

# Information for Families: Schizophrenia



## Pamphlet No. 1

- WHAT IS SCHIZOPHRENIA
- HOW SHOULD ONE BEHAVE
- MAINTAINING YOUR OWN HEALTH
- TAKING MEDICATIONS
- RECOMMENDED MEDICATION DOSAGES

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## WHAT IS SCHIZOPHRENIA?

Schizophrenia is the most persistent and disabling of the major mental illnesses. People usually develop schizophrenia between the ages of 16 and 30, as they are beginning to realize their potential. It affects approximately one in 100 people worldwide, (one per cent of the population), affecting men and women almost equally. While it is treatable in many cases, there is as yet no cure.

The mind controls the basic functions of thinking, feeling (emotions), perception (the five senses) and behaviour. These functions ordinarily work together, enabling us to:

- tell the difference between fantasy and reality
- keep anxiety at manageable levels
- have appropriate emotional responses
- make sense of what happens to us
- maintain a stable sense of who we are
- establish and maintain relationships with others

In schizophrenia, the interaction of these mental functions is disturbed in various ways. The word schizophrenia does not mean “split personality” but a disruption of the balance among mental functions.

### THE CAUSES

We do not yet understand what causes this condition. Scientists generally agree that schizophrenia is a group of conditions rather than one simple disease and may therefore be found to have several causes. It is generally accepted by researchers that defects in the brain—chemical or structural, or both—may play a part in the disorder.

Genetic research also suggests that while no one gene has been found for schizophrenia, several genes may cause a predisposition that can be triggered by certain life events.

### THE SYMPTOMS

Symptoms vary greatly. Common symptoms are:

**Delusions:** False, but strongly held beliefs, which feel entirely real to the sufferer. They can cause the individual to have a greatly exaggerated belief in his or her own importance, power, knowledge, abilities, or identity. Some people have delusions of persecution (paranoia)—for example, the false belief that they are being attacked, harassed, cheated, spied on or conspired against by others. Some people believe that occurrences in the outside world are referring to them (ideas of reference). Examples are believing that other people are doing things because of you or that the TV or radio are referring specifically to you, often in negative ways.

**Hallucinations:** Seeing, hearing, feeling, touching smelling or tasting things that aren't there. Hallucinations have to do with the senses. Hearing voices is the most common hallucination among people with schizophrenia.

**Illusions:** Disturbances in perception that are less intense than hallucinations. The individual experiences periods of heightened sensory awareness, during which sounds seem louder or sharper than usual and colours appear brighter, or periods of muted awareness, when sensory input seems closed off. Other illusions may include objects seeming closer or farther away than they really are, or one's own voice or reflection seeming different or even threatening.

**Thought Disturbances:** Often called muddled thinking by those who experience

them, thought disturbances are characterized by an inability to concentrate, to connect thoughts logically, or to think clearly. Thought processes may speed up (racing thoughts) or slow down, or may seem blocked so that the person's mind feels completely blank. Disturbances in thinking are sometimes compared to a broken filter that allows everything that enters the mind to have the same importance—for example, attaching the same significance to licence plate numbers as to a questions from a teacher.

**Emotional & Behavioural Changes:** The person can experience sudden, inexplicable changes in mood, such as intense sadness, happiness, excitement, depression or anger that come on without reason or warning. Lack of feelings can be equally disturbing. Symptoms that deprive a person of a range of normal emotions are often described as negative symptoms. The person seems less able to feel anything, including pain or joy. Sometimes this loss of feeling extends to the "sense of self". The individual experiences a sense of unreality about who and where s/he is or where their body ends. More than any of the symptoms described above, the behavioural changes indicate to others the possible presence of the condition.

An early sign of disturbance is often **social withdrawal**, as the individual finds interactions with people and things progressively more difficult. One such common response is inability to take an interest in personal hygiene and appearance. Lack of energy, interest and motivation or decreased levels of activity, movement or speech should alert friends and family that something may be amiss. Similarly, behaviour patterns that are unusual in the particular individual, or responses that are clearly inappropriate (excessive laughing or crying in inappropriate circumstances, or excessive talking to oneself) may indicate the approach of an episode of schizophrenia.

