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Diagnostic and Therapeutic Challenges in Schizoaffective Disorder with Schizoid Personality Comorbidity

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Abstract

Schizoaffective disorder, depressive type, is a severe psychiatric condition characterized by the coexistence of psychotic symptoms and a major depressive episode, with substantial functional impairment and potential suicide risk. Diagnostic and therapeutic complexity may increase when the disorder co-occurs with schizoid personality disorder, particularly because social withdrawal, restricted affect, and anhedonia can resemble negative or depressive symptoms. This case report describes a 33-year-old woman diagnosed with schizoaffective disorder, depressive type, with comorbid schizoid personality disorder. Clinical assessment included psychiatric interviews, collateral information from family members, mental status examination, behavioral observation, reconstruction of symptom chronology, and review of psychosocial history. The patient developed auditory hallucinations and persecutory ideas approximately four weeks before admission, followed by prominent depressive symptoms and suicidal ideation after the sudden death of a primary support figure. Long-standing social detachment, preference for solitary activities, restricted emotional expression, and limited interpersonal relationships were present since early adulthood and preceded the psychotic episode, supporting the diagnosis of schizoid personality disorder. Inpatient management consisted of risperidone, sertraline, and low-intensity supportive psychosocial interventions adapted to the patient's preference for limited interpersonal engagement. During approximately 14 days of hospitalization, hallucinations and suicidal ideation decreased and basic self-care improved. At two-week follow-up, no recurrent suicidal ideation was reported, although mild auditory hallucinations and social withdrawal persisted. This case emphasizes the importance of longitudinal assessment and collateral information in distinguishing enduring personality characteristics from state-related negative or depressive symptoms. Individualized treatment that combines pharmacological stabilization with appropriately paced psychosocial engagement may improve treatment acceptability and functional stabilization in complex psychiatric comorbidity.

KEYWORDS

schizoaffective disorder; schizoid personality disorder; comorbidity; diagnostic challenges; negative symptoms; psychiatric case report.

Introduction

Schizoaffective disorder (SAD) is a complex psychiatric condition characterized by the coexistence of psychotic and prominent mood symptoms. Its diagnostic position between schizophrenia-spectrum and mood disorders has generated longstanding debate because the boundaries between these syndromes can be difficult to establish using a single cross-sectional assessment. Contemporary diagnostic approaches emphasize the longitudinal course of illness rather than simply the simultaneous presence of psychotic and affective symptoms. In DSM-5, schizoaffective disorder requires a major mood episode during the illness together with a period of at least two weeks of delusions or hallucinations in the absence of a prominent mood episode, while

mood episodes must be present for the majority of the illness course (Association, 2022; Malaspina et al., 2013, 2021; World Health Organization, 2019). The World Health Organization's ICD-11 Clinical Descriptions and Diagnostic Requirements similarly emphasizes the temporal relationship between psychotic and affective phenomena and the need for careful longitudinal characterization (World Health Organization, 2024).

The longitudinal requirement is clinically important because the diagnosis can be unstable when information is obtained only during an acute episode. Psychotic symptoms may occur in severe depressive illness, whereas mood symptoms may also occur during schizophrenia-spectrum disorders. Reviews of schizoaffective disorder continue to describe uncertainty regarding its nosological status, but they also support the practical value of carefully reconstructing the course of psychosis and mood symptoms over time (Ghafari et al., 2016; Malaspina et al., 2013; Pagel et al., 2019; Pavlichenko et al., 2024). This diagnostic complexity has direct implications for treatment because clinicians must address psychosis, depression, suicide risk, adherence, and functional impairment simultaneously.

Schizoaffective disorder, depressive type (SAD-D), is particularly challenging because depressive symptoms may overlap with negative symptoms of psychotic disorders. Anhedonia, social withdrawal, reduced speech, diminished emotional expression, low motivation, and impaired self-care may be observed in both depression and schizophrenia-spectrum illness. Negative symptoms themselves are heterogeneous and may be primary features of psychotic illness or secondary to depression, psychosis, medication effects, substance use, or social isolation (Kirkpatrick et al., 2006; Mosolov & Yaltonskaya, 2022). Failure to distinguish these possibilities can lead to inaccurate formulation and inappropriate treatment decisions. A longitudinal approach that examines symptom onset, persistence, fluctuation, and relationship to mood and psychosis is therefore essential.

