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Switching from Antipsychotic Polypharmacy to Monotherapy in Hebephrenic Schizophrenia: A Case Study

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ABSTRACT: Schizophrenia is a chronic psychiatric disorder that imposes a substantial burden on patients and caregivers. Antipsychotic polypharmacy remains a common clinical practice to manage persistent positive and negative symptoms, although growing evidence indicates it does not significantly improve treatment outcomes and may instead increase adverse effects, treatment costs, and non-adherence. This case study aimed to describe the clinical benefits and rational considerations of switching from antipsychotic polypharmacy to monotherapy in a patient with hebephrenic schizophrenia. A 37-year-old woman with a 20-year history of hebephrenic schizophrenia was observed. She had previously received a combination of chlorpromazine and trifluoperazine with trihexyphenidyl for extrapyramidal symptom prevention. Clinical evaluations were performed to assess therapeutic effects, side effects, and medication adherence before and after the switch to chlorpromazine monotherapy. During the polypharmacy phase, the patient experienced several side effects, including insomnia, restlessness, irritability, and mild extrapyramidal symptoms. After transitioning to monotherapy with an adjusted chlorpromazine dose, she showed notable improvement in psychotic symptoms, sleep quality, and social functioning without severe adverse reactions. Medication adherence increased as the patient reported greater comfort and tolerance with a single-drug regimen. This case suggests that switching from antipsychotic polypharmacy to monotherapy can reduce side effects, improve adherence, and maintain clinical stability. Rational and individualized use of antipsychotics should be prioritized to achieve better long-term outcomes and quality of life in schizophrenia management.

Keywords: Hebephrenic Schizophrenia, Polypharmacy, Monotherapy, Antipsychotic, Medication Adherence.

INTRODUCTION

Schizophrenia is a severe and chronic psychiatric disorder characterized by disturbances in perception, thought, emotion, and behavior, profoundly impacting the individual's ability to function in daily life and maintain social relationships. It affects approximately 24 million people worldwide, making it one of the leading causes of disability among mental illnesses (Organization, 2023). The heterogeneity of

schizophrenia presents significant challenges in diagnosis and treatment, necessitating tailored approaches to address the diverse symptom profiles observed across patients. Among its various forms, hebephrenic schizophrenia—also known as disorganized schizophrenia—is distinguished by early onset, flattened affect, and disorganized speech and behavior, often leading to significant functional impairment from a young age. Although recent diagnostic systems have eliminated subtype classifications, the hebephrenic type remains clinically relevant because of its chronic course, poor prognosis, and limited functional recovery, often requiring long-term, multifaceted management strategies (Cahyaningsih & Syahrul, 2019). The persistent nature of symptoms in hebephrenic schizophrenia frequently leads to complex treatment regimens, as clinicians strive to address both positive and negative symptoms that are resistant to first-line interventions.

Pharmacological management remains the cornerstone of schizophrenia treatment, with antipsychotic medications serving as the primary tool for symptom control and relapse prevention. However, antipsychotic polypharmacy—the concurrent use of two or more antipsychotic agents—has become a widespread yet controversial practice in clinical psychiatry, often implemented in an attempt to achieve better symptom control when monotherapy proves insufficient (Hashimoto et al., 2023; Kim et al., 2022). Clinicians often adopt polypharmacy when monotherapy fails to control persistent positive, negative, or cognitive symptoms, driven by the clinical urgency to stabilize patients experiencing severe psychosis or functional deterioration. Despite its popularity, accumulating evidence shows that polypharmacy does not consistently improve therapeutic efficacy and may increase adverse effects such as extrapyramidal symptoms, sedation, and metabolic disturbances, in addition to raising treatment costs and complicating medication adherence (Lin, 2021) Yulianty et al., 2017; (Gallego et al., 2012). The rationale for polypharmacy often stems from the desire to target multiple neurotransmitter systems simultaneously, but this approach may inadvertently lead to excessive dopamine blockade, resulting in heightened side effect burden without corresponding therapeutic benefits.