## THE TREATMENT

**Some Statistics:** Studies from past years indicate that after 10 years 25% of people diagnosed with schizophrenia have recovered fully. Another 25% are able to function with minimum support. A further 25% need family and social supports to continue to function. 15% do not respond to treatment and 10% have died prematurely, the majority of these from suicide. And physical health complications.

**Medications:** New medications for schizophrenia along with better prescribing practices (more appropriate dosing), make treatment more successful than in the past. Schizophrenia is treated with medications called antipsychotics. In the last 10 years new compounds have been introduced that have significantly fewer side-effects. In addition it has been recognized that stabilization and recovery are significantly enhanced with the complimentary treatment of social, employment, and family supports.

Anti-psychotic medications work on several levels. They can have an immediate calming effect, reducing anxiety, agitation and restlessness in the person with symptoms of schizophrenia. It can take up to four weeks to reduce symptoms such as hallucinations. Thought disturbances and paranoia are more resistant to medications.

Some people are unwilling to take tablets, even for a short period, because they do not believe they are ill, or because of a previous unpleasant experience with medication. In addition to tablets, medications are also available by injection every two to three weeks. These are especially helpful for people who tend to lose or forget to take their pills.

A growing amount of research into the action of medication offers hope for the invention of better medications in the

future. It goes without saying that patients are more willing to take medications when they feel that they are doing them good.

#### **Social Supports & Rehabilitation:**

People with schizophrenia are particularly vulnerable and need social supports—decent housing, income support, supportive friends and family, and something worthwhile to do. Most people

with schizophrenia become ill at the age they would be making career choices, undergoing training and forming adult relationships. As a result, they have been unable to develop their social and work skills. So in addition to medication, they may need training in social skills, money management and problem-solving. Those who can work often need further training and employment support.

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## HOW SHOULD ONE BEHAVE

### **Overview**

It may seem odd that one has to ask, "How should one behave towards a person with schizophrenia or an allied disorder?" However, most people do not understand what it is that makes it difficult for people with the disorder to communicate. The general public feels embarrassed and sometimes frightened to hold a conversation with a person who has a mental illness. This article tries to give some pointers on how to behave (for families, mental health professionals and the general public).

### **Speak Slowly & Clearly**

We have learned that we need to speak slowly and clearly to persons with schizophrenia—to make the sentences short so that they are not too complicated and to wait to make sure that what we are saying is reaching the person.

Why is this technique useful? A person with schizophrenia explains: "My concentration often floats in and out so that I only hear part of a sentence. Maybe I will miss two or three words. This will make it very difficult for me to understand. Recently I went on a family outing. There were other families there and I could hear everything that everyone was saying to everyone else. The sound and all the people moving about came in on me so much I began to get quite

frightened. I was agitated and irritated at the same time. I felt I wanted to defend myself in some way. My dad took me to a quiet place where we sat and had a cup of tea. We didn't talk about it. We just sat and drank our tea and I began to feel less threatened."

### **Provide Structure**

People who are, as we say, living a normal life, have structure in their lives provided by their work and family life. People with schizophrenia who are not recovered enough to work also need structure. This the family and the professional carer (psychiatrist, social worker) can attempt to provide. Routines that are comforting and predictable are useful to someone whose medical condition often makes life very unpredictable. It is useful to help them set up a schedule and a few tasks to accomplish at certain times of the day or week.

Is it possible to achieve this? Some people with schizophrenia are very disabled or become so from time to time. It is not always possible for them to follow a schedule, although it is beneficial to try to maintain a definite routine, like getting up at a regular time, or going for dinner with a family member on a regular day. It is important to involve family and friends as they may be able to help by arranging social events outside the person's home. Examples: invite the person to go shopping,

watch a sport, baby-sit his/her nieces, nephews.

