NCLEX • MENTAL HEALTH • 2026 TEST PLAN | PSYCHOSOCIAL INTEGRITY | HIGH-YIELD COMPARISON

Psychosis vs. Delirium vs. Dementia

Three altered states of cognition that look alike at the bedside — but the wrong call can cost a life. Master the differential, the priority action, and the test traps the NCLEX loves to set.

System: Neurocognitive / Psychiatric
NCLEX Category: Psychosocial Integrity
Reversibility: Delirium ✓ • Dementia ✗ • Psychosis ↔
Memory aid: Acute → Delirium

REALITY DISTURBANCE
Psychosis
Loss of contact with reality. Hallucinations + delusions + disorganized thinking. **LOC intact.** Dopamine-driven. Variable onset.

ACUTE • REVERSIBLE
Delirium
Sudden, fluctuating confusion from an underlying medical cause. **Medical emergency.** Treatable — find the cause and reverse it.

CHRONIC • PROGRESSIVE
Dementia
Slow, irreversible decline in memory + cognition. Months to years. **Memory loss is the hallmark.** Plan for safety + caregiver support.

SECTION 01 — DEFINITION & OVERVIEW
What each one is, and why the differential matters

Psychosis
- A **symptom syndrome**, not a single diagnosis — break from reality testing
- Seen in schizophrenia, schizoaffective, bipolar (manic / depressive psychotic features), substance-induced, brief psychotic disorder
- Hallmark: **auditory hallucinations + delusions** with intact level of consciousness

Delirium
- An **acute, fluctuating disturbance** in attention + awareness from a medical cause
- Hours-to-days onset. Hospitalized older adults, ICU, post-op, infection, polypharmacy
- **Reversible** if the cause is found and corrected — every minute counts

Dementia
- A **chronic, progressive** loss of memory + ≥1 other cognitive domain
- Alzheimer's (most common), vascular, Lewy body, frontotemporal
- Insidious onset over **months-to-years**. Not a normal part of aging

Why this matters → A confused 78-year-old isn't always "just dementia." If onset is *acute*, treat it as delirium until proven otherwise — search for infection (UTI is #1), hypoxia, electrolytes, drugs, or pain. Mistaking delirium for dementia is one of the most dangerous errors in geriatric nursing.

SECTION 02 — PATHOPHYSIOLOGY (SIMPLIFIED)
What's happening in the brain

Psychosis
1. **Genetic + environmental triggers** (stress, substance use, trauma)
↓
2. **Excess dopamine** in the mesolimbic pathway → positive symptoms (hallucinations, delusions)
↓
3. **Low dopamine** in mesocortical pathway → negative symptoms (flat affect, avolition)
↓

Delirium
1. **Acute insult:** infection (UTI, pneumonia), hypoxia, electrolytes, drugs, pain, post-op
↓
2. **Acetylcholine deficiency** + dopamine excess + inflammatory cytokines flood the CNS
↓
3. Reticular activating system + prefrontal cortex disrupted → **attention collapses**
↓

Dementia
1. **Slow neuronal loss** begins decades before symptoms
↓
2. **Alzheimer's:** β-amyloid plaques + tau tangles → synaptic failure, hippocampus first
↓
3. Acetylcholine ↓↓ → memory + learning impaired (target of cholinesterase inhibitors)
↓

4 Glutamate (NMDA) dysfunction + serotonin imbalance amplify the picture

4 Fluctuating LOC, sleep-wake reversal, perceptual disturbances — **reversible if treated**

4 Cortical atrophy spreads → language, judgment, ADLs lost. **Irreversible.**

SECTION 03 — SIGNS & SYMPTOMS

The differential at the bedside

FEATURE	PSYCHOSIS	DELIRIUM	DEMENTIA
Onset	Variable — days to weeks (acute first break) or insidious in chronic illness	RAPID Hours to days. **Sudden change** is the giveaway.	Insidious. Months to years.
Course	Episodic with remissions; chronic in schizophrenia	**Fluctuates hour-to-hour**; lucid intervals between confusion	Steady, progressive decline
Level of consciousness	**Alert + oriented** (unless severe disorganization)	ALTERED Clouded → hyperalert OR drowsy (mixed type)	Alert until late stage
Attention	Usually intact	IMPAIRED Cannot sustain or shift attention — **hallmark**	Preserved early; impaired late
Memory	Generally preserved	Recent memory poor (attention failure)	**Short-term memory loss = hallmark.** Long-term lost later.
Hallucinations	**Auditory** most common (command hallucinations = risk)	**Visual** most common (bugs, shadows, animals)	Visual in Lewy body; uncommon in early Alzheimer's
Thought process	Delusions, looseness of associations, word salad, neologisms	Disorganized, illogical, rambling	Impoverished, concrete, perseveration
Sleep-wake	Often disrupted, especially in mania-related psychosis	**Reversed** — agitation at night, somnolence by day	SUNDOWNING Late-day confusion + agitation
Reversibility	Often improves with treatment; some chronic	**YES** — treat the cause	**NO** — manage, don't cure
Red flags	Command hallucinations to harm self/others; catatonia; first-break psychosis	Any acute mental status change in an elder → **rule out infection NOW**	Wandering, falls, weight loss, caregiver burnout, elder abuse risk

