The concepts described here have been developed over a 30-year career in psychiatric nursing. Attempts to communicate with the fearful, or angry, or delusional person resulted in feelings of frustration, and even hostility on my part, as my initial approaches failed. Altering and modifying as I went along, I have retained and refined the successful approaches.

I met one young man with his face red, eyes wide, and gaze fixed, after being literally dragged into the clinic by his family. “Uncooperative, hostile, and paranoid,” had been the description from the admission clerk. He began with the statement that his family was plotting against him, that he did not need psychiatric care, and that there was nothing wrong with him.

He leaned forward, gripping the arms of the chair until his knuckles blanched. “How would you like it if the FBI was following you around, mess-

Everything I Learned, I Learned From Patients: Radical Positive Reframing

by Mary Lou San Blise, RN

and with your mind, knowing every thing you do?” The answer was spontaneous honesty. “I’d hate it. I don’t even like it when the Highway Patrol is following me. I’d be a wreck if it was the FBI.” At that response, he sat back in his chair, his affect relaxed, and he said, “You would?”

His sudden alteration encouraged me to continue that approach. I assured him that no one likes being followed, that the normal response is anxiety, and heightened awareness. We began, together, to explore his illness as a normal response to an unexplained experience. Reframing, technically speaking, means to redirect or change the perceptual experience of a situation by placing it in another appropriate context (Watzlawick, Weakland, & Fisch, 1974).

Reframing changes the meaning of the situation and, therefore, its consequences. The effect is change while the concrete facts remain the same.

Tom Sawyer’s success in getting his friends to whitewash the fence for him is an example of reframing. Reframing helps to view a problem in a different light and avoid feeling trapped (Miller & Osmunson, 1989). The traditional view is that reframing requires an external change agent who is both skillful and not enmeshed in the problem. However, Pettegrew (1979) found that individuals demonstrate varying degrees of reframing ability. Miller & Osmunson found that reframing can be rapidly taught as a self-help skill to college students.

The radical concept is teaching the use of this cognitive technique to clients with thought disorders. In the past 7 years, 226 references to reframing were noted in psychiatric abstracts, and only one directly refers to the use of reframing with psychotic clients. Milton (1978) compared the effectiveness of confrontational methods with teaching the clients to search for alternative methods (reframing). Delusions were decreased in both groups; but there was more improvement in the reframing
group. Based on this study, Corrigan & Storzbach (1993) recommended its use.

The positive aspect of this technique is that alternative explanations are proposed that allow the client to view self in a more positive light. Reframing schizophrenia as a normal response to an unusual illness—an incurable chronic illness caused by an imbalance of neurohormones—takes away much of the stigma. Erickson & Binder (1986) comment that the most obvious and disruptive behaviors respond well to medication while the negative symptoms, being less dramatic, often get overlooked. They propose “the development of rehabilitative approaches that focus on the patient’s profile of competencies and deficits.”

Let us assume that our clients have been telling us the truth. Clients do have episodes of hearing voices that are making negative comments about the client. Clients do have episodes of anxiety, even panic, that seem to be related to external events.

Any experience has two internal responses, a cognitive one and an emotional one. When something happens to us, we think about it, and we feel about it. There is no reason to assume that there is any difference between our responses and that of our clients.

When clients hear a hallucinatory voice, they usually feel fear initially, then anger. Then they begin the cognitive process of figuring out who is talking to them, and why. This is the genesis of the delusional system. Rather than confront their explanation as a “false, fixed belief,” accept that the delusion is probably an excellent explanation for a poorly understood internal process. Accepting the person’s story is a characteristic of self-help groups, who use similar strategies, without the theoretical concepts of reframing available to them.

In looking at schizophrenia as an illness, reframing is in order not only for the client but the caregiver as well. Towl (1990) comments that the commonly held view is that schizophrenia is “without insight.” He then cites examples of delusional clients’ ability to recognize auditory hallucinations and argues that, “It is important that their views are not held in doubt simply on the ground that they sometimes have delusions.”

