blood sugars, which can lead to diabetes. Given how complicated these choices may be, it is necessary for any individual with schizoaffective disorder and their loved ones to discuss medication management strategies with their doctors.

*What is Tardive Dyskinesia?

Tardive dyskinesia (TD) is one of the most disturbing potential side effects of antipsychotic medications. Tardive (late) dyskinesia (bad movement) is a movement disorder that occurs over months, years and even decades. TD is a principle concern of first generation antipsychotic medication but has also been reported in second generation antipsychotic medication. All people who take these medications need to be carefully monitored. TD is one of a group of side effects called “extrapyramidal symptoms” that includes akathesia (restlessness), dystonia (sudden and painful muscle stiffness) and Parkinsonism (tremors and slowing down of all body muscles). TD is perhaps the most severe of these side effects and does not occur until after many months or years of taking antipsychotic drugs.

TD is primarily characterized by random movements of different muscles within the body and can occur in the tongue, lips or jaw (e.g., facial grimacing). It may also consist of purposeless movements of arms, legs, fingers and toes. In some severe cases, TD can include swaying movements of the trunk or hips or affect the muscles associated with breathing. TD can be quite embarrassing and—depending on its severity—can be disabling as well.

Recovery

Recovery does not mean that the illness has gone into complete remission. Over time, and after what for many can be a long and difficult process, individuals can come to terms with their illness by first learning to accept it and then moving beyond it.

This includes learning coping mechanisms, believing in themselves as individuals by learning their strengths as well as their limitations, and coming to realize that they have the capacity to find purpose and enjoyment in their lives in spite of their illness. **RECOVERY IS POSSIBLE**!

How to Get Help

No insurance? Call the NAMI Southern Arizona office to help guide you to access mental health services.

If you have Schizoaffective Disorder:

- Seek medical care through a psychiatrist and/or your primary care physician.
- Find the right combination of treatment that works for you which may include medication, therapy, support groups, etc. **Sometimes people must try several different treatments or combinations of treatment before they find the one that works for them.*
- Take NAMI’s Peer-to-Peer course and/or join the NAMI Connection support group.
- LEARN about your illness. The more you know, the more you are able to help yourself. Start with NAMI today!

SCHIZOAFFECTIVE DISORDER

SHOW YOU CARE.
WEAR A SILVER RIBBON.

- **Help break down the barriers to treatment and support.**
- **Help reduce stigma —talk about it!**

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NAMIsa.org

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Educational information and local support provided by:

NAMI SOUTHERN ARIZONA
National Alliance on Mental Illness

What is schizoaffective disorder?

Schizoaffective disorder is a serious mental illness that affects about one in 100 people. Schizoaffective disorder as a diagnostic entity has features that resemble both schizophrenia and also serious mood (affective) symptoms. Many of the strategies used to treat both schizophrenia and affective conditions can be employed for this condition. These include antipsychotic and mood stabilizing medications, family involvement, psychosocial strategies, self-care peer support, psychotherapy and integrated care for co-occurring substance abuse (when appropriate).

A person who has schizoaffective disorder will experience delusions, hallucinations, other symptoms that are characteristic of schizophrenia and significant disturbances in their mood (e.g., affective symptoms). According to the DSM-5, people who experience 2 or more weeks of psychotic symptoms in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness—may have schizoaffective disorder. Schizoaffective disorder is thought to be between the bipolar and schizophrenia diagnoses as it has features of both.

Depressive symptoms associated with schizoaffective disorder can include—but are not limited to—hopelessness, helplessness, guilt, worthlessness, disrupted appetite, disturbed sleep, inability to concentrate, and depressed mood (with or without suicidal thoughts). Manic symptoms associated with schizoaffective disorder can include increased energy, decreased sleep (or decreased need for sleep), distractibility, fast ("pressured") speech, and increased impulsive behaviors (e.g., sexual activities, drug and alcohol abuse or gambling).

While it is a hot-topic of debate within the mental health field, most experts believe that schizoaffective disorder is a type of chronic mental illness that has psychotic symptoms at the core and with depressive and manic symptoms as a secondary—but equally debilitating—component. Because it consists of a wide range of symptoms, some people may be inappropriately diagnosed with schizoaffective disorder. This is problematic because it can lead to unnecessary treatments, specifically medication-treatment with antipsychotics when they are not otherwise indicated.

People who have depression or mania as their primary mental illness may experience symptoms of psychosis (including disorganized speech, disorganized behavior, delusions, or hallucinations) during severe episodes of their mood disorder but will not have these symptoms if their mood disorder is well treated. Sometimes people with other mental illnesses, including borderline personality disorder, may also be incorrectly diagnosed with schizoaffective disorder.

This further underscores how important it is to have regular and complete mental health assessments from one's doctors, preferably over time so that patterns of what is happening and what works can be fully understood together.

Culture-Related Diagnostic Issues

Cultural and socioeconomic factors must be considered, particularly when the individuals and the clinician do not share the same cultural and economic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. There is also some evidence in the literature for over diagnosis of schizophrenia compared with schizoaffective disorder in African American and Hispanic populations, so care must be taken to ensure a culturally appropriate evaluation that includes both psychotic and affective symptoms.

What treatments are available?

For most people with schizoaffective disorder, treatment will be very similar to treatment of schizophrenia and will include antipsychotic medications to help address symptoms of psychosis. Finding the right type and dose of antipsychotic medication is important and requires collaboration with a doctor. In some cases, people with schizoaffective disorder will be offered treatment with long-acting-injectable (also called LAI, decanoate) formulations of antipsychotic medications. These FDA approved medications—including haloperidol (Haldol Decanoate), risperidone (Risperdal Consta), palperidone (Invega Sustenna)—are given in the form of an intramuscular injection ("shot") approximately once or twice each month and have been shown to decrease the rates of relapse and hospitalization.

Treatments such as cognitive behavioral therapy to target psychotic symptoms, support groups to increase family and community support, peer support and connection, and work-and-school rehabilitation, such as social skills training, are very helpful for people with schizoaffective disorder.

Maintaining a healthy lifestyle is also of critical importance: the role of good sleep hygiene, regular exercise, and a balanced diet cannot be underestimated. Omega-3 fatty acids (commonly marketed as "Fish Oil") are an over-the-counter supplement that some may find useful.

Symptoms of depression—in people with schizoaffective disorder—may be treated with antidepressant medications or lithium in addition to antipsychotic medications. People with bipolar symptoms may be treated with mood-stabilizers such as lithium or anticonvulsants, including valproic acid (Depakote), lamotrigine (Lamictal), and carbamazepine (Tegretol), in addition to their antipsychotic medications.

There are some studies that suggest that older ("first-generation," "typical") antipsychotic medications are not as effective in controlling the mood symptoms associated with schizoaffective disorder as newer ("second-generation," "atypical") antipsychotic medications. Newer antipsychotic medications may be less likely to cause side effects such as *tardive dyskinesia,* but they are more likely to cause weight gain, high cholesterol, and increased