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Difficulty in Diagnosing Schizoaffective Disorder and Bipolar Disorder Based on a Clinical Case

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Abstract

Since Schizoaffective Disorder and Bipolar Disorder share some overlapping symptoms, when a patient presents with symptoms similar to both Schizoaffective Disorder and Bipolar Disorder, it becomes necessary to provide continuous and careful care while simultaneously reviewing all knowledge about both disorders. The objective of this work is to address the pre-diagnosis phase, the moment of diagnosis, and the post-diagnosis phase of a patient initially diagnosed with Schizoaffective Disorder who, after years of various treatments until finding the most appropriate one, was diagnosed with Bipolar Disorder Type I. The methodology used for this work was bibliographic research in databases such as SciELO, PubMed, Google Scholar, etc., using the descriptors: schizoaffective disorder, bipolar disorder, childhood mental health, and psychoactive drugs. This entire process lasted approximately six months, during which around 20 publications addressing the chosen descriptors were analyzed, resulting in the selection of 14 articles or scientific papers. The results of this analysis demonstrated that the process of observing symptoms to arrive at a diagnosis and then the treatment process does not reside solely in the current aspects presented by the patient during initial consultations, but also in the patient's past history. This is because there are often previous problems that can affect the diagnosis and the treatment process, which is frequently observed in cases of overlapping symptoms, for example.

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Keywords: *Schizoaffective Disorder, Bipolar Disorder, Mental Health*

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1. INTRODUCTION

The development of this article occurred in parallel with another one written by the same author, which addressed Schizoaffective Disorder (SZA) and Bipolar Affective Disorder (BAD) within clinical practice. However, unlike the other, this one delves deeper into the clinical care itself and the essential moments that led to the revision of a diagnosis and the finding of a more effective treatment for the patient.

This construct provides an approach related to Clinical Psychology and Psychotherapy, because as a psychologist, care must be provided in accordance with the precepts of Psychology. However, the treatment of a patient with mental disorders involves joint monitoring with other professionals, such as a psychiatrist, therefore updating the diagnosis was feasible. It is important to clarify this information due to the ethical and professional responsibility that must be respected during care.

One of the main points this article seeks to address is how the process of illness and the emergence of a mental disorder involves a timeline of the patient's entire life, where situations that occurred in the past may have served as triggers for both previous severe crises and more recent ones. Important aspects of childhood and adolescence, such as family relationships, can severely impact both an individual's mental health and the treatment process, because the family can often be considered a support network, even though it is not necessarily a positive and healthy element in the patient's life.

Bearing in mind that these main points are related to diagnosis and the treatment process, this article will discuss a clinical case that exemplifies the importance of life history and the stages prior to the start of treatment, and the difficulties that arise during treatment when there are overlapping symptoms, characteristics that do not fully correspond to what is stated in the main diagnostic manuals used, and the need for collaborative work between the patient and the psychiatrist treating them.

Other topics that will be addressed include drug use during adolescence and how mental health is related to it, the worsening of symptoms of a mental disorder leading up to the first episode, overlapping symptoms between mental disorders (in the case of this article, between Schizoaffective Disorder and Bipolar Disorder), the treatment process in the face of this overlap until it is clarified, updating a diagnosis, pharmacological treatment in SZA and Bipolar Disorder, the context of comorbidities, and finally, the importance of ethical and careful care from the professionals involved in the treatment.

2. MENTAL HEALTH IN CHILDHOOD

One of the most essential periods in an individual's life is their childhood, because it is during this time that the main cognitive and psychological developmental processes occur, as well as psychic structuring. If these stages do not occur in a healthy way, a mental disorder with significant symptoms such as Schizoaffective

Disorder (SZA) or Bipolar Disorder (BAD) may appear in the future.

The care of the patient in the clinical case presented in this article allowed us to observe both the present period (from the beginning of treatment to the present day) and their past, from childhood to the most critical period of their clinical condition. Having this extensive and broad perspective on the patient's life allowed us to understand how genetic heritability and environment contributed to the development of their symptoms.

The relationship between their biological parents was always extremely troubled, with a history of psychological and physical aggression, to the point that they separated some time after the patient's birth. In addition to a history of abuse, his mother had a diagnosis of major depression (though possibly bipolar affective disorder, due to psychotic episodes and characteristic manic periods), and his father is an alcoholic with a long history of aggressive and self-destructive behavior, having had little effective work experience as a police officer, spending much of his time away from work.

The patient had contact with his father, but lived most of his life with his mother and stepfather. However, in both family environments (his father's and mother's homes), he experienced an aggressive and unaffectionate relationship, where he did not feel considered a son, so much so that neither of them called him "son." During childhood, when he began to have difficulties coping with that environment and performing his daily activities, he began to be psychologically abused by his mother, without receiving any positive support regarding what he was experiencing.

Aligning the clinical case with the field of childhood mental health, regardless of family structure (regarding who composes it), it is through this nucleus that the child's development will occur until adulthood. The family ends up having an important role "in promoting mental health and caring for its members in every sense, as it is the first group that will interact with the child, from birth" (Bertolote, 2020). Therefore, if the family structure is unable to offer this to the child, the way they will receive, interpret, and deal with critical situations in daily life will be very bad, potentially causing a series of traumas and difficulties that may lead to disorders or problems in the future.

