TAC
Treatment Advocacy Center

Schizophrenia Fact Sheet

Schizophrenia spectrum disorders impact 1.2 percent of U.S. adults ages 18-65 — about 3.7 million people. Schizophrenia spectrum disorders include schizophrenia, schizoaffective disorder, and schizophreniform disorder (RTI International).

Basic definition of schizophrenia

Schizophrenia is a brain disorder that impacts how a person thinks, feels, and behaves. The National Institute of Mental Health (NIMH) defines schizophrenia as "a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions." Although the illness can progress differently among individuals, schizophrenia is typically chronic, persistent, and disabling.

Common symptoms

- **Psychosis**: Inaccurate perceptions of reality, referred to as "positive symptoms" of schizophrenia. Psychosis symptoms often include:
  - **Hallucinations**: Hearing, seeing, smelling, tasting, or feeling things that aren't real.
  - **Delusions**: Firm beliefs about things that aren't true.
  - **Paranoia**: Intense feelings of distrust and suspicion towards others, often with bizarre claims to justify the fear.
  - **Disorganized thinking**: Speech that is too disorganized for basic communication.
  - **Abnormal motor behavior**: Decreased reactivity (catatonia), unpredictable agitation, bizarre or rigid posturing.
- **Altered sense of self**: Often includes lack of awareness of illness (anosognosia).
- **Withdrawal**: Lack of emotional expression (often called "flat affect"), diminished motivation, disengagement from others and activities — referred to as "negative symptoms" of schizophrenia.
- **Cognitive impairments:** Challenges with memory, attention, planning, communicating.

Age of onset

- Symptoms typically start in late adolescence through early adulthood, with about 80 percent of cases beginning before age 40.

- Cognitive impairments and unusual behaviors may appear during childhood but may only be identified in hindsight.
- About 20 percent of cases start after age 40, with higher numbers of late-onset schizophrenia among women.

Mortality risks

Schizophrenia is associated with one of the highest mortality risks of all psychiatric disorders, with adults dying 15-20 years prematurely, often for reasons listed below. Life expectancy improves when treatment is initiated early and if medication therapy includes clozapine or a long-acting injectable and is combined with psychosocial interventions.

- Suicide
- Co-occurring substance use disorder
- Pneumonia or other illnesses/injuries related to exposure
- Diabetes
- Cancer or other serious medical conditions that go unrecognized

Other conditions in the schizophrenia-spectrum

- **Schizoaffective disorder:** Includes chronic schizophrenia symptoms in addition to mood disorder symptoms that are also typical with severe bipolar disorder, such as depression, mania, and hypomania (a milder form of mania that often precedes full-blown mania and psychotic breaks from reality).
- **Schizophreniform disorder:** Includes symptoms typical with schizophrenia, but the duration is shorter — lasting 1-6 months. About two-thirds of people diagnosed with schizophreniform disorder will have symptoms that are ongoing and thus will be further diagnosed with schizophrenia or schizoaffective disorder.

Related disorders

- **Schizotypal disorder:** Also known as borderline schizophrenia, this personality disorder displays many schizophrenia symptoms but doesn't present with intense or persistent psychosis. People with schizotypal disorder may seem eccentric, paranoid, or antisocial, with a tendency to distrust other people and/or misinterpret other's motivations. People with this condition often can see that their distorted ideas differ from reality.
- **Delusional disorder:** A condition in which a person cannot tell what's real from what's imagined. Delusions (fixed false beliefs) may be persecutorial, jealous, or grandiose, and with this condition are somewhat plausible, despite being untrue. Unlike schizophrenia, delusional disorder doesn't come with hallucinations, disorganized speech, or diminished emotions. Onset is most common after age 40.
- **Autism spectrum disorder** (ASD): A developmental disability that is usually diagnosed during childhood, autism spectrum conditions are entirely separate from schizophrenia. However, youth with ASD are 3-6 times more likely to develop schizophrenia than their neurotypical counterparts, and research shows some overlapping characteristics,

including social withdrawal, impaired communication, neurocognitive deficits, and behavioral atypicality. Combined care is critical when autism and schizophrenia co-occur.

- **Paranoid personality disorder** (PPD): A condition marked by long-term patterns of mistrust, paranoid personality disorder causes a person to be convinced, without evidence, that others are trying to demean, harm, or threaten them. Without delusions or hallucinations, a person experiencing this condition requires a different treatment approach than someone with schizophrenia.

What causes schizophrenia?

Schizophrenia research has been dominated by theories related to genetic predisposition and neurotransmitters, particularly dopamine, which is the neurotransmitter targeted by most anti-psychotic medications. More recently, researchers have considered infections, cannabis use, and inflammatory conditions as causes. The reality may be that underlying vulnerabilities combined with drug use, fever, brain injury, trauma, or something entirely unknown could cause this spectrum of conditions.

Schizophrenia is often diagnosed when a person has significant symptoms of psychosis. Conditions that might cause psychosis or mimic psychosis are Lyme disease, epilepsy, tumors, and autoimmune diseases. A bacteria called Bartonella may be linked to psychosis, and in that type of situation an antibiotic might be an important aspect of treatment.

How is schizophrenia diagnosed?

A comprehensive examination by a licensed medical provider is necessary for a diagnosis and to rule out possible physical illnesses that could be causing or contributing to the symptoms. To fully investigate what might be happening, the individual or family may want to consult psychiatrists, neurologists, infectious disease doctors, and other specialists who are able to conduct diagnostic testing or contribute relevant insight.

Although the brain's structure and function are altered in individuals with schizophrenia, no single condition can be tested or measured to produce a definitive diagnosis. Without such measures, the disease is diagnosed based on symptoms.

