MENTAL HEALTH · PSYCHIATRIC NURSING

NGN NCLEX 2026

Paranoia *vs* Delusion *vs* Hallucination

High-yield comparison of three commonly confused psychiatric symptoms — with definitions, nursing priorities, therapeutic communication, pharmacology, and NCLEX test traps.

📚 **Source Disclosure:** This topic was not present in uploaded notes. Content compiled from standard NCLEX references — Saunders Comprehensive Review for the NCLEX-RN (10th ed.), ATI Mental Health Nursing Edition 11.0, Boyd's Psychiatric Nursing: Contemporary Practice (7th ed.), Stuart's Principles & Practice of Psychiatric Nursing, and the DSM-5-TR (APA, 2022).

1 Definitions & Side-by-Side Comparison

PARANOIA

SUSPICION + FEAR

A pervasive feeling/theme of extreme distrust, suspiciousness, and fear that others intend harm — without proportionate evidence.

KEY FEATURE

It is a *theme or attitude*, not necessarily a fixed belief. Often appears *within* delusions (persecutory) but can exist alone.

COMMON IN

- Paranoid personality disorder
- Schizophrenia
- Substance-induced psychosis (cocaine, meth, PCP)
- Dementia / delirium (elderly)

EXAMPLE

"The staff is poisoning my food" — said while refusing every tray.

DELUSION

FIXED FALSE BELIEF

A fixed, false belief not based in reality that *cannot be reasoned away* with logic or evidence, despite being clearly improbable.

KEY FEATURE

The patient holds it firmly; logic and proof do not change it. *Belief — not sensory.*

TYPES (HIGH-YIELD)

- **Persecutory** — "They're trying to kill me" (most common; overlaps with paranoia)
- **Grandiose** — "I am the Messiah"
- **Somatic** — "My organs are rotting"
- **Erotomanic** — "A celebrity loves me"
- **Jealous** — "My partner cheats"
- **Ideas of reference** — "The TV is sending me messages"
- **Thought broadcasting / insertion / withdrawal**

HALLUCINATION

FALSE SENSORY EXPERIENCE

A false sensory perception experienced *without an external stimulus* — the patient sees, hears, feels, smells, or tastes something that is not there.

KEY FEATURE

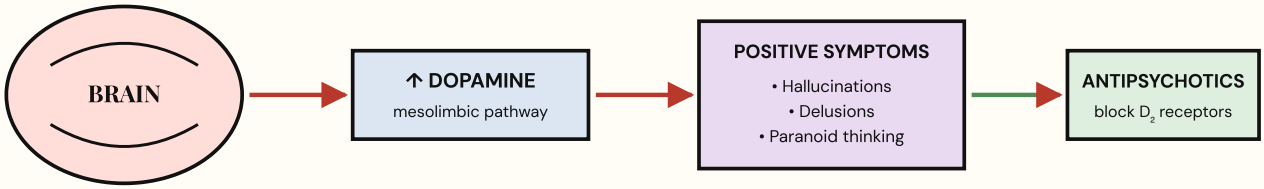
It is *sensory*, not belief-based. The brain generates the perception with no stimulus to receive.

TYPES (HIGH-YIELD)

- **Auditory** — hearing voices (MOST COMMON; classic in schizophrenia)
- **Visual** — seeing things (think delirium, substance use, Lewy body dementia)
- **Tactile** — feeling things on/under skin (think alcohol withdrawal/DTs, cocaine — "formication")
- **Olfactory** — smelling (often a seizure aura)
- **Gustatory** — tasting

🚨 **Command hallucinations — voices ordering self-harm or harm to others = TOP SAFETY PRIORITY.**

2 Pathophysiology — Simplified



Dopamine hypothesis: excess dopamine in the mesolimbic pathway drives positive psychotic symptoms

SCHIZOPHRENIA / PRIMARY PSYCHOSIS

Genetic + environmental triggers → Dopamine dysregulation (mesolimbic excess) → Disrupted reality testing →

Hallucinations · Delusions · Paranoia

SUBSTANCE-INDUCED (STIMULANTS, WITHDRAWAL)

Cocaine/meth/PCP/alcohol withdrawal → Massive dopamine/glutamate release or rebound →

