Schizoaffective Disorder with Emotional Dependence and Psychosomatic Manifestations: A Case Report and Biopsychosocial Management Approach

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ABSTRACT

Background: Schizoaffective disorder is a complex psychiatric condition characterized by the concurrent presence of psychotic symptoms and mood disturbances. Cases presenting with pronounced emotional dependence on family members and prominent psychosomatic manifestations are infrequently documented in Indonesia, posing diagnostic and therapeutic challenges. **Case Presentation:** A 36-year-old unmarried male presented with a 10-year history of uncontrolled emotions, auditory and visual hallucinations, persistent fear, chest heat sensation, and an impending sense of death. Symptoms were exacerbated when anticipating separation from his parents. The patient had experienced occupational decline, marital dissolution due to aggressive behavior, and progressive social withdrawal. Clinical assessment using DSM-5 criteria established a diagnosis of schizoaffective disorder, depressive type, comorbid with paranoid schizophrenia. The patient exhibited significant emotional dependence on his parents and impaired psychosocial functioning**. Management and Outcome:** A comprehensive biopsychosocial approach was implemented, comprising pharmacotherapy (risperidone, chlorpromazine, lorazepam, and clozapine), cognitive-behavioral therapy, psychoeducation, and family therapy. Multidisciplinary interventions resulted in reduced psychotic symptom severity, improved emotional regulation, and enhanced family support systems. **Conclusion:** Schizoaffective disorder with psychosomatic manifestations and emotional dependence necessitates an integrated biopsychosocial framework. Combined pharmacotherapy, psychotherapy, psychoeducation, and family-centered interventions are essential to promote patient autonomy, improve social

functioning, and enhance overall quality of life. This case underscores the importance of recognizing caregivers as integral partners in psychiatric rehabilitation.

Keywords: biopsychosocial; emotional dependence; family therapy; psychosomatic; schizoaffective disorder

Introduction

Schizoaffective disorder is a complex psychiatric condition characterized by the coexistence of psychotic symptoms including hallucinations and delusions with mood disturbances, manifesting as either depressive or manic episodes that occur concurrently or in close temporal proximity.[1] This disorder occupies an intermediate position between schizophrenia and affective disorders, frequently posing substantial diagnostic and therapeutic challenges. The lifetime prevalence of schizoaffective disorder is estimated at approximately 0.3%, with typical onset occurring in early adulthood.[2]

Patients with schizoaffective disorder commonly experience significant psychosocial functional impairment, including difficulties in emotional regulation, interpersonal relationships, and occupational performance.[3] Emotional dysregulation may present as irritability, excessive dependence on family members, or impaired stress tolerance. In some cases, psychosomatic symptoms such as chest heat sensation, dyspnea, or intense fear may accompany both psychotic and affective episodes, further complicating the clinical picture.[3]

The interaction between psychotic symptoms, emotional instability, and psychosomatic complaints can profoundly impact patients' quality of life and treatment adherence. Furthermore, pronounced emotional dependence on family members frequently impedes autonomy and recovery processes. Therefore, comprehensive understanding of the interplay among biological, psychological, social, and spiritual factors is essential for designing individualized and effective therapeutic plans.[2]

This case report describes a 36-year-old male diagnosed with schizoaffective disorder who exhibited prominent emotional dependence on his parents and psychosomatic manifestations including chest heat sensation, fear, and an impending sense of death. This case highlights the critical importance of a biopsychosocial-spiritual approach in managing schizoaffective disorder with complex emotional and somatic presentations.

Material and Methods

Study Design: This case report was compiled based on the clinical experience of a patient treated at the Psychiatry Outpatient Clinic of Muhammadiyah Lamongan Hospital, East Java, Indonesia.

Subject: An adult male (Mr. R.S., 36 years old) referred to the psychiatric clinic with persistent psychotic and affective complaints.