The family nucleus is "the first social space of an individual; even before attending school, the child, through the family, comes into contact with other people who make up their growth environment" (Rocha, 2020). This interaction allows the child to learn to communicate, listen, and interact with people, thus building a bond with them. Therefore, if the environment is affectionate, it will have a positive impact on intellectual and emotional development into adulthood, and if this is not offered, the effect will be the opposite.

Recognizing this family dysfunction is not intended to blame the family for these situations, but rather to help the family become aware of it and work individually or together to mitigate the damage (Bertolote, 2020). Psychotherapy serves as an important tool at this time, working not only with the patient but also with the family.

Since the family continues to play an important role in the field of mental health by promoting protective factors and reducing the risks of mental illness, activities and tools focused on health in childhood and adolescence should address not only the patient but also family members. This point relates to child and adolescent clinical practice, but may also be relevant in adult clinical care. (Rocha, 2020)

For adults, the family's function is no longer "one of identity formation, but rather of supporting experiences throughout life, whether the individual copes well or not with suffering" (Rocha, 2020). If an adult can find a point of support in their family, they will have good results when facing difficulties, because, as mentioned earlier, even as an adult, their mental health can be impacted by family ties, and regardless of whether they leave and build a new family, this impact will continue if left untreated. (Rocha, 2020)

In addition to psychotherapy, family life education programs, support groups, counseling, etc., emerge as means to change family instability. Another fundamental point in anyone's life is school, which is a different environment from the family, but which can also interfere. It is a place where the individual may be able to compensate for the wear and tear and suffering they may experience due to their family. (Asevedo, 2020).

A pertinent point for mental health professionals, when analyzing a patient's childhood period and in the care of a child (if there was previous care and now they are an adult), is the care we need to take not to view the developmental process as something standardized and rigid, which can sometimes happen because of the way we learn in undergraduate studies. Each relationship is unique, possessing a singularity in facing life's circumstances, and this will be reflected in clinical observations, where there are moments when something unexpected can occur in an individual's life, at a time that theoretically wouldn't be so serious for other people, but which can be severe enough to make someone ill (Fernandes, 2019).

There are situations, such as the case of the patient mentioned in the article, where the individual is exposed for a long time to a harmful environment for various reasons and factors, and the issues that were difficult to deal with in childhood end up persisting into adulthood and continue to fuel the worsening of the patient's symptoms. This persistence of difficulties breaks the conception that the developmental process has specific phases and that after each one, there should be an abandonment of what happened during that phase. For this reason, it is important to look in detail at the patient's entire life history and not allow clinical practice to be limited by certain methodological conceptions, as well as to understand the importance that childhood can have in the context of mental health.

3. FIRST PSYCHOTIC BREAK AND USE OF PSYCHOACTIVE DRUGS

Before the onset of more severe symptoms and the first episode, the patient had been exhibiting a series of characteristics demonstrating vulnerability in regulating and managing their emotions, as well as difficulties with attention and learning since late childhood. This could be indicative of symptoms related to a possible primary mental disorder, namely Attention Deficit Hyperactivity Disorder (ADHD). Because they lived in a chaotic and neglectful family environment, these symptoms were never recognized by family members, and the few times treatment was attempted, it was not effective or complete, ultimately leaving the patient even more vulnerable mentally and emotionally.

During adolescence, he ended up building friendships with people who had destructive or self-destructive behaviors, which corresponded to what he was also feeling, as he lived a mix of being a victim of school violence and feeling the need for friendship groups to "distract" himself. It was through these friendship groups and family customs that he ended up experimenting with alcohol

and, after a while, some types of illicit drugs, which did not seem wrong to him, due to the vulnerability he had been harboring for a long time.

Regarding drug use, in a general context, people use them not only "to numb pain, but also as an instrument of pleasure" (Lima & Surjus, 2019). For adolescents, early drug experiences serve both as an attempt to construct a social identity and feel a sense of belonging to a particular group, as well as functioning as a remedy that alleviates and numbs their own anxieties and emotions, which they often don't know how to handle. This complicates the recognition of psychological suffering and the worsening of symptoms before adulthood (Lima & Surjus, 2019).

In cases where reality is so violent and cruel to the mind, drugs begin to play a dual role: providing excitement and a possible new reality, which is illusory and anesthetizing, where the individual no longer cares about danger or contact with death. Furthermore, the drug fills the void, the holes within the psyche, providing pleasure that is not felt when in contact with reality, and this experience ends up being imprinted on the subjectivity, reinforcing substance use (Lima & Surjus, 2019).

Recognizing the suffering behind drug use in adolescence can offer not only avenues to ensure young people receive dignified treatment, but also allows for working with the manifestation of emotions such as anger, which tends to be one of the central feelings in adolescence. When individuals are in an environment that offers care and recognition, they learn to manage this anger, but without this, they cease to transform anger into a driving force for achieving positive goals and instead use it as an instigator of violent acts against themselves and others (Lima & Surjus, 2019).

