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Holistic Management of Depressive-Type Schizoaffective Disorder: A Case Illustration

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Abstract

Schizoaffective disorder is a complex psychiatric condition characterized by the coexistence of psychotic and mood symptoms, often requiring comprehensive and long-term management. Achieving sustained clinical stability in depressive-type schizoaffective disorder remains challenging, particularly when psychosocial stressors and limited support systems are present. This case illustration describes a holistic management approach integrating pharmacological treatment, structured family involvement, and patient-centered spiritual coping within an Indonesian cultural context. We present the case of a 44-year-old female diagnosed with depressive-type schizoaffective disorder based on the Indonesian Guidelines for the Classification and Diagnosis of Mental Disorders, corresponding to international diagnostic principles. Clinical data were obtained through psychiatric interviews, longitudinal clinical observation, and review of medical records. The intervention consisted of combined antipsychotic and antidepressant pharmacotherapy, accompanied by structured family support and ethically integrated spiritual coping strategies aligned with the patient's preferences. Over the course of follow-up, the patient demonstrated a reduction in psychotic symptoms (notably ideas of reference) and depressive features, alongside improvements in sleep patterns, self-care, treatment adherence, and emotional regulation. Functional gains were observed in daily activities and engagement with meaningful roles, with no acute relapse reported during the observed follow-up period. Family involvement contributed to adherence monitoring and stress reduction, while spiritual coping functioned as an internal resource for meaning-making and resilience rather than as a standalone intervention. This case illustrates that a holistic management strategy addressing biological, psychosocial, and spiritual dimensions may support clinical stabilization and functional recovery in depressive-type schizoaffective disorder. While findings from a single case cannot be generalized, this report highlights the potential clinical value of integrating family support and patient-centered spirituality into routine psychiatric care within culturally relevant settings.

KEYWORDS

schizoaffective disorder; holistic management; pharmacotherapy; family support; spiritual coping.

Introduction

Schizoaffective disorder is a complex and heterogeneous psychiatric condition characterized by the coexistence of psychotic symptoms and prominent mood disturbances within the same illness episode. The disorder occupies a diagnostic position at the interface between schizophrenia spectrum disorders and mood disorders, making it one of the most challenging entities in contemporary psychiatry (American Psychiatric Association, 2022).

The defining feature of schizoaffective disorder is the presence of psychotic symptoms—such as delusions, hallucinations, or disorganized thinking—that occur both during and outside of mood episodes, accompanied by sustained affective disturbances. This longitudinal requirement distinguishes it from major depressive disorder with psychotic features and schizophrenia, yet diagnostic ambiguity remains common in clinical practice (Peralta & Cuesta, 2018).

The depressive subtype of schizoaffective disorder is particularly associated with chronic low mood, anhedonia, impaired cognitive functioning, and reduced psychosocial performance. Patients often exhibit a fluctuating clinical course characterized by partial remission, residual symptoms, and recurrent exacerbations (Jäger et al., 2011). Compared to bipolar-type schizoaffective disorder, the depressive subtype is more strongly linked to functional impairment, social withdrawal, and diminished quality of life, highlighting the need for comprehensive and sustained management strategies.

Pharmacological treatment remains the cornerstone of management, typically involving second-generation antipsychotics combined with antidepressants or mood stabilizers depending on symptom profile and clinical course. Although these interventions are effective in reducing acute psychotic and affective symptoms, growing evidence suggests that pharmacotherapy alone is insufficient to address the multifactorial nature of schizoaffective disorder. The illness trajectory is shaped not only by neurobiological mechanisms but also by psychosocial stressors, environmental context, and individual coping capacities (Correll et al., 2017; van Os et al., 2010).

The stress–vulnerability model provides a useful framework for understanding the development and progression of schizoaffective disorder. According to this model, individuals possess varying degrees of biological vulnerability, which interact with environmental stressors to precipitate symptom onset and relapse. Psychosocial factors such as interpersonal conflict, occupational stress, and social isolation have been consistently identified as contributors to symptom exacerbation and relapse in psychotic disorders (Addington et al., 2015). Conversely, protective factors—including social support and adaptive coping mechanisms—play a critical role in stabilizing symptoms and promoting recovery (World Health Organization, 2022).

Among these protective factors, family environment has emerged as a key determinant of clinical outcomes. High levels of expressed emotion within families, including criticism, hostility, and emotional overinvolvement, have been associated with increased relapse rates in psychotic disorders. In contrast, structured family interventions—particularly those involving psychoeducation and collaborative problem-solving—have demonstrated significant benefits in improving medication adherence, reducing relapse, and enhancing overall functioning (Dixon et al., 2016; Pharoah et al., 2010). In collectivist societies such as Indonesia, where family structures often serve as the primary support system, the role of family involvement becomes even more central in the management of chronic mental illness.

