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"Individualized Homoeopathic Management As An Adjuvant In A Case Of Chronic Schizophrenia With Residual Symptoms: A Case Report"

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ABSTRACT

Background:
Chronic schizophrenia with persistent residual symptoms poses significant therapeutic challenges, particularly in patients with long-standing illness and repeated relapses due to medication non-adherence. Individualized homoeopathic prescribing has been explored as an adjunctive approach in chronic psychiatric conditions.

Case:
A 57-year-old woman with a 20-year history of schizophrenia presented with persistent social withdrawal, guilt feelings, irritability, subjective cognitive complaints, and a fixed erotomaniac delusion. The illness was precipitated by significant psychosocial stressors, including financial loss and bereavement. The patient had a history of multiple hospitalizations, long-term institutional care, repeated modified electroconvulsive therapy (mECT), and ongoing antipsychotic treatment.
The PANSS score of 45 at baseline.

Intervention:
An individualized homoeopathic remedy, *Ignatia Amara* 200C, was prescribed based on totality of symptoms, including ailments from grief, self-reproach, sensitivity, aversion to company, desire for sweets and music, and chronic constipation. The patient continued conventional psychiatric medications concurrently.

Outcome:
Over a three-month follow-up period, improvement was observed in mood, affective reactivity, and guilt intensity. Subjective forgetfulness improved, and overall functioning showed stabilization. However, the fixed erotomaniac delusion persisted. The PANSS total score at last follow-up was 33.

Conclusion:
This case highlights the complexity of chronic schizophrenia with residual features and suggests that individualized homoeopathic treatment may serve as a complementary approach in long-term integrative management. Controlled studies are required to further evaluate therapeutic effects.

Keywords: Schizophrenia, Residual symptoms, Erotomania, Homoeopathy, Ignatia amara, PANSS.

INTRODUCTION

Schizophrenia is a chronic, severe, and disabling psychiatric disorder characterized by disturbances in thought processes, perception, emotional responsiveness, and behaviour [(1)(2)]. It typically presents with positive symptoms such as delusions and hallucinations, negative symptoms including affective flattening, avolition, and social withdrawal, and cognitive impairments affecting memory, attention, and executive functioning [(1)(3)]. The lifetime prevalence of schizophrenia is approximately 0.5–1%, and the disorder is associated with significant functional disability, reduced quality of life, and increased caregiver burden. [(4)].

Earlier diagnostic systems classified schizophrenia into subtypes such as paranoid, disorganized, catatonic, and residual [(5)]. Although the DSM-5 and ICD-11 have removed these subtypes due to limited diagnostic stability and validity, the concept of a *residual phase* remains clinically meaningful. The residual state refers to a stage in which prominent positive psychotic symptoms are no longer florid, yet persistent negative symptoms, cognitive deficits, attenuated delusional beliefs, and social dysfunction continue to impair functioning. Patients in this phase may appear externally stable while experiencing enduring internal distress, reduced affective reactivity, diminished motivation, and subtle but fixed delusional ideas. [(6)]

Residual or chronic schizophrenia differs from acute psychotic episodes in several important ways. While acute phases are dominated by hallucinations, formal thought disorder, and overt behavioural disturbances, the residual state is characterized by reduced psychotic intensity but persistent psychosocial impairment. Negative symptoms and cognitive deficits in this phase are often more resistant to treatment and are major determinants of long-term disability. Persistent delusional beliefs, such as erotomaniac ideation, may remain despite apparent stabilization of other symptoms. [(7)(8)].

Pharmacological treatment with antipsychotic medications remains the cornerstone of conventional management. Antipsychotics are effective in reducing positive symptoms and preventing relapse. Clozapine and other second-generation antipsychotics are often used in treatment-resistant cases. [(9)] However, conventional treatment has recognized limitations. Negative symptoms and cognitive impairments frequently show limited responsiveness to medication. Long-term therapy may be associated with adverse effects such as metabolic disturbances, extrapyramidal symptoms, sedation, and anticholinergic effects. Additionally, medication non-adherence is common and significantly increases the risk of relapse, rehospitalization, and functional deterioration. Psychosocial interventions, rehabilitation programs, and cognitive remediation therapies are therefore essential components of comprehensive care [(10)].