Despite having experimented with alcohol and drugs, the patient claimed that he used them only a few times before his first psychotic episode. However, early in adulthood, around the age of 19, the use of a specific drug coincided with a catalyzing situation that was strong enough to further expose his mental and emotional vulnerability, to the point where he was unable to cope, triggering his first psychotic episode.

The situation involved a work problem. He had previously worked in a very welcoming environment where he finally felt recognized; things were going smoothly, and he was able to perform all his duties. However, there was a sudden change of workplace, coupled with a lack of communication within the company about this change. His ongoing tasks were left unfinished, preventing him from completing them. This created a significant problem, and the blame fell on him, ultimately destabilizing him completely.

The patient's first episode included symptoms such as delusions of persecution, auditory hallucinations, panic attacks, and avoidance behaviors. It was a very hazy and turbulent period for the patient, who took a long time to remember what happened during that time in his life. Medication and hospitalization provided some relief from the symptoms, but the condition persisted for a long time. After the episode, for three years, the patient used alcohol and cocaine as a way to try to hide and alleviate some symptoms, to the point where he could socialize with other people. It was the choice of cocaine, specifically, that made the situation even more serious.

The use, and especially the abuse of drugs, puts the health of the user at risk, in addition to leaving them exposed and vulnerable to the effects of the drug and the possible consequences of its consumption. The context of drug use is so serious that it transcends an individual problem and becomes a public health issue. In the context of illicit drugs, there are psychoactive substances that act directly on the CNS (Central Nervous System), causing a high degree of abuse and dependence (Ferreira, *et al.*, 2017). In the patient's case, the illicit drug of choice was cocaine, which is psychoactive.

Cocaine has a high dopaminergic effect, causing a high rate of dependence. When an individual uses it for a long time, they may develop serious psychiatric symptoms such as anxiety, mania, depression, panic, personality disorders, etc. (Ferreira *et al*., p. 361, 2017). Other damages caused by cocaine use include impaired cognitive function, chronic exhaustion, and alterations in frontal lobe function (Ferreira *et al*., 2017).

Since the patient used drugs combined with alcohol after the episode, for a period it ceased to be sporadic use and became chronic, possibly leading to neuroadaptations due to neurochemical changes resulting from cocaine and alcohol use, which subsequently manifested as problems with memory and perception, for example. These neuroadaptations occur to maintain brain homeostasis while the drug is present in the body; without it, or with reduced use, an imbalance occurs, leading to withdrawal syndrome (Ferreira *et al*., 2017).

In particular, cocaine acts directly on dopamine, norepinephrine, and serotonin, with dopamine being the most affected. With this alteration, the individual tends to "feel excessively self-confident, powerful, irresistible, and capable of solving any challenge" (Ferreira et al., p. 365, 2017). However, this only happens in the initial stages of use; after a while, the individual uses the drug solely for the reward it provides. At this point, the individual has already disconnected from social, family, emotional, learning, and professional interests in order to experience the potential gains offered by the drug (Ferreira et al., 2017).

Neurochemical alterations and occasional changes due to drug use can be stable and long-lasting, where even after a considerable period without use, the individual may still experience withdrawal symptoms and risk relapse. Furthermore, there are significant damages depending on the duration of use and the amount of drug consumed, such as memory loss, loss of analytical ability, among others (Ferreira *et al*., 2017).

Another important topic to address for clarification is the concept of addiction and chemical dependency, considering the patient's history of drug use. Addiction is a behavioral condition in which "there is a craving for the drug, where its consumption can end up controlling behavior and motivation for use" (Ferreira *et al*., 2017). Chemical dependency, on the other hand, is a situation where both the mind and body have become accustomed to the frequent use of the drug, leaving the individual in a state where they need the drug to survive without experiencing withdrawal symptoms. Since the use of the substance ended years before the patient began the current therapeutic process, most of the lingering effects of withdrawal syndrome had disappeared, leaving only the symptoms related to Bipolar Affective Disorder and comorbidities.

4. OVERLAPPING SYMPTOMS BETWEEN SCHIZOAFFECTIVE DISORDER AND BIPOLAR DISORDER

This topic regarding the overlap of symptoms between Schizoaffective Disorder (SZA) and Bipolar Disorder (BAD) was chosen because it accurately reflects what happened in the clinical case. For many years, the patient had a diagnosis of Schizoaffective Disorder, postulated during one of his hospitalizations and subsequently maintained by all the psychiatrists who treated him. However, there is a complicating factor in this matter: because

hospitalizations occurred and the patient did not stay with the same professional for many months, the diagnosis was maintained without an in-depth analysis of the symptoms, and thus the condition remained the same. Only later, when he began to be treated by the same psychiatrist for more than 2 years, did this hypothesis begin to be analyzed.

This factor mentioned in the previous paragraph occurs in specific contexts, which are not so common in a clinical setting, but can arise in other settings, such as psychiatric referral centers, for example. These are cases of homeless individuals who lack identification or sufficient information, as well as patients who end up being hospitalized due to an acute psychotic crisis or suicide attempt. In these situations, multiple hospitalizations may occur, and patients may be seen by various professionals, which can lead to incorrect diagnoses, differing from one another, directly affecting symptom remission and proper treatment. (Costa *et al*, 2024).

