Formal Thought Disorder

1. **Derailment/Loose Associations:** thinking characterized by speech in which ideas shift from one subject to another that is completely unrelated or only obliquely related to the first without the speaker's showing any awareness that the topics are unconnected. Statements that lack a meaningful relationship may be juxtaposed, or the person may shift idiosyncratically from one frame of reference to another.

2. **Incoherence/Word Salad/Neologisms:** the use of totally unrelated words to describe thoughts, feelings, actions, etc., in such a way the average listener has no ability to understand the meaning of the conversation. The person uses a mixture of phrases that are meaningless to the listener and often to the patient. The word jargon is frequently applied to this concept. It often involves derailment. Neologisms are new words invented by the person, distortions of existing words, or standard words to which the subject has given new, highly idiosyncratic meaning.

3. **Tangentiality:** a type of association disturbance in which thought and speech divert or digress from the topic of the moment so that they appear unrelated or irrelevant.

4. **Illogical Speech:** a pattern of speech in which conclusions are reached on faulty premises or due to faulty inductive inferences. Frequently the term non-sequiturs is applied to this form of speech.

5. **Circumstantiality:** speech that is indirect and delayed in reaching the point because of unnecessary, tedious details and parenthetical remarks. Circumstantial replies or statements may be prolonged for many minutes if the speaker is not interrupted. The speaker remains aware of the original point, goal, or topic.

6. **Pressure of Speech:** an increase in the amount of speech as compared to what is ordinary or socially customary. The person speaks very rapidly and is difficult to interrupt. Often the speech is loud and emphatic. The person may start talking without any prompt and without anyone listening.

7. **Distractible Speech:** a pattern very similar to derailment, however, the shift in topic is due to distractions in the immediate environment as opposed to loose thought associations. The person stops talking in the middle of a sentence or idea and changes the subject in response to something nearby.

8. **Clang Associations:** speech in which sounds, rather than meaningful, conceptual relationships govern word choice. Clang often includes rhyming and punning.

9. **Alogia:** a term coined from the Greek (a = no logia = mind, thought) to refer to impoverished thinking and cognition characterized by poverty of content of speech and poverty of speech. Poverty of speech refers to restriction in the amount of speech and poverty of content refers to a normal amount of speech that conveys little information. The language may be over-abstract or over-concrete.

Sensory Modalities Involved in Hallucinations

SENSE	CHARACTERISTICS	OBSERVABLE CLIENT BEHAVIORS
Auditory	Hearing noises or sounds most commonly in the form of voices. Sounds that fluctuate from a simple noise or voice, to a voice talking about the client, to complete conversations between two or more people about the person who is hallucinating. Additional types include audible thoughts in which the client hears voices that are speaking what the client is thinking.	◆ Moving eyes back and forth as if looking to see who or what is talking. ◆ Listening intently to another person who is not speaking or to an inanimate object such as a piece of furniture. ◆ Engaging in conversation with an inanimate object or with an invisible person. ◆ Moving mouth as if speaking or responding to a sound.
Visual	Visual stimuli in the form of flashes of light, geometric figures, cartoon figures, and/or elaborate and complex scenes or visions. Visions can be pleasant or terrifying, as in seeing monsters.	◆ Suddenly appearing startled, frightened, or terrified by another person, an inanimate object, or by no apparent stimulus. ◆ Suddenly running into another room.
Olfactory	Putrid, foul, and rancid smells of a repulsive nature, such as blood, urine, or feces. Occasionally the odors can be pleasant. Olfactory hallucinations are typically associated with stroke, tumor, seizures, and the dementias.	◆ Wrinkling nose as if smelling something horrible. ◆ Smelling parts of the body. ◆ Smelling the air while walking toward another person. ◆ Responding to an odor with terror, as in smelling fire or blood. ◆ Throwing a blanket or pouring water on another person, as if putting out a fire.
Gustatory	Putrid, foul, and rancid tastes of a repulsive nature, such as blood, urine, or feces.	◆ Spitting out food or a beverage. ◆ Refusing to eat, drink, or take medications. ◆ Suddenly leaving the dinner table.
Tactile	Experiencing paid or discomfort with no apparent stimuli. Feeling electrical sensations coming from the ground, inanimate objects, or other people.	◆ Slapping self, as if putting out a fire. ◆ Jumping up and down on the floor, as if avoiding pain or other stimuli to the feet.
Cenesthetic	Feeling body functions, such as blood pulsing through the veins and arteries, food digesting, or urine forming.	◆ Verbalizing and/or obsessing about body processes. ◆ Refusing to complete a task that may require a part of the body that the client believes isn't working.