Given these therapeutic challenges, interest has grown in complementary and integrative approaches that may support overall well-being, emotional processing, and individualized symptom expression in chronic psychiatric conditions. Homoeopathy, based on the principle of individualization and totality of symptoms,

considers not only diagnostic labels but also characteristic emotional, cognitive, and somatic features unique to the patient. In chronic mental illnesses, individualized prescribing aims to address underlying susceptibility patterns, emotional triggers, and psychosomatic expressions [(11)].

In cases where psychosocial stressors such as bereavement and financial loss precede illness onset, homoeopathic assessment places emphasis on modalities such as ailments from grief, guilt, self-reproach, social withdrawal, and characteristic desires or aversions. As an adjunct to conventional psychiatric treatment, homoeopathy may potentially contribute to improvements in subjective well-being, affective expression, and functional adaptation. However, evidence in the form of controlled clinical trials remains limited, and most available data derive from case reports and observational studies. [(12)(13)].

The present case report describes a patient with chronic schizophrenia presenting predominantly with residual symptoms and persistent erotomaniac delusion, managed with individualized homoeopathic treatment alongside ongoing conventional pharmacotherapy. The report aims to explore clinical reasoning, integrative management, and observed outcomes in a long-standing, treatment-requiring condition.

CASE:

A 57 years old unmarried women, Hindu by religion, studied till B. Com, living in Vijayawada, Name of Informant- Self & Sister, Date of the case taking: 05/12/24

CHIEF COMPLAINTS:

- Low mood and social withdrawal since last 20 years
- Irritability and Aggressiveness 1 month ago

History of Presenting Illness (HOPI)

The illness began approximately 20 years prior following significant psychosocial stressors. The family experienced substantial financial loss in their textile business after being cheated by a business partner, resulting in a marked decline in socioeconomic status and relocation to a smaller rented house. Within months, her father died due to myocardial infarction, followed three months later by the death of her elder brother due to stroke.

Following these events, the patient developed persistent low mood, social withdrawal, reduced interaction, and diminished interest in routine activities. She preferred remaining alone and avoided social contact. A few months later, she experienced brief episodes of auditory hallucinations consisting of unknown male voices proposing marriage. These episodes lasted approximately two days.

Psychiatric consultation was sought, and antipsychotic treatment was initiated.

Over the subsequent years, the course was characterized by relapses primarily associated with medication non-adherence. Discontinuation of medication resulted in irritability, verbal aggression, and on one occasion physical aggression toward her mother. During one such episode, she received modified electroconvulsive therapy (mECT).

For the past 15 years, due to recurrent behavioural disturbances and poor adherence, she has resided in multiple rehabilitation centres across different cities. At the time of presentation, she was living in a structured rehabilitation facility and receiving supervised medication.

A fixed erotomaniac delusion was present. She believed that a former neighbour from approximately 30 years ago was in love with her and would eventually come to take her away from the rehabilitation centre and marry her. The belief was persistent but not behaviourally acted upon.

There were no current hallucinations.

N/H/O: increased energy, any overactivity, excessive worry, palpitations, sweating, anticipatory anxiety, recurrent intrusive thoughts, any use of substance, any phobias, head injuries.

Past Psychiatric Treatment History

The patient had been on continuous psychiatric treatment for approximately 20 years.

She has been on: T. SIZOPIN 200mg, T. DON FORTE, T. DYSKINIL, T. GLYCOLATE 2mg, T. THYRONORM, T. KAYAM

She underwent multiple courses of modified electroconvulsive therapy:

- 4 mECT sessions following physical aggression toward her mother (approximately 15 years ago)
- 4 mECT sessions during stay at a psychiatric facility in Hyderabad
- Regular mECT (2 sessions per month) during a prolonged stay in rehabilitation centre for approximately 9 years

Medication discontinuation in the past repeatedly resulted in relapse of behavioural symptoms.

Past Medical History

- Hyperthyroidism for 7–8 years (on Levothyroxine)
- No history of diabetes, hypertension, seizures, or major medical illness
- No significant surgical history

Family History

- Father: Deceased (myocardial infarction)
- Elder brother: Deceased (stroke)
- Elder sister: Diabetes mellitus, thyroid disorder, hypertension
- Younger sister: No known psychiatric or medical illness

There was no documented family history of psychotic disorders.