Tactile/visual hallucinations + paranoia

DELIRIUM / DEMENTIA (ELDERLY)

Acute illness · infection · meds · dehydration → Acetylcholine deficit / global brain dysfunction →

Visual hallucinations + paranoid ideation (often reversible)

3 Signs & Symptoms — Behavioral Cues

PARANOIA

- Refuses food/meds (fear of poisoning)
- Hyper-vigilant, scans the room
- Guarded posture, mistrustful of staff
- Misinterprets neutral events as threats
- Resistant to care; demands explanations
- May isolate or pace

Aggression risk if patient feels cornered or threatened.

DELUSION

- Persistent false statements ("I am God")
- Will not be talked out of belief
- Behavior consistent with the belief (e.g., refuses food b/c "it's contaminated")
- May reference TV/radio/strangers
- Disorganized speech (looseness of associations)
- Often co-occurs with hallucinations

Persecutory delusion + identified "enemy" = violence risk.

HALLUCINATION

- Talks/responds to no one ("internal stimuli")
- Head tilted as if listening; sudden laughter
- Looks at, swats at, or describes objects others don't see
- Picks at skin, brushes off invisible bugs
- Reports voices, smells, or tastes
- Distracted, unable to focus during conversation

Command hallucinations to harm self/others = IMMEDIATE safety priority.

4 Priority Nursing Interventions — Therapeutic Communication

SYMPTOM	✓ DO	✗ DO NOT
PARANOIA	• Use a calm, matter-of-fact, honest tone • Maintain professional **distance** — do not stand too close • Use **same staff** consistently to build trust • Offer **sealed/canned foods** if food paranoia present • Approach openly; announce yourself before entering • **Airway/safety first** if agitation escalates	• Do NOT **whisper or laugh** in their presence (fuels paranoia) • Do NOT touch without explicit warning • Do NOT argue or try to "prove" they are wrong • Do NOT make sudden movements • Do NOT take suspicions personally
DELUSION	• **Acknowledge the feeling, not the content**: "I understand you feel afraid, but I don't see what you see." • Present reality calmly and briefly • **Redirect** to reality-based, structured activities • Explore feelings *underneath* the delusion (fear, loss of control) • Document content, frequency, intensity • **Assess safety** — especially persecutory or grandiose with risky plans	• Do NOT **argue, debate, or use logic** to disprove the delusion • Do NOT **agree with or reinforce** the delusion (no playing along) • Do NOT laugh at or dismiss the belief • Do NOT touch the patient unexpectedly • Do NOT focus on delusion content excessively
HALLUCINATION	• **ASSESS first** — ask, "What are the voices telling you?" (rule out command) • Validate the experience *without* validating reality: "I don't hear voices, but I know they are real to you." • Use **distraction** — music, walks, structured activity • Reduce environmental stimulation • **Safety first** — 1:1 observation if command hallucinations • Teach patient to tell voices "Go away"	• Do NOT **pretend to hear/see** the hallucination • Do NOT ask the patient to describe content in excessive detail (reinforces) • Do NOT challenge the realness of the perception • Do NOT leave alone with command hallucinations to harm

NCLEX Priority Rule: When all three coexist, prioritize using **SAFETY (Maslow) → ABCs**. *Command hallucinations to harm = always #1.* Persecutory delusion with violent plan = #2. Generalized paranoia without imminent threat = ongoing therapeutic-relationship work.

