

Longitudinal Diagnostic Reassessment of Schizoaffective Disorder in Chronic Psychosis: A Case Report

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Abstract

Differentiating schizophrenia from schizoaffective disorder remains a significant diagnostic challenge due to substantial symptom overlap and reliance on cross-sectional assessment. This case illustrates how systematic longitudinal reconstruction of mood symptom trajectories supported diagnostic revision after prolonged treatment under an initial schizophrenia diagnosis. A descriptive clinical case approach was employed, involving comprehensive patient interview, collateral family interview, longitudinal symptom mapping, and reassessment based on DSM-5-TR criteria. The patient was a 33-year-old woman with a 13-year history of chronic psychosis initially diagnosed as paranoid schizophrenia. Retrospective reconstruction identified five recurrent major depressive episodes lasting approximately 6–12 months each, accounting for an estimated 6–7 years of the illness course. In addition, at least one documented period of persistent psychosis lasting more than two weeks occurred in the absence of mood symptoms, fulfilling DSM-5-TR criteria for schizoaffective disorder, depressive type. Following diagnostic revision, antidepressant augmentation and structured psychosocial intervention were initiated. At three-month follow-up, depressive symptoms decreased, passive suicidal ideation resolved, and functional status improved as measured by the Personal and Social Performance (PSP) scale (from 40 to 60), with no rehospitalization. This case underscores the importance of longitudinal assessment in chronic psychosis and highlights its implications for diagnostic accuracy and treatment planning.

KEYWORDS

schizoaffective disorder; schizophrenia; longitudinal assessment; mood symptoms.

Introduction

Differential diagnosis within the schizophrenia spectrum remains one of the most challenging areas in contemporary psychiatric practice, particularly at the interface between schizophrenia, schizoaffective disorder, and mood disorders with psychotic features. Substantial phenomenological overlap exists among these conditions, including hallucinations, delusions, affective disturbances, cognitive impairment, and functional decline (Barch et al., 2013; Heckers et al., 2013; Jäger et al., 2012). Cross-sectional clinical assessment often captures only the dominant symptom cluster at a given time, potentially obscuring the longitudinal relationship between psychotic and mood symptoms (Carpenter & Tandon, 2013; Tandon et al., 2013; van Os et al., 2019). As a consequence, diagnostic boundaries may shift over time, especially in chronic psychiatric illness.

The differentiation between schizophrenia-spectrum disorders and affective psychoses has historically represented a major challenge in psychiatric nosology. Since the classical conceptualizations of Kraepelin and Bleuler, debate has persisted regarding whether psychotic disorders should be regarded as distinct categorical entities or as dimensional syndromes with overlapping psychopathological features (Marneros, 2003). Schizoaffective disorder emerged as a diagnostic construct intended to describe patients who simultaneously demonstrate persistent psychotic symptoms and substantial affective pathology but who do not fully conform to either schizophrenia or primary mood disorder classifications. Despite repeated revisions within modern diagnostic systems, uncertainty regarding the validity and stability of schizoaffective disorder continues to generate considerable clinical and theoretical debate (Grande et al., 2016; Peralta & Cuesta, 2017).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), schizoaffective disorder requires the presence of a major mood episode concurrent with Criterion A symptoms of schizophrenia, together with at least two weeks of psychotic symptoms occurring in the absence of prominent mood symptoms. DSM-5 and DSM-5-TR further emphasize that mood episodes must be present for the majority of the total duration of illness, reflecting an effort to improve diagnostic reliability and reduce overdiagnosis (Malaspina et al., 2013; Pagel et al., 2013). Nevertheless, controversy remains regarding the nosological validity of schizoaffective disorder, with some authors conceptualizing it as a heterogeneous midpoint between schizophrenia and bipolar disorder rather than a discrete diagnostic entity (Lake & Hurwitz, 2007; Peralta & Cuesta, 2017).

One major source of diagnostic complexity involves the fluctuating nature of symptom expression across time. Patients with chronic psychotic disorders frequently experience alternating periods of psychosis, depressive symptoms, partial remission, and psychosocial deterioration. During acute psychiatric encounters, clinicians often prioritize immediately observable symptoms such as hallucinations, delusions, behavioral disorganization, or agitation. Consequently, affective symptoms that occur intermittently or outside acute phases may receive insufficient attention. This limitation is particularly relevant in long-term outpatient care, where clinical documentation may be fragmented across multiple providers and healthcare settings.

