

walking naked in the streets may accept an explanation like, "You know, you were exhibiting bizarre psychotic symptoms."

HOW TO COPE WITH DEMORALIZATION

Often, demoralization occurs after the psychotic phase. For the purposes of this article, we will assume that the consumer does not have a depression or neuroleptic-induced akinesia that is causing demoralization.

Demoralization often is a function of failing to meet societal or familiar expectations, for example, shame over not achieving higher education goals. Not achieving these expected goals affects all other aspects of the consumer's self-esteem. Consumers who have to drop out of college because of schizophrenia, for example, may go on to depreciate all of the remaining intellectual gifts. As a result depression is common.

Self-depreciating trends can be recognized by a tendency to comment negatively on one's performances. There is an accompanying tendency not to blame others. A central difficulty of this assessment is the consumer's frequent reluctance to disclose any feeling of stigma, low self-esteem or self-depreciation.

One of the keys is to maintain a positive attitude. A hopeless attitude is a major problem for many family members and people with severe neurobiological disorders. It is very important to maintain morale and hope; otherwise, the consumer's attitude will be a reflection of yours, which leads to a vicious cycle of demoralization.

Statements of admiration have special power when used sincerely. While this may seem obvious, in practice it is common to see problems stressed at the expense of strengths. One way to assist in sincerity of admiration is to consider, and reflect to the consumer, the inner strengths needed to keep on going with life despite having disabilities.

The use of admiring statements can however backfire. There are two common traps. The first is insincerity and making patronizing remarks. Choose only admiring statements that are genuine and sincere. Allegedly "admiring" statements are frequently said in a degrading or sarcastic tone, especially by professionals who are accustomed to focusing on psychopathology, not strengths. The second trap is to be discouraged by the subsequent rejection of the admiring statement. Expect initial rejection. In fact, the consumer's disowning of approval suggests that you are "on target."

As with many aspects of schizophrenia, becoming educated about negative symptoms can be of help. Negative symptoms of schizophrenia (apathy, inertia, etc.) can mimic or cause demoralization. When a consumer understands that these are symptoms of the disorder, they may feel better. Use medical language in this case. Laziness becomes avolition; tiredness becomes apathy; and lack of appreciation becomes anhedonia.

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being intrusive. Some emotional distance should be maintained. Anxiety over excessive verbal interventions or interpersonal closeness can make psychotic symptoms worse. Too much activity, emotional reaching towards the loved one, or inquiring about symptoms can backfire by overstimulating the psychosis. Many mental health professionals and family members have trouble with the notion of being alone with a consumer, feeling that being quiet together means that they are experienced as indifferent or hostile. Actually, the consumer doesn't feel like that at all, and is able to sense the difference.

HOW TO DEAL WITH STIGMA

Many consumers will not admit to stigma because an admission is equated to acknowledging that they suffer from a "mental" illness. Therefore stigma's presentation is often indirect a refusal to participate in treatment or programs. However, keep in mind that refusal to participate may also come about because a program is inappropriate, ineffective or otherwise substandard. It is important to determine what is the cause of the consumer's refusal before trying to help.

Stigma may also lead to substance abuse, where having psychotic symptoms in the sense of "getting high" is seen as normal. Stigma may also be the underlying cause of unrealistic expectations, such as a seemingly foolish attempt to overreach vocational goals. For example, a very poorly functioning and symptomatic consumer who signs up for prelaw exams.

Stigma can explain the commonly seen paradoxical situation of when the consumer seems to deny illness but voluntarily takes anti-psychotic medication. Stigma may be greatest in consumers who had good presickness

Talking about yourself is a way of normalizing the consumer's experiences. It allows consumers to compare their frustrations with yours. Use concrete examples taken from your own life (for example, trouble with authority or experiencing failure) to assure the consumers that not all of their difficulties come from illness. functioning, come from a higher socio-economic background, or whose families have trouble accepting the diagnosis of their relative. Acknowledge the stigma, normalize the consumer's experiences. Support self-esteem and help save face.

Stigmatized consumers tend to attribute all of their struggles on being ill. which is an attitude that fosters greater stigma and isolation. Normalizing the consumer's experience as much as possible can be very helpful. Many consumers idealize the lives of "normal" people. These consumers do much better if they know that many of the trials and tribulations of life are experienced by so-called "normals."

You should not patronize or trivialize the consumer's real-life difficulties. For example, getting a mediocre grade in a course is not a comparable setback to dropping out of school because of mental illness. Avoid disclosing socially taboo or over-stimulating topics such as sexual issues.

