

# Management of Paranoid Schizophrenia with Suicide Risk and Command Hallucinations in a Religious Leader Post-COVID-19 Infection: A Case Report

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**Abstract.** *Paranoid schizophrenia is a severe mental disorder manifested by hallucinations and delusions. This case report presents the comprehensive management of a thirty three year old male religious leader diagnosed with paranoid schizophrenia, who exhibited a high psychiatric emergency risk of suicide attempts driven by command hallucinations. Clinical evaluation revealed that the exacerbation of psychotic symptoms was triggered by the interaction between neurobiological vulnerability post coronavirus infection and chronic psychosocial stress due to severe financial debt. The patient displayed somatic symptoms, panic attacks, and massive suicidal ideation. Combination pharmacotherapy using chlorpromazine and risperidone proved effective in reducing positive symptoms and acute agitation during the stabilization phase. Nevertheless, the prognosis is considered poor due to persistent environmental stressors including family conflicts. A holistic approach involving psychoeducation is absolutely necessary to prevent relapse and mitigate fatal risks in the future.*

**Keywords:** *Paranoid Schizophrenia, Suicide, Psychosocial Stress, Combination Therapy*

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## INTRODUCTION

Schizophrenia is a severe, chronic mental disorder affecting millions of individuals globally, characterized by fundamental distortions in thinking, perception, emotion, and behavior (Jauhar et al., 2022; Masika, 2025; Minzenberg et al., 2008). Recent epidemiological data indicate that schizophrenia contributes significantly to the global burden of disease, causing severe disability in social and occupational functioning (Charlson et al., 2018; Solmi et al., 2023; Rössler et al., 2005; Defar et al., 2023; Świtaj et al., 2012). Among its various subtypes, Paranoid Schizophrenia (F.20.0) is the most common clinical manifestation, often dominated by positive symptoms such as persistent delusions and auditory hallucinations.

The etiology of schizophrenia is multifactorial, involving a complex interaction between genetic and neurobiological susceptibility, as well as environmental stressors (Schmitt et al., 2012; Van et al., 2008; Wahbeh & Avramopoulos, 2021; Zamanpoor, 2020; Misiak et al., 2018). In recent years, the medical literature has begun to highlight the impact of the pandemic, with COVID-19 infection and physical isolation policies proving to be new precipitating factors triggering reactive psychotic episodes and exacerbating psychological vulnerability in individuals with severe mental illness (Hao et al., 2020; Zhand & Joober, 2021; Brown et al., 2020; Caponnetto

et al., 2021; De Hert et al., 2021). In addition to infectious factors, severe psychosocial stressors such as financial difficulties, debt, and marital instability have also been shown to strongly correlate with symptom exacerbation and a poorer prognosis in patients with mental disorders (Stickley et al., 2023; Astill et al., 2023).

One of the most critical aspects of schizophrenia management is the risk of self-harm and suicide (Mork et al., 2013; Ventriglio et al., 2016; Taylor et al., 2015; Roy & Pompili, 2009; Challis et al., 2013). The risk of this psychiatric emergency increases dramatically if the patient experiences intense command hallucinations (Pompili et al., 2025).

This case report presents the comprehensive management of a 33-year-old male religious leader (Ustadz) diagnosed with paranoid schizophrenia following COVID-19 infection and severe financial stress. The purpose of this case report is to describe a holistic diagnostic approach and a combined pharmacological and psychosocial therapy strategy in managing a case of schizophrenia with a high risk of suicide, while also adding to the literature on the psychosocial impact in the post-pandemic era.

## **METHODS**

This study is a retrospective case report based on direct clinical observation and medical record reviews. Clinical data were primarily obtained through auto-anamnesis with the patient and hetero-anamnesis with the patient's family, conducted by the attending psychiatrist during the patient's admission to the Emergency Department in September 2025. To ensure the credibility of the case documentation, subjective clinical accounts and potential discrepancies between the patient and family narratives were systematically cross-checked with the patient's existing outpatient medical records. Ethical procedures were strictly followed; written informed consent was obtained from the patient and his legal guardian for the publication of this case report, ensuring complete anonymity and confidentiality of personal identifiers.