The overlap of symptoms is a very important issue, and we need to be constantly aware of it because it can happen, especially with disorders that have very similar symptoms. This makes it very difficult to distinguish the patient's specific disorder, whether it is unique, or if there are other comorbidities. This situation occurs frequently between mood disorders and psychotic disorders, such as schizoaffective disorder, for example. (Assunção, 2024).

Regarding Schizoaffective Disorder (SZA), diagnosis is extremely necessary and must be carried out with great care, as small details will differentiate it from schizophrenia or a Bipolar Affective Disorder. The symptoms of schizoaffective disorder according to the DSM-5-TR are: A prolonged and uninterrupted period of episodes of altered mood (manic or depressive), occurring simultaneously with two or more symptoms of diagnostic criterion A of schizophrenia, which include delusions, hallucinations, disorganized speech, catatonic or disorganized behavior, and negative symptoms. SZA is divided into 3 subtypes: manic, depressive, and mixed. (APA, 2023). The main detail to distinguish the symptoms of SZA and BAD within these criteria is that delusions and hallucinations must persist for 2 weeks or more during the absence of a mood episode (manic or depressive) and must remain so for the entire duration of the disorder until the time of diagnosis.

For many years, SZA was treated superficially, without much change regarding how to diagnose it, the methods or tools for diagnosis, and its treatment. This is noticeable both in the little or almost no change in recent manuals, as well as in the few research studies and articles that address both the disorder and the overlap of symptoms with Bipolar Affective Disorder. (Abrams *et al*, 2008)

This superficial treatment can be explained in part by the uncertainty that the manifestation of SZA symptoms can cause, and this is what ultimately hinders a consensus on the conceptual and clinical characteristics of the disorder. Some of the doubts would be the following: Could SZA be a reflection of the simultaneous occurrence of two diseases (schizophrenia and bipolar disorder) and therefore not need a category (single subcategory) in the main diagnostic manuals; could it be a variant of schizophrenia, where the symptoms of mood alteration would be more expressive than usual in schizophrenia, but not so discrepant; and could SZA be a more acute form of major depressive or bipolar disorders, where there would be remnants of psychotic symptoms between episodes of mood alteration? And unfortunately, it is these doubts that discredit the characteristics of SZA. (Abrams *et al*, 2008).

These questions stem from a restriction generated by a categorical approach or by a large part of the manuals and practices of mental health professionals, where the clinical and symptomatic conditions of a disorder need to be organized into distinct categories. Disorders like SZA, which has a complex symptomatic manifestation, can generate complications when organizing and categorizing these symptoms, where many clinical observations demonstrate the perception that not all symptoms fit completely. Therefore, the shift towards a more dimensional approach has been very welcome in recent years (Abrams *et al*, 2008).

An important point that helps to understand why difficulties with overlapping symptoms still occur is the diagnostic criteria of the main diagnostic manual used by psychiatrists, the DSM. The first criteria established as we know them today were in the DSM III R, and since that edition, there have been no consistent changes that would provide clearer information about the symptoms and pathological manifestations that would be observed and that would be part of SZA, as this would prevent the easy overlap of symptoms between SZA, Bipolar Disorder, and Schizophrenia. (Abrams *et al*, 2008).

Even though the only recognized set of SZA symptom criteria is that of the DSM, some authors address clinical symptoms that help differentiate between SZA and Bipolar Disorder (BAD). According to Abrams et al. (2008), "delusions at the first consultation are more frequent among people with Bipolar Disorder, while hallucinations are more common among people with schizophrenia than among those with SZA or Bipolar Disorder." Another observation is that, subtly, patients with SZA present a lower intensity of mood alteration and are less playful than patients with manic episodes in Bipolar Disorder. (Abrams *et al*, 2008).

There are certain characteristics and symptoms, in addition to those mentioned in the previous paragraph, that, depending on how they appear in the initial consultations, can ultimately influence the diagnosis, and every professional needs to be attentive to these aspects. If the first episode observed by the professional is depressive, there is a high probability that the final diagnosis will be bipolar disorder (BAD), while if the first episode is manic, the greater chances may end up being a diagnosis of Schizoaffective Disorder (SZA) or Bipolar Disorder. This demonstrates that, when being seen at the beginning of psychological care, the observed clinical characteristics and pathological manifestations will guide the diagnostic hypothesis towards the formation of a future diagnosis. (Abrams *et al*, 2008).

In the last decade, new methods with imaging exams and other related types are being researched to improve the collection of information for diagnosis. However, since most studies are individual, there hasn't yet been a clear endorsement to make the analysis of neuroendocrine, neurochemical, neurobiological, and genetic functions viable through these tests, as this would allow for the verification of alterations in these areas in relation to each mental disorder. However, even without a clear and standardized resolution for the use of these tests, they are a good option in cases of overlapping symptoms, such as those that occur between Bipolar Disorder and Schizoaffective Disorder, as they would help in distinguishing and separating the alterations to find the correct diagnosis.