In addition to psychosocial factors, increasing attention has been directed toward the role of spirituality in mental health. Spirituality, broadly defined as the search for meaning, purpose, and connection to something greater than oneself, has been associated with improved psychological resilience, emotional regulation, and quality of life across various psychiatric populations. In individuals with severe mental disorders, spiritual coping may function as an internal resource that supports meaning-making and reduces distress in the face of chronic illness (Peteet, 2019). However, the integration of spirituality into psychiatric care requires careful clinical judgment, particularly in patients with psychotic symptoms, where religious themes may overlap with delusional content. Ethical and patient-centered approaches are therefore essential to ensure that spiritual engagement supports recovery without reinforcing psychopathology.

Cultural context further shapes how psychiatric symptoms are experienced, interpreted, and managed. Cultural beliefs influence help-seeking behavior, explanatory models of illness, and adherence to treatment, making culturally responsive care an essential component of effective psychiatric practice (Bhugra et al., 2021; Kirmayer et al., 2014). In many non-Western settings, including Indonesia, mental illness is often understood through an integrative biopsychosocial-spiritual framework, where family involvement and religious or spiritual beliefs play a significant role in coping and recovery. Despite this recognition, clinical literature that explicitly demonstrates how these dimensions can be systematically integrated into routine psychiatric care remains limited(Lacro et al., 2002; Millan et al., 2012).

Recent developments in recovery-oriented psychiatry emphasize that successful treatment outcomes should not be defined solely by symptom remission but also by improvements in functional capacity, personal meaning, and quality of life (Leamy et al., 2011). This perspective underscores the importance of holistic care approaches that address not only biological symptoms but also psychosocial functioning and existential well-being. In this context, integrating pharmacological treatment with structured family support and patient-centered spiritual coping represents a potentially valuable approach to enhancing recovery outcomes in schizoaffective disorder(Borsboom, 2017; Drake et al., 2010).

Therefore, this case illustration aims to describe the implementation of a holistic management strategy in a patient with depressive-type schizoaffective disorder within an Indonesian cultural context. By integrating pharmacological treatment, structured family involvement, and patient-centered spiritual coping, this report seeks to provide a clinically grounded example of how multidimensional care can support symptom stabilization, functional improvement, and sustained recovery. Rather than establishing causal relationships, this study aims to contribute to the growing body of literature advocating for culturally responsive and integrative approaches in the management of complex psychiatric conditions.

Methods

Study Design

This study employed a qualitative case illustration design, supported by a narrative literature review to contextualize the clinical findings within existing theoretical and empirical frameworks. The case illustration approach was selected to allow an in-depth exploration of the patient's clinical presentation, longitudinal course, and the implementation of a holistic management strategy in a real-world psychiatric setting. The manuscript was prepared in accordance with the essential elements of the CARE Case Report Guidelines, including clear description of diagnosis, interventions, outcomes, and ethical considerations.

Case Description and Data Sources

The subject of this case illustration was a 44-year-old female patient diagnosed with depressive-type schizoaffective disorder. Clinical data were collected through semi-structured psychiatric interviews with the patient and selected family members, direct clinical observation during outpatient follow-up, and review of longitudinal medical records. Data sources included information on demographic background, psychiatric history, symptom onset and progression, psychosocial stressors, treatment history, adherence patterns, and functional status.

Diagnostic Assessment and Differential Diagnosis

The diagnosis of depressive-type schizoaffective disorder was established by a psychiatrist based on the Indonesian Guidelines for the Classification and Diagnosis of Mental Disorders (Pedoman Penggolongan dan Diagnosis Gangguan Jiwa / PPDGJ), which correspond to internationally accepted diagnostic principles for schizoaffective disorder.

Diagnostic clarification was based on the following clinical features:

1. Symptom timeline: The patient exhibited a longitudinal course marked by episodic psychotic symptoms occurring alongside sustained depressive episodes, rather than psychotic symptoms limited exclusively to mood episodes.
2. Psychotic symptoms: Prominent ideas of reference were observed, in which neutral conversations and environmental cues were interpreted as personally significant, persisting beyond periods of acute mood disturbance.
3. Depressive episode features: The patient met clinical criteria for a major depressive episode, including persistent low mood, anhedonia, social withdrawal, diminished self-esteem, and reduced emotional responsiveness.
4. Course and pattern: The illness followed a fluctuating but continuous course with overlapping psychotic and affective symptoms over time, supporting a diagnosis of schizoaffective disorder rather than episodic mood disorder alone.
5. Differential diagnosis: Schizophrenia was considered less likely due to the consistent and clinically significant presence of mood symptoms throughout the illness course. Major depressive disorder with psychotic features was ruled out because psychotic symptoms were not exclusively confined to depressive episodes.

