

Case Report



Ayurvedic Approach to Schizoaffective Disorder, Depressive type, with combined with AUD: A Case report

^{1*}Rajimunnisa Begam Shaik, ²Sunil Kumar, ³Bawadkar Prasad, ⁴Bhushan Mhaiskar

ABSTRACT:

Background: Schizoaffective disorder, depressive type with comorbid alcohol use disorder, is a complex condition with overlapping psychotic, mood, and substance-use symptoms. Diagnosis and management are challenging. In *Ayurveda*, it aligns with *Sannipataja Unmada*, where there is a coexistence of psychotic and mood symptoms, including both positive symptoms like hallucinations, delusions, and negative symptoms like social withdrawal, impaired cognition, blunted affect, and it's a highly debilitating condition. **Clinical findings:** A 50-year-old alcoholic male with a known case of Type 2 Diabetes Mellitus and Hypertension for 15 years, on treatment with irregular adherence leading to suboptimal glycaemic and blood pressure control, presented with longstanding low mood, frequent anxiety, occasional hallucinations, paranoid ideation, and persistent alcohol use despite repeated medical advice. Mental health examination revealed impaired memory and concentration, partial insight, and mild psychomotor agitation. Standardized assessments revealed moderate-to-severe depressive symptoms (HDRS), mild anxiety, harmful drinking (AUDIT), cognitive impairment (MMSE), and positive suicidality (C-SSRS). Based on clinical presentation and ICD-11, Schizoaffective Disorder, Depressive Type with Alcohol Use Disorder was diagnosed. **Intervention:** protocol was administered alongside ongoing pharmacotherapy. This included *Panchakarma (Nasya)*, external therapies (*Shirodhara, Shiropichu, etc.*), *Shamana medicines (Brahmi Vati, Draksharishtam, etc.)*, *Satwawajaya Chikitsa (psychotherapy)*, *Marma therapy*, and *Yoga*. **Outcome:** The patient showed significant overall improvement over 90 days of treatment, with cognitive function (MMSE) improving by 43.8%. There was a marked reduction in depressive (65.4%), anxiety (50%), insomnia (33.3%), alcohol use (46.7%), suicidality (90.9%), and psychotic symptoms (34.9%). These findings indicate clinical recovery and stabilization, but not remission, and thus require continued management. Alcohol dependence made abstinence challenging, though intake was reduced, with the last use before admission. **Conclusion:** A multidimensional Ayurvedic treatment approach can help to address and manage diagnostic and therapeutic challenges in schizoaffective disorder with alcohol use disorder. While outcomes are promising, validation through larger controlled studies is required.

KEYWORDS: AUD, Case Report, Marma Chikitsa, Panchakarma, Sannipataja Unmada, Satvaajayachikitsa, Schizoaffective disorder depressive type

RECEIVED ON:

20-03-2026

REVISED ON:

05-04-2026

ACCEPTED ON:

10-04-2026

Access This Article Online:

Quick Response Code:



Website Link:

<https://jahm.co.in>

DOI Link:

<https://doi.org/10.70066/jahm.v14i3.2658>

Corresponding Author Email:

dr.razia.sk@gmail.com

CITE THIS ARTICLE AS

Rajimunnisa Begam Shaik, Sunil Kumar, Bawadkar Prasad, Bhushan Mhaiskar. Ayurvedic Approach to Schizoaffective Disorder, Depressive type, with combined with AUD: A Case report. Journal of Ayurveda and Holistic Medicine (JAHM) 2026; 14(3):98-106.

1. INTRODUCTION

Schizoaffective disorder (SAD) is characterized by the coexistence of psychotic (hallucination, delusion) and mood (depressive or manic) features. According to DSM-5, it includes major mood episodes concurrent with schizophrenia like features with delusion or hallucination persisting more than 2 weeks without mood disturbance, differentiating it from other mood disorders with psychotic features [1]. As per ICD-10 F-25, SAD may be either a bipolar or depressive type [2] [3]. It accounts for 10-30% among psychotic admissions [4] and missed most of the times, often complicated by Alcohol Use Disorder (AUD) [5], worsening prognosis.

In Ayurveda, features align with *Sannipataja Unmada* [6] with *Madatyaya* [7] [8], arising from deranged *Tridoshas* and *Tamas*, affecting *Buddhi*, *Smriti*, *Bhakti*, and *Sheela*. “Integrating a whole-system Ayurveda approach addresses gaps in current treatment, which predominantly focuses on symptom control while giving comparatively less attention to functional and psychosocial recovery, through restoration of *dosha* balance and enhancement of *Satva*.”

