•:• CASE 26

A 15-year-old girl is brought to your office by her family after a recent hospitalization for a suicide attempt. She made this attempt shortly after a party she attended the previous weekend. At this party, she reportedly argued with her best friend and left very angry. Her history at admission shows a several month history of irritability, worsening performance in school, poor sleep, anhedonia, anergia, and isolation from her family and friends. Her discharge summary has an admitting diagnosis of major depression for which she was started on fluoxetine (Prozac). She sees you 2 weeks after her 3 day hospitalization and is quite cheery, energetic, and happy. She reports no problems and dismisses her earlier suicide attempt as a childish act to get attention. She reports that the staff at the hospital were absolutely wonderful and helped her solve all her problems. She says that she was so impressed with them, that she has decided to go into psychiatry herself so she can help others. Later, while meeting with the parents, they report that at home she is sleeping well and appears in a good mood. But. they are concerned because they also report that she is worried about whether there were cameras in the doctor's office that were recording her. She also reports that she believes she is being stalked by several of the boys at her school.

- **What is the most likely diagnosis?**
- **What is the best therapy for this condition?**
- **Should this patient be hospitalized?**

ANSWERS TO CASE 26: Schizoaffective Disorder

Summary: This is a 15-year-old girl who has a diagnosis of and evidence of major depression with a suicide attempt. She is treated for this and seems to respond well. The parents however note that she has some evidence of paranoia that is still present after the mood symptoms have resolved.

- **Most likely diagnosis:** Schizoaffective disorder (Table 26-1).
- **Best therapy:** An antipsychotic agent (such as haloperidol or risperidone) should be tried initially. If it is ineffective alone. antidepressants (a selective serotonin reuptake inhibitor [SSRI] **is** generally tried first) should also be administered.

4^ Is hospitalization needed: No. The patient is currently not a danger to herself or others and appears to be able to care for herself. This disorder as presented here should be treated in an outpatient setting unless the suicidal ideation returns and/or worsens.

Analysis

Objectives

1. Recognize schizoaffective disorder in a patient and diagnose it accurately.
2. Know that the disease has two subtypes: depressive and bipolar.
3. Know the recommended pharmacologic treatment for this disorder.
4. Know the indications for hospitalization of a patient with this disorder.

Considerations

This patient has a several month history of what sounds like mood (depressive) symptoms which seem to have remitted with fluoxetine. However, there is evidence of paranoid delusion (believing there are cameras in the doctor's

Table 26-1
DIAGNOSTIC CRITERIA FOR SCHIZOAFFECTIVE DISORDER

1. Patients must exhibit psychotic symptoms consonant with the acute phase of schizophrenia.
2. Psychotic symptoms are accompanied by prominent mood symptoms (mania or depression) during part of the illness.
3. At other points in the illness, the psychotic symptoms are unopposed: that is, no mood symptoms are present. Periods of illness in which there are only psychotic symptoms, and no mood symptoms, must last for at least 2 weeks.
4. The disorder cannot be caused by a substance or by a general medical condition.

office recording her) that persists without mood symptoms. The **psychotic episodes occur during the mood episodes,** but the mood symptoms do not always occur during the psychotic episodes, which is the key to the diagnosis. Although the patient was not asked about manic symptoms, the presence of such symptoms is a crucial element in the patient's history because it changes the subtype of schizoaffective disorder from depressive type to bipolar type and in turn affects the pharmacologic treatment choices. Without these symptoms the patient's disorder would be characterized as depressive type. (For example, a mood stabilizer such as valproic acid might be used in a patient with the bipolar type of schizoaffective disorder.)

APPROACH TO SCHIZOAFFECTIVE DISORDER

Definitions

Anergia: Lack of energy

Anhedonia: Lack of interest in one's usual pleasure-seeking activities, such as hobbies

Tangential speech (tangentiality): A disorder of thought process in which one's thoughts "take off on a tangent" from the initial question or line of thought and do not return to the original line of thinking

Clinical Approach

Differential Diagnosis

The key to developing a differential diagnosis for schizoaffective disorder is to carefully examine the longitudinal functioning of patients by reviewing their histories (provided by the patients and ideally by significant others). Periods of psychosis, and psychosis and mood symptoms (mania and/or depression), must be carefully teased out over a time period of years if possible. Conditions causing substance-induced mood disorder, which can be difficult to differentiate from schizoaffective disorder, include cocaine or amphetamine intoxication (manic symptoms), cocaine withdrawal (depressive symptoms), and the effects of a host of prescribed medications including steroids and antiparkinsonian medications. The symptoms of schizophrenia can appear similar, but the mood symptoms sometimes present in that disorder are generally transient and are brief in relation to the total length of the illness. Patients with bipolar disorder, mania, generally have had mood symptoms (euphoria, irritability) predating development of the psychoses, as have patients with major depression with psychotic features (a depressed mood predating the onset of psychosis).