Several recent systematic reviews and meta-analyses have reaffirmed that antipsychotic monotherapy should remain the standard of care whenever feasible, emphasizing the importance of optimizing single-agent regimens before considering combination therapy (National Institute for Health and Care Excellence (Hatta et al., 2018; *National Institute for Health and Care Excellence (NICE)*, 2023). For instance, (Lawrence et al., 2024) reported that high-dose therapy and polypharmacy offered no significant advantages over standard-dose monotherapy but were associated with more frequent side effects, suggesting that increasing medication burden does not necessarily translate to improved outcomes. Likewise, a large nationwide cohort study in South Korea found that patients on monotherapy—particularly those using clozapine—had lower hospitalization and relapse rates than those on multiple antipsychotics, highlighting the potential benefits of streamlined treatment approaches (Zhang et al., 2022). These findings emphasize the importance of rational prescribing and individualized treatment strategies in schizophrenia care, advocating for a balanced approach that prioritizes patient safety and long-term stability over aggressive pharmacological interventions that may compromise tolerability and adherence.

Beyond pharmacological safety, polypharmacy also poses challenges to medication adherence, which is a key determinant of relapse and long-term outcomes in schizophrenia management. Complex regimens and multiple side effects often lead patients to discontinue medication prematurely, contributing to recurrence and reduced quality of life, creating a cycle of instability that undermines treatment goals (Mubin et al., 2019) (Dwidiyanti & Sari, 2019; Velligan et al., 2017). Consequently, switching from polypharmacy to monotherapy represents a promising strategy to enhance adherence, reduce adverse effects, and improve overall treatment tolerability, potentially breaking the pattern of relapse and hospitalization that characterizes poorly managed schizophrenia (Stroup & Gray, 2018). This approach aligns with the principles of patient-centered care, which emphasize simplifying treatment regimens to match patients' capabilities and preferences, thereby fostering greater collaboration in the therapeutic process and improving outcomes through sustained engagement.

Despite increasing evidence supporting antipsychotic monotherapy, there remains a scarcity of detailed, case-based reports illustrating the clinical rationale, process, and outcomes of switching from polypharmacy to monotherapy in specific schizophrenia subtypes. This gap is particularly relevant for hebephrenic schizophrenia, where chronicity and poor adherence often complicate long-term management, necessitating innovative approaches to treatment optimization. Therefore, the present case study aims to describe the therapeutic reasoning, clinical outcomes, and practical considerations of transitioning from antipsychotic polypharmacy to monotherapy in a patient with hebephrenic schizophrenia, contributing to evidence-based optimization of pharmacotherapy in chronic psychotic disorders. By examining the nuances of treatment modification in a real-world context, this report seeks to provide clinicians with practical insights into deprescribing strategies that balance efficacy with tolerability, ultimately enhancing the quality of life for patients navigating the complexities of schizophrenia management.

METHOD

This report employed a qualitative descriptive case study design to illustrate the clinical process of switching from antipsychotic polypharmacy to monotherapy in a patient diagnosed with hebephrenic schizophrenia. A case study approach enables in-depth exploration of real-world clinical decision-making, emphasizing the rationale for treatment modification and the observed outcomes in symptom control, tolerability, and adherence, providing rich contextual details that quantitative methods may overlook (Green & Thorogood, 2022; Yin, 2018). This methodological choice allows for a comprehensive examination of the individual factors influencing treatment response, including patient-specific characteristics, caregiver dynamics, and environmental variables that collectively shape the therapeutic journey. Through detailed narrative description, the case study format captures the complexity of clinical decision-making in psychiatry, where treatment choices must balance empirical evidence with personalized considerations, offering valuable insights for practitioners facing similar challenges in their practice.

The case was managed at the Psychiatric Outpatient Clinic of Islamic Hospital Surabaya Jemursari, in collaboration with the Department of Psychiatry, Faculty of Medicine, Universitas Nahdlatul Ulama Surabaya. Informed consent was obtained from the patient's biological mother, who served as her primary caregiver, ensuring that ethical standards were maintained throughout the treatment and documentation process. Ethical approval was obtained in accordance with institutional regulations and the Declaration of Helsinki for research involving human participants, safeguarding the patient's rights and welfare while contributing to the advancement of clinical knowledge (W. M. Association, 2013). The collaborative nature of this case management highlights the importance of interdisciplinary cooperation in psychiatric care, where medical expertise, family support, and institutional resources converge to create a supportive treatment environment that addresses both biological and psychosocial dimensions of illness.