Longitudinal studies have consistently demonstrated lower diagnostic stability for schizoaffective disorder compared with schizophrenia and bipolar disorder, with substantial proportions of patients experiencing diagnostic shifts during follow-up (Salvatore et al., 2009; Vollmer-Larsen et al., 2017). These findings raise concerns about potential misclassification when diagnoses are based primarily on early or cross-sectional presentations. Furthermore, dimensional models of psychosis suggest that psychotic and affective symptoms may exist along a spectrum rather than as discrete categories, complicating categorical distinctions (Allardyce et al., 2007; Cuthbert, 2015).

In addition to phenomenological overlap, increasing evidence suggests that schizophrenia-spectrum disorders and affective psychoses may share partially overlapping neurobiological and genetic mechanisms. Family studies have demonstrated increased rates of mood disorders

among relatives of individuals with schizoaffective disorder, while schizophrenia-spectrum traits may also occur among relatives of patients with bipolar disorder (Craddock et al., 2009; Van Snellenberg & de Candia, 2009). Neurobiological research similarly reveals shared abnormalities involving dopaminergic dysregulation, frontotemporal connectivity, emotional processing networks, and cognitive dysfunction. These findings support the possibility that psychotic disorders may be more accurately conceptualized along a spectrum rather than as rigidly separated conditions.

Depressive symptoms are common in schizophrenia and may be interpreted as secondary phenomena, including post-psychotic depression or demoralization (Sim et al., 2006; Uptegrove et al., 2017). However, failure to systematically document the duration, recurrence, and proportional burden of depressive episodes may obscure the presence of a primary affective component consistent with schizoaffective disorder. The distinction is clinically meaningful, as persistent affective pathology may influence pharmacological strategy, including the need for antidepressant augmentation, mood stabilization, or structured psychosocial intervention (Murru et al., 2011; Stroup & Gray, 2018).

The clinical consequences of diagnostic imprecision are substantial. Patients incorrectly diagnosed with schizophrenia may primarily receive antipsychotic-centered treatment approaches while significant affective symptoms remain undertreated. Persistent depressive pathology has been associated with impaired quality of life, poorer functional recovery, increased caregiver burden, reduced treatment adherence, and elevated suicide risk among individuals with psychotic disorders (Hor & Taylor, 2010). Therefore, accurate identification of longitudinal mood symptom burden is clinically relevant not only for diagnostic clarification but also for long-term management and prognosis.

Another important issue involves diagnostic inertia in chronic psychiatric care. Once a patient receives a diagnosis of schizophrenia, subsequent clinicians may continue using the same diagnostic formulation without systematically reevaluating the longitudinal course of illness. Over time, repeated documentation of the original diagnosis may reinforce diagnostic assumptions even when evolving symptom patterns suggest an alternative explanation. This tendency may be particularly pronounced in chronic psychosis because longstanding hallucinations and delusions frequently dominate clinical impressions. As a result, recurrent affective episodes may become conceptualized merely as secondary emotional reactions rather than integral manifestations of the primary disorder.

Recent psychiatric literature increasingly emphasizes the value of longitudinal and dimensional assessment approaches. Rather than relying solely on categorical classification at a single point in time, clinicians are encouraged to evaluate symptom trajectories across the full illness course, including recurrence patterns, proportional symptom duration, psychosocial stressors, and periods of remission (van Os et al., 2019). Such approaches are especially important in schizoaffective disorder because DSM-5-TR criteria explicitly require temporal analysis of the relationship between psychotic and mood symptoms. Careful reconstruction of symptom chronology may therefore improve diagnostic accuracy and facilitate more individualized treatment planning.

Despite extensive theoretical discussion regarding diagnostic instability and nosological controversy, detailed clinical illustrations demonstrating structured longitudinal

reconstruction of psychotic and affective symptom trajectories in chronic psychosis remain relatively limited in routine outpatient settings. In particular, practical examples explicitly applying DSM-5-TR temporal criteria across long-term illness courses may assist clinicians in reconsidering entrenched psychiatric diagnoses.