### **Case Presentation**

A 33-year-old man (Mr. N), a religious teacher and caretaker at an Islamic boarding school in Lamongan, was admitted to the Emergency Department (ER) on September 20, 2025. His primary complaint was persistent auditory hallucinations in the form of whispers commanding him to commit suicide (in the right ear) and self-harm (in the left ear). These complaints were accompanied by primary somatic symptoms such as nausea, early morning vomiting, decreased appetite, sleep disturbances, and shivering. Based on auto-anamnesis and hetero-anamnesis from the family, behavioral changes and neuropsychiatric symptoms began to appear after the patient was infected with COVID-19 while undergoing isolation in Mecca. Since then, the patient has experienced frequent panic attacks, stiffness, and loss of consciousness. Auditory hallucinations occurred more than five times a day. The patient had a history of fatal suicide attempts (self-harm), including cutting his hand with scissors while unconscious in 2019 and July 2025. In the July 2025 incident, the patient overdosed on sedatives during a panic attack and explicitly expressed a desire to die. The patient also exhibited symptoms of agoraphobia, feeling anxious in crowds, and fearing contact with others, especially at night.

A psychosocial history review revealed severe financial stressors. The patient had a history of taking out a motor vehicle loan since 2017, which resulted in debt. This situation triggered prolonged domestic conflict, leading to stress for his wife and her requiring psychiatric treatment at Menur Hospital in 2023. The patient currently lives separately from his wife and child. His past medical history includes gastritis, hypercholesterolemia, gout, and a history of minor head trauma from falling into a well during elementary school. Previously, the patient was a regular outpatient at the psychiatric clinic, with poor medication adherence that was prone to uncontrolled anxiety. A systematic mental status examination revealed the following domains: The patient appeared cooperative with adequate self-care, but exhibited psychomotor agitation. Speech was spontaneous but softly spoken. Mood was assessed as hypothymic with an appropriate affect. Regarding perception, active command auditory hallucinations were present

without visual hallucinations. Thought process was coherent, but thought content was unrealistic and heavily dominated by persistent suicidal ideation. Biologic functions indicated severe insomnia and decreased appetite. Cognition, orientation, and memory were intact (compos mentis consciousness). Crucially, given the suicide risk, the patient's impulse control was severely impaired, and clinical judgment was poor. The information provided was deemed reliable when cross-checked with the family. The patient's insight was at level 2, where he was aware of his illness but did not fully understand the etiology or the urgency of long-term treatment adherence.

The diagnostic procedure was established using the multi-axial framework of the Guidelines for the Classification and Diagnosis of Mental Disorders (PPDGJ-III). The patient fulfilled the specific criteria for F20.0 Paranoid Schizophrenia due to the presence of prominent imperative auditory hallucinations and unrealistic thought content persisting for more than one month, in the absence of primary depressive or manic episodes preceding the psychosis. Differential diagnoses were systematically ruled out. Substance-induced psychosis and psychotic disorder due to a general medical condition were excluded as there was no history of illicit drug use or sedative overdose prior to symptom onset, and physical examinations were unremarkable. Post-infectious neuropsychiatric syndrome was considered due to the COVID-19 history, but ruled out because the psychotic symptoms persisted long after the acute infection resolved without delirium. Major depressive disorder with psychotic features and schizoaffective disorder were excluded because the mood symptoms (hypothymia) were secondary and not pervasive enough to meet the criteria for a full mood episode. Brief psychotic disorder was ruled out due to the chronicity of the symptoms extending beyond one month. Multi-axially, Axis II had no diagnosis; Axis III presented gastritis and hypercholesterolemia; Axis IV presented specific psychosocial problems (economic and family). Axis V presented a Global Assessment of Functioning (GAF) scale of 20-11. The assessment of this critically high suicide risk was methodologically based on comprehensive clinical judgment rather than a specific structured rating scale. This risk evaluation was scientifically defensible, formulated through the clinical interview, history of previous fatal attempts, presence of active command hallucinations, access to means, and severe functional impairment. A summary of the disease course and multi-axial diagnoses is shown in Figure 1.