### **Accomplishing Tasks**

The family and the person often feel more comfortable with each other if the person who is unwell is invited to perform a few tasks. Remembering that this may be difficult for them it is important to apply the same principles as in normal conversation, that is: **be clear and uncomplicated when explaining what is to be done.**

When your relative, client or friend attempts a task but isn't able to complete it or does it wrong it is not at all helpful to say things like: "Can't you get anything right?" or "I might as well have done it myself". Even when you are very frustrated stay calm. See if the task can be broken down into even more simple steps to create the possibility of success and to encourage the feeling of being useful. **Give only one instruction at a time.**

### **Maintain Equilibrium**

Sometimes you may feel you are walking on eggs when your relative or someone you know is having a particularly difficult time. At that time you have to summon up all your energy so that you can maintain their trust while at the same time maintaining equilibrium at home. Here are some ideas towards that goal:

- Be friendly
- Be accepting
- Be encouraging
- Make time to listen
- Include them
- Treat them with respect

These behaviours should also be adopted by the general public. **Avoid the following:**

- Being patronizing
- Being critical

- Pushing them into situations they are not comfortable with
- Being gloomy
- Arguing with them, or with others while they are present
- Giving them a lecture or talking too much
- Getting yourself into difficult situations with them.

### **When a Crisis Comes**

Sooner or later when a person has schizophrenia a crisis will occur. When this happens there are some things you can do to reduce or avoid the potential for disaster. Here are a few pointers:

- Remember that you cannot reason with acute psychosis
- Remember that the person may be terrified by his/her own feelings of loss of control
- Do not express irritation or anger
- Do not shout
- Do not use sarcasm as a weapon
- Decrease distractions— turn off TV, radio, fluorescent lights that hum, etc.
- Ask any casual visitors to leave—the fewer people the better
- Avoid direct continuous eye contact
- Avoid touching the person
- Sit down and ask the person to sit down also

### **Changes in Circumstances**

It is quite common for people with schizophrenia to move house often, possibly in the hope of making things better for themselves. This complicates things for their professional carers, their families and their friends, because they fail to tell people of the move. The best solution is to keep in regular contact not less than once a week, for family and

friends, and not less than once a month for professional carers.

This cannot be considered "over-protective". It is just one way of not losing contact with someone you love. It is very difficult for people who are unwell to take responsibility for keeping people informed. Some members of the public take the attitude: "Well, s/he has to learn!" But it may be that learning is not possible for someone who is not always stable, and whose thinking can be muddled. It is important for everyone to realize that this is the result of illness and not willful behaviour.

By keeping in touch regularly and being willing to discuss day-to-day activities and problems we can avoid the complications that arise when we are not involved, e.g. a pension or social assistance cheque fails to arrive and the person is cut off from benefits. Bank communications, bills, etc., are not received and not paid. Rent is neglected, and the person is evicted. Possessions are left behind. Premises are left unclean. Our advice is look after these matters if you suspect your friend/ relative won't.

### **Offer Choices**

People like to feel that they are in control of their lives. Sometimes it is difficult to persuade someone with schizophrenia to do what is best for them. Thus it is useful to offer a choice. "Will you take a walk now or after lunch", might be a way to suggest a walk, a shower, or any activity that you may feel useful or enjoyable. Another choice is: "Will you take your medications this morning or later on?" This suggestion may avoid any confrontation that might occur about taking medications.

People with schizophrenia often have feelings that change very frequently, so that what someone may refuse at this moment he or she may agree to do later in the day or week. This also gives the person some

degree of control in their lives.

### **Going to the Doctor**

A person with schizophrenia gives their perspective: "A lot of people I know complain that they want to get real counseling from their psychiatrists, but often the psychiatrist is mainly interested in the medications. They would like to talk about their housing and they would like to talk about what the psychiatrist can do to help them get back to work, or at least what would be their strengths if they tried.