This case report describes a woman with a 13-year history of chronic psychosis initially diagnosed as paranoid schizophrenia, in whom systematic longitudinal symptom mapping supported diagnostic revision to schizoaffective disorder, depressive type. The report aims to illustrate how careful reconstruction of temporal symptom patterns may clarify diagnostic formulation, reduce diagnostic inertia, and inform treatment planning in chronic psychotic disorders.

Methods

Study Design

This study employed a descriptive clinical case report design with a structured longitudinal diagnostic reassessment approach. The objective was to reconstruct the temporal relationship between psychotic and affective symptoms over the full course of illness in a patient with a long-standing diagnosis of schizophrenia. The case report format was selected to allow detailed clinical characterization and systematic diagnostic reevaluation consistent with recommendations for psychiatric case reporting.

Setting and Participant

The assessment was conducted at the psychiatric outpatient clinic of RSI Jemursari, Surabaya, Indonesia, in October 2025. The patient was a 33-year-old Indonesian woman with a 13-year history of chronic psychotic symptoms. She had previously received a diagnosis of paranoid schizophrenia and had undergone multiple treatment episodes across different psychiatric services.

Data Collection

Clinical data were obtained through:

1. A comprehensive semi-structured patient interview
2. A collateral interview with a close family informant
3. Review of available prior medical records

Information collected included age at onset, precipitating stressors, symptom evolution, duration and recurrence of psychotic and mood symptoms, treatment history, psychosocial functioning, and history of hospitalizations.

To enhance temporal accuracy, symptom onset and episode duration were anchored to significant life events (e.g., occupational changes, family events) and cross-validated with collateral information and documented treatment records.

Discrepancies between patient and family reports were resolved through consensus discussion and reference to medical documentation when available.

Mental Status and Functional Assessment

A comprehensive mental status examination was performed during the outpatient visit, assessing appearance, behavior, speech, mood, affect, thought process, thought content, perception, cognition, insight, and judgment.

Functional status was evaluated using the Personal and Social Performance (PSP) scale, which assesses functioning across four domains: socially useful activities, personal and social relationships, self-care, and disturbing

or aggressive behavior. The PSP was selected due to its clinical relevance and compatibility with DSM-5-era practice.

Longitudinal Symptom Mapping

A structured longitudinal timeline was constructed to categorize symptom periods into four clinical states:

1. Psychosis with concurrent major depressive episode
2. Psychosis without mood symptoms
3. Major depressive episode without prominent psychosis
4. Relative remission or partial stabilization

Major depressive episodes were identified based on DSM-5-TR criteria, requiring at least two weeks of depressed mood or loss of interest accompanied by additional neurovegetative and cognitive symptoms.

The proportion of illness duration attributable to depressive episodes was estimated by summing the cumulative duration of all identified episodes relative to the total 13-year course.

Special attention was given to identifying documented periods of at least two weeks of persistent psychosis in the absence of clinically significant mood symptoms, as required for the diagnosis of schizoaffective disorder.

Diagnostic Framework

Diagnostic reassessment was conducted according to criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (American Psychiatric Association, 2022). Diagnostic formulation required:

- Fulfillment of Criterion A symptoms of schizophrenia
- Presence of major depressive episodes for the majority of illness duration
- At least two weeks of psychosis without mood symptoms
- Exclusion of substance-induced or medical causes
- Diagnostic conclusions were reached through integrated clinical judgment based on longitudinal evidence rather than cross-sectional presentation alone.

Ethical Considerations

This case report was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from the patient for clinical assessment and publication of anonymized information. Identifying details were removed to protect confidentiality, and no research-specific interventions were introduced beyond routine clinical care.

Result and Discussion

The patient was a 33-year-old woman who presented to the psychiatric outpatient clinic accompanied by a family member. She reported persistent persecutory delusions, expressing the belief that people in her environment intended to harm her. She described recurrent auditory hallucinations consisting of voices commenting on her behavior, as well as intermittent visual hallucinations involving shadow-like figures. These psychotic symptoms had recurred episodically throughout a 13-year illness course and were particularly prominent during acute exacerbations.

