

From the October, 1999 issue of Anchor Point

Towards a Sane View of Insanity: NLP and the Treatment of Schizophrenia

by Dr. Richard Bolstad and Margot Hamblett

This article explores the use of NLP based techniques in the treatment of people diagnosed as suffering from Schizophrenia. “Schizophrenia” is without a doubt a poorly defined nominalisation. The fact that we are writing this article in no way suggests that we believe that such a thing as Schizophrenia exists; only that if it did exist, it could be changed. The fact that we wrote that last sentence in no way suggests that we suffer from the disorder we are discussing, only that if we did, we’d have a different way of thinking about it. Confused? Read on.

In 1973 psychologist D.L. Rosenhan published a study in which his psychology students went to prestigious Psychiatric hospitals in their community and claimed to have one symptom out of the ordinary (e.g., hearing a voice in their head). They were all admitted, and most were diagnosed schizophrenic, although in every way apart from their one symptom they behaved normally. After one week, they reported the symptom gone and asked to be discharged. Their experiment was over. Unfortunately, the hospitals would not release them, until finally Rosenhan rang up and explained the situation. Rosenhan then told the hospitals there were others who had not been named, who were in the experiment. Within a few days the hospitals found and released other patients whom they now realised were sane, although in fact there were no more psychology students (Rosenhan, 1973). These other patients, apparently as sane as Rosenhan's students, would otherwise have remained under treatment, diagnosed as having lifelong “incurable”

[SUBSCRIBE](#)

[Archives
& Articles](#)

[Articles -
Español](#)



illnesses. There may or may not be a real thing called schizophrenia. But at the very least, all that glitters is not gold.

The West's Most Expensive “Disease”

Schizophrenia is the most frequently discussed of the psychoses (disorders where the person is assessed by psychiatrists as out of touch with reality). Many psychiatrists consider that there may in fact be a number of different and overlapping syndromes which are being described under the one label of “schizophrenia” (Perris, 1989, p. 4). Perhaps one of the clearest areas of agreement, though, is that schizophrenia is a separate disorder entirely from split or multiple personality, with which it has previously been confused in the public mind. Schizophrenia is perhaps best described as a disorder of thought and perception. The DSM-IV(tm) (American Psychiatric Association, 1994) lists its symptoms as delusions, hallucinations, disorganised speech, disorganised behaviour or immobility, and loss of emotion or will. To be diagnosed, two of these symptoms need to be present in such a way as to damage achievement in social, career or self care areas, over at least six months duration. This requirement has been included partially as a result of concern over studies such as Rosenhan’s (above).

The cost of current schizophrenia treatments is enormous. In the United States 0.5% of the gross national product goes into the treatment of schizophrenia (World Health Organisation, 1996, p. 3). In Canada (and probably elsewhere in the west) 8% of all hospital beds are taken up by people with this diagnosis, using up more hospital beds than any other single disorder (Long, 1997). 6.2% of prisoners in US jails have been diagnosed schizophrenic, and an estimated one in three homeless persons suffer from the condition (Kopelowicz and Liberman, 1998, p. 192). Schizophrenia is not often enjoyable. Depression and self medication with drugs or alcohol are common amongst those diagnosed, and are associated with poorer chances of improvement. 25% of schizophrenics attempt suicide, and



10% succeed (Kopelowicz and Liberman, 1998, p. 192).

What Gets Someone Diagnosed Schizophrenic

Cognitive research shows that in persons diagnosed schizophrenic, there are major problems with cognitive strategies (Perris, 1989, p. 22-23).



1) Living In Castles In The Air: Schizophrenia is associated with difficulty “chunking down” in NLP terms (Perris, 1989, p. 43, pp. 148-151, p. 157 and Arieti, 1948). The person with this problem is not identifying the distinctions between situations fully. Rather than chunk down to the sensory specific details of a problem event, they talk vaguely or metaphorically. One client, discussing this very problem with the authors, said “Some days it hurts when I walk on the earth. I need to keep up in the air.” This is a good example of metaphorical communication. I might say that same sentence metaphorically, but this young man experienced it as a sensory fact. He was unable to explain what days, specifically, or how specifically it hurt, but he believed it to be true in the same way that one might say “Some days my legs are a little stiff in the morning, and I need to stretch them out and exercise.” He believed that at times he physically floated in the air because the ground was too painful. In NLP terms, this man was unfamiliar with metamodelling his experience. Having a conversation with someone diagnosed schizophrenic can be like immersing oneself in a festival of Milton model patterns: mind reads, layered presuppositions, lost performatives, deletions, nominalisations etc. We have often had the experience where one sentence said by a client takes 15 minutes to carefully unpack before we can actually move on usefully. One person, for example, came up to Richard at the start of a training day and said “Thank you so much for what you did last night. It was beautiful.” Richard had not had any contact with her the previous evening. Another time, a client told us “I know what you are doing here. I know you’ve called down Pavlov's dogs.” In Ericksonian terms, the person diagnosed schizophrenic is experiencing a profound trance state (Donan, 1985, pp. 27-28). It’s a standard joke in