Treatment of SAD generally requires an antipsychotic as the pharmacological foundation, with antidepressants or mood stabilizers added according to the predominant affective presentation. Evidence remains less extensive than for schizophrenia or major depressive disorder, but controlled studies and reviews support antipsychotic treatment for psychotic and affective components, with paliperidone having specific evidence and regulatory indications for schizoaffective disorder (Alphs et al., 2016; Bustillo et al., 2022; Lindenmayer & Kaur, 2016). In clinical practice, other antipsychotics may be used according to symptom profile, previous response, tolerability, and local practice. For patients with significant suicidal risk, treatment planning should also include systematic suicide-risk assessment, safety planning, family involvement, and consideration of pharmacological strategies supported by the broader psychosis literature (Zisook et al., 2023).

An additional source of complexity arises when a personality disorder is present. Personality pathology can occur in people with psychotic disorders and may influence symptom interpretation, treatment engagement, interpersonal functioning, and prognosis. A systematic review found substantial variability in reported rates of personality disorder among people with psychotic disorders, partly because of differences in diagnostic instruments and clinical settings (Barrio et al., 2023; Newton-Howes et al., 2008). More recent work argues against treating personality disorder and psychosis as mutually exclusive constructs and emphasizes that symptoms and traits may coexist and interact (Leclerc et al., 2024). Personality pathology should therefore be considered as part of the overall formulation rather than automatically dismissed as secondary to psychosis.

Schizoid personality disorder (SPD) is characterized by a pervasive pattern of detachment from social relationships and restricted emotional expression. Typical features include limited interest in close relationships, preference for solitary activities, reduced interest in interpersonal interaction, and constricted affect (Association, 2022; Raine, 2020; Tantam & Green, 2018; Torrico & Madhanagopal, 2024). The condition is relatively understudied compared with other personality disorders, and evidence regarding specific treatments remains limited. Recent research on schizoid traits also highlights the importance of dimensional assessment and careful differentiation from neighboring schizophrenia-spectrum constructs (Meyer et al., 2024; Widiger & Crego, 2019).

The diagnostic challenge becomes particularly prominent when SPD co-occurs with a psychotic disorder. Social withdrawal and restricted affect may be longstanding personality characteristics, but the same observable behaviors can arise during an acute psychotic or depressive episode. Negative symptoms may also fluctuate according to illness phase and may improve when positive symptoms or depression are treated (Mosolov & Yaltonskaya, 2022). Conversely, enduring interpersonal detachment that predates psychosis and remains relatively stable across different states may support a personality-based formulation. Evidence on the longitudinal stability of personality disorder criteria suggests that stability is not absolute, but schizoid criteria may show comparatively persistent patterns, reinforcing the value of longitudinal assessment rather than relying on a single interview (d'Huart et al., 2023; Zanarini & Frankenburg, 2018).

Psychosocial treatment presents another challenge. Conventional interventions may depend on frequent interpersonal contact, emotional disclosure, and active participation. Patients with prominent schizoid traits may experience intense interpersonal demands as uncomfortable and may respond with further withdrawal. This does not imply that psychosocial treatment is ineffective; rather, the therapeutic approach may need to be paced according to the patient's tolerance and goals. Recent systematic reviews indicate that psychosocial interventions can benefit people with personality disorders, although the evidence base is much stronger for some personality disorders than for schizoid personality disorder specifically (Cheli et al., 2025; Emmelkamp & Meyerbröker, 2025; Katakis et al., 2023). General principles of personality-disorder psychotherapy therefore need to be translated cautiously into individualized clinical care.

The interaction between personality structure and psychotic illness is also clinically relevant during periods of psychosocial stress. Bereavement and other major losses can precipitate or intensify depressive symptoms, suicidal thinking, and functional deterioration in vulnerable individuals. In a patient who already has limited social support and restricted interpersonal engagement, the loss of a primary support figure may have an especially pronounced effect on coping and help-seeking. This case therefore provides an opportunity to examine how temporal symptom reconstruction, premorbid personality information, collateral history, and treatment adaptation can be integrated in a complex psychiatric presentation.

Although the interface between personality pathology and psychosis has received increasing attention, detailed case descriptions of schizoaffective disorder, depressive type, with comorbid schizoid personality disorder remain uncommon. The present case report aims to describe the diagnostic reasoning and therapeutic challenges encountered in such a presentation. Particular attention is given to the differentiation of enduring schizoid traits from negative and depressive symptoms, the role of longitudinal and collateral assessment, and the adaptation of psychosocial management to the patient's interpersonal style.