Levels of Intensity of Hallucinations

LEVEL	CHARACTERISTICS	OBSERVABLE CLIENT BEHAVIORS
Stage I: Comforting **Moderate Level of Anxiety** Hallucination is generally of a pleasant nature.	The hallucinator experiences intense emotions, such as anxiety, loneliness, guilt, and fear and tries to focus on comforting thoughts to relieve anxiety. The individual recognizes that thoughts and sensory experiences are within conscious control if the anxiety is managed. **NON-PSYCHOTIC**	◆ Grinning or laughter that seems inappropriate. ◆ Moving lips without emitting any sounds. ◆ Rapid eye movements. ◆ Slowed verbal responses, as if preoccupied. ◆ Silent and preoccupied.
Stage II: Condemning **Severe Level of Anxiety** Hallucination generally becomes repulsive.	Sensory experience of any of the identified senses is repulsive and frightening. The hallucinator begins to feel a loss of control and may attempt to distance self from the perceived source. Individual may feel embarrassed by the sensory experience and withdraw from others. **NON-PSYCHOTIC**	◆ Increased autonomic nervous system signs of anxiety, such as increased heart rate, respiration, and blood pressure. ◆ Attention span begins to narrow. ◆ Preoccupied with sensory experience and may lose ability to differentiate hallucination from reality.
Stage III: Controlling **Severe Level of Anxiety** Sensory experiences become omnipotent.	Hallucinator gives up trying to combat the experience and gives in to it. Content of hallucination may become appealing. Individual may experience loneliness if sensory experience ends. **PSYCHOTIC**	◆ Directions given by the hallucination will be followed, rather than objected to. ◆ Difficulty relating to others. ◆ Attention span of only a few seconds or minutes. ◆ Physical symptoms of severe anxiety, such as perspiring, tremors, unable to follow directions.
Stage IV: Conquering **Panic Level of Anxiety** Generally become elaborate and interwoven with delusions.	Sensory experiences may become threatening if individual doesn't follow commands. Hallucination may last for hours or days if there is no therapeutic intervention. **PSYCHOTIC**	◆ Terror-stricken behaviors, such as panic. ◆ Strong potential for suicide or homicide. ◆ Physical activity that reflects content of hallucination, such as violence, agitation, withdrawal, or catatonia. ◆ Unable to respond to complex directions. ◆ Unable to respond to more than one person.

Interventions During Chronic Hallucinations

The experience of hallucinations can be especially troublesome for the consumer who does not have anyone to talk to about them. To facilitate monitoring of symptoms, the consumer needs to be comfortable informing you of their occurrence. If a consumer has encountered negative responses from other who think their ideas are strange, they often learn not to discuss their unusual experiences with anyone.

Interactive discussion of hallucinations is a vital element in the development of reality testing skills. Communicating right at the time of the hallucination is particularly helpful. The first step toward attainment of this goal is communicating with the consumer in a facilitative manner. Honesty, genuineness, and openness are the foundation for effective communicating during hallucinations. The following interventions will be useful in teaching your consumer how to differentiate between hallucinations and actual environmental stimuli.

1. **Establish a trusting, interpersonal relationship:**

   - It will be easier for your consumer to open up if you express your feelings in an open, honest, and direct manner. Your consumer's behavior toward you often reflects your own behavior. If you are frightened, the consumer will be frightened.
   - Have as consistent a routine as possible.
   - Be patient, show acceptance, and listen.
   - Remember that hallucinations increase your consumer's level of anxiety, fear, loneliness, and low self-esteem.
   - Be patient and use active listening techniques.

