

## A LOOK AT THE DIFFICULTIES IN THE DIAGNOSIS, MANAGEMENT AND TREATMENT OF PATIENTS WITH SCHIZOAFFECTIVE DISORDER

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*Received on : 10-07-2017*

*Accepted on : 23-04-2018*

### ABSTRACT

In this case we discuss patient RJ (not real initials) a young African American Muslim male who presents near the start of his illness and the struggles he is facing of accepting his diagnosis and treatment plan. This case illustrates several problems facing patients especially the difficulties in the diagnosis, management and treatment of people with schizoaffective disorder and other psychotic diseases.

**KEYWORDS:** Schizoaffective disorder, psychotic disease.

### INTRODUCTION

This case study introduces a young African American male who has a recent diagnosis of Schizoaffective disorder. Patient presented to the clinic for initial evaluation after being hospitalized twice in less than 3 months for psychiatric problems. In this case study we will take a look at the difficulties in treating patients diagnosed along the schizophrenia spectrum. We will also discuss the three most likely diagnosis for someone presenting such as our patient did and the steps taken in coming up with his final diagnosis of Schizoaffective disorder.

Patient is a 20yo African American male who presents to the clinic today for an initial evaluation following two recent hospitalizations within a three month period. Patient states that he is in office due to a diagnosis of Multiple Personality Disorder. Patient states that in September of 2016 he developed a lung infection that was treated with steroids for 1 week and approximately 1 week after treatment he started developing psychiatric symptoms and was admitted to the in-patient ward of a Hospital in the Atlanta, Georgia area by his family because he was "acting weird". Patient states that he believed that he was more than one person including the deceased Tupac Shakur and Jesus Christ. Patient states that he also thought his boss was possessed by the devil. Patient admits to seeing snakes and flying snakes but states that his friend also saw the snake and threatened his life if he told anyone about the snakes.

While in patient at the hospital, patient was admitted to the psychiatric center for evaluation and treatment for seven days. During his hospitalization, patient states that he knelt to pray which caused the nurse to call for security where he was handcuff and placed on the floor. He was

given an injection but is unsure of what and states that it caused him to fall asleep. During his hospitalization, patient would attend group sessions throughout the day and was under the care of a psychiatrist who at this time patient diagnosed the patient with Bipolar disorder and treated with Lithium and Risperdal (dosage unknown). One week after being released from the hospital, patient states that he stopped taking his medication because he was able to "conquer his disease". Patient last took his medication in November 2016.

Patient was again later admitted to the Psychiatric ward at a different hospital in the Atlanta, Georgia area. Patient states that he went to the Emergency Room (ER) because he was having "stomach issues." Patient states that the ER doctors lied to him and instead of taking care of his stomach issues he was instead admitted to the psychiatric ward because they thought he was acting weird. Patient was admitted for evaluation and treatment for three days and doesn't remember his diagnosis or the medication he was given. While admitted for in-patient care, patient attended group therapy throughout the day and was treated with medication but admit to "cheeking" his medication and throwing it away later in the toilet. Per the patient, he was released from the hospital when his mother came to get him because she stated that it was a "waste of money."

Patient states that because of his psychiatric sickness, he was unable to keep his job and was fired in December 2016 as he was no longer able to focus and do his job properly. Patient states he was working at a large cellular phone company store as a technician.

Patient also states to feeling like his parents tone is very piercing and sharp and this affects him and it feels like it is piercing his inside. . Patient denies any

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feelings of anhedonia- stating that he still has fun with his family. Appetite is stable, sleeping is normal with roughly 6-8 hours of sleep per night

Patient admits to feeling anxious and states that his anxiety stem from the things going on in his life such as trying to get his job back and school. Patient was unable to further expand on his anxiety and instead started to focus on the fact that he is trying to get his job back and if we would be able to help him in this. Denies any past history of panic attack/ panic disorder.

Patient denies currently being depressed but states that he felt depressed when he lost his job but is no longer worrying about it because now he is in school. Patient is currently enrolled at a State University and is studying Computer Information System. Patient started fall 2016 but had to withdraw from all his classes before the end of the semester due to his illness.

Denies substance abuse based on his religion

Denies any suicidal Ideations, current plan or access to any guns.