No standardized symptom rating scales (e.g., PANSS or HAM-D) were routinely administered during clinical care. This limitation is acknowledged; therefore, diagnostic and outcome assessments relied on structured clinical evaluation and longitudinal observation documented in medical records.

Intervention and Management Approach

Pharmacological Management

Pharmacological treatment consisted of a combination of an atypical antipsychotic and a selective serotonin reuptake inhibitor (SSRI), consistent with guideline-based recommendations for depressive-type schizoaffective disorder. The antipsychotic was initiated at a low dose and gradually titrated based on clinical response and tolerability to target psychotic symptoms, particularly ideas of reference. The SSRI was introduced to address persistent depressive symptoms and emotional dysregulation.

Medication adherence was monitored during outpatient follow-up through patient self-report and family feedback. The patient demonstrated gradual symptom improvement over several weeks, with no severe adverse effects reported that required discontinuation. Minor side effects were managed conservatively, and treatment adherence improved over time with family involvement.

Structured Family Support

Structured family support was implemented as a psychosocial intervention to reduce environmental stressors and enhance treatment adherence. Family involvement included regular psychoeducation sessions conducted during outpatient visits, focusing on illness understanding, early warning signs of relapse, medication adherence, and stress management strategies. Family members were encouraged to adopt supportive communication patterns and to assist in monitoring daily routines, sleep patterns, and treatment compliance.

The frequency of family engagement varied according to clinical need but generally occurred during scheduled follow-up appointments. Indicators of successful family support included improved adherence, reduced interpersonal conflict reported during follow-up, and earlier recognition of symptom changes.

Spiritual Support and Patient-Centered Coping

Spiritual support was integrated in a patient-centered and non-directive manner, based on the patient's expressed beliefs and preferences. The clinical team acknowledged the patient's spiritual framework as a coping resource without introducing religious content or reinforcing delusional interpretations. Spiritual coping strategies primarily involved meaning-making, acceptance, and reflection, as articulated by the patient herself.

The patient's spiritual beliefs were discussed during clinical encounters to ensure alignment with treatment goals and ethical boundaries. No external religious authority was involved in clinical decision-making. Observable clinical correlates of adaptive spiritual coping included improved emotional regulation, reduced distress in response to psychosocial stressors, and increased engagement in daily activities.

Data Analysis

A descriptive qualitative approach using thematic analysis was employed to synthesize clinical data. Analysis focused on identifying key themes related to symptom dynamics, stressors, coping strategies, and recovery processes. The emphasis was placed on illustrating the interaction between pharmacological treatment, family involvement, and spiritual coping within the patient's longitudinal recovery trajectory rather than on generating statistically generalizable findings.

Ethical Considerations

Written informed consent was obtained from the patient for the use of anonymized clinical information for academic and publication purposes. All identifying information was removed to ensure confidentiality. According to local institutional policy, formal ethical committee approval was not required for single anonymized case reports. The study was conducted in accordance with ethical principles for clinical reporting."

Result and Discussion

Clinical Course and Baseline Presentation

At baseline, the patient presented with a combination of persistent psychotic symptoms and prominent depressive

features. Psychotic manifestations were dominated by ideas of reference, in which neutral conversations and environmental cues were repeatedly interpreted as personally directed. These symptoms were accompanied by depressive features including low mood, anhedonia, social withdrawal, diminished self-confidence, emotional blunting, and reduced motivation.

Functionally, the patient demonstrated impaired daily functioning, irregular sleep patterns, limited engagement in meaningful activities, and inconsistent treatment adherence. Psychosocial stressors—including occupational difficulties, marital separation, and ongoing family conflict—were identified as recurrent triggers for symptom exacerbation.

Initiation of Treatment and Early Response

Pharmacological treatment was initiated with a combination of an atypical antipsychotic and a selective serotonin reuptake inhibitor. During the initial weeks of treatment, gradual reduction in psychotic symptoms was observed, particularly in the frequency and intensity of ideas of reference. The patient reported decreased preoccupation with perceived external messages and improved reality testing during daily interactions.

Concurrently, early improvement in depressive symptoms was noted, including slight mood elevation, improved sleep continuity, and reduced emotional withdrawal. No severe adverse effects were reported during the early treatment phase, and medication adherence was initially variable but progressively improved with support from family members.