Psychiatry that neurotics build castles in the air, whereas psychotics actually live in them (and Psychiatrists collect the rent!).

2) Not Thinking About Thinking: The person diagnosed schizophrenic is often also unable to adequately classify situations from a metaposition (for example to distinguish a real memory from a hallucinated one, or an internal thought from an external voice). Many cognitive psychologists consider this the core of the disorder (see Jacobs, 1980). Much of such metacommenting on experience in “non-psychotic” persons is done using the auditory digital sense. This sense is the one most commonly experienced as “out of control” by the person diagnosed schizophrenic. Contrary to popular belief, the most common form of hallucination in schizophrenia is auditory, and “uncontrollable” internal thoughts are also a frequent complaint of persons diagnosed schizophrenic. In NLP terms, the person diagnosed schizophrenic does not have adequate submodality distinctions between real and unreal, self and other, etc. In a sense, the schizophrenic person is well dissociated from their internal experience (so that their own thoughts may not feel like “theirs”). But this dissociation is not a metaposition. To use L. Michael Hall's terminology (Hall, 1997), we might say that Schizophrenia is a disorder resulting from the failure to develop adequate meta-states. In our discussing this article with Michael, he pointed out that this view of Schizophrenia has references back to the Bicameral theory of Julian Jaynes (1976). Jaynes proposed that until quite recently in human history, most people experienced much of their auditory digital self talk as coming from real, externally existing voices (e.g. the voices of the “gods”) and acted accordingly. He proposed that these external voices might be generated in the non-dominant hemisphere (though we now know that the person experiencing auditory hallucination has the “normal” speech areas of the brain active). For our discussion, the important claim Jaynes made was that during most of human history, “hallucinated” voices were not metacommented on by the hearer, but were accepted as the result of separately existing minds. This capacity is often rediscovered by the person

diagnosed schizophrenic, says Ryan DeMares (1998) who describes his own experiences with auditory hallucination using Jaynes' model.

3) Missing Social Subtleties: Interpersonally, the person diagnosed schizophrenic behaves much like you would if you were unexpectedly placed in a totally foreign culture. Their attempts to communicate subtly mismatch the cultural norms. Often they mistakenly assume that others share their own unique sensory experiences, values, beliefs, and metaprograms. They may use "socially unexpected" gestures, body postures, proximity, facial expressions, voice tonality and phrasings, without apparently noticing that these meta-communications appear or sound odd to others. Such mismatching is so profoundly culturally determined that we as authors doubt the ability of a person from one culture to diagnose schizophrenia accurately in a person from another culture. People who move from one culture to another are in fact far more likely to be diagnosed schizophrenic (Pomare and de Boer, 1988, p. 120). On the other hand, many people working with schizophrenia note that their own way of diagnosing the condition is not primarily by the classical symptoms but by the very strange feeling that they get when they are with the person diagnosed this way. This feeling is described as a "lack of affective resonance" (Perris, 1989, p. 5), and equates, in our experience, with the person diagnosed schizophrenic having great difficulty using socially normal rapport skills. Often, this difficulty emerges quite early in life, and some cognitive psychologists consider its effects on the parent-child relationship to be central in the development of schizophrenia (Perris, 1989, pp. 33-34). It leaves the person especially vulnerable to confusion in any situation that involves meta-communication. An example is the "double bind" identified by Gregory Bateson (Perris, 1989, pp. 51-54), where a person might for example say to the client "Come and give me a hug." while grimacing at the client with anxiety. Research has since shown that most families generate double binds; but the person diagnosed schizophrenic cannot process the two communications from a metaposition.

