Yeah — **C-PTSD** and **SIPD** (*substance-induced psychotic disorder*) can absolutely get mistaken for **schizophrenia**, because the brain's "threat system" and the brain's "psychosis system" can produce some eerily similar outward behavior.

Why the mix-ups happen

1) C-PTSD can look "psychotic" from the outside
ICD-11 Complex PTSD is basically PTSD **plus** "disturbances in self-organisation": big emotion regulation problems, relationship problems, and a deeply negative self-concept, on top of re-experiencing/avoidance/hypervigilance.
When someone is hypervigilant, dissociated, sleep-deprived, flooded with shame/anger, and constantly scanning for danger, they can sound paranoid or disconnected in ways that resemble psychosis.

2) PTSD can include real psychotic symptoms in some people
There's a described pattern called **PTSD with secondary psychotic features**: PTSD symptoms first, then hallucinations/delusions later; the psychotic symptoms may persist and aren't limited to flashbacks. (PubMed)
So even if someone truly has hallucinations/delusions, that still doesn't automatically equal schizophrenia.

3) SIPD can look *exactly* like schizophrenia during the episode
Substance-/medication-induced psychosis is defined as hallucinations and/or delusions caused directly by a substance or withdrawal (not delirium). Symptoms are often brief once the substance clears, but stimulant-triggered psychosis can last weeks. (MSD Manuals)
Australian comorbidity guidance also notes it's "extremely difficult" to distinguish SIPD from other psychotic disorders; visual/tactile hallucinations and a return to normal functioning during abstinence can point toward SIPD. (Comorbidity Guidelines)

The practical "how do clinicians tell?" pieces

Schizophrenia (DSM-5 framing) requires a *pattern over time*: characteristic symptoms for a meaningful chunk of a month, and **continuous disturbance for at least 6 months** with functional decline.
So a big diagnostic hinge is **course + timeline**:

- **Timing vs substances/withdrawal/med changes** (hours–days onset after use, improving with sobriety → more SIPD-ish). (MSD Manuals)
- **Persistence in a clear period of abstinence** (if psychosis keeps going well beyond intox/withdrawal windows, schizophrenia or another primary psychotic disorder becomes more likely — but PTSD-related psychosis can also persist, so trauma history still matters). (MSD Manuals)
- **Negative/cognitive symptoms and "inter-episode" functioning** (SIPD often has better return to baseline between episodes; schizophrenia more often has ongoing negative/cognitive changes). (Comorbidity Guidelines)
- **Trauma sequencing** (PTSD symptoms clearly predate psychosis → supports PTSD-SP possibility). (PubMed)

If you’re worried you were misdiagnosed

A solid next move is a **structured re-assessment** (psychiatrist or clinical psychologist), *with receipts*:

- a written **timeline**: trauma exposure/PTSD symptoms, first psychotic symptoms, substance use periods, withdrawals, medication starts/stops, sleep disruption
- collateral info (someone who knew you before/after episodes)
- toxicology / substance history taken seriously (not morally, medically)