



## Caring for a person experiencing Delusions

---

For more information also see the following MIND Essentials resources – ‘Caring for a person experiencing hallucinations’ and ‘Schizophrenia fact sheet’.

### Case study

Lisa is 35 years old. She has been brought to hospital after being hit by a car on a pedestrian crossing. It has been established that she has no serious injuries apart from a severe laceration requiring stitches and a torn knee ligament. Lisa has paranoid delusions. She thinks that there are people who want to hurt her and that staff are involved in plotting against her with these people. Her care plan includes referral to community health for wound care and follow-up with mental health services on discharge.

The following information could help you nurse a patient like Lisa.

### What are delusions?

Delusions are false fixed beliefs that are out of touch with reality. They are beliefs that are not shared within the person’s culture or religion. For example, believing that you are possessed by a spirit is an accepted and respected state if you believe in Voodooism or Pentecostalism; however, in other social circumstances such a belief would be viewed as a delusion. It is a delusion if you believe that you are, for example, captain of the Australian hockey team when in fact you are not.

Delusions are held with total conviction and cannot be altered by the presentation of facts or by appeal to logic or reason. They may be understood as attempts to make sense of abnormal internal experiences such as hallucinations or feelings of anxiety or distress. Around three in 100 people will experience psychosis (losing touch with reality through hallucinations, delusions or disorganised thoughts) at some point in their lives.

### Types of delusions

Several types of delusions exist. These include delusions of **grandeur** (belief of exaggerated importance), **persecutory** delusions (belief of deliberate harassment and persecution), **reference** delusions (belief that the thoughts and behaviour of others are directed towards oneself) and **somatic** delusions (belief that part of the body is diseased, distorted or missing).

## Causes of delusions

People may experience delusions due to a range of illnesses or other causes, including:

- ◆ brain chemistry imbalance (delirium)
- ◆ problems with perception
- ◆ mood disorders
- ◆ psychotic disorders (including substance-induced psychosis)
- ◆ organic disorders (such as dementia).

### A person's perspective on what it is like to experience a delusion

'When I was travelling home on the bus from high-school once, I sat in my seat convinced that the people behind me had machines that could read my mind. Everytime the people on the bus laughed, I thought they were laughing at my thoughts. The bus trip took half an hour and so I desperately tried to think of nothing for the whole time, but it didn't work and I became even more distressed.'

## Some reported reactions to people experiencing delusions

Nurses who have worked with people who are experiencing delusions have reported the following reactions:

- Disregard** Nurses may assume that complaints of actual physical discomfort are part of the delusions and so may not take the time to investigate the problem.
- Confusion** Sometimes a person with delusions will treat the nurse as though the nurse is someone else. Knowing how to respond appropriately can be challenging and confusing.
- Anxiety** Some nurses report feelings of anxiety when nursing people experiencing delusions due to their unusual beliefs.
- Inadequacy** Nurses may feel that it is beyond the range of their skills to effectively intervene.
- Avoidance** A nurse might experience a desire to avoid such patients due to a lack of confidence, insufficient knowledge or the difficulties in engaging with the person.

## Goals for nursing a person experiencing delusions

Appropriate goals for caring for a person with delusions in a community or hospital setting include:

- ◆ Develop a relationship with the person based on empathy and trust.
- ◆ Promote an understanding of the features and appropriate management of delusions.
- ◆ Promote effective coping strategies for anxiety, stress or other emotions which may act as triggers for a delusion.
- ◆ Promote positive health behaviours, including medication compliance and healthy lifestyle choices (for example, diet, exercise, not smoking and/or limit consumption of alcohol and other substances).
- ◆ Promote the person's engagement with their social and support network.
- ◆ Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.

- ◆ Support and promote self care activities for families and carers of the person experiencing delusions.

### Guidelines for responding to a person experiencing delusions

- ◆ Arrange for a review of the person's medication for delusions and an initial or follow-up mental health assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment'.
- ◆ A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For more information visit [www.health.qld.gov.au/pahospital/qtmhc/default.asp](http://www.health.qld.gov.au/pahospital/qtmhc/default.asp)
- ◆ In your initial assessment, ask the person to talk about the delusions and obtain details by asking the following questions: 'Who is trying to hurt you? Could you think why? How might this happen?'.
- ◆ Validate any part of the delusion that is real. For example, depending on the situation, you could say: 'Yes, there was a doctor at the nurse's desk, but I did not hear him talking about you.'
- ◆ Do not maintain that what the person is thinking is wrong. Instead, show that you respect his or her point of view regardless of whether you agree, and give your own understanding or impression of the situation. Listen quietly until there is no further need to discuss the delusion.
- ◆ Do not expect that rational thinking will have an effect on the person's delusions. If you debate the delusion, the person may expand the details to counter your argument or include you in the delusion.
- ◆ Try not to take the person's accusations personally, even if they are directed at you.
- ◆ Let the person know that you recognise the feelings that can be evoked by the delusions. For example, you could say: 'It must feel very frightening to think that there is a conspiracy against you.' Respond to the underlying feelings and encourage discussion of these rather than the content of the delusion.
- ◆ Try to identify triggers and establish if the delusions are related to stress, anxiety or other feelings or emotions. Try to make this gentle questioning, not an interrogation.
- ◆ Through observing, try to notice any interactions or events that seem to increase the person's anxiety and delusions (these could include television, radio or particular visitors). Promote problem-solving by helping the person work out ways in which he or she can cope more effectively with stressors. It may be useful to remove or substitute certain items in the room to eliminate potential for misperception or misidentification.
- ◆ Develop a symptom management strategy. This could involve encouraging the person to talk about things that are based in the immediate reality. Suggest that it would be helpful to discuss other subjects based in the 'here and now'. Encourage participation in reality-based physical activities where possible.
- ◆ Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any medication and work with the person to develop appropriate actions to address any issues.