Intermediate Follow-Up and Psychosocial Stabilization

During subsequent outpatient follow-up, structured family involvement was implemented alongside ongoing pharmacotherapy. Family members participated in psychoeducation sessions and assisted in monitoring medication adherence, sleep routines, and early warning signs of relapse.

At this stage, the patient demonstrated more consistent treatment adherence, further reduction in psychotic ideation, and improved emotional regulation. Depressive symptoms such as anhedonia and low self-worth became less prominent, and the patient reported increased capacity to manage interpersonal stress without acute symptom escalation.

Sleep patterns normalized gradually, and the patient resumed basic self-care activities more consistently. Family-reported interpersonal conflict decreased, and communication during follow-up visits became more collaborative and supportive.

Functional Improvement and Coping Development

As clinical stability improved, the patient showed functional gains in daily activities and engagement with meaningful roles. Although vocational functioning remained limited, the patient demonstrated renewed interest in structured daily routines and activities aligned with her personal interests and professional background.

Spiritual coping emerged as an internal resource during this phase. The patient articulated a more stable and adaptive meaning-making framework, describing stressful experiences as manageable challenges rather than overwhelming threats. Clinically, this was associated with reduced emotional reactivity, improved distress tolerance, and sustained engagement with treatment.

Outcome at Latest Follow-Up

At the most recent follow-up, the patient remained clinically stable without acute relapse. Psychotic symptoms were markedly reduced and no longer interfered significantly with daily functioning. Depressive symptoms persisted at a subthreshold level but no longer met criteria for a major depressive episode.

Overall improvements were observed in sleep regulation, self-care, emotional stability, treatment adherence, and psychosocial functioning. The combined management approach was associated with sustained stabilization over the observed follow-up period, supported by continued pharmacological treatment, family involvement, and adaptive coping strategies.

Diagnostic Considerations and Clinical Complexity

This case illustrates the diagnostic complexity inherent in depressive-type schizoaffective disorder, particularly in differentiating it from schizophrenia and major depressive disorder with psychotic features. Longitudinal assessment remains central to diagnostic accuracy, as schizoaffective disorder requires the presence of psychotic symptoms occurring independently of mood episodes while mood symptoms remain prominent throughout the illness course.

Previous studies have emphasized that cross-sectional evaluations may obscure diagnostic boundaries between psychotic and mood disorders, underscoring the importance of temporal symptom mapping and functional assessment over time (Barrio et al., 2023; Malaspina et al., 2013). In the present case, sustained depressive symptoms alongside persistent ideas of reference supported the diagnosis of depressive-type schizoaffective disorder rather than schizophrenia or mood disorder with psychotic features.

Pharmacological Stabilization and Symptom Trajectory

The gradual reduction of psychotic and depressive symptoms following combined antipsychotic and antidepressant treatment is consistent with current clinical recommendations for depressive-type schizoaffective disorder (Citrome, 2014; Kane et al., 2019). Rather than achieving abrupt remission, symptom improvement occurred progressively, reflecting the chronic and fluctuating nature of the disorder.

Importantly, treatment response was evaluated through functional indicators such as sleep regulation, emotional stability, and treatment adherence. This functional approach aligns with recovery-oriented models, which emphasize meaningful daily functioning over complete symptom elimination, particularly in severe mental disorders (Slade, 2009).

Role of Structured Family Involvement

Family involvement played a significant supportive role in this case by enhancing treatment adherence, reducing interpersonal stress, and facilitating early recognition of symptom changes. Extensive evidence indicates that structured family interventions, including psychoeducation and collaborative care, are associated with improved outcomes and reduced relapse rates in psychotic disorders.

Rather than functioning as a standalone therapeutic modality, family support in this case served as a contextual enhancer of pharmacological treatment. This finding supports systemic and relational models of care, particularly relevant in collectivist cultures where family dynamics strongly influence illness course and recovery (Bhugra & Becker, 2005).

Spiritual Coping as an Adaptive Resource

Spiritual coping functioned as an internal psychological resource rather than as a causal therapeutic intervention. When addressed in a patient-centered and non-directive manner, spirituality may contribute to emotional regulation, resilience, and meaning-making without reinforcing

psychopathological beliefs (Koenig, 2012; Pargament, 2011).

Previous research suggests that acknowledging patients' spiritual frameworks—while maintaining clear clinical boundaries—can enhance engagement and therapeutic alliance, especially in culturally diverse settings. In this case, spiritual beliefs were explored cautiously to support adaptive coping, avoiding prescriptive or doctrinal interventions.

