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Michelle Hart Marlowe
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Recovery-Oriented
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ABSTRACT

This theoretical study examines narrative approaches in recovery-oriented psychotherapy with individuals with schizophrenia. This study was undertaken in an effort to address a gap in the literature regarding theoretical frameworks to guide psychotherapists in providing services that facilitate the recovery process for individuals with schizophrenia.

Psychotherapy has had an evolving and often contentious role in the treatment of schizophrenia. Psychotherapy was once a standard form of treatment for schizophrenia, but currently psychopharmacology is the dominate treatment method. Interest in psychotherapy in treatment for schizophrenia is once again increasing, however. Influenced by the mental health recovery movement, the mental health system has begun explore ways that treatment can promote recovery by addressing the social and emotional difficulties that individuals with schizophrenia struggle with after the onset of their illness.

To address the lack of theoretical frameworks guiding recovery-oriented psychotherapy, this study examines three emerging narrative therapy approaches with individuals with schizophrenia: Michael White's narrative therapy, personal narrative construction, and open dialogue. These narrative approaches, while requiring further

research to understand their effectiveness, show promise as potential frameworks for recovery-oriented services.

NARRATIVE APPROACHES TO RECOVERY-ORIENTED PSYCHOTHERAPY
WITH INDIVIDUALS WITH SCHIZOPHRENIA

A project based upon independent investigation
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

ACKNOWLEDGEMENTS

I would like to thank my research advisor, Yoosun Park, for her consistent guidance throughout the writing process.

I would also like to thank family and friends, both near and far, who offered support and encouragement.

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CHAPTER I

INTRODUCTION

Up to 51 million people worldwide are thought to be diagnosed with schizophrenia (Torrey, 2001). In the United States alone, an estimated 2.2 million people, or eight people out of every 1000, suffer from schizophrenia (Torrey, 2001). Schizophrenia is usually diagnosed during late adolescence or early adulthood, with symptoms including a change and disturbance in behavior and affect, presence of delusions or hallucinations, and the lack of “capacity to sustain coherent, reality-based thoughts” (Berzoff, Flanagan, & Hertz, 2002, p. 270). Individuals with schizophrenia also struggle with a lack of social relationships, isolation, and a disturbed sense of self after the onset of the illness (Estroff, 1989).

Developing effective treatment methods for schizophrenia has been an evolving, and at times, contentious process. While psychotherapy was a recommended form of treatment for schizophrenia in first half of the twentieth century, psychopharmacology now predominates. Schizophrenia is currently understood through the lens of the medical model, which views schizophrenia as a biologically-based illness and recommends medication, rather than psychotherapy, as the most effective form of treatment. Medications such as anti-psychotics can effectively reduce the acute symptoms of schizophrenia, such as delusions, hallucinations, and disorganized thought patterns for many individuals with schizophrenia.

After symptom relief has been achieved through medication, however, individuals with schizophrenia often find that they continue to struggle with the effects of the illness in their lives. They are often isolated, without any social support or direction as how to re-engage with the community. Confronted with the stigma of a schizophrenia diagnosis, they may feel hopeless, lacking agency or a sense of empowerment to plan for their future and work towards goals. Mental illnesses such as schizophrenia:

Challenge people's deepest sense of self, their ability to maintain a satisfactory relationship with self and others, their feeling of having a minimum of control over their lives. The feeling of weakness and vulnerability generally associated with mental problems develops and is reinforced through a series of experiences, difficulties and failures. It is not logical to think that one can lessen this feeling with any single intervention, be it medication, rehabilitation, or life skills training. (Corin, 1992 as cited in Jeffries, 1995, p. S24)

Although medication has been inarguably helpful to many people with schizophrenia, individuals with schizophrenia require more than relief from symptoms such as hallucinations, delusions, or disturbed thinking patterns in their treatment from the illness. Medication as the sole form of treatment may not address the social and emotional effects of the illness on individuals' lives (France & Uhlin, 2006).

Recently, however, interest in psychotherapy as a form of treatment that can address the social and emotional needs of individuals with schizophrenia has increased. This rising interest has been influenced by the emergence of the mental health recovery movement in the 1970s, which increased awareness and hopefulness about the ability to reach personal levels of recovery after being diagnosed with a major mental illness. The recovery movement, which defines recovery as managing symptoms of mental illness while re-engaging with life and achieving personal goals, emphasizes the need for holistic, recovery-oriented treatment in clinical practice with individuals with

schizophrenia. The recovery movement criticizes the medical model's exclusive focus on diagnosing and controlling symptoms, stating that treatment should also help individuals with schizophrenia develop goals and hope for the future, reconnect with the community, and develop social relationships. Recent research on the course of schizophrenia diagnoses has confirmed the recovery movement's claim that individuals with major mental illness can attain levels of recovery and lead personally meaningful lives. Despite its reputation as the “‘scarlet letter’ of mental illness” (Berzoff et al., 2002, p. 272), research has shown that schizophrenia is not an automatic sentence of a chronically debilitating illness (Jenkins & Carpenter-Song, 2005) and suggested that levels of recovery may be attainable for as many as one half to two thirds of individuals with schizophrenia (Harding, 2003).

Research on psychotherapy as a form of treatment for schizophrenia has indicated its potential as a form of treatment that, in conjunction with medication, can address quality of life issues, helping individuals with schizophrenia develop meaningful relationships and gain a sense of agency and hope in the recovery process (Fenton, 2000; France & Uhlin, 2006; Gottdiener & Haslam, 2002). Literature from consumer-survivors of the mental health system also describes the value of a therapeutic relationship in recovery from major mental illness, as Fisher (1999), a consumer-survivor and psychiatrist, states in his personal reflections on recovery from schizophrenia:

When someone is labeled with mental illness, it is as if all that has been learned to be helpful in therapy is thrown out...our lived experiences speak otherwise. Our lives show that people labeled with mental illness need a therapist and other people who believe in them. We who have been labeled with mental illness, remain just as human if not more so than others who are temporarily not labeled. Our needs are human needs of which the most basic is to enter into trusting, loving, and caring relationships. These relationships need to be nurtured and

cultivated for us to find the compass of our true self to guide our recovery. Any system of care which disturbs or interferes with these relationships is preventing not promoting recovery. (para. 10-11)

Deegan (1996), also a consumer-survivor of the mental health system and psychologist, describes her experience recovering from schizophrenia and the need for training mental health professionals to be able to provide services that facilitate recovery, stating:

A new age is upon us. We must help the students of today to understand that people with psychiatric disabilities are human beings with human hearts. Our hearts are as real and vulnerable and as valuable as yours are. Understanding that people with psychiatric disabilities are first and foremost people who are in process, growing and changing is the cornerstone of understanding the concept of recovery. We must not let our hearts grow hard and calloused toward people with psychiatric disabilities. Our role is not to judge who will and will not recover. Our job is to establish strong, supportive relationships with those we work with. And perhaps most of all, our greatest challenge is to find a way to refuse to be dehumanized in the age of managed profit, and to be bold and brave and daring enough to remain human hearted while working in the human services. (p. 101)

Therapists who have reported successfully treating individuals with schizophrenia offer humanistic suggestions for recovery-oriented psychotherapy that addresses the quality of life issues individuals with schizophrenia struggle with (Silver & Larsen, 2003; Walsh, 1995; Yip, 2004). A formal framework, however, is lacking to guide other therapists interested in providing recovery-oriented psychotherapy to individuals with schizophrenia.

An emerging framework of psychotherapy for schizophrenia is narrative therapy, which looks at change in the form and content of individuals' narratives as a means to assess outcomes in schizophrenia. These narrative therapy approaches prioritize the development of personal agency and a sense of self apart from the diagnosis of schizophrenia, as well the creation of a therapeutic relationship that values the client's self-determination, all of which are prominent goals of the recovery movement.

Emerging narrative therapy approaches have begun to be applied to clinical work with individuals with schizophrenia with promising results, yet there is little literature exploring narrative therapy approaches as potential frameworks of recovery-oriented treatment for individuals with schizophrenia.

This research will attempt to address the lack of information in the literature about theoretical frameworks that can inform recovery-oriented psychotherapy with individuals with schizophrenia. The purpose of this theoretical research will be to explore three emerging approaches to narrative therapy with individuals with schizophrenia and the potential of these approaches to align with the goals of the recovery movement and serve as a framework for recovery-oriented psychotherapy. By reviewing literature on psychotherapy with individuals with schizophrenia and the recovery movement and its implications for treatment with individuals with schizophrenia, three emerging narrative therapy approaches for individuals with schizophrenia will be explored to understand their implication for recovery-oriented psychotherapy with individuals with schizophrenia.

Definition of Terms

Schizophrenia

Schizophrenia is defined in The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR) by a set of six criteria, including positive symptoms such as delusions, hallucinations, disorganized speech or behavior and negative symptoms such as flattened affect, catatonic behavior, or poverty

of thought. Other criteria include social or occupational dysfunction and duration of symptoms.

Medical model

The medical model understands schizophrenia from a biological perspective, basing etiology and treatment of the illness in the balance of chemicals in the brain (Luhmann, 2000). The biological perspective looks at understanding structural changes in brain anatomy, neurochemical imbalances in the brain, with a focus on the relationship between dopamine and schizophrenia and the role of genetics in the development of schizophrenia (Torrey, 2001). The medical model recommends psychopharmacology as the primary and most effective form of treatment for schizophrenia.

None of the biologically-based theories, however, have provided a complete explanation for the etiology and causes of the development of schizophrenia (Sierbert, 1999). Other theories attempt to combine biological and environmental theories, suggesting that individuals with a genetic risk for schizophrenia who live in a “stressful” family environment, assessed by areas of hostility, rigidity, and levels of communication, are more likely to develop the illness than children who live in family environments deemed “healthy” (Tienari, Wynne, Sorri, Lahti, Laksy, Moring, et al. 2004). Additional theories have pointed to the role of trauma and stress in the development of schizophrenia, pointing to common sources of trauma and stress such as child abuse, racism, poverty and urbanicity in the lives of individuals who develop schizophrenia (Berzoff et al., 2002; Read, Goodman, Morrison, Ross, & Aderhold, 2004; Read & Ross, 2003).

Recovery

Recovery, as defined by the recovery movement, is seen as the process of managing symptoms while re-engaging with life and pursuing personal goals. In contrast to the medical model's definition of recovery as complete symptom cessation, this definition of recovery also focuses on reintegration into the community, empowerment, and regaining hope while coping with symptoms.

Narrative therapy

Narrative therapy focuses on the importance of narrative as a way that people organize and make meaning out of life (White & Epston, 1990), emphasizing the importance of meaningful connections between the past, present, and future. Narrative therapy assumes that people experience problems when the narratives they have created about their lives do not adequately represent their experience. This research will focus on three narrative approaches of psychotherapy that have been applied to treatment with individuals with schizophrenia.