One technique that works very well is the use of performative statements. Performative speech refers to statements that derive their power simply from being made, providing that they are made by the right person under the right circumstances. Should the consumer not acknowledge your authority, then the performative statement can be given by someone else with credentials that are acknowledged by the consumer.

Blunt or direct use of emotionally laden terms may backfire when used on stigmatized consumers. Often, consumers are confronted with "psychoeducation" before they are ready. Be tactful. Use descriptors rather than medical terms. For example, someone brought in with handcuffs after

topic with something like: "Other people have found that... Is it possible that this is true for you?"

- 4) Anticipate setbacks after successfully addressing denial. When denial of illness abates, be prepared for trouble ahead. Demoralization, sense of failure or despair often follows. The most striking example is the development of suicidal despair during the period when the recently psychotic consumer is regaining insight. This is often triggered by setbacks with the recovery process. The denial may have been proactive-shielding the consumer from attributing setbacks to his/her symptoms. When consumers become aware of their real-life defeats, show how apparent defeat sometimes represents real progress. Success and progress frequently go unnoticed. Even the most striking success can be viewed (by the consumer or you) as a failure. Often, the hidden success is the willingness and courage to make an attempt.

HOW TO DEAL WITH THE MANAGEMENT OF TERROR

Many consumers are terrified that they can no longer find or maintain coherent mental functioning. What often follows is a desperate search for normal mental functioning combined with an attempt to hide this struggle from other people. Be aware of how bad the terror can be and how common it is. Recognizing terror from having psychotic symptoms depends on a number of familiar signs. Because consumers often can't or won't verbalize their terror, it is all too easy to ignore this problem, or become indifferent to it. You need to look for indirect evidence of terror: thoughts are scattered or dissociated; feelings are volatile, inappropriate or absent; and behaviour unpredictable or contradictory.

The goal is to decrease the sense of terror and despair that comes with awareness of being psychotic. Treating the reaction to loss of normal mental functions requires an intervention that, in some respects, is not easily described. Ask the consumer about being frightened, and state that you would be frightened under the same circumstances. The knowledge that someone else can recognize the sense of terror without it having to be explained can be tremendously reassuring. Perhaps the greatest difficulty facing you is to understand the extent of the consumer's desperation while, at the same time, not becoming overwhelmed by it.

Reassure. While obvious, this simple measure is often overlooked. Help reassure the consumer that the fear is normal, and that the psychotic experience-although terrible-will improve. Avoid false cheerfulness, which will be picked up as feigned.

Provide companionship. Even when verbal communication cannot be reciprocated, companionship can be helpful, reassuring consumers that they are not alone. While in the presence of terrified consumers, proper physical positioning is important. You should remain slightly to one side and avoid staring; one aims for easy accompanying. An air of quiet confidence is also needed because anxiety is contagious. Little should be said, except occasional reflections about what must be experienced by the consumer's presumed state of mind. Words like "wandering," "aimless," "frightened," "bewildered" or "vulnerable" might be tried to see if the consumer can acknowledge any of these states. These attempts to make contact with withdrawn and frightened consumers are best rendered by combining these descriptions with short emphatic statements such as: "How awful" or "It must be frightening."

Leave the consumer alone. Paradoxically, at the same time as offering companionship, you need to be able to leave the consumer alone. The skill here is to know how to be able to sit with the consumer and, at the same time, give the consumer enough emotional space. It is important to avoid

the previous one. The eventual goal is for the consumer to tell the case worker, "Don't be so paranoid."

As an example, Ms. C blames her last hospitalization on a police conspiracy to terrorize her. Rather than confront her with her own behaviour that led to her being arrested, her case manager agrees that the police cannot be trusted and goes on to talk about his own outrage at the Rodney King case. By the end of the conversation, Ms. C tells the case worker to stop treating the police so unfairly.

- 7) Postpone psychoeducation about mental illness, especially diagnosis. Consumers in the midst of a paranoid state often cannot tolerate psychoeducation, because they are unable to acknowledge to others the existence of a psychotic illness. Rather, consumers will deny the illness and blame others for their difficulties. Until the consumer is strengthened, and the paranoia lessened, no attempt should be made to identify, correct or argue with the consumer about paranoid or delusional symptoms. Until a sound alliance is made, you should avoid the more traditional psychoeducational approach that teaches about illness and benefits of education.