SECTION 04 — PRIORITY NURSING INTERVENTIONS

What you do first — and why

Psychosis — SAFETY FIRST

- → **Assess** for command hallucinations + suicidal/homicidal ideation — ask directly
- → **Maintain** a calm, low-stimulation environment; reduce TV, lights, group noise
- → **Use** short, clear, concrete statements — one nurse at a time
- → **Acknowledge** the feeling, present reality: *"I don't hear the voice, but I can see you're frightened."*
- → **Do NOT argue** with delusions or hallucinations
- → **Administer** antipsychotic; monitor for EPS + NMS
- → **Build** therapeutic trust + medication adherence plan

Delirium — FIND THE CAUSE

- → **Assess** ABCs + vitals + O_2 sat — hypoxia is a top reversible cause
- → **Obtain** urinalysis, CBC, BMP, glucose; review meds (anticholinergics, opioids, benzos)
- → **Reorient** frequently — clock, calendar, daylight, glasses + hearing aids on
- → **Mobilize** early; promote normal sleep-wake; avoid restraints if possible
- → **Keep** family at bedside; familiar voices ground the patient
- → **Avoid** benzodiazepines (worsen delirium) *except* alcohol/benzo withdrawal
- → **Low-dose haloperidol** only if severe agitation threatens safety

Dementia — STRUCTURE & SAFETY

- → **Maintain** a consistent routine + familiar caregivers
- → **Simplify** environment — remove clutter, use labels, single-step directions
- → **Validate** feelings, redirect rather than confront
- → **Prevent** wandering: door alarms, ID bracelet, bed in low position
- → **Schedule** activities during peak energy; calm evenings to prevent sundowning
- → **Support** the caregiver — burnout is a safety risk for the patient
- → **Assess** for pain (often expressed as agitation) before sedating

A — Airway | B — Breathing | C — Circulation | S — Safety

Delirium + altered LOC → aspiration risk. Side-lying, suction ready.

Hypoxia is the #1 reversible delirium cause.
`O₂ + pulse ox FIRST.`

Sepsis, dehydration, MI can present as confusion in elders.

Falls, wandering, self-harm in command hallucinations. Never minimize.

SECTION 05 — PHARMACOLOGY

The drugs that show up on the exam

For Psychosis
ANTIPSYCHOTICS

`haloperidol (FGA)`
D_2 receptor blockade
- EPS: dystonia, akathisia, parkinsonism, tardive dyskinesia EPS
- NMS: fever, rigidity, ↑CK, autonomic instability EMERGENCY
- Monitor: AIMS scale, vital signs, hydration

`risperidone, olanzapine (SGA)`
D_2 + 5-HT_2A blockade
- Metabolic: weight gain, ↑glucose, ↑lipids
- Less EPS than FGAs but still possible
- Olanzapine + dementia = ↑ stroke risk BBW

`clozapine`
Treatment-resistant schizophrenia
- Agranulocytosis — weekly WBC/ANC BBW
- Myocarditis, seizures, severe sedation

For Delirium
TREAT THE CAUSE FIRST

`— Treat underlying cause —`
Antibiotic for UTI/pneumonia, O_2 for hypoxia, fluids, electrolyte correction, stop offending drug

`haloperidol (low-dose)`
Last resort for severe agitation
- QTc prolongation — check ECG
- Use lowest effective dose, shortest duration

`lorazepam — AVOID`
Worsens delirium in most cases
- **Exception:** alcohol or benzodiazepine withdrawal delirium EXCEPT
- Use CIWA protocol for ETOH withdrawal

For Dementia
SLOW PROGRESSION

`donepezil, rivastigmine, galantamine`
Cholinesterase inhibitors — ↑ACh
- Mild-to-moderate Alzheimer's
- GI: nausea, diarrhea, anorexia
- Bradycardia, syncope — monitor HR
- Take with food; give at bedtime if drowsy

`memantine`
NMDA-receptor antagonist
- Moderate-to-severe Alzheimer's
- May be combined with donepezil
- Dizziness, headache, confusion

`Avoid in dementia`
High-risk medications
- Benzodiazepines, anticholinergics (diphenhydramine), antipsychotics in elders BBW

NCLEX pearl — Anticholinergic drugs (diphenhydramine, oxybutynin, tricyclics, first-gen antipsychotics) *cause and worsen delirium*, and they oppose the cholinesterase inhibitors used in dementia. Always review the home med list when a patient presents confused.