Methods

Study Design

This study used a clinical case-report design to provide a detailed description of diagnostic reasoning, symptom progression, treatment, and short-term clinical outcome in a patient with schizoaffective disorder, depressive type, and comorbid schizoid personality disorder. The report was prepared with reference to the CARE case-report framework to improve transparency in the description of the clinical course and management.

Setting and Time Frame

The patient was evaluated in a psychiatric emergency service and subsequently treated in an inpatient psychiatric unit of a tertiary referral hospital in Surabaya, Indonesia. Clinical data were collected during the acute admission and approximately 14-day inpatient treatment period, followed by a two-week post-discharge follow-up. The report focuses on the acute episode and early outcome and does not attempt to establish long-term prognosis.

Data Collection and Clinical Assessment

Information was obtained from a comprehensive psychiatric interview with the patient, collateral interviews with the husband and sibling, serial mental status examinations, direct behavioral observation, and review of available medical and psychosocial history. Collateral information was considered particularly important because acute psychosis and severe depression can affect the reliability and completeness of self-reported premorbid history. A structured reconstruction of symptom chronology was performed to establish the temporal relationship between psychosis and mood symptoms.

Diagnostic Assessment

Schizoaffective disorder, depressive type, was formulated using DSM-5-TR criteria. The assessment focused on the presence of a major depressive episode, psychotic symptoms occurring during the mood episode, and evidence of at least two weeks of hallucinations or delusions without prominent mood symptoms. Differential diagnoses included major depressive disorder with psychotic features, schizophrenia with secondary depressive symptoms, primary or secondary negative symptoms, and trauma- or bereavement-related emotional withdrawal. The diagnostic formulation was also considered in relation to the broader conceptual uncertainty surrounding schizoaffective disorder described in the literature (Ghafari et al., 2016; Malaspina et al., 2013; Pagel et al., 2019; Pavlichenko et al., 2024).

Symptom Timeline

Approximately four weeks before admission, the patient developed auditory hallucinations and persecutory ideas without prominent depressive symptoms while maintaining basic daily functioning. Approximately two weeks before admission, following the sudden death of a close family member who had been a primary source of emotional support, she developed persistent sadness, anhedonia, hopelessness, social withdrawal, and suicidal ideation while psychotic symptoms continued. This chronology provided the key clinical evidence for psychosis occurring outside a prominent mood episode.

Assessment of Schizoid Personality Disorder

SPD was assessed through longitudinal clinical history and collateral information. Relevant features included a longstanding preference for solitary activities, lack of desire for close interpersonal relationships, restricted emotional expression, limited social interaction, and constricted affect. These features were reported to have been present since early adulthood and clearly preceded the current psychotic episode. Because the patient was acutely ill, a structured personality-disorder interview such as SCID-5-PD was not administered. Consequently, the diagnosis should be understood as a clinically supported formulation rather than a diagnosis established by a standardized personality instrument.

Ethical Considerations

Written informed consent was obtained from the patient for publication of anonymized clinical information. Identifying details were removed. No intervention beyond routine clinical care was undertaken for research purposes.

Data Analysis

Clinical data were analyzed narratively, with emphasis on symptom chronology, diagnostic formulation, differentiation between enduring personality traits and state-related symptoms, treatment response, and short-term functional outcome. Because this was a single case report, no inferential statistical analysis was performed.

Result and Discussion

Case Presentation

A 33-year-old married woman was brought to the psychiatric emergency unit by family because of progressive social withdrawal, psychotic symptoms, and suicidal ideation. Approximately four weeks before admission, she began experiencing auditory hallucinations described as voices calling her name and commenting on her behavior, accompanied by persecutory ideas that other people were watching and judging her. During this initial period, no prominent depressive syndrome was reported and she retained basic daily functioning. The persistence of psychosis in the relative absence of prominent mood symptoms was clinically important for the subsequent diagnostic formulation.

Approximately two weeks before admission, the sudden death of a close family member who had served as a primary emotional support was followed by marked deterioration. The patient developed persistent sadness, anhedonia, hopelessness, social withdrawal, and recurrent thoughts of death while hallucinations and persecutory ideas persisted. By admission, she displayed a combination of active psychosis, severe depressive symptoms, and suicidal ideation. The temporal sequence supported the diagnosis of schizoaffective disorder, depressive type, rather than major depressive disorder with psychotic features alone.