The uniqueness of this case is the coexistence of schizoaffective disorder, depressive type, with comorbid alcohol use disorder in a known diabetic and hypertensive patient, making it a diagnostic and treatment challenge. The documentation of such evidence-based multimodal holistic *Ayurveda* intervention enriches the evidence base of *Ayurvedic* psychiatry and allows clinicians to harness the clinical insights in the management of such complex psychotic-mood disorders in clinical practice.

2. CASE REPORT

Table 1: Timeline of events that occurred and current information

Timeline	Event / Observation
20 years ago	Daily alcohol consumption begins (<i>Madya Asakti / Surapana</i>) initially occasional and later progressing to daily intake (approx. 180–360 ml/day of locally available spirits such as whisky/brandy). Frequency and quantity gradually increased over time, indicating tolerance. Drinking was mainly in the evening for stress relief as he is a crematorium worker. Before treatment, use was persistent despite advice; currently, there is reduced intake with periods of abstinence during follow-up.

Clinical findings: A 50-year-old male, with a known history of diabetes mellitus and hypertension for 15 years, presented to *Manasollasa* OPD, KLE Ayurveda Hospital, and MRC (MR No.250019478) the patient is a 50-year-old male with a 20-year history of alcohol use, which began as occasional social drinking (primarily whisky/brandy) in small quantities and gradually progressed to daily consumption of approximately 180–360 ml/day over time, indicating the development of tolerance and dependence. The drinking pattern was initially limited to evenings for stress relief but later became habitual and compulsive. There were intermittent attempts at abstinence in the past, during which the patient sought medical consultation and received counseling along with pharmacological treatment; however, adherence was irregular and sustained abstinence was not achieved.

Over the past 8 months, the patient developed psychiatric symptoms including persistent low mood, anxiety, auditory hallucinations, paranoid delusions (such as beliefs of external influence/black magic), disturbed sleep, impaired memory and concentration, social withdrawal, and passive suicidal ideation. At the time of presentation to the OPD, the patient had his last alcohol intake 1 day before admission, indicating ongoing alcohol dependence. He was brought by his wife (attender) and was cooperative, though he exhibited mild psychomotor agitation, anxious affect, and partial insight into his condition. The overall clinical presentation was suggestive of schizoaffective disorder with delusions coexisting with alcohol use disorder, posing significant diagnostic and therapeutic challenges. The timeline of events is presented in tabular form. ([Table 1](#))

Past medical history	Diagnosed with Hypertension and Type 2 Diabetes Mellitus 15 years ago, the patient was prescribed Tab. Amlodipine 5 mg once daily and Tab. Metformin 500 mg twice daily.
8 months ago	The delusions had an insidious onset 8 months prior, beginning with suspiciousness and progressing to paranoid beliefs of harm and supernatural influence from the same period. There was no clear acute trigger observed, though chronic stress and long-standing alcohol use were contributory. Symptoms persisted even during periods of abstinence, indicating they were not solely alcohol-induced.
8 months to present	Episodic course, symptoms occur 1–2 times/month; some episodes are accompanied by subjective perception of external supernatural influence (“black magic”)
Past interventions (6 months back)	The patient was prescribed Tab. Risperidone 2 mg/day and Tab. Escitalopram 10 mg/day approximately 6 months before admission, but adherence was irregular with frequent missed doses, and intake was inconsistent. During the present treatment period, both medications were continued regularly under supervision.
Current presentation	Confirmed history by patient and attender; ongoing mood disturbances, psychotic features, social withdrawal, occupational stress, and alcohol use; the patient had previously consulted psychiatric services and was prescribed Tab. Risperidone 2 mg/day and Tab. Escitalopram 10 mg/day for a duration of approximately 6 months;

