CASE PRESENTATION
Mr. M is a 70-year-old retired typesetter and father of two who was admitted to a psychiatric facility after an attempt to strangle his wife of 50 years. He is a devout Catholic and explained that a message from God convinced him that his wife intended to kill their granddaughter. In the past weeks, he had cluttered the home with religious shrines of candles, flowers, and photographs of religious figures. His wife’s protests only resulted in his mounting anger and accusations that her attention to his needs—both culinary and sexual—was flagging. He had been preoccupied with religious themes before, but the sexual content was new and distressing. Since emigrating from Italy he had persevered through numerous manic and depressive episodes, often associated with religious delusions. With multiple trials of psychotropic agents, a therapeutic effect was achieved. Mr. M had been a successful provider for his family and was well respected in the community. Complicating his condition was idiopathic Parkinson’s disease (diagnosed 2 years ago), type II diabetes, hypertension, hypothyroidism, and benign prostatic hypertrophy with subsequent urinary incontinence. With the exception of recent changes in the dose of carbidopa/levodopa for Parkinson’s disease, his other conditions were stable. Mr. M’s family noted mild cognitive decline and impaired gait over the past year, which they excused as part of his advancing age.

Neuropsychological testing found his overall cognitive abilities to be severely impaired. Attention was assessed with normal digit span, but registration, recall, visuospatial skills, constructional skills, and language were all markedly impaired. These findings were consistent with a diagnosis of dementia, most likely related to Parkinson’s disease. Laboratory and neurology assessments and a magnetic resonance imaging (MRI) of the brain did not reveal any reversible causes of cognitive decline.

As a result of the findings, the psychiatrist suggested adding donepezil to the patient’s regime of lithium and quetiapine, which had been initiated to reduce his psychosis and religious preoccupations. However, his family was worried that he was already taking too many medications. His children had searched the Internet for information on donepezil, and were concerned about side effects of nausea, vomiting, diarrhea, and potential worsening of Parkinson’s symptoms. They also complained that the patient appeared sedated, and that his gait
impairment was more noticeable. The family requested a change in medication. To avoid exacerbating his Parkinson’s disease, clozapine was substituted for quetiapine.

Over the course of the admission, Mr. M’s wife and children attended multiple family meetings, often bringing homemade Italian pastries for the patient and staff. The family was able to maintain a sense of humor to deal with their stress over the patient’s decline. His son and daughter were able to express their frustration with his bizarre religious preoccupations that were especially difficult to accept given the importance of Catholicism in the family. They were also very concerned about the heredity of mental illness, and exactly what risk this posed to themselves, and especially their own children. Although the substitution of clozapine for quetiapine had led to some improvement in Mr. M’s delusions and bizarre behavior, the dose had to be reduced because of drooling—a side effect the family found particularly mortifying. Mr. M’s wife was herself suffering from significant depression but was able to be an active participant in family meetings, despite difficulties with English. She struggled with her distaste and shame over the new, hypersexual twist that his religious delusions had taken. She felt guilt over the thought of transferring her husband to a nursing facility. Mr. M accused her of trying to kill him by sending him to a nursing home. However, he needed daily physical therapy to improve his gait, and he required assistance with basic activities of daily living. Although his psychosis improved, his judgment and insight remained impaired. His medication regimen was complex, and further cognitive decline related to progressive dementia was likely. Mr. M remained religiously preoccupied, but instead of preaching adamantly, he prayed quietly to himself. Even a remote possibility of another attack on their mother was unthinkable for the children, so Mr. M was transferred to a nursing home for rehabilitation and long-term care.

DISCUSSION

Emil Kraepelin, in 1919, was the first psychiatrist to differentiate schizophrenia from the affective disorders based on symptom profile and prognosis.1 Although the distinction has become a standard feature of psychiatric assessment, substantial numbers of patients experience symptoms and disability characteristic of both disorders and are diagnosed as schizoaffective. The clinical utility of the diagnosis remains controversial, with some investigators arguing that the disorder is a subtype of schizophrenia based on similarity of cognitive impairments, while others prefer the affective category based on the more favorable prognosis.2 With advanced age and associated comorbidity, the choice of treatments for these patients and their families is vexing, and likely to become more so with the increasing number of adults surviving into old age with mental illness.3 The case presented in this article illustrates the challenge of initiating and sustaining the treatment plan for an older adult suffering from chronic schizoaffective disorder across the chain of care.