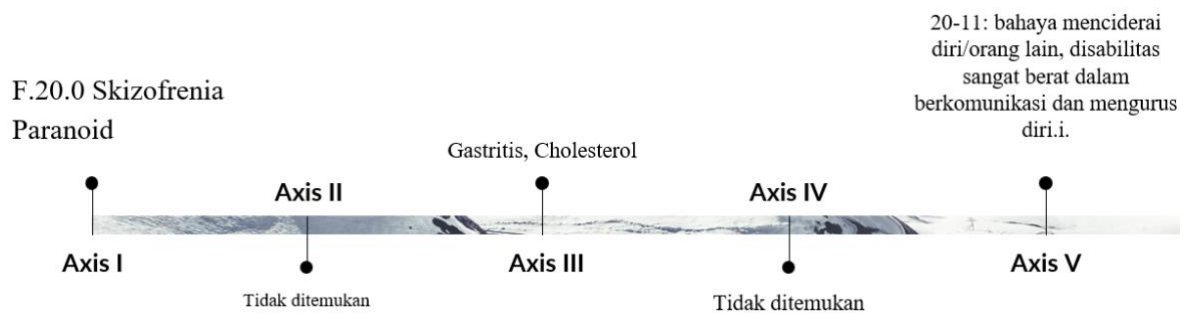


Figure 1. Multi-axial Diagnosis and Timeline of The Patient's Disease Course

Pharmacological management in this case consisted of a combination of typical and atypical antipsychotics, namely Chlorpromazine 50 mg (0-0-50 mg) to provide a sedative effect and control nocturnal agitation, and Risperidone 2 mg (0-0-2 mg) to address positive symptoms of psychosis. The psychotherapy approach focused on psychoeducation of the patient and family regarding medication adherence, recognition of side effects, avoidance of stress triggers, and environmental modifications to reduce high emotional expression (HE) in the home environment.

## RESULT AND DISCUSSION

In this case report, the clinical findings present a 33-year-old male facing a severe psychiatric emergency, characterized by acute imperative auditory hallucinations specifically commanding self-harm and suicide. Clinical evaluation established a definitive diagnosis of Paranoid Schizophrenia (F.20.0). The patient's initial Global Assessment of Functioning (GAF) score was evaluated at 20-11, reflecting a critical, immediate danger of self-harm and profound

disability in communication and self-care. Immediate acute management involved a combination pharmacotherapy of Chlorpromazine (50 mg) and Risperidone (2 mg). This intervention successfully stabilized the acute psychomotor agitation, reduced the intensity of the positive symptoms, and managed the severe insomnia during the initial stabilization phase.

Table 1. Summary of comprehensive management for Mr. N

Therapy Category	Type of Intervention	Dosage / Details	Objective / Rationale
Pharmacotherapy	Chlorpromazine	50 mg (0-0-50 mg)	Provides sedative effects, reduces agitation, and improves sleep disturbances (insomnia).
	Risperidone	2 mg (0-0-2 mg)	Controls positive symptoms of schizophrenia (imperative auditory hallucinations and suicidal ideation).
Psychotherapy & Education	Medication Adherence	Patient & Family	Ensures continuity of treatment to prevent relapse.
	Side Effect Awareness	Patient & Family	Prevents medication discontinuation due to side effects and educates about signs of medical emergencies.
	Trigger Management	Patient & Family	Modifies environment, reduces High Expressed Emotion (HEE), and manages financial stressors.
	Self-Care Management	Family	Empowers family to guide patients in resuming Activities of Daily Living (ADL).

## Discussion

A structured suicide risk formulation is critical for this patient due to the severity of the psychiatric emergency (Hawton et al., 2022; Pisani et al., 2016; Stewart, I., & Lees-Deutsch, 2022; Pompili, 2024; Silverman & Berman, 2014). The patient's acute risk factors included active command hallucinations directing self-harm, persistent suicidal ideation, a history of previous fatal suicide attempts (in 2019 and 2025), poor medication adherence, panic attacks, severe insomnia, and ongoing family conflict. Conversely, the clinical assessment also identified several protective factors that mitigated the immediate fatal outcome (Carlin & Moon, 2017; Berman & Silverman, 2020; Rennie & Dolan, 2010; Janiri et al., 2020; Fowler, 2012). These included active family involvement (who brought him to the emergency department), his religious role which provided a foundational moral resistance to the hallucinations, a willingness to seek psychiatric care, and cooperative behavior during the mental status examination. Balancing these structured factors, the acute suicide risk was deemed critically high but manageable through immediate pharmacological intervention and close clinical monitoring.