4) Other Symptoms: In persons diagnosed schizophrenic, there is also often a reduced attention span, reduced memory, impaired goal achievement skill, flattened emotional response, and reduced ability to learn from verbal sources (while visual and kinesthetic skills seem relatively good). This cluster of disabling symptoms could be considered the result of the primary difficulty metacommenting and metamodelling. Schizophrenia often is first diagnosed when the person has an “acute” or “florid” state where delusions, confused activity, and hallucinations are marked. This acute state often occurs in response to some social stress (such as starting a new job), and more fully approximates common expectations of “insanity.” A prolonged cognitive confusion and social “ineptness” is the more fundamental pattern out of which this florid state emerges. Medication often reduces the florid state without affecting the core problems at all.

Causes?

Schizophrenia Societies, often set up as support groups for families of Schizophrenics, are not always a reliable source of information about Schizophrenia. In their drive to remove blame from families, they have frequently publicised erroneous and reductionist claims about the biological origins of the disorder. For example, most say that Schizophrenia is a disorder seen in the same prevalence throughout the world. World Health Organisation statistics show that Schizophrenia does not occur equally around the world. When diagnosed with the same careful standards, its prevalence ranges from one in a thousand in many non-western countries to one in a hundred in the west. Many non-industrialised societies have no incidence whatsoever (Kleinman, 1991).

Within western society, it is dramatically more prevalent in cities. A recent Danish study followed up 1,750,000 people born to Danish women between 1935 and 1978 (Mortensen et alia, 1999). In this group there were 2669 cases of diagnosed schizophrenia. The “population attributable risk”

was 5.5% for a family history of schizophrenia, and 34.6% for having an urban place of birth. That is, living in the city has over six times more effect on the development of the disorder than genetics and family upbringing combined! Even season of birth was twice as significant as family and genetic factors (the highest risk births are in late winter: February–March). The social and physical environment in which a person is raised is extremely significant in the development of the problem. It now seems clear that some kind of vulnerability from family/genetic and perinatal (around birth) factors leads to schizophrenia in the presence of social stresses which occur far more in some cultures than others.

Recovery rates from schizophrenia also vary depending on where people live. World Health Organisation studies show that in Nigeria, 58% of diagnosed schizophrenics fully recover within two years, and in India 50% recover within two years. In Denmark, only 8% recover within two years, despite having vastly more drug treatment. (Jablensky et alia, 1992). Nonetheless, if we follow up even western people with “well diagnosed and severe forms of schizophrenia” we find that within 20-30 years a full 50% will be functioning normally (Kopelowicz and Liberman, 1998, p. 191). Schizophrenia is certainly not usually a lifelong disorder. Most people with schizophrenia will recover fully. Western levels of drug treatment do not enhance their recovery (and may inhibit it). Family and social support, as well as simplicity of life style, are clearly associated with more successful outcomes. With support, a calm life style, and helpful feedback, the person diagnosed schizophrenic will learn new skills which fully resolve their “problem.”

There are differences in the child development of people who will later be diagnosed schizophrenic (Jones et alia, 1994). The British national child development study followed up almost all children born in Britain in one week in March 1959. From these, 17,000 individuals diagnosed schizophrenic have now been identified, and their childhood results studied. At age 7, these children had unusual

difficulties pronouncing words and reading. At 11, they had less hemispheric dominance than the rest of the population (they could just as easily tick squares with their left as with their right hand). This suggests that something unusual is happening in the “schizophrenic” brain long before it is identified as unusual, impairing the auditory digital sense in particular. New brain scan studies are beginning to shed further light on the differences. When a person diagnosed schizophrenic is having an auditory hallucination, the area of their brain called Broca’s area is active (as shown on PET scan; Barnaby, 1995). This is true also for a “normal” person as they talk to themselves. But interestingly, if the “normal” person imagines an “alien” voice talking to them, a region of the temporal lobe is activated to monitor and distinguish between internal–external speech. This area is not activated by the brain of the person experiencing an auditory hallucination. Note that none of this tells us “how” these problems emerge. We know that they emerge more in the city than in the countryside, more in Europe than in Africa.

People also have different opinions about the precipitating factors that lead to the acute symptoms of schizophrenia. Those diagnosed schizophrenic tend to describe their primary concerns as involving identity and fundamental beliefs about life; issues which may well be raised more intensely in industrialised city environments. Psychiatrist Peter Breggin says “so called schizophrenics, especially during their initial crisis, almost always are preoccupied with the meaning of life, God, love, and their own personal identity, often with cataclysmic implications about the end of the world or the disintegration of their own personalities.” He says that their metaphorical communication and behaviour “can be understood as conflicts or confusion about... identities, values and aspirations rather than as biological aberrations.” In a sense, the issues which the person is struggling with are meta–commenting issues.