Methodology

The following chapter contains a brief history of treatment methods for schizophrenia and the benefits of psychotherapy for individuals with schizophrenia, such as addressing quality of life issues, medication compliance, and the reduction of the overall cost of treatment of schizophrenia. The concept of schizophrenia as a chronic and debilitating illness will be addressed, and emerging research demonstrating that outcomes

for individuals with schizophrenia are not as hopeless as once thought will be introduced.

The third chapter will introduce the history and vision of the recovery movement. Implications of the recovery movement for treatment for individuals with schizophrenia will be discussed, as well as the suggestions for humanistic, recovery-oriented psychotherapy found in the clinical literature. The need for the development of a recovery-oriented framework to guide psychotherapy with individuals with schizophrenia will be explored.

The fourth chapter will examine three emerging approaches to narrative therapy with individuals with schizophrenia. These approaches include narrative therapy as introduced by Michael White, personal narrative construction, and open dialogue, a treatment model from northern Finland. This chapter will discuss the approaches' relevance to recovery-oriented services for individuals with schizophrenia, and provide suggestions for further research to improve understanding of the role of narrative therapy with individuals with schizophrenia.

Finally, the fifth chapter will summarize the theories introduced in the previous chapters. Limitations of this study will be discussed, and well as recommendations for research that will allow greater understanding for using narrative therapy approaches in recovery-oriented services with individuals with schizophrenia. Finally, implications for the field of social work and recommendations for social work practice, policy, and education will be explored.

CHAPTER II

PSYCHOTHERAPY AND SCHIZOPHRENIA

Psychotherapy has shifted from a standard form of treatment for schizophrenia in the 1940s and 50s to a currently contentious form of treatment in a mental health system dominated by the medical model. Research and clinical literature such as Fenton (2000), France and Uhlin (2006), Gottdiener and Haslam (2002), and Lysaker, Lancaster, and Lysaker (2003), argue, however, that interest in psychotherapy as treatment for schizophrenia is once again increasing as psychotherapy has been shown to be effective in addressing quality of life issues, increasing medication and treatment compliance with individuals with schizophrenia, and decreasing the overall cost of treatment for individuals with schizophrenia. This chapter will explore briefly the history of psychotherapy as treatment for schizophrenia and discuss these arguments in favor of psychotherapy as an effective treatment modality.

Outcomes in Schizophrenia Diagnoses

Emil Kraepelin, a leading psychiatrist of the 19th century, first diagnosed schizophrenia in 1878 as dementia praecox, or “dementia of the early onset” (Kyziridis, 2005, p. 45). Kraepelin characterized schizophrenia as a chronically degenerative illness leading to symptoms similar to end-stage dementia in the majority of patients (Berzoff et al., 2002; Kyziridis, 2005). For years, implications of a schizophrenia diagnosis echoed this belief in a chronic, degenerative illness without any chance of hopeful outcomes.

Today, a diagnosis of schizophrenia is still clouded with fear and stigma (Berzoff et al., 2002; Torrey, 2001). Recent research has shown, however, that outcomes are not as hopeless as originally thought, with the possibility of improvement and recovery for some individuals with schizophrenia. Individual outcomes in levels of improvement are varied and “heterogeneous outcomes (which include substantial improvements for some sufferers) are the norm rather than the exception” (France & Uhlin, 2006, p. 54). Harding (2003) studied the outcome of schizophrenia diagnoses in ten long term studies and found that, in contrast to the historical perception of schizophrenia as a chronic illness, “approximately one half to two thirds of people with schizophrenia can achieve a state of significant improvement or even recovery” (p. 2). An analysis of literature (Gottdiener & Haslam, 2002) on outcomes in schizophrenia has shown that approximately half of individuals diagnosed with schizophrenia in the past 100 years who received treatment (defined as a combination of medication and psychosocial interventions) have recovered to a level of self-sufficiency and independent living.

Treatment Methods for Schizophrenia

In the early 1900’s, Freud wrote that individuals suffering from psychosis were unable to form transference in the therapeutic relationship and were not appropriate for psychoanalytic treatment (Fenton, 2000). The usual course of treatment for schizophrenia at this point in history was institutional care, often for the span of the individual’s life (Fenton, 2000). Treatment began to shift towards psychotherapy in the 1920s and 1930s when influential and prominent therapists such as D.W. Winnicott, Henry Stack Sullivan, Frieda Fromm-Reichmann, and Harold Searles focused on

psychologically based treatments for schizophrenia and therapeutic value of the client-therapist relationship. While the 1940s brought new experimental treatments for schizophrenia, such as trials of electro-convulsive therapy (ECT) and lobotomies, psychotherapy remained the prominent form of treatment for individuals with schizophrenia (Luhmann, 2000; Whitaker, 2002).

In 1954, chlorpromazine was developed and marketed as a safe and effective antipsychotic in the treatment of schizophrenia (Whitaker, 2002). Antipsychotics are intended to provide relief from acute symptoms of schizophrenia and help the individual stabilize. They are most effective in managing positive symptoms of schizophrenia, such as delusions, hallucinations, and thinking disorders (Torrey, 2001). Antipsychotics are less effective, however, in managing negative symptoms, such as flattened affect, apathy, and poverty of thought (Torrey, 2001). With the introduction of chlorpromazine, psychiatrists moved to a more medical model for treatment of schizophrenia, and the efficacy of psychotherapy began to be debated, taking an increasingly smaller role in the treatment of schizophrenia.

The effects of deinstitutionalization, which began in the 1960s, also heavily influenced the change to a medical model of treating schizophrenia (Torrey, 2001). Deinstitutionalization was designed to move individuals with mental illness out of institutions and help integrate them into the community. Although deinstitutionalization, a result of public concerns about the horrible conditions and financial burden of state psychiatric hospitals, may have been a “humane and reasonable idea” (Torrey, 2001, p. 21), it ultimately failed to achieve its goals. Adequate funds were not provided to achieve the goal of comprehensive community-based care, and individuals discharged

from institutions did not receive sufficient care and services in the community (Berzoff et al., 2002). The effects of deinstitutionalization's economic problems were influential factors in the shift away from psychotherapy (Luhmann, 2000). In the 1980s and 1990s, states searched for ways to cut mental health care costs and close hospitals while still providing care for clients in the community and medication, seemingly a cheaper treatment method than psychotherapy became the increasingly favored treatment (Whitaker, 2002). Decreased amount of time spent on psychiatric wards and lack of insurance coverage for outpatient treatment made the provision of psychotherapy difficult. Additionally, the development of atypical antipsychotics in the 1980s and 1990s, with fewer unpleasant side effects than the original antipsychotics, was also an influence in the shift of standard treatment for schizophrenia away from psychotherapy and towards a reliance on medication management (Luhmann, 2000; Walsh, 1995).

Another reason for the decline of psychotherapy as standard treatment for schizophrenia has been the conflicting conclusions of empirical studies exploring the efficacy of psychotherapy as opposed to medication in treatment for schizophrenia (Luhmann, 2000). Widely cited studies by May (1968) and Karon and VandeBos (1972) yielded opposite results regarding the efficacy of psychotherapy with clients with schizophrenia. Both studies were randomly controlled trials comparing the effects of individual therapy without medication to treatment based on medication only. Karon and VandeBos (1972) placed study participants into three groups. Two groups were treated with individual psychodynamic therapy, one of which received small doses of medication at the beginning of the study, which was withdrawn after the first few weeks. The third group received medication only. Results found that both groups that were

treated with individual psychodynamic psychotherapy without medication produced greater change and improvement than the group that received medication alone, which produced significantly less change (Karen & VandeBos, 1972). May (1968) found the opposite, concluding that medication produced the greatest changes and psychotherapy was of little help in treatment (as cited in Gottdiener, 2006).

A meta-analytic review by Gottdiener and Haslam (2002) determined that over the course of 37 studies examining the efficacy of psychodynamic, cognitive behavioral, and non-psychodynamic supportive therapy in the treatment of individuals with schizophrenia, psychotherapy was found to be helpful. The meta-analysis included studies that examined the efficacy of psychotherapy with participants who also received medication, other psychosocial support services, or no medication at all, finding that participants who received both medication and psychotherapy showed greater levels of improvement than those who received other combinations of treatment (Gottdiener & Haslam, 2002). The meta-analysis found that among all of the participants in the 37 studies, “65% of the population that received psychotherapy improved compared with only 34% of the population that did not receive psychotherapy” (Gottdiener & Haslam, 2002, p. 171).

Treatment methods for schizophrenia have shifted away from psychotherapy towards a reliance on medication management, influenced by the development of the medical model and difficulty providing psychotherapy after deinstitutionalization and the resulting managed care environment. Psychotherapy, however, has been found to be an effective form of treatment for individuals with schizophrenia in various studies (Gottdiener, 2006; Gottdiener & Haslam, 2002; Karen & VandeBos, 1972), suggesting

that psychotherapy should not be disregarded as a form of treatment and bringing to question how psychotherapy can be incorporated into standard treatment in order to provide the best care possible for individuals with schizophrenia.

Finding a Balance in Treatment: Antipsychotics and Psychotherapy

While antipsychotic medications have provided relief for some sufferers of schizophrenia and their importance in treatment should not be dismissed, a number of individuals' treatment needs cannot be addressed through medication alone (Silver & Larsen, 2003). Lack of compliance with medication is a common problem; citing uncomfortable and problematic side effects, 75% of clients diagnosed with schizophrenia stop taking their antipsychotics within 2 years of beginning treatment (Gottdiener & Haslam, 2002). Over the entire course of treatment for the illness, between 40% and 75% of individuals with schizophrenia do not take their medication regularly (Gottdiener & Haslam, 2002). Results from Gottdiener and Haslam (2002) suggest that individual psychotherapy has the potential to provide effective treatment for individuals for whom medication is ineffective or for those who refuse to take medication.

Despite the division between some supporters of biological and psychotherapeutic models of treatment, one form of treatment does not necessarily have to exclude the other. Many therapists agree that medication can be an indispensable part of treatment and that psychotherapy is often most effective when partnered with medication to control symptoms (Gottdiener & Haslam, 2002). A meta-analysis by Mojtabi et al. (1998) reviewed 10 studies that paired psychotherapy with antipsychotic medication and found that a combination of psychotherapeutic treatments with antipsychotic medication led to

significant improvements in psychosocial functioning compared to outcomes of medication only treatment (as cited in Gottdiener, 2006).