Clinical examination stated the patient was alert, oriented, and cooperative, but had mild hand tremors, which may be suggestive of chronic alcohol use. His vital parameters were within normal range except for increased blood pressure 140/90 mmHg. Systemic examination of Cardiovascular, Respiratory, Abdominal, and Neurological examination did not reveal any gross deficits and cranial nerve findings also normal. Mental Status Examination (MSE) produced a well-groomed but obviously restive patient, who exhibited mild psychomotor agitation. Speech was coherent but occasionally tangential, mood invariably low but anxious at times and affect constricted/blunted. Cognition exhibited poor concentration, impairment of memory (*Smriti*) and mild reduction in abstract thinking (*Buddhi*). Insight was partial, and judgment was mildly compromised. Assessment of *Manasika Bhavas* was carried out using a structured CRF-based scoring system, wherein each parameter was graded on a scale of 0 to 3 (0 = Absent, 1 = Mild, 2 = Moderate, 3 = Severe) to quantify the severity of psychological attributes, yielding a total score of 18/27, indicating moderate to severe *Manasika Dushti*, with a predominance of *Shoka*, *Moha*, *Buddhi*, *Smriti*, *Jna*, *Samjna*, *Bhakti Sheela* and *Chinta*.

Evaluation of *Satva Bala* showed *Madhyama Satva* (score 2/3), characterized by partial insight, moderate coping ability, and dependence on external support for emotional regulation and treatment adherence. These findings are consistent with the involvement of *Rajas* and *Tamas* in the pathogenesis.

Diagnosis: Routine lab analyses including complete blood count, liver and renal functions, lipid profile, glycemic parameters, EEG and serum electrolytes were normal expected with some exceptions where total cholesterol was raised and glycemic parameters were elevated, ruling others that might have contributed to it out. Standardized rating scales was used to support the assessment, which revealed mild anxiety on Hamilton Anxiety Rating Scale (HAM-A) with score of 6, moderate-severe depressive factors on Hamilton Depression Rating Scale (HAM-D) with score of 25, mild impairment on Minimal State Examination (MMSE), substandard insomnia on Insomnia Severity Index (ISI) with score of 6, harmful consumption of alcohol on Alcohol Use Disorders Identification Test (AUDIT) with score of 15 and positive Columbian-Suicide Severity Positive and negative characteristics in PANSS (Positive and Negative Symptom

Scale) rating with a moderate severity (total score 86) were observed. **Diagnostic Challenges:** The case presented with some diagnostic challenges, first between psychotic and mood symptoms, and second, having chronic alcohol use obscuring the picture, along with other comorbid conditions, delayed presentation, financial constraints and some cultural beliefs with attributed to occurrences of black magic, which rendered appropriate clinical assessment and subsequent psychiatric care a challenging diagnostic issue.

Criteria for Diagnosis: As per presentation and DSM-5 criteria, the patient was diagnosed as Schizoaffective Disorder, Depressive type, and Alcohol use disorder, distinguishing it from major depressive, psychotic, and purely alcoholic conditions (ICD-11: F25) as these symptoms appear irrespective of each other. (Table.2) In Ayurveda, it correlates with features of *Sannipataja Unmada* with *Madatyaya* involving derangement of *Mansika Bhavas*.

Table 2: Differential Diagnosis

Condition	Key Clinical Features	Overlap with Present Case	Reason for Exclusion
Schizophrenia	Persistent psychotic symptoms (delusions, hallucinations), minimal mood symptoms	Presence of hallucinations, delusions, impaired cognition	Prominent and persistent depressive symptoms present; mood symptoms are significant → favors schizoaffective disorder
Major Depressive Disorder with Psychotic Features	Severe depression with mood-congruent psychotic features	Low mood, suicidality, psychotic symptoms	Psychotic symptoms occur independent of mood episodes for >2 weeks → excludes MDD with psychotic features
Bipolar Disorder with Psychotic Features	Episodic mania/hypomania with psychosis	Episodic course, psychotic symptoms	No history of manic/hypomanic episodes → ruled out
Substance-Induced Psychotic Disorder (Alcohol-induced)	Psychosis occurring during intoxication or withdrawal	Long history of alcohol use, tremors	Psychotic and mood symptoms persist beyond periods of intoxication/withdrawal → not solely substance-induced
Alcohol Use Disorder with Mood Symptoms	Mood changes secondary to chronic alcohol use	Alcohol dependence, depressive symptoms	Presence of independent psychotic symptoms and structured mood syndrome → primary psychiatric disorder exists
Delusional Disorder	Non-bizarre delusions without marked functional impairment	Paranoid ideation	Presence of hallucinations, mood symptoms, and functional decline → excludes
Organic Mental Disorder (e.g., metabolic, neurological)	Cognitive impairment, behavioral changes due to medical cause	Diabetes, hypertension, mild cognitive impairment	Normal EEG, labs (except metabolic parameters); no focal neurological deficits → organic causes unlikely

Prognosis: Guarded to moderate prognosis due to chronic illness and alcohol dependence; however, early improvement suggests a favorable outcome with sustained treatment adherence, abstinence, and regular follow-up.

