NCLEX-RN · 2026 TEST PLAN · PSYCHOSOCIAL INTEGRITY

Schizophrenia

A chronic, severe brain disorder marked by disturbances in thinking, perception, emotion, and behavior. The most studied of all psychotic disorders — and the most heavily tested.

SYSTEM · **PSYCHIATRIC / MENTAL HEALTH**

LIFETIME PREV · **~1%**

ONSET · **LATE TEENS – EARLY 30S**

5	6mo	1°	2x
SYMPTOM DOMAINS	MINIMUM FOR DX	PRIORITY ALWAYS SAFETY	SUICIDE RISK VS PUBLIC

INSIDE THIS GUIDE

8 Sections · Built for NCLEX Recall

FULL COLOR · PRINT-READY

> *When in doubt on a schizophrenia NCLEX question, pick the answer that protects safety, builds trust, and presents reality without arguing.*

01

DEFINITION · OVERVIEW

What Schizophrenia Is

Schizophrenia is a chronic psychotic disorder causing a profound break from reality. It distorts how a person thinks, feels, perceives, and behaves — usually for life, but it is manageable with medication and therapy.

Diagnostic essentials (DSM-5-TR): ≥2 core symptoms for ≥1 month (one must be hallucinations, delusions, or disorganized speech), with continuous disturbance lasting ≥6 months. Functioning declines below previous baseline.

Key Terms — Quick Reference Glossary

Master these definitions first — every NCLEX schizophrenia question uses this vocabulary.

Psychosis
A break from reality. Patient cannot distinguish what is real from what is not.

Hallucination
False sensory perception *without* a real stimulus (hearing voices that aren't there).

Illusion
A real stimulus that is *misperceived* (mistaking a coat on a chair for a person). Not the same as a hallucination.

Delusion
A fixed, false belief that cannot be changed by logic or evidence.

Delusion of Grandeur
Belief in inflated power or identity ("I am the president of the universe").

Delusion of Persecution
Belief that others are plotting harm ("The FBI is poisoning my food").

Delusion of Reference
Belief that random events/media carry personal messages ("The TV is talking to me").

Delusion of Control
Belief that an outside force is controlling thoughts or actions.

Flat / Blunted Affect
Reduced facial expression and emotional tone. Speaks with little inflection or expression.

Anhedonia
Inability to feel pleasure from activities once enjoyed.

Avolition
Lack of motivation to start or finish goal-directed activity.

Alogia
Poverty of speech — short, empty replies. ("A" = without, "logia" = words.)

Echolalia
Meaningless repetition of another person's spoken words.

Echopraxia
Involuntary imitation of another person's movements.

Word Salad
A jumbled, meaningless string of words with no connection ("Sky run yellow happy door").

Neologism
Invented words that only have meaning to the patient ("The grilbie is glooping").

Loose Associations
Rapidly shifting between unrelated topics. Thoughts don't logically connect.

Tangentiality
Wanders off topic and *never* returns to the original point.

Circumstantiality
Excessive, unnecessary detail but *eventually* returns to the point.

Clang Association
Linking words by sound/rhyme, not meaning ("The cat, the bat, the rat is flat").

Catatonia
Marked psychomotor disturbance — immobility, rigidity, or excessive purposeless movement.

Waxy Flexibility
Patient holds whatever posture you place them in, like a wax figure. Catatonic feature.

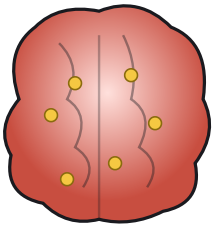
Anosognosia
Inability to recognize one's own illness. The #1 reason patients stop their meds.

Prodromal Phase
Early warning phase before full psychosis — social withdrawal, odd beliefs, declining function.

PATHOPHYSIOLOGY · SIMPLIFIED

02 What's Happening in the Brain

Schizophrenia is a neurotransmitter imbalance disorder — primarily an excess of dopamine in some brain regions and a deficit in others. This is the foundation behind every antipsychotic drug.