PHYSICAL GENERALS

Appetite – moderate 3 times a day

Thirst – 2-3 lit/ day

Desires – Sweets, spicy

Aversions – bland food

Sleep: Refreshed

Dreams – cannot remember

Physiological Eliminations:

Stools – hard, once in 2-3 days (since many years), takes Kayam churna daily

Urine – Clear, no burning, D/N - 3-4 times /0-1time

Perspiration – generalized on exertion

Menstrual History: Menarche at 13 yrs of age, regular menses, no complaints during menstruation, menopause attained at 48 years of age.

Thermals: Ambi thermal patient

LIFE SPACE INVESTIGATION

The patient was born and brought up in Vijayawada in an upper-middle-class family engaged in the textile business. She was the third child among four siblings. Developmental milestones were achieved at appropriate ages, and there was no history of childhood behavioural disturbances.

Academically, she performed well during school years but was described as emotionally sensitive and dependent on her mother. She reported reluctance to attend school during childhood and preferred staying close to family members. During adolescence and early adulthood, she became increasingly reserved and maintained limited social relationships. She completed a Bachelor of Commerce degree but had only a small circle of friends and avoided extensive social interaction.

A significant turning point occurred when the family experienced financial loss due to business failure. This was followed by the deaths of her father and elder brother within a short interval. These cumulative stressors were perceived as overwhelming. Following these events, she became withdrawn, stopped sharing her emotions, and exhibited persistent sadness.

The patient reported ongoing guilt regarding past aggression toward her mother and expressed distress about being unable to meet or care for her. She avoids discussing her emotional difficulties with her siblings to prevent causing them further worry. She tends to suppress emotional expression and internalize distress.

General Physical Examination

- Afebrile
- Pulse: 64 bpm
- Blood pressure: 110/90 mmHg
- Respiratory rate: 16/min
- Weight: 49 kg

No significant abnormalities were detected on systemic examination.

Positive physical findings:

- Pale conjunctiva

Mental Status Examination

Appearance: Kempt, cooperative, Rapport Established
Psychomotor activity: Normal
Speech: Low tone, coherent, relevant
Mood: I am good
Affect: Flat, restricted range, reduced reactivity
Thought form: Goal-directed
Thought content: Persistent erotomaniac delusion; guilt and self-reproach
Perception: No hallucinations at present
Cognition: Oriented to time, place, and person; attention aroused concentration not sustained; recent memory mildly impaired; remote memory intact
Insight: Grade 0

PROVISIONAL DIAGNOSIS: Residual Schizophrenia

HOMOEOPATHIC MANAGEMENT

TOTALITY OF SYMPTOMS

- Aliments from death of loved once
- Aliments from loss of money
- Guilt
- Sensitive, self-blaming
- Aversion to company / social withdrawal
- Desire for music
- Desire for sweets and spicy food
- Hard stools
- Forgetfulness

REPERTORIAL TOTALITY

The following rubrics were selected:

- Mind – ailments from – death of loved once
- Mind – ailments from – money; from losing
- Mind – company – aversion to
- Mind- memory – weakness of memory – happened, for what has
- Mind – sensitive
- Mind- reproaching oneself
- Mind - Company, aversion to
- Mind- Music, desire for
- Generalities - Food, sweets, desire
- Generalities - Food, spicy, desire
- Stool – hard

Repertorization

Repertorization was performed using the Synthesis Repertory through repertory software- RADAR 10.5.003