"I am sure there are people who have found their psychiatrists helpful like this, but with me the trouble is that I find it difficult to stay in the office more than a few minutes and generally answer 'Fine', to any questions. If he suggests that I see the social worker, that just seems like another burden for me! Making appointments is difficult especially if I have to make a phone call. I need a lot of encouragement and real physical help in order to do this. I have such high anxiety just walking in the out-patient door that by the time the doctor says 'Come in,' all I want to do is get out of there!"

### **Holiday Times or Festivals**

A sister speaks:

"I dread holiday times when families are all supposed to get together, eat and drink and generally enjoy each others' company. For me, times like these bring back feelings of disappointment, resentment, sadness and a whole host of other emotions. Christmas, for example, has not been a good time for me or the family for many years. There were times my brother was in hospital, times he was home but barely stable, times he had to be taken to hospital during the holiday, times the police came. If I dread it, what does it mean to him? When he thinks a lot is expected of him, he usually handles it well for a few hours, but after that he 'crashes' - I mean he retreats to his inner self, or he gets extremely agitated. Last year each

visiting family member took my brother aside for a mini-visit in a quiet room, a one-on-one chat and that seemed to work a little. At least he knew everyone cared. But when it came to the big dinner he disappeared to his room. He just cannot process a lot of noise, people, snatches of conversation—it's just too much for him."

### **Final Thoughts**

Do you help frail, old ladies across the street? Use some of that attitude in rethinking your treatment and interaction with a person who suffers from schizophrenia who may live near you. This doesn't mean that you need to be overly friendly, but don't ignore them. Engage them in conversation,

but don't be intrusive. People with schizophrenia, like a physically frail person, cannot defend themselves as well as a person in full possession of physical and mental powers.

Some people are on heavy doses of medication that may slur their speech or make them react slowly. (Quite often this is mistaken for drunkenness.)

Take into account that sometimes the person may be anxious and may withdraw. Let people withdraw, but "leave the door open". Maybe ask them to visit you when they feel they are able. Offer a cake or a plant or some other friendly gesture. Send or drop off a postcard or greeting card with a brief, friendly message every so often.

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## **MAINTAINING YOUR OWN HEALTH**

Too often families coping with a brain disorder in a close relative neglect their own health. They are so emotionally involved that they fail to realize that they are under tremendous strain. This pamphlet is based on ideas from families around the world.

When anyone gets sick with any serious disorder they go through the various stages outlined in this pamphlet. Disbelief and denial are the first to appear, followed shortly after by blame and anger. When someone becomes ill with a brain disorder like schizophrenia, feelings and emotions are not very much different. What may be different is the long time people take to recognize mental illness and the need to seek treatment.

We hope that the pointers presented here will help families understand that feelings of loss, blame and sorrow are quite normal and that there are ways of overcoming them in time.

### **Denial**

Most people, when faced with the diagnosis

of schizophrenia in a loved one, go through a phase of denial. This makes it very difficult for other members of the family to cope. Any efforts they make on the "patient's" behalf may be stymied when another family member won't accept the diagnosis. This type of denial is a form of self-protection. Removing the defences of a family member in denial can be difficult and distressing. Arguments may occur to disrupt the household even further.

There is no particular solution to this problem, except to provide information about schizophrenia so that the person can see that many of the events happening in the family could be related to the disorder. Time may be the ingredient necessary for acceptance, even when knowledge and support are available.

### **Blame**

Sometimes families look around for a scapegoat for their situation. A common one is the doctor/psychiatrist. Sometimes the victim himself comes in for some blame. The sooner everyone realizes that the real enemy

is the brain disorder itself, the sooner they can begin to cooperate with each other and work towards the person's recovery.

### **Shame**

To come to terms with feelings of shame, it is necessary to assess how you felt about mental illness before it happened to you. If your attitude was of compassion before, then you may have no problem with shame. If you viewed mental illness with fear, extreme embarrassment or even horror, your feelings of shame will be difficult to overcome. Remember that 30 years ago people were ashamed if a relative developed cancer. It was spoken of in whispers because it frightened and horrified people. Today no one would dream of being ashamed about cancer. Through education, understanding and better medical knowledge, society has come to terms with a devastating disease. In time, this will be true about schizophrenia.

