

SCHIZOPHRENIA AND PSYCHOTIC DISORDERS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which term corresponds to the onset descriptor that occurs between late teens and mid-30s; rare before adolescence?**
 - A. Onset of schizophrenia
 - B. Peak age of onset for men
 - C. Peak age of onset for women
 - D. Psychotic features emergence
- 2. Delusional disorder is distinguished from schizophrenia by the absence of which features?**
 - A. Delusions
 - B. Prominent hallucinations, disorganized speech, and negative symptoms
 - C. Mood disturbances
 - D. Cognitive decline
- 3. What is the daily dosage of captopril mentioned as part of the management plan for antidiuretic hormone dysfunction?**
 - A. 12.5 mg/day
 - B. 2.5 mg/day
 - C. 50 mg/day
 - D. 100 mg/day
- 4. Which metabolic pathway is associated with lamotrigine interactions according to the material?**
 - A. CYP450 enzymes
 - B. P-glycoprotein
 - C. SLC transporters
 - D. UGT enzymes
- 5. Which antipsychotics have reported associations with thrombocytopenia?**
 - A. Asenapine, clozapine, olanzapine, quetiapine, risperidone, ziprasidone
 - B. Clozapine only
 - C. Haloperidol and chlorpromazine
 - D. Aripiprazole and lurasidone

- 6. Which factors influence prognosis in schizophrenia?**
- A. Duration of Illness
 - B. Severity of Illness
 - C. Gender
 - D. All of the Above
- 7. Quetiapine dosing: initial and target range per material.**
- A. 2-3 mg daily, increase by 1 mg/day to max of 6 mg/day
 - B. 5-10 mg daily, increase by 2 mg/day to max of 20 mg/day
 - C. 1-2 mg daily, increase to 5 mg/day
 - D. 10-15 mg daily, increase to 30 mg/day
- 8. If a patient develops anticholinergic effects, what is the recommended management?**
- A. Increase the antipsychotic dose
 - B. Add another anticholinergic medication
 - C. Reduce the dose or switch to another antipsychotic
 - D. Discontinue antipsychotics abruptly without replacement
- 9. For a patient with CrCl 50-79 mL/min, what is the recommended daily dose when grapefruit juice interaction is present?**
- A. 25 mg/day
 - B. 12.5 mg/day
 - C. 5 mg/day
 - D. 50 mg/day
- 10. Cogentin pharmacokinetics: which drug has bioavailability 95%?**
- A. Benadryl
 - B. Valbenazine
 - C. Cogentin
 - D. Haloperidol

Answers

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1. D
2. B
3. A
4. D
5. A
6. D
7. A
8. C
9. B
10. C

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Explanations

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1. Which term corresponds to the onset descriptor that occurs between late teens and mid-30s; rare before adolescence?

- A. Onset of schizophrenia
- B. Peak age of onset for men
- C. Peak age of onset for women
- D. Psychotic features emergence**

Onset timing of schizophrenia is described as typically beginning in late adolescence to early adulthood, with it being rare before adolescence. This descriptor focuses on when the disorder first appears, not on which sex is more likely to have it or on when psychotic symptoms specifically first emerge. So the term that best fits the described timing is the onset of schizophrenia, because it directly labels the event and period when the disorder tends to start. The other options either specify peak ages for particular groups or refer to the emergence of psychotic features, which are not the general onset descriptor for the disorder.

2. Delusional disorder is distinguished from schizophrenia by the absence of which features?

- A. Delusions
- B. Prominent hallucinations, disorganized speech, and negative symptoms**
- C. Mood disturbances
- D. Cognitive decline

Delusional disorder is defined by fixed delusions with relatively preserved overall functioning, whereas schizophrenia involves a broader set of psychotic symptoms. In schizophrenia you typically see perceptual disturbances (prominent hallucinations), disorganized thinking that disrupts speech, disorganized or abnormal behavior, and negative symptoms like flat affect or avolition, often with some cognitive impairment. The absence of those prominent, wide-ranging psychotic features is what distinguishes delusional disorder from schizophrenia. Mood disturbances can occur in both, and cognitive decline is more characteristic of other conditions, but the defining difference here is that delusional disorder lacks the prominent hallucinations, disorganized speech, and negative symptoms that define schizophrenia.

3. What is the daily dosage of captopril mentioned as part of the management plan for antidiuretic hormone dysfunction?

- A. 12.5 mg/day**
- B. 2.5 mg/day
- C. 50 mg/day
- D. 100 mg/day

Dosing captopril in this context is about starting with a very low, tolerable amount to begin ACE inhibition while monitoring the patient's response and safety. The plan specifies a small daily amount, 12.5 mg, which fits a cautious approach to avoid first-dose hypotension and to allow gradual adjustment. Higher daily doses, such as 50 mg or 100 mg, would carry greater risk of adverse effects and aren't what this plan uses. A dose as low as 2.5 mg/day is typically insufficient to achieve meaningful ACE inhibition. So, 12.5 mg/day is the best match to the management plan described.

4. Which metabolic pathway is associated with lamotrigine interactions according to the material?

- A. CYP450 enzymes
- B. P-glycoprotein
- C. SLC transporters
- D. UGT enzymes**

Lamotrigine is cleared mainly through glucuronidation by UDP-glucuronosyltransferase (UGT) enzymes, especially UGT1A4. This glucuronidation pathway is where most clinically relevant interactions occur—most notably with valproic acid, which inhibits UGT-mediated glucuronidation and raises lamotrigine levels, increasing the risk of serious rash. The CYP450 system, P-glycoprotein, and SLC transporters are not the primary routes for lamotrigine metabolism, so interactions via those pathways are less expected.