Medication, Anyone?

Since 1954 a large number of medications have been used to treat the symptoms of schizophrenia. In general, American

studies show that, given a placebo, about 20% of people diagnosed schizophrenic will have their perceptual symptoms such as hallucinations disappear (Sheitman et alia, 1998, p. 168). Treatment with “antipsychotic” drugs pushes this percentage up to around 60%, but does not generally affect the other symptoms of thought disorder and lack of interest in life. Furthermore, it is important to understand that the extra 40% who benefit in this way from the drugs have only been given temporary relief. If they stop taking the drugs, their symptoms are likely to return. For this reason, we wish to emphasise that those on antipsychotic medication should not come off that medication without medical supervision. On the other hand, several studies show that those treated with placebo show greater clinical improvement and less overall functional disturbance than those treated with antipsychotic drugs (Breggin, 1992, pp. 77-83). In one study re-admission rates for those given placebo were 8%, compared to readmission rates of 47% for those given the actual medication.

The other concern with drug treatment is that typical antipsychotic drugs are associated with long term with brain damage. The 1986 Manual of Clinical Psychopharmacology says that the brain damage of tardive dyskinesia occurs in 50-60% of chronic users of these drugs. The June 1990 Clinical Psychiatry news updates this, saying that exposure for 15 years or more leads to “almost certain” tardive dyskinesia. (Breggin, 1992, p. 95). This causes the odd rocking motions, tremors, bizarre postures and twisting tongue movements we often imagine as features of long term psychiatric clients. It’s the clinical end result of interfering with the flow of dopamine and other neurochemicals between the lower brain and the frontal lobes of the brain—a process which could be termed chemical lobotomy.

Long-term stays in the hospital environment are also clearly unhelpful in the treatment of schizophrenia. When someone is admitted for acute schizophrenia, assigning them to an 11 day hospital treatment with follow-up leaves them with better results than a 60 day hospital treatment with the same

follow-up. Social functioning even two years later is better for those who return to normal support networks in the community (Kopelowicz and Liberman, 1998, p. 202). Traditional psychodynamically oriented therapy (exploring the “causes” of the person’s problems and their unconscious “dynamics”) has also been shown to have little or even adverse effects on the course of schizophrenia, although occasional, rare cases of sudden success do occur, with any treatment tried, perhaps because they would have occurred anyway (Kopelowicz and Liberman, 1998, p. 202 and Perris, 1989, pp. 64-69).

Modelling Sanity in Insane Places

Surely, you might be thinking, someone will have studied how the vast majority of people diagnosed schizophrenic are recovering! Surely, someone will be organising rural retreats with a promise of 50% recovery in two years! Not quite. However, there is increasing evidence that approaches based on cognitive and social education are successful in increasing the percentage of complete “cure.”

So what has been shown to work? Studies beginning in the 1960’s show that behaviour therapy (giving rewards for “appropriate behaviour”) produces change in the in-patient situation but the gains prove very difficult to transfer to community life where the rewards are no longer controlled (Kopelowicz and Liberman, 1998, p. 197). Training in Community Living programs (where training in life skills and direct assistance is given to people living in the community) have resulted in increased social functioning and less readmission. Training in social skills combined with family assistance often reduces readmission to zero (Kopelowicz and Liberman, 1998, pp. 200-203). Training in the cognitive functions which are damaged in schizophrenia (attention span, verbal learning, memory, etc.) and training in identification of perceptual distortions (such as hallucinations) has been successful, but there is as yet little evidence that it affects social interaction and other outcomes. Shifting to teaching new skills by using the (unimpaired) visual and kinesthetic senses has also been

tried with some success (Kopelowicz and Liberman, 1998, pp. 198-199, 205).