Psychotherapy has also been shown to assist with medication compliance. The strength of the alliance between the therapist and the client could strongly affect the client's willingness to comply with medication (Fenton, 2000; Roth & Fonagy, 1996).

Fenton (2000) reviewed studies on the efficacy of psychotherapy with clients with schizophrenia and noted that:

Patients able to form a good alliance with the therapist within the first 6 months of treatment were more likely to remain in therapy and comply with medication. These patients achieved better outcomes and used less medication than those who did not form a therapeutic alliance. (Fenton, 2000, p. 54)

Providing psychotherapy to individuals with schizophrenia can also help decrease the overall cost of treatment as opposed to the cost of the current treatment model.

Schizophrenia is a costly illness; in addition to the emotional cost to individuals with schizophrenia and their families and friends, the total costs of schizophrenia in 2000 were approximately \$40 billion, which is "more than the entire budgets of the National Institutes for Health and the VA medical system combined" (Torrey, 2001, p. 5). The high cost of long-term psychotherapy is often compared to the cheaper cost of antipsychotic medication and cited as an argument against the use of psychotherapy (Gottdiener & Haslam, 2002; Walsh, 1995). Empirical studies, however, have suggested that providing psychotherapy can actually decrease the overall cost of treatment.

Individuals receiving psychotherapy have fewer hospitalizations and are less likely to be placed in inpatient treatment as opposed to those receiving medication only (Gabbard, Lazar, Hornberger, & Spiegel, 1997; Karen & VandeBos, 1972).

Aside from psychotherapy's uses in promoting medication compliance and reducing the overall cost of treatment, it also offers tools to improve the quality of life of individuals with schizophrenia. Treating schizophrenia solely through medication may ignore many spiritual and quality of life issues that affect individuals with schizophrenia (Walsh, 1995). A common symptom of schizophrenia is the inability to form sustaining and meaningful relationships with others (Lysaker & Daroyanni, 2006). Walsh (1995) wrote that abandoning psychotherapy for a strictly medical model of treatment may cause individuals with schizophrenia to "become further socially isolated if their interpersonal problems are not addressed" (p. 72). Psychotherapy can provide an environment to form a meaningful relationship that addresses the issues that arise while living with major mental illness. This is demonstrated in the clinical literature, which describes a history of psychotherapists who demonstrated the importance of developing a therapeutic relationship in treatment with clients with schizophrenia and psychotherapy's effectiveness in addressing these quality of life issues. Psychotherapists such as Fromm-Reichman (1960), Karen and VandenBos (1972), Searles (1965), and Sullivan (1962), who began practicing psychotherapy before the discovery of antipsychotics, tended to avoid providing medication as treatment and favored treatment based on psychotherapy. More recently, however, psychotherapists such as Holma and Aaltonen (1998b) and White (1995) have discussed the value of providing treatment that, when most beneficial to the client, incorporates medication with psychotherapy.

Individuals living with schizophrenia often describe experiencing their feelings as misunderstood and attributed to their symptoms, rather than as genuine emotions resulting from the experience of living with mental illness (Horowitz, 2002). As

Horowitz (2002) explained in his case study of psychotherapy with a man with schizophrenia, his client consistently complied with medication and had stayed out of the hospital for four and a half years. Horowitz complimented him on his success, but his client disagreed with this definition of successful treatment, responding, “But there’s no love in my life” (Horowitz, 2002, p. 239). Horowitz (2002) wrote that “improvements that stem from medication may leave people looking far more functional than they actually feel” (p. 239). While medication may help individuals cope with symptoms and regain daily functioning capacities, medication cannot alter the experience of estrangement and relational difficulties that emerges after a struggle with mental illness such as schizophrenia (Berzoff et al., 2002; Silver & Larsen, 2003).

When the mental health system sends the message that, unlike most other diagnoses, those with schizophrenia do not “merit the attention of therapists” (Walsh, 1995, p. 72), it increases stigma and the sense of isolation surrounding the illness. Silver and Larsen (2003) echoed this sentiment in a description of a typical response from a psychiatrist to a treatment team’s attempt to talk to a client with schizophrenia, asking ““Why are you bothering to talk to X? We are medicating him/her. That’s enough”” (p. 1). A growing awareness within the mental health community that for some individuals, medication alone will not address the social and emotional difficulties that accompany schizophrenia or restore full functioning has led to an increased interest in once again exploring the role of psychotherapy in the treatment of schizophrenia (France & Uhlin, 2006).

Conclusion

This chapter provided an overview of the history of psychotherapy as treatment for schizophrenia and the current debate regarding incorporating psychotherapy as a form of standard treatment for individuals with schizophrenia. The next chapter will examine the recovery movement and the role that psychotherapy plays within this movement.

CHAPTER III

RECOVERY MOVEMENT AND SCHIZOPHRENIA

The recovery movement emerged in the 1970s, led by consumer-survivors of the mental health system who used their own experience recovering from major mental illness to publically give voice to the vision of recovery (Carpenter, 2002). This vision criticized the existing medical model of treatment, calling for a restructuring of the mental health system and for recognition that individuals with mental illness can recover (Carpenter, 2002). In the medical model, the main goal of treatment is controlling or curing symptoms, and doctors and mental health providers determine the course of treatment for the clients they treat (Glyn, Cohen, Dixon & Niv, 2006). Supporters of the recovery movement object to this model of treatment, describing it as dehumanizing and focusing only on “symptoms and deficits, failing to recognize the whole person” (Carpenter, 2002, p. 87).

There is not a standardized definition of recovery. In stark contrast to the medical model’s definition of recovery as complete symptom cessation, however, the recovery movement conceptualizes recovery as the process of managing symptoms while leading a personally meaningful life (Roe & Davidson, 2008). The recovery movement envisions treatment that addresses more than symptom relief, focusing on empowerment, social recovery, and reintegration into the community, and challenges assumptions about the inevitable chronicity of mental illness diagnoses (Carpenter, 2002; Peebles et al., 2007). This perspective describes recovery as a “process where persons with serious mental

illness reengage with life and, via positive coping, experience a restoration of a sense of self and purpose in life” (O’Conner & Delaney, 2007, p. 172). The recovery model focuses on “personal success” (Carpenter, 2002, p. 88) in treatment, describing a “life beyond psychiatric diagnosis that is both vital and valuable, whether or not symptom relief is ever achieved” (Carpenter, 2002, p. 88). The recovery movement is centered on principles of clients’ empowerment, self-determination, and assumption of responsibility in treatment (Carpenter, 2002; Schiff, 2004). Recovery is a highly individualized journey, requiring the validation and acknowledgment on behalf of the therapist that each individual must define their own concept of recovery (Borg & Kristiansen, 2004; Jensen & Wadkins, 2007).

Recovery and Schizophrenia

As discussed in Chapter II, outcomes in schizophrenia are varied and may include substantial improvement in symptom management and quality of life for some individuals (France & Uhlin, 2006; Harding, 2003). The medical model measures levels of recovery in concrete treatment outcomes, such as significant or complete symptom cessation as well as measureable outcomes in daily functioning, such as obtaining employment and living independently (O’Conner & Delaney, 2007). The recovery movement, however, describes recovery in schizophrenia in broader terms that acknowledges the individual experience in the recovery process. This perspective defines recovery as managing symptoms of schizophrenia while reintegrating with the community and achieving personally defined goals (Farden, Nesvag, & Marder, 2008).

Critics of the recovery perspective note that some of its values, such as consumer self-determination in treatment, could be detrimental to treatment for schizophrenia (Frese, Stanley, Kress & Vogel-Scabilia, 2001). Individuals with acute schizophrenia are seriously impaired in their thought process and reality testing and at this acute stage of illness, unable to make decisions for their care (Frese et al., 2001). Within the recovery model, however, there is recognition that medication has improved the lives of many individuals with schizophrenia, and can be an important aspect of the individual's recovery. For individuals with acute symptoms, a medical model treatment plan that focuses primarily on medication, symptom relief and stabilization may be the best form of initial treatment (Frese et al., 2001). As acute symptoms decrease, however, "the locus of control should increasingly shift from the treatment provider to the person who is recovering" (Frese et al., 2001, p. 1464). The role of medication should be evaluated to understand how it enhances or subtracts from the quality of life, and how it, in combination with other psychosocial services, can help the individual maintain stability and continue moving towards personal goals (White, 1995). The recovery model advocates for a balance between recovery and medical model perspectives, warning that an exclusive focus on the medical model and medication leads to a "vision of the client as a diagnosis rather than an individual" (Carpenter, 2002, p. 87).

Implementing Recovery-Oriented Mental Health Services

The recovery movement gained presence in national mental health policy with the *Surgeon General's Report on Mental Health* (1999), which established that all mental health services should have recovery as their overarching goal and that treatment should

be consumer-oriented (Roe & Davidson, 2008). The President's New Freedom and Commission on Mental Health (2003) further expanded upon this recommendation, calling for a transformation in the mental health system to create a recovery oriented treatment system (Roe & Davidson, 2008). The report called for policies that "would enable adults with serious mental illness and children with serious emotional disturbance to live, work, learn, and participate fully in their communities" (The President's New Freedom and Commission on Mental Health, 2003, p.1 as cited in Farone, 2006, p. 22). With these recommendations, increased attention has been placed on ways recovery can be conceptualized as a framework and implemented into practice.

The concept of recovery has been developed through the voices of consumer-survivors and experiences of recovery-oriented mental health professionals rather than through empirical studies (Peebles et al., 2007). Supporters of grounding recovery concepts in a scientific base note that developing a clear understanding of recovery oriented treatment will improve understandings of how recovery-oriented services work, thus improving the quality of services (Peebles et al., 2007; Silverstein & Bellack, 2008). Evidence-based guidelines may also prevent current treatment systems from being "repackaged in non-significant ways with the claim that they are now recovery-oriented" (Silverstein & Bellack, 2008, p. 1109).

Grounding the recovery movement in a scientific base, however, may not acknowledge many of the more intangible values of the recovery movement. Empirical research focuses on studying concrete measures of recovery, such as symptom cessation and participation in the community, living independently, or obtaining employment (Peebles et al., 2007). This measurement of recovery does not recognize many of the

goals that are the foundation of the consumer driven definition of recovery, such as empowerment or an increased sense of agency (Peebles et al., 2007). An empirical model of recovery that does not incorporate these personal definitions of recovery could lead to discrepancies about how the individual actually feels about their stage of recovery. Individuals might feel invalidated and that their individual achievements are not recognized by a standardized recovery model (O’Conner & Delaney, 2007). Conversely, they could feel that an empirical model would describe them as being more recovered than they actually feel, causing them to be “distressed by residual symptoms...stigmatized by the illness, frustrated by an inability to achieve one’s ambitions, and hopeless about the future” (Bellack, 2006, p. 434 as cited in O’Conner & Delaney, 2007, p. 174). Developing empirical models of recovery, then, must take these concerns into consideration and allow for recognition of the unique aspects of each individual’s recovery process.

