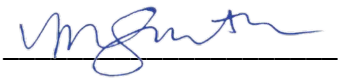
Behavioral Health Services (BHS)

Psychotic Disorders
Clinical Practice Guideline

2026

Approval	Signature	Date
Michelle Smith Deputy Director		7/22/2026

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Introduction

Purpose

This guideline advises on the treatment and management of psychosis and schizophrenia in adults. The guideline recommendations consider the perspectives of multidisciplinary teams of healthcare professionals, people with psychosis and schizophrenia, their families and guideline methodologists after careful consideration of the best available evidence and practices. It is intended that the guideline will be useful to clinicians and service providers in providing and planning high quality care for people with psychosis and schizophrenia while also emphasizing the importance of the experience of care for people with psychosis and schizophrenia and their caregivers.

Intended Audience

All staff providing direct clinical services within the Health Care Agency's (HCA) Behavioral Health Services (BHS) County-operated and County-contracted programs, referred to as **BHS Providers** throughout this document, are the target audience for these Guidelines. BHS Providers include licensed and pre-licensed clinicians, supervisors, medical staff, peer support, and other non-clinical direct service providers.

Background

Development of Guideline

This Practice Guideline was developed in 2026 by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, researchers, nurses, social workers and case managers who represent all BHS areas (e.g., Adult and Older Adult Behavioral Health, Children and Youth Services, Crisis and Acute Care, Forensics, Justice Involved and Reentry, Substance Use Disorders and Quality Management Services). The Practice Guideline Workgroup was developed to create standardized clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g. internet resources) in the field.

Selection of Evidence

Existing practice guidelines developed by national and international associations were used as resources in the development of this Practice Guideline. Journal articles referencing established guideline recommendations were also included. All resources used to develop these guidelines were published in the years 1998 through 2025.

Documentation of Need

Justification

Schizophrenia is a diagnostic term describing a serious mental disorder that affects approximately 1% of the world population; more than 20 million people (McGrath et al. 2008). Schizophrenia imposes a substantial financial burden on individuals, families, and societies.

The economic cost of schizophrenia reached nearly $367 billion for roughly 3.1 million US adults in 2024, driven largely by unpaid caregiving, premature mortality, unemployment, and other indirect costs (1). Results from the study published in *JAMA Psychiatry* showed the estimated national societal cost of schizophrenia was $366.8 billion. Among the more than 3 million adults with schizophrenia spectrum disorders, 68% lived independently, 19% lived in supportive housing, 5% were in long-term or skilled nursing care, 5% were incarcerated, and 3% were unhoused.

Twenty percent of the national estimate was attributed to direct costs. This included healthcare ($37 billion), homelessness and supportive housing ($35 billion), justice system factors ($12 billion), and benefits from social security disability ($5 billion). Indirect costs included unpaid wages and out-of-pocket expenses for caregivers ($149 billion after cost offsets), patient unemployment and reduced wages ($55 billion), premature mortality ($47 billion), and quality-of-life issues ($41 billion).

On the state level, total schizophrenia costs varied, with California's costs at $45.6 billion and Wyoming's at $600 million. Alaska had the highest per-person cost at $126,222, while Utah had the lowest at $110,975. Cost-of-living differences, size of unhoused populations, and mortality rates were among the factors that affected local variations in costs.

The findings suggest a 'substantial, multisector schizophrenia-related economic burden with state-level variation', highlighting the need for better coordinated care and cross-sector responses (1).

Consistency with Policies, Regulations, Laws, and Professional Standards

Definition of Terms

Psychosis – The word psychosis is used to describe conditions that affect the mind, in which people have trouble distinguishing between what is real and what is not. When this occurs, it is called a psychotic episode (2). Psychosis appears in a person's late teens or early twenties. Approximately three out of 100 people will experience an episode of psychosis in their lifetime (2). Psychosis affects men and women equally and occurs across all cultures and socioeconomic groups.

Psychosis is comprised of a collection of symptoms that indicate a disconnection from reality where a person might experience hallucinations (false perceptions) or delusions (false beliefs). Psychosis can be caused by mental and physical conditions including schizophrenia, schizoaffective disorder, brief psychotic disorder, delusional disorder, substance-induced psychotic disorder and other medical conditions like brain trauma or dementia. Psychosis can also happen with certain types of mood disorders including bipolar disorder and major depression. The symptoms of psychosis are often categorized as either "positive" or "negative".

First Episode Psychosis (FEP) – The initial experience of a psychotic episode is considered the marker for first episode psychosis. The first episode of psychosis can be frightening, confusing and distressing. Psychosis is treatable. Many people recover from a first episode and never experience another psychotic episode.

Positive Symptoms – Positive symptoms are experiences or behaviors that represent an excess or distortion of the person's normal functioning. They include:

- Delusions – false beliefs that are firmly held and are out of keeping with the person's cultural environment. Common delusions include belief of:
    - being followed by others
    - being monitored by camera
    - possessing special abilities or powers
    - certain songs or comments communicating a hidden meaning
    - one's thoughts being controlled by an outside force
- Hallucinations – during psychosis, people may hear, see, taste, or feel something that is not actually there. Examples include hearing voices or noises no one else can hear, seeing things that are not there, or experiencing unusual physical sensations. These changes in perception are considered hallucinations.
- Disorganized speech, thoughts or behavior – disorganized speech might involve a person switching rapidly from one subject to the next, or being so garbled that speech is not comprehensible; people experiencing psychosis may have changes in their thinking patterns and may find it hard to concentrate and follow a conversation, thoughts may speed up, slow down or become jumbled and not make sense; behavior may also be disorganized in such a way that they

have difficulty performing daily activities like cooking meals, self-care, or expressing the appropriate affect social situations.

Negative Symptoms – Negative symptoms involve normal functioning becoming lost or reduced. Negative symptoms are not as obvious to identify as positive symptoms. They may include:

- restricted emotional and facial expression
- restricted speech and verbal fluency
- difficulty with generating ideas or thoughts
- reduced ability to begin tasks
- reduced socialization and motivation

Other Symptoms – Other symptoms or difficulties often occur alongside the psychotic symptoms. They include:

- cognitive symptoms, such as difficulties with attention, concentration, memory and executive function (e.g., planning and organizing, sequencing, and behavioral inhibition)
- mood changes where the person may be unusually excited, depressed or anxious, or have highly changeable mood swings
- suicidal thoughts or behavior
- substance abuse
- sleep disturbances
- difficulties in functioning

Duration of Untreated Psychosis (DUP) –The definition of DUP varies, with some defining it as the time from the onset of psychotic symptoms to the first hospitalization, while others define it as the time from the first onset of psychotic symptoms or diagnosis to the first specific/effective/antipsychotic treatment. The duration of untreated psychosis plays a critical factor in determining the prognosis of individuals with psychotic disorders. Studies have shown that a longer DUP is associated with worse mental health outcomes, including lower remission rates and higher levels of suicidal behavior.

