A GUIDE FOR FAMILY & LOVED ONES

Schizophrenia & Psychosis

Understanding unusual experiences, responding without escalating fear, supporting treatment and recovery, and protecting the wellbeing of the whole family.

An important starting point

Psychosis is a group of experiences, not a description of someone's personality. Schizophrenia is one condition in which psychosis can occur, but psychotic symptoms can also appear in other mental-health conditions, after substances or medicines, and in some physical or neurological illnesses. A person needs individual assessment rather than being diagnosed by relatives or from a checklist.

What psychosis can mean

Psychosis can affect how a person perceives, interprets and makes sense of reality. Experiences may include hallucinations, delusions or strongly held unusual beliefs, confused or disorganised thinking, and changes in behaviour or functioning. The experience can feel completely real to the person. Telling them simply that it is nonsense rarely removes the fear and may damage trust.

Hallucinations are sensory experiences without an external source that other people can verify. Hearing voices is common, but people may also see, smell, taste or feel things. Voices can be neutral, comforting, critical, frightening or commanding. The content matters clinically, especially if a voice tells someone to harm themselves or another person.

Delusions are strongly held beliefs that are not shared by others and persist despite contrary evidence. Someone may believe they are being watched, followed, harmed, controlled or sent special messages. Others may develop grandiose or religious beliefs. Families should avoid ridicule. The person's fear may be genuine even when you do not share the explanation for it.

Disorganised thinking can make conversation difficult to follow. The person may move rapidly between topics, lose the thread, use unusual connections or struggle to organise everyday tasks. At other times their speech may be entirely clear. Symptoms can fluctuate.

Schizophrenia is more than hallucinations

Schizophrenia is diagnosed through a pattern of symptoms, duration and impact, after other explanations are considered. Alongside psychotic symptoms, some people experience reduced motivation, less spontaneous speech, social withdrawal, reduced emotional expression or difficulty initiating tasks. Cognitive difficulties can affect attention, memory, planning and processing speed.

These so-called negative and cognitive symptoms can be misread as laziness, rudeness or lack of caring. A person may want to shower, answer messages or attend an appointment but struggle to organise the sequence of actions. Families can support structure without taking over every responsibility.

What psychosis may feel like from the inside

Imagine being absolutely certain that something dangerous is happening while everyone around you says it is not. The person may feel frightened, suspicious, overwhelmed, confused or isolated. If voices comment on everything they do, concentrating on a family conversation can be extremely difficult. If they believe food is unsafe, encouragement to eat may feel like pressure to do something dangerous.

Some people have partial insight and can say, 'Part of me knows this might be a symptom, but it still feels real.' Others have little insight during an acute episode. Insight can improve as the episode settles. Families should not use insight as a moral test or accuse the person of refusing to see sense.

Validate emotion without confirming the belief

Try: **'I can see that you are frightened. I don't hear the voice, but I believe that you are hearing it.'** Or: **'I don't share the belief that someone is watching the house, but I can see how unsafe you feel. What would help us get through tonight safely?'**

What can contribute to psychosis?

There is no single cause. Vulnerability can involve biological, psychological and social factors. Stress, sleep disruption, trauma, isolation and substance use may be relevant for some people. Certain drugs, including cannabis and stimulants, can increase psychosis risk in susceptible people. Physical illness, neurological conditions and prescribed medicines can sometimes produce psychotic symptoms and need consideration in assessment.

Families should avoid searching for one person or event to blame. A formulation is more useful: what vulnerabilities, triggers, stresses and protective factors appear relevant for this individual, and what can reduce future risk?

Early warning signs and changes families may notice

Changes can include worsening sleep, increasing suspiciousness, unusual interpretations of ordinary events, withdrawal, neglect of self-care, talking or laughing when alone, marked agitation, difficulty following conversation, reduced eating, abrupt decline in work or study, or becoming preoccupied with a particular belief. None of these signs alone proves psychosis.

If the person has experienced previous episodes, create an individual relapse-signature plan. One person's earliest sign may be sleeping only two hours; another's may be withdrawing from friends or believing television programmes contain personal messages. Early recognition can allow treatment teams to respond before a crisis becomes severe.