As clients describe their experience, it is helpful to respond to the information in a supportive, nonjudgmental way. Given the lack of scientific information to explain auditory hallucinations, it might be logical to assume that some powerful entity like the CIA or an alien has targeted the client and is causing the torment. Stating that you can see how the client arrived at that conclusion does not reinforce the delusional system, it reinforces the logical process. That is exactly the part of the brain least likely to be impaired. Both clients and caregivers must remember that a diagnosis of schizophrenia does not indicate complete mental incapacity. Calling schizophrenia a mental illness is too global. At this point, all we know is that schizophrenia alters some mental processes. The rest of the brain is not impaired, but it is influenced by the disease process.

Consider the fact that although diabetes is the number one cause of blindness in the United States, it is not known as a disorder of the eye. It causes more amputations than any other disease, yet we do not call it a disease of the foot. Because we understand the etiology of those conditions, they are seen as symp-

We began to explore his illness as a normal response to an unexplained experience.

toms of an inadequate insulin supply or delivery. Both staff and clients must remain aware that symptoms are not specific to the site of the disorder. The symptoms of schizophrenia are in the mind, but that may not be the etiological site.

Thus, radical positive reframing becomes a tool with which to fight the
Reframing, technically speaking, means to redirect or change the perceptual experience of a situation by placing it in another appropriate context.

stigma of mental illness.

A 26-year-old woman came to group one day because she had been told that she would lose her board-and-care placement if she did not get some help. She was angry, with a kind of radiant hostility. She came in to the group glaring, stomping her feet, cursing, and denying any need for treatment. The whole group breathed a sigh of relief when she stomped back out again. But the next day, she came back. She had already lost so much that this placement was all she had left. She really did not want to lose it.

“What do you think you can do for me?” she stormed. “I have been in five different hospitals. I have had 10 different psychiatrists. I have been on Thorazine and Trilafon and Prolixin and Stelazine and Mellaril and Haldol and respiridone. I still hear demons telling me what to do. People follow me around, trying to kill me. They put thoughts in my mind, and messages on the television. So, what the hell do you think you can do for me?” She stood in the middle of the room, leaning forward, face red, hands on her hips, challenging every best effort that psychiatry had attempted.

“Wow, you must be a really strong person,” the nurse responded.

The client looked startled and said, “What did you say?”

“You must really be a strong person. You have one of the worst cases of schizophrenia I have seen. Yet, you still managed to get dressed and come here today. You are tough.”

“Are you saying that I have schizophrenia?”

“Yes, that is what it sounds like to me. You have all the symptoms that go with that diagnosis. We have fancy names for them. We call it thought insertion, or thought broadcasting. But that is what it sounds like. Plain, old, ordinary, garden-variety schizophrenia.”

She dropped into a chair, as if her feet had been yanked out from under her. “I have schizophrenia.” Her face cleared as relief replaced hostility. “That’s what’s causing all that stuff. Thank God! I thought I was losing my mind!”

After we laughed together, she explored with me the condition that was, for the first time, acceptable to discuss.

“What is schizophrenia?”

“Probably some alteration of chemicals in parts of your brain.”

“How much of my brain is affected?”

“Maybe 10%.”

“Do you mean that 90% of my brain is okay?”

“Those things are symptoms!”

“Oh, thank God! I really thought it was real!”

This young woman had spent years denying and resisting the well-intentioned interventions of various nurses, doctors, and therapists. When someone listened and accepted her experience, she was able to reframe her entire psychotic process as a series of symptoms, rather than actual events that even she was able to recognize as highly unlikely. This woman joined the group and
later was overheard talking to another client who was crying because he saw a crow on the roof and he believed that meant somebody in his house was going to die. "Yep, that’s schizophrenia," she said. "It makes things seem much more important than they really are."

Symptom Management

Paranoia

One of the common symptoms reported by schizophrenia is the feeling that "someone is always after me... knowing everything I do...spying on me." It is persistent, and free-floating. Behavior that creates this feeling in another is identified as stalking, and in many states it is against the law. Paranoia is a hallmark symptom of schizophrenia, however, and the only difference is that our clients cannot identify the stalker.