Intervention: The patient was treated with multimodal holistic Ayurvedic intervention, which includes *Panchakarma*

(*Nasya* etc.) therapies, therapeutic *Yoga*, *Satwawajayachikitsa*, *Marma therapy* (Therapeutic Stimulation of Vital Points), along with *Shamana* medicines over a 3-month duration, *Nasya* was preferred due to its direct action on *Urdhvajatrugata* regions and *Manovaha* Srotas, and was considered safer in view of active psychosis,

chronic alcohol use, and comorbidities. *Virechana* and *Basti* were deferred. The 3-month treatment showed a significant reduction in delusional intensity (PANSS improvement) but not complete remission, indicating the need for long-term management. Challenges included poor prior adherence, difficulty in alcohol abstinence, fluctuating insight, and compliance with multimodal therapy. The timelines of management are stated in (Table 3) During the treatment period, the patient continued psychiatric medications, including Tab. Risperidone 2 mg/day and Tab. Escitalopram 10 mg/day. He was also maintained on previously prescribed anti-diabetic and anti-hypertensive medications Tab. Amlodipine 5 mg once daily and Tab. Metformin 500 mg twice daily, taken regularly without dose modification throughout the study period.

3. RESULTS:

Follow-up and Outcomes: After initiation of multimodal *Ayurvedic* therapy, serial assessments (at discharge, 15th day, 60th and 90th day) showed progressive improvement across all clinical scale and domains showing cognitive, emotional and functional recovery with reduced alcohol use and suicidality. (Table 3)

Adherence: Participant was instructed to maintain a daily log for documenting the timing, frequency, and completion of the prescribed intervention.

Tolerance: Participant was asked to report any discomfort, adverse events, or difficulties experienced during the treatment period through structured questionnaires and follow-up interviews.

Adverse effects: No adverse reactions were observed throughout this study

Table 3: Timeline of Comprehensive Treatment Plan at different time-points (IP-Inpatient-based and Home-based)

Therapy Type Intervention		Drugs / Materials	Dose / Duration	IP based	Home-based				
				(20/08 - 27/08/25)	27/08 - 04/09/25	05/09 - 19/09/25	20/09- 19/10/25	20/10 - 18/11/25	
Nasya	<i>Marsha Nasya</i>	<i>Kalyanaka Ghrita</i> (KLE Ayurved Pharmacy, Batch no:241/2)	8 drops each nostril, 7 days	✓	-	-	-	-	
	<i>Shirodhara</i>	<i>Brahmi Taila</i> (KLE Ayurved Pharmacy, Batch no:252)	1.5 L, 7 days	✓	-	-	-	-	
External Therapy	<i>Sarvanga Abhyanga & Bashpa Sweda</i>	<i>Bala-Ashwagandhadi Taila</i> (KLE Ayurved Pharmacy, Batch no:252)	Daily, 7 days	✓	-	-	-	-	
	<i>Shiropichu</i>	<i>Brahmi Taila</i> (KLE Ayurved Pharmacy, Batch no:252)	Home based daily after IP	-	✓	✓	✓	-	
	Shamana Medicines	<i>Agnitundi Vati</i> (KLE Ayurved Pharmacy, Batch no:251)	1 tab BID, prior 5 days	✓	-	-	-	-	
<i>Draksharishtam</i> (KLE Ayurved Pharmacy, Batch no:252)		3 tsp BID with warmwater	✓	-	-	-	-		

	<i>Brahmi Vati</i> (KLE Ayurved Pharmacy, Batch no:251)	2 tab BID	✓	✓	✓	✓	✓
	<i>Saraswatarishta</i> (KLE Ayurved Pharmacy, Batch no:252/2)	3 tsp BID with warmwater	–	✓	✓	✓	✓
	<i>Madiphala Rasayana</i> (KLE Ayurved Pharmacy, Batch no:252/2)	2 tsp BID with warmwater	–	✓	✓	✓	✓
Satwawajayachi kitsa (Psychotherapy)	<i>Manaprasadana</i> (Mental pacification), <i>Mananigrah</i> (Thought regulation) and <i>Asvasana</i> (Reassurance)	30 min daily / during visit	✓	✓	✓	✓	✓
Marma Therapy (Therapeutic Stimulation of Vital Points)	Gentle stimulation through pressure tech. to specific <i>marma</i> (<i>Indrabasti, Manibandha, Talahridaya</i>)	16 press per marma, once in a day (05 minutes)	✓	–	–	–	–
Yoga	<i>Asanas</i>	20 min daily, 60 days	✓	✓	✓	✓	✓
	<i>Pawanmuktasana, Tadasana, Shavasana</i>						
	<i>Pranayama</i>						
Controlled Breathing	<i>Nadi Shodhana</i> <i>Kumbhaka: Puraka: Rechaka</i> (1:2:1)						