You may feel that you cannot tell anyone about the schizophrenia in your family, but making up false excuses or white lies for your relative's behaviour will only compound the problem which is difficult enough. Confide in close friends who will lend positive support.

Finding the words is sometimes difficult. Calling schizophrenia "a mental breakdown" or a "thought disorder" is an introduction to further explanation if you cannot bring yourself to say the word. Explain some of the symptoms. Your friends will want to know, as you did, what schizophrenia means. You may want to join a self-help group where your problems will be treated in confidence, where you can speak freely about your experiences and fears.

In many countries, schizophrenia family organizations provide a help line where you can talk about your situation. You should also request information from this source. There are also chat sites on the internet.

### **Guilt**

Whenever anyone gets any illness, members of the family wonder how the illness developed. The difference with mental illness is that society has, for a long time, erroneously believed that it had to do with family life or events in one's past. Thus people spend endless hours wondering if in some mysterious way they could be responsible for the illness. It is doubtful whether families can avoid this soul searching but it is important that this initial reaction be overcome.

By listening to informed speakers through a self-help group (WFSAD can provide literature and put you in touch with a local group), by watching documentary films and listening to radio programs about schizophrenia and by speaking to other families experiencing similar problems, you will realize that you are not to blame. More and more research indicates that schizophrenia is a biological brain disease with an as yet unknown cause.

Guilt over being well while one's loved one is ill is a common occurrence, particularly among siblings. It is difficult to enjoy your successes—a first job, attending college, relationships with friends, while your brother or sister has none of these. It is paradoxical that dwelling on these things may reduce your own self-worth. Parents may not appear to value your achievements because they do not want to upset the person who is ill. Support from close friends should enable you to rebuild your sense of self-esteem and your ability to be proud of your own achievements. Parents should not neglect their children who are well.

### **Anger**

Strong emotions are natural when your suspicions are confirmed by a diagnosis of a brain disorder. Realize that anger can be destructive to other members of the family as well as to yourself. Your relative will also sense a more stressful environment.

When anger or grief are overwhelming, release these emotions in as harmless a way as possible, away from your family. This release may take the form of vigorous physical activity. One relative bought an old punching bag from a boxing gymnasium and hung it in his garage. Another would drive to a quiet spot and scream as loud as she could for several minutes to release the built up tension. A third relative enjoyed squash and would force himself to go to the squash court and play at times of anxiety. Some relatives simply go out for a long walk or run. Everyone should experience the release of tears, the body's own way of reducing tension.

None of us is perfect, so from time to time anger will spill over when you are caring for a sick relative and you will raise your voice in frustration. Many things that are said in anger are bitterly regretted afterwards. Try to maintain some control.

### **Acceptance**

Accepting illness is often looked on as proof that you are not going to fight against it. It suggests resignation. Those who have been diagnosed quite naturally often feel that they are unable to accept the diagnosis.

Coming to terms with a brain disorder means knowing the stigma and fear with which society has surrounded it. If you accept what people say about the possible long term nature of the illness, then hopes and dreams for the future are in jeopardy. Families sometimes continue to seek the same goals for their relatives, despite the limitations that the illness may impose on them. Not only the person, but also his family has to come to terms with the degree of disability imposed by the symptoms of schizophrenia, while still maintaining hope for the future.

When this is done, small measures of recovery can give rise to optimism and pleasure. This takes time. You may understand that you must accept what has

happened, but actually feeling acceptance will be a long process. Knowledge can help family understand and begin to accept. Accepting does not mean giving up hope. It means that you reduce the frustrations which stem from unrealistic objectives.

### **Happiness**

Even happy moments are difficult to enjoy. Sometimes it seems as if there are no happy moments. We are so busy seeing to the needs of our relative that we are worn out. Families have found that by putting parts of their lives into what one could call "compartments," they are able to feel some happiness. Thus, they force themselves not to worry about what might happen tomorrow so that they may enjoy a happy event today.