If you have ever been followed by a police car, you know how anxious you can feel. Even though you are obeying the law, you start to feel nervous. How would you feel if you did not know who the police were or even what the rules were? Schizophrenic clients with paranoia have an intense version of that feeling. Because the feeling is so intense, the client believes that it must be based on fact.

Emotions can be based on actual or perceived events, and the unconscious mind cannot tell the difference. Feelings are real. The tears shed at a movie are real, even though we understand that the experience is generated by a script, the emotion is still real. Clients’ feelings are real. Frequently, these feelings are linked to some external happening that gets connected simply because the level of fear triggers a much stronger recall of that event, thus making it much more significant than other memories. There is a strong drive to understand this experience. This drive to make some sense of an incomprehensible experience leads to interpretations that come to be accepted as fact.

A premise basic to successful reframing is that patients are telling us the truth. Once we can accept this, our responses will follow in the style that is most comfortable for us. By focusing on the emotional content, we can easily express our natural support for the person who is in distress about the events in their lives.

Have you ever medicated anyone for pain? Did you believe the pain was real? Could you see it? Believe that the diagnosed with schizophrenia client’s distress is real. Tell the client, “There is nothing I can do, but it must feel terrible.”

Tracing the progression of symptoms helps clients believe you do understand what they’re talking about. Ask, “Did it start with kind of a murmuring in the background? At first you could not really make out any words?”

Next, move on to helping the client process how the symptoms have been interpreted and that the interpretation of the symptoms might be faulty. One client complained that people always slowed down in front of his house to plant thoughts in his mind. After the day treatment group had a picnic at his house, the nurse realized the problem. The client was asked to drive past his house at the speed limit. Just before he reached the house, he started to slow down. “Why are you slowing down?” the nurse asked.

“Well, I have to slow down for the curve,” he responded. Then he grabbed the steering wheel with both hands, and shouted, “The curve! It’s the curve! People are slowing down for the curve. Why didn’t I think of that?”

 Violence

We have all been taught that the appropriate therapeutic response to delusions is
FIGHTING THE FEAR

My name is Kurt. Ten years ago, I got out of the hospital and was sent to a day treatment program. I did not want to go, but I thought I would have to go back in the hospital if I did not. I had been into the hospital three times, and I did not want to go back. But I did not think very much would change, no matter what I did. I felt pretty dead inside, and felt I must be a bad person to have the things happening to me no matter what I did. The first thing is, Mary Lou smiled at me like she really liked me. I was having a hard time trusting people, but I thought she was different. She said she was really glad I was there, and I was too.

I was having a hard time looking at people. I thought they could know what I was thinking. So I kept my head down. In the hospital when I did that, somebody was sure to tell me to look at them, or to look at the group. Mary Lou just told me she was proud of me for being there, when it was hard. She never asked me to look up, but would tell me she was glad I was fighting the fear and kept coming back. It made me think that I was doing something good, sitting in her group, instead of doing wrong.

I think that was what was the first thing that got into me. No matter what we told her, she would find the good in it. If worries would keep me up at night, she said she thought it showed commitment to come into the clinic anyway instead of using it as an excuse to stay in bed like I used to. She showed me that it was okay to have symptoms, and that I did not do anything to make them happen. She showed me that I was stronger than I thought, and that I could live with it, because it would never be as bad as it had been in the beginning. She told me one time that I thought I could not live with it, she said, “But you are doing it, Kurt. You are DOING it.” And I was. I still am. It might not go away, but it will not ruin my life. I am doing it.

to avoid reinforcing the delusion. Our attempts usually come across as a denial of the clients’ experience. This frustrates clients in their attempts to communicate. Being ignored, having others not listening when one tries to communicate about a problem, generates anger in almost anyone. The clients’ frustration at this denial of their experience frequently causes an upsurge in energy as they struggle to find someone to listen. These struggles can escalate into the violent behavior that is a major target behavior of treatment. Pat Deegan (1993), a person with a schizophrenic label writes, “Your anger is not a symptom of mental illness. Your angry indignation is a sane response to the situation you are facing.”