5 Pharmacology — Antipsychotics

CLASS	DRUGS (GENERIC)	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Typical (1st gen) *"-azine," haloperidol*	`haloperidol`, `chlorpromazine`, `fluphenazine`, `perphenazine`	Strong D_2 blockade	**EPS** (acute dystonia, akathisia, parkinsonism, tardive dyskinesia), anticholinergic, sedation, ↓ BP, **NMS**	Best for **positive symptoms**. Monitor AIMS for tardive dyskinesia. Treat acute EPS with `benztropine` or `diphenhydramine`.
Atypical (2nd gen) *"-pine, -done, -piprazole"*	`risperidone`, `olanzapine`, `quetiapine`, `aripiprazole`, `ziprasidone`, `paliperidone`	D_2 + 5-HT_2A blockade	**Metabolic syndrome** (weight gain, ↑ glucose, ↑ lipids), sedation, orthostatic hypotension, less EPS than typicals	1st line for most psychosis. Baseline + ongoing **weight, BMI, fasting glucose, lipid panel**. `Olanzapine` — highest metabolic burden.
Atypical — Clozapine (reserved)	`clozapine`	D_2 + 5-HT_2A blockade	**AGRANULOCYTOSIS** 🚨, seizures, myocarditis, severe metabolic effects, hypersalivation	Used for **treatment-resistant schizophrenia**. **Mandatory WBC + ANC monitoring** (weekly × 6 mo, then less often). Hold for ANC < 1,500/mm³. Report fever/sore throat immediately.

🚨 EPS — RECOGNIZE FAST

- **Acute dystonia** — muscle spasm, oculogyric crisis, torticollis (within hours-days) → emergency; give `benztropine` IM/IV
- **Akathisia** — restless, can't sit still → ↓ dose, add propranolol
- **Pseudoparkinsonism** — tremor, rigidity, shuffling gait → anticholinergic
- **Tardive dyskinesia** — lip smacking, tongue movements (late, often IRREVERSIBLE) → AIMS, discontinue or switch

🚨 NMS — LIFE-THREATENING

Neuroleptic Malignant Syndrome — rare but fatal.

- **F**ever (hyperthermia > 102°F)
- **E**ncephalopathy (altered LOC)
- **V**itals unstable (tachycardia, BP swings)
- **E**levated CPK / enzymes
- **R**igidity (lead-pipe muscle rigidity)

Action: STOP drug → cool the patient → IV fluids → `dantrolene` & `bromocriptine`. Mnemonic: **FEVER**.

6 NCLEX Test Traps — Wrong vs Right

Patient says, "The CIA put a chip in my head."

✗ TRAP "That's not possible — let me show you the X-rays."

✓ BEST "That sounds frightening. I don't share that belief, but I can see it's distressing for you."

Patient is responding to voices telling them to "do it now."

✗ TRAP "Try to ignore the voices — they're not real."

✓ BEST "What are the voices telling you to do?" → assess for command to harm, then initiate 1:1 / safety.

Paranoid patient refuses all meals.

✗ TRAP "You must eat — the food is safe, I promise."

✓ BEST Offer factory-sealed, single-serve foods (sealed crackers, canned drinks, individually wrapped items).

Patient says, "Tell me the voices are real — you hear them too, right?"

✗ TRAP "Yes, I hear them too" (collusion) — OR — "There are no voices, stop pretending."

✓ BEST "I don't hear any voices, but I understand they are very real to you."

Elderly patient on Day 2 post-op suddenly sees "people in the corner."

✗ TRAP Assume new schizophrenia or worsening dementia.

✓ BEST Suspect **delirium** — assess for infection (UTI), meds, electrolytes, hypoxia. Visual hallucinations + acute onset = delirium until proven otherwise.

Patient feels "bugs crawling under the skin."

✗ TRAP Treat as psychotic disorder.

✓ BEST Suspect **tactile hallucination (formication)** — think alcohol withdrawal (DTs) or cocaine/meth use. Assess CIWA, vitals, last drink.

7 Patient & Family Education

FOR THE PATIENT

- **Take medications as prescribed** — even when feeling better. Stopping abruptly = relapse risk.
- Effects of antipsychotics build over **2–6 weeks**; do not expect overnight change.
- **Avoid alcohol and illicit drugs** — they worsen psychosis and interact with meds.
- Learn personal warning signs of relapse (sleep changes, suspicious thoughts, withdrawing).
- Use coping strategies: tell voices to "go away," distract with music, ground with senses.
- Keep follow-up appointments; report side effects (movement changes, fever, sore throat on clozapine).
- Carry crisis line numbers (e.g., **988 Suicide & Crisis Lifeline**).