After discussing SZA in depth, it's also important to briefly discuss the symptoms of Bipolar Affective Disorder and, especially, the psychotic symptoms that occur when a manic, mixed, or depressive episode has reached an acute and very serious stage. Bipolar disorder (BAD) is divided into subcategories, the first being Type I Bipolar disorder, which has the following symptoms: elevated mood, including euphoria, feelings of grandeur, hyperactivity, increased sexual activity, decreased need for sleep, risky behaviors, irritability, and aggressiveness, among others;

all corresponding to manic episodes. However, there are also depressive episodes, which have symptoms such as anhedonia, sadness, vegetative symptoms, and psychomotor changes. In addition to these reported episodes, there is also the mixed episode, where mania and depression occur simultaneously. (Scaini *et al*, 2020).

The second subtype would be Bipolar Disorder Type II, which includes episodes of hypomania and depression, the latter being predominant within this specific type. Hypomania has diagnostic criteria similar to a manic episode, but the intensity of the symptoms is somewhat milder, not causing substantial and abrupt impairments in the patient's life like mania, for example. However, it still tends to leave the patient confused, due to the particular characteristics of this subtype, where even with hypomania, their thoughts may remain negative along with increased energy, which can contribute to suicide attempts and substance use. (Soares *et al*, 2024)

The other subtypes of Bipolar Affective Disorder are Cyclothymic Disorder (Cyclothymia), Substance- or Medication-Induced Bipolar and Related Disorder, Bipolar and Related Disorder Due to Another Medical Condition (which may be caused by a disease or disorder that causes similar symptoms), and Other Specified or Unspecified Bipolar and Related Disorder. (APA, 2023). Regarding substance-induced Bipolar Disorder, to differentiate it from primary Bipolar Disorder (unrelated to medication/substance), it is important to understand that to receive this diagnosis, it is necessary to analyze whether the patient has persistent symptoms long after the substance is no longer being used. (Soares *et al*, 2024).

Within Bipolar Disorder, psychotic symptoms are a fundamental topic because they involve the context of overlaps, as they can occur in both Bipolar Disorder and Schizoaffective Disorder. There are cases where they appear sporadically throughout the individual's life (as happened with the patient cited in this article) and others where they occur very frequently, being more recent. Generally, delusions are much more common in Bipolar Disorder than hallucinations, but both can occur and appear much more frequently in manic or mixed Type I episodes than in Type II. Psychotic symptoms are not as severe as those of schizophrenia at its core, however, the damage to the patient's life can be extensive due to the combination of these symptoms with the mood swing episode. (Chakrabarti & Singh, 2022)

The frequency of psychotic symptoms in bipolar disorder is equivalent to that of schizophrenia, and there are no significant qualitative distinctions in the delusions and hallucinations of the two. Furthermore, due to this high occurrence, especially in manic states, it may be impossible to distinguish between bipolar disorder and primary psychotic disorders during the acute phase of symptoms. The main delusions that appear are grandiosity, persecution, and reference, while the hallucinations would be auditory, verbal, and visual (Chakrabarti & Singh, 2022). Psychotic symptoms can be mood-congruent or incongruent (of the episode) and can also be first-order, including: thought broadcasting, hallucinatory voices that converse, voices that comment on the action, experience of bodily influence, thought theft or insertion, thought broadcasting, delusional perception, and experiences of passivity (Malinoswki *et al*., 2020).

With these descriptions of psychotic symptoms, it is possible to understand why the timing of their occurrence is crucial for symptom overlap, since the presence of delusions and hallucinations can lead to the false impression that the patient may have a psychotic disorder while they are experiencing a psychotic episode. Often, in emergency situations where rapid drug therapy is necessary, misdiagnoses can occur, negatively impacting the individual's life due to inadequate treatment (Chakrabarti & Singh, 2022).

The next section will address the treatment process and diagnostic update of the clinical case presented in this article. This involved a meticulous psychodiagnostic process over several months, with monitoring of the treatment and symptomatic picture, until issues involving misdiagnosis, ineffective treatment, and the negative consequences generated over several years of the patient's life were analyzed.

5. TREATMENT PERIOD AND DIAGNOSTIC UPDATE

When the patient sought to begin therapy again (he had previously done so with another professional), he had already been receiving psychiatric care for several years, but felt that the treatment was not entirely effective and that many symptoms were still directly affecting his daily life. The main symptoms he reported were: mood swings, sleep paralysis, excessive sleep (he slept about 12 to 14 hours a day, and in other situations, much more), panic and feelings of escape, racing and negative thoughts, muscle stiffness upon waking, to the point of experiencing pain in the wrist, arm, and leg joints, anhedonia, lack of self-care and hygiene.

In the first months of treatment, the patient was still living with his mother and was unable to return to the labor market, spending almost all his time at home. In his attempts to get an interview and find a job, he would manage to go to the first day, but would begin to experience symptoms of panic, feelings of escape, altered sensory perception, racing thoughts, eventually leading to delusions of persecution. During the night, while sleeping, he had a series of nightmares until he felt he was experiencing sleep paralysis. Most of these nightmares involved dying or killing someone (usually his parents). At this time, the patient was already taking an antipsychotic, a mood stabilizer, and an antidepressant. Therefore, in parallel with the clinical appointments, which are part of the diagnostic process, the use of the medications and their effects were also being monitored. This procedure became essential for correcting the treatment.