The subject was a 37-year-old woman with a 20-year history of hebephrenic schizophrenia, first diagnosed at the age of 17, marking the beginning of a prolonged struggle with psychiatric symptoms that significantly impacted her developmental trajectory and life course. She exhibited incomplete remission, auditory hallucinations, disorganized behavior, and recurrent insomnia following irregular medication adherence, creating a pattern of instability that hindered her ability to achieve consistent functional recovery. The patient lived with her mother, having previously married at age 14 and later divorced, leading to long-term social withdrawal and functional decline, illustrating how early-onset psychosis can disrupt normal social maturation and independent living. Her living situation, characterized by dependence on maternal support, reflects the broader social challenges faced by individuals with severe mental illness, where family caregivers often become essential partners in treatment management and daily functioning, bearing significant emotional and practical burdens.

For several years, the patient had been treated with a polypharmacy regimen consisting of chlorpromazine 100 mg twice daily, trifluoperazine 5 mg twice daily, and trihexyphenidyl 2 mg twice daily, representing a typical approach to managing complex schizophrenia symptoms through combined pharmacological action. Despite adherence to this regimen, her mother reported limited improvement in psychotic symptoms and frequent adverse effects including restlessness, confusion, insomnia, irritability, and transient syncope, suggesting that the treatment burden may have outweighed the therapeutic benefits. Episodes of medication discontinuation often led to relapse, characterized by aggression and self-harming behavior, highlighting the delicate balance between symptom control and treatment tolerability in chronic schizophrenia management (Hashimoto et al., 2023; Lin, 2021). This pattern of treatment response underscores the challenges of polypharmacy, where increased medication load may paradoxically undermine stability by provoking side effects that compromise adherence, ultimately perpetuating the cycle of relapse and recovery that defines poorly controlled psychotic illness.

After psychiatric re-evaluation, the clinical team decided to switch from polypharmacy to monotherapy with chlorpromazine, based on a comprehensive assessment of the patient's symptom profile, side effect burden, and treatment history. This decision was based on its pharmacological

profile, which includes sedative, anxiolytic, and anti-aggressive properties suitable for managing disorganized behavior and insomnia, offering a targeted approach to the patient's most distressing symptoms while minimizing unnecessary pharmacological complexity (Maslim, 2019). The switching followed a cross-tapering method designed to ensure continuity of symptom control while gradually reducing medication burden, a strategy that balances the need for stability during transition with the long-term goal of regimen simplification. Specifically, the transition involved: Weeks 1–2: gradual reduction of trifluoperazine while maintaining chlorpromazine 100 mg twice daily; Weeks 3–4: discontinuation of trifluoperazine with continuation of chlorpromazine 100 mg twice daily and trihexyphenidyl 2 mg daily to prevent extrapyramidal symptoms. Follow-up assessments were conducted weekly during the first month and monthly for the subsequent six months to monitor symptom stability, side effects, and medication adherence, allowing for timely adjustments and supportive interventions as needed (Keks et al., 2019; Takeuchi et al., 2022). This structured approach to treatment modification exemplifies careful clinical management, where gradual changes are accompanied by close monitoring to mitigate risks and optimize outcomes, demonstrating how systematic deprescribing can be integrated into routine psychiatric practice.

Clinical outcomes were evaluated through four primary domains: 1. Symptom changes — improvement or relapse of hallucinations, behavior, and mood disturbances; 2. Side-effect profile — presence of extrapyramidal symptoms, sedation, or autonomic disturbances; 3. Medication adherence — assessed through caregiver reports, refill records, and clinician evaluation; 4. Functional recovery — improvement in social interaction, daily activities, and sleep pattern. Although no standardized psychiatric scales such as the Positive and Negative Syndrome Scale (PANSS) or Clinical Global Impression (CGI) were used, qualitative observations provided comprehensive insight into clinical progress and tolerability, capturing nuanced changes that may not be fully reflected in quantitative metrics. This multidimensional assessment framework acknowledges that treatment success in schizophrenia extends beyond symptom reduction to encompass functional improvement, quality of life, and caregiver burden, reflecting a holistic approach to psychiatric care that values patient and family perspectives alongside clinical observations. The inclusion of adherence metrics recognizes the central role of medication consistency in determining long-term outcomes, while functional assessments connect pharmacological management to real-world recovery goals, bridging the gap between clinical intervention and daily living.