Acknowledging the need to integrate the current environment of managed care and evidenced based practices with the emerging recovery framework, Silverstein and Bellack (2008) noted that an “important goal of future research is to determine how symptom reduction and other ‘medical model’ treatment can most effectively be delivered within the context of the values of a recovery orientation” (p. 1114). As the recovery framework gains prominence in the mental health system, further research on the recovery process and practices that are conducive to recovery is needed to help guide policy and practice (Ridgway, 2001).

The Recovery Process

The recovery movement emphasizes recovery as a process rather than discrete outcomes (Carpenter, 2002). Set-backs and relapses are part of the process, rather than labeled with medical model terms such as “regression” or “decompensation” (Bradshaw, Armour, & Roseborough, 2007; Carpenter, 2002, p. 89). As Deegan (1988), a consumer survivor of the mental health system, psychologist, and recovery movement advocate, defined recovery:

Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again...The need is to meet the challenge of our disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration to live, work, and love in a community in which one makes a significant contribution. (p. 15 as cited in Onken, Craig, Ridgway, Ralph & Cook, 2007, p. 19)

Empirical research on the recovery process describes the phases individuals with mental illness may pass through during treatment. Common phases cited in this process are cultivating hope, defining a sense of self that is separate from the mental illness, and connecting with the community (Bradshaw et al., 2007; Jacobson & Greenely, 2001; Spaniol, Wewiorski, Gagne & Anthony, 2002; Young & Ensing, 1999). Spaniol et al. (2002) studied the recovery process with 12 participants diagnosed on the schizophrenia spectrum over the course of four years. The qualitative study described three phases in the recovery process (Spaniol et al., 2002). During the first phase participants identified feeling overwhelmed by mental illness and unable to understand or control daily life, while during the second phase they described struggling with an explanation for the mental illness and developing coping mechanisms (Spaniol et al., 2002). Participants in

later stages of recovery identified the third phase as learning to live with the mental illness, regaining a sense of self and managing daily life (Spaniol et al., 2002). During this phase, “while the person still feels limited by the disability, he or she has found a niche in the world” (Spaniol et al., 2002, p. 331).

While studying the recovery process with schizophrenia is an emerging field of research, more studies exist on the recovery process with major mental illness in general. Young and Ensing (1999) developed a model of the recovery stages after interviewing eighteen people with a diagnosis of major mental illness. Stages of recovery progressed from initial tasks such as overcoming feelings of being stuck to having hope and motivation to change, followed by regaining what was lost as a result of mental illness, discovering self-empowerment, and gaining insight about self and the relationship between self and illness (Young & Ensing, 1999). The later stages of recovery involved enhancing and improving quality of life, increasing an overall sense of well-being, and reaching new potentials of higher functioning (Young & Ensing, 1999).

Bradshaw et al. (2007) examined experiences in the recovery process over the course of a 3 year longitudinal study of 45 adults with serious and persistent mental illness. Results found three phases of recovery, with participants reporting feeling overwhelmed and demoralized during the first year of their diagnosis, developing coping skills to deal with the mental illness during the second year, and reintegrating into the community during the third year (Bradshaw et al., 2007). Reintegration was comprised of reintegration into the community, with family and friends, with case manager, and integration of self and illness (Bradshaw et al., 2007). This phase of reintegration was marked by struggles with stigma and barriers to social inclusion, navigating changes in

roles with families and friends, and becoming “less engulfed in a mentally ill identity” (Bradshaw et al., 2007, p.40). Jacobson and Greenely (2001) analyzed mental health consumers’ reports the recovery process, and found that having hope, defining a sense of self separate from the mental illness, reducing symptoms, developing a sense of empowerment and building social relationships were essential steps in the recovery process.

Reconstructing a sense of self and re-authoring a narrative of life and illness are important steps in the recovery process (Davidson & Strauss, 1992; Estroff, 1989; Onken et al., 2007). Schizophrenia can change perceptions of identity, both inwardly by the individual suffering, and outwardly to others (Estroff, 1989). Individuals with schizophrenia often have an identity that is only the “residue of what the person once was” (Walsh, 1995, p. 75). Davidson and Strauss (1992) explored the reconstruction of a sense of self in the experience of recovery in 66 individuals diagnosed with schizophrenia, schizoaffective disorder, and major affective disorder. Four phases in the reconstruction of self emerged: discovery of an active self that is not completely identified by illness, understanding capabilities and potential for growth and change, putting these rediscovered aspects of self into action, and finally, creating an “enduring sense of self as agent” (Davidson & Strauss, 1992, p. 139).

Estroff (1989) wrote that the onset of schizophrenia drastically alters an individual’s sense of identity, resulting in a narrative of loss. This narrative is a “tale of the new, strange, disturbed and disturbing, not-really-who-they-were-before-but-still-somehow-the-same-person” (p. 191). Re-authoring personal narratives is a collaborative

process between client, family, and mental health professionals, and as Onken et al.

(2007) noted, this process:

Involves replacing a view of the self as centered on a psychiatric disability to that of one who is a whole person facing challenges, thus broadening the telling of one's life story through the transformation of suffering into a significant life experience. (p. 13)

Rather than uncovering a new self or reclaiming the former self before the onset of illness, this process creates a broader sense of self that integrates the experience, trauma, and stigma of mental illness into a new sense of self (Davidson & Strauss, 1992; Onken et al., 2007).

Recovery-Oriented Psychotherapy

Prominent themes echoed throughout literature on the recovery process include gaining insight and awareness of having mental illness, rebuilding a sense of self, cultivating a sense of hope and empowerment, developing coping mechanisms, and sustaining social support (Young & Ensing, 1999). To facilitate this process, however, clinicians and mental health systems must understand how to provide recovery-oriented services. Psychotherapy, as examined in Chapter II, can be useful in treatment for schizophrenia because it can attend to quality of life issues that medication or an exclusively medical model form of treatment cannot address. These quality of life issues, such as developing a sense of self separate from illness, and reconnecting with others in the community, are also core values of the recovery process. Additionally, many of the common characteristics of supportive therapeutic relationship, such as a "highly collaborative relationship with the client, fostering self-efficacy...fostering and

promoting hope and expected improvement” (Peebles et al., 2007, p. 573) are compatible with the recovery movement's vision.

Psychotherapists such as Estroff (1989), Silver and Larson (2003), Sullivan (1962), Walsh (1995), Yip (2004) have provided descriptions of successful treatment with clients in recovery with schizophrenia and offer recommendations for psychotherapy that facilitates this process. These recommendations are centered on humanistic principles that echo the recovery movement’s values, emphasizing the importance of promoting the client’s self-determination and agency, understanding the client’s illness narrative, helping the client reconstruct a sense of self, and treating the person behind the schizophrenia diagnosis.

Henry Stack Sullivan, while providing psychotherapy to individuals with schizophrenia in the 1920s and 1930s, guided his work by the principle that clinicians should understand individuals with schizophrenia as humans first, rather than following a model of pathology (Fenton, 2000; Sullivan, 1962; Yip, 2002). Roe and Davidson (2008) wrote that a recovery oriented clinician working with individuals with schizophrenia must operate from a strengths-based perspective and “place as much, possibly even more, emphasis on clients’ personal narratives and quality of life as on their symptoms and diagnosis” (p. 573). Walsh (1995) stated that effective psychotherapy with a client with schizophrenia accepts the client’s agenda, affirms the client’s strengths and the sense of self, and attends to spirituality. Most importantly, the therapist should convey that the client has “abilities and personal worth, simply by his existence as a human being” (Walsh, 1995, p. 83). Yip (2004) similarly emphasized the importance of treating the person with schizophrenia, rather than only the person's symptoms, and the need to help

the person with schizophrenia cope with the disruption of self that results from the illness. Silver and Larsen (2003) wrote that the most important guidelines when developing treatment strategies for clients with schizophrenia is to remember that above all that “there is a person who has this disease” and that “that person needs human support” (p. 1).

Estroff (1989) discussed the shortcomings of an exclusively biological treatment model and the goals of psychotherapy with individuals with schizophrenia. A focus only on the history of schizophrenia captures only part of the client’s life narrative, for

There is a configuration of self that exists over time: an enduring entity that precedes, transcends, outlasts, and is more than an illness or diagnosis. While clinical accounts often document the course of an illness, they seldom provide a narrative of the person through time, in time – both personal and social. The psychiatric history is only a portion of the personal history, yet it must be located, situated in the *lifetime* of the person now experiencing schizophrenia. (Estroff, 1989, p. 190)

The goal of psychotherapy is to integrate the client’s life history with the new story that emerges after the onset of schizophrenia (Estroff, 1989). This new story should be “the construction (or reconstruction) of a coherent self first between therapist and patient, and eventually within the patient” (Estroff, 1989, p. 193).

The recovery perspective notes that the medical model cannot address many of the distressing symptoms that individuals with schizophrenia struggle with, even if medication successfully alleviates symptoms such as hallucinations or bizarre thought processes. Such symptoms include confusion over identity, a disturbed sense of self, and a struggle to share a mutually constructed reality with others (Estroff, 1989; Holma & Aaltonen, 1998b; Walsh, 1995). The severity of the symptoms of schizophrenia, compounded by the isolation and stigma of the illness, results in schizophrenia being

“more than an illness that one *has*; it is something a person *is* or may *become*” (Estroff, 1989, p. 189). Silver and Larsen (2003) noted that schizophrenia challenges ways that individuals are able to think, feel, and most importantly, the way they experience their sense of self. They described schizophrenia as becoming part of the individual's identity, stating that the symptoms are “not something you have in addition to being you, it changes your experience of being all together” (Silver & Larsen, 2003, p. 7).

Psychotherapy is advocated as a treatment that can help address concerns of identity and restructuring the narrative of self (Estroff, 1989; Silver & Larsen, 2003).

Walsh (1995) noted that the disordered, bizarre, and concrete thought processes which accompany schizophrenia result in a loss of mutual symbolism with others, or an inability to interpret commonly held social symbols. Individuals diagnosed with schizophrenia are often isolated from the social world and lose the connection and validation that comes with being a part of a society with shared meanings (Walsh, 1995). The person with schizophrenia instead lives in a world constructed by symbols not shared or understood by the outside world (Walsh, 1995). This affects the ability to connect and reintegrate with society as “one can only function as a participating member of a social group to the extent that he or she has internalized and can manipulate the symbols around which that group has been organized” (Walsh, 1995, p. 75). Psychotherapy provides an environment to begin the work of reconnecting and constructing mutual meanings with another person (Walsh, 1995).