Adherence to Treatment – Adherence to treatment in mental health is a critical factor that significantly impacts the effectiveness of mental health interventions. It involves a patient's commitment and consistency in following recommended therapeutic interventions, including medication regimens, psychotherapeutic protocols, and lifestyle modifications. Non-adherence can lead to relapse, worsened mental health, and a higher risk of suicide.

Sudden Onset – Sudden onset is defined as a change from a nonpsychotic state to a clearly psychotic state within 2 weeks, usually without subtle changes in thoughts, perceptions and functioning, also referred to as a prodromal phase.

Critical Period – The concept of critical period proposes the rapid progression of symptomatic, cognitive and psychosocial decline during the early phase of psychosis including the period of untreated psychosis. Afterwards, progression of morbidity slows or stops, as does the level of disability sustained or recovery attained (3). Research has narrowed the critical period time frame for successful intervention to a range between 2 -5 years.

Remission – Remission refers to a temporary or permanent decrease or absence of symptoms of a psychological disorder, often to the point where the individual no longer meets the diagnostic criteria for that disorder. It is an important concept in understanding the course and treatment of various mental health conditions, indicating a positive outcome in treatment, although it does not necessarily mean full recovery.

The Remission in Schizophrenia Working Group (RSWG) criteria for remission are based on the Positive and Negative Syndrome Scale (PANSS-8). These criteria are used to assess symptom severity and time to determine remission status. The RSWG criteria include:

- Symptomatic Remission:
  - Symptom Severity: A score of ≤ 3 points on the eight items of the PANSS-8, which corresponds to mild severity or less. This includes items related to delusions, conceptual disorganization, hallucinatory behavior, blunted affect, social withdrawal, lack of spontaneity, mannerisms and posturing, and unusual thought content.
  - Time in Remission: To indicate remission, the criteria for symptom severity need to be met for at least 6 months. These criteria have been validated and shown to be effective in clinical settings and research, providing a structured approach to assessing remission in schizophrenia.
  - Clinical implications: Symptomatic remission is a prerequisite for recovery but does not guarantee full functional recovery.
- Functional Remission:
  - Adequate performance in social, occupational, and daily living roles, despite possible residual psychiatric symptoms.
  - Assessment Tools: Groningen Social Disabilities Schedule (GSDS): Measures functioning across seven (7) social roles, including self-care, family relationships, vocational role, and community integration.
  - Criteria: Minimal or no disability (score 0–1) in each role; major impairment (score 2–3) is not compatible with functional remission.
  - Duration: Sustained improvement is required – often assessed over 6 to 24 months.
  - Significance: Functional remission may lag behind symptomatic remission and is influenced by cognitive and social factors, early treatment, and rehabilitation support. Some patients may achieve functional remission without complete symptomatic remission, indicating that real-world functioning can improve even with mild lingering symptoms.
- Temporal and Operational Considerations
  - Acute vs long-term staging: Remission can be short-term (post-acute episode) or sustained, with longer durations associated with better prognosis.
  - Broad vs narrow definitions:
    - Narrow: Follow strict RSWG criteria (symptoms + duration).
    - Broad: Focus on symptom reduction only, ignoring duration.

Recovery - Recovery from psychosis is operationalized through a combination of clinical criteria and psychological interventions, focusing on both symptom management and functional recovery. Key aspects include:

- Early Identification: Accurate early identification of psychosis is crucial for prompt treatment, which can significantly improve recovery rates.
- Treatment Approaches: Targeting negative symptoms and integrating pharmacological and psychological interventions, along with support for education, training, or employment, is essential for comprehensive recovery.
- Clinical Recovery: A standard definition of clinical recovery includes full psychotic symptom remission and adequate functioning for a minimum of one year.
- Subjective Factors: The experience of self-consolidation and making meaning from the experience of psychosis are important for personal growth and recovery.

These operationalizations aim to provide a holistic approach to recovery, addressing both the immediate and long-term needs of individuals with first-episode psychosis.

Practice Guideline

Guideline Statement

The guideline makes recommendations for the treatment and management of psychosis and schizophrenia. It aims to:

- improve access and engagement with treatment and services for people with psychosis and schizophrenia
- evaluate the role of specific psychological, psychosocial and pharmacological interventions in the treatment of psychosis and schizophrenia
- evaluate the role of psychological and psychosocial interventions in combination with pharmacological interventions in the treatment of psychosis and schizophrenia
- evaluate the role of specific service-level interventions for people with psychosis and schizophrenia
- integrate the above to provide best-practice advice on the care of individuals throughout the course of their psychosis and schizophrenia
- promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the APA DSM-5 TR (4)

Causes of Psychosis

Psychosis occurs in a variety of mental and physical disorders, so it is often difficult to know what has caused a first episode. Psychosis itself is a cluster of symptoms that can be due to medical conditions, prescription drugs, substance use, or toxicities, as well as psychiatric disorders. The most common cause of a first episode of psychosis in young adults is schizophrenia.

There are other disorders that healthcare providers will consider. Medical professionals understand how the symptoms of psychosis are produced in only a few of these disorders. Some of the disorders have a genetic basis (i.e. family history of psychotic disorders). Others have an environmental basis and frequently psychosis is the result of a combination of these factors. Traumatic experiences can also add to the development of mental disorders.

Stress and psychosis – Potential sources of life stress may play a role in triggering an episode of psychosis, they include:

- physical stress, such as irregular sleep, binge drinking, use of street drugs, poor routine, poor diet, physical sickness
- environmental stress, such as inadequate housing, lack of social support, unemployment, major life changes (e.g., starting a new school or job)
- emotional stress, such as relationship problems, difficulties with family or friends
- acute life events, such as bereavement, accidents, illness, trouble with the law, pregnancy or childbirth, physical or sexual assault or abuse
- chronic stress, such as trouble with housing, or money
- bullying, such as racism or homophobia, cyber-bullying

Substance use and psychosis - Some drugs, such as amphetamines, can directly induce psychosis. Others, including cannabis (marijuana), can cause a psychotic episode by increasing a person's existing vulnerability to psychosis. There is also the risk that a psychotic episode in the context of substance use may cause the onset of a chronic (long-term) psychotic disorder.

