International Journal of Medical Science and Health Research

Vol.10, No.06; 2026

ISSN: 2581-3366

Unmasking Schizoaffective Disorder in a 16-Year-Old Patient With Autism Spectrum Disorder

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doi: 10.51505/ijmshr.2026.10604 URL: http://dx.doi.org/10.51505/ijmshr.2026.10604

Received: Oct 22, 2026 Accepted: Nov 02, 2026 Online Published: Nov 13, 2026

Abstract

Background: Autism Spectrum Disorder (ASD), a neurodevelopmental disorder characterized by social communication difficulties and rigidity, and schizoaffective disorder, which involves the presence of psychosis/schizophrenia and mood disorder, are psychiatric conditions that can cause significant distress to children and adolescents, especially when they present together and overlap with each other, potentially leading to diagnostic overshadowing.

Case Presentation: We investigate the case of a 16-year-old male with established ASD presenting with new-onset psychotic and mood symptoms and explore the barriers to diagnosing and treating his schizoaffective disorder.

Conclusion: This case highlights the importance of clearly determining baseline functioning and evaluating new psychiatric symptoms and behavioral changes independently in patients with ASD to prevent delayed recognition and treatment of comorbid schizoaffective disorder.

Keywords: Autism Spectrum Disorder (ASD), Schizoaffective Disorder, Psychosis, Diagnostic Overshadowing, Psychiatric Comorbidity

Introduction:

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that manifests as lasting and significant deficits in social interactions and communication as well as rigidity and repetition of certain behaviors and thoughts (1). It is commonly associated with other mental health conditions like ADHD and Obsessive-Compulsive Disorder (OCD). There is also an association with schizophrenia-spectrum disorders, which include schizophrenia and schizoaffective disorder, with the pooled prevalence of these disorders in Adults with ASD being around 12%,

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ISSN: 2581-3366

significantly higher than the 1-2% prevalence of this spectrum of conditions in the general population (2)(3).

Schizoaffective disorder is a psychiatric disorder that is characterized by the presence of schizophrenia along with a mood disorder (4). Specifically, for a patient to be diagnosed with schizoaffective disorder as per the DSM-5, they must meet Criterion A for schizophrenia, in addition to having experienced a major episode of mania (bipolar type) or depression (depressive type). The patient must also have gone through a period of atleast two weeks during which they experience symptoms of psychosis (delusions or hallucinations) in the absence of a major mood episode (5).

This case presentation focuses on a patient with a long-established history of ASD presenting with features of schizoaffective disorder, which included distressing auditory hallucinations, increased aggression, and sleep disturbance linked to elevated mood. It explores the potential for diagnostic overshadowing relating to the attribution of affective and psychotic symptoms to established neurodevelopmental conditions and the potential to miss addressing new-onset or latent psychotic disorders because of this (6).

Case Presentation:

A 16-year-old boy presented, with his parents, with increased aggression and complaining of hearing voices. These symptoms had occurred persistently for about 2 months without any clear trigger. His aggressive behavior included violence, which was growing more concerning and harder to manage for his parents. During these outbursts, he would sometimes hit his mother, but became very remorseful afterward. The voices that he was hearing were not recognizable to him and did not speak directly to him but they spoke about him regarding topics he found very distressing. The patient was evaluated in the emergency room twice, first around one month after the onset of symptoms and next two weeks before his presentation, both for episodes that included screaming, hitting and talking to himself. Additionally, the patient complained of severe sleeping difficulties, feeling too excited and not tired at night in addition to some anxiety and general agitation. Further investigation revealed a distinct manic episode, which involved a decreased need for sleep, psychomotor agitation, and excitability. The third-person auditory hallucinations he experienced and disorganized behavior he demonstrated also persisted for over two weeks after his specific mood episode ended.

Notably, at two years old, the patient was diagnosed with ASD. His gestational and birth history was unremarkable, although his walking was delayed. At around 15 months of age, his mother noticed a rather sudden behavioral change, where he became very irritable and would refuse food, throw objects and engage in harmful repetitive actions like banging his head on the table. As he grew older, the patient demonstrated significant cognitive rigidity and difficulty socializing with others. He would also, starting from his preteen years, talk to himself often.

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ISSN: 2581-3366

When these more recent symptoms emerged, it was initially unclear to both his parents and medical professionals whether they might represent an exacerbation of his preexisting condition. Following psychiatric admission and the exclusion of a medical cause, it was determined that the patient met the criteria for schizoaffective disorder, bipolar type, and he was prescribed aripiprazole for his psychotic symptoms, lithium and divalproex sodium for his mood symptoms and olanzapine and diphenhydramine to help with sleep.

Discussion:

There is a lot of overlap between ASD and schizophrenia-spectrum disorders, from an epidemiological, genetic, and phenotypic perspective. Firstly, those with ASD are between three to six times more likely to develop schizophrenia than neurotypical individuals (2). There are numerous theories about why this might be the case, including shared heritable traits and common pathophysiological mechanisms relating to overlapping neural network abnormalities driving the two conditions (2)(7). As such, it is important for physicians to be particularly vigilant for psychotic and mood symptoms in their patients with autism.

Although the epidemiological link between ASD and schizophrenia/schizoaffective disorder is relatively well known, similarities in the way the two conditions present can sometimes lead to diagnostic overshadowing. For example, both conditions can feature idiosyncratic beliefs and unconventional behavior (8). In ASD, these beliefs and behaviors are typically linked to rigidity and a preference for a specific way of doing things that provides comfort through order and repetition (1)(8). Conversely, in schizoaffective disorder and schizophrenia, these beliefs are fixed and false, representing delusions and, together with hallucinations, drive witnessed behavior and internal agitation (4)(8). The patient had rigid beliefs and related behavior linked to his ASD but then also developed hallucinations that were distinct from his established rigidity.

Additional shared features between the two, like social withdrawal/isolation, flat affect, and difficulties in nonverbal communication, can also contribute to late or missed diagnoses of psychosis and mood disturbance, as such “negative” or depressive/manic symptoms can be mistakenly labeled as core symptoms of ASD. To best ascertain the potential comorbidity of these 2 conditions in a child, it is important to first determine the normal, baseline functioning of the individual and rule out any non-psychiatric (i.e., environmental or medical) causes of the symptoms in question. Then, the onset of new symptoms becomes clearer and easier to ascribe to a novel, second psychiatric diagnosis for the patient, such as schizoaffective disorder (8)(9).

The prompt recognition and treatment of secondary psychiatric diagnoses is essential in this already vulnerable population. As ASD is also linked with other mental health conditions like ADHD, patients may be taking medications like stimulants, which could increase the risk of psychosis in schizophrenia (10). Furthermore, there is evidence to suggest that there may be a poorer initial response to treatment for psychosis in individuals with ASD, which may complicate management and highlights the importance of close monitoring and individualized treatment (2).

Ultimately, this case emphasizes the need to investigate all new psychiatric symptoms with due diligence and without bias, especially in those with preexisting psychiatric and neurodevelopmental disorders like ASD. Physicians should note both the overlap in incidence of ASD and schizophrenia-spectrum disorders and the similarities in how they can present, which may mask the discovery of the co-occurrence of these two conditions.

Declaration of Conflicting Interests

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Consent for Publication

Informed consent for the publication of this case report was obtained. All patient-identifiable information has been omitted to protect patient confidentiality.

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