DOPAMINE EXCESS

The Dopamine Hypothesis (the BIG one)

Hyperactive dopamine in the *mesolimbic pathway* → produces **positive symptoms** (hallucinations, delusions). Hypoactive dopamine in the *mesocortical pathway* → produces **negative symptoms** (flat affect, avolition).

Antipsychotics work by **blocking D2 dopamine receptors** — which calms the excess but can also cause motor side effects.

1 Genetic vulnerability

Strong heritable component — risk rises sharply if a first-degree relative is affected (~10%). Twin concordance ~50%.

↓

2 Environmental triggers

Prenatal infection, obstetric complications, cannabis use in adolescence, severe stress, urban upbringing.

↓

3 Neurotransmitter imbalance

Dopamine ↑ in mesolimbic pathway, dopamine ↓ in mesocortical. Glutamate dysfunction and serotonin involvement.

↓

4 Structural brain changes

Enlarged ventricles, decreased gray matter (prefrontal cortex, hippocampus), reduced frontal lobe activity ("hypofrontality").

↓

5 Clinical psychosis emerges

Prodromal phase → first psychotic break (often late teens/early 20s in men, mid-20s/30s in women).

FOUR DOPAMINE PATHWAYS · WHY SYMPTOMS LOOK DIFFERENT

↑ MESOLIMBIC

Too much dopamine → hallucinations, delusions (positive symptoms)

↓ MESOCORTICAL

Too little dopamine → flat affect, avolition (negative symptoms)

↓ NIGROSTRIATAL

D2 block → EPS, tardive dyskinesia (drug side effects)

↓ TUBEROINFUNDIBULAR

D2 block → ↑ prolactin → gynecomastia, galactorrhea, sexual dysfunction

03

SIGNS · SYMPTOMS

The 4 Symptom Categories

Schizophrenia symptoms split into positive (things *added* that shouldn't be there), negative (things *missing* that should be there), cognitive, and affective. The NCLEX wants you to tell them apart.

+ POSITIVE · "ADDED"

What Shouldn't Be There

- **Hallucinations** (most often auditory — voices)
- **Delusions** (persecutory, grandiose, reference, control)
- **Disorganized speech** (word salad, loose associations, neologisms, clang)
- **Disorganized behavior** (bizarre, unpredictable)
- **Paranoia & suspiciousness**
- Catatonia, posturing, echolalia, echopraxia

- NEGATIVE · "REMOVED"

What's Been Taken Away

- **Flat / blunted affect** (no facial expression)
- **Alogia** — poverty of speech
- **Avolition** — no motivation, no goals
- **Anhedonia** — no pleasure
- **Asociality** — social withdrawal
- **Apathy** — emotional indifference

⊕ COGNITIVE

Thinking & Memory

- Poor attention & concentration
- Impaired working memory
- Difficulty with executive function
- Trouble making decisions
- Difficulty applying learned information
- **Anosognosia** — doesn't believe they're ill

♥ AFFECTIVE / MOOD

Emotional Disturbance

- Depression (very common)
- Hopelessness
- **Suicidal ideation** (~5–10% complete suicide)
- Inappropriate affect (laughing at sad news)
- Anxiety, agitation
- Mood lability

RED FLAG FINDINGS · ACT IMMEDIATELY

Command hallucinations to harm self or others · sudden calm or giving away possessions (suicide risk) · catatonic stupor with refusal to eat or drink · acute paranoia with weapon access · NMS triad (fever + rigidity + altered LOC) · WBC drop on clozapine.

04

PRIORITY NURSING INTERVENTIONS

What the Nurse Does First

1 SAFETY › 2 TRUST › 3 REALITY › 4 SELF-CARE › 5 MEDICATION ADHERENCE

For schizophrenia, the answer is almost always safety first: assess for harm to self or others before anything else. Use Maslow + ABCs to prioritize.