A sense of humour has helped many a family through difficult times. Laughter is therapeutic as long as you are all laughing together. Periodic breaks away from your relative will "recharge your batteries." Parents may have always shared holidays before. If this is not possible now, each family member must have recreational time free from worry.

### **Caring**

Sometimes a care giver tries to compensate for what she/he has lost in his relative by becoming over protective. Personal pain is assuaged by the total management of the relative's life. The person, often the mother, becomes dependent on the caring role, in some cases treating an adult son or daughter like a child. This is not only destructive to the care giver, it is also stressful to the person with schizophrenia. The motto should be "Moderation in Caring."

### **Knowledge**

The more you learn about schizophrenia the more you will realize that you are far from being alone. The major mental illnesses are thought to have a prevalence of 5% (United States National Institute of Mental Health statistics). Schizophrenia itself has a lifetime

prevalence of 1 in 100. Your knowledge will arm you against any ignorance you meet. You will feel satisfaction in being able to impart the knowledge you have learned.

### **Making Adjustments**

When serious illness hits a family all the usual, well known behaviours of all the members are upset. Everyone has to adjust

to the new reality. Because schizophrenia is a disease so closely associated with feelings and perceptions it is all the more important that the family react without too much display of emotion. It is also important that the person with the disorder does not feel abandoned because everyone is so perplexed. Quiet reassurances of love and respect are needed between all members of the family.

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## **TAKING MEDICATIONS**

One of the major problems people with schizophrenia or other mental illnesses must face is the need to take medications over a long period of time, sometimes for their whole life. Over the long term there may be many reasons that a person does not wish to continue to take medication. Some people refuse to take medications right from the start. Remember also that people with other conditions such as heart disease often do not adhere to their medication regimen! There are no fail-safe solutions to help some one to keep taking their medication. However, here are some reasons people do not take medications (*in italics*) and some tips that the patient, the family or friends may find useful.

***Forgets to take them – no one to remind him***

***Confusion over when to take the tablets***  
***Annoyed that people keep reminding them to take their tablets***

Take pills only once a day

Use a pill case which has various compartments and days of the week marked

Family member puts pills ready on kitchen table each evening so it becomes routine and doesn't have to be talked about a lot

***Doesn't think he needs them any more because he feels better since taking them***

Explain that the pills only control symptoms **while** you take them. Without pills the symptoms will return usually within weeks.

***Doesn't think he needs them – lack of insight into his condition***

For those with no insight it can be helpful to remind the patient of times when he was well and on medication, how much better he looked – but do not belabour your point. Bring it up from time to time.

***Doesn't like the feeling of being a patient all her life***

***Embarrassed about taking medications all the time***

Advise the person that many people have to take pills/ injections all their life: people with diabetes, high blood pressure, heart problems, arthritis, etc.

***Doesn't feel normal on the medications in some way: sluggish, feels drugged.***

***Doesn't like the side effects: tremor; muscle spasm; general muscular discomfort; weight gain.***

Make sure the doctor is aware of unpleasant side effects or too large/small a dose and their effects on your functioning. There must be a balance between control of symptoms and ability to function. When medications are given at a dose that is able to control symptoms, yet leave the patient feeling at least somewhat normal, a person is much more likely to continue to take them.

While wanting to stop the medication may be linked with being fed up with taking pills it is also linked to the amount of recovery from symptoms and behaviours that people feel when they take them. It is unrealistic to expect a person to continue to take a medication which may control symptoms but makes him feel even worse.

Many of the medications prescribed for mental illness have a weight gain component. However, some medications can cause severe weight gain in some people. If the person feels really well, s/he has to decide whether the new body weight changes how s/he feels about him/herself; does it reduce self esteem? Does it impact health? In some cases the person may do just as well on another medication but without the weight gain. There may be a need to discuss healthy eating habits and caloric intake.