The most effective acute management technique for violence is to really listen to what the client is saying. Acknowledge the client’s anger. “You sound really angry.” Ask, “Who are you mad at?” Violent clients may calm when someone will listen.

Denying a person’s experience is not only frustrating, it is corrosive. It corrodes not only one’s sense of self esteem, but one’s sense of being as well. One homeless man with a mental illness in the psychiatric emergency department was astonished that the police could see him. “I am invisible. I pass hundreds of people on the streets, and no one can see me.”

Client groups are effective in learning long-term management of the frustration that can lead to violence. The nurse asks if anyone has ever said, “Nobody ever listens to me.” This usually gets an unanimous response.

“Well, you are right. Nobody has to listen to you, because lots of the stuff you talk about are kind of weird. If the only things you ever talk about sound nutty, staff think that they are right and avoid talking about the thing you are trying so hard to figure out. So, how do we get them to listen?

“There are two rules. First, do not talk crazy. That means, do not ask us to try to figure out who is plotting against you. We cannot know what you were going through, or why. The second thing is to talk about how you feel, not what you think is causing it. If you say that the FBI is following you around, someone is sure to tell you that it is not so. But, if you say that you have the feeling of being followed, no one can argue. Your feelings are real, and most people respect that.” At this point, it is helpful to clarify the difference between thinking and feelings.

Ambivalence

What if you believed that if you made the wrong decision, you could be locked up for the rest of your life? Would you be immobilized by ambivalence? There are 114 decisions required to get out the front door. Do you turn the alarm off before or after you get out of bed? Which side of the bed do you get up on? Acknowledge the tremendous effort that
has been required of the client to be up and dressed. Often, each of those decisions generates an intense fear. When a client is dressed and in group, each of those decisions has been made successfully. Remembering to praise the client for this effort may be the first positive reinforcement heard.

Auditory hallucinations

A client commented, “The voices are afraid of you. When I’m in your group, I don’t hear the voices.”

“The brain cannot hear two things at once. So when you are really listening in group, your brain cannot hear the voices. Just like when you are watching television and the telephone rings. You turn down the television or cover your ear, so you can listen to the voice on the phone. The normal brain cannot listen to two auditory messages at the same time. When you are bothered by the voices, talk to someone else.” People diagnosed with schizophrenia desperately want to be “normal,” so using examples of events that could happen to anyone, help fulfill this desire.

“Then I shouldn’t holler at them?”

“No, when you focus on the voices, they get worse.”

“Sometimes the voices say if I have something to drink, they’ll go away.”

“Hallucinations affect the auditory tract, not the motor tract. Have you ever refused to take medicine? If voices could make people do things, how could anybody refuse medications? There is a voice, telling you what to do, but you do not do it. Sometimes when you’re upset, what the voices say, seems like a good idea. But voices cannot make you do anything, unless you want to. How much of you have ever held your breath under water? Here is the most essential message from your brain telling you to take a breath, but you didn’t do it. If you can do that, you can do anything. You can just decide it is not a good idea.” Reframing voices to just one source of input that the client can to choose to follow or not, empowers the client.

Reframe symptom management to client’s personal goals

Often, nursing goals do not incorporate the client’s needs. One client personified the poster child of self-care deficit. He smelled so bad that when he would come into the room, people would get up and leave. Getting him to take a shower became a red alert priority with the nursing staff; but the more they tried, the more resistant the client became. When the client was asked what he would like to have when he left the hospital, he responded, “Friends. Nobody likes me. When I sit down next to someone, they move away.” This was a fellow who was threatening to take the staff on physically when he was approached about his poor grooming, and his “self-care deficit.” His grooming had been so bad for so long, he no longer was aware of his olfactory impact upon the people around him.

The response was, “I think people move away from you because you smell bad. You need to take a bath. Let’s try something. Go sit at the table with those two guys playing cards and see what happens.” A few minutes after the client sat at the table, the card players started to leave the room.

Given the lack of scientific information to explain auditory hallucinations, it might be logical to assume that some powerful entity like the CIA or an alien has targeted the client and is causing the torment.