On mental status examination, the patient was alert and fully oriented to time, place, and person. Speech was coherent but slowed. She described her mood as persistently sad, and affect was constricted yet congruent with stated mood. Thought processes were circumstantial,

and thought content was notable for persecutory delusions and ideas of reference. Auditory and visual hallucinations were present at the time of assessment. She endorsed passive suicidal ideation without active plan or intent. Insight into illness was partial, and social judgment was impaired. Functional assessment using the Personal and Social Performance (PSP) scale yielded a score of 40, indicating marked impairment in occupational functioning and interpersonal relationships.

Longitudinal reconstruction of the illness trajectory revealed a complex interaction between psychotic and affective symptoms. The first psychotic episode occurred approximately 13 years prior, reportedly following occupational loss. During the initial two years, persistent hallucinations and delusions were documented, although clear evidence of a major depressive episode at onset was not established. Between the third and fifth years of illness, two major depressive episodes were identified, each lasting approximately eight to ten months. These episodes were characterized by depressed mood, anhedonia, insomnia, appetite disturbance, psychomotor slowing, feelings of worthlessness, and passive suicidal ideation.

During years six to eight, psychotic symptoms persisted. Notably, at least one documented period of approximately three months involved ongoing hallucinations and delusions in the absence of clinically significant depressive symptoms, indicating the presence of psychosis independent of mood disturbance. Between years nine and eleven, two additional depressive episodes occurred, lasting approximately six to twelve months each. In the final two years prior to reassessment, the patient experienced another depressive episode meeting full criteria for major depressive episode, again accompanied by passive suicidal ideation and functional decline.

In total, five distinct major depressive episodes were identified across the 13-year illness course. Each episode lasted longer than two weeks and was associated with significant functional impairment. The cumulative duration of depressive episodes was estimated at approximately six to seven years, representing a substantial proportion of the overall illness duration. Importantly, at least one clearly documented period exceeding two weeks—lasting approximately three months—demonstrated persistent psychotic symptoms in the absence of prominent mood symptoms.

There was no history of substance misuse, and no medical or neurological condition was identified that could account for the symptomatology. Bipolar disorder was considered unlikely due to the absence of manic or hypomanic episodes. Major depressive disorder with psychotic features was also considered but deemed less consistent with the clinical course, as psychotic symptoms persisted outside mood episodes.

Based on integrated longitudinal analysis in accordance with DSM-5-TR criteria, the diagnosis was revised from paranoid schizophrenia to schizoaffective disorder, depressive type. Following diagnostic reassessment, treatment was modified to include antidepressant augmentation in addition to ongoing antipsychotic therapy and structured psychosocial intervention. At three-month follow-up, depressive symptoms had decreased, passive suicidal ideation had resolved, sleep and appetite had improved, and functional status increased from a PSP score of 40 to 60. No rehospitalization occurred during this period.

This case illustrates the diagnostic complexity at the intersection of schizophrenia and schizoaffective disorder and highlights the clinical value of longitudinal reconstruction in chronic psychosis. Although the patient had carried a diagnosis of schizophrenia for more than a

decade, systematic temporal mapping revealed that major depressive episodes accounted for approximately half of the illness duration, fulfilling the proportional mood criterion required for schizoaffective disorder under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (American Psychiatric Association, 2022). This finding underscores the importance of evaluating proportional symptom burden rather than relying solely on cross-sectional presentation (Malaspina et al., 2013).

Diagnostic instability between schizophrenia and schizoaffective disorder has been consistently documented. Longitudinal studies demonstrate that schizoaffective disorder shows lower diagnostic stability compared with schizophrenia and bipolar disorder, with substantial rates of category shift over time (Jäger et al., 2012; Vollmer-Larsen et al., 2017; Jäger et al., 2020). Such instability likely reflects overlapping phenomenology and evolving symptom predominance across illness phases. Dimensional perspectives of psychosis further challenge rigid categorical boundaries, proposing that affective and psychotic symptoms exist along intersecting continua rather than discrete entities (Allardyce et al., 2007; van Os et al., 2019; Cuthbert, 2015).