Cannabis and psychosis - Cannabis use increases the risk of developing psychosis. The earlier someone starts using cannabis, and the more they use, the higher their risk of developing psychosis later in life. Additionally, cannabis use increases the risk of a person developing schizophrenia, whether or not other risk factors such as genetics and stress are present. In addition, ongoing cannabis use makes the symptoms of psychosis less responsive to treatment and increases the risk of relapse (recurrence of the symptoms).

Phases of Psychosis

Psychosis occurs in three phases, however not all people experiencing a psychotic episode will experience clear symptoms of all three phases—each person's experience will differ.

Prodromal Phase – The prodromal phase usually lasts several months, though the duration can vary. This first phase of psychosis involves symptoms that may not be obvious, such as changes in feelings, thoughts, perceptions and behaviors. Some common prodromal symptoms are:

- reduced concentration and attention, disorganized thoughts
- reduced motivation, changes in energy level, less interest in usual activities
- social withdrawal
- sleep disturbance
- suspiciousness
- irritability, anxiety, depressed mood
- no longer going to school or work, or performance deteriorating
- intense focus on specific ideas, which may seem odd or disturbing to others

These symptoms are very general and may not necessarily be a sign of psychosis. For example, they could represent normal adolescent behavior. Family members should track these changes over time—if they persist, this may suggest a prodromal phase.

Acute Phase – In the acute, or active, phase, people typically experience positive psychotic symptoms, such as hallucinations, delusions and disorganized thinking. Some negative symptoms may also emerge. This phase is the easiest to recognize and diagnose and is typically when most people begin receiving treatment. The earlier treatment starts, the greater the chance of successful recovery.

Recovery Phase – In the recovery or residual phase, acute symptoms reduce in intensity, though some may not disappear altogether. After recovery from a first episode of psychosis, some people never experience a relapse (a second episode). To reduce the risk of relapse, adherence to medication schedules and other treatments as recommended by the physician and clinical team are critical. The recovery process varies from person to person in terms of the time (2 to 5 years) and amount of improvement documented. Once the acute symptoms of psychosis respond to treatment, assistance may still be necessary with residual issues such as depression, anxiety, decreased self-esteem, social problems, and school or work difficulties. Additionally, family and caregivers may need their own support and help in coping effectively at this phase.

Types of Psychosis

There are a number of mental illnesses that can include psychosis as a symptom. In the early phases of a psychotic episode, it is usually difficult to diagnose the exact type of psychotic disorder that is happening. This is because the factors that determine a specific diagnosis are

often unclear during the psychotic episode. It is important to recognize and understand symptoms, and to communicate them to the treatment team. Any concerns or questions about diagnosis should be discussed with a mental health professional. A thorough medical assessment, to rule out any physical illness that may be the cause of the psychosis, may be recommended. The following list provides the names and brief descriptions of different types of psychotic illness.

Schizotypal Personality Disorder

A personality disorder is characterized by enduring patterns of inner experience and behavior that significantly deviate from cultural expectations. These patterns are pervasive and inflexible, manifest across a broad range of personal and social situations, begin by adolescence or early adulthood and lead to distress or impairment in functioning. (4)

Personality disorders are further characterized by clusters. One of the cluster A disorders is Schizotypal personality disorder. Criteria includes:

- Ideas of reference (not full delusions)
- Odd beliefs or magical thinking, inconsistent with cultural norms (e.g., telepathy, superstition)
- Unusual perceptual experiences, including bodily illusions
- Odd thinking and speech (e.g., vague, metaphorical)
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Eccentric appearance or behavior
- Lack of close friends or confidants, except close relatives
- Excessive social anxiety that does not lessen with familiarity and is often rooted in paranoid fears rather than negative self-judgment

Delusional Disorder

This type of psychosis consists of very strong and fixed beliefs in things that are not true. Changes in perception, such as hallucinations, are not seen in this illness. A delusional disorder does not usually affect a person's ability to function.

- Erotomania – applies when the central theme of the delusions is that of another person in love with the individual.
- Grandiose – applies when the central theme of the delusions is the conviction of having some great but unrecognized talent, insight, or having made an important discovery.
- Jealous – applies when the central theme of the delusions is that his or her spouse or lover is unfaithful.
- Persecutory – applies when the central theme of the delusions involves the belief that the individual is being conspired against, cheated, spied on, followed, poisoned or

drugged, maliciously maligned, harassed, or obstructed in the pursuit of long term goals.

- Somatic – applies when the central theme of the delusions involves bodily functions or sensations
- Mixed – applies when no one delusional theme predominates
- Unspecified – applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types

Brief Psychotic Disorder

Sometimes symptoms of psychosis come on suddenly and, in some cases, are triggered by a major stress in the person's life, such as a death in the family. This type of psychosis lasts less than a month. The characteristic symptoms of brief psychotic disorder are identical to schizophrenia criterion (A), and the episode lasts at least one day but less than one month. The individual has a full return to the premorbid level of functioning, and all other explanations have been ruled out.

Schizophrenia

The term schizophrenia refers to a diagnosis in which a person experiences a combination of psychotic symptoms for at least six months, with a significant decline in the person's ability to function. The symptoms and length of the illness vary from person to person. The criteria include (4):

A. Two or more of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
    1. Delusions
    2. Hallucinations
    3. Disorganized speech (e.g. frequent derailment or incoherence)
    4. Grossly disorganized or catatonic behavior
    5. Negative Symptoms (i.e. diminished emotional expression or avolition)
B. For a significant portion of the time since the onset of the disturbance, the level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to onset.
C. Continuous signs of the disturbance persist for at least 6 months and must include at least 1 month of symptoms (or less if successfully treated) that meet criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms.
D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out.
E. The disturbance is not attributable to the physiological effects of a substance (e.g. drug or medication) or another medical condition.

Schizophreniform Disorder

The characteristic symptoms of this type of psychosis are identical to schizophrenia except that the symptoms have lasted for at least one month but no more than six months. The duration requirement for a diagnosis of schizophreniform is intermediate between that for brief psychotic disorder, which lasts more than one day and remits by one month, and schizophrenia, which lasts for at least six months. The illness may completely resolve or may persist and progress to other psychiatric diagnoses, such as schizophrenia, bipolar disorder or schizoaffective disorder.

Bipolar Disorder

With this type of illness, the symptoms of psychosis relate more to a mood disturbance rather than a thought process disturbance. A person will experience elevated mood (mania) and sometimes depression, which may persist or fluctuate in intensity. When psychotic symptoms arise, they often reflect the person's mood. For example, people who are depressed may hear voices that put them down. People who are experiencing an elevated mood may believe they possess special traits and are capable of amazing things.