Cultural Context and Holistic Care

The present case highlights the relevance of culturally responsive psychiatric care. In the Indonesian context, family structures and spiritual worldviews often play integral roles in health-related decision-making and coping processes. Integrating these dimensions into clinical management, while maintaining evidence-based pharmacological treatment as the core intervention, may enhance adherence and continuity of care.

Holistic care in this context does not imply equivalence between biological, psychosocial, and spiritual interventions. Rather, it reflects an integrated framework in which pharmacotherapy is supported by contextual factors that influence recovery trajectories.

Extended Analytical Perspective

Beyond the immediate clinical outcomes, further analytical perspectives are necessary to contextualize the broader implications of this case within contemporary psychiatric frameworks.

From a neurocognitive standpoint, the reduction in ideas of reference may reflect improvements in salience attribution and cognitive bias. Psychotic symptoms are often associated with the misinterpretation of neutral stimuli as personally meaningful, and their reduction suggests a gradual normalization of cognitive appraisal processes. This change is likely influenced not only by pharmacological stabilization but also by improved environmental predictability and reduced psychosocial stress.

Behaviorally, the patient's re-engagement in daily routines—including improved sleep patterns and self-care—may have contributed to symptom stabilization through reinforcing adaptive habits. Such behavioral activation processes are known to support mood regulation and reduce vulnerability to relapse, particularly in chronic mood–psychosis conditions.

In terms of illness trajectory, the absence of relapse during follow-up should be interpreted cautiously as an indicator of short-term stabilization rather than sustained remission. Schizoaffective disorder is characterized by a fluctuating and recurrent course, and long-term outcomes are strongly influenced by adherence, stress exposure, and support systems. The combined presence of pharmacological treatment, family involvement, and adaptive coping mechanisms in this case likely contributed to reducing relapse risk during the observed period.

Although derived from a single case, the principles illustrated here may have broader clinical relevance. The integration of pharmacotherapy with structured psychosocial support and culturally meaningful coping strategies represents a pragmatic model that can be adapted across similar settings, particularly in contexts where family systems play a central role in care. Importantly, this integrative approach should be understood as complementary to, rather than a replacement for, evidence-based medical treatment.

Limitations

Several limitations must be acknowledged. As a single-case illustration, the findings cannot be generalized. The absence of standardized symptom rating scales limits quantitative outcome measurement, and clinical improvement was primarily assessed through observational and self-reported indicators. In addition, the follow-up period was relatively limited, restricting conclusions regarding long-term relapse prevention.

Clinical Implications

Despite these limitations, this case offers clinically relevant insights. First, longitudinal diagnostic assessment is essential in complex mood–psychosis presentations. Second, structured family involvement may substantially support adherence and stability. Third, patient-centered integration of spiritual coping—when ethically and clinically bounded—may enhance emotional regulation and engagement without compromising psychiatric care.

Conclusion

This case illustrates the clinical complexity of depressive-type schizoaffective disorder and highlights the importance of longitudinal diagnostic assessment in differentiating mood–psychosis spectrum conditions. Sustained stabilization in this patient was associated with a coordinated management strategy in which pharmacological treatment remained central, supported by structured family involvement and patient-centered spiritual coping.

Rather than suggesting causal efficacy, this report demonstrates how integrating biological, psychosocial, and culturally relevant dimensions within routine psychiatric care may enhance treatment adherence, emotional regulation, and functional stability. Structured family engagement contributed to environmental support and relapse monitoring, while ethically bounded acknowledgment of spiritual coping served as an adaptive resource for meaning-making and resilience.

Although findings from a single case cannot be generalized, this illustration underscores the potential value of holistic, culturally responsive approaches in managing complex affective–psychotic presentations. Future research incorporating standardized outcome measures and longer follow-up periods is warranted to further evaluate integrated care models in schizoaffective disorder.

Author contributions

Muh Azka Aldani Fadhlurahman, conceptualized the study, developed the research design, and led the overall coordination of the manuscript preparation, collected clinical data, contributed to the interpretation of the patient's clinical course, and drafted the initial sections of the Case Presentation and Clinical Management. Yekti Mumpuni performed the literature review, contributed to the synthesis of evidence in the Introduction and Discussion, and participated in revising the manuscript for intellectual content. Hafid Algristian supervised the methodological framework, ensured compliance with the CARE case report guidelines, and provided critical revisions to the final manuscript. All authors reviewed the manuscript, approved the final version, and agreed to be accountable for all aspects of the work.

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Conflict of interest

The authors declare no conflicts of interest related to this study. There were no financial, personal, or professional relationships that could be perceived as influencing the content or interpretation of this manuscript.

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