Table 4: Follow-ups and Outcomes at different points in time

Follow-up point	Time since baseline	Clinician-assessed outcomes	Patient-assessed outcomes
Baseline	02/08/25	MMSE: 16/30 (moderate cognitive impairment); HAM-D-25, HAM-A-6, ISI-6 AUDIT: 15, C-SSRS- 11, PANSS-83	Gradual improvement in attention, memory, abstract thinking
Follow-up (Discharge)	27/08/25	MMSE:18, HAM-D- 20, HAM-A-5, ISI-5, AUDIT: 1415, C-SSRS-8, PANSS-76	Shift from moderate-to-severe to subclinical depressive symptoms
Follow-up 2 (15th Day)	04/09/25	MMSE:18, HAM-D-18, HAM-A-5, ISI-5, AUDIT: 13, C-SSRS- 6, PANSS-70	Reduction from mild to subclinical anxiety
Follow-up 3 (30th Day)	19/09/25	MMSE:22, HAM-D 14, HAM-A-4, ISI-4, AUDIT: 11, C-SSRS- 3, PANSS- 63	Marked improvement in memory, mood stability, minimal alcohol craving, independent daily functioning (no alcohol consumption in last 1 month)
Follow-up 4 (60th Day)	19/10/25	MMSE: 23 HAM-D-9, HAM-A-3, ISI-4, AUDIT: 8, C-SSRS- 1, PANSS-56	Steady decline in suicidal thoughts, minimal risk at 2 months
Follow-up 5 (90 th Day)	18/11/25	MMSE: 23 HAM-D-9, HAM-A-3, ISI-4, AUDIT: 8, C-SSRS- 1, PANSS-54	Gradual reduction in positive and negative symptoms, functional recovery

4. DISCUSSION

The present case highlights the effectiveness of multimodal holistic Ayurvedic intervention in a patient diagnosed with

Schizoaffective Disorder with Depressive type. The treatment was planned considering *Sannipataja Unmada* with *Madatyaya* [9] [10], along with comorbid Type 2 Diabetes

Mellitus and Hypertension, aiming at *Tridosha* balancing, *Tamas-Rajas* pacification, and *Manovaha Srotas* correction. Interventions like *Nasya*, *Shirodhara*, *Shamana Rasayanas*, *Satwawajaya Chikitsa*, *Marma* therapy, and *Yoga* were planned for their neurocognitive, anxiolytic, and Satva-enhancing effects, while also being safe and non-aggravating in metabolic disorders. The approach ensured holistic management addressing psychiatric symptoms, alcohol dependence, and metabolic stability simultaneously. *Nasya* with *Kalyanaka Ghrita* was administered considering the nose as the gateway to the head, [11] facilitating drug absorption through nasal mucosa and influencing central nervous system functions. [12] It aids in clearing vitiated *Doshas* from *Manovaha Srotas*. *Kalyanaka Ghrita*, indicated in *Unmada*, has *Medhya* properties and pacifies *Vata-Pitta*, improving cognition and emotional stability. [13] [14] *Shirodhara* and *Shiropichu* with *Brahmi Taila* promoted relaxation and psycho-somatic balance. [15][16] *Brahmi* exhibits anxiolytic and cognitive-enhancing effects. [17] *Sarvanga Abhyanga* and *Bashpa Sweda* with *Bala-Ashwagandha Taila* targeted *Majja Dhatu*, reducing psychomotor agitation and improving wellbeing. [18]