When interpreting the etiology, the temporal correlation between the patient's initial mental decompensation and his COVID-19 infection during isolation in Mecca presents a clinically relevant hypothesis. While a single case report cannot establish a definitive causal relationship, the SARS-CoV-2 infection likely acted as a precipitating factor. This exacerbation was potentially mediated by a combination of neurobiological inflammation (often referred to as a "cytokine storm"), extreme psychological stress, strict isolation protocols, and the patient's pre-existing psychiatric vulnerability (Brown et al., 2020; Valdés-Flórido et al., 2020).

Furthermore, the patient's identity as an *Ustadz* and *pesantren* caretaker provides an important cultural and spiritual context. During anamnesis, the patient reported feeling overwhelmed by guilt and a profound sense of responsibility toward his congregation, perceiving a heavy moral burden to maintain social expectations during the pandemic crisis. These feelings of inadequacy regarding his religious duties served as direct, hidden psychosocial stressors. This psychological burden was further compounded by chronic financial distress stemming from a

vehicle loan debt, which empirically correlates with increased anxiety, mood fluctuations, and psychotic exacerbations (Stickley et al., 2023; Astill et al., 2023). This financial strain contributed to a high expressed emotion (HEE) environment at home, evident from his wife's subsequent need for psychiatric care. A high HEE environment is a well-documented catalyst for schizophrenic relapse and caregiver burden (Rahmani et al., 2022; Awad & Voruganti, 2008; Putri et al., 2024; Lee et al., 2025).

The pharmacological strategy utilized in this case aligns with current literature. Risperidone effectively targeted the positive symptoms with a tolerable extrapyramidal profile (Deng et al., 2023; Leucht et al., 2023), while low-dose Chlorpromazine addressed the severe insomnia and agitation (Nasim et al., 2025). As summarized previously in Table 1, the immediate clinical response was positive. However, the long-term prognosis remains guarded unless these environmental and psychosocial stressors are continuously managed through structured family psychoeducation to ensure long-term medication adherence (Zhand & Joobar, 2021; Velligan et al., 2010; Ockene et al., 2002; Carroll et al., 2022; Razali, 2010).

## **CONCLUSION**

This case report highlights the complexity of managing Paranoid Schizophrenia (F.20.0) in a 33-year-old patient with a professional background as a religious leader, characterized by imperative auditory hallucinations and a high risk of suicide and self-harm. The onset of psychotic symptoms in this patient was triggered by a synergistic interaction between neurobiological vulnerability following COVID-19 infection and chronic psychosocial stress stemming from financial debt. Pharmacological intervention, a combination of typical (Chlorpromazine) and atypical (Risperidone) antipsychotics, was an effective tactical step in the acute stabilization phase to reduce agitation and control positive symptoms. However, the prognosis in this case is considered *dubia ad malam* due to the persistence of environmental stressors such as family conflict and economic problems. Therefore, the success of long-term therapy and prevention of relapse absolutely requires a holistic biopsychosocial spiritual approach, which includes not only strict medication adherence but also environmental modifications to reduce the family's emotional burden in a sustainable manner.

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## **AUTHOR CONTRIBUTIONS**

Gemilang Mutsaqqofa Arsyadana served as the primary author, responsible for collecting the patient's clinical data (history taking and examination), conducting the literature review, and preparing the initial draft of the manuscript. Era Catur Prasetya served as the clinical supervisor, validating the diagnosis and medical treatment, providing critical intellectual guidance, and reviewing and approving the final manuscript prior to publication.

## **ETHICS**

This case report was prepared in accordance with the principles of medical ethics. The author has obtained written informed consent from the patient and family (guardian) to use and publish the medical data and medical history for scientific purposes. The patient's true identity is kept strictly confidential to maintain privacy.

## CONFLICT OF INTEREST

The authors declare no conflicts of interest (financial or non-financial) with respect to the research, authorship, and/or publication of this article.

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