Premorbid Personality

Collateral information from the husband and sibling indicated a longstanding pattern of interpersonal detachment dating to early adulthood. The patient had few close

Table 1. Mental Status Examination at Admission

Domain	Findings
Appearance	Poor grooming
Behavior	Withdrawn, minimal interaction
Speech	Slow, reduced quantity
Mood	Depressed
Affect	Constricted
Thought process	Coherent but preoccupied with death
Thought content	Suicidal ideation and persecutory ideas
Perception	Auditory and occasional visual hallucinations
Insight	Limited
Judgment	Impaired

relationships, preferred solitary activities, rarely sought social contact, and was described as emotionally reserved with limited affective expression. These characteristics were not limited to the acute episode and were present before the emergence of hallucinations and persecutory ideas. Their persistence across time supported a comorbid schizoid personality formulation rather than interpreting all social withdrawal as a manifestation of psychosis or depression.

The baseline mental status examination showed simultaneous affective, psychotic, and interpersonal abnormalities (see Table 1). Importantly, the observed withdrawal could not be attributed to a single domain because the patient had both an acute depressive syndrome and a documented premorbid pattern of social detachment.

Treatment

The patient received inpatient psychiatric care for approximately 14 days. Pharmacological treatment consisted of risperidone 2–4 mg/day, titrated according to clinical response, for psychotic symptoms and sertraline 50 mg/day for depressive symptoms. The selection of an antipsychotic plus an antidepressant was consistent with the general treatment principle of addressing both psychosis and the depressive component of SAD-D, although evidence for schizoaffective disorder remains less extensive than for schizophrenia and major depressive disorder (Alphs et al., 2016; Bustillo et al., 2022; Lindenmayer & Kaur, 2016).

Medication adherence is an important determinant of long-term outcome in schizophrenia-spectrum disorders, including schizoaffective disorder; therefore, treatment plans should address the patient's understanding of medication, perceived benefits, adverse effects, and practical barriers to continuation (Acosta et al., 2023; Dixon et al., 2016).

Supportive psychosocial management was intentionally low intensity and non-intrusive. The intervention emphasized maintenance of basic daily functioning, gradual behavioral activation, supportive emotional presence, and avoidance of excessive interpersonal demands. The approach was based on the patient's observed interpersonal style rather than an assumption that social withdrawal should immediately be challenged. This strategy was intended to preserve therapeutic engagement while the acute psychotic and depressive symptoms were stabilized.

During hospitalization, the frequency and intensity of hallucinations decreased, suicidal ideation became absent, and self-care improved (see Table 2). The patient began to participate minimally in ward activities. Social interaction remained limited but showed slight improvement, while insight demonstrated partial improvement. These changes indicate short-term stabilization rather than resolution of the underlying personality pattern.

At the two-week post-discharge follow-up, the patient remained adherent to medication and no recurrence of suicidal ideation was reported. Mild auditory hallucinations persisted, together with a preference for social withdrawal. Overall functioning remained stable compared with discharge. The residual social withdrawal was interpreted cautiously because it could reflect both residual illness and enduring schizoid personality characteristics.

This case demonstrates why diagnosis in complex psychotic mood presentations should be longitudinal rather than based solely on symptoms observed at admission. The patient initially developed hallucinations and persecutory ideas without prominent depressive symptoms and subsequently developed a clear depressive syndrome while psychosis persisted. This sequence is consistent with the DSM-5-TR requirement for a period of psychosis outside a prominent mood episode and illustrates the central diagnostic distinction between schizoaffective disorder and mood disorder with psychotic features (Association, 2022; Malaspina et al., 2013). Contemporary reviews continue to describe schizoaffective disorder as diagnostically challenging, with substantial overlap with schizophrenia and affective psychoses (Pagel et al., 2019; Pavlichenko et al., 2024).

The reconstruction of symptom chronology was therefore one of the most important components of the assessment. Cross-sectional examination at admission could have resulted in a diagnosis centered on major depression with psychotic features because the patient was markedly depressed and suicidal. Conversely, the presence of hallucinations and persecutory ideas could have led to a schizophrenia-spectrum diagnosis without sufficient attention to the temporal structure of mood symptoms. The longitudinal history provided by the patient and family allowed the clinical team to identify psychosis that preceded the depressive episode. This approach is particularly relevant because the reliability of schizoaffective diagnoses has historically been affected by incomplete longitudinal information (Malaspina et al., 2013; Pagel et al., 2019).