Traditionally, therapists have avoided the use of hypnosis with persons diagnosed psychotic, on the grounds that it may increase their dependency and confusion. As with depression, psychosis need not be considered a contraindication for hypnosis; rather it is an indication to use hypnosis educationally, to build inner resources, and to pace and lead the person carefully to reality based experiences. Joan Murray–Jobsis (previously publishing under the name Joan Scagnelli–Jobsis; see Scagnelli–Jobsis, 1982) has reviewed the literature on the use of hypnosis with psychosis, and proposed a (non–Ericksonian) model of assisting the person to learn new ways of responding to life. She notes that while some studies find that persons diagnosed psychotic do not respond to hypnosis, others find that they respond normally, and still others find that they respond with a wider than normal variation. Ericksonian therapists have pointed out that this is because the person diagnosed psychotic is already in a deep trance state (Dolan, 1985, p. 128).

In the history of Ericksonian and Neuro Linguistic psychotherapy, there have been a range of interventions used with people diagnosed schizophrenic. The anecdotal and research evidence from these suggests several useful strategies to assist the person in creating the type of successful change that naturally occurs in over 50% of “schizophrenics” world–wide.

Rapport: The Medium Is The Message

From the core issues identified earlier, our goals with the person diagnosed schizophrenic will tend to include helping them 1) chunk down, 2) make metadistinctions about their thinking (to “reality check,” as it’s called in Psychiatry),

and 3) learn rapport skills. Unfortunately, when we meet these people, their goals will often be chunked up, unrealistic, and totally out of rapport with everyone around

them. Yet if we respond to these chunked up, confused and mismatched goals by imposing our “vision” of sanity, we respond insanely (in an unrealistic and mismatched way) to the people who need sanity most. A therapist is unlikely to “win an argument” with a schizophrenic client about what is real. While you may choose to make it clear that you do not yourself perceive and believe what the client perceives and believes, it remains important to respect their “map of the world.” The most successful initial move must convey powerfully your intention to get rapport with the client.

Many of the accounts of successful therapy with persons diagnosed schizophrenic begin with dramatic rapport building. Dr. Karl Whitaker gives an interesting example of such an approach: “For instance, in one first interview with a family with a schizophrenic girl, I turned to the girl after I’d been talking fairly emptily with the parents and asked, ‘What are you here for?’ She said, ‘Contact is good for colds.’ I said, ‘How long have your parents been cold?’ and she said, ‘Twenty years.’ We went on talking schizophrenese like this without any hesitation.” (Haley and Hoffman, 1967, p. 272).

Yvonne Dolan identifies a similar pattern in the work of Milton Erickson (Dolan, 1985, pp. 58-61). One case involved a man who had only spoken six sensible words in the five years he was in hospital. Otherwise he spoke in “word salad”—a long jumble of sounds, words and syllables in no apparent order. Psychiatrists, nurses, and others made numerous unsuccessful attempts to talk to him, or even find out his full name (his six words included “My name is George”). To begin, Erickson had his secretary record, in shorthand, a sample of the man’s “speech.” Erickson then studied this sample until he could improvise a word salad similar in form. Now he was ready. He sat down next to George and introduced himself. George spat out an angry stream of word salad. Erickson replied with an equally long stream of the same type of noise. George appeared puzzled and added more word salad, and Erickson responded in kind.

A few days later Erickson returned and again George spoke in word salad, this time for four hours. Erickson, aware that George was watching a clock on the wall facing them, replied in kind for another four hours, missing his lunch. George listened carefully, and they then traded another two hours. The next day George gave only two sentences of word salad. After Erickson returned his own two sentences, George did an extraordinary thing. In plain English, he said “Talk sense Doctor!”

“Certainly, I'll be glad to. What is your last name?” Erickson asked.

“O'Donavan, and it's about time somebody who knows how to talk asked. Over five years in this lousy joint...” and he lapsed back into word salad. But this was the breakthrough. A few months later, George O'Donavan left the hospital and found himself a job. Erickson followed his progress for some years and he was not readmitted.

Erickson's Pace and Lead To Sanity

Jeffrey Zeig identifies a sequencing in Milton Erickson's work (Erickson, M.H. and Zeig, J. “Symptom Prescription for Expanding the Psychotic's World View” pp. 335-337 in Rossi 1980) Erickson explains: “No two people necessarily have the same ideas, but all people will defend their ideas whether they are psychotically based or culturally based, or nationally based or personally based: When you understand how man really defends his intellectual ideas and how emotional he gets about it, you should realize that the first thing in psychotherapy is not to try to compel him to change his ideation; rather, you go along with it and change it in a gradual fashion and create situations wherein he himself willingly changes his thinking. I think my first real experiment in psychotherapy occurred in 1930. A patient in Worcester State Hospital, in Massachusetts, demanded he be locked in his room, and he spent his time anxiously and fearfully winding string around the bars of the window of the room. He knew his enemies were going to come in and kill him, and the window was the only opening. The thick

iron bars seemed to him to be too weak, so he reinforced them with string.”

