

Although schizophrenia (SZ) and schizoaffective (SAD) disorder are very similar conditions in terms of the psychotic symptoms (e.g. hallucinations, delusions, disorganized thought/speech, etc), SAD patients also present with symptoms of mood disorder (i.e. mania, depression). Due to this difference, the recommended pharmacotherapy for each condition is also different: while both types of patients should receive one antipsychotic medication, SAD patients generally also require a mood stabilizer or antidepressant. Because providing appropriate therapy hinges on accurately diagnosing patients, we were interested in how psychiatrists conceptualize these two conditions and how that impacted the treatment they provided. During our psychiatric pharmacy rotation, we conducted semi-structured interviews with seven psychiatrists from three inpatient adult psychiatric units. Questions centered on their diagnostic procedures, how they made their treatment decisions, and what they generally used for treatment. Afterwards, we reviewed the health records of five patients for each interviewed psychiatrist to determine how well their knowledge and opinions translated into real-world clinical practice. We were pleased to find the psychiatrists' practice was consistent with their conceptualization of SZ and SAD and was in concordance with evidence-based best practices. These psychiatrists did their best to adhere to treatment guidelines, such as using one antipsychotic medication per patient (on average 1.67 medications per SZ patient and 1.38 medications per SAD patient) and prescribing mood stabilizers primarily for their SAD patients rather than for their SZ patients (on average 0.33 vs. 0.59 medications per patient, respectively). And while these psychiatrists did recognize a difference between the diagnosis of the two conditions and the subsequent difference between the recommended pharmacotherapy for each condition, it was interesting to find out that there was no difference in how these psychiatrists addressed patient adherence for both conditions. All of them said that patient adherence is the most important aspect of care because if the patient does not understand and buy into the prescribed therapy (pharmacologic and/or non-pharmacologic), they will have a hard time controlling or improving their symptoms. During our research, we found that more than half of the patients with each condition (66.6% of SZ patients and 72.4% of SAD patients) had a reasonable discharge plan in place prior to discharge from inpatient units, which reinforced the emphasis that these psychiatrists placed on maintaining patient adherence for both types of patients.