HOW TO DEAL WITH THE DENIAL OF ILLNESS

Avoid an overzealous attack on the consumer's denial. When the denial of illness is chronic and seems unrelated to relapse, the first step is to determine whether the denial should be addressed at all. Denial of illness may not be harmful as long as the consumer is doing well and is compliant with treatment. Indeed, several studies have shown that the consumers who deny their illness see themselves as having more purpose in life, are more optimistic and have fewer affective symptoms. This is a difficult concept for families to accept. But denial of illness often only needs to be addressed if it is causing problems with accepting proper medical treatment.

If denial has to be addressed, it should be addressed indirectly. Enlarge the consumer's perspective by helping the consumer acknowledge the existence (or at least the possibility of) different points of view. There are four steps to accomplish this, as outlined below.

- 1) Recognize the consumer's point of view. Assume the consumer's point of view is to be believed, even cherished, highly learned or over-determined. For example, if the consumer says, "I'm not sick, it is others who are sick and making up these stories about me," hold off about disagreeing. Instead, you should think (but not say to the consumer): "Let me assume this statement is true. Now in what way can this be true?" In this context, you can acknowledge the consumer's beliefs as being one of "point of view"-even if delusional-without having to agree with that point of view.
- 2) Establish that the consumer's view is only one point of view. After you have comprehended the consumer's rationalization of the denial, the goal here is to establish with the consumer that people can have legitimate differences in view points and options, and that people can "agree to disagree" without taking personal affront at the disagreement. Discuss non-threatening issues (for example, recent political events, sports, music, etc.) and come to an understanding that different opinions are acceptable and a part of life. Then you can bring up that it is acceptable to hold different points of view about the consumer's own situation or need for treatment.
- 3) Supply an alternative. This step marks the first time denial is directly addressed. You have to suggest alternative explanations in a way that leaves the consumer a way to disagree without getting into a power struggle with you. Be respectful. Try to see why it is necessary for the consumer to take the position of denying the symptoms. For example, you may broach a new

HOW TO DEAL WITH SOME COMMON SYMPTOMS OF SCHIZOPHRENIA

Edited from an article by Dr. Peter Weiden and Dr. Leston Havens
Our sincere thanks for permission to print this valuable information.

Everyone is an individual. No two individuals, consumers or otherwise are identical. Knowing the consumer is the first step towards helping. This article is meant to provide suggestions that have worked in some cases, but will not work in all cases. Apply common sense when attempting to use any of the suggestions offered. Please take note that these suggestions are not substitutes for a psychiatric assessment or medication.

SIX STEPS TO HANDLE PARANOIA

- 1) Place yourself beside the consumer, rather than face-to-face. This side-by-side position tends to deflect the paranoid fears away from you. Instead, both you and the consumer are looking out at the (hostile) world together. This positioning technique may improve the chances that you will form a working therapeutic relationship with the consumer later on. Don't stand directly in front of the individual. That may be considered confrontational by the consumer.
- 2) Avoid direct contact. Direct eye contact often makes a paranoid individual feel even more so. Look elsewhere.
- 3) Speak indirectly. Avoid speaking directly to the consumer. Substitute pronouns such as it, he, she, or they for the words I and you. Like the body positioning, the purpose is to deflect the consumer's paranoid projections away from one-on-one interactions with the case worker. Instead, paranoid symptoms are directed towards external and more general 'real world' issues.
- 4) Identify with, rather than fight, the consumer. Whenever possible, your attitudes and emotional expressions should parallel the consumers' attitudes and expressions. The goal is to help the consumer feel understood. Meet anger with reciprocal anger, frustration with frustration (i.e. you also express anger and frustration with the difficult circumstances).
- 5) Don't try to rationalize how the beliefs can't be true. In fact, do the opposite. Share mistrust. The intuitive approach with paranoid people is to try to persuade them to be more trusting. It is often better to do the opposite, that is, for you-along with the consumer-to mistrust the world together. No attempt is made to correct or contradict the consumer, or to test reality. Temporarily, the consumer's account of reality is accepted as reality. The assumption behind this technique is that, in the midst of a paranoid state, the consumer is over-burdened and overwhelmed by a mixture of real-life stresses and distress from psychotic symptoms. While being careful to avoid collusion with the psychotic symptoms, you should attempt to find certain believable or credible aspects of the paranoid belief system. This allows you to agree with the consumer on something.
- 6) You then move on to a symptom area, attempt to substitute a less paranoid, more benign (and general) explanation for the more highly personalized paranoid one.

The process of exchanging the person's personalized beliefs for benign paranoid beliefs is best done in a step-wise fashion, where the alternate explanation is only a notch less paranoid than