A second major issue was the differentiation between schizoid personality traits and negative symptoms. Social withdrawal, reduced emotional expression, anhedonia, low verbal output, and diminished motivation can occur in schizophrenia-spectrum disorders and depressive episodes. Negative symptoms are themselves multidimensional and may be primary or secondary to depression, positive symptoms, medication effects, substance use, or social isolation (Kirkpatrick et al., 2006; Mosolov & Yaltonskaya, 2022). In the present case, the patient's longstanding preference for solitude and limited interpersonal relationships preceded psychosis by many years. This premorbid pattern was the principal evidence supporting SPD rather than interpreting all withdrawal as an acute negative symptom.

The distinction between trait and state remains clinically useful even though personality pathology is not completely static. A recent systematic review and meta-analysis found that personality disorders demonstrate only moderate diagnostic stability overall, indicating that clinicians should avoid assuming that every personality feature is permanently fixed (d'Huart et al., 2023; Zanarini & Frankenburg, 2018). At the same time, the persistence of schizoid criteria in longitudinal studies and the patient's collateral history support the practical value of examining functioning before the onset of the acute illness. In other words, the relevant question is not whether personality traits ever change, but whether the pattern is longstanding, pervasive, and present independently of the acute psychotic or depressive episode.

The overlap also has implications for interpretation of treatment response. Positive psychotic symptoms may improve relatively quickly with antipsychotic treatment, while social withdrawal and restricted affect may persist. If persistent withdrawal is automatically interpreted as treatment failure, clinicians may unnecessarily escalate antipsychotic treatment or overlook the role of personality structure and residual depression. Conversely, if all withdrawal is attributed to personality, clinicians may fail to recognize secondary negative symptoms or persistent depressive symptoms that remain treatable. Careful reassessment after psychosis and acute depression improve is therefore important.

Table 2. Clinical Course and Outcome

Domain	Admission	Discharge
Hallucinations	Frequent	Occasional
Suicidal ideation	Present	Absent
Self-care	Poor	Improved
Social interaction	Minimal	Slightly improved
Insight	Limited	Partial improvement

The pharmacological management in this case used risperidone and sertraline. Evidence for pharmacological treatment of schizoaffective disorder is comparatively limited, but antipsychotics are central to management and antidepressants may be used when depressive symptoms are prominent. Reviews of antipsychotic treatment identify evidence for paliperidone and risperidone, while acknowledging that the evidence base is smaller than that available for schizophrenia (Alphs et al., 2016; Bustillo et al., 2022; Lindenmayer & Kaur, 2016). The improvement in hallucinations and suicidal ideation during admission is clinically consistent with stabilization, but because this is a single case without standardized symptom scales, the response cannot be attributed to a specific medication with certainty.

Suicidal ideation was a particularly important acute-risk feature. The combination of psychosis, severe depression, bereavement, social withdrawal, and impaired judgment created a clinically high-risk presentation. Management therefore required inpatient containment, monitoring, treatment of the underlying psychiatric syndrome, and reassessment of suicidal thinking during recovery. Pharmacological strategies for suicide prevention in psychotic disorders include clozapine in appropriate schizophrenia-spectrum populations, while broader suicide-prevention practice emphasizes treatment of the underlying disorder and systematic risk management (Zisook et al., 2023). The present case does not provide evidence for a specific antisuicidal medication effect; rather, the disappearance of suicidal ideation occurred within a multimodal inpatient intervention.

The psychosocial approach was intentionally adapted to the patient's interpersonal style. Rather than demanding intensive verbal interaction or rapid expansion of social participation, clinicians focused on basic functioning, gradual behavioral activation, and a supportive presence with limited interpersonal pressure. This approach is compatible with the broader principle that treatment engagement should be individualized. Recent evidence suggests that psychosocial interventions can be beneficial across personality disorders, although the evidence is uneven and particularly limited for Cluster A disorders (Cheli et al., 2025; Emmelkamp & Meyerbröker, 2025; Katakis et al., 2023). Therefore, the low-intensity strategy in this case should be viewed as a clinically reasoned adaptation, not as an established disorder-specific protocol.

The concept of therapeutic alliance is especially relevant when a patient is uncomfortable with interpersonal closeness. A highly demanding approach may inadvertently increase withdrawal, whereas a predictable and respectful relationship can create enough safety for gradual engagement. The goal is not to force a patient with schizoid traits into a level of social interaction that is inconsistent with their baseline functioning, but to establish sufficient collaboration for medication adherence, risk monitoring, self-care, and recovery. This is also consistent with the contemporary view that personality pathology and psychosis should not be treated as mutually exclusive categories (Leclerc et al., 2024).