- ✓ **Assess for suicidal & homicidal ideation** — every shift. Ask directly. Ask about command hallucinations: "Are the voices telling you to do something?"
- ✓ **Provide a safe, low-stimulus environment** — quiet, well-lit, predictable. Reduce noise, TV, crowds.
- ✓ **Approach calmly, slowly, face-on** — never sneak up on a paranoid patient. Speak in short, clear, concrete sentences.
- ✓ **Acknowledge feelings, not the delusion** — "I understand you feel frightened, but I don't hear the voices."
- ✓ **Do not argue, agree with, or reinforce** delusions or hallucinations. Don't try to logic them away.
- ✓ **Present reality gently** — "I know you see a snake on the floor; I don't see one." Then redirect.
- ✓ **Distract & redirect** when hallucinations escalate — engage in a simple task, walk, listen to music.
- ✓ **Set firm but kind limits** on bizarre or unsafe behavior. Be consistent across staff.
- ✓ **Build trust slowly** — short, frequent contacts. Keep promises. Don't whisper or laugh nearby (paranoia trigger).
- ✓ **Monitor food, fluid, hygiene, sleep** — negative symptoms often mean self-neglect. Offer finger foods if paranoid about poisoning.
- ✓ **For paranoia: open / sealed food** — let the patient open packages themselves. Don't take pills from a cup someone else handled.
- ✓ **Administer & evaluate antipsychotic meds** — watch for EPS, NMS, metabolic effects. Long-acting injectables if non-adherent.
- ✓ **Encourage participation** in group/milieu therapy when stabilized — not during acute psychosis.
- ✓ **Document objectively** — describe what you see and hear, not your interpretation. Quote the patient.

05

PHARMACOLOGY

Antipsychotic Medications

All antipsychotics block dopamine D2 receptors. First-generation (typical) drugs block D2 strongly → high EPS risk. Second-generation (atypical) drugs also block serotonin → fewer motor effects but more metabolic problems.

First-Generation (Typical) Antipsychotics

FGA · D2 BLOCKERS

Best for: positive symptoms (hallucinations, delusions). **Worst for:** EPS, tardive dyskinesia, NMS.

haloperidol (Haldol)	High-potency. Often given IM for acute agitation. **Highest EPS risk.** Monitor for NMS.
chlorpromazine (Thorazine)	Low-potency. More sedation, anticholinergic effects, orthostatic hypotension. Less EPS.
fluphenazine (Prolixin)	Available as long-acting depot IM injection — useful for non-adherent patients.
perphenazine	Mid-potency. Balanced side effect profile.

Second-Generation (Atypical) Antipsychotics

SGA · D2 + 5HT2A

First-line treatment. Treat both positive AND negative symptoms. **Main risk:** metabolic syndrome — weight gain, ↑ glucose, ↑ lipids.

risperidone (Risperdal)	Most prolactin elevation of the atypicals. Watch for gynecomastia, galactorrhea, sexual dysfunction.
olanzapine (Zyprexa)	Highest weight gain & metabolic risk. Monitor weight, glucose, lipids regularly.
quetiapine (Seroquel)	Sedating — often given at bedtime. Lower EPS risk. Watch for orthostatic hypotension.
aripiprazole (Abilify)	D2 partial agonist. Less weight gain, less sedation. Can cause akathisia and insomnia.
ziprasidone (Geodon)	Lower metabolic risk. **Take with food** (≥500 cal) for absorption. Monitor QT interval.
clozapine (Clozaril)	**Most effective** for treatment-resistant cases — but reserved due to **agranulocytosis risk**. Requires weekly ANC/WBC monitoring × 6 mo, then biweekly, then monthly. Hold for ANC <1500. Also: seizures, myocarditis, severe sedation, drooling.

Extrapyramidal Symptoms (EPS) · The 4 You Must Recognize

Caused by D2 blockade in the nigrostriatal pathway. Treat with anticholinergics like **benztropine (Cogentin)** or **diphenhydramine (Benadryl)**.

1. Acute Dystonia

Sudden, painful muscle spasms — neck (torticollis), tongue, eyes (oculogyric crisis). **Hours to days** after starting. Treat IMMEDIATELY with IM benztropine/Benadryl.

2. Akathisia

Inner restlessness, can't sit still, pacing. **Days to weeks.** Often mistaken for anxiety/worsening psychosis — don't increase the drug! Treat with propranolol or benzo.