Jeffries (1995) and Roe and Davidson (2008) described the onset of psychosis and diagnosis of schizophrenia as a traumatic assault to the sense of self, changing perceptions of identity and capabilities in life. Psychotherapy is a tool to address this

trauma so that the person with schizophrenia can move forward in recovery (Roe & Davidson, 2008). Jeffries (1995) recommended that while working with individuals with schizophrenia, “psychotherapy should focus on resolution of the conflicts engendered by the trauma...and allowing him or her to grieve” (p. S22-S23).

Conclusion

The recommendations by psychotherapists explored in this chapter for echo many of the values and goals of the recovery movement, such as a treating the person behind the symptoms of schizophrenia, helping the client define an identity that is separate from the diagnosis, and sustaining hope. These psychotherapists, however, do not provide a specific theoretical framework to guide psychotherapy. While recovery is emerging as a new framework, there is a need for a greater understanding of how psychotherapy can facilitate this process and evolve “into a well constructed paradigm that can effectively guide policy and practice” (Ridgway, 2001, p. 335). The next chapter will explore three emerging narrative approaches and their potential to act as a framework of recovery-oriented psychotherapy for individuals with schizophrenia.

CHAPTER IV

NARRATIVE THERAPY APPROACHES

Narrative therapy is an emerging focus in psychotherapy practice with schizophrenia. Narratives help construct meaning and “place daily experience in an historical context of life” (France & Uhlin, 2006, p. 55). Narrative therapists believe that “personal narratives sew together the wide range of identifications that orient one’s sense of self, ultimately lending coherence to identity” (France & Uhlin, 2006, p. 55). A sense of self develops from the stories that people tell, both to themselves and to others, which connect their past to their present and their daily experience to the outside world (Lysaker, Davis, Jones, Strasburger, & Beattie, 2007; Lysaker, Lysaker, & Lysaker, 2001).

Narrative therapy is commonly associated with the work of Michael White and David Epston, who introduced narrative therapy in the context of family work (France & Uhlin, 2006). White (1995) explains the importance of self-narratives, stating that “we live by the stories that we have about our lives, that these stories actually shape our lives, and that they ‘embrace’ our lives” (p. 14). According to White and Epston (1990), goals of a narrative focused therapy include “a sense of authorship and re-authorship of one’s life and relationships in the telling and retelling of one’s story” (p. 83) and acknowledgment on part of the client of multiple perspectives and meanings within every story. Beels (2001) described narrative therapy’s co-construction of narrative between the therapist and client, explaining that therapists:

Take each person as a competent teller of his story, and having made that assumption, they say, 'Tell me this story, let us see what we can make of it together.' This is what is meant by collaborative, narrative therapy. The telling and hearing of the story are a collaboration on one of many versions, one of many ways that consultant and client can travel across the landscape of experience together, perhaps retracing their path again and again, ultimately looking for a preferred path to a preferred place. (p. 163)

While originally developed in the context of family therapy, narrative therapy has been expanded to address needs of other populations and is now “described as an eclectic and evolving” (France & Uhlin, 2006, p. 54) framework. As a result, narrative therapy has been increasingly recognized as having relevance with other populations, including individuals with schizophrenia (France & Uhlin, 2006). Interest in narrative development with individuals with schizophrenia has been influenced by the increased effectiveness of antipsychotic medication for symptoms of schizophrenia (Lysaker, Lancaster et al., 2003). With the stabilization of symptoms, individuals are better able to participate in psychotherapy and address remaining concerns about the effects of schizophrenia on social relationships and their sense of self (Duckworth, Nair, Patel, & Goldfinger, 1997 as cited in Lysaker, Lancaster et al., 2003). Narrative therapy is an emerging framework with potential to address these quality of life issues. Although narrative therapy with schizophrenia can take several approaches, such as personal narrative construction or creating shared narratives between the client, family, and treatment team, the goal of these approaches are “to create stories that are not yet told or are held in subjugation” (Holma & Aaltonen, 1998b, p. 254).

Narratives and Schizophrenia

The narrative theory of self “stresses that the sense of self can vary from more to less coherent according to how it is constituted within the stories one tells oneself and others” (Lysaker, Buck, Hammoud, Taylor & Roe, 2006, p. 242). Studies have suggested that a cohesive narrative and functional sense of self are important sources of improvement for individuals with mental illness, helping them maintain relationships with others, articulate hope and goals for the future, and develop agency in their lives (Davidson & Strauss, 1992; Lysaker, Lancaster et al., 2003). A cohesive narrative is an evolving life story that is understandable and meaningful to self and others and is characterized by qualities such as logical connections and a temporal order of details (France & Uhlin, 2006). A functional sense of self is defined as “an enduring sense of the self as an active and responsible agent,” (Davidson & Strauss, 1992, p. 131). Davidson and Strauss (1992) studied the importance of the reconstruction of an enduring sense of self in interviews of 66 individuals diagnosed with psychosis and found that “becoming aware of a more functional sense of self and building upon it in the midst of persisting psychotic symptoms and dysfunction is alluded to over and over again by persons suffering from these disorders” (p. 131). An enhanced sense of self was perceived as a source of refuge from their diagnosis as well as a “foundation upon which they may then take up the work of recovery in a more active and determined fashion” (Davidson & Strauss, 1992, p. 131).

The symptoms of schizophrenia, however, often result in a fractured narrative and a “profound diminishment in the ability to experience and represent one’s life as an evolving story” (Lysaker & Lysaker, 2006b, p. 172). Non-coherent narratives are

disorganized conceptually and temporally and lack a sense of meaningful interactions with others (Lysaker & Lysaker, 2006b). Non-coherent narratives do not convey agency, failing to portray the individual as the protagonist in their own life and leading to feelings of lack of control, hopelessness, and difficulty planning for the future (Davidson & Strauss, 1992).

A non-coherent narrative leads to difficulties communicating concrete facts to others, and “these diminishments contribute to a sense of self riddled with anguish and lacking depth and richness” (Lysaker & Lysaker, 2006b, p. 172). Incoherent narratives negatively affect the ability to sustain connection and support from others. When narratives are incoherent, “they disorient, irritate, turn away, or overload a listener; they do not help in getting the latter’s cooperation” (Dimaggio, 2006, p. 105). This can prevent the establishment of social connection with others as well as the ability to be understood in a social context (Dimaggio, 2006; McAdams, 2006).

Individuals with schizophrenia often lack a coherent and evolving narrative about their life (France & Uhlin, 2006; Lysaker, Buck & Roe, 2007). Symptoms such as disorganized thought patterns, psychosis, and poor reality testing can cause the narratives that individuals with schizophrenia tell to be indecipherable to others (Lysaker & Lysaker, 2002). Narratives of individuals with schizophrenia may also demonstrate a lack of a sense of agency, or the ability to see oneself as a protagonist in their own life (Lysaker, Buck et al., 2007). In an analysis of narratives of individuals with schizophrenia, Lysaker, Wickett, and Davis (2005) found fewer references to personal agency and social worth than in narratives of people with medical disabilities or other

psychiatric diagnoses (as cited in Lysaker & Buck, 2006). The effects of schizophrenia appear to alter and decrease an individual's sense of agency.

The symptoms of schizophrenia, such as psychosis, lack of social relationships, and diminished affect also lead to confusion about the self and how one fits into the world (Dorman, 2008; Estroff, 1989; Holma & Aaltonen 1998a; Walsh, 1995). Estroff (1989) wrote that schizophrenia affects the cohesiveness of narratives about self and others, stating that a “lack of agreement or constructive interaction between self and others *about* self may also result in an incomprehensibility of person, identified by Rosenberg (1984) as the hallmark of psychosis” (p. 190). To address the loss of a coherent sense of self, psychotherapy should address the core issues of “who and what existed *before* the illness, and who and what endure *during* and *after*?” (Estroff, 1989, p. 191). With successful narrative development in psychotherapy, a cohesive dialogue that is mutually understood will develop and the “therapist and patient will share a common language with which to communicate about the latter's difficulties” (Fenton, 2000, p. 50).

While these theories provide insight into the importance of coherent narratives, it is important to note that these theories about narrative coherence make universalist claims as to what comprises a healthy narrative. These theories, primarily developed by individuals from the United States and Europe, appear to reflect “a Western emphasis on the value of individuality and the overriding power of the individual” (Onken et al., 2007, p. 11). As a result, these theories do not appear to take into consideration the values that other populations might value as part of a coherent and complex narrative and sense of self, a limitation of this study.

Psychotherapy lends itself naturally to the creation of narrative, which can help clients recover a sense of self, both inwardly and in relation to others (Fenton, 2000; Lysaker & Lysaker, 2002). Narrative therapy has evolved to address the needs of individuals with schizophrenia, and different narrative approaches have recently emerged in the field of psychotherapy with schizophrenia. These emerging frameworks include narrative therapy as developed by Michael White, a focus on personal narrative construction and addressing narrative impoverishment in psychotherapy, and open dialogue, a successful treatment model for schizophrenia in Finland.

Michael White's Narrative Therapy

Narrative therapy focuses on re-authoring problem saturated stories that often dominate individual's lives (White & Epston, 1990). White (1995) writes that these problem stories often define people's identities, as:

Persons come to believe that the problem speaks of their identity – so often problems present persons with what they take to be certain truths about their character, nature, purposes, and so on, and these truths have a totalizing effect on their lives. (p. 22)

Narrative therapy focuses on the creation of a new narrative that explores areas of the client's life that is not dominated by the presenting problem (White & Epston, 1990).

The distressing and difficult symptoms of schizophrenia take over individual's perception of self (Estroff, 1989; White and Epston, 1990). Recognizing this effect of schizophrenia, White (1995) applied narrative therapy to his work, exploring ways that a schizophrenia diagnosis can be an oppressive narrative in an individuals' life (France & Uhlin, 2006). Narrative therapy can help individuals with schizophrenia deconstruct

problematic stories “that hold them hostage to certain life-denying meanings that trap them in a story, forcing them to live with a ‘spoiled identity’, for example by succumbing to schizophrenia” (Roberts, 2000, p. 437).