- ◆ Assess the delusions daily to determine changes in their frequency and intensity, and document any changes. Disorientation to time and place may suggest that the person sustained a brain injury.
- ◆ Provide family members and carers with information about delusions if appropriate, as well as reassurance and validate their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- ◆ Be aware of your own feelings when caring for a person experiencing delusions. Arrange for debriefing for yourself or for any colleague who requires support or assistance — this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit <http://qheps.health.qld.gov.au/eap/home.htm>

### Treatment of delusions

Psychosocial strategies and antipsychotic drugs may both be an important part of the person's management regime. Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication. Given that compliance with antipsychotic drugs may be an issue, you may need to provide close supervision. Discussion with the person about non-compliance may elicit suspicions. If so, inform the treating doctor, who may need to consider alternative treatment.

**Adverse effects** to antipsychotic medication can occur. These may include:

- ◆ sedation
- ◆ anticholinergic effects — such as dry mouth, urinary retention and constipation
- ◆ extrapyramidal effects — which include dystonias (painful muscle contractions or jerking movements that may cause airway obstruction), Parkinsonism (tremors, shuffling gait) and akathisia (restlessness and/or inability to sit still)
- ◆ orthostatic hypotension (fall in blood pressure when standing)
- ◆ tardive dyskinesia (repetitive involuntary movements, which are usually irreversible)
- ◆ agranulocytosis
- ◆ photosensitivity
- ◆ lowered seizure threshold
- ◆ Neuroleptic Malignant Syndrome (NMS) — a life-threatening condition that can occur in up to one per cent of people taking antipsychotics. Symptoms including fever, extreme muscle rigidity and altered consciousness can occur hours to months after commencing or increasing drug therapy.

Management of minor side effects may involve altering the dose, change of medication or symptomatic management with monitoring and patient education. More severe side effects (such as dystonia) can be treated with an anticholinergic agent such as benztropine given IM or IV.

#### **Neuroleptic Malignant Syndrome needs to be treated as a MEDICAL EMERGENCY**

requiring cessation of the antipsychotic medication, reduction of body temperature, and cardiovascular, renal and respiratory support.

## Discharge planning

Discuss referral options with the person and consider referrals to the following:

- ◆ GP
- ◆ Community Child Health
- ◆ Community Health
- ◆ Mental Health Services (infant, child and youth or adult)
- ◆ Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 48).

## Further reading

For more information, see the Mental Health First Aid Manual at [www.mhfa.com.au](http://www.mhfa.com.au) (internet access required).

## Sources

- Centre for Mental Health. (2001). *Mental health for emergency departments — A reference guide*. Gladesville: Better Health Centre for NSW Health.
- Diehl, T. S. & Goldberg, K. (2004). *Psychiatric nursing made incredibly easy*. Philadelphia: Lippincott, Williams & Wilkins.
- Elder, R., Evans, K. & Nizette, D. (Eds.). (2005). *Psychiatric and mental health nursing*. Sydney: Elsevier.
- Gorman, L. M., Sultan, D. & Luna-Raines, M. (1989). *Psychosocial nursing handbook for the nonpsychiatric nurse*. Baltimore: Williams & Wilkins.
- Krupnick, S. L. W. & Wade, A. (1999). *Psychiatric care planning* (2nd ed.). Pennsylvania: Springhouse Corporation.
- Shives, L. R. (2008). *Psychiatric–mental health nursing* (7th ed.). Philadelphia: Lippincott, Williams & Wilkins.
- Singh, B. & Kirkby, K. (2001). The psychiatric interview, mental state examination and formulation disorders. In S. Bloch & B. Singh (Eds.), *Foundations of clinical psychiatry* (pp. 82-113). Melbourne: Melbourne University Press.
- Stuart, G. (2005). *Handbook of psychiatric nursing* (6th ed.). St Louis: Elsevier Mosby.
- Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.). St Louis: Elsevier Mosby.