How to communicate during an episode

Keep communication simple, respectful and calm. Reduce the number of people speaking. Give extra processing time. Avoid rapid questioning or cornering the person. If they are suspicious, sudden touch, whispering with other relatives or blocking the doorway may increase fear. Explain what you are doing before you do it.

Do not enter a prolonged argument about the belief. Repeatedly presenting evidence can make the person feel interrogated. Equally, do not pretend to agree with something you do not believe. Use neutral language: 'That isn't how I understand what is happening, but I can see it feels very real to you.'

If voices are distracting them, ask what helps. Some people prefer conversation, music, headphones, a simple task or a quieter environment. Others need space. If voices are threatening or commanding, ask directly and calmly about safety rather than avoiding the subject.

What not to do

Avoid mocking, filming the person for proof, deliberately testing their beliefs, shouting, threatening hospital as punishment, crowding them, making sudden movements, telling them to 'act normal', or discussing them as though they are not present. Do not encourage or elaborate unusual beliefs in an attempt to gain trust.

Reducing stimulation and maintaining dignity

A busy room, loud television, several relatives, bright lights or conflict can make an overwhelmed person more distressed. Where possible, create a calmer space and offer simple choices. Preserve privacy and dignity. An acute episode does not remove adulthood or personhood.

Food, drink, sleep and medication can become difficult. Offer practical support without creating a power struggle. Significant refusal of food or fluids, severe sleep deprivation, medication problems or rapid deterioration should be discussed with professionals.

A calm-response plan

Agree when well: **early signs**; preferred people; helpful phrases; touch/no-touch; what reduces stimulation; medication arrangements; who can contact the clinical team; what the person wants family to do if they become very unwell; and the specific signs that mean urgent or emergency help is needed.

When the person refuses help

Lack of insight, fear of services, previous difficult experiences or paranoid beliefs can make help feel threatening. Families can offer choices where possible: GP, care coordinator, crisis team, a trusted clinician, or another agreed route. Use concrete observations rather than labels: 'You have slept three hours in four nights and you haven't eaten today; I am worried about your health.'

There are situations where urgent assessment may be needed even when the person does not want it, particularly if risk or severe deterioration is present. Families should seek professional advice rather than attempting to manage a dangerous situation alone.

Assessment, treatment and recovery

Assessment can include the person's experiences, duration and impact of symptoms, mood, substance use, physical health, medication, sleep, trauma where relevant, functioning and risk. Clinicians may need to consider bipolar disorder, severe depression, substance-induced psychosis, neurological or medical causes and other diagnoses. Family information can be valuable with appropriate consent and confidentiality boundaries.

Antipsychotic medication

Antipsychotic medicines are commonly used to treat psychotic symptoms. Different medicines have different side-effect profiles, and response varies. Potential issues can include sedation, movement-related effects, sexual side effects, weight and metabolic changes, hormonal effects and others. Prescribing, changes and monitoring belong with qualified clinicians.

Families can support medication routines if the person wants this, but should not secretly medicate someone or alter doses themselves. If side effects are making adherence difficult, help the person communicate this to the prescriber rather than framing non-adherence as simple defiance.

Psychological and family interventions

NICE guidance for psychosis and schizophrenia includes psychological interventions such as cognitive behavioural therapy and family intervention alongside appropriate medical care. Family work can improve communication, problem-solving, understanding of relapse signs and the way stress is managed at home. The aim is not to blame families for illness.

Recovery is personal and broader than symptom removal. It can include improved sleep, reduced distress from voices, returning to education or employment, rebuilding relationships, managing medication collaboratively, recognising early warning signs, developing confidence and having meaningful roles and goals.

Hope without false promises

Some people experience one episode and recover well; others have recurrent or persistent difficulties. Families can hold hope without promising a particular outcome. 'We will keep working with what is happening now' is often more helpful than 'You will definitely never hear voices again.'

Supporting everyday functioning

Break complex tasks into manageable steps. A prompt such as 'Would it help to put the appointment time in your phone?' supports more autonomy than taking over the entire diary. Encourage routines around sleep, meals, movement, appointments and meaningful activity while recognising that severe symptoms can temporarily reduce capacity.