3. Pseudoparkinsonism

Tremor, rigidity, bradykinesia, shuffling gait, mask-like face, drooling. **Weeks to months.** Treat with benztropine or amantadine.

4. Tardive Dyskinesia (TD)

Involuntary lip-smacking, tongue protrusion, grimacing, choreiform movements. **Months to years** — often IRREVERSIBLE. Use AIMS scale to screen. Stop or switch drug; may add valbenazine.

🚨 Neuroleptic Malignant Syndrome (NMS) — LIFE-THREATENING

Triad: hyperthermia (often >104°F), severe muscle rigidity ("lead pipe"), altered mental status. Plus autonomic instability (BP swings, tachycardia, diaphoresis), ↑ CPK, ↑ WBC.

Nursing actions: STOP the antipsychotic immediately · cool the patient · IV fluids · notify provider STAT · transfer to ICU · expect **dantrolene** (muscle relaxant) and **bromocriptine** (dopamine agonist).

06

NCLEX TEST TRAPS

⚠ What Students Get Wrong

Patient says "I see snakes crawling on the floor." What do you say first?

✗ TRAP ANSWER

"There are no snakes — those aren't real." (Arguing with the hallucination = patient feels dismissed.)

vs

✓ CORRECT

"I know they feel real to you, but I don't see any snakes." (Validate the feeling, present reality, don't argue.)

Patient on Haldol becomes restless and is pacing. What's the priority?

✗ TRAP ANSWER

Increase the Haldol — they're getting more psychotic. (You'll worsen akathisia!)

vs

✓ CORRECT

Recognize akathisia (EPS), notify provider, expect to add propranolol or anticholinergic, possibly lower dose.

Patient on clozapine reports sore throat and fever. What's the priority action?

✗ TRAP ANSWER

Give acetaminophen and reassess in 4 hours.

vs

✓ CORRECT

STAT CBC with differential — rule out **agranulocytosis**. Sore throat + fever on clozapine = infection from low WBC until proven otherwise.

Paranoid patient refuses to eat the meal on their tray. What do you do?

✗ TRAP ANSWER

Tell them firmly the food is safe and they must eat it.

vs

✓ CORRECT

Offer sealed/packaged foods the patient can open themselves (chips, a banana, sealed milk). Trust > confrontation.

A patient with schizophrenia who has been depressed for weeks suddenly seems calm and is giving away possessions. What's your concern?

✗ TRAP ANSWER

The treatment is working — document and continue current plan.

vs

✓ CORRECT

Suicide risk has just increased. Sudden calm + giving away belongings = made a plan. 1:1 observation, suicide precautions, notify provider.

A patient has high fever, muscle rigidity, and altered LOC after starting haloperidol. What is the priority?

✗ TRAP ANSWER

Administer the next scheduled dose of Haldol and notify the provider.

vs

✓ CORRECT

STOP the drug immediately — this is NMS. Cool the patient, IV fluids, transfer to ICU, expect dantrolene.

Positive vs Negative symptoms — what's the difference?

✗ COMMON CONFUSION

"Positive = good symptoms, negative = bad symptoms."

vs

✓ REALITY

Positive = something **added** (hallucinations, delusions). Negative = something **missing** (flat affect, avolition). Both are bad.

07

PATIENT · FAMILY EDUCATION

Teaching for Long-Term Success

Anosognosia and stigma make adherence the #1 challenge. Family education is just as important as patient education — relapse usually starts with stopping the medication.

Medication Adherence

- **Take every day** — even when feeling well. Stopping = relapse.
- Do not skip doses, even after feeling "back to normal."
- Full effect can take **2–6 weeks.** Be patient.
- Ask about long-acting injectables if pills are hard to remember.
- Never stop suddenly — taper with provider guidance.