White (1995) uses narrative techniques to explore individual’s experiences with psychosis. Narrative therapy can help people revise their relationship with auditory hallucinations, or “voices,” and distinguish between voices that are controlling and powerful and those that can be supportive (White, 1995). White explains that the controlling voices are often troublesome because “they succeed in convincing their subjects that they speak with authority, with objective knowledge; that they speak of the truth of their subject’s identity” (White, 1995, p. 130). White explores the client’s relationship to their voices through externalization. Externalization is a technique used in narrative therapy that “encourages persons to objectify, and, at the same time, to personify the problem that they experience as oppressive” (White & Epston, 1990). This technique assumes that the problem is not an intrinsic aspect of the person’s identity, but rather the problem is a separate entity acting upon the person’s life. Through externalization, people can explore and identify with other healthy and successful aspects of their identity that are not dominated by a problematic narrative. Externalization techniques can be used to understand the voices as separate entities from the individual by asking questions such as “What is it that the voices are trying to convince you of at this time? What are they trying to talk you into? How does this fit with their overall plans for your life?” (White, 1995, p. 131-132). These questions are used to distinguish the voices’ goals and purposes and how they fit in with the individual’s expectations for their own life.

Externalizing the symptoms of schizophrenia can also help define an identity separate from the diagnosis (White, 1995). France and Uhlin (2006) noted that culture's dominant narrative of schizophrenia is a stigmatizing perspective that conveys the diagnosis as a chronic and hopeless illness. People "internalize the 'dominant narratives' of our culture, easily believing that they speak the truth of our identities" (Freedman & Combs, 1996, p. 39), and individuals with schizophrenia can find it difficult to develop a more positive and empowered identity during the recovery process. By externalizing the symptoms of schizophrenia, however, and searching for healthier aspects of the self to identify with, the individual can strengthen their sense of agency and hope (White, 1995). Narrative therapy's focus on treatment that addresses both symptom reduction and quality of life issues complements the recovery movement's vision for treatment for individuals with schizophrenia.

Similar to the recovery movement's recognition that medication may not address all of an individual's treatment needs, White (1995) discusses the role of medication in treatment, explaining that:

I have witnessed drugs being used in ways that have a profound effect in opening up the horizons of people's lives, in ways that bring a range of new possibilities for action. And I have also witnessed drugs being used in ways that are primarily for the purposes of social control, in ways that subtract very significantly from people's possibilities for action, in ways that dispose people of choice. (p. 117-118)

Narrative therapy should be used as a way to help the individual understand whether medication enhance or subtract from their quality of life and to help the individual monitor the effects of medication, such as side effects or its influence on the individual and their relationships with others (White, 1995).

This framework of narrative therapy has been criticized as reinforcing individual's psychotic symptoms. Some theories of schizophrenia argue that the voices as already externalized and that, in contrast to narrative therapy's externalization of voices, the "voices of schizophrenia really represent parts of the person that the person needs to integrate" (White, 1995, p. 134). Additionally, a lack of empirical studies brings into questions the efficacy of the treatment and an understanding of what population of people this framework of treatment may benefit. Further research would provide insight into how narrative therapy can benefit individuals with schizophrenia who are struggling with quality of life issues.

Personal Narrative Construction

An emerging framework of psychotherapy uses integrative psychotherapy to address narrative impoverishment and narrative construction during therapy (Lysaker & Lysaker, 2002). Integrative psychotherapy refers to "psychotherapy that assumes that the complexity of human dilemmas is beyond the purview of any single theory" (O'Brien, 2004, as cited in Lysaker et al., 2007, p. 28). Integrative psychotherapy attempts to create a cohesive psychological self, helping fragmented pieces of self narratives merge (Lysaker, Buck, et al., 2007).

This form of narrative construction is based on principles of the dialogical self, which emphasizes that the self is "the product of ongoing conversations both within the individual and between the individual and others" (Lysaker & Lysaker, 2002, p. 209). For individuals without mental illness, the "'normal' self appears not of a single, fixed entity, but rather as a collection of internal dialogues among complementary, competing,

and, at times contradictory positions” (France & Uhlin, 2006, p. 58). A unified sense of self “paradoxically results from interacting aspects of self that do not subsume one another” (Lysaker & Lysaker, 2002, p. 211). Individuals without mental illness are able to fluidly switch between these self-positions, creating a dynamic and coherent narrative (Lysaker & Lysaker, 2002). The disruption to the sense of self that occurs during schizophrenia, however, impedes the ability to incorporate different self-positions, leading to difficulties telling a cohesive narrative (Lysaker & Lysaker, 2002). To address this disruption to the sense of self, the goal of psychotherapy should be to help the client switch between self-positions, creating more complex and evolving narratives (Lysaker & Lysaker, 2002).

Lysaker and Lysaker (2002) and Lysaker and Lysaker (2006a) analyzed case studies of individuals with schizophrenia and theorized that disruptions in the dialogical self leads to the barren, cacophonous, or monological narratives characteristic of many individuals diagnosed with schizophrenia. These narratives, in contrast to the complex and cohesive narratives of individuals without mental illness, are confusing, lack a sense of agency, and overwhelm others. A barren narrative, lacking descriptions of self and others, is conceptualized as having limited numbers of self-positions with difficulty shifting between them (Lysaker & Lysaker, 2006a). As opposed to a barren narrative with limited self-positions, in a cacophonous narrative “a dizzying array of self-positions might be evident, with each self-position speaking without order and/or without reference to each other” (Lysaker & Lysaker, 2006a, p. 60). A monological narrative is characterized by stories and self descriptions dominated by a singular voice and self-position (Lysaker & Lysaker, 2002). In order to generate new narratives, the task of

psychotherapy is to “help clients find and expand the voices of individual self-positions, to notice that individual self-positions exist in relation to one another, and to facilitate the emergence of a fluid order of self-positions” (Lysaker & Lysaker, 2006a).

Changes in narratives, such as increased complexity, references to a sense of agency, and descriptions of self in relation to others, can be measured during integrative psychotherapy (Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003). Lysaker, Wickett, Campbell and Buck (2003) developed the Scale to Assess Narrative Development (STAND). STAND measures changes over time in individual’s narratives that experience psychosis, tracking changes in numbers of references and descriptions of social worth, personal agency, and social alienation (Lysaker, Wickett et al., 2003). By using STAND to examine 16 psychotherapy transcripts from four individuals with a schizophrenia spectrum diagnosis, the study concluded that the STAND is able to measure narrative coherence as well as changes in narratives regarding social worth, personal agency, and social alienation (Lysaker, Wickett et al., 2003).

Lysaker, Lancaster et al. (2003) analyzed psychotherapy transcripts over 14 months from a client with acute symptoms of schizophrenia and Lysaker, Davis et al. (2007) analyzed psychotherapy notes from one client with schizophrenia over the course of 22 months to study narrative changes in psychotherapy. Psychotherapy did not transform the clients’ narratives into “new” narratives or unearth a new sense of self (Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003). Instead, psychotherapy “was linked to improvements over time, first in the capacity to narrate self experience and then in the ability to narrate self-experience more richly” (Lysaker, Davis, et al., 2007, p. 83). Significant changes occurred in the narrative content, as narratives became

richer in “complexity, dynamism, and subtlety” (Lysaker, Lancaster et al., 2003, p. 295). Narratives increasingly mentioned interactions with other people and more complex descriptions of self positions (Lysaker, Lancaster et al., 2003).

Using STAND, Lysaker and Buck (2006) evaluated psychotherapy transcripts over 19 months with a client with schizophrenia, and found consistently increasing scores each month, indicating the efficacy of the narrative building technique. As the STAND scores increased, the client began experiencing improvements in quality of life, showing growing awareness of thought patterns, ability to engage in vocational rehabilitation for the first time, and new observations about hope and goals for the future (Lysaker & Buck, 2006). Higher scores on STAND were also associated with higher levels of psychosocial functioning in a study of 65 people diagnosed with schizophrenia spectrum disorder (Lysaker, Buck et al., 2006).

Additional case studies have demonstrated improvements in quality of life for individuals with schizophrenia who participate in narrative focused psychotherapy. Lysaker, Davis et al. (2007) found that after 22 months of integrative psychotherapy focusing on narrative construction, the client continued to experience infrequent hallucinations and mildly blunted affect after treatment, but improved in psychosocial areas, living independently for the first time and exploring new social relationships. The “growth of self” in therapy was “mutually constructed in a shared narrative about events in the client’s life and the developing therapeutic relationship” (Lysaker, Davis et al., 2007, p. 84). Increased ability to tell coherent narratives can result in higher self esteem and the “capacity to plausibly explain complex life events and to cope actively and adaptively” (Lysaker & Buck, 2006; Lysaker & Hermans, in press; Lysaker, Davis,

Eckert, Strasburger, Hunter, & Buck, 2005 as cited in Lysaker, Buck et al., 2007, p. 29). Additional studies have suggested that narrative coherence has been linked with increased hopefulness for the future and higher interpersonal functioning (Lysaker, Buck et al., 2006).

Personal narrative construction attempts to enrich clients' narratives by increasing references of social worth, relationships with others, and goals for the future (Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003; Lysaker, Wickett et al., 2003). This focus on treating the person, rather than focusing solely on symptom management, aligns with the recovery movement's vision of treatment that engages the whole person. This framework focuses on creating narratives that portray the individual as a protagonist in their life, highlighting aspects of their life that are not defined entirely by schizophrenia, such as social worth, relationships with others, and goals for the future (Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003; Lysaker, Wickett et al., 2003). Empirical studies examining the effects of narrative enrichment in psychotherapy found that as STAND scores increased, so did improvements in areas of quality of life, such as engaging in social relationships, living independently, or participating in vocational rehabilitation programs and expressing hope for the future (Lysaker & Buck, 2006; Lysaker, Buck et al., 2007; Lysaker, Davis et al., 2007). Using the Scale to Assess Narrative Development (STAND), personal narrative construction techniques in psychotherapy were also found to increase references to a sense of agency (Lysaker, Davis et al., 2007; Lysaker, Wickett et al., 2003). These improvements in quality of life are relevant to phases of recovery, including regaining hope, developing a sense of

agency, reaching new potentials in personal functioning, and building social relationships (Jacobson & Greenely, 2001; Young & Ensing, 1999).

Studies have also examined therapeutic techniques that are important to narrative construction during psychotherapy. Lysaker and Buck (2006) reviewed therapy notes over 18 months with a client diagnosed with schizophrenia and identified obstacles in psychotherapy as the therapist's countertransference, difficulties working with the symptoms of psychosis, and client's transference reactions. To understand how to overcome these obstacles, Lysaker and Buck (2006), Lysaker, Buck et.al (2007) and Lysaker and Lysaker (2002) explored characteristics of successful narrative construction in psychotherapy with clients with schizophrenia. The therapist should offer encouragement to the client's construction of narrative, helping the client remember and expand upon the details of his life that he shares in session (Lysaker & Buck, 2006; Lysaker, Buck et al., 2007; Lysaker & Lysaker, 2002). A detailed study of psychotherapy notes from 30 individuals diagnosed with schizophrenia revealed that common therapeutic techniques in narrative construction included acting as a "cognitive prosthesis," helping the client filter material and think abstractly (Lysaker, Buck et al., 2007, p. 33). Therapists must not impose their own views and interpretation of narrative content on the client (Lysaker & Buck, 2006; Lysaker & Lysaker, 2002). These techniques echo the recovery movement's emphasis on the individuality of treatment needs and the need for awareness of power in the clinical relationship, encouraging respect for the client's individual process and ability to determine goals for the future (Carpenter, 2002; Schiff, 2004). Providing a holding environment that helps the client to synthesize his "selves" is a central task to the personal narrative construction, requiring

that the therapist tolerate ambiguity and rigid or loose dialogues so that clients' narratives "not be merely replaced with therapists' own politically or personally motivated monologues" (Lysaker & Lysaker, 2002, p. 216).