“I went into the room and helped him reinforce the iron bars with string. In doing so, I discovered that there were cracks in the floor and suggested that those cracks ought to be stuffed with newspaper so that there was no possibility (of his enemies getting him), and then I discovered cracks around the door that should be stuffed with newspaper, and gradually I got him to realize that the room was only one of a number of rooms on the ward, and to accept the attendants as a part of his defense against his enemies; and then the hospital itself as a part of his defense against his enemies; and then the Board of Mental Health of Massachusetts as part, and then the police system—the governor. And then I spread it to adjoining states and finally I made the United States a part of his defense system; this enabled him to dispense with the locked door because he had so many other lines of defense. I didn’t try to correct his psychotic idea that his enemies would kill him. I merely pointed out that he had an endless number of defenders. The result was: the patient was able to accept ground privileges and wander around the grounds safely. He ceased his frantic endeavors. He worked in the hospital shops and was much less of a problem.”

The same pattern is clear in the work of Dr. Patch Adams (Adams, 1998) as seen in the film “Patch Adams” starring Robin Williams. Himself a client in a Psychiatric hospital, Adams helps his roommate Rudy to deal with his terror of hostile chipmunks (which no-one else can see, but which prevent Rudy getting to the toilet or leaving his room). After acknowledging that he himself cannot see the chipmunks, Adams achieves success by joining Rudy in an imaginary shoot-out with them.

Zeig cautions “If such an initial intervention were made in a sarcastic manner, or from a frame of reference of trying to trick the patient out of his symptom, the positive outcome would be limited. An attitude of empathy and respect on the part of the therapist is crucial to ensure successful change.” (in Rossi, 1980, p. 336). He explains, “This pattern can be

divided into three major elements, which occur in the following sequence: (1) meeting the patient where the patient is; (2) establishing small modifications that are consistent with, and follow from, the patient's behavior and understandings; and (3) eliciting behaviors and understandings from the patient in a manner that allows the patient to initiate change.”

What If You're Not Erickson?

Erickson and Adams were both willing to go to considerable lengths to pace the metaphorical world of their clients. The same basic principle can still be applied where ethical or personality restraints inhibit you from talking word salad or shooting chipmunks with your client.

Steve Lankton gives a great example in his work with a client named Greg (Lankton and Lankton, 1986, pp. 128-135). Greg believed that the doctors at his hospital were killing people for experimentation purposes. He had never dated (he had decided that he wouldn't date until he had a Master's degree), and he couldn't read or write. But that isn't why he came to see Steve Lankton. He came because he wanted to be an ambassador. Lankton took on this goal. In twice weekly, three hour trance sessions, he had Greg practice reading and writing. One of the first things he had Greg do outside the therapy sessions was to go to a restaurant and order two desserts. After this he was to write a report on the two desserts. After all, one of the things an ambassador has to do is take out other diplomats and be able to tastefully recommend a dessert. In this way, Lankton had followed Erickson's model of (1) meeting the patient where the patient is; (2) establishing small modifications that are consistent with, and follow from, the patient's behaviour and understandings; and (3) eliciting new behaviours and understandings. At the time Lankton was writing this, Greg had a Master's degree in Administration and Policy, and an MBA.

Another example of entering the client's model of the world with respect is given by Richard Bandler in his work with

Andy (videotapes of his three sessions with Andy have been published by NLP Comprehensive). Bandler recounts the story thus (Bandler, 1993, pp. 107-108): “One schizophrenic I worked with hallucinated people coming out of the television set and following him around. Think about that. When I heard this, I said, ‘Wow! That’s great!’ He looked at me and said, ‘What do you mean it’s great?’ I said, ‘Well, what do you watch?’ He said, ‘Little House on the Prairie.’ On that show there’s a snippy little bitch named Mary. She kept coming out of the screen and following this guy around going, ‘Aarrhh, aarrhh, aarrhh’ just like she does on the program. She would bitch and moan until he would freak out and start screaming. Of course he was a paranoid schizophrenic!... I said to him, ‘This is a multi-million-dollar disorder!’ The guy looked at me and said, ‘What are you talking about?’ I said, ‘Does the term “Playboy Channel” mean anything to you?’ ... I said, ‘Think about it. We could run courses and train travelling salesmen in this. They could be monogamous and have the best time they ever had. This is a multi-million-dollar disorder that would give people the ability to never be lonely again.’ I told him, ‘I want to know how to do this.’ And this guy, who had spent five years trying to get rid of a problem, began by saying, ‘Well, maybe I’ll tell you and maybe I won’t.’ Now that shows a changed attitude.”