Data were analyzed descriptively using a qualitative clinical evaluation approach, focusing on narrative synthesis of observed changes across treatment phases rather than statistical comparison. Changes in symptoms, adverse effects, and adherence were compared between the polypharmacy and monotherapy phases, with attention to patterns of improvement or deterioration that might inform clinical decision-making. Interpretations were made within the framework of recent literature on rational pharmacotherapy and antipsychotic switching strategies, contextualizing individual observations within broader evidence-based practices (Keks et al., 2019; Lawrence et al., 2024; Zhang et al., 2022). This analytical approach prioritizes clinical relevance over methodological rigor, aiming to generate practical insights that can inform similar treatment decisions in other settings, while

acknowledging the limitations inherent in single-case analysis. By grounding observations in established pharmacological principles, the analysis seeks to balance idiographic detail with nomothetic understanding, contributing to the ongoing dialogue about optimal schizophrenia management while respecting the uniqueness of individual treatment journeys.

RESULT AND DISCUSSION

Clinical Course

Before the therapeutic switch, the patient continued to exhibit persistent psychotic symptoms, including auditory hallucinations, irritability, and disorganized behavior, despite years of pharmacological intervention, indicating treatment resistance or inadequate regimen optimization. Despite long-term administration of chlorpromazine and trifluoperazine, her condition remained unstable, leading to multiple hospitalizations over the past decade, reflecting the recurrent nature of her illness and the limitations of the existing treatment approach. Family members frequently reported insomnia, restlessness, and episodes of aggression, highlighting the pervasive impact of uncontrolled symptoms on both the patient and her support system, and underscoring the need for a treatment reevaluation that might break this pattern of instability. The chronicity of her symptoms and the frequency of acute exacerbations suggested that the polypharmacy regimen, while intended to enhance control, may have contributed to a cycle of side effects and non-adherence that ultimately undermined therapeutic goals, necessitating a fundamental reconsideration of pharmacological strategy.

During the polypharmacy phase, treatment adherence was inconsistent due to distressing side effects such as restlessness, confusion, transient syncope, and excessive sedation, creating a barrier to consistent symptom management. The caregiver reported that the patient often discontinued medication once symptoms improved, resulting in relapse within one to two weeks, illustrating how side effect burden can directly compromise treatment continuity and long-term stability. This pattern of intermittent adherence reflects a common challenge in schizophrenia management, where immediate adverse experiences overshadow long-term preventive benefits, leading to a cycle of treatment initiation and discontinuation that perpetuates illness chronicity. The caregiver's observations provide valuable insight into the practical realities of medication management in home settings, where family members must navigate complex trade-offs between symptom control and treatment tolerability, often without professional guidance during critical decision points.

After switching to chlorpromazine monotherapy, gradual stabilization of psychotic symptoms was observed within three weeks, suggesting that simplified treatment may enhance neurobiological adaptation and reduce competing pharmacological effects. The patient demonstrated improved sleep quality, reduced irritability, and diminished frequency of hallucinations, indicating broad-based improvement across symptom domains that had previously been resistant to intervention. No significant extrapyramidal symptoms were observed, and mild drowsiness resolved within the first week of adjustment, reflecting favorable tolerability of the monotherapy regimen compared to the

previous combination approach. This positive response to treatment simplification challenges the assumption that complex symptom profiles necessarily require complex pharmacological solutions, suggesting instead that reducing medication burden may sometimes enhance overall treatment effectiveness by improving tolerability and adherence. The timing of improvement aligns with typical antipsychotic onset patterns, while the absence of severe side effects supports the safety of carefully managed deprescribing in this clinical context.

Adherence and Tolerability

Following the simplification of the treatment regimen, medication adherence markedly improved, suggesting that regimen complexity represents a significant barrier to consistent medication use in this population. Caregiver reports indicated an increase in adherence from approximately 60% during the polypharmacy phase to about 95% during the monotherapy phase, reflecting a substantial enhancement in treatment consistency that likely contributed to observed clinical improvements. The patient showed better understanding and comfort with her medication routine and expressed satisfaction with the simplified regimen, indicating that treatment simplification may empower patients through increased comprehensibility and reduced burden, fostering greater engagement in their own care. These adherence gains demonstrate how pharmacological interventions intersect with behavioral and cognitive factors in determining treatment outcomes, where regimen acceptability influences implementation success independently of direct neurobiological effects.

