Background associated with schizoaffective disorder

The term schizoaffective psychosis was introduced by the American psychiatrist Jacob Kasanin in 1933 to describe an episodic psychotic illness with predominant affective symptoms that at the time to be good-prognosis schizophrenia. Kasanin concept of the illness was influenced by the psychoanalytic teachings of Adolf Meyer and Kasanin postulated that schizoaffective psychosis was caused by “ emotional conflicts” of a “ mainly sexual nature” and that psychoanalysis “ would help prevent the recurrence of such attacks.” He based his description on a case study of nine individuals. Other psychiatrists, before and after Kasanin, have made scientific observations of schizoaffective disorder based on assumptions of a biological and genetic etiology of the illness. In 1863, German psychiatrist Karl Kahlbaum (1828-1899) described schizoaffective disorders as a separate group in his vesania typical circularis. Kahlbaum distinguished between cross-sectional and longitudinal observations. (Cross-sectional refers to observation of a single, specific episode of the illness, for example, one episode of psychotic depression; while longitudinal refers to long-term observation of many distinct episodes [similar or different] often occurring over the span of years.) In 1920, psychiatrist Emil Kraepelin (1856-1926), the founder of contemporary scientific psychiatry, observed a “ great number” of cases that had characteristics of both groups of psychoses that he originally posited were two distinct and separate illnesses, dementia praecox (now called schizophrenia) and manic depressive insanity (now called bipolar disorder and recurrent depression) Kraeplin acknowledged that “ there are many overlaps in this area”, that is, the area between schizophrenia and severe mood disorders In 1959, psychiatrist Kurt Schneider (1887-1967) can be said to have been the first to begin to conceptualize the different forms

that schizoaffective disorders can take since he observed “ concurrent and sequential types”. The concurrent type of illness he referred to is a longitudinal course of illness with episodes of mood disorder and psychosis occurring predominantly at the same time; while his sequential type refers to a longitudinal course predominantly marked by alternating mood and psychotic episodes.) Schneider described schizoaffective disorders as “ cases in-between” the traditional Kraepelinian dichotomy of schizophrenia and mood disorders. historical phenomenological observation that schizoaffective disorder is an overlap of schizophrenia and severe mood disorders has more recently been assumed to be explained by genes for both illnesses being present in individuals with schizoaffective disorder. However, recent research shows that schizophrenia and severe mood disorders appear to share common genes and polygenic variations also. Schizoaffective disorder was included as a subtype of schizophrenia in DSM-DSM-II and I, though research showed a schizophrenic cluster of symptoms in individuals with a family history of mood disorders whose illness course, other symptoms and treatment outcome were otherwise more akin to bipolar disorder than to schizophrenia. DSM-III placed schizoaffective disorder in “ Psychotic Disorders Not Otherwise Specified” before being formally recognized in DSM-III-R. DSM-III-R included its own diagnostic criteria as well as the subtypes, bipolar and depressive. In DSM-IV, published in 1994, schizoaffective disorders belonged to the category “ Other Psychotic Disorders” and included almost the same criteria and the same subtypes of illness as DSM-III-R, with the addition of mixed bipolar symptomatology the cause of schizoaffective disorder is unknown, the cause may be similar to schizophrenia nature versus nurture. To date, no specific genetic markers

have been identified. Environmental causes of malnutrition, viral infections, or complication at birth may play a role. Finally, abnormalities of the neurotransmitters serotonin, nor epinephrine, and/or dopamine could all have a role in this disorder. More research is needed. The causes of schizoaffective disorder biological models of schizophrenia, genetic predisposition, infectious agents, allergies, and disturbances in metabolism have all been investigated. Schizophrenia is known to run in families. Thus, the risk of illness in an identical twin of a person with schizophrenia is 40-50%. A child of a parent suffering from schizophrenia has a 10% chance of developing the illness. The risk of schizophrenia in the general population is about 1%. The current concept is that multiple genes are involved in the development of schizophrenia and that factors such as prenatal (intrauterine), prenatal, and nonspecific stressors are involved in creating a disposition or vulnerability to develop the illness. Neurotransmitters (chemicals allowing the communication between nerve cells) have also been implicated in the development of schizophrenia. The list of neurotransmitters under scrutiny is long, but special attention has been given to dopamine, serotonin, and glutamate. In addition, recent studies have identified subtle changes in brain structure and function, indicating that, at least in part, schizophrenia could be a disorder of the development of the brain It is important for doctors to investigate all reasonable medical causes for any acute change in someone’s mental health or behavior. Sometimes a medical condition that might be treated easily, if diagnosed, is responsible for symptoms that resemble those of schizophrenia.