Notice that in this case, Bandler does not claim that the people from the television are “real”—merely that seeing them could be useful. In NLP terms, he offers a reframe. In the same way, Yvonne Dolan describes reframing episodes of catatonic immobility as a great way for a client to give himself some space. This results in the client almost immediately reducing his catatonic sessions from 4-5 hours down to 15 minutes at a time, and then even discovering that he could talk while still “giving himself some space” (Dolan, 1985, pp. 90-106).

This pacing and reframing of the “problem” can be done very lightly. When a therapist demonstrates that they can understand the inner world of the client, they do not have to talk as if they are stepping on eggshells. Carlo Perris

encourages therapists who are challenging schizophrenic cognition to lighten up. If the client claims their disorder is “always there” for example, he asks “Do you mean you are crazy even when asleep?” When a client says during a phone call that she had previously believed that she was telepathic, but is now over the delusion, Perris says “Then you could have saved the cost of the telephone call and got in touch with me telepathically.” While arguing with the person’s “delusions” is clearly counterproductive, aligning with the person to consider the delusions light-heartedly can be very effective. It communicates that the therapist is willing to “act normally” around the client. (Perris, 1989, p. 141, 138)

Building Rapport With Metaphorical Communication

As mentioned earlier, schizophrenic communication itself can be thought of as metaphorical. Yvonne Dolan discusses the therapeutic use of metaphor with psychotic clients (1985, pp. 128-140). Her goals include relaxing the person, providing a context to intersperse positive suggestions, and allowing the client to respond to suggestions at their own pace. She emphasises two practical points about telling metaphors to persons diagnosed schizophrenic. The first is that being relaxed and confident yourself is a crucial starting place. The ability of psychotic clients to “pick up” anxiety or incongruity in therapists and others (their sensory acuity) is well known. The second point is that the topic of a metaphor told to a schizophrenic client is most usefully an actual life event, rather than a “fairy tale” or fantastical/theoretical story.

Dolan gives an example of her work with a client named Nathan, whose first psychotic episode had happened when he was 17 years old. Nathan hallucinated an experience where he received a message saying “Your future is your past.” He believed that this showed that he was going backwards in life, and became extremely anxious and obsessed about this. Dolan told him a story about another therapist, Kate, who had lived out in the country when she was 17. At this time, her parents went away for the weekend, leaving her with instructions not to use the family

car to go to a party. Kate and her friends eventually found a way to get to the party without it registering on the car's odometer. They drove carefully backwards on the quiet country roads. Dolan emphasised "You know country roads, so you know that you can carefully and very comfortably go pretty far backwards while going in the actual direction in which you really want and need to go forward." (Dolan, 1985, p. 136). Immediately after being told this story, Nathan got his first good night's sleep since his hallucinated experience. His obsession stopped from that point.

The basic principle of therapy with clients diagnosed schizophrenic is the same as with all clients: to pace and lead. So far, we have considered four main ways of doing this:

- 1) Accept the client's metaphorical communication, and enter into it with them; e.g., Erickson's use of word salad with George, and Whitaker's comment about how long the girl's parents have been cold.
- 2) Assist the client in reaching their goals (however "delusional" they may seem) in such a way as to offer a subtle shift in focus to more useful skills, e.g. Adams joining the struggle with the chipmunks, Erickson helping the man to reinforce his windows with string, and Lankton getting Greg to write a report on the two desserts.
- 3) Accept the strategies with which the client is generating "schizophrenic symptoms" and reframe them as useful skills; e.g., Bandler's offer to market Andy's hallucination skill, and Dolan's advise to the catatonic man to give himself some space.
- 4) Use real-life stories as metaphorical communication; e.g., Dolan's story of going backwards into the future.

In the second part of this article we will discuss the use of an educational model to create change once rapport is established with these clients.