The bereavement preceding the acute depressive deterioration provides another clinically meaningful element. The temporal association does not establish causation, but it suggests that loss of a primary support figure may have acted as a precipitating stressor in a person with pre-existing psychiatric vulnerability. This interpretation is consistent with a stress-vulnerability framework in which biological, psychological, and interpersonal factors interact. In this patient, limited interpersonal connectedness may have reduced the availability of alternative sources of support after the loss. The clinical implication is that discharge planning should include attention to social support and early identification of renewed suicidal thinking, not only medication continuation.

The case also demonstrates the importance of collateral information in personality assessment. During acute psychosis or severe depression, patients may have difficulty providing a reliable developmental history. Family members can help establish whether social withdrawal, restricted affect, and limited relationships were present before illness onset. However, collateral reports must also be interpreted critically and should be integrated with direct clinical observation. In this case, convergence between family descriptions and observed interpersonal style strengthened the formulation of comorbid SPD.

The absence of a structured personality instrument is an important limitation. Instruments such as SCID-5-PD can improve diagnostic standardization, but they may be difficult to administer during an acute psychiatric admission. The present diagnosis was supported by longitudinal history and multiple informants but should therefore be interpreted with appropriate caution. Future cases and studies should consider standardized personality assessment after acute stabilization, when the patient's capacity to participate is improved. Dimensional approaches may also help distinguish enduring interpersonal traits from symptom-related social dysfunction (Leclerc et al., 2024; McWilliams, 2015; Meyer et al., 2024).

Another limitation is the short follow-up period. The patient was observed for only two weeks after discharge, so the report cannot determine whether the improvement in psychosis and suicidality was sustained over months or whether residual hallucinations would resolve with continued treatment. No standardized depression, psychosis, negative-symptom, or functioning scale was used, limiting objective quantification of change. The clinical outcome should therefore be interpreted as descriptive rather than as evidence of treatment efficacy.

Despite these limitations, the case offers several practical lessons. First, the diagnosis of schizoaffective disorder should be supported by a carefully reconstructed longitudinal timeline. Second, negative symptoms should be differentiated from depressive symptoms, medication effects, and enduring personality traits. Third, collateral history is particularly valuable when personality disorder is suspected in an acutely psychotic patient. Fourth, psychosocial interventions may need to be paced and adapted to the patient's interpersonal style. Finally, suicidal risk should remain a central treatment target throughout hospitalization and early follow-up.

Taken together, the findings support a formulation in which schizoaffective disorder, depressive type, and schizoid personality disorder interact without being collapsed into a single syndrome. The psychotic and depressive symptoms were acute and partially responsive to treatment, whereas the patient's interpersonal detachment was longstanding and persisted after acute stabilization. Recognizing this distinction allows clinicians to set realistic goals: control psychosis and depression, maintain safety, improve self-care and functioning, and establish a therapeutic relationship that respects the patient's interpersonal boundaries.

Conclusion

This case highlights the diagnostic and therapeutic challenges of schizoaffective disorder, depressive type, occurring with schizoid personality disorder. The principal diagnostic challenge was distinguishing enduring social detachment and restricted emotional expression from negative and depressive symptoms. A longitudinal history and collateral information showed that schizoid features were present since early adulthood and preceded the psychotic episode, supporting a comorbid personality formulation.

The clinical course also demonstrates the value of

individualized treatment. Pharmacological stabilization with risperidone and sertraline was accompanied by a low-intensity, non-intrusive psychosocial approach that respected the patient's limited preference for interpersonal engagement. During hospitalization, hallucinations and suicidal ideation decreased and basic self-care improved. At short-term follow-up, suicidal ideation had not recurred, although mild auditory hallucinations and social withdrawal remained.

Because this is a single case without standardized personality assessment and with short follow-up, the findings should not be generalized as evidence of treatment efficacy. Nevertheless, the case emphasizes that careful temporal assessment, collateral information, individualized psychosocial pacing, and ongoing suicide-risk monitoring are important components of care when psychotic mood disorders coexist with schizoid personality characteristics.

Author contributions

Putri Faradisa Kamila 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. Nur Azizah contributed to clinical data interpretation and manuscript review. Nur Aida 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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