Assessment and Plan: After speaking to the patient and reviewing his past medical history, a diagnosis of with schizoaffective disorder- Bipolar type with a DSM-5-code of 295.7 was made.

The following treatment plan was decided upon: Patient is a Poor historian who is in denial of his illness. Patient is non compliant with his medication and did not take any medication while in the hospital. Patient does not want to take any medications at this time. Patient is advised to return to the clinic in 1 week for follow-up and advised to come back with his parents.

## DISCUSSION

In this case study we take a look at RJ, a 20 year old African American Muslim male who presents in office after being hospitalized twice in three months for psychotic episodes.

This case illustrates the struggles of treating patients diagnosed with a disease within the schizophrenia spectrum. As is often in patients who are diagnosed with a disease within the schizophrenia family, they are commonly in denial of their disease and many of them will stop their medication as they do not see themselves as ill and in need of medication. "The level of denial of illness among people suffering from schizophrenia is quite high [and] it is estimated that approximately 50% of patients with schizophrenia do not take their prescribed medication as directed." (Wirshing & Buckley, 2003). In this case, RJ states that believing that he was no longer sick, he decided he no longer needs to be medicated and so during his second hospitalization in the psychiatric unit he started "cheeking" his medication and flushing the pills down the toilet. This denial of his

illness is further complicated by the patient's religion and beliefs as the patient believes that he can heal himself by pure force of will and that what he is unable to cure by the force of will he can do by taking natural herbs.

This case is further complicated by the patient being a poor historian who is unable to tell exactly what occurred around his two hospitalizations and who is in denial of his illness and what it will take to treat and stabilize him. The disorganized, circumstantial and flight of thoughts/ideas seen when talking to the patient during the initial patient interview makes it hard to get a clear picture of who the patient is and the circumstances of his illness. It therefore becomes important for the provider to meet with various family members so as to gain a clearer picture of who the patient was before and during his illness so as to ensure that the patient is accurately diagnosed and treated.

The importance of getting RJ family involved not only in the diagnosis but in the management and treatment is of his disorder will go far towards helping him understand and accept his diagnosis and also lessen the likelihood of relapse and increase the chances of medication and treatment compliance. "Extensive evidence supports the importance of the involvement of families in the mental health care of patients with schizophrenia another serious mental illnesses." (Hackman & Dixon, 2008). Schizophrenia places a burden on the family financially and mentally. It therefore becomes imperative that family members are provided with the resources and support available to through the provider. "Families provide emotional and financial support, as well as advocacy and facilitation of treatment for their mentally ill relatives. Understanding the burden experience by families of patients with schizophrenia, as well as the evidence-based practice of working with families, can help the practicing psychiatrist meet the needs of individuals with schizophrenia and their families." (Hackman & Dixon, 2008)

Another complicating factor in treating this patient is that he lacks an understanding of his diagnosis as the patient is insistent that he was misdiagnosed during his first hospitalization as Bipolar. Patient instead beliefs that he has Multiple Personality Disorder as during his initial psychotic break he believed himself to be Jesus and Tupac Shakur and that the FBI was after him. During my interview with this patient he was aware that these beliefs were abnormal but does not think they help in diagnosing him with Schizoaffective disorder but instead confirms to him that he has Multiple Personality Disorder.

It therefore becomes important for us to help this patient accept his diagnosis and adhere to his prescribed medications as this can help him in being a functioning

member of society. The importance of adherence is discussed by Aldebot et al in their where it is noted that “lower rate of adherence are associated with considerably higher rates of relapse and poorer course of illness...[t]hese findings suggest that targeting denial coping strategies in treatment may foster more optimal strategies for managing schizophrenia” (Aldebot & Weisman de Mamani, 2010)

## CONCLUSION

After talking with the patient and carefully examining the information presented, the patient is diagnosed with Schizoaffective disorder- bipolar type instead of Bipolar disorder with psychosis as he was originally diagnosed during his hospitalization. This diagnosis was made on the fact that the patient had a psychotic break with weird beliefs who also exhibits features of a mood disorder associated with hypomania.