Shamana therapies including *Draksharishta*, *Saraswatarishta*, and *Brahmi Vati* provided *Medhya* and *Balya* effects. [19] *Saraswatarishta* has shown neuroprotective and antidepressant properties, [15] while *Draksharishta* aided *Agni* correction and reduced alcohol craving, and *Brahmi Vati* supported cognition. [20] *Satwawajaya Chikitsa* improved coping and emotional regulation, [21] while *Marma* therapy supported neurophysiological balance. [22] Yoga practices enhanced stress reduction and mental clarity. [23] Also, the observed improvements in blood pressure may be attributed to combined mechanisms including alcohol abstinence, sympathetic down-regulation, and modulation of the hypothalamic-pituitary-adrenal (HPA) axis. Therapies such as *Shirodhara* and *Nasya* exert *Vata-shamaka* and anxiolytic effects, contributing to autonomic recalibration and improved cardiovascular stability. Overall, the multidimensional Ayurvedic intervention demonstrated meaningful improvements across mood, cognition, psychotic experiences and alcohol-use parameters, highlighting its potential role as adjunct to standard pharmacotherapy in complex psychiatric presentations (figure 1).

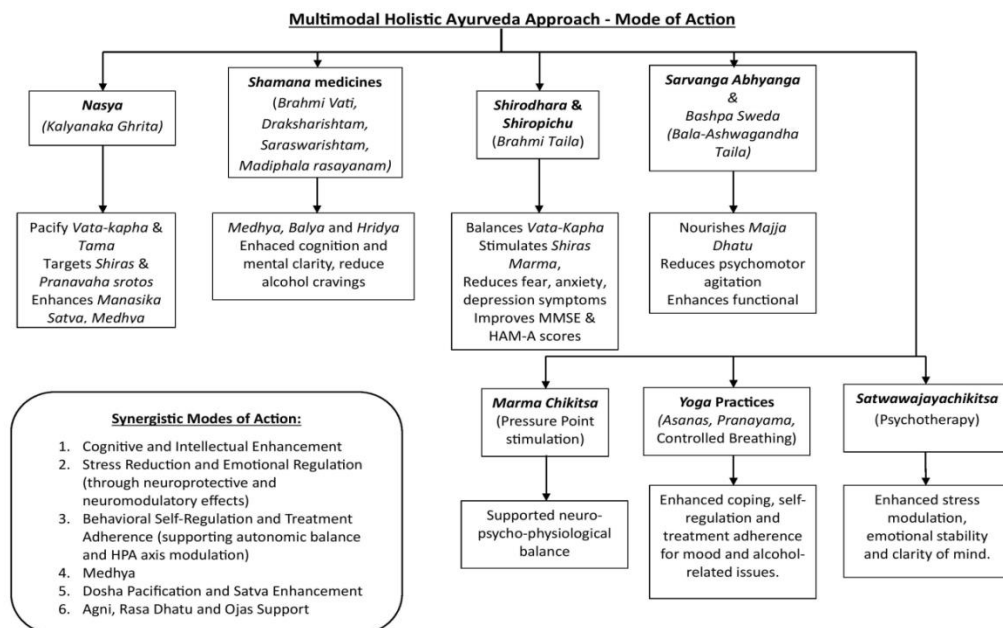


Figure 1: Mode of action of Multimodal Holistic Ayurveda treatment approach

5. CONCLUSION

This case highlights potential of multimodal Ayurveda treatment comprising panchakarma, external therapies, *yoga*, *satwawajayachikitsa*, *marma chikitsa* along with *shamana* medicines in managing complex psychiatric condition like schizoaffective disorder with alcohol use disorder. The case demonstrated partial improvement in both positive and negative psychotic symptoms (reduced PANSS and C-SSRS scores), a reduction in alcohol use, though complete abstinence was not sustained at 90 days. The findings indicate clinical improvement but not full remission, suggesting that prolonged, continuous treatment is necessary for stable outcomes. Challenges included maintaining alcohol abstinence, fluctuating insight, adherence to medications and therapies, and managing comorbid metabolic conditions. This led to cognitive, emotional, and functional recovery beyond symptom recovery. However, findings of this case report are limited by its single-case design, lack of a comparator, and observer bias. The takeaway message is that an individually tailored, holistic management approach can lead to multidimensional recovery in complex psychotic mood disorders, where functional recovery may be limited with conventional treatment alone. Further validation and standardization on a large scale are needed to ensure reliability and clinical applicability.

Declaration of Patient Consent – The authors confirm that they have acquired a patient consent form, in which the patient or caregiver has granted permission for the publication of the case, including accompanying images and other clinical details, in the journal. The patient or caregiver acknowledges that their name and initials will not be disclosed, and sincere attempts will be undertaken to safeguard their identity. However, complete anonymity cannot be assured.