No severe adverse reactions or psychiatric emergencies occurred throughout the six-month follow-up period, supporting the safety of supervised antipsychotic simplification in stable outpatient settings. Regular clinical evaluations showed stable mood, consistent behavioral control, and no clinically relevant changes in vital signs or body weight, indicating that monotherapy maintained physiological stability while reducing previous side effect burdens. This safety profile is particularly important in chronic schizophrenia management, where long-term treatment sustainability depends on balancing efficacy with tolerability, and where adverse effects often dictate treatment discontinuation more than lack of therapeutic effect. The absence of metabolic changes or significant autonomic disturbances suggests that chlorpromazine monotherapy, while carrying its own side effect profile, may present a more favorable risk-benefit ratio than the previous combination regimen in this specific clinical scenario, though individual variation necessitates careful monitoring in all cases.

Functional and Behavioral Outcomes

Over the course of monotherapy, the patient demonstrated notable improvement in social and functional domains, indicating that treatment benefits extended beyond symptom reduction to encompass broader recovery goals. She began assisting her mother with household chores, maintained regular sleep patterns, and engaged in limited social activities within her neighborhood, reflecting

gradual reintegration into family and community life that had been previously limited by psychiatric instability. The caregiver also reported reduced burden and fewer disruptive episodes, indicating enhanced psychosocial stability that benefited both the patient and her support system, highlighting the reciprocal relationship between patient functioning and caregiver well-being in chronic illness management. These functional improvements represent meaningful outcomes that translate pharmacological efficacy into real-world benefits, connecting medication management to quality of life enhancements that matter most to patients and families navigating long-term mental health challenges.

Summary of Clinical Findings

A concise comparison between the patient's condition before and after switching therapy is presented in Table 1, which synthesizes multidimensional outcomes across treatment phases. The table highlights key domains of change, providing a structured overview of treatment effects that complements the narrative description of clinical course. This comparative format facilitates quick assessment of treatment impact while preserving the complexity of clinical observation, serving as a practical reference for clinicians considering similar treatment modifications in their own practice. The tabular presentation organizes qualitative data into accessible categories, bridging the gap between detailed case narrative and summary evaluation, and demonstrating how multiple outcome domains can be integrated into a comprehensive assessment of treatment success.

Table 1. Clinical Comparison Before and After Switching Antipsychotic Therapy

Parameter	Polypharmacy (Chlorpromazine + Trifluoperazine)	Monotherapy (Chlorpromazine)
Symptom control	Partial improvement; frequent relapse	Stable remission for ≥6 months
Side effects	Restlessness, insomnia, confusion, syncope	Mild drowsiness (transient)
Medication adherence	~60% (frequent discontinuation)	~95% (consistent intake)
Behavioural control	Aggression, irritability	Calm, cooperative
Sleep pattern	Fragmented, difficulty initiating sleep	Regular 7–8 hours/night
Social functioning	Isolated, dependent	Assists mother, improved interaction
Hospitalization frequency	Multiple admissions (≥2/year)	None within 6-month follow-up

Summary of Clinical Findings

Overall, switching from polypharmacy to monotherapy produced notable clinical benefits across multiple domains, suggesting that treatment simplification can simultaneously address efficacy, tolerability, and functional outcomes. The patient experienced a marked reduction in adverse effects,

accompanied by improved adherence and better sleep regulation, creating a positive feedback loop where reduced side effects enhanced treatment consistency, which in turn promoted greater symptom stability. Symptom remission was sustained throughout the six-month follow-up period, with stable behavior and reduced irritability, indicating that monotherapy provided adequate antipsychotic coverage for this patient's specific symptom profile without the additional burden of combined pharmacological action. In addition, her daily functioning improved, as reflected by increased participation in household activities and enhanced social interaction, which also contributed to greater caregiver satisfaction, demonstrating how pharmacological optimization can create ripple effects throughout the patient's ecosystem of care. These findings collectively indicate that simplifying the antipsychotic regimen to a single-drug therapy can maintain clinical stability, minimize pharmacological burden, and improve overall treatment tolerability, offering a viable alternative to polypharmacy in selected cases where combination therapy has not yielded optimal results. The comprehensive nature of improvement across biological, psychological, and social domains underscores the interconnectedness of treatment elements in schizophrenia management, where changes in one area often catalyze improvements in others, creating synergistic benefits that exceed the sum of individual interventions.