Schizoaffective Disorder

During this type of psychosis, a person will experience symptoms of schizophrenia and, at some point in the course of illness, concurrent symptoms of a mood disturbance.

Depression with Psychotic Features

Sometimes a person will experience severe depression with symptoms of psychosis, without the mania associated with bipolar disorder. This type of depression is referred to as a psychotic depression or depression with psychotic features.

Drug-induced Psychosis

The use of drugs such as marijuana, cocaine, ecstasy, ketamine, LSD, amphetamines and alcohol can sometimes cause psychotic symptoms to appear. In drug-induced psychosis, once the effects of the drugs wear off, the symptoms of psychosis can spontaneously resolve or may require medical treatment.

Organic Psychosis

Symptoms of psychosis may manifest as a result of physical illness or a head injury. A thorough medical examination should be conducted to rule out or confirm this type of psychosis. This examination may involve some tests or investigations such as a brain scan.

Diagnostic Considerations for Psychosis

It may be difficult to make a diagnosis in the early stages of psychosis. Often patterns of symptoms must be assessed over many months, and determining a diagnosis may take some

time. Therefore, initially it may be more helpful to focus on the symptoms and their impact on the person's functioning rather than on a particular diagnosis. It is also important to remember that everyone's experience of psychosis is different: the course and the outcome will vary from person to person.

Treatment of Psychosis

In 1998 Birchwood et al, (3) proposed the hypothesis of the "critical Period" of psychosis, during which symptomatic and psychosocial deterioration progresses quickly. Since that time the vast body of experimental and clinical research strongly supports the notion of a critical period suggesting, the earlier clinical intervention is provided, the better the treatment outcome. Help seeking behavior at the earliest onset of psychosis therefore becomes critical. However, in the early stages of a first episode of psychosis, many people don't understand what is happening to them or are unaware of the changes and do not seek treatment. Others who are aware may be wary of the treatment demands and resist seeking help.

Assessment – Before treatment initiation, a thorough assessment of the patient must be conducted by mental health professionals including psychiatrists, psychologists, psychiatric nurses, clinicians, occupational therapists and social workers. This includes a comprehensive interview to help behavioral health teams understand the patient's lived experience of psychosis from a client perspective. Additional information, time frames, and personal history provided by family members offer further context for understanding the range and veracity of symptoms.

Blood tests and other screenings, such as brain scans may be recommended by psychiatrists to rule out any physical causes of symptoms. Neurocognitive testing may also be recommended to assess areas of memory, attention, reasoning, problem solving and rate of information processing. These tests are not used to diagnose schizophrenia but to exclude other neurological or medical problems that could be present with psychotic symptoms. All these tests serve to set baselines to track cognitive changes resulting from a first episode of psychosis and provide an indication of a person's potential for recovery. Information gathered during the assessment period enables a more precise diagnosis of the type of psychosis, possible causes, and possible treatment(s) including medication and psychosocial interventions.

Diagnostics tools for assessing psychosis and social context –

- DSM-5 – Diagnostic and Statistical Manual of Mental Disorders
- CCRDPSS – Clinician-Rated Dimensions of Psychosis Symptom Severity
- BPRS – Brief Psychotic Rating Scale
- PANSS – Positive and Negative Syndrome Scale
- MSPSS – Multidimensional Scale of Perceived Social Support

- SCID – Structured Clinical Interview for DSM-V
- SUMD – Scale to Assess Unawareness of Mental Disorder

Medication – Antipsychotic medication is typically an essential part of a treatment plan for psychosis and specifically FEP, relieving the most overt symptoms of a first episode psychosis and critically preventing further episodes.

Antipsychotic medications, also known as neuroleptics, are divided into three categories: typical (first generation) affecting the dopamine system, newer atypical (second generation affecting the dopamine system) and novel (affecting the acetylcholine muscarinic system). (5)

- Typical antipsychotic medications have been used for many years, and those that are commonly used include: chlorpromazine, flupentixol, fluphenazine, haloperidol, loxapine, perphenazine, pimozide, thioridazine, thiothixene, trifluoperazine and zuclopenthixol
- The newer, atypical antipsychotics include: clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), paliperidone (Invega), aripiprazole (Abilify), ziprasidone (Zeldox), lurasidone (Latuda) and asenapine (Saphris)
- Novel antipsychotics include: xanomeline-trospium chloride, the only FDA-approved medication currently in its class (Cobenfy). (5)

Atypical antipsychotics are increasingly replacing typical antipsychotics as first-line treatments due to the lower risk of extrapyramidal side-effects associated with first generation medications. Newer antipsychotics differ from one another in terms of side-effects, allowing for differences in a person's ability to tolerate one medication against another to be identified and swapped out if necessary.

Novel antipsychotics represent the next wave of pharmacological treatment for schizophrenia. Advances include fewer side effects and significant symptom reduction. These medications have been found to be uniquely effective with the negative and cognitive symptoms of psychosis in addition to the positive symptoms. (5)

Treatment typically begins with a low dose of medication monitored closely for any side-effects, which can occur within the first hours, days or weeks of starting antipsychotics. Side-effects can be managed by a few strategies including lowering the dosage of prescriptions, adding a medication to reduce impact, or recommending a different medication altogether.

The details of a specific medication program typically take some time to develop and are worked out between physician and patient in stages. If the initial antipsychotic medication does not produce clinically satisfactory results, patients will be offered one or two additional trials using the medications listed above. The medication management strategy aims to provide effective symptom relief while using the least amount of antipsychotics to minimize potential side-effects. Antipsychotic medications may take days or sometimes weeks to

produce an improvement in psychotic symptoms, underscoring the need to manage side-effects to maintain adherence to treatment until results are observable.

Clozapine is a medication that may prove effective for those who fail to respond well to other antipsychotics. Its use is only recommended after at least two standard antipsychotics have failed to produce an effective response, because it carries some special risks, including possible harm to white blood cells. While these risks are low, people prescribed clozapine require weekly blood tests to monitor their white blood cell count.

Adherence to the specific medication program and timeline remain critical to remission. The full course of antipsychotic medication must be maintained over the prescribed timeline even after the onset of symptom relief. When medication is discontinued too early, there is a very high risk that symptoms will return. This may not necessarily happen right away and can occur several months after medication is stopped.

Side-effects – Many side-effects tend to diminish over time. Some people experience no side-effects at all.