Courtney is a 27-year-old student at Walters State Community College that is diagnosed with schizoaffective diosder. Courtney felt that she was not as good as other people were therefore she mainly kept to herself mostly and she avoided social interactions with other people. Courtney was taking care of her 75 years old grandmother who had Alzheimer's disease for the last four years. Courtney communication between her family seems to be distance because of her family negative outlook toward her diagnosis that causes hostile behavior toward Courtney. Courtney has had problems in the past result from manic depression, that she had received treatment for about two years ago. She has experience manic episode and her symptoms range from sleep interruptions and drowsiness and crabbiness during days at a time. Furthermore she also found herself in a do not care mood most of the time and her school and work suffered from this aspect. Three weeks ago, Courtney depression began to become worst that Courtney began to cry and slept every moment. She was extremely angry with everybody for various reasons. At times she would think how other people were mistreating her and doing her wrong she though the world was unfair and rude. Courtney was experiencing anger mixed in with depression so bad that she began to clean her bedroom and she throw out many of her clothes. She also felt that she should take a drive in order to burn off anger. Furthermore, she began to withdraw from family and friends. Afterwards Courtney family had to call mobile crises because they felt that Courtney was experience a manic episode. Evenly Courtney was committed to a psychiatric Hospital. People with schizoaffective disorder received treatment in a psychiatric hospital. The setting of a psychiatric hospital is where symptoms of psychosis can be observed and evaluated as medication begins to take effects doctors and

nurse can evaluate whether the target symptoms are resolved and side effects are kept to a minimum. Courtney diagnosis is based on the self-reported experiences of the person as well as abnormalities in behavior reported by family members, friends or co-workers to a psychiatrist, psychiatric nurse, social worker or clinical psychologist in a clinical assessment. This of criteria that must be met for someone to be so diagnosed. These depend on both the presence and duration of certain signs and symptoms. DSM-IV-TR criteria for a diagnosis of schizoaffective disorder are two or more of the following symptoms. That is present for the majority of a one-month period or a shorter period. Symptoms consist of the following delusions, hallucinations disorganized speech for instance, frequent derailment or incoherence which is a manifestation of formal thought disorder. Furthermore, grossly disorganized behavior for example, dressing inappropriately, crying frequently or catatonic behavior negative symptoms such as, affective flattening lack or decline in emotional response and alogia lack or decline in speech. Avolition lack or decline in motivation. Anhedonia is the lack or decline in ability to experience pleasure and social withdrawal. Negative symptoms that are not present or diminished in the affected persons but are normally found in healthy persons. Delusions are judged by bizarre or hallucinations that consist of hearing one voice participating in a running commentary of the individual’s actions or of hearing two or more voices conversing with each other, only that symptom is required to meet criterion above. The speech disorganization criterion is only met if it is severe enough to substantially impair communication and at some time during the illness there is either one, two or all three of the following includes major depressive episode , manic episode and mixed episode. During the

illness, delusions or hallucinations were present for a minimum of two weeks, without major mood symptoms. For a substantial part of the overall duration of the both the active and residual period of the illness, symptoms meeting criteria for a mood episode are present. Symptoms are not caused by drug abuse, medication or another medical condition. Two subtypes of schizoaffective disorder exist and may be noted in a diagnosis based on the mood component of the disorder. Bipolar type if the disturbance includes manic episode and mixed episode. Major depressive episodes usually, but not always, also occur in the bipolar subtype; however, they are not required for DSM-IV diagnosis. The depressive type is noted when the disturbance includes major depressive episodes exclusively. This subtype applies if major depressive episodes only (and no manic or mixed episodes) are part of the presentation.