Avoid making the person's whole identity about illness. Talk about music, football, grandchildren, work, humour, hobbies, plans and ordinary life. Recovery is strengthened when the person remains a family member, friend or colleague rather than becoming only 'the patient'.

Substances and relapse prevention

Alcohol and drugs can complicate symptoms, treatment and risk. Cannabis is particularly important to discuss because it can increase psychosis risk and worsen outcomes for some people. Conversations are more productive when they are factual and non-shaming. If substance use is significant, integrated mental-health and substance-use support may be needed.

A relapse-prevention plan can include sleep changes, stressors, early symptoms, medication issues, substance use, appointments, trusted contacts, preferred interventions and what helped during previous episodes. Review it after a relapse rather than waiting until the next crisis.

Safeguarding yourself while supporting someone

Families can become frightened and exhausted, especially when episodes involve night-time calls, accusations, repeated crises, financial problems or uncertainty about risk. Supporters may begin monitoring constantly, hiding the situation, missing work or feeling responsible for preventing every deterioration. Your wellbeing is not secondary.

Psychosis does not equal violence

Most people with schizophrenia or psychosis are not violent, and stigma can be deeply harmful. Risk is individual and influenced by many factors. However, families should also be able to discuss actual frightening behaviour without being told that doing so is discriminatory. If there are threats, weapons, serious aggression, coercion, dangerous driving, fire-setting, severe self-neglect or other concrete risks, seek professional or emergency help.

Boundaries are not abandonment

Examples: 'I will listen, but I won't agree that the neighbours are definitely spying on you.' 'I can drive you to the appointment, but I cannot miss work every day.' 'I will not give you money for drugs.' 'If you threaten me, I will leave and get help.' 'I cannot be awake all night; this needs the crisis team.' A boundary protects the relationship by clarifying what family support can and cannot safely provide.

When accusations are directed at you

Paranoid beliefs can sometimes involve the people closest to the person. Being accused of poisoning food, spying, stealing or plotting can be painful and frightening. Avoid endless attempts to prove innocence in the heat of the episode. State your position once, acknowledge the distress and focus on safety. If you feel unsafe, leave and seek help.

Carer fatigue and burnout

Signs include poor sleep, dread when the phone rings, irritability, resentment, anxiety when away from the person, reduced concentration, cancelling your own life, financial strain, neglecting your health or becoming emotionally numb. Supporters may also experience grief for the future they expected or guilt about wishing for a break.

Supporter wellbeing check-in

Ask: **Am I physically safe? Am I sleeping? Am I carrying responsibilities that belong to services? Can I leave the house? Are my finances protected? Do I have someone I can tell the whole truth to? Are children being affected? What boundary or extra support is needed now?**

Financial and practical safeguarding

During severe episodes, judgement and spending can sometimes be affected. Protect your own accounts and credit. Do not take on unsustainable debt because you feel guilty. If exploitation, coercion or vulnerability to scams is occurring, seek appropriate advice. Decisions about another adult's finances or capacity require proper legal and professional processes, not informal family control.

Children and vulnerable family members

Children need age-appropriate explanations that remove blame: 'Mum's brain is making some things feel very frightening at the moment. Adults and doctors are helping.' They should not be asked to monitor medication, challenge beliefs or manage crises. If a child's safety or emotional wellbeing is affected, seek support.

Support versus rescue

Support helps the person use their own abilities and professional network. Rescue makes the family the entire system. You can sit beside someone while they call the team without making every call. You can help plan meals without becoming solely responsible for eating. You can care without agreeing to be available twenty-four hours a day.

Getting support for yourself

Carer assessments, family intervention, counselling, peer support and trusted relatives can all matter. Ask the clinical team what information they can provide to carers. Confidentiality may limit what professionals can tell you, but it does not prevent you from giving them information about risks or changes you have observed.

Urgent and emergency situations

Seek urgent professional help if the person is rapidly deteriorating, severely confused, unable to care for basic needs, not sleeping for prolonged periods, highly agitated, expressing suicidal intent, responding to dangerous command hallucinations, threatening serious harm, or presenting another immediate risk. New psychosis also warrants prompt assessment.