This emerging framework of psychotherapy merits further research. Literature on the recovery process from schizophrenia has begun to mention the emerging research on personal narrative construction. Silverstein and Bellack (2008) identified in their study of the recovery process for individuals with schizophrenia that future research on recovery should "examine whether people who achieve improvements in functional status, or a subjective sense of moving towards recovery, are characterized by changes in internal dialogue, sense of agency, and narrative complexity" (p. 1115).

Most of the empirical studies on personal narrative construction are comprised of case studies of men, ranging from 30 to 40 years old (Lysaker & Buck, 2006; Lysaker, Buck et al., 2007; Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003; Lysaker, Wickett et al., 2003). None of the case studies gave information about the participants' racial or ethnic identity. While case studies allow for detailed and in depth analysis, studies with larger sample sizes and more diverse populations are needed to further explore the effectiveness of this framework. Studies with larger sample sizes by Lysaker, Buck et al. (2006), Lysaker, Buck et al. (2007) studied narrative construction in participants who were mostly males in their 40s, the majority of whom were white. The lack of diversity in these studies leads to concerns about the development of definitions of a healthy and complex narrative that are culturally bound, prioritizing values of autonomy and the importance of the individual, and as a result may not recognize aspects of healthy narratives from other cultures. The lack of diverse sample sizes also limits the

ability to generalize the results and apply them to other populations, and studies that explore the experience of women, individuals with different ethnic and racial backgrounds, and individuals from other age groups are needed to further validate and understand this framework.

Open Dialogue

Open dialogue is a model of narrative-based therapy used in Northern Finland for clients diagnosed with schizophrenia. This treatment model primarily focuses on the creation of dialogue during treatment, enabling “the construction of a new language in which to express difficult events in one’s life” (Seikkula, Alakare, & Aaltonen, 2001a, p. 252). Open dialogue is based on principles of social constructionism, the understanding that narratives are socially constructed between people (France & Uhlin, 2006). The goal of open dialogue is for the client to move from “stuck monologues to more deliberating dialogues” (Smith, 1997 as cited in Seikkula et al., 2006, p. 216) between the client and others. This dialogue is created through the shared narratives of the client, the client’s family, and the treatment team (Seikkula et al., 2006).

Due to symptoms such as hallucinations and impaired reality testing, it can be difficult for an individual with schizophrenia to share socially constructed and mutually understood meanings and narratives with others (Holma & Aaltonen, 1998b). The creation of dialogue, however, is a method through which therapists, patients, and families can share and “create new meanings for the patient’s behavior and symptoms” (Haarakangas, Seikkula, Alakare & Aaltonen, 2007, p. 224). The goal of open dialogue is to open a range of explanations that describe experiences with psychosis, leading to a

shared understanding between the client, family, and treatment team (France & Uhlin, 2006).

This narrative approach has a primary focus on the creation of dialogue during treatment. The treatment team, which remains consistent throughout the duration of each client's treatment, provides immediate intervention after a psychotic episode and invites family members and significant people in the client's life to participate in treatment. Open dialogue advocates for flexibility in treatment decisions as well as tolerance of uncertainty during treatment and avoidance of hasty treatment decisions about medication or hospitalization (Haarkangas et al., 2007).

Open dialogue explores the subjective experience of psychosis as a way to achieve mutual understanding between the client and others during treatment. Seikkula et al. (2001a) describe the process of creating mutually understood meanings during treatment, stating:

Whatever their background, it is important to take hallucinations seriously and not to challenge the patient's reality during the crisis situation, especially in the beginning phase of treatment. Instead, the therapist could ask: 'I do not follow how it is possible that you can control other people's thoughts. I have not found myself to be able to do that. Could you tell me more about it?' The other network members in the meetings could then be asked: 'What do you think of this? How do you understand what M is saying?' The purpose of such questioning is to allow different voices to be heard concerning the themes under discussion, including the psychotic experience. If the team manages to generate a deliberating atmosphere allowing different, even contradictory, voices to be heard, the network has the possibility of constructing narratives of restitution or reparation. (p. 252-253)

Holma and Aaltonen (1998b) describe a case study of successful treatment with a 33 year old woman. Initial meetings with the client and her family were difficult, and the client attempted to voice her struggle for a sense of agency in a family that she perceived as oppressive. Mutual understanding could not be created between the client, family, and

treatment team. The treatment team switched to individual meetings with the client in hopes of facilitating a better outcome in treatment. During these meetings, the client read a passage from the Bible before answering questions asked by the treatment team. Despite their initial assumptions of religious meanings and the psychotic nature of the activity, the treatment team attempted to understand the meaning of reading the Bible to the client. Rather than finding religious meaning in reading the Bible as the treatment team originally assumed, the client revealed that reading the Bible “helped her find her unbroken self” (Holma & Aaltonen, 1998b, p. 259). After reaching a mutual understanding of the meaning of reading the Bible with the treatment team, the client began to talk openly in treatment for the first time, relating a story about her ex-boyfriend and how she found the relationship to be oppressive. At the end of the session she described feeling unbroken and asked to stay in the room in order to retain the feeling. In the next therapy session she told this story to her parents for the first time. This narrative was understood and meaningful to the client and family and from this narrative stemmed new narratives that expressed themes of oppression that the family had struggled with but had never been able to communicate before (Holam & Aaltonen, 1998b).

A danger of not being able to organize and share narratives is the creation of a cycle of untold narratives that deepens over time (Holma & Aaltonen, 1998a).

Individuals with schizophrenia and their families “find themselves stuck in this unnarrated experience and try to narrate it without success, at the same time as other subsequent experiences remain unnarrated” (Holma & Aaltonen, 1998a, p. 275). When individuals feel stuck in their current narrative, they are unable to continue to construct further narratives for the future, decreasing their sense of agency (Holma & Aaltonen,

1998a). Breaking out of the cycle is important, as Holma and Aaltonen (1998a) described, because:

By becoming a competent narrator an individual also receives the ability to plan and narrate the future and direct action to the future. The sense of agency arises when you are no longer stuck in the experience. You are able to see yourself more as an active narrator than passive victim of the past. This happens once you have narratively structured the past. This can happen when the team reflectively... offers multiple stories for the construction of experiences. (p. 274)

Literature on open dialogue concluded that creating coherent narratives allows the individual to present oneself as an active protagonist in one's life, rather than as victim of schizophrenia (Holma & Aaltonen, 1998a). A sense of agency helps individuals set goals and plan for the future, an important task in the recovery process (Young & Ensing, 1999).

Therapists are guided by principles of social constructionism and maintaining a "not knowing" stance (Haarkangas et al., 2007) rather than acting as an expert in the therapeutic process. This stance brings the client as an equal partner into the relationship requiring that both client and therapist "search together for meaning, and though the mutual sharing of different experiences and perspectives, they find understanding" (Haarkangas et al., 2007, p. 228; Holma & Aaltonen, 1998b). To help facilitate the construction of mutual meaning in treatment, therapists also act as a reflecting team, creating a setting that encourages equal participation in the dialogue between client and family (Holma & Aaltonen, 1998b). All treatment decisions, such as medication or hospitalization, are transparently discussed by reflective team in front of the client and family in order to "open up a range of alternatives from among which a course of action is chosen" (Seikkula et al., 2001a, p. 253). This aligns with the recovery movement's

vision of treatment that promotes clients' empowerment, self-determination, and assumption of responsibility in treatment (Carpenter, 2002; Schiff, 2004).

Open dialogue attempts to create "nonpathologizing discourse" around the client's symptoms and experiences, as well as "respect for [the client's] personal narratives and definitions of the problem" (Seikkula et al., 2001a, p. 255). Without a personal narrative that describes and explains the experience of schizophrenia, there is a danger that an individual with schizophrenia will only be understood through clinical and "diagnostic stories" (Holma & Aaltonen, 1998b, p. 254). As in the medical model, this leads to the treatment of the symptoms of schizophrenia, rather than focusing on empowering the individual to strengthen a sense of self (Seikkula et al., 2001a).

Seikkula et al. (2001a) explored the importance of language in creating dialogues about the experience of schizophrenia, explaining:

Psychological reality is, in all cases, constructed by using language in a special way. If we opt for the disordering discourse type of diagnosis, we treat the symptoms of the illness, but if, instead, we aim at generating polyphonic dialogues within the social network, we become interested in everyone's voice regarding the problem. We no longer think of a specific illness as the agent, but of a language in which the meaning-making process takes place. (p. 255-256)

Walsh (1995) discussed the effects of psychosis and the loss of mutual symbolism with others that occurs after the onset of schizophrenia. Regaining mutual symbolism and developing a shared understanding with others is part of the recovery process (Walsh, 1995). Similarly, open dialogue is built upon the premise of creating mutually understood dialogues between the client and people in the client's life, regaining a sense of mutual symbolism and a way of understanding the client that is not dominated by diagnoses or symptoms of schizophrenia (Seikkula et al., 2006). The recovery movement

criticizes the medical model for focusing solely on the client's diagnosis and symptoms and failing to "recognize or engage the whole person" (Carpenter, 2002, p. 87) during treatment. Open dialogue's focus on respecting the client's experience of schizophrenia and understanding the person behind the diagnosis aligns with the recovery movement's vision of humanistic and empowering treatment (Carpenter, 2002; Young & Ensing, 1999).

Open dialogue has been shown to be an effective form of treatment for individuals with schizophrenia. A study examining the effectiveness of open dialogue with individuals experiencing first-time psychosis found that "after 2 years of treatment, 83% had returned to their jobs or studies or were seeking employment, and 77% had no remaining psychotic symptoms. In some cases, problems emerged with 21% having at least one relapse" (Seikkula et al., 2000; Seikkula, 2002 as cited in Haarkangas et al, 2007, p. 222-223). Seikkula, Alakare and Aaltonen (2001b) studied good and poor outcomes in a two year follow of 78 patients diagnosed with schizophrenia. Sixty-one of these patients fell into the good outcome category, meaning that they were "working, studying, or job-seeking with not more than mild residual psychotic symptoms" (Seikkula et al., 2001b, p. 274). The remaining 17 patients were classified as having poor outcomes, continuing to experience moderate or severe psychotic symptoms and lower levels of functioning in daily life (Seikkula et al., 2001b). The study found that individuals with a lower quality social network before the onset of schizophrenia were more likely to be in the poor outcome group (Seikkula et al., 2001b).