During these initial appointments, the psychodiagnostic process took place, which is a very important step and needs to be carried out in a detailed and careful manner. It involves the analysis of the symptoms presented by the patient, together with what is being observed by the psychologist, and physical and neurological examinations, to verify alterations in both cognitive function and brain structures, as this will make it possible to rule out other medical conditions that may be causing the symptoms. It is also interesting to apply assessment scales "to measure the severity of symptoms, the damage caused by them, and then to verify possible changes influenced by the therapeutic intervention" (Assunção *et al*, p. 1458, 2024). However, the application of scales is not mandatory, because these changes can be monitored through observation during clinical sessions.

Regarding treatment, this is carried out through a combination of medications, psychological and psychiatric care, as well as modifications to the patient's daily life and activities. Therefore, what differentiates the treatment of someone with schizoaffective disorder is the use of antipsychotics, mood stabilizers, and antidepressants, while in bipolar disorder, depending on the type, the use of antidepressants can worsen symptoms. This is why the issue of overlapping symptoms is important, because if it is not

done carefully, a medication may end up being prescribed that will not bring improvements to the patient. (Assunção, *et al*, 2024)

Within the treatment, it is pertinent that professionals attending a patient with bipolar disorder or schizoaffective disorder carry out clinical observation throughout the treatment period, but without focusing solely on monitoring symptoms, because this can impair the perception of disease progression and improvement, as well as make it difficult to readjust the treatment plan and perceive possible manifestations of crises, which can occur even with medication use. (Assunção, *et al*, 2024)

With this in mind, the consultations continued for several more months, during which many symptoms were observed that sometimes coincided with the previous diagnosis (SZA), but at other times did not correspond, and this began to generate some questions. Gradually, it became possible to understand that there was some problem hindering the effectiveness of the medications being used, mainly because the patient seemed to oscillate between episodes of mania and depression, even having mixed episodes, to the point of presenting first-order symptoms, in addition to some visual hallucinations.

After the initial symptoms subsided, the diagnosis of Schizoaffective Disorder remained in mind due to the visual hallucinations that can also occur in this disorder. However, after this acute episode of psychotic symptoms, no further symptoms at this level emerged, allowing the previous questions to be investigated in parallel with the therapy sessions. Gradually, it became clearer when the patient was experiencing a manic episode, a depressive episode, a mixed episode, and when he was euthymic. Simultaneously, some medication changes occurred. The patient first stopped using the mood stabilizer he had used for a long time (valproate) and switched to lithium, then discontinued the antidepressant, maintained the antipsychotic he had been taking for many years (quetiapine), and began using bupropion.

With this change, most of the symptoms decreased in intensity, and he began to be able to work more stably, without experiencing the more severe symptoms that had occurred previously, which raised a red flag. Due to some health problems he began experiencing with lithium use, mainly gastrointestinal issues and severe tremors, he switched from lithium to valproate and from quetiapine to aripiprazole, due to the intense sedation he felt with quetiapine, which caused him significant lethargy throughout the day. During this readjustment, the patient experienced a manic episode, which allowed for a clearer observation of all the symptoms that appeared during this episode, since he never again experienced the psychotic episodes together. From this observation, made over several weeks, it became clearer that the symptoms corresponded to Bipolar Disorder Type I.

Bipolar Disorder (BAD) is a mental illness that becomes a chronic disorder over the course of its manifestations, characterized by mood swings, with Types I and II being the main subtypes. Due to mood swings, functional and relational impairment can occur in multiple areas of the patient's life, mainly because they may have difficulty recognizing the severity of the symptoms, which is more noticeable to those who live with the individual. (Scaini *et al*, 2020). This condition tends to worsen when psychotic symptoms are present, because due to its dispersion, it tends to further aggravate the course, prognosis, and response to treatment of the patient. (Chakrabarti & Singh, 2022).

Currently, there are pharmacological and non-pharmacological treatments that can be used, some of which are quite effective in many patients. However, some patients may remain symptomatic even with treatment. Therefore, there is a focus on advancing the understanding of the neurobiology of bipolar disorder in order to identify new therapeutic targets, as well as biomarkers for possible early detection, prognosis, and treatment response (Scaini *et al*., 2020).

This advancement is important because the biochemical brain changes in patients with bipolar disorder are quite complex, and exposure to a chaotic environment conducive to this can lead to the development of the first episode, as well as subsequent worsening and chronicity. Therefore, information such as "genetic, epigenetic, molecular, physiological, clinical, environmental, and neuroimaging factors" (Scaini *et al*., p. 536, 2020) can greatly assist in improving both diagnosis and treatment, and in overcoming a negative prognosis, as well as serving as a complement to all these stages, which are currently essentially clinical (Scaini *et al*., 2020).

In the last decade, numerous studies have explored the clinical application of neuroimaging exams, at least as a complementary tool for treatment; however, a resolution enabling the more comprehensive use of these exams has not yet been established (Scaini *et al*., 2020). While it may seem different from the other topics discussed in this article, this issue of exams is important to address because it presents a challenge at various points in treatment, not just at the beginning. There are times when the diagnosis needs to be re-evaluated, and these exams would be a key element. In addition to being a complication for clinical and pharmacological treatment, there is no biomarker with consistent scientific validation for a more effective intervention in bipolar disorder.