“Just a minute. Why are you leaving?”

“That guy really stinks.”

“Did you tell him?”

“Well, no. Didn’t want to hurt the guy’s feelings.”

A few minutes of direct interaction, the man headed happily for the shower—not to improve his self-care deficit, which was the problem identified by the nurses, but to meet his need to have friends.
Medication compliance

Do we medicate to meet hospital or client goals? Hospital goals are to eliminate disruptive behavior, alleviate symptoms, and to have the client “get well and go home.”

Contrast what we say about medications to the clients’ experiences with medications. We tell them that the medication will improve their thought processes, but this is what one client said about her medications. “I hate them. They make my mouth dry, I am constipated and my thinking is fuzzy. I realize, ‘Oh my God, I have lost my edge.’ They make me feel stupid and I cannot feel stupid because they will get me!”

Discussing responses to medication, such as extrapyramidal symptoms as side effects, minimizes their very real impact. These are unwanted effects. When a client complains about a medication, show acceptance by saying, “Yeah, that is one of the bad things about that medication.” After a discussion of negative effects of antipsychotic medication, students invariably respond when asked if they would like to take those medications, “No, I like myself the way I am.” Clients often like many things about themselves that the medications take away. There has been a great reluctance to discuss the negative effects of psychotropic medications. The reasons are, “They are crazy” and “If we have to be honest, they will not take it.” Clients will never be compliant with medications without preparation for the negative effects.

Before antipsychotic medications, we could not even understand what the client was saying, now the clients complain about the medication. The medications are meeting some of the clients’ needs. When drugs are initiated, the nurse must help the client identify all of the problems that are currently being experienced. This provides a baseline to help the client identify the positive effects of the medications. When symptoms go away, the tendency is to forget about the real distress that occurred without the medication. “At the same time that you feel a little foggy, your fear level has gone down. Remember how jumpy and nervous you used to be? You are easier to talk to when you are calmer. It is easier to understand your speech.” Often, when a problem has resolved, we forget to comment on the improvement. That leaves the client focused on the negative effects, without any perceived improvement.

Do not raise unrealistic expectations about medications. Clients need to have us admit out loud that we cannot fix everything with medications. Telling the client that antipsychotic medications turn down the volume on the voices is more realistic than saying that the medication will “help them,” or that it is for their own good. Admit, “We are not very good at getting chemicals into the synapses just right.”

Clients must learn to understand what the drugs do well and what they do poorly. Symptoms of schizophrenia come and go (remissions and exacerbations). These changes in symptoms are not necessarily related to the medication, yet the first response to an escalation of symptoms is an investigation of medication compliance that implies blame. One client accepted the blame for not taking her medications, when she was, in fact, compliant. Other clients will experience an exacerbation of symptoms, decide that their medications are not helping, then stop taking them. Frequently, because the client is not clear on the reasons for medication, only the negative effects are experienced. Naturally, the client then stops taking them, “because they just make me feel bad.”

You must target the symptoms that concern the clients. Help the client reframe medication use in terms of personal goals. When one fellow was told

have schizophrenia.” Her face cleared as relief replaced hostility. “That's what's causing all that stuff. Thank God! I thought I was losing my mind!”
that medication would help his thinking, his response was, “There is nothing wrong with my thinking. I just do not like the way people look at me.”

The response was, “That feeling will be reduced. In fact, the medication will tone down everything; even how alert you feel. But it will not be obvious from the outside. It will not make you so stupid that other people will notice.” This client’s goal was to be able to live in the park without being picked up by the police all the time. When he could see how his Prolixin would help him meet this goal, he has continued to be compliant with medications and has regular attendance at outpatient medication clinics over a period of several years.

Positive reframing allows the client to choose the frame of reference that gives the most power and the least guilt in relation to schizophrenia. Townes et al. (1985) has identified five distinct profiles of competencies and deficits in clients diagnosed with schizophrenia. Areas of further study could include determining which behavior patterns respond best to reframing and the most effective ways to teach reframing techniques to the client diagnosed with schizophrenia.

References