5. Which antipsychotics have reported associations with thrombocytopenia?

- A. Asenapine, clozapine, olanzapine, quetiapine, risperidone, ziprasidone**
- B. Clozapine only
- C. Haloperidol and chlorpromazine
- D. Aripiprazole and lurasidone

Thrombocytopenia can be a rare adverse effect of several antipsychotics, reflecting idiosyncratic or immune-mediated destruction of platelets. Among these medications, multiple second-generation (atypical) antipsychotics have documented reports of thrombocytopenia, including asenapine, clozapine, olanzapine, quetiapine, risperidone, and ziprasidone. This breadth is why this set is the best answer: it captures the class-wide potential for this hematologic reaction, based on clinical reports and pharmacovigilance data. In practice, if a patient on these drugs develops signs of bleeding or petechiae, or has unexpectedly low platelets on a CBC, clinicians should evaluate the platelets and consider the antipsychotic as a contributing factor, balancing risks and benefits and monitoring accordingly. Clozapine, in particular, is well known for hematologic risks and requires regular monitoring for neutropenia, while other antipsychotics may present thrombocytopenia less predictably but have documented associations.

6. Which factors influence prognosis in schizophrenia?

- A. Duration of Illness
- B. Severity of Illness
- C. Gender
- D. All of the Above**

Prognosis in schizophrenia is shaped by multiple interacting factors, not a single predictor. The duration of illness matters because untreated or long-standing illness tends to lead to more entrenched functional impairment and poorer outcomes. The severity of illness matters because fuller, more intense symptoms—especially prominent negative symptoms and cognitive difficulties—are linked to worse functioning and lower chances of remission. Gender can also influence prognosis; on average, women may have a somewhat better course due to later onset and other protective factors, though individual variation is large and this is not a guarantee. Because each of these factors can affect outcomes, the best answer is the one that includes all of them. In practice, prognosis is more accurately considered as a multifactorial picture, with additional influences like premorbid functioning, duration of untreated psychosis, treatment adherence, social support, and comorbidities playing important roles as well.

7. Quetiapine dosing: initial and target range per material.

- A. 2-3 mg daily, increase by 1 mg/day to max of 6 mg/day**
- B. 5-10 mg daily, increase by 2 mg/day to max of 20 mg/day
- C. 1-2 mg daily, increase to 5 mg/day
- D. 10-15 mg daily, increase to 30 mg/day

Starting quetiapine with a very low dose and titrating slowly is a common strategy to maximize tolerability while monitoring how the patient responds. The pattern of 2-3 mg daily at the outset, with increases of about 1 mg each day up to a maximum of 6 mg, embodies this cautious approach. It minimizes early side effects such as sedation or dizziness and gives clinicians a chance to assess both efficacy and adverse effects before committing to higher doses. The other options propose higher starting amounts or faster increases, which raise the likelihood of uncomfortable or harmful side effects before any clear benefit is established. This tiny-step plan aligns with a careful, patient-safety first titration mindset.

8. If a patient develops anticholinergic effects, what is the recommended management?

- A. Increase the antipsychotic dose
- B. Add another anticholinergic medication
- C. Reduce the dose or switch to another antipsychotic**
- D. Discontinue antipsychotics abruptly without replacement

Anticholinergic effects from antipsychotics come from blocking muscarinic receptors, which leads to symptoms like dry mouth, constipation, urinary retention, blurred vision, and cognitive slowing. When these effects appear, the best management is to lower the antipsychotic exposure or switch to a different antipsychotic with less antimuscarinic activity. This tackles the root cause by reducing receptor blockade that causes the symptoms. Increasing the dose or adding another anticholinergic would worsen the problem, not help it. Stopping the antipsychotic abruptly without a plan risks relapse of psychotic symptoms and destabilization, so it's not the right move unless there's a specific, safer transition strategy in place. In more severe cases of anticholinergic toxicity, other treatments may be needed, but for routine cases, dose reduction or switching is the appropriate approach.

9. For a patient with CrCl 50-79 mL/min, what is the recommended daily dose when grapefruit juice interaction is present?

- A. 25 mg/day
- B. 12.5 mg/day**
- C. 5 mg/day
- D. 50 mg/day

Grapefruit juice blocks intestinal CYP3A4, which can significantly raise the amount of drug that reaches the bloodstream. When renal function is also moderately reduced (CrCl 50–79 mL/min), the drug clearance is lower, so the combination can push exposure into a toxic range. To keep exposure within the safer, therapeutic range, the dose is often halved. Starting from a standard 25 mg daily dose, reducing to 12.5 mg/day accounts for both the grapefruit interaction and the decreased renal clearance. The higher doses could lead to toxicity, while a much smaller dose might be ineffective. This half-dose approach is the best balance in this scenario.

10. Cogentin pharmacokinetics: which drug has bioavailability 95%?

- A. Benadryl
- B. Valbenazine
- C. Cogentin**
- D. Haloperidol

Bioavailability is the fraction of an oral dose that reaches the bloodstream. Cogentin (benztropine) has an oral bioavailability of about 95%, so nearly the entire dose you take orally becomes available to exert its effects. This high value reflects efficient absorption from the GI tract and minimal loss to first-pass metabolism, making the drug's systemic and CNS effects more predictable after oral dosing. Other drugs on the list don't reach that level of reliability in absorption due to differences in how they're absorbed and metabolized, so benztropine's nearly complete oral availability stands out.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://schizopsychodisorders.examzify.com>

We wish you the very best on your exam journey. You've got this!

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