- Common side-effects – most common side effects are typically not serious and diminish over time. These include fatigue, sedation, dizziness, dry mouth, blurry vision and constipation.
- Extrapyramidal side-effects – this term includes restlessness, tremor, and abnormal involuntary movements. These include tardive dyskinesia (TD), which refers to involuntary, spontaneous movements of the tongue, lips, jaw or fingers. For every year that a person receives the older, typical antipsychotic medication, there is a five per cent risk of developing tardive dyskinesia. This rate adds up over time so that after two years the risk is 10 percent and after five years it is about 25 per cent. It is believed that this rate is lower for atypical antipsychotics.
- Metabolic side-effects - While all antipsychotics can increase body weight, atypical medications as a group are more likely to cause side-effects such as weight gain, high blood levels of glucose and cholesterol, and diabetes. In general, clozapine and olanzapine have the greatest metabolic risk, followed by risperidone and quetiapine. Aripiprazole, ziprasidone, lurasidone, and asenapine are thought to have a lower risk. Metabolic side-effects can be mitigated by lifestyle measures such as proper nutrition and regular exercise.
- Hormonal and sexual side-effects - Some antipsychotics can cause changes in sex drive, along with other sexual problems, menstrual changes, and the abnormal production of breast milk (in both sexes).
- Other Medications – Other medications may also be used in conjunction with antipsychotics in treating a first episode of psychosis:
    - Benzodiazepines (sedatives) may be used to control agitation while treatment with an antipsychotic is begun at a low dose.

- Antidepressants may be used to treat co-occurring issues such as anxiety and depression.

Risk Factors

Suicide Risk

Approximately 5%-6% of individuals with schizophrenia die by suicide, about 20% attempt suicide on one or more occasions, and many more have significant suicidal ideation. Suicidal behavior is sometimes in response to command hallucinations to harm oneself or others. Suicide risk remains high over the whole lifespan for males and females, although it may be especially high for younger males with comorbid substance use. Other risk factors include having depressive symptoms or feelings of hopelessness and being unemployed. The risk is higher, also, in the period after a psychotic episode or hospital discharge.

Socioeconomic Factors

While many potential risk factors for psychotic disorders have been studied, only a limited number show suggestive or stronger evidence. Ethnic minority status and urbanicity are strong risk factors, however; they do not imply causation. Others include socio-environmental adversities such as social stress, discrimination, and isolation. Several additional factors, including certain perinatal factors, childhood trauma, and cognitive or neurobiological vulnerabilities, show suggestive evidence, while others have weaker support due to limited data. Overall, risk factors for psychotic disorders are linked to social and developmental adversities and emphasize the need for further research on mechanisms, protective factors, and context-specific influences.

Psychosocial Interventions

Case Management – Those recovering from a first episode of psychosis often benefit from the services of a case manager. Case managers coordinate the care that a person may need at that time. The role of case manager can be filled by a nurse, occupational therapist, psychologist, clinician or social worker with specialized training and experience in psychiatry. They provide emotional support to the person and the family. Going through a first episode of psychosis may leave one feeling very frightened, confused and overwhelmed. Meeting with and talking to a case manager on a regular basis can help one cope with such feelings and is an important part of recovery. A case manager can also provide education about the illness itself and its management, and practical assistance with day-to-day living. This helps people resume their lives, re-establish a routine, return to work or school, find suitable housing and obtain financial assistance. Case managers may suggest consultation with other team members regarding specific concerns. They may also recommend programs in the community that contribute to recovery and provide a steppingstone to longer-term goals involving work or

school. Case management can be conducted individually or in group format. Group formats offer young people experiencing a first episode an opportunity to begin socializing again with others and avoid feeling less alone.

Psychoeducation – Psychoeducation provides information about the illness, including symptoms, causes and how to manage symptoms and the side-effects of medication. It also includes information on the recovery process, maintaining a sense of well-being, and learning how to prevent a recurrence of psychosis. Psychoeducation offers practical skills like stress management, meditation, social skills training, problem solving and other life skills.

Vocational and Educational Counseling – Work and school may often be disrupted for those experiencing a first episode of psychosis. Issues about whether to continue to pursue work or school, or to explore other career options may arise. In these cases, a referral to an occupational therapist for short term counselling can be useful. Occupational therapy explores objectives and interests. Skill-oriented evaluations are used to identify people's strengths and challenges in a work or school setting. Counsellors and case managers can also connect clients to resources to help them find employment. Finally, a referral to a psychologist for neurocognitive testing may be beneficial. This type of assessment evaluates a person's cognitive strengths or limitations. This information can help clients choose a vocational or educational path that is suited to them and identify any potential accommodations needed to help them succeed.

Cognitive Behavioral Therapy for Psychosis (CBTp) – CBTp is an evidence-based psychological therapy recommended by APA as an adjunct to medication management to reduce the distress associated with psychosis symptoms and improve functioning; aims to modify appraisals and responses to an event which maintains distress rather than the event itself; initially developed as an individual treatment, and later as a group-based intervention. Treatments are distinguished by severity and qualifications of practitioners - for full CBTp (16 or more sessions over at least six months provided by a qualified CBT therapist), CBT-informed interventions (provided by mental health practitioners not meeting the criteria of a full CBTp therapist), Targeted CBTp interventions (targeting clearly specified mechanisms with a CBTp therapist). Essential features include: the collaborative development of a shared formulation or understanding of the client's experiences and factors maintaining these experiences; normalization of the psychotic experience; and acceptance of psychotic symptoms.

Dialectical Behavior Therapy (DBT) – DBT combines cognitive-behavioral therapy techniques with acceptance and mindfulness practices (e.g., meditations, breathing, mantras, centering techniques) emphasizing emotional regulation, interpersonal effectiveness, and distress tolerance. DBT places a strong emphasis on validating an individual's thoughts, emotions, and experiences. This validation can foster a therapeutic alliance and create a supportive environment. DBT helps a person manage overwhelming emotions and strengthens their

resilience and ability to effectively manage distressing situations. Therapy is offered in both individual and group sessions. Skills taught include coping effectively with distressing situations, focusing on the present moment, avoiding getting overwhelmed by emotions, and developing effective interpersonal skills. DBT has specific strategies for addressing behaviors that can interfere with the therapeutic process, such as noncompliance, avoidance, or aggressive behaviors.

Cognitive Behavioral Social Skills Training (CBSST) – CBBST combines CBT and social skills training techniques aimed at the achievement of individual social, behavioral and/or vocational goals. The approach assists in self-regulating unhelpful thoughts interfering with goal attainment by providing training and techniques to 'catch, check and change' such thinking. It also provides training to develop communication and problem-solving skills.

