Diagnosis and Treatment of Schizoaffective Disorder

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Introduction: Schizoaffective disorder presents significant diagnostic challenges due to its overlap with both bipolar disorder and schizophrenia. It's crucial to obtain as meticulous and reliable a history as possible, although this can be difficult with patients experiencing active psychosis. Ideally, you'll establish the timing of mood and psychotic symptoms, which is essential for ensuring an accurate diagnosis.

Diagnosis

Patients with schizoaffective disorder have symptoms of both psychosis and major mood issues—either mania or depression or both. There are two subtypes of schizoaffective disorder—depressed type and bipolar type, and you have to specify the type in the medical record. Just writing "schizoaffective disorder" is not enough.

Diagnosing it can be tricky, because you have to distinguish it from other disorders that can also blend psychosis with mood symptoms, such as bipolar disorder, depression with psychosis, or schizophrenia with depression. For a comprehensive fact sheet on the differential diagnosis of psychosis, see "**How to Determine the DSM-5 Diagnosis of Patients with Psychosis."**

Diagnostic criteria for schizoaffective disorder:

- **Concurrent Psychotic and Mood Symptoms:** A significant period where psychotic symptoms occur alongside mood symptoms. (See below for what qualifies as psychotic and mood symptoms).
- **Psychotic Symptoms**: Presence of at least two of the following five major symptoms of psychosis—(1) delusions, (2) hallucinations, (3) disorganized speech, (4) disorganized behavior, or (5) negative symptoms. At least one of the two qualifying psychotic symptoms must be delusions, hallucinations, or disorganized speech. (This is the same as the requirement for diagnosing schizophrenia).
- **Major Mood Episode**: A major mood episode must be present for a majority of the total duration of the illness. A "major mood episode" can be either a major depressive episode, a full blown manic episode, or a mixed manic episode.
    - Note: A hypomanic episode or dysthymia does not meet the criteria.
- **Delusions or hallucinations for at least two weeks without prominent mood symptoms.**
    - This is a difficult criterion to ascertain. Often you will have to check in with collaterals like outpatient providers or family members to confidently confirm that at some point in the patient's life, they have been psychotic for 2 weeks without either mania or depression. This requirement helps distinguish it from conditions like bipolar disorder with psychosis or major depressive disorder with psychosis, where psychotic symptoms occur exclusively during mood episodes.

Treatment

Pharmacological Management

- **Antipsychotics**:
    - The only FDA approved medication for schizoaffective disorder is **paliperidone** (Invega), though **risperidone** (from which paliperidone is derived) also has good efficacy data.
    - It's likely that most, if not all, other antipsychotics are just as effective as the above medications, but the studies have not yet been published to prove this. A reasonable approach is to review the patient's history of medications, and if there is no documented trial of either paliperidone or risperidone, give

these a try. But if they have already failed these agents, choose any other antipsychotic in the same way that you choose medications for schizophrenia, e.g. based on side effect potentials and preferences of individual patients.

- **Mood Stabilizers**: For those with bipolar-type schizoaffective disorder, add a mood stabilizers such as lithium, valproate, or lamotrigine.
- **Antidepressants**: For depressive-type schizoaffective disorder, add your antidepressant of choice.

Psychosocial Interventions

- **Cognitive Behavioral Therapy (CBT)**: Targets delusional beliefs and hallucinations while also focusing on mood symptom improvement.
- **Family Therapy**: Just a few sessions on the inpatient unit will help to educate family members, and, post-discharge, to bolster treatment adherence and reduce relapse rates.
- **Psychoeducation**: This helps patients develop a better understanding of the disorder; also, promotes adherence to treatment and will help patients identify early signs of a potential relapse post-discharge.
- **Social Skills Training and Supported Employment/Education Programs:** While these long term interventions might not be initiated in the hospital, they are crucial for long term success because schizoaffective disorder is a chronic and disabling condition. Collaborate with your social worker in referring patients to these kinds of community programs.