This case study illustrates the clinical process and therapeutic outcomes of switching from antipsychotic polypharmacy to monotherapy in a patient with hebephrenic schizophrenia, providing concrete examples of how deprescribing principles can be applied in real-world psychiatric practice. The transition to a single-drug regimen resulted in improved medication adherence, fewer adverse effects, and stable symptom remission over six months, demonstrating that treatment simplification can yield comprehensive benefits without compromising efficacy. These findings are consistent with contemporary evidence emphasizing monotherapy as the preferred strategy for long-term management of schizophrenia, while adding practical detail about implementation challenges and solutions in complex clinical scenarios (Lin, 2021; (*National Institute for Health and Care Excellence (NICE)*, 2023). The case contributes to a growing body of literature questioning routine polypharmacy in schizophrenia, while affirming that careful, individualized treatment modification can enhance outcomes even in chronic, treatment-resistant presentations, offering hope for optimization in challenging clinical situations.

Interpretation of Findings

The improvement observed following the switch to chlorpromazine monotherapy was likely influenced by the drug's sedative and anxiolytic properties, which contributed to better sleep and behavioral regulation, addressing core disturbances in hebephrenic schizophrenia beyond straightforward antipsychotic action. In contrast, the previous combination with trifluoperazine may have intensified dopaminergic blockade, leading to confusion, restlessness, and extrapyramidal symptoms—adverse effects commonly associated with excessive D_2 receptor antagonism that may have paradoxically exacerbated behavioral dysregulation (Keks et al., 2019; Yulianty et al., 2017)

(Correll et al., 2020). This pharmacological interpretation suggests that polypharmacy may sometimes create iatrogenic complications through cumulative receptor effects that undermine therapeutic goals, particularly when medications with similar mechanisms are combined without clear synergy. The case illustrates how understanding individual medication profiles and their interactive effects can inform more precise prescribing, moving beyond symptomatic matching toward mechanistic optimization that considers both intended and unintended pharmacological consequences.

These results support the pharmacological principle that antipsychotic polypharmacy should be reserved for cases in which adequate monotherapy trials have failed, rather than employed as first-line strategy for complex presentations. International treatment guidelines, including those from the National Institute for Health and Care Excellence (NICE, 2023) and the American Psychiatric Association (A. P. Association, 2020), recommend that concurrent antipsychotic use be limited to brief transitional periods or to treatment-resistant cases where clozapine is ineffective or poorly tolerated, emphasizing the importance of sequential optimization before considering combination approaches. The positive clinical course observed in this patient highlights the therapeutic feasibility and safety of carefully supervised deprescribing strategies, challenging assumptions about the necessity of polypharmacy in chronic schizophrenia management. This case adds to evidence supporting guideline recommendations by demonstrating successful implementation in a real-world setting, providing a model for other clinicians considering similar treatment modifications in their practice, while acknowledging the need for individualized assessment and monitoring throughout the process.

Comparison with Existing Literature

Findings from this case align with results from large real-world studies examining antipsychotic prescribing patterns and outcomes, suggesting that observations from individual cases can reflect broader treatment principles. Kim et al. (2022) demonstrated that patients maintained on antipsychotic monotherapy, particularly clozapine, exhibited lower relapse and hospitalization rates compared to those on multiple agents, supporting the long-term advantages of streamlined treatment approaches. Similarly, Lawrence et al. (2024) reported no significant advantage of high-dose or combination antipsychotic therapy over standard-dose monotherapy, but noted a higher frequency of adverse reactions and treatment discontinuation in the polypharmacy group, highlighting the risk-benefit imbalance that often characterizes combined regimens. Moreover, Hashimoto et al. (2023) found that simplifying antipsychotic prescriptions during hospitalization improved adherence and reduced extrapyramidal side effects in chronic schizophrenia patients, suggesting that deprescribing benefits extend across treatment settings and patient populations. Collectively, these findings support the growing clinical consensus that rational monotherapy can provide comparable efficacy with improved safety and adherence, though implementation requires careful patient selection and monitoring (Hasan et al., 2021; Tiihonen et al., 2019). This case contributes qualitative depth to these quantitative findings, illustrating how guideline recommendations translate into clinical actions and patient experiences, bridging the gap between population-level evidence and individual treatment decisions.