Data Collection: Data were collected through:

1. Auto-anamnesis (Direct Patient Interview): A face-to-face interview was conducted to explore the patient's medical history, subjective symptoms (hallucinations, fear, chest heat sensation), as well as occupational and marital history.
2. Hetero-anamnesis (Collateral Interview): An interview was conducted with the patient's family members (parents) to confirm the history of the illness, the progression of symptoms, the dynamics of emotional dependence, and the patient's social functioning at home.
3. Psychiatric Status Examination (MSE): A comprehensive mental status examination was performed to assess appearance, behavior, speech, mood/affect, thought flow and content, perception (hallucinations), cognition (orientation), insight, and judgment.

Diagnostic Instruments: The diagnosis was established using the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, 5th edition) and PPDGJ III (the Indonesian Guidelines for the Classification and Diagnosis of Mental Disorders) criteria through a multi-axial approach (Axis I–V). The patient's psychosocial functioning was measured using the Global Assessment of Functioning (GAF) scale (0–100).

Interventions: The patient received a biopsychosocial approach comprising:

- Pharmacotherapy: Risperidone, Chlorpromazine, Lorazepam, and Clozapine (at measured doses).
- Psychotherapy: Cognitive-Behavioral Therapy (CBT) and family psychoeducation.
- Monitoring: Clinical evaluations were conducted every 2–4 weeks to assess symptom response and monitor for adverse drug effects.

Results

Baseline Patient Characteristics

Mr. R.S., a 36-year-old unmarried male with a high school education, was currently unemployed (previously worked as a physical education teacher). The patient resided with his parents.

Initial Clinical Findings

1. Psychotic Symptoms: Auditory hallucinations (voices calling his name) and visual hallucinations (a half-bodied human figure) occurring without identifiable triggers.
2. Affective Symptoms: Uncontrolled emotions, irritability, excessive fear, and an

impending sense of death.

3. Somatic Symptoms: A burning sensation in the chest that worsened during periods of anxiety.
4. Precipitating Factors: Symptoms worsened when the patient anticipated being separated from his parents (separation anxiety).
5. Psychosocial History: Failed marriage (divorced in 2015 due to aggressive behavior), occupational loss, and social isolation (rarely interacted with friends).

Diagnostic Results

Based on the clinical examination, the diagnosis was established as Schizoaffective Disorder, Depressive Type (F25.1) with comorbid Paranoid Schizophrenia (F20.0). On Axis IV, problems with the primary support group and occupation were identified. The patient's initial GAF score was in the 21–30 range, indicating severe impairment in communication and reality testing.

Post-Intervention Results (3-Month Follow-up)

Following combined pharmacological therapy (Risperidone 2x2 mg, Chlorpromazine 2x25 mg, Lorazepam 1x0.5 mg, and Clozapine 1x12.5 mg) along with psychoeducation and family therapy, the following clinical improvements were observed:

1. Psychotic Symptoms: The frequency and intensity of auditory/visual hallucinations decreased markedly (from frequent to occasional).
2. Emotional Regulation: The patient began to manage his anger and no longer engaged in aggressive outbursts.
3. Somatic Symptoms: The chest heat sensation and impending sense of death were significantly reduced.
4. Insight: The patient's insight improved to Grade 6 (fully understands the illness and the need for treatment).
5. Social Functioning: The patient became more communicative with extended family members and demonstrated improved cooperation.
6. GAF Score: Improved to the 31–40 range (moderate impairment in social/occupational functioning, but with evident improvement).

Discussion

Diagnostic Analysis and Criteria

The case of Mr. R.S. presents a classic manifestation of schizoaffective disorder, depressive type, where psychotic symptoms (hallucinations) and mood symptoms

(depression, fear) co-occurred within the same illness episode.[1] The diagnosis was confirmed after ensuring there was a period of at least two weeks where psychotic symptoms presented without prominent mood symptoms, distinguishing it from a primary mood disorder with psychotic features.[2] This finding aligns with the literature stating that schizoaffective disorder occupies a spectrum position between schizophrenia and bipolar disorder.[3]

Differential Diagnosis

Several differential diagnoses were carefully considered:

1. Schizophrenia: Although psychotic symptoms were dominant, the presence of distinct depressive episodes occurring concurrently with psychosis favored schizoaffective disorder over pure schizophrenia.[4]
2. Mood Disorder with Psychotic Features: This was ruled out because the patient had a history of psychotic periods without concurrent mood disturbances.
3. Borderline Personality Disorder (BPD): Although the patient exhibited emotional dependence and impulsivity, the psychotic symptoms were persistent and not limited to extreme stress situations, making them more consistent with an endogenous psychotic disorder rather than BPD.[5]