Another complicating factor in the diagnostic process of Bipolar Disorder is that the disorder has a symptoms chart with certain patterns, but also characteristics and manifestations that differ among all sufferers. In addition to various comorbidities and cognitive impairment depending on the case, many genetic and environmental factors need to be analyzed. Through anamnesis, interviews, monitoring in sessions, and even if the psychiatrist indicates some examination, this entire process occurs within the clinical setting, which requires that treatment and care be carried out correctly and continuously, without interruptions. (Scaini *et al*, 2020).

6. AFTER DIAGNOSTIC UPDATE

It's not just the complexity of the clinical picture that makes Bipolar Disorder more difficult to understand, but also the influence that environmental exposure can have, not only before the onset of the first crisis, but also after the episodes. The environment in which the individual lived before and now is associated not only with a risk that contributes to the illness, but can also serve as protection and aid in resilience during treatment. In the specific clinical case of this article, the continuity of treatment, the reduction of symptoms, the discovery of some key complications, and the updating of the diagnosis were only possible because there was a change in the patient's environment, which helped to make him increasingly participatory in the treatment.

After the diagnosis, two concerns guided the clinical observation of the professionals involved: comorbidities and the action of medications. This precaution exists to avoid the risk of a manic episode and the return of more severe symptoms, such as psychotic ones, as this would mean a relapse and a very damaging recurrence for the patient, especially during a period of symptom stabilization.

Regarding medications, "despite the proven efficacy of several medications for the treatment of bipolar disorder, lithium is the only medication considered fundamental as a mood stabilizer"

(Scaini et al, 2020). Lithium is frequently prescribed for patients who experience acute manic episodes, serving both for treatment and maintenance, with the goal of preventing new episodes. However, it does not have a potent antidepressant effect, which can be problematic for those with frequent depressive episodes, because there is a susceptibility to manic or hypomanic switching with the use of antidepressants. Therefore, this interaction needs to be carefully considered until the right combination is found.

For cases like that of the patient discussed in this article, where lithium did not respond well to treatment, the medication of choice is sodium divalproate (Depakote). In addition to valproate, carbamazepine, an anticonvulsant in the same class as valproate, may also be prescribed. In parallel, an antipsychotic may also be chosen, among which there are typical and atypical antipsychotics. Typical antipsychotics include haloperidol and chlorpromazine, while atypical antipsychotics primarily include aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone, and asenapine. All of these listed medications have also demonstrated efficacy in research. (Scaini *et al*, 2020)

Most antipsychotics are approved for the acute treatment of mania, with the exception of clozapine, and can be used for the maintenance of the clinical picture of bipolar disorder, mainly olanzapine, aripiprazole, and quetiapine (Schatzberg & DeBattista, 2017). These are precisely the medications prescribed in the clinical case of this article, all of which were effective during the period they were used. Quetiapine was the first, then aripiprazole, and finally the patient resumed using olanzapine, which had been used years before. However, what is being sought with this information is not only about the change in medications, but also the reason behind these modifications, which would be the side effects.

During the process of using psychopharmacological medications, there is a very important aspect that the professional needs to be aware of in order to act if side effects are observed. These effects can occur both during the medication adaptation period (at the beginning of use) and during use over the months. At this point, they are residual effects, to which the patient must build tolerance over time. If the patient has significant difficulty adapting to the effects, a specific and preventative action by the professional would be necessary, which would involve conducting a psychoeducation process about the medications, their functioning, side effects, and which ones the patient could tolerate according to their clinical history.

This psychoeducational process is essential because it facilitates timely medication changes without harming treatment, since insisting on continuing with medication that is not as effective and greatly bothers the patient can lead to treatment abandonment, for example. This act can harm the entire clinical process that was being carried out and cause negative emotional, social, relational, and financial consequences for the patient with bipolar disorder (Chakrabarti & Singh, 2022).

On the other hand, antipsychotics play an important role in the treatment of bipolar disorder because they have "proven to be versatile, fast-acting, and more effective in depressive phases, where mood stabilizers such as lithium and valproate are not equally effective," and they serve as an alternative to antidepressants, as some can trigger a manic switch as mentioned earlier. (Schatzberg & DeBattista, 2017)

Regarding olanzapine (the current antipsychotic used by the patient in the clinical case), it was the first atypical antipsychotic to be approved for the treatment of acute mania, and the third, along with lithium and lamotrigine, to demonstrate benefits in preventing mania and depression in bipolar I patients. Its most well-known side effects are akathisia, as well as increased weight gain and sedation (less so for the patient than with quetiapine). (Schatzberg & DeBattista, 2017)

Regarding aripiprazole, it appears to significantly reduce the irritability, mood swings, and aggression that occur in acute mania (Schatzberg & DeBattista, p. 206, 2017). Research supports its effectiveness in the maintenance treatment of Type I Bipolar Disorder, as it helps delay the onset of mania. However, aripiprazole can cause some side effects, such as sedation and extrapyramidal motor symptoms (EPS), especially in children and adolescents. Akathisia, an example of EPS, is more common in adults. In fact, this was the effect that most distressed the patient, especially when resting or going to sleep, in addition to muscle rigidity and dystonia, which greatly affected sleep and work performance—two fundamental problems for him.