#### **Doesn't like injections/ blood tests**

This may be because of the embarrassment of having to undress to get the needle. It is usually possible to have the injection in the thigh or even upper arm to avoid this. No one likes injections but all children must submit to them on a routine basis to be protected against illnesses, so why not you, as an adult.

#### **Cannot afford to stay on the medications**

In cases of real hardship clinics may provide patients with supplements of sample medication. In some countries the pharma-

ceutical companies have a program for those who cannot afford to pay full price. In some countries there are government entitlements that cover medication costs. Find out what help is available in your country.

#### ***Finds it difficult to keep doctor appointments and get renewed prescription***

Ask the receptionist at the clinic if you can be reminded of your appointment the day before. If you miss your appointment request the doctor to call you to see why. Some families leave an envelope with a little cash at the doctor's office for pick-up by the patient after seeing the doctor to increase motivation.

#### ***Trust not built up between patient and physician/ Doses of medication are too high; too low***

Sometimes these two reasons go together. It is important that family indicate to the doctor their interest in keeping their sick loved one as well as possible. They are the support for the patient in explaining things to the doctor when the person has difficulty expressing what they feel.

For those living with a person who has mental illness, understanding about why people don't like to take medications is only one aspect of caring for someone at home. Knowing more about the illness and how you should behave and respond will help you understand your relative's behaviours and symptoms.

**RECOMMENDED ANTIPSYCHOTIC DOSAGE RANGES FOR THE  
TREATMENT OF SCHIZOPHRENIA**

**Dosage Table from the Schizophrenia Patient Outcomes Research Team (PORT) Report  
published in 2004 in the Schizophrenia Bulletin (Vol. 30, No.2.)**

Medication	Chlorpromazine equivalence <sup>1</sup>	Acute therapy	Maintenance Therapy
<b>First generation antipsychotic medications</b>			
Fluphenazine HCl	2	6-20 mg/day	6-12 mg/day
Fluphenazine decanoate <sup>2</sup>	NA	NA	6.25-25 mg/2Wks
Trifluoperazine	5	15-50 mg/day	15-30 mg/day
Perphenazine	10	30-100 mg/day	30-60 mg/day
Mesoridazine	50	150-400 mg/day	150-300 mg/day
Chlorpromazine	100	300-1,000 mg/day	300-600 mg/day
Thioridazine	100	300-800 mg/day	300-600 mg/day
<b>Butyrophenone</b>			
Haloperidol	2	6-20 mg/day	6-12 mg/day
Haloperidol decanoate <sup>3</sup>	NA	NA	50-200 mg/4wks
<b>Others</b>			
Thiothixene	5	15-50 mg/day	15-30 mg/day
Molindone	10	30-100 mg/day	30-60 mg/day
Loxapine	10	30-100mg/day	30-60 mg/day
<b>Second generation antipsychotic medications</b>			
Clozapine	NA	150-600 mg/day	150-600 mg/day
Risperidone	NA	2-8 mg/day	2-8 mg/day
Olanzapine	NA	10-20 mg/day	10-20 mg/day
Quetiapine	NA	300-750 mg/day	300-750 mg/day
Ziprasidone	NA	120-160 mg/day	120-160 mg/day
Aripiprazole	NA	10-30 mg/day	10-30 mg/day

Note – NA = not applicable

1: Approximate dose equivalent to 100 mg of chlorpromazine (relative potency); it may not be the same at lower vs. higher doses. Chlorpromazine equivalent doses are not relevant to the second generation antipsychotics and therefore are not provided for these agents.

2: Fluphenazine decanoate dosage recommendations are based on an empirical rule suggested by Kane (1996) (25 mg every 3 wks of decanoate is equivalent to 665 chlorpromazine equivalents per day). These are theoretically determined values and should be interpreted as approximations only (Baldessarini et al. 1988).

3: Haloperidol decanoate dosage recommendations are based on the following rules: 5 mg oral haloperidol (250 chlorpromazine equivalents) per day is equivalent to 50 mg haloperidol decanoate every month. These are theoretically determined values and should be interpreted as approximations only (Zito 1994)

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