Biopsychosocial Conceptualization

1. Biological Factors: There was no family history of psychiatric illness; however, a history of Herniated Nucleus Pulposus (HNP) ten years prior may have acted as an initial physical stressor. Neurobiologically, dysregulation of dopamine and serotonin pathways plays a significant role in the pathophysiology of this disorder.[3]
2. Psychological Factors: The patient's profound emotional dependence on his parents indicates an insecure attachment pattern. Psychological trauma from divorce and job loss exacerbated separation anxiety.[6]
3. Social Factors: Prolonged social isolation and limited support networks (other than parents) hindered the development of autonomy. Research indicates that living with families exhibiting high expressed emotion can increase the risk of psychotic relapse.[7]

Management and Literature Review

The treatment approach combined pharmacotherapy and psychotherapy, which is consistent with current guidelines for managing schizoaffective disorder.[1]

1. **Pharmacotherapy:** The use of Risperidone and Clozapine (atypical antipsychotics) targeted both positive and negative symptoms. Clozapine was selected because it is often effective in treatment-resistant cases of schizophrenia.[8] Lorazepam was

administered as a bridging therapy for acute anxiety.

2. **Psychotherapy:** Cognitive-Behavioral Therapy (CBT) has proven effective in reducing cognitive distortions in patients with hallucinations and delusions.[9] Meanwhile, Family Therapy was crucial in this case to transform the dependency dynamic into adaptive support, preventing the patient from being overly emotionally reliant on his parents.[10]

Case Uniqueness and Clinical Implications

The uniqueness of this case lies in the presence of psychosomatic manifestations (chest heat and impending death sensation) accompanying psychotic episodes. Somatic complaints are often overlooked in schizophrenic patients, yet they can serve as early indicators of relapse or high anxiety intensity.[11] Clinical implications from this report include:

1. Psychiatrists should routinely explore somatic complaints in psychotic patients.
2. Interventions should target not only the patient but also involve the family as co-therapists to break the cycle of emotional dependence.
3. A spiritual approach (e.g., supporting the patient in maintaining religious practices) should be integrated to enhance inner peace, especially in Indonesia's strong religious culture.

Study Limitations

This case report is limited by its reliance on observational clinical data from a single patient, without the use of standardized quantitative rating scales (e.g., PANSS for psychosis or HAM-D for depression), and lacks supporting laboratory data to rule out organic causes.

Conclusion

This case report describes a 36-year-old male with schizoaffective disorder, depressive type, who presented with prominent psychotic symptoms, psychosomatic manifestations, and pronounced emotional dependence on his parents. The complexity of this presentation underscores the critical importance of a comprehensive biopsychosocial and spiritual approach in the assessment and management of schizoaffective disorder. The patient's clinical history encompassing a 10-year illness trajectory, progressive occupational and social deterioration, marital dissolution, and family dependency illustrates the multifaceted impact of schizoaffective disorder on multiple life domains. Multimodal interventions, including antipsychotic pharmacotherapy, cognitive-behavioral therapy, psychoeducation, and family therapy, were implemented to address the biological, psychological, and social

dimensions of the illness.

This case highlights several key implications for clinical practice: (1) the necessity of distinguishing schizoaffective disorder from other psychotic and mood disorders through careful longitudinal assessment; (2) the importance of addressing family dynamics and emotional dependence as integral components of treatment; (3) the value of integrating somatic symptom evaluation into routine psychiatric care; and (4) the role of cultural and spiritual sensitivity in promoting engagement and recovery. The successful management of schizoaffective disorder requires not only effective symptom control but also the restoration of functional capacity, social connectedness, and personal autonomy. Recognizing family caregivers as essential partners in the treatment process and addressing their needs alongside those of the patient represents a fundamental tenet of comprehensive psychiatric rehabilitation. Future research should continue to explore the mechanisms underlying emotional dependence in psychotic disorders and develop targeted interventions to promote autonomy and recovery.

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