Motivational Interviewing (MI) – Initiating change is difficult for anyone in life, no exceptions. A sense of ambivalence or mixed emotions often prevails early on in efforts to initiate personal change. Motivational interviewing is an approach used in many disciplines that facilitates the thought process and internal conversation of those exploring the possibility of initiating changes in their lives. Structured as a collaborative process between provider and patient, MI helps individuals explore their motivation and ambivalence about making a specific change and then to establish and reinforce that commitment. Questions posed to patients are open-ended and framed to elicit honest responses to 'what stands in the way or prevents' taking the first step towards, for example, a lifestyle change. If an honest response is elicited it is typically followed by 'what would that look like if you let that notion or fear go' in an ongoing conversation that allows the patient to work through their own fears and inhibitions.

Acceptance and Commitment Therapy (ACT) - ACT helps individuals who may feel consumed or trapped by certain thoughts, to notice and accept their thoughts, and to view the thoughts as separate from their sense of self. It helps individuals focus on the present moment. In this way, ACT helps people develop greater psychological flexibility, enhances their commitment to key values, and helps them take actions in the here and now, toward doing the things of value to them.

Mindfulness Meditation – Mindfulness is defined as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience" (Kabat-Zinn, 2003). It helps individuals center their thoughts without judging them good or bad. It is a skill that can be learned, and plays a role in increasing self-awareness, fostering relaxation and coping with difficult situations or overwhelming emotions. It employs meditation, breathing and centering techniques, visualization, and mantras to break through mental loops of circular thought. Rooted in Buddhist and Hindu teachings of striving towards enlightenment, it was first developed as a technique to treat chronic pain. Rather than proceeding from a position of attempting to avoid pain, which often leads to

deeper distress, mindfulness teaches acceptance without judgement and offers techniques to tolerate and move beyond the pain to a different part of our consciousness.

Cognitive Adaptation Training (CAT) – Individuals experiencing psychosis often also experience cognitive symptoms, such as difficulty solving problems that can make every-day functioning difficult. CAT helps individuals work around their cognitive difficulties to improve their daily functioning, including adherence to medication regimens and practicing selfcare. After completing a comprehensive assessment, appropriate environmental supports to improve functioning (such as signs, pill dispensers, and checklists) are put into place in the person's living environment as guides and reminders.

Treatment for Concurrent Disorders – Research shows that when a person with psychosis also has substance use problems, it is most effective to treat them together. For this reason, first episode psychosis programs provide treatment for substance use as well as for symptoms of psychosis. The substance use treatment may be within the program or provided by an external agency.

Family Involvement

The onset of psychosis takes a toll on many family members and partners, finding the experience extremely distressing, often leaving them feeling frightened, helpless, and confused. Family involvement is important to the plan toward recovery, benefiting both family and individuals experiencing a FEP. Participating in the treatment plan allows family to provide important details about a person's functioning before the onset of symptoms, to describe the symptoms and their development, to address their own concerns and distress, and assert agency over their own mental health and wellbeing. By working with treatment teams, family members receive education about the nature of the illness and available treatment options, guidance on issues such as how to relate to and support a relative that is ill. For example, it is best to communicate in a calm, clear manner, and to avoid overwhelming an individual with too much information. It is also important for family members to be aware that their relatives need time to recover and may not be able to fully engage in all activities of daily living right away. A structured approach to gradually taking on tasks and activities usually works best.

Often family members discover they need to develop coping strategies of their own and more effective communication skills to better support the family member experiencing psychosis. Individual family counselling, psychoeducation workshops and support groups are offered to develop these strategies and skills. Beyond education and training, support groups and skill workshops also provide emotional and practical support to families to assist them in discovering the appropriate balance between supporting a recovering family member and caring for themselves and needs.

Models of Care Delivery

High Fidelity Wraparound

High Fidelity Wraparound (HFW) is an evidence-based model of care coordination that uses a highly structured, team-based, family-centered management process for moving social-service-system-involved families towards independence and success. Typically, children and youth served by HFW are involved in multiple child service systems. The process involves intensive, individualized planning and managing for children and youth (ages 12-21) with serious social, emotional, or behavioral concerns.

Dosage

During Phase 1 of Wraparound, which lasts 1–4 weeks, the care coordinator conducts an initial 1- to 3-hour meeting with the youth and family and engages all potential additional team members. In Phase 2, completed within the first 30–45 days of referral, the wraparound team meets once or twice for up to 90 minutes per meeting. During Phase 3, which varies in duration, the wraparound team typically meets for 60–90 minutes every 4 weeks or as needed. Wraparound support in Phase 3 typically continues until the wraparound team determines that Wraparound is no longer needed. At that point, the team begins Phase 4 and holds meetings as needed to prepare the youth and family for transitioning out of Wraparound services.

Recommended Locations/Delivery Settings

Wraparound can be delivered in a range of settings, including participants' homes, alternative residential placements (e.g., foster care, residential facilities, or group homes), or community-based settings such as schools or mental health clinics.

Education, Certifications and Training

Wraparound is implemented by care coordinators with participation from additional team members depending on family needs, such as parent and youth support partners, direct support service providers, and clinicians. The process is supported by program supervisors/directors and administrative staff. Education requirements are determined by the organization implementing Wraparound and the specific role.

Training is recommended for care coordinators implementing Wraparound. The National Wraparound Implementation Center (NWIC) provides training, written protocols, assessment tools, and implementation support to states, sites, and organizations implementing Wraparound. Following training, care coordinators may go through an apprenticeship phase where they observe a peer or supervisor implementing Wraparound, practice implementing Wraparound while being observed, and receive coaching feedback and skill assessment.

High-Fidelity Wraparound is being implemented by the California Department of Health Care Services (DHCS). Implementation is ongoing and will begin in July 2026. DHCS published a concept paper on the subject. (6)

Coordinated Specialty Care for First Episode Psychosis (CSC)

Coordinated Specialty Care (CSC) is a multi-component, evidence-based, early intervention service for individuals experiencing a first episode of psychosis. CSC programs aim to provide early intervention and holistic support to individuals experiencing FEP, with the goal of reducing symptoms, improving functioning, and preventing further episodes of psychosis. Research has shown that CSC programs can be highly effective in improving outcomes for individuals experiencing FEP, including reducing hospitalizations, improving social and occupational functioning, and promoting long-term recovery. As a result, CSC has become increasingly recognized as a best practice model for early intervention in psychosis. Details on implementation will be forthcoming. (7) Key components of Coordinated Specialty Care typically include:

Multidisciplinary Team

CSC teams typically consist of various professionals such as psychiatrists, psychologists, social workers, case managers, peer specialists, and other mental health professionals. This multidisciplinary approach ensures that individuals receive comprehensive care addressing their physical, psychological, and social needs.