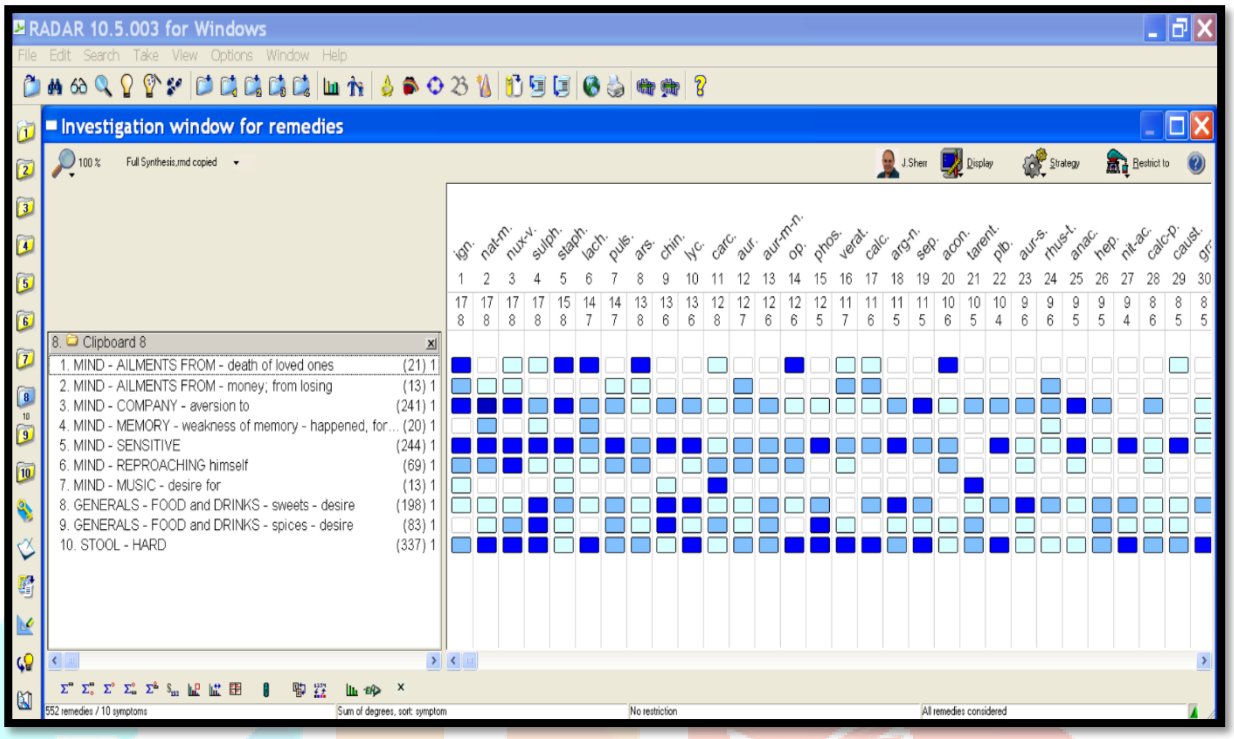

FIGURE 01: REPERTORIAL TOTALITY

FINAL PRESCRIPTION

On 05/12/24

RX –

1. IGNATIA AMARA 200 – weekly 1 dose HS x 3 weeks
2. SL 4-0-4 x 3 weeks

PANSS Score – 45

FOLLOW UP

Date	Follow up	Prescription
26/12/24	Still feels guilty about hitting her mother Hard stools once in 3-4 days Forgetfulness no improvement Mood better after taking medication	Rx SL -3 wks 4-0-4
16/01/25	Mood – feeling positive after taking medicine Forgets things where she kept Guilt present Difficulty in explaining her complaints Stools – soft, once in 3-4 days MMSE –30	Rx IGNATIA 200 (stat) SL -3 wks 4-0-4
06/02/25	Forgetfulness better Mood – I'm good Affect – euthymic, range- full MMSE - 30	RX SL – 3 weeks 4-0-4
27/02/25	Forgetfulness better Guilt reduced now understands that because of stopping medicine she reacted that way	RX SL – 3 weeks 4-0-4
20/03/25	Delusion of love still persistent Occasionally forgetting to take medicine PANSS Score – 33	RX SL – 3 weeks 4-0-4

PANSS RATING FORM

FIGURE 02: PANSS Rating form[14].

		Absent	minimal	mild	moderate	moderate severe	severe	extreme
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7

FIGURE 03: Assessment by MODIFIED NARANJO Criteria (MONARCH) Score[15]

Domains	Yes	No	Not Sure or N/A
1)Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2		
2)Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	+1		
3)Was there an aggravation of symptoms?	+1		
4)Did the effect encompass more than the main symptom or condition, i.e. were other symptoms ultimately improved or changed?	+1		
5)Did overall wellbeing improve? (suggest using validated scale)	+1		
6)(A) Direction of cure: Did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1		
6)(B) Direction of cure: Did at least two of the following aspects apply to the order of improvement of symptoms: - from organs of more importance to those of less importance? - from deeper to more superficial aspects of the individual? - from the top downwards?	+1		
7)Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?		0	
8)Are there alternate causes (other than the medicine) that – with a high probability – could have caused the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)		+1	
9)Was the health improvement confirmed by any objective data? (E.g. lab test, clinical observation, etc.)	+2		
10)Did repeat dosing, if conducted similar clinical improvement?	+1		