SECTION 06 — NCLEX TEST TRAPS ⚠

Where students lose points

TRAP 01
"Confused 82-year-old" ≠ automatically dementia

WRONG	RIGHT
Assume it's worsening dementia and reorient.	Acute change → screen for delirium FIRST. Vitals, O_2, UA, glucose.

TRAP 02
Hallucination type clues you in

WRONG	RIGHT
"Hallucinations = psychosis = give antipsychotic."	Visual = think delirium or Lewy body. Auditory = think primary psychosis.

TRAP 03
Benzos for confusion

WRONG	RIGHT
Give lorazepam to calm a delirious elder.	Benzos WORSEN delirium. Only use for ETOH/benzo withdrawal.

TRAP 04
Arguing with delusions

WRONG	RIGHT
"There's no one in your closet, that's not real."	Acknowledge feeling, present reality: "I don't see anyone, but I can see you're scared."

TRAP 05
Restraints for a wandering dementia patient

WRONG	RIGHT
Apply soft restraints to keep them safe.	Last resort. Try door alarms, bed alarm, redirection, family at bedside first.

TRAP 06
NMS vs serotonin syndrome vs EPS

WRONG	RIGHT
Hold all antipsychotics any time the patient is rigid.	NMS = fever + lead-pipe rigidity + ↑CK. STOP drug, cool, IV fluids, dantrolene.

SECTION 07 — PATIENT & FAMILY EDUCATION

What they need to know going home

Psychosis — Family teaching

- ✓ Take medication every day, even when feeling better
- ✓ Report side effects: stiffness, restlessness, fever, jaw movements
- ✓ Avoid alcohol, cannabis, stimulants — trigger relapse
- ✓ Identify early warning signs: sleep loss, suspicion, isolation
- ✓ Have a crisis plan + 988 / local crisis line saved
- ✓ Attend follow-up + therapy; family support reduces relapse

Delirium — Family teaching

- ✓ Delirium can recur — recognize the early signs of confusion
- ✓ Bring glasses, hearing aids, and a familiar object to any hospital stay
- ✓ Stay with the patient when possible — familiar voices ground them
- ✓ Review the home medication list with the provider — many drugs trigger delirium
- ✓ Treat infections + dehydration EARLY, especially UTIs
- ✓ Promote normal sleep, daylight, and gentle activity

Dementia — Caregiver teaching

- ✓ Use simple, one-step directions and a calm tone
- ✓ Keep a daily routine; same caregivers when possible
- ✓ Label drawers, put away dangerous items, install door alarms
- ✓ Plan for sundowning: calm evenings, dim lights, soft music
- ✓ Schedule respite — caregiver burnout is a patient safety risk
- ✓ Advance directives + power of attorney while patient can participate

SECTION 08 — MEMORY BOOSTERS

Mnemonics & quick-recall patterns

☆ STAR MNEMONIC — CAUSES OF DELIRIUM

D · E · L · I · R · I · U · M

D	**Drugs** — anticholinergics, opioids, benzos, polypharmacy
E	**Electrolytes / Endocrine** — Na^+, Ca^{2+}, glucose, thyroid
L	**Lack of drugs** — withdrawal (ETOH, benzos)
I	**Infection** — UTI #1 in elders, pneumonia, sepsis
R	**Reduced sensory input** — missing glasses, hearing aids
I	**Intracranial** — stroke, bleed, post-ictal, tumor
U	**Urinary / fecal** retention — common, fixable
M	**Myocardial / pulmonary** — MI, hypoxia, hypoperfusion

PATTERN RECOGNITION

"Acute → Delirium. Chronic → Dementia. Reality → Psychosis."

If the question stem stresses sudden onset, your answer is delirium. Months of decline → dementia. Hallucinations with intact LOC → psychosis.

3 A'S OF ALZHEIMER'S

Amnesia · Aphasia · Apraxia

Memory loss + language trouble + can't perform learned motor tasks. Add Agnosia (can't recognize) = 4 A's.

POSITIVE VS NEGATIVE PSYCHOSIS SX

"Positive = ADDED. Negative = REMOVED."

Positive: hallucinations, delusions, disorganized speech (added to normal). Negative: flat affect, avolition, alogia, anhedonia (removed from normal). SGAs treat both better than FGAs.

"FEVER-ED-UP PATIENT" → NMS

F·E·V·E·R: Fever · Encephalopathy · Vitals unstable · Enzymes ↑ (CK) · Rigidity

Stop the antipsychotic. Cool. IV fluids. Dantrolene or bromocriptine. NMS is a true emergency.