Individualized Treatment Planning

Individuals in CSC receive a personalized treatment plan tailored to their specific needs and preferences. This may include medication management, psychotherapy, family support and education, vocational and educational assistance, and support for independent living skills.

Family Involvement

CSC recognizes the importance of involving family members and caregivers in the treatment process. Family psychoeducation and support are often integral components of CSC programs, as they can help improve communication, reduce stress, and enhance understanding and coping strategies for all involved.

Supported Employment and Education

Many CSC programs offer supported employment and education services to help individuals with FEP reintegrate into the workforce or educational settings. This may involve vocational training, job placement assistance, and support with academic pursuits.

Peer Support

Peer Support Specialists, who have lived experience with mental illness themselves, play a crucial role in CSC programs by providing support, encouragement, and mentorship to individuals undergoing treatment. Peer support can help reduce feelings of isolation, stigma, and hopelessness, and promote recovery. Certification for peers has been implemented by the Department of Health Care Services (DHCS). (8) (9)

Continuity of Care

CSC emphasizes the importance of continuity of care, ensuring that individuals receive ongoing support and monitoring even after their symptoms improve. This may involve regular follow-up appointments, relapse prevention strategies, and coordination with other healthcare providers and community resources.

Multiple Family Group Therapy (MFGT)

MFGT brings several families together in one therapeutic group led by one or more therapists. It is used across diverse settings—including outpatient clinics, post-discharge programs, correctional facilities, and schools—and serves families dealing with mental illness, addictions, and trauma (11). Group size can range from a few to many families in formats that vary from brief intensive sessions to ongoing weekly groups. This model integrates principles of both family and group therapy, with the presence of multiple families serving as a central mechanism for change (12).

O'Shea and Phelps (13) define MFGT as a structured psychosocial intervention involving two or more multigenerational families meeting together with a trained therapist, focusing on common concerns and emphasizing cross-generational interaction. Families learn from each other through shared experiences, observable interaction patterns, and natural feedback.

Role of the Therapist

The MFGT therapist takes a highly active, directive role—similar to a conductor—managing a fast-paced environment with complex family dynamics. Skills include facilitating emotional expression, identifying alliances, remaining neutral, and keeping the group focused on core themes. Although therapists guide the process, the group itself becomes the primary agent of change by offering reflection, support, challenge, and modeling (12).

MFGT relies on systems theory, recognizing that families carry their relationships and history into the group. Interactions among whole family units intensify group dynamics and allow for clearer observation of patterns than in traditional individual group therapy. Curative factors include universality, identification, cross-interaction, reality testing, role change, and catharsis (14). Whole-family participation creates an environment where concrete behavioral examples foster insight more effectively than abstract explanations.

A distinctive feature of MFGT is its creation of a supportive social network, with families functioning as co-therapists and providing cohesion and mutual support (13) (12).

Cost-Effectiveness
With increasing economic constraints and managed care pressures, MFGT offers a cost-effective alternative to individual or single-family therapy. Its structure allows more families to be served with fewer staff hours and reduced operational costs, benefiting both clinical programs and administrative systems.

The Process of Recovery

Recovery is an ongoing process. During the recovery journey there will be growth and setbacks, times of change and possibly times where there seems to be little change. It takes time to rebuild confidence and abilities after experiencing the effects of psychosis.

The recovery process will vary from person to person in terms of duration and degree of functional improvement. Some people will recover from the psychosis very quickly and be ready to return to their life and responsibilities soon after. Other individuals will need time to respond to treatment and may need to return to their responsibilities more gradually.

Recovery from the first episode usually takes a number of months. If symptoms remain or return, the recovery process may be prolonged. Some people experience a difficult period lasting months or even years before things stabilize.

People in recovery may experience:

- impatience (recovery may seem slow)
- depression and isolation
- social anxiety
- lowered self-esteem
- difficulty accepting that they have an illness
- trouble accepting support and working with the treatment team

Psychosis arises due to a combination of genetic vulnerabilities and social/environmental stressors. While we cannot change our genetic vulnerabilities, we can influence the social and environmental elements lived in. Recovery includes the concept of treating the symptoms of psychosis along with environmental stressors, increasing a person's ability to function in everyday life and achieve the goals they set out to accomplish.

Naturalistic studies of FEP outcome studies suggest that the most positive outcomes come from a team approach of professionals working closely with the individual and their family and support networks, finding the right medication at the right dose, and managing, decreasing or eliminating major stressors, and developing a lifestyle that supports mental wellness.

Acute Psychosis Assessment & Treatment Planning

1. At first presentation, APA ***recommends*** (**1C**) that the initial assessment of a patient with a possible psychotic disorder include:
   - Reason the individual is presenting for evaluation
   - Patient's goals and preferences for treatment
   - A review of psychiatric symptoms and trauma history
   - An assessment of tobacco use and other substance use
   - Psychiatric treatment history
   - An assessment of physical health (vital signs, body weight/ height, hematology, pregnancy, toxicology, EEG, imaging)
   - An assessment of psychosocial and cultural factors
   - A mental status examination, including cognitive assessment
   - An assessment of risk of suicide and aggressive behaviors

   Expert opinion suggests that conducting such assessments as part of the initial psychiatric evaluation improves diagnostic accuracy, appropriateness of treatment selection, and treatment safety.

   Implementation

   - Understanding the patient's goals, their view of the illness, and treatment preferences gives a framework for recovery and serves as a starting point for person-centered care and shared decision-making.
   - A detailed assessment is important in establishing a diagnosis, recognizing cooccurring conditions, identifying psychosocial issues, and developing a treatment plan to reduce associated symptoms, morbidity, and mortality.
   - Tests such as imaging, genetic testing, or an EEG may help identify conditions with an increased risk of developing schizophrenia (e.g., 22q11.2 deletion syndrome) or that may mimic schizophrenia (e.g., neurosyphilis, Huntington's disease, Wilson's disease, anti-NMDA receptor encephalitis).

2. Based on general principles of assessment and clinical care in psychiatric practice, APA **recommends** (**1C**) that the initial psychiatric evaluation of a patient with a possible psychotic disorder include a quantitative measure to identify and determine the severity of symptoms and impairments of functioning that may be a focus of treatment.

   Implementation

   - Patient self-report ratings and clinician-based ratings:
     - Provide a structured replicable way to document baseline symptoms

    - Determine which symptoms should be the target of intervention
    - Track treatment effects or the need for a shift in the treatment plan
- Example measures: 6-item and 30-item versions of Positive and Negative Syndrome Scale (PANSS-6, PANSS-30), Scale for the Assessment of Negative Symptoms (SANS), Brief Psychiatric Rating Scale (BPRS), World Health Organization Disability Schedule 2.0 (WHODAS 2.0)

3. Based on general principles of assessment and clinical care in psychiatric practice, APA **recommends** (**1C**) that patients with schizophrenia have a documented, comprehensive, and person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments.