Treatment

Patients with schizoaffective disorder generally respond to antipsychotic agents and often require long-term therapy. Although haloperidol (Haldol) and typical antipsychotics were once the treatments of choice (indeed, the only options available), newer atypical (second-generation) antipsychotics are now used far more frequently because of their more benign side-effect profile. These medications are not known to cause tardive dyskinesia, most extrapyramidal symptoms, or neuroleptic malignant syndrome. They are likely well tolerated because they also produce fewer anticholinergic side effects. Both typical and atypical antipsychotic medications have approximately the same duration of action, making once or twice per day dosing feasible in both cases.

Mood stabilizers such as lithium, carbamazepine, and valproic acid should be administered to patients with schizoaffective disorder who exhibit manic symptoms. It is sometimes helpful to combine an antidepressant and an antipsychotic for patients with schizoaffective disorder with a depressed mood. However, such patients should be treated with an antidepressant in addition to their antipsychotic only if the antipsychotic alone does not ameliorate the mood symptoms. Other treatment modalities can include hospitalization, particularly when patients are psychotic and unable to care for themselves. Psychosocial rehabilitation, such as is used in the treatment of schizophrenia, is often indicated as well because these patients can suffer from the same social isolation, apathy, and disturbed interpersonal relationships that schizophrenics do. although usually not with the same degree of severity.

Comprehension Questions

|26.1] Schizoaffective disorder, depressed type, is diagnosed in a 32-year-old woman. She is first treated with an antipsychotic, and 3 weeks later her auditory hallucinations have improved. She reports, however, that she still feels "very low" and has no energy or interest in the activities she used to enjoy. Which of the following should the psychiatrist do next?

A. Inform the patient that these symptoms are the negative symptoms common to the disorder.
B. Refer the patient for supportive psychotherapy.
C. Treat the patient with fluoxetine (an SSRI).
D. Increase the dose of the antipsychotic.
E. Add a mood stabilizer to the regimen.

[26.2] A 28-year-old man is brought to a psychiatrist complaining that he has been hearing voices for the past several weeks. He says that he also heard these voices 3 years ago. He notes that his mood is "depressed" and rates it 3 on a scale of I to 10 (with 10 being the best he has ever felt). He does not recall if his mood was depressed the last time he had psychotic symptoms. Which of the following actions should the physician take next?

A. Obtain more detailed information about the time course of the psychotic symptoms and the mood symptoms.
B. Treat the patient with an antipsychotic agent.
C. Treat the patient with an antidepressive medication.
D. Request a urine toxicology screening.
E. Refer the patient to supportive psychotherapy.

[26.3] A 40-year-old man with schizoaffective disorder has been hospitalized in an inpatient psychiatry unit for the third time in the last 5 years. During each episode, he becomes noncompliant in taking his medications, develops manic symptoms and auditory hallucinations, and then becomes violent. In the inpatient unit, he physically threatens other patients and staff and is generally agitated. He is put in isolation to help quiet him. The patient is prescribed a mood stabilizer and an antipsychotic medication. Which of the following medications might also help relieve this patient's acute agitation?

A. Buspirone
B. Fluoxetine
C. Chloral hydrate
D. Lorazepam
E. Benztropine

Answers

[26.1] C. Although data are not clear as to the efficacy of administering antidepressants to patients with schizoaffective disorder (and depressive symptoms), the continued presence of depressive symptoms makes this treatment worth trying.

[26.2] A. The time course of the mood symptoms and psychotic symptoms determines the treatment of the patient because the diagnosis can be schizoaffective disorder versus major depression. Although the patient should undergo a urine toxicology screening, this should not be done until a complete history is obtained so that further targeting of laboratory testing can be accomplished.

[26.31 D. Benzodiazepines such as lorazepam and clonazepam have been shown to be effective adjunctive treatments for acute mania both in patients with schizoaffective disorder and in patients with bipolar disorder.

CLINICAL PEARLS

Unlike patients with schizophrenia, patients with schizoaffective disorder have mood symptoms that occur during significant portions of their illness.

Once a very clear longitudinal history of symptoms and functioning is obtained, it is often possible to diagnose either a bipolar illness or schizophrenia in a patient with schizoaffective disorder.

Patients with schizoaffective disorder and manic mood symptoms should be treated with a mood stabilizer and an antipsychotic. Patients with schizoaffective disorder and depressive mood symptoms should be treated with an antipsychotic alone: if this is not effective, an antidepressant should also be used.

REFERENCES

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