optimal modality or approach. Some prefer group psychotherapy while others favor individual therapy in view of the isolative nature of this illness and concern about the potential for group process to intimidate these persons served.

Generally though, the type of psychotherapy recommended is supportive with a focus on either socialization or reality orientation. If available, it's advisable to obtain family involvement although it is often challenging since many persons have exhausted their family resources (both financially and emotionally). Psychotherapy that is overly intrusive or focuses on insight-orientation is not advisable.

Psychoeducation for the person served and family is highly recommended. Community support groups, self-help groups, and formal rehabilitation programs also may provide therapeutic benefits.