   Implementation

   - A comprehensive and person-centered treatment plan will typically delineate treatments aimed at improving functioning, reducing positive and negative symptoms, and addressing co-occurring psychiatric symptoms or disorders
   - It is essential to consider both nonpharmacological and pharmacological treatment approaches and recognize that a combination of nonpharmacological and pharmacological treatments will likely be needed to optimize outcomes
   - Strategies to promote adherence are always important to consider in developing a patient-centered treatment plan
   - Address other goals of treatment (e.g., development of social support networks; interpersonal, family, or intimate relationships; parenting status; living situation; past trauma or victimization; school or employment; financial considerations, including disability income support; insurance status; legal system involvement)
   - Intervening to reduce the risk of suicide and aggressive behaviors
   - Determining the optimal setting of treatment
   - Encouraging smoking cessation (if relevant) and treating other co-occurring substance use disorders
   - Adjusting treatment if clinically indicated for:
       - Other co-occurring psychiatric symptoms or diagnoses
       - Other specific circumstances such as correctional settings
       - Women who plan to become or are pregnant, or breastfeeding
   - Identifying additional needs for history or mental status examination; physical examination; laboratory testing, imaging, electrocardiography, or other clinical studies
   - Collaborating with other treating clinicians (including provision of integrate care) to avoid fragmentation of treatment efforts and assure care for co-occurring substance use disorders and physical health conditions

- Engaging patients, family members and others involved in the patient's life and providing them with information (e.g. treatment options, early symptoms of relapse, need for ongoing monitoring, coping strategies, case-management services, and community resources, including peer support programs)

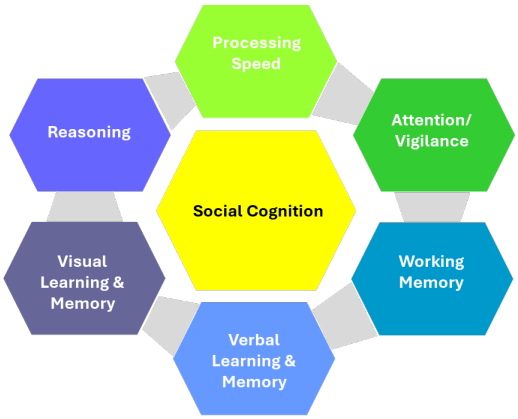

Figure 1: Cognitive Domains affected in patients with schizophrenia

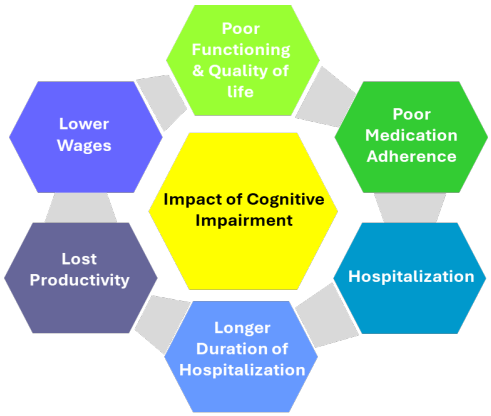

Figure 2: Negative consequences of cognitive impairment in schizophrenia

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Quick Guide

Family Involvement

Best practices for treatment of psychotic disorders include family involvement.

- Families often experience significant distress at the onset of psychosis, which can affect their ability to support the individual.
- Family involvement provides critical collateral information and enhances engagement and treatment planning for psychotic disorder treatment.
- Clinicians can help families manage their own distress and develop effective communication strategies to reduce overstimulation.
- Psychoeducation about the course of psychosis and pacing of recovery helps families set realistic expectations and support gradual functional reengagement.
- Counseling, psychoeducation, and support groups strengthen families' coping skills and help them balance caregiving with their own wellbeing.

Resources for family members to consider:

- NAMI OC – our Orange County chapter of NAMI, the National Alliance on Mental Illness
    - Family-to-Family, an educational program taught by NAMI-trained family members with lived experience.
    - Support Groups to help family members connect to each other
    - Additional resources are available.
- OCNavigator – local resources on health, wellness and many others.
- OCLINKS – behavioral health information, referrals, crisis response and more.
- 211 OC – health and human service resources, provided by OC United Way.
- 988 Lifeline – call, text, or chat for suicide and crisis support. Supports deaf and hard of hearing as well.

Types of Psychosis Reference Table

This Quick Guide is not an exhaustive list. Please use this table in conjunction with the rest of the Practice Guideline.

Type of Psychosis	Key Features	Duration	Distinguishing Points
Schizotypal Personality Disorder	Odd beliefs, unusual perceptual experiences, eccentric behavior, odd thinking/speech, social anxiety	Begins in adolescence; chronic	A personality disorder; symptoms are psychotic-like but not full delusions or hallucinations
Delusional Disorder	Fixed false beliefs; minimal hallucinations; functioning mostly preserved	At least 1 month	Includes erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified subtypes
Brief Psychotic Disorder	Sudden onset of hallucinations, delusions, or disorganization; often stress-related	1 day to <1 month	Full return to premorbid functioning; identical to schizophrenia Criterion A but brief
Schizophrenia	Delusions, hallucinations, disorganized speech/behavior, negative symptoms, functional decline	≥ 6 months (≥ 1 month active)	Requires ≥2 Criterion A symptoms; includes prodromal and residual phases; excludes mood/medical causes
Schizophreniform Disorder	Same symptoms as schizophrenia	1 to 6 months	Duration defines disorder; may resolve or progress to schizophrenia, bipolar, or schizoaffective
Bipolar Disorder w/ Psychosis	Mania and/or depression with mood-congruent psychosis	Variable	Psychosis occurs only during mood episodes; content reflects mood state
Schizoaffective Disorder	Schizophrenia symptoms plus mood episodes	Variable but chronic	Psychosis occurs ≥2 weeks without mood symptoms; mood present majority of illness
Major Depression w/ Psychosis	Severe depression with psychosis	Duration of depressive episode	Psychosis occurs only during depression; usually mood-congruent
Drug-Induced Psychosis	Psychosis triggered by substances	Often resolves after substance fades	Clear link to substance use; may unmask underlying vulnerability
Organic Psychosis	Psychosis caused by medical illness or brain injury	Depends on condition	Requires medical evaluation; improves with treatment of medical cause