Early diagnosis and treatment are known to improve long-term outcomes. Early episode programs exist in most states and are worth advocating for. These programs are often referred to as Coordinated Specialty Care (CSC), and the Substance Abuse and Mental Health Services Administration (SAMHSA) provides an Early Serious Mental Illness Treatment Locator.

Treatments and therapies

While there is no cure for schizophrenia, symptoms are treatable and recovery is possible. Medication can be key to stability and works best when combined with psychosocial interventions, which are described in best-practice guidelines from the American Psychiatric Association (APA).

Despite positive outcomes with prompt, comprehensive, and consistent treatment, at least 40 percent of individuals diagnosed with schizophrenia are untreated because of barriers related to treatment laws, provider and medication access issues, lack of insurance parity, and bed shortages. A significant treatment barrier is anosognosia, a symptom that blocks a person's ability to see that they are sick or understand how treatment can improve their quality of life. Motivational interviewing is an evidence-based intervention to improve outcomes for people who lack insight into their condition.

Global guidance for schizophrenia treatment was announced April 16, 2025, on Psychiatrist.com. INTEGRATE, which stands for International Guidelines for Algorithmic Treatment, prioritizes early interventions and patient-centered approaches and makes specific medication recommendations that are incorporated into TAC's resource about medication management.

Here are approaches to consider alongside pharmaceutical interventions:

- Cognitive behavioral therapy for psychosis (CBTp)
- Cognitive enhancement therapy (CET)
- Psychoeducation
- Supportive housing
- Assistance with employment or other meaningful activities

Medications for schizophrenia

Antipsychotics: Used to treat symptoms of psychosis.

- **First-generation antipsychotics** are "typical," including these options: chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), loxapine (Adusuve), molindone (Moban), perphenazine (Trilafon), pimozide (Orap), prochlorperazine (Compazine, Compro), thiothixene (Navane), thoridazine (Mellaril), trifluoperazine (Stelazine).
- **Second-generation antipsychotics** are "atypical," including these options: aripiprazole (Abilify), asenapine (Secuado), brexpiprazole (Rexulti), cariprazine (Vraylar), iloperidone (Fanapt, Zomaril), lumateperone (Caplyta), lurasidone (Latuda), olanzapine (Zyprexa), quetiapine (Seroquel), paliperidone (Invega), risperidone (Risperdal), ziprasidone (Geodon).
- **Long acting injectables (LAIs)** are recommended by APA best-practice guidelines and global guidelines, INTEGRATE, for people who need help with treatment adherence. Included are these options: fluphenazine decanoate (Prolixin), haloperidol decanoate (Haldol), flupentixol (Depixol), risperidone microspheres (Risperdol Consta), risperidone (Uzedy), aripiprazole monohydrate (Abilify Maintena), aripiprazole lauroxil (Aristada), olanzapine pamoate (Zyprexa Relprevv), paliperidone palmitate (Invega Sustenna, Trinza, or Hafyera).
- **Clozapine** (Clozaril) is the only FDA-approved medication for treatment-resistant schizophrenia and may be effective where other medicines fail to reduce psychotic symptoms that contribute to aggression and/or suicide. For many years clozapine was limited in the U.S. by strict usage protocols, called REMS — Risk Evaluation and Mitigation Strategy — which was discontinued in February 2025.

Mood stabilizers: Used to treat acute mania, hypomania, and mixed mood episodes.

- Lithium was the first federally approved mood stabilizer and remains widely used under trade names such as Eskalith, Lithobid, and Lithonate. Some anti-anxiety and anti-convulsant medications also might be used to stabilize moods.

Interventions to ameliorate side effects

Some common side effects of antipsychotic medication can improve with prompt interventions, including these:

- **Metabolic effects, including weight gain:** Can be treated with metformin, GLP-1 agonists (commonly used to treat type 2 diabetes), lifestyle modification, or a change in antipsychotics.
- **Apathy/social withdrawal:** Psychosocial support is vital. Interventions might also include reducing an antipsychotic dosage, switching to the antipsychotics cariprazine (Vraylar) or aripiprazole (Abilify), or adding low dose amisulpride (anti-nausea drug).
- **Cognitive decline:** May be addressed with a review of medications to determine if they are having a negative impact due to anticholinergic burden, caused by medications that reduce the neurotransmitter acetylcholine, which plays a role in thinking and can affect motivation and attention. Lowering dosages of antipsychotics and cognitive remediation therapies, such as cognitive enhancement therapy (CET), may help.
- **Movement disorders, sometimes called extrapyramidal side effects**:
  - **Tardive dyskinesia** (involuntary, repetitive body movements): Can be treated with VMAT2 inhibitors (vesicular monoamine transporter-2 inhibitors), which are also used to treat movement disorders caused by Huntington's disease.
  - **Dystonia** (involuntary muscle movements that resemble Parkinson's symptoms): Can be treated with anticholinergic medications that block certain neurotransmitters to prevent an overreaction of the parasympathetic nervous system.

Books and other resources

- "Surviving Schizophrenia, 7th Edition: A Family Manual," by E. Fuller Torrey, M.D. Dr. Torrey provides a roadmap for navigating the journey ahead.
- "Becoming Fluent in LEAP," by Xavier Amador, Ph.D. Written to help people who want to communicate better with someone who lacks insight into their condition due to the symptom of anosognosia.
- "Malady of the Mind: Schizophrenia and the Path to Prevention," by Jeffrey A. Lieberman, M.D. This book includes guidance about early treatment and how to prevent relapse and worsening of illness symptoms. He hints at science being on the brink of discovering methods for preventing schizophrenia.
- "Schizophrenia & Related Disorders: A Handbook for Caregivers" by Nicole Drapeau Gillen. This book equips care partners with practical tools and guidance.
- TAC provides additional multimedia resources, including videos and podcasts.