Psycho-Social Intervention Handout

**Definitions**

**Delusions-** which are strongly held fixed false beliefs about something. They may be based in the idea of feeling paranoid or that people are out to hurt them or grandiose like they have a mission to accomplish. These beliefs are not shared by their culture or ethnic group. A person may believe in something false even though there is evidence it is not true or possible.

**Delusional Disorder-** characterized by a delusion without hallucinations or thought disorders. People don’t usually have a loss of function and appear normal most of the time. The delusions are usually fixed and non-bizarre which means that they are usually rooted in reality something like ‘my neighbor is trying to kill me’ versus something bizarre like ‘aliens are above my house trying to steal me away’.

**Disorganized thoughts/behaviors-** A person may be thinking in a dysfunctional way that impacts a person’s ability to care for themselves and how they communicate with others. This could be something like being unable to logically connect thoughts or ideas, may speak in a ‘word salad’. A person may experience thought blocking where it feels like your train of thought suddenly stops and the idea has been taken from your head. This can sometimes cause a person to just stop talking and forget what they would say.

**Flat affect-** feeling very little emotion or no emotion where a person is unable to express joy, sadness, fear, etc.

**Hallucinations-** a person sees or hears things that other people may not hear (auditory) or see (visual) This could be something like a low humming, garbled words, or even clear sentences for auditory. For visual, it may be seeing shadows, partial people or figures, or even fully formed people or things.

**Negative Symptom-** are things that take away a feeling, thought, or behavior that is desired or something most people experience (like taking away feelings of motivation or of desire).

**Positive Symptom-** are things that add a behavior thought or feeling that most people don’t experience and cause distress (like adding a auditory hallucination).

**Schizoaffective disorder**- schizophrenia with periods of 2 weeks or more of depression or periods of manic symptoms with increased energy, talk too much, can’t sleep, have too much activity + mood episodes. It is like schizophrenia and bipolar disorder had a baby. We have delusions, hallucinations but also have depression and mania. In this disorder what makes it different than Bipolar disorder where you have mood episodes and delusions and hallucinations is that in schizoaffective disorder these delusions and hallucinations are without depression or increased mood for some or all of the time. You would need at least two weeks of psychotic symptoms without mood symptoms like mania or depression to be schizoaffective.

**Schizophrenia**- brain disorder that impacts the development of the brain and causes disordered thinking, emotion and behavior. It is genetic and no one’s fault. Symptoms must last for at least 6 months.

**Schizophreniform**- same definition of schizophrenia except the active symptomology lasts between 1 and 6 months.

**Symptom Interventions**

**Empathetic listening**- thoughts may be racing in the head of the member. Focus on short ideas and sentences you can repeat to reinforce your purpose ‘What can I do to help’ ‘What do you need now’ ‘What can I do to make things better’.

**Intervening calmly**- arms at side, relaxed and knees bent and giving a person a line of egress to leave if a person is agitated.

**Help people feel safe**- offering choices and giving a person a say in what is going on. Getting them to say yes or to agree to something can move a stressed mind to a place of more clarity. By providing options in context to a member’s situation, you can work to see their understanding of the situation.

**Give them space**- it is ultimately the member’s decision to either do or not do something. Explaining our role as a supportive resource but noting our limitations and capabilities can help develop boundaries to maintain a healthy rapport.

**Be receptive and helpful-** don’t promise something you can’t provide.

**Strategies for Hallucinations & Delusions**

**Respond with caution-**if the hallucination isn’t causing a problem for the person or putting them at risk, it may be best to ignore it. By discussing it openly or contradicting what a person believes or sees, it may cause agitation, frustration, or withdrawal.

**Distraction-** taking focus away from hallucinations with something like favorite music, news program, podcast and refocusing energy on new topic. Studies suggest headphones as especially helpful to minimize other distractions in environment.

**Mindfulness techniques**- having the member pay attention to the present and increase their awareness of symptoms (Crisis Plan, Treatment Plan from therapy). Common technique is ‘acceptance and commitment’ where a person agrees to acknowledge the voices but doesn’t accept guidance/direction from them.

**Respond Honestly-** if asked about the hallucination ‘Do you see him/her/it’ you may respond ‘I know that you see something, but I don’t see it’. This way you aren’t denying what the person sees or hears but you avoid creating an argument by claiming it is not real.

**Keeping a Diary** – by tracking when, how often, who and what kind of voices a person may hear, it can help build coping strategies and identify situations in which a member will work with their providers to intervene.

**Keep sentences simple and short**- a person may have difficulty concentrating due to delusion/hallucination, focus on simple ideas and concepts to mitigate confusion.

**Reality Testing**- checking in with others who don’t struggle with schizophrenia to see if what you heard or saw wasn’t real. This can be done to help ground someone who may be experiencing symptoms and access help.

**Promote positive behaviors-** including medication compliance, healthy lifestyle choices (diet, exercise, not smoking)

**Respond to underlying feelings-** encourage discussion of feelings caused by hallucination or delusion rather than actual hallucination or delusion. For example, “it must be very frightening to think there is a conspiracy against you” and work to move the person’s mind to discuss how they work through feeling frightened rather than how they can work through their belief of a conspiracy against them.

**Thought observing-** look to notice interactions that increase anxiety and delusions/hallucinations (tv programs, newspapers, radio ads, neighbors etc). Promote problem solving by helping work with member to better manage and cope through stressors. This is a way to highlight Crisis Plan protective factors.

**Other Resources**

Programs listed in Monroe Plan’s Community Resource Directory.

Linking member with treatment programs like outpatient clinical treatment: <https://www.monroecounty.gov/health_providers>

Emergency services: <http://www2.monroecounty.gov/mh-emergency-resources>

Mental Health Association:

<https://www.mharochester.org/finding-your-way-guide/monroe-county/>

National Alliance on Mental Illness: <http://namiroc.org/>