In an immediate life-threatening emergency call 999 or attend A&E.; NHS 111 can provide urgent health advice. If the person has a crisis team or care coordinator, follow the agreed plan. Samaritans can be contacted on 116 123 in the UK and ROI for emotional support. Do not place yourself in danger while waiting for help.

Practical family coaching tools

1. Observation versus interpretation. Observation: 'He has slept two hours, is pacing and says the television is sending him messages.' Interpretation: 'He is being difficult.' Keeping these separate improves communication with professionals and reduces blame.

2. Validate emotion, not certainty. Practise three sentences: 'I can see you are frightened.' 'I don't experience it in the same way.' 'What can we do right now that helps you feel safer?'

3. Relapse signature. List the person's earliest five changes, the next five signs of deterioration, what has helped before, who should be contacted and what threshold requires urgent help. Include sleep and substance-use changes where relevant.

4. Family stress map. What increases tension at home? What conversations repeatedly escalate? Which expectations are realistic during acute illness? Which responsibilities can return gradually during recovery? What ordinary family routines should be protected?

5. Boundary plan. I can... / I cannot... / If I am threatened I will... / My protected time is... / My financial boundary is... / The responsibility that belongs to professionals is... / The people I can call are...

6. Crisis information sheet. Diagnosis if known; medication list; allergies; clinician/team; previous helpful interventions; previous adverse reactions; risks; preferred communication; emergency contacts; children/pets needing arrangements. Keep it updated and accessible.

Common myths

'Schizophrenia means split personality.' No. It is not dissociative identity disorder. **'Everyone with psychosis is dangerous.'** No. Risk must be assessed individually. **'Arguing hard enough will remove a delusion.'** Usually not; confrontation can increase mistrust. **'Families cause schizophrenia.'** No. Family support can be part of treatment, but families should not be blamed for causing the illness. **'Recovery is impossible.'** Outcomes vary, and many people achieve meaningful recovery and satisfying lives.

Recommended reading and resources

Surviving Schizophrenia - E. Fuller Torrey: a detailed family-oriented overview, best used alongside current UK clinical guidance. **The Complete Family Guide to Schizophrenia** - Kim T. Mueser and Susan Gingerich: practical family strategies and recovery-oriented information. **Living with Voices** - Marius Romme and Sandra Escher: a voice-hearing perspective that may broaden understanding; it represents a particular approach rather than the only clinical model.

UK sources include NHS information on schizophrenia and psychosis, NICE guideline CG178 on psychosis and schizophrenia in adults, and Mind information on psychosis and schizophrenia. Rethink Mental Illness also provides information and carer resources. Local NHS early intervention in psychosis services can be especially important for first episodes. Service availability varies by area.

Clinical note

This guide is educational, not diagnostic, and does not replace individual medical or mental-health advice. Psychotic symptoms can have psychiatric, substance-related, medication-related, neurological or other medical causes. New or severe symptoms require appropriate assessment. Medication should only be started, stopped or altered with qualified clinical advice.

A message from Maggie

When somebody you love begins hearing, seeing or believing things that you cannot share, it can feel as though the rules of your relationship have suddenly changed. You may be frightened of saying the wrong thing. You may want to prove what is real, or you may find yourself agreeing with things you do not believe because you are desperate to keep the peace.

You do not have to win an argument with psychosis. You can stay respectful without pretending you experience the same reality. You can acknowledge fear, reduce pressure, encourage professional support and keep communication simple. Sometimes the most powerful sentence is: 'I don't experience it that way, but I can see how frightening this is for you, and I want us to get the right help.'

I also want families to hear something that is often missed: you matter too. Supporting someone through psychosis can affect sleep, work, finances, friendships and your own sense of safety. Understanding a diagnosis does not mean accepting abuse or becoming the only person responsible for keeping someone well. You are allowed boundaries and you are allowed help.

Recovery should not mean that the whole family lives permanently on alert. The aim is to build a wider support system, recognise early signs, use professional care appropriately and keep ordinary life alive wherever possible. The person experiencing psychosis is still a whole person with interests, relationships, strengths and hopes - and the supporter is a whole person too.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

What would make your family support system safer and more sustainable if symptoms became difficult again - and which part of that plan needs to be put in place **before** the next crisis?