Recognize Warning Signs

- Trouble sleeping, withdrawal, suspiciousness returning
- Hearing voices again or new strange beliefs
- Stopping self-care (hygiene, eating)
- Call the provider *before* a full crisis
- Family: keep a written list of relapse signs

Healthy Lifestyle

- **Avoid alcohol, cannabis, stimulants** — they trigger relapse.
- Regular sleep schedule reduces relapse risk.
- Balanced diet & exercise (counter metabolic side effects).
- Limit caffeine and nicotine — they affect drug levels.
- Manage stress: simple routines, breathing, support groups.

Side Effect Self-Monitoring

- Weight & waist circumference monthly.
- Report unusual movements (lip smacking, tremor) — could be TD.
- Report fever + sore throat **immediately** (clozapine).
- Sunscreen — antipsychotics cause photosensitivity.
- Use stool softeners for constipation; sugar-free gum for dry mouth.

Safety & Crisis Planning

- Save the crisis line number; rehearse who to call.
- Family: lock up sharps and firearms when symptoms flare.
- Know the closest psychiatric emergency facility.
- Carry a card listing medications & diagnosis.
- Discuss advance directive when patient is stable.

Family · Caregiver Support

- This is a brain disorder — **not** a character flaw or weakness.
- Speak clearly, simply, calmly. Avoid arguing with delusions.
- Reduce stress and "expressed emotion" in the home (criticism, hostility, over-involvement increase relapse).
- NAMI family-to-family groups and respite support.
- Caregiver burnout is real — get your own support.

MEMORY BOOSTERS · MNEMONICS

08 Stick It in Your Brain

"4 A's"

BLEULER'S CLASSIC NEGATIVE SYMPTOMS

- **A** **Affect** — flat or blunted
- **A** **Alogia** — poverty of speech
- **A** **Avolition** — lack of motivation
- **A** **Anhedonia** — no pleasure (sometimes also Associality / Apathy)

"FEVER"

NMS — NEUROLEPTIC MALIGNANT SYNDROME RED FLAGS

- **F** **Fever** (often >104°F)
- **E** **Encephalopathy** — altered mental status
- **V** **Vitals unstable** — BP swings, tachycardia, tachypnea
- **E** **Elevated enzymes** — ↑ CPK from muscle breakdown
- **R** **Rigidity** — "lead pipe" muscle stiffness

"DAP-T"

THE 4 EPS IN ORDER OF ONSET

- **D** **Dystonia** (acute) — hours to days · spasms of neck, tongue, eyes
- **A** **Akathisia** — days to weeks · inner restlessness, pacing
- **P** **Pseudoparkinsonism** — weeks to months · tremor, rigidity, mask face
- **T** **Tardive dyskinesia** — months to years · involuntary mouth/tongue movements (often irreversible)

"CRAZY"

POSITIVE SYMPTOMS OF SCHIZOPHRENIA

C **Catatonia** — odd movement or stillness

R **Reality distorted** — delusions

A **Auditory hallucinations** — voices (most common)

Z **Zoned out speech** — word salad, loose associations

Y **Yelling / bizarre behavior** — disorganized actions

"CLOZAPINE"

PATTERN TIP — THE "Z" DRUG NEEDS A "Z"-CBC EVERY WEEK

★ Clozapine has the *only* mandatory weekly WBC/ANC monitoring of all antipsychotics. The first letter "C" reminds you: **C**BC, **C**lozaril, **C**heck weekly.

★ Fever + sore throat on clozapine = STOP the drug, get the CBC. Sudden infection signs = agranulocytosis until proven otherwise.

Quick Pattern Tips

FAST RECALL FOR EXAM DAY

→ **"-pine" and "-done" = atypical** (clozapine, olanzapine, risperidone). **"-zine" / haloperidol = typical.**

→ **Olanzapine = O for Obesity.** Highest metabolic risk.

→ **Hallucination vs Illusion:** Hallucination = *no* stimulus. Illusion = misperceived *real* stimulus.

→ **Delusion vs Hallucination:** Delusion = false *belief* (thinking). Hallucination = false *perception* (sensing).

→ **If unsure, pick SAFETY.** For schizophrenia NCLEX questions, safety is almost always the right answer.

→ **Never argue with a delusion.** Acknowledge the feeling, present reality, redirect.