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Introduction Differentiating between bipolar (BD) and schizoaffective disorder (SAD) can be challenging, especially during early stages of the illness.
Objectives Comparing clinical profiles and socio-demographic characteristics of patients diagnosed with BD and SAD.
Methods The study, conducted between 2014–2016, included 67 inpatients from the Timisoara Psychiatric Clinic, diagnosed with either BD ($n=35$) or SAD ($n=32$), according to ICD-10 criteria. The following parameters were analyzed: number of episodes, number of times hospitalized, onset age, frequency and nature of psychotic symptoms, family history of psychiatric disorders and socio-demographic characteristics (age, sex, marital status). Data were obtained by direct interview and patient files. Symptom severity was measured with Brief Psychiatric Rating Scale (BPRS).
Results There were no significant differences between the two samples regarding age or sex distribution. Schizoaffective patients were more frequent unmarried ($P=0.007$). Onset age was significantly lower in SAD patients (22.41 years for SAD, 28.36 years for BD). SAD patients had the highest number of episodes and needed more frequent hospitalization. Bipolar patients had higher percentage of family history of affective disorders when compared to schizoaffective patients (41% versus 36%). Hallucinations were more frequently found in schizoaffective patients than in bipolar patients ($P=0.004$). We found no significant differences between the two samples regarding the presence or the type of delusions. The SAD sample had significantly higher BPRS total scores than bipolar patients ($P=0.035$).
Conclusions Although this study revealed numerous similarities between BD and SAD, it also identified differences that may be helpful in establishing the correct diagnosis.
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EV0071

Temporality in mania: Phenomenological, neurobiological and therapeutic consequences

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Manic disturbances of temporality are underemphasized in present-day accounts. For example, they are not included among criteria for manic episodes in DSM or ICD. Nonetheless, as already claimed by Binswanger (1964), aberrant temporality is core to the disorder. Persons with mania live almost exclusively in the present and hardly into the future. Especially in the larger scheme of things, their future is already here. There is no "advancing, developing or maturing," anticipations have been achieved, all that I strive for is present – if you will just get out of my way! A half century ago, Binswanger spelled out this temporal foundation for mania and summed up consequences. The manic self, not living into the future, "is not, to borrow a word, an existential self."
This presentation will describe phenomenological characteristics of such a manic self and then present correlating findings from contemporary neuroscience. Importantly, such findings clarify present and future therapeutic interventions. Of critical importance is manic chronobiology: clocks in our brains afford receptor sites for the lithium ion. At these sites, lithium potently inhibits the circadian rhythm regulator glycogen synthase kinase 3 and alters the biological cascade that follows. By taking a close look, we can comprehend implications for mania as well as for treatment with lithium: Neurobiologically, lithium disrupts manic rhythm dysregulation and restores a more "normalized" temporality. The consequence is no less than the return of the existential self.
A receptor mechanism of action for lithium additionally portends future specific and safer treatment options "after lithium."
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Putting it all together: How disordered temporality is core to the phenomenology and neurobiology of mania

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Disturbances of temporality in mania, underemphasized in present-day accounts, are nonetheless core to understanding both the phenomenology and the neurobiology of the disorder:
– phenomenology: already in 1954, Binswanger had articulated that persons with mania live almost exclusively in the present and hardly at all into the future. Especially in the larger scheme of things, their future is already here. There is no "advancing, developing or maturing," anticipations have already been achieved, and all that I strive for is basically present if you will just get out of my way! A half century ago, Binswanger summed up the consequence of manic temporality: the manic self, not living into the future, "is not. . . an existential self." This presentation will further describe phenomenological characteristics of such a self in mania;
– findings from contemporary neuroscience correlate remarkably well with the above phenomenology, importantly clarifying present and future therapeutic interventions. Of critical importance in mania, clocks in our brains afford receptor sites for the lithium ion. Once bound to the receptor, lithium potently inhibits the circadian rhythm regulator glycogen synthase kinase 3 (GSK3) and profoundly alters the biological cascade that it initiates. In this presentation, by taking a close look, step-by-step, we will clarify how lithium disrupts mania rhythm dysregulation and restores a more "normalized" temporality. The consequence is no less than the return of the existential self. We will also briefly glance, in this presentation, at the window that lithium cellular efficacy offers for treatment options "after lithium."
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Antidepressants induced mania in patients with diagnosed unipolar depression: Case report and literature discussion

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