Schizoaffective illness has features of both schizophrenia and affective or mood disorders. Recent studies suggest that gene interactions between Disrupted in Schizophrenia 1 and Phosphodiesterase 4B may explain the overlap.4,5 As shown in Table I,6 if a patient has significant mood and psychotic symptoms together for more than 6 months, as well as at least a 2-week period of psychotic symptoms in the absence of disturbed mood, schizoaffective disorder should be considered. The depressive type of schizoaffective disorder may be more common in older persons than in younger persons, and the
While the lifetime prevalence of schizoaffective disorder is less than 1%, due to the growing number of older adults, clinicians will see more elderly patients suffering from psychoses of various etiologies. A common misconception is that psychiatric disorders other than dementia rarely have their onset late in life. Therefore, mental illnesses that first occur in the elderly are often overlooked or inappropriately treated. Clinicians often assume that psychotic symptoms in the elderly are caused by dementing illnesses and that antipsychotic medication will be required for a limited period of time, if at all. As our case illustrates, this is not always so, and clinicians need to keep in mind that psychotic symptoms have a variety of etiologies. This is especially important given that the treatment approach may vary greatly depending on the specific etiology (Table II).

Mood stabilizers (lithium, valproate sodium, carbamazepine), antidepressants, and antipsychotics are the mainstays of treatment for schizoaffective disorder. When complicated by Parkinson’s disease, atypical antipsychotics such as quetiapine or clozapine are preferred. The regimen can be complicated when medications used are from several classes of drugs; the nursing home staff may be less familiar with medications such as clozapine, which are com-

### Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a major depressive episode, a manic episode, or a mixed episode concurrent with symptoms that meet criterion A for schizophrenia.

Note: The major depressive episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiologic effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.

Specify type:
- **Bipolar type:** if the disturbance includes a manic or a mixed episode (or a manic or a mixed episode and major depressive episodes)
- **Depressive type:** if the disturbance only includes major depressive episodes

monly prescribed for schizophrenia but used less often in nursing home residents. Patients also benefit from a combination of family therapy, social skills training, and cognitive rehabilitation. The range of symptoms can be quite large, as patients contend with both ongoing psychosis and varying mood states. It can therefore be extremely difficult for family members to contend with the changing needs of these patients. It is critical to incorporate family-focused therapy into the treatment plan.10

In conclusion, Mr. M’s longstanding schizoaffective disorder was exacerbated by treatment for Parkinson’s disease and the progression of dementia, all of which ultimately exceeded his family’s capacity to meet his needs despite their unquestioned devotion. Lack of familiarity with the diagnosis and with clozapine may lead nursing homes to underestimate the severity of this psychosis. With the increasing number of persons surviving into late life with schizoaffective disorder, it is critical that geriatric providers become more familiar with this perplexing condition.

OUTCOME OF THE CASE PATIENT

Several weeks later, the inpatient psychiatrist received a call from Mr. M’s son. He explained that his father was “falling apart over night” at the nursing home. Mr. M appeared harried and unkempt, was barely sleeping, and was once again receiving messages from God about an imminent “judgment day.” He was desperate to convert everyone to Catholicism. The inpatient psychiatrist suggested that the family request a care plan meeting with the nursing facility staff. During this meeting, it was discovered that Mr. M had never received the clozapine that was prescribed for him at discharge from the hospital. His family’s shock and anger were mitigated by the discovery of so simple an explanation for his deterioration. Nonetheless, he required re-admission to a psychiatric facility within days. A plan was formulated to stabilize the patient on clozapine and return him to the nursing home as soon as possible.

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REFERENCES