In clinical practice, depressive symptoms in patients diagnosed with schizophrenia are frequently conceptualized as secondary phenomena, including post-psychotic depression or medication-related effects (Sim et al., 2006; Uptegrove et al., 2017). However, insufficient quantification of episode duration and recurrence may obscure a primary affective pathology. In this case, five distinct major depressive episodes lasting between six and twelve months were identified, cumulatively accounting for approximately six to seven years of illness. This temporal burden substantially exceeds what would typically be expected for transient depressive reactions within schizophrenia and aligns more closely with schizoaffective disorder criteria (Cheniaux et al., 2015; Jäger et al., 2020).

The requirement of at least two weeks of psychosis in the absence of mood symptoms serves as a key diagnostic safeguard against over-attribution of affective pathology (American Psychiatric Association, 2022). The documented three-month period of mood-independent psychosis in this patient satisfies that criterion and differentiates the condition from major depressive disorder with psychotic features. Moreover, the absence of manic or hypomanic episodes argues against bipolar spectrum disorders (McGlashan et al., 2003).

The nosological validity of schizoaffective disorder remains debated. Some authors consider it a heterogeneous midpoint between schizophrenia and mood disorders, whereas others interpret it as reflecting diagnostic uncertainty or transitional states (Laursen et al., 2014; Siris, 2001). Nevertheless, the DSM-5-TR operational framework provides clinically actionable criteria that emphasize longitudinal proportionality (Malaspina et al., 2013). This case demonstrates how retrospective course-based assessment can clarify entrenched diagnoses in chronic psychosis.

Importantly, the diagnostic revision had therapeutic implications. Following antidepressant augmentation and structured psychosocial intervention, short-term follow-up demonstrated reduction in depressive symptoms, resolution of passive suicidal ideation, and improvement in functional status as reflected by the Personal and Social Performance scale. Although causal conclusions cannot be drawn from a single case, the improvement aligns with literature suggesting that targeted management of affective symptoms may enhance functional outcomes in

schizoaffective presentations (Murru et al., 2011).

Suicide risk represents a critical concern across psychotic disorders, particularly when depressive symptoms are recurrent and severe. Meta-analytic evidence indicates elevated suicide risk among individuals with schizophrenia-spectrum disorders, with depressive symptoms serving as a significant contributor (Hor & Taylor, 2010). The patient's passive suicidal ideation occurring predominantly during depressive phases reinforces the importance of accurate identification and active management of mood pathology.

Methodologically, this case underscores the value of structured longitudinal assessment. Cross-sectional diagnostic approaches risk privileging dominant acute symptoms, whereas timeline reconstruction allows estimation of cumulative episode duration and symptom proportionality (van Os et al., 2019). Although retrospective reporting may be subject to recall bias, triangulation with collateral informants and available medical records increases reliability. Incorporating systematic temporal mapping into routine clinical practice may reduce diagnostic inertia in chronic psychiatric disorders. Several limitations warrant consideration. This report describes a single patient, limiting generalizability. Historical symptom severity was reconstructed retrospectively without continuous standardized rating scales, which may affect precision. Additionally, follow-up duration was limited to three months; longer-term observation would be necessary to determine diagnostic stability and sustained functional improvement (Jäger et al., 2020). Despite these limitations, this case provides a practical illustration of how proportional mood burden and mood-independent psychosis can be systematically identified in chronic psychotic illness. It supports a temporally informed, course-based approach to differential diagnosis at the schizophrenia–schizoaffective interface and emphasizes the clinical importance of revisiting established diagnoses when longitudinal patterns warrant reconsideration.

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Conclusion

This case highlights the importance of longitudinal, course-based assessment in differentiating schizophrenia from schizoaffective disorder in chronic psychosis. Systematic reconstruction of symptom trajectories demonstrated that major depressive episodes accounted for a substantial proportion of the illness course while mood-independent psychosis was also present, supporting diagnostic revision. Clarifying the longitudinal relationship between psychotic and affective symptoms informed treatment modification and was associated with short-term symptomatic and functional improvement. These findings underscore the clinical value of revisiting established diagnoses when longitudinal patterns suggest alternative formulations.

Author contributions

Tegar Narindra Putra conceptualized the study, conducted the literature search, and drafted the initial manuscript. Hafid Algristian provided theoretical input, contributed to the analysis, and critically revised the discussion for intellectual content. Budi Cahyono supervised the project, contributed to data interpretation, and approved the final version of the manuscript. All authors read and approved the final manuscript.

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