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Clinical Judgment of Differentiating the Diagnosis and Treatment of Schizophrenia and Schizoaffective Disorder

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THINK BIG WE DO℠

Background

Schizophrenia (SZ) is a disorder that is characterized by disordered thinking, memory, and perception in its patients. Schizoaffective disorder (SAD) is a separate disorder that features symptoms of schizophrenia and mood disorders. Because of the overlap in symptoms it is relatively easy to confuse schizoaffective disorder and schizophrenia.

To be diagnosed with schizophrenia, patients must have at least two of the characteristic symptoms for a significant portion of time during a 1-month period and experience significant disturbance in functioning:[1]

- **delusions**
- **hallucinations**
- **disorganized speech**
- **grossly disorganized or catatonic behavior**
- **negative symptoms**

To be diagnosed with schizoaffective disorder, patients must exhibit the symptoms required for schizophrenia in addition to presenting with a major mood episode.[1]

- **elevated and depressed moods, with their associated symptoms**

Neither condition is preventable or curable, but various treatments exist for symptomatic suppression. However there are differences in how the two disorders are treated, so accurate diagnosing is imperative to ensure patients receive the appropriate evidence-based treatment.

Purpose

- **To understand how the diagnostic criteria on paper translates into real clinical practice**
- **To develop interventions to improve the care of patients with schizophrenia and schizoaffective disorder.**

Methodology

1. **Conduct semi-structured qualitative interviews with psychiatrists to understand how they diagnosis and treat patients with schizophrenia and schizoaffective disorders.**
2. **For every psychiatrist interviewed, complete chart reviews of five of their patients with schizophrenia and schizoaffective disorder.**
3. **Compare the real-world diagnosis and treatment of these patients with information gathered from the psychiatrists' conceptualization of these disorders to explore patterns and trends associated with providing psychopharmaceutical care.**

Results

Table 1: Patient Baseline Characteristics

Characteristic	SZ n = 6 (%)	SAD n = 29 (%)
Gender		
Female	3 (50%)	13 (44.8%)
Male	3 (50%)	16 (55.2%)
Race		
Caucasian	5 (83.3%)	18 (62.1%)
African American	0	4 (13.8%)
Hispanic	0	1 (3.4%)
Other	0	1 (3.4%)
Undefined	1 (16.7%)	5 (17.2%)
Age (yrs)		
< 25	0	1 (3.4%)
25-35	0	5 (17.2%)
35-45	0	2 (6.9%)
45-55	2 (33.3%)	8 (27.6%)
55-65	2 (33.3%)	8 (27.6%)
≥ 65	2 (33.3%)	5 (17.2%)
Alcohol Use		
Never drank	1 (16.7%)	11 (37.9%)
Former drinker	0	4 (13.8%)
Current drinker	1 (16.7%)	6 (20.7%)
Unknown	4 (66.7%)	8 (27.6%)
Illegal Drug Use		
Never used	1 (16.7%)	8 (27.6%)
Former user	0	4 (13.8%)
Current user	1 (16.7%)	7 (24.1%)
Unknown	4 (66.7%)	10 (34.5%)
Housing		
Lives alone	1 (16.7%)	6 (20.7%)
Lives with family/friends	1 (16.7%)	7 (24.1%)
Lives in group home	3 (50%)	11 (37.9%)
Lives in homeless shelter	1 (16.7%)	5 (17.2%)
Prior Psych Hospitalizations		
Two or less	3 (50%)	6 (20.7%)
Three - Four	1 (16.7%)	6 (20.7%)
Five or more	2 (33.3%)	16 (55.2%)
Unknown	0	1 (3.4%)

Eight psychiatrists were actively recruited but only seven psychiatrists were interviewed

Effective methods of improving adherence discussed by psychiatrists

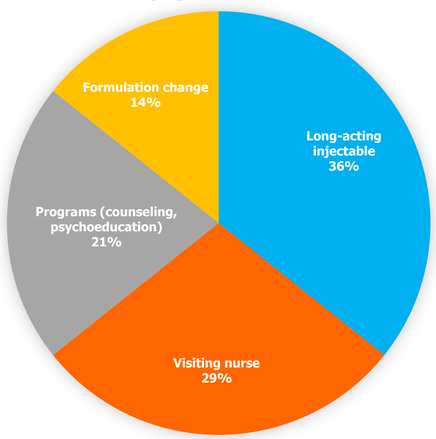

Table 2: Outcome Results

Criteria	SZ n = 6 (%)	SAD n = 29 (%)
Diagnosis		
Total # of patients before admission	6 (100%)	29 (100%)
Total # of patients after admission	4 (66.6%)	29 (100%)
# of change in diagnosis	2 (33.3%)	0 (0%)
Treatment		
Total # of antipsychotics before admission	6	45
Total # of antipsychotics after admission	7	40
Average # of antipsychotics per patient	1.67	1.38
Total # of mood stabilizers before admission	3	16
Total # of mood stabilizers after admission	2	17
Average # of mood stabilizers per patient	0.33	0.59
Net improvement in mental status exam before vs. after hospitalization None = 0 Minimal < 2 Moderate 2-4 Significant ≥ 5	3.5	3.0
Adherence		
Total # of long-acting medications prescribed at discharge	2 (33.6%)	9 (31%)
Total # of patients setup with outpatient medical supervision at discharge	4 (66.6%)	21 (72.4%)

- **No diagnosis changes from SAD, while still possibly changing SZ to SAD, reflects how the psychiatrists conceptualized the distinction between diagnosing these two conditions**
- **Majority of psychiatrists suggested SAD patients tend to have more success from therapy, opposite of the greater net improvement seen in SZ patients**
- **Overall decrease in pill burden after admission implies that psychiatrists do work towards minimizing medications for patients**
- **Majority of the psychiatrists reported preferring single agents and short-acting agents, unless adherence was compromised**
- **72.4% of SAD patients and 66.6% of SZ patients received adherence support, showing that psychiatrists helped more than half of their patients receive these services because of their great concern regarding continued patient adherence to therapy**

Conclusion

Preliminary trends have been evident as we proceed with our data analysis. The majority of psychiatrists did acknowledge a distinction between the two conditions and this distinction is supported by their diagnosing and treatment habits. However, they did not draw distinctions when discussing the issue of adherence, as almost all of them considered the lack of patient adherence as the main challenge of treatment. Larger and more structured studies are needed to further explore and confirm these findings.

References & Disclosures

1. **American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 5th ed. Washington, DC: American Psychiatric Press; 2013.**

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