REFERENCES:

Adams, P. *Gesundheit!*, Healing Arts Press, Rochester, Vermont, 1998

Arieti, S. "Special logic of schizophrenic and other types of autistic thought" in *Psychiatry*, 11, pp. 325-338, 1948

Bandler, R. *Videotaped Client Sessions #2 and #4: Paranoid Schizophrenia*, NLP Comprehensive, Boulder, Colorado, 1988

Bandler, R. *Time For A Change*, Meta, Cupertino, California, 1993

Barnaby, W. "Saner Views of Schizophrenia," Briefing, The Royal Society, London, 1995

Breggin, P. *Toxic Psychiatry*, Fontana, London, 1992

DeMares, R. "Interspecies Communication" at <http://www.dolphininstitute.org>, Dolphin Institute, 1998

Dolan, Y. M. *A Path With A Heart*, Brunner/Mazel, New York, 1985

Haley, J. and Hoffman, L. *Techniques of Family Therapy*, Basic Books, New York, 1967

Hall, L.M. *NLP: Going Meta -Advanced Modelling Using Meta-levels*, ET Publications, Grand Junction, Colorado, 1997

Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J.E., Day, R., and Bertelsen, A., "Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organisation ten country study." In *Psychological Medicine*, Supplement 20, p 1-97, 1992

Jacobs, L. "A cognitive approach to persistent delusions" in *American Journal of Psychotherapy*, 34, p 556-563, 1980

Jaynes, J. *The Origin of Consciousness in the Breakdown of the Bicameral Mind*. Houghton Mifflin Company, Boston, 1976.

Jones, P. B., Rodgers, B., Murray, T. M. and Marmot, M.

“Child developmental risk factors for adult schizophrenia in the British 1946 birth cohort” in *Lancet*, 344, p 1398-1402, 1994

Kleinman, A. “The Psychiatry of Culture and the Culture of Psychiatry” in *The Harvard Mental Health Letter*, President and Fellows of Harvard College, July 1991

Kopelowicz, A. and Liberman, R. P. “Psychosocial Treatments for Schizophrenia,” pp. 190-211 in Nathan, P. E. and Gorman, J. M. *A Guide to Treatments That Work*, Oxford University Press, New York, 1998

Lankton, S. R. and Lankton, C. H. *Enchantment and Intervention in Family Therapy*, Brunner/Mazel, New York, 1986

Long, W. L. “Schizophrenia: Youth’s Greatest Disabler” in *Internet Mental Health*, British Columbia Schizophrenia Society, www.mentalhealth.com, 1997

Mortensen, P. B., Pedersen, C. B., Westergaard, T., Wohlfahrt, J., Ewald, H., Mors, O., Andersen, P. K., and Melbye, M. “Effects of Family History and Place and Season of Birth on the Risk of Schizophrenia” in *The New England Journal of Medicine*, February 25, Vol. 340, No. 8, 1999

Perris, C. *Cognitive Therapy With Schizophrenic Patients*, Cassell, London, 1989

Pomare, E. W. and de Boer, G. M. *Hauora: Maori Standards of Health*, New Zealand Department of Health and Medical Research Council, Wellington, 1988

Rhue, J. W. *Handbook of Clinical Hypnosis*
Rosenhan, D. L. “On Being Sane In Insane Places” in *Science*, January 19, 1973, p 250-278

Rossi, E. L. ed. *The Collected Papers of Milton H. Erickson on Hypnosis: Volume IV, Innovative Hypnotherapy*, Irvington, New York, 1980

Scagnelli-Jobsis, J. “Hypnosis with psychotic patients: A

review of the literature and presentation of a theoretical framework” in American Journal of Clinical Hypnosis, 25, p 33-45, 1982

Sheitman, B.B., Kinon, B.J., Ridgway, B.A. and Lieberman, J. A. “Pharmacological Treatments of Schizophrenia.” pp. 167-189 in Nathan, P.E. and Gorman, J.M. A Guide to Treatments That Work, Oxford University Press, New York, 1998

World Health Organisation, “Mental Health” WHO Fact Sheet N130, Geneva, August 1996

© Dr. Richard Bolstad and
Margot Hamblett

***Dr Richard Bolstad and Margot Hamblett are NLP Trainers and the developers of the Transforming Communication seminar. They can be reached at: 26 Southampton Street, Christchurch 8002, New Zealand, Phone/Fax +64-3-337-1852
E-mail nlp@chch.planet.org.nz Home Page
<http://www.transformations.net.nz/>***