DISCUSSION

This case illustrates the chronic residual phase of schizophrenia, in which florid psychotic symptoms are minimal but negative symptoms, cognitive complaints, and fixed delusional beliefs persist. The patient had a 20-year illness course marked by repeated relapses associated with medication non-adherence, prolonged institutionalization, and multiple sessions of modified electroconvulsive therapy. At the time of presentation, there were no active hallucinations; however, affective flattening, social withdrawal, guilt, self-reproach, and a persistent erotomaniac delusion were prominent. Such residual features are known to significantly impair long-term functioning and quality of life.

Negative symptoms and cognitive deficits are often less responsive to antipsychotic medications compared to positive symptoms. In this patient, supervised pharmacotherapy likely contributed to stabilization and prevention of acute exacerbations. Nevertheless, persistent affective restriction, internalized guilt, and reduced emotional expression continued to cause distress. This reflects the broader therapeutic challenge

in chronic schizophrenia, where psychosocial and affective domains remain inadequately addressed despite adequate pharmacological control.

The homoeopathic intervention was individualized based on the totality of symptoms, particularly ailments from grief, financial loss, suppressed emotional expression, sensitivity, aversion to company, desire for sweets and music, and chronic constipation. The temporal association between cumulative bereavement and illness onset was clinically significant and guided remedy selection. *Ignatia amara* was prescribed in 200C potency.

Over the follow-up period, improvement was observed in mood stability, affective reactivity, reduction in guilt intensity, bowel regularity, and subjective memory complaints. Affect became more euthymic with fuller range, and the PANSS total score was 33 at last assessment, suggesting relative symptom stabilization. However, the fixed erotomaniac delusion remained unchanged, consistent with evidence that entrenched delusional systems may be more resistant to therapeutic modification.

The Modified Naranjo Criteria (MONARCH) suggested a possible causal relationship between the homoeopathic intervention and clinical improvement. However, interpretation must remain cautious, as the patient continued concurrent antipsychotic medication and structured rehabilitation care, both of which are known to influence outcomes. Additionally, residual schizophrenia may exhibit periods of partial symptomatic fluctuation independent of specific interventions.

This case highlights the multidimensional nature of chronic schizophrenia and the importance of integrative management approaches. While conventional treatment remains essential for relapse prevention and psychosis control, adjunctive individualized homoeopathy in this case was associated with improvements in affective and subjective domains. Given the limited high-quality evidence for homoeopathy in severe psychiatric disorders, further controlled studies with longer follow-up and objective outcome measures are required to clarify its role in integrative psychiatric practice.

CONCLUSION

This case report describes a 57-year-old woman with chronic schizophrenia in the residual phase, characterized by persistent negative symptoms, cognitive complaints, and a fixed erotomaniac delusion despite long-term conventional psychiatric treatment. The illness followed a chronic course with repeated relapses related to medication non-adherence and required prolonged institutional care and electroconvulsive therapy.

Individualized homoeopathic intervention with *Ignatia amara* 200C, prescribed on the basis of totality of symptoms and etiological factors such as grief and emotional suppression, was administered alongside ongoing antipsychotic therapy. Over a three-month follow-up, improvements were observed in mood stability, affective reactivity, guilt intensity, bowel regularity, and subjective cognitive clarity. However, the persistent erotomaniac delusion remained unchanged, indicating partial but not complete symptom modification.
This case highlights the complexity of managing chronic residual schizophrenia and the predominance of negative and affective symptoms in determining long-term functioning. While conventional pharmacotherapy remains essential for relapse prevention and psychosis control, adjunctive individualized homoeopathy in this case was associated with improvement in certain affective and subjective domains.

Given the limitations of a single-case design and concurrent conventional treatment, causal inference cannot be established. Further well-designed controlled studies with larger samples and longer follow-up are required to evaluate the potential role of individualized homoeopathy within integrative psychiatric care.

CONFLICT OF INTEREST

Nil

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