2. **Assess for symptoms of a hallucination:**

   - Remember that hallucinations are caused from errors in the way the brain is processing stimuli.
   - Observe your consumer's sensory responses to environmental stimuli. Modulation of sensory stimulation to an optimal level is a useful technique for helping the consumer minimize the perceptual confusion. Some consumers do well with minimal environmental stimulation, while others find that noise and distraction help to drown out auditory hallucinations. You will need to be sensitive to your consumer's response, or lack of response, to the level of environmental stimuli.
   - Observe the consumer for behavioral clues the hallucination is in the first level of intensity. Behavioral clues include grinning or laughing inappropriately, moving lips without speaking, rapid blinking, slow verbal responses, silence, sitting on the couch staring into space, or making frequent telephone calls.
   - The major goal is to reduce hallucinations to the first or second level of intensity.

3. **Focus on the behavioral clue and ask your consumer to describe what is happening:**

- The goal is consumer empowerment to understand the symptoms experienced or demonstrated. This aids the consumer to gain control of the illness, seek help, and hopefully prevent the hallucination from reaching a greater level of intensity.

- You need to find out what the person is seeing, hearing, tasting, touching, or smelling.

4. **Identify environmental triggers of the hallucinations, including the use of drugs and/or alcohol:**

- In general, objects that are reflective, or have the potential to cause glare, such as television screens, photos in non-glare frames, and fluorescent lights can contribute to visual hallucinations.

- Auditory hallucinations can be caused by excessive noise, as well as sensory deprivation. Consumers often withdraw from sensory stimuli in an attempt to decrease their sensory responses.

- Assess if your consumer is using street drugs and/or alcohol. You need to teach that this is extremely dangerous. The effects of alcohol are greatly intensified by psychotropic medications, yet many consumers use illicit drugs/alcohol as a coping mechanism or as a quick means to manage symptom intensity. The combination of brain disease and drugs/alcohol may cause irreparable harm and promote a long relapse.

5. **If asked, point out simply that you are not experiencing the hallucination:**

- The goal is to guide your consumer through the hallucinatory experience and let him know what is actually happening in the environment.

- Do not argue about what is or is not occurring, the consumer is usually seeking validation and unless the hallucination is one of comfort, is grateful to learn that you are not experiencing the same phenomenon.

6. **Help the person describe the current hallucination and compare it to those recently experienced:**

- Encourage your consumer to remember when hallucinations first began. This is similar to obtaining a nursing history regarding any other symptom.

- In order to predict future symptoms, it is important to understand if a pattern of past hallucinations exists.

7. **Identify emotional triggers of the hallucinations:**

- Encourage your consumer to observe and describe thoughts, feelings, and actions, both present and past, that may be related to the frequency and intensity of the hallucination.

- Clients experience both positive and negative effects of hallucinations (Miller, et al, 1993).

- The ability to cover up symptoms to appear "normal" is a common survival technique. Your consumer may be used to his hallucinations and their manifestation as a way to self-monitor his illness. As a result, your consumer may not want them to go away completely.

- Talking about feelings related to hallucinations gives your consumer permission not to use so much energy and concentration trying to hide and control the hallucinations.

- Be careful not to imply blame regarding the consumer's ability to control and manage the hallucination.

8. **Help the person describe emotional needs that may be reflected in the content of the hallucination:**

   - It can be helpful to group basic emotional needs into the following four categories: being able to express anger, having power and control of decisions that affect daily life, feeling egosyntonic with human sexuality, and experiencing positive self esteem.

   - If one or more of these needs are not met, emotional distress can result. For survival of the self, hallucinations may partially reflect these unmet needs (Miller, et al, 1993).

9. **Help your consumer to identify if there is a correlation between the hallucination and the needs it may be reflecting:**

   - Focus on the unmet emotional need the person may be experiencing and discuss if there is a relationship to the appearance of hallucinations.

   - Encourage the person to keep a chart or calendar of when hallucinations occur and how long they last in an effort to identify an emotional trigger.

10. **Suggest coping techniques useful in managing the hallucination:**

    - Reinforce the use of interpersonal relationships in meeting the need. It is important to find at least one person who will give honest feedback to help your consumer sort out reality from the hallucination. It will be important that this person is readily accessible to the client.

    - Anxiety reduction is an integral factor in interrupting hallucinations.

    - Consumers have identified distraction, ignoring the voices, selective listening, and setting limits on the influence of the voices as four helpful coping techniques that can be implemented without anyone else knowing.