Finally, quetiapine, which "is an effective medication for the acute treatment of mania, in addition to helping reduce anxiety in bipolar depression, and may have significant antidepressant properties" (Schatzberg & DeBattista, p. 202, 2017). Although it is an excellent medication for various mental disorders, it has side effects such as drowsiness and dizziness, which may be tolerable for most people, but for those with specific sleep problems (hypersomnia) or who work driving, it would be necessary to find ways to minimize the difficulties and adapt. Other medications that can be used as adjuncts along with antipsychotics and mood stabilizers are benzodiazepines, which participate in treatment for a period to help with sleep, anxiety, and agitation that patients with acute mania may experience. (Schatzberg & DeBattista, 2017).

In addition to medications and comorbidities (which will be discussed later), a very problematic and concerning issue that occurred in this clinical case and may occur with other patients with bipolar disorder is the depressive episode phase. According to Schatzberg (p. 251, 2017), "depression is the predominant mood state in bipolar disorder. Individuals with type I bipolar disorder spend about 32% of their lives in a depressive state, while 9% are in a manic state and 6% in mixed or cyclical states." Furthermore, it is the most difficult to treat, and as the medication section demonstrates, there are few drugs that effectively treat bipolar depression without causing undesirable results, as there is a high risk not only of relapse but also of suicide attempts due to increased energy, anxiety, and depressive symptoms.

In the treatment of bipolar disorder (BAD), professionals need to carefully monitor the possible development of comorbidities. There is a high risk of their occurrence, which consequently increases the risk of mortality. Some types of comorbidities and medical conditions associated with BAD include: cardiovascular diseases, diabetes mellitus, injuries caused by external factors, and respiratory diseases. Due to comorbidities, the life expectancy of individuals with BAD is reduced by 9 years compared to the general population.

Finally, a factor that directly influenced the treatment was that both professionals attending the patient, the psychologist and the psychiatrist, focused on listening and not just on standard protocols and treatments. Maintaining a focus solely on standard treatments reduces the experiences in a person's life and fails to address the difficulties that certain treatments can create. This is why it was only after several years, after seeing various professionals and using various medications, that the symptomatic picture became more stable, as the patient began to be treated by both a psychologist and a psychiatrist for a considerable period.

When we listen, we can understand why some situations and symptoms are more harmful to one patient than to others; we see how they react to what makes sense or not during treatment, giving them an active role in this process. This entire process is a two-way street, and they need to be a participant in their own treatment; how they dealt with their problems before and how they deal with them now will directly influence their improvement. (Katz, 2019)

7. FINAL CONSIDERATIONS

When we receive a patient, even an adult, we must be aware that they come to the clinic already having a life history with and without mental disorders. Therefore, it is invariably impossible to ignore these experiences when accompanying the patient from the initial assessment to treatment. In some cases, such as the one discussed in this article, it is demonstrated that when the individual was a child, they responded "to the place reserved for them in the culture and within the family that received them" (Katz, 2019). For a child, this place will function differently, and their response will also be equivalent to their understanding. They may accept living in an extremely chaotic environment, reject or transform all layers of absorbed information, and this will be reflected in their psychic structure and mental health. (Katz, 2019)

Aligning the context of mental health in childhood and adolescence with mental disorders, in the case of Bipolar Affective Disorder, it is not only the complexity of the clinical picture that makes it more difficult to understand, but also the influence that exposure to the family and social environment can have, not only before the appearance of the first symptoms, but also after the episodes. Checking the patient's life context, who they live with, and whether a support network exists during the anamnesis process and initial interviews is fundamental, not only to understand how much the environment may be contributing to the patient's illness, but also to determine if there will be support from someone important during treatment.

Depending on when the first symptoms are noticed, the patient with Bipolar Disorder may end up facing residual mood symptoms, cognitive and functional impairment, psychosocial disability, and decreased quality of life, even with the best treatment. This happens because it is increasingly noted that bipolar disorder is a progressive condition, where delayed diagnosis and inadequate treatment can lead to the continuation of mood episodes, some symptoms that are disabling and resistant, the development of comorbidities, etc. (Scaini *et al*, 2020).

Even with a prognosis that seems quite negative, due to the many variables and complex contexts discussed in this article, with good treatment it is possible to reverse a large part of the consequences that the episodes, crises, and outbreaks of Bipolar Disorder can cause in people's lives. The psychiatrist's work, with pharmacological intervention and psychotherapeutic treatment together, is fundamental because it provides a reduction in residual symptoms, prevention against recurrence of episodes, and a better quality of life for the patient, their family, and those who live directly with them. Alongside working with the symptomatology, psychotherapy can also help the patient cope with critical and stressful situations that often previously served as triggers for acute crises. (Soares *et al*, 2024)

The construction of this work revolved around addressing a line of reasoning that can occur in quite complex cases, where the professional often encounters overlapping symptoms, a series of complaints and demands from the patient and sometimes even from family members, with little involvement of the patient in the treatment, in addition to the doubts and questions themselves during the clinical analysis. Therefore, it is hoped that the necessary care that the professional needs to take, the most important information to clarify the overlaps, and the importance of a multidisciplinary approach with those attending to the patient have become easily understandable.

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