Patient's Perspective: Both the patient and his family said that initially they were not certain about Ayurveda treatment. As he was frequently depressed, nervous and confused before the treatment despite conventional treatment, along some occasional hallucinations and also struggling to manage his alcohol consumption. After treatment they observed, he became more relaxed, more focused and more equipped to cope with stress and cravings following the extensive treatment including *Panchakarma*, *Yoga*, counseling

sessions, whereby his sleep, memory and daily functioning were improved. *Yoga*, home routine and follow up counseling helped him feel more capable of what and what to think than he used to. He became more active in his day to day activities and with other social people in his life, noticed his family.

Authors Details:

¹PhD Scholar, Mahatma Gandhi Ayurveda Medical College, Datta Meghe Institute of Higher Education and Research, Deemed to be a university, Wardha, Maharashtra

²Associate Professor, Department of Kayachikitsa, KLE Academy of Higher Education and Research, Deemed to be University, Shri BMK Ayurveda Mahavidyalaya, Shahpur, Belagavi, Karnataka, India- 590003

³Final Year Post Graduate Scholar, Department of Kayachikitsa, KLE Academy of Higher Education and Research, Deemed to be University, Shri BMK Ayurveda Mahavidyalaya, Shahpur, Belagavi, Karnataka, India- 590003

⁴Associate professor, Dept. of Samhitha Sidhantha, Mahatma Gandhi Ayurveda Medical College, Datta Meghe Institute of Higher Education and Research, Deemed to be a university, Wardha, Maharashtra

Authors Contribution:

Conceptualization and Clinical Management: BP, RBS, R.SD

Data Collection and literature search: BP, RBS

Writing -Original Draft: BP, R.SD

Proofreading/Copyediting: RBS, BP, R.SD

Consent to Publish Final Manuscript: All authors

Declaration of Generative AI

The authors declare this manuscript was written without the use of generative artificial intelligence tools. All the content, including text generation, data analysis and references was developed and reviewed by the author without assistance from AI technologies.

Conflict of Interest – The authors declare no conflicts of interest.

Source of Support – The authors declare no source of support.

Additional Information:

Authors can order reprints (print copies) of their articles by visiting:

<https://www.akinik.com/products/2281/journal-of-ayurveda-and-holistic-medicine-jahm>

Publisher's Note:

Atreya Ayurveda Publications remains neutral with regard to jurisdictional claims in published maps, institutional affiliations, and territorial designations. The publisher does not take any position concerning legal status of countries, territories, or borders shown on maps or mentioned in institutional affiliations.

REFERENCES:

1. Wy TJP, Saadabadi A. Schizoaffective disorder. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan–. Updated 2023 Mar 27. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK541012/>