Clinical Implications

This case underscores the importance of individualized pharmacotherapy in chronic schizophrenia management, where treatment decisions must balance general principles with specific patient characteristics and circumstances. Simplifying the regimen not only improved the patient's adherence and symptom stability but also enhanced her social functioning and caregiver satisfaction, demonstrating how pharmacological interventions can create positive ripple effects throughout the patient's life and support system. For clinicians, the case demonstrates that deprescribing or switching strategies, when guided by close monitoring and patient engagement, can reduce unnecessary medication load while maintaining clinical efficacy, offering a practical approach to optimizing long-term treatment outcomes. Furthermore, strengthening the therapeutic alliance between the clinician, patient, and family is crucial in ensuring long-term adherence and relapse prevention, highlighting that pharmacological management occurs within relational contexts that significantly influence implementation success (Stroup & Gray, 2018; Velligan et al., 2017). These implications extend beyond pharmacological technique to encompass broader aspects of psychiatric care, including communication, education, and collaborative decision-making that empower patients and families in the treatment process, fostering sustainable management approaches that adapt to changing needs over time.

Limitations and Future Directions

While this report contributes valuable insight into the benefits of monotherapy, several limitations should be acknowledged to contextualize findings appropriately. As a single-case study, the findings cannot be generalized to all schizophrenia populations, and individual variation in treatment response necessitates caution when applying these observations to other clinical scenarios. The absence of standardized psychometric instruments such as the Positive and Negative Syndrome Scale (PANSS) or the Clinical Global Impression (CGI) limits the objectivity of clinical improvement measurement, though qualitative assessment captures dimensions of change that may be missed by standardized tools. Additionally, the six-month follow-up duration restricts conclusions regarding long-term relapse prevention and functional recovery, and extended observation would be needed to determine whether benefits persist beyond the initial transition period. These limitations highlight the complementary roles of different research methodologies in building clinical knowledge, where case studies generate hypotheses and illustrate principles that can then be tested through more systematic investigation.

Future research should employ prospective or longitudinal designs with larger sample sizes to evaluate clinical, functional, and metabolic outcomes of antipsychotic simplification, providing stronger evidence for deprescribing strategies in schizophrenia management. Incorporating patient- and caregiver-reported outcomes would further enrich understanding of adherence dynamics and quality-of-life improvements following pharmacological streamlining, capturing perspectives that are essential to treatment success but often underrepresented in clinical research. Studies comparing different

switching strategies, such as cross-tapering versus direct substitution, could optimize implementation approaches, while investigations of predictors for successful monotherapy conversion would help identify patients most likely to benefit from treatment simplification. Additionally, research examining the neurobiological correlates of polypharmacy versus monotherapy might elucidate mechanisms underlying differential treatment responses, connecting clinical observations to underlying pharmacological processes. These future directions would build upon case-based insights to develop more systematic approaches to antipsychotic optimization, ultimately improving outcomes for individuals navigating the complex landscape of schizophrenia treatment across diverse clinical settings and cultural contexts.

CONCLUSION

This case report demonstrates that switching from antipsychotic polypharmacy to monotherapy can be a safe and effective strategy for patients with chronic schizophrenia, including the hebephrenic subtype, offering a viable approach to treatment optimization when combination therapy yields suboptimal results. The transition to chlorpromazine monotherapy led to reduced adverse effects, improved medication adherence, and sustained clinical stability over a six-month observation period, illustrating comprehensive benefits across multiple outcome domains that matter to patients, families, and clinicians. These improvements highlight how pharmacological simplification can enhance treatment experience without sacrificing efficacy, creating conditions for long-term management success through improved tolerability and consistency.

These findings highlight the significance of rational and individualized antipsychotic prescribing, prioritizing minimal effective doses and avoiding unnecessary drug combinations that may complicate rather than enhance treatment outcomes. Simplifying pharmacotherapy not only minimizes pharmacological burden but also promotes patient comfort, caregiver cooperation, and better psychosocial functioning, connecting medication management to broader recovery goals that extend beyond symptom control. This case illustrates how deprescribing principles can be applied in psychiatric practice through careful assessment, gradual implementation, and ongoing monitoring, providing a model for optimizing complex regimens in chronic mental illness.

More broadly, this report underscores the need for routine re-evaluation of polypharmacy practices in schizophrenia management, challenging automatic continuation of combination therapy without periodic assessment of continued necessity and benefit. Clinicians are encouraged to adopt a stepwise deprescribing approach supported by close monitoring, patient education, and shared decision-making to optimize long-term therapeutic outcomes and quality of life, integrating pharmacological management within a comprehensive care framework that addresses biological, psychological, and social dimensions of illness. By balancing evidence-based principles with individualized considerations, psychiatric practice can move toward more sustainable treatment approaches that

respect patient autonomy while providing effective symptom management, ultimately transforming the therapeutic journey for individuals living with schizophrenia and their families.

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