The diagnosis of a patient with schizoaffective disorder is difficult. This is due to the closeness of schizoaffective disorder to other disorders and the difficulty of differentiating schizoaffective disorder from mood disorders or schizophrenia. “When psychotic symptoms occur exclusively during a Mood Episode, DSM-5 indicated that the diagnosis is the appropriate Mood disorder with Psychotic Features, but when such a psychotic condition includes at least a two week period of psychosis without prominent mood symptoms, the diagnosis may be either schizoaffective disorder or schizophrenia” (Malaspina, et al., 2013).

Schizoaffective disorder as diagnosed by the DSM-5 criteria as “an uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia” (American Psychiatric Association, 2013). In diagnosing a patient with schizoaffective disorder, the provider then has to specify whether the patient is bipolar type or depressive type.

While patient RJ does exhibit features of a mood disorder, he does not meet the full diagnostic criteria for Bipolar I disorder in which there must be at least one manic episode and the occurrence of the manic and major depressive episode is not better explained by schizophrenia spectrum or other psychotic disorder. To meet the criteria for a diagnosis for Bipolar II, the patient must have at least one hypomania episode and at least one depressive episode, never have had a manic episode and is not better explained by a psychotic disorder or disease within the schizophrenia spectrum. (American Psychiatric Association, 2013). RJ's most prominent feature of his mental illness is the psychosis and even though his mood disorder could be seen as Bipolar II, his symptoms are better explained by a diagnosis of Schizoaffective disorder. Social

impairment is also seen in most people with schizoaffective disorder. This is seen in this patient who, due to his mental illness had to withdraw from college for a semester and also lost his job due to his inability to function in these social settings.

In patient RJ, the presenting symptoms of psychosis as well as the patients' hypomanic appearance with flight of ideas and expansive, talkative mood during the patient encounter lends credence to the diagnosis of schizoaffective disorder-bipolar type. The prominence of this patients' psychosis that included visual hallucinations and persecutory delusions that the FBI is after him and the belief that he can mentally cure his illness, his weird belief of thinking he is Jesus and Tupac Shakur, coupled with the fact that the patient exhibited disorganized speech and behavior all meet the diagnostic criteria for schizoaffective under the schizophrenia Criterion.

Another diagnosis to consider in this patient is schizophreniform which would later be converted to schizophrenia if patients' mental illness persists beyond six months. For a diagnosis of Schizophreniform, DSM-5 states that patient must have at least two of the following symptoms of delusions, hallucination, disorganized speech, negative symptoms or grossly disorganized or catatonic behavior lasting greater than one month but less than six months. There can be no major depressive or manic episode in the patient and schizoaffective disorder and bipolar disorder with psychosis must be ruled out (American Psychiatric Association, 2013). While this patient does meet the diagnostic criteria for Schizophreniform, the presence of his mood symptoms as exhibited during the initial patient encounter makes the diagnosis of schizoaffective disorder more accurate diagnosis.

Finally, before diagnosis any patient with a mental disorder it is imperative to rule out any underlying medical illness or drug use as a source of the patient psychosis. In this case the patient recounts the presence of a lung infection that was treated with oral steroids for one week prior to his first psychotic episode. Lewis and Smith notes the following: “although it is well-established that psychiatric symptoms can develop in association with the administration of corticosteroids, the nature of this relationship is poorly understood....Our findings indicate that severe psychiatric reactions occur in approximately 5% of steroid-treated patients, and that a large proportion of these patients have affective and/or psychotic symptoms. Psychiatric disturbances usually occur early in the course of steroid therapy. Female sex, systemic lupus erythematosus and high doses of prednisone may be risk factors for the development of a steroid-induced

psychiatric syndrome” (Lewis & Smith, 1983)

According to DSM-5, substance/ medication-induced psychotic disorder requires the presence of hallucinations and/ or delusions with evidence from the patients history, physical examination or laboratory findings that these symptoms developed during or soon after exposure to or withdrawal from the substance/ medication and the medication/substance has to be capable of production the symptoms of psychosis. These symptoms cannot either precede the onset of the substance or medication use and should not persist for a substantial period of time. (American Psychiatric Association, 2013). While there is evidence of the psychosis occurring following the reported use of oral steroids, there is evidence that the patients psychosis persist for an extended period of time including a subsequent hospitalization in the hospital for psychiatric reasons. This coupled with the patients' presentation during the initial evaluation makes substance/ medication-induced psychosis less likely and further supports his diagnosis of Schizoaffective disorder.

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