2. Malaspina D, Owen MJ, Heckers S, Tandon R, Bustillo J, Schultz S, et al. Schizoaffective disorder in the DSM-5. *Schizophr Res*. 2013;150(1):21–25. <https://doi.org/10.1016/j.schres.2013.04.026>
3. Pavlichenko A, Petrova N, Stolyarov A. The modern concept of schizoaffective disorder: A narrative review. *Consortium Psychiatry*. 2024;5(3):42–55. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11542913/>
4. Azorin JM, Kaladjian A, Fakra E. Current issues on schizoaffective disorder. *Encephale*. 2005;31(3):359–365. Available from: <https://pubmed.ncbi.nlm.nih.gov/16142051/>
5. Morris J, Boness CL, Burton R. (Mis)understanding alcohol use disorder: Making the case for a public health first approach. *Drug Alcohol Depend*. 2023;253:111019. <https://doi.org/10.1016/j.drugalcdep.2023.111019>
6. Yadavaji Trikamaji, editor. *Charaka Samhita of Charaka*, Chikitsasthana, Chapter 9, Verse 13–14. Reprint ed. Varanasi: Chaukhambha Orientalia; 2015:468.
7. Yadavaji Trikamaji, editor. *Susruta Samhita of Susruta* with Nibandhasangraha commentary of Dalhanacharya, Sutrasthana, Chapter 1, Verse 5. Reprint ed. Varanasi: Chaukhambha Orientalia; 2019:6.
8. Sharma S, Dash B, editors. *Charaka Samhita of Charaka* with Chakradatta's Dipika commentary, Chikitsa Sthana; Madatyaya Chikitsa, Chapter 24, Verse 6. Reprint ed. Varanasi: Chaukhamba Sanskrit Series; 2019:89.
9. Bhisagacharya Harisastri Paradakara Vaidya, editor. *Astangahridayam of Vagbhata*, Sutrasthana, Chapter 20, Verse 1–2. Reprint ed. Varanasi: Chaukhambha Orientalia; 2015:287.
10. Sharma RK, Dash B, editors. *Charaka Samhita of Charaka* with Chakradatta's Dipika commentary, Chikitsa Sthana; Unmada Chikitsa, Chapter 9, Verse 25–28. Reprint ed. Varanasi: Chaukhamba Sanskrit Series; 2019:421–422.
11. Paradkar BH, editor. *Astangahridayam of Vagbhata* with Sarvanga Sundara commentary of Arunadatta and Ayurveda Rasayana commentary of Hemadri, Sutra Sthana; Nasyavidhi Adhyaya, Chapter 20, Verse 5. Reprint ed. Varanasi: Chaukhambha Sanskrit Series; 2006:287.
12. Ramteke RS, Patil PD, Thakar AB. Efficacy of Nasya (nasal medication) in coma: A case study. *Anc Sci Life*. 2016;35(4):232–235. <https://doi.org/10.4103/0257-7941.188188>
13. Sharma RK, Dash B, editors. *Charaka Samhita of Charaka* with Chakradatta's Dipika commentary, Sutra Sthana; Annapanavidhi, Chapter 27, Verse 231–232. Reprint ed. Varanasi: Chaukhamba Sanskrit Series; 2019:537.
14. Sharma RK, Dash B, editors. *Charaka Samhita of Charaka* with Chakradatta's Dipika commentary, Sutra Sthana; Annapanavidhi, Chapter 27, Verse 231–232. Reprint ed. Varanasi: Chaukhamba Sanskrit Series; 2019: 537.
15. Dhuri KD, Bodhe PV, Vaidya AB. Shirodhara: A psycho-physiological profile in healthy volunteers. *J Ayurveda Integr Med*. 2013;4(1):40–44. <https://doi.org/10.4103/0975-9476.109550>
16. Chaudhari MP, Prasad KSR. Brahmi Taila Shiroabhyanga in Chittodwega (Anxiety Neurosis). *J Indian Syst Med*. 2014;2(3):127–131. <https://doi.org/10.5005/JISM-11051-02304> Deo YK, RK C. Critical review on pharmacological properties of Brahmi. *Int J Ayurvedic Med*. 2013;4(2). Available from: <https://doi.org/10.47552/ijam.v4i2.238>
17. Deo YK, RK C. Critical review on pharmacological properties of Brahmi. *Int J Ayurvedic Med*. 2013;4(2). <https://doi.org/10.47552/ijam.v4i2.238>
18. Javed D, Anwar S, Gupta D, Dhama Y. Shirodhara and Abhyanga for better sleep, reduced mental stress, and improved heart rate variability: A case report. *J Ayurveda Case Rep*. 2023;6(2):45–49. https://doi.org/10.4103/ijacr.ijacr_47_22
19. Kulkarni R, Girish KJ, Kumar A. Nootropic herbs (Medhya Rasayana) in Ayurveda: An update. *Pharmacogn Rev*. 2012;6(12):147–153. Available from: <https://pubmed.ncbi.nlm.nih.gov/23055641>
20. Parekar RR, Jadhav KS, Marathe PA, Rege NN. Effect of Saraswatarishta in animal models of behavioural despair. *J Ayurveda Integr Med*. 2014;5(3):141–147. <https://doi.org/10.4103/0975-9476.140469>
21. Pandey VB, Rathi RB, Pandey S, Verma J. Scope of management of academic stress with Sattvavajaya Chikitsa. *Int J Ayurvedic Med*. 2023;14(1):50–56. <https://doi.org/10.47552/ijam.v14i1.3258>
22. Choudhary M, Rajan A, Sharma S. Psychological benefits of Marma therapy. *Int Ayurvedic Med J*. 2025;13(4). <https://doi.org/10.46607/iamj3213042025>
23. Capon H, O'Shea M, McIver S. Yoga and mental health: A synthesis of qualitative findings. *Complement Ther Clin Pract*. 2019;37:122–132. <https://doi.org/10.1016/j.ctcp.2019.101063>