Courtney treatment for schizoaffective disorder consists of a combination of medicine, psychotherapy and psychosocial rehabilitation focused on recovery or symptom management, depending on a patient’s unique situation. A licensed psychiatrist will prescribe combinations of medicine for Courtney. Common medicines used to treat schizoaffective disorder for psychotic symptoms narcoleptic medications such as risperidone may be used. For manic symptoms, mood stabilizer medications may be prescribed along with a narcoleptic for examples are Lithium salt (Lithium), (Depakote ER) Carbamazepine (Tegretol). For depression, antidepressant medications may be prescribed along with a narcoleptic. Examples are SSRI antidepressants (includes celexa and Zoloft among others) Lamictal (a mood stabilizer with antidepressant properties). In schizoaffective individuals with

manic symptoms, combining lithium, carbamazepine, or valproate with a narcoleptic has been shown to be superior to narcoleptics alone. Lithium-narcoleptic combinations, however, may produce severe extrapyramidal reactions or confusion in some patients. When lithium is not effective or well tolerated in manic individuals with schizoaffective disorder, Tegretol or Depakote are frequently used. Granulocytopenia can occur during the first few weeks of carbamazepine treatment, and narcoleptic blood levels may be decreased substantially due to hepatic enzyme induction. Valproate in rare cases, cause liver toxicity and platelet dysfunction. Calcium channel blockers such as verapamil may also be an effective treatment for manic symptoms but are seldom prescribed for that purpose. The degree of benefit for Courtney should be considered carefully, as each of these medications carries its own risks. Benzodiazepines such as Ativan and Klonopin are effective adjunctive treatment agents for acute manic symptoms, but long-term use may result in dependency. In schizoaffective individuals with depressive symptoms, an antidepressant (for example, Prozac or other SSRIs) may be prescribed with a narcoleptic. The SNRI antidepressants and Wellbutrin tend not to be prescribed in schizoaffective disorder because they may cause mixed episode symptoms and induce psychosis, respectively. The anticonvulsant Lamictal is gaining prominence in treating depressed schizoaffective individuals because antidepressants appear to increase the risk of mood cycling in some individuals, which is a safety concern. Often a sleeping pill will be prescribed initially to allow the individual rest from his or her anxiety, delusions, or hallucinations. Long-term use of sleeping medications can cause dependence and can cause delusions and hallucinations thereby exacerbating psychosis. Nutritional supplements and

lifestyle changes are both being studied to augment existing treatments as well. Frequently co-occurring conditions such as mitochondrial dysfunctions, adrenal fatigue, sleep disorders, and diabetes are the targets of nutritional and lifestyle changes. Omega-3 fatty acid supplementation is used as a nutritional aid for many mental disorders including schizoaffective disorder. Some depressed schizoaffective individuals use 5-HTP, an amino acid and precursor to serotonin, in place of SSRI antidepressants to avoid associated side effects. Other supplements with antidepressant properties, St John's Wort and SAM-e, however, may cause adverse reactions of mixed-state symptoms or psychosis in depressed schizoaffective individuals. The only medicine that is FDA-approved for Schizoaffective Disorder is paliperidone.

Patients who have schizoaffective disorder can greatly benefit from psychotherapy and well as psycho educational programs. They should receive therapy that involves their families, develops their social skills, and focuses on cognitive rehabilitation. Psychotherapies should include supportive therapy and assertive community therapy in addition to individual and group forms of therapy and rehabilitation programs. Treatment includes education about the disorder and its treatment, family assistance in compliance with medications and appointments, and maintenance of structured daily activities such as schedule of daily events for the patient. Family involvement is needed in the treatment of this particular disorder. Family education is particularly important in this disorder secondary to the various mood and psychotic states. Families need information regarding patient's mediations and the dynamic nature of this illness Psychosocial rehabilitation helps Courtney develop skills to work and get along with other

people. Courtney goal is to her live as she chooses and eventually to have as little professional assistance as possible. Psychosocial rehabilitation programs includes clubhouse that Courtney can attend during the day to learn cooking, maintenance or clerical skills. Psychosocial agencies often operate affordable housing programs that offer a range of choices that have more or less supervision. Options may include group's homes, supervised apartments, or independent housing with a roommate. On the other hand complications of treatment are similar to those for schizophrenia and major mood disorders. This includes problems following medical treatment and therapy. Secondly, use of unsanctioned drugs in an attempt to self-medicate . Thirdly short-term side effects and problems arising from long-term use of prescribed medications, including drug interactions. Then problems resulting from manic behavior for example, spending sprees, sexual indiscretion. Finally, suicidal behavior tends to depressive or psychotic symptoms. However Courtney Prognosis with schizoaffective disorder tend to have better outlook than those with schizophrenia, and about the same or worse outlook depressive subtype having the least favorable outlook as those with bipolar disorder. It is important to note that individual outcomes may be more or less favorable. Prognoses are based on statistical averages of large groups of patients. As with any chronic illness, compliance with medication is important, especially since more than one medication is often prescribed. Psychiatric rehabilitation plays an important part in maximizing the individual's chances at recovery, which may result in a better prognosis.

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