FOR THE FAMILY

- **Do NOT argue** with delusions or hallucinations — it does not help and damages trust.
- Do NOT play along or pretend to hear/see what the patient does.
- Use simple, clear language. Avoid whispering near the patient.
- Maintain a low-stimulation, predictable home routine.
- Recognize relapse signs (sleep loss, increased suspiciousness, isolation, medication refusal) — call the prescriber early.
- **Remove access to weapons/firearms**; safely store medications.
- Engage in support resources — **NAMI** family support groups, family psychoeducation programs.
- Call 911 or go to ED for command hallucinations to harm, suicidal/homicidal ideation, or NMS symptoms (fever + rigidity).

8 Memory Boosters & Pattern Recognition

PARANOIA

"SUSPICION"

Starts with S — like **S**uspicion. A pervasive theme of mistrust. Often hides *inside* a persecutory delusion.

DELUSION

"FIXED & FALSE"

A **B**elief — not a sensation. *"D for Delusion = Distorted thinking."* Logic cannot remove it.

HALLUCINATION

"SENSE w/o STIMULUS"

Hallucination = **H**earing/seeing what's not there. A *sensory* experience with no source.

THE "3 S" QUICK-RECALL RULE

PARANOIA	DELUSION	HALLUCINATION
Suspicion	Stubborn belief	Sensation alone

Hallucination Type → Likely Cause Pattern:

- **Auditory** → Schizophrenia (most common)
- **Visual** → Delirium, substance use, Lewy body dementia
- **Tactile (formication)** → Alcohol withdrawal (DTs), cocaine, meth
- **Olfactory** → Seizure (temporal lobe aura), brain tumor
- **Gustatory** → Seizure or rare neurological cause

9 NCJMM Clinical Judgment — Full 6-Step Walkthrough

> ***VIGNETTE:*** *A 24-year-old man with a history of schizophrenia is admitted involuntarily. He paces the unit, glances repeatedly at the corner of the room, and mutters under his breath. He refuses his lunch tray, stating, "The kitchen workers are mixing arsenic into my food." When the nurse approaches, he tilts his head as if listening, then says, "The voices say I have to stop them before they stop me." VS: HR 108, BP 142/88, RR 22, T 99.1°F.*

STEP 1 RECOG — **Recognize Cues**

Pacing, hyper-vigilance, responding to internal stimuli (head tilt, muttering), refusing food (paranoia), persecutory delusion ("arsenic in my food"), **command-type auditory hallucination with violent content** ("stop them before they stop me"), elevated HR/BP/RR.

STEP 2 ANALYZE — **Analyze Cues**

All three psychotic phenomena are present simultaneously: **paranoia** (suspicion theme), **persecutory delusion** (fixed false belief about poisoned food), and **auditory hallucinations of the command type** (voices ordering action). Command hallucinations to harm others elevate this from a mental-health concern to an *imminent safety event*.

STEP 3 PRIORITIZ — **Prioritize Hypotheses**

#1 — Risk for harm to others (and self) from command hallucination → highest priority. #2 — Acute psychosis with persecutory delusion. #3 — Inadequate intake / refusal of meds 2° paranoia. #4 — Hemodynamic effects of acute agitation.

STEP 4 GENERATE — **Generate Solutions**

Initiate **1:1 continuous observation**; ensure environmental safety (remove sharp/breakable items); approach calmly with another staff member visible; offer PRN antipsychotic (e.g., **`haloperidol` ± `lorazepam`** per orders); offer **sealed/canned foods**; do not argue with delusion; assess what the voices are saying and how often; notify provider; document precisely.

STEP 5 TAKE ACTION — **Take Action**

Place patient on 1:1; remove any potential weapons from the room; use a calm, neutral voice; ask, "What are the voices telling you to do?" — confirm command. Administer ordered antipsychotic. Acknowledge feeling: "I can see you feel threatened. You are safe here." Offer a sealed bottle of water. Notify the provider and document VS, behavior, voiced thoughts, and interventions.

STEP 6 EVALUATE — **Evaluate Outcomes**

Expected:

Within 30–60 min — decreased pacing, ↓ HR/RR, accepts sealed water/food, no harm to self/others, denies acting on voice content.

Re-escalate

if: voices intensify, patient identifies a target, refuses meds, or vital signs worsen. Reassess every 15 min while on 1:1 until stabilized.