Conclusion

A focus on narrative creation, whether through narrative therapy, the enrichment of content and form in personal narratives, or the co-construction of dialogue, is an emerging framework for psychotherapy that addresses many of the quality of life issues individuals with schizophrenia face when dealing with the effects of the illness.

Narrative therapy, personal narrative construction, and open dialogue focus on developing a sense of agency, regaining connection with family, friends, and others in the community, and defining a sense of self separate from the diagnosis of schizophrenia.

All three frameworks of narrative therapy, however, require further research to understand how they can be effectively implemented. While these narrative therapy approaches are based on principles of co-constructionism and collaboration between client and therapist, the frameworks themselves are based upon pre-determined ideas of healthy narratives and have been developed by largely homogenous participant populations and researchers. These set ideals limit the co-construction between client and therapist during treatment. While narrative therapy explicitly discusses the need for client self-determination and the therapist's awareness of power in the relationship, these frameworks still operate from a set of pre-determined ideals that allows the therapist to determine what comprises a coherent and healthy narrative, and what does not. Despite these limitations, these approaches show potential as effective psychotherapy frameworks that align with phases of the recovery process, providing insight into ways that narrative therapy has possibilities to provide a framework for recovery-oriented services for individuals with schizophrenia.

CHAPTER V

DISCUSSION

The purpose of this theoretical research has been to explore three emerging approaches to narrative therapy and their potential to serve as a framework for recovery-oriented psychotherapy for individuals with schizophrenia. This chapter will summarize the ideas explored in the previous chapters as well as discuss limitations of this study and recommendations for further research. Finally, this chapter will also discuss implications of this research for the field of social work.

Summary

Chapter II examined the history and role of psychotherapy in treatment for schizophrenia. Psychotherapy is a beneficial form of treatment for schizophrenia as it can address quality of life issues, increase medication compliance, and decrease the overall cost of treatment (Fenton, 2000; France & Uhlin, 2006; Gottdiener & Haslam, 2002; Lysaker, Lancaster et al., 2003). Despite these advantages, the efficacy of psychotherapy as treatment for schizophrenia has been debated since the development of anti-psychotics in the 1950s, leading to an increasingly medicalized model of treatment. Medication has been a beneficial and necessary form of treatment for many individuals with schizophrenia, offering relief for positive and negative symptoms, such as delusions, hallucinations, and disturbance in behavior and affect. While medication may help manage these acute symptoms, it does not always address the social and emotional

difficulties that individuals with schizophrenia struggle with after their other symptoms subside. Berzoff et al. (2002) explains the risk on relying exclusively on the medical model when providing treatment to individuals with schizophrenia, noting that:

By understanding the disorder in solely neurobiological and genetic terms, the medical model has at times minimized psychosocial factors and rationalized assigning clients with schizophrenia to episodic 15-minute medication appointments while discontinuing other psychotherapeutic interventions. This often leads to the treatment of symptoms, and *not* the person with the symptoms. For many of the clients with schizophrenia, isolation and loneliness are all too often constant by-products of their illness. Psychotherapy may not cure them; it does, however, offer a relationship in which their daily struggle is recognized and shared, and in which they can feel valued, safe, and understood. Along with medication, a therapeutic relationship can provide them with an opportunity to regain some mastery over their lives and to reduce their sense of alienation from others. (p. 281)

Psychotherapy can also be an important component of treatment for schizophrenia as individuals may discover, paradoxically, that as their acute symptoms decrease, their awareness of other effects of schizophrenia, such as social isolation, disturbance of a sense of self, and a lack of hope for the future, increases (Lysaker, Lancaster et al., 2003). A growing awareness that medication does not always address the social and emotional struggles of individuals with schizophrenia has led to an increased interest in exploring psychotherapy as a form of treatment for schizophrenia to address these needs (France & Uhlin, 2006; Silver & Larsen, 2003; Walsh, 1995).

Chapter III explored the history of the mental health recovery movement and its influence on treatment for schizophrenia. The recovery movement criticizes the medical model for focusing solely on the client's diagnosis and symptoms and failing to "recognize or engage the whole person" (Carpenter, 2002, p. 87) during treatment. The recovery movement, with its roots in the voices of consumer-survivors of the mental

health system, defines recovery as the process of managing the symptoms of mental illness while leading a personally meaningful life (Roe & Davidson, 2008). For individuals with schizophrenia, recovery is generally understood as managing acute symptoms, developing social relationships, and achieving personal goals (Farden et al., 2008). Prominent themes found in the literature about the recovery process included developing agency in one's life, rebuilding a sense of self, cultivating hope, and sustaining social support (Young & Ensing, 1999).

The goals of the recovery movement have been introduced into national mental health policies such as the *Surgeon General's Report on Mental Health* (1999) and the President's New Freedom and Commission on Mental Health (2003), which call for mental health systems to be guided by the recovery paradigm. Psychotherapists such as Sullivan (1962), Estroff (1989), Walsh (1995) and Yip (2004) describe experiences providing psychotherapy to clients in recovery from schizophrenia and offer recommendations for psychotherapy that facilitates this process. These recommendations are humanistic and client centered. The suggestions of both the national mental health policies and psychotherapists working with clients with schizophrenia, however, are vague and lack clear guidelines to inform other psychotherapists working with this population. As the recovery vision gains prominence in the mental health system, further research on services and psychotherapy approaches that promote recovery is needed to guide mental health policy and practice (Ridgway, 2001).

Chapter IV discussed emerging approaches of narrative therapy with individuals with schizophrenia. Three approaches of narrative therapy with individuals with schizophrenia were introduced: Michael White's narrative therapy, personal narrative

construction, and the open dialogue model of treatment for schizophrenia. White's narrative therapy focused on re-authoring stories, exploring areas of the client's life that are not dominated by symptoms and stigma of schizophrenia, and externalizing symptoms of schizophrenia in order to develop a sense of self separate from the diagnosis.

Personal narrative construction seeks to enrich the impoverished narratives that are characteristic of individuals with schizophrenia. The goal of this narrative approach is to create more complex and coherent narratives with references to self-agency, descriptions of self in relation to others, and hope for the future. Studies on personal narrative construction found that as narrative complexity increased, references to improvements in quality of life, such as re-engagement with social relationships, observations about agency and hope for the future, awareness of thought patterns, and levels of psychosocial functioning also increased (Lysaker & Buck, 2006; Lysaker, Buck et al., 2006; Lysaker, Davis et al., 2007).

Open dialogue focuses on creating mutually understood dialogues during treatment, allowing the client successfully narrate their lives and experiences with schizophrenia in ways that are meaningful to themselves and to others involved in the treatment process. Holma and Aaltonen (1998a) describe the importance of breaking free from stuck narratives in order to directly plan for the future and increase a sense of self-agency. This narrative approach also emphasizes the importance of client-centered treatment that respects the individual needs and struggles of each person, and helping clients define a sense of self separate from a schizophrenia diagnosis.

As discussed in Chapter IV, the goals of these narrative approaches align with many of the goals of the recovery movement. Developing a sense of agency is a goal in narrative therapy with clients with schizophrenia (Holma & Aaltonen, 1997; Lysaker, Wickett et al., 2003; White, 1995) and understood as a valuable source of improvement in the recovery process (Young & Ensing, 1999). The importance of agency is discussed by Lysaker, Wickett, Wilke and Lancaster (2003), who ask:

Without a story about one's condition, or a story of oneself as suffering from, or living with schizophrenia, how, for example, could someone converse about his or her condition, elicit support, or develop realistic goals? Because personal narratives are so integral to effective agency, their disruption in schizophrenia has come to be regarded as a factor that affects recovery and may be a focal point for psychotherapy and rehabilitation. (p. 154)

The narrative therapy approaches and literature on the recovery process both focus on the importance of providing treatment that addresses the acute symptoms of schizophrenia as well as the social and emotional needs of an individual with schizophrenia (Estroff, 1989; Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003; Roe and Davidson, 2008; Seikkula et al., 2006; Silver & Larsen, 2003; Walsh, 1995; White, 1995; Yip, 2004; Young & Ensing, 1999). Literature on the recovery process also describes the importance of developing a sense of self apart from the mental health diagnosis (Bradshaw et al., 2007; Davidson & Strauss, 1992; Estroff, 1989; Jacobson & Greenely, 2001; Onken et al., 2007). The symptoms and stigma of schizophrenia challenge an individual's sense of self; at times the diagnosis engulfs the individual's identity (Estroff, 1989; Silver & Larsen, 2003). Narrative therapy approaches also seek to empower the individual to identify with aspects of their self that are not defined by schizophrenia (Lysaker, Davis et al., 2007; Lysaker, Lancaster et al., 2003; White, 1995).

The narrative therapy approaches explored in Chapter IV have potential to inform and guide psychotherapy with individuals with schizophrenia. While each take a modified approach to creating narratives during psychotherapy, all three approaches are based on creating coherent narratives that empower the individual by increasing a sense of self separate from the illness and a sense of self agency, both of which are essential steps in the recovery process. These narrative approaches attempt to treat the individual behind the symptoms, creating narratives that allow the individual to identify and express healthy aspects of their self and move forward towards recovery.

This theoretical research is limited by its need for further empirical studies to expand and validate the theories explored. While these narrative approaches show promise in recovery-oriented treatment of schizophrenia, further research on all three approaches is needed. All three approaches require studies with more diverse participant groups in order to examine universalist claims on the components of healthy narratives and ways that definitions of healthy narratives are culturally bound. Additionally, since these narrative approaches have been studied and developed by the same researchers, additional studies are needed by a more diverse group of researchers to allow for new perspectives and critiques.

Implications for Social Work

The National Association of Social Worker's (NASW) *Code of Ethics* embodies many of the core values of the recovery movement, such as a strengths-based perspective, "consumer empowerment, self-determination, work of the individual, and concern for the environmental role in personal experience" (Carpenter, 2002, p. 90). Although the

recovery movement is gaining prominence in the mental health system, treatment for schizophrenia remains dominated by the medical model. Social workers operate within this mental health system, yet have the opportunity to “adopt a professional stance, that, true to the values of the profession, advances client empowerment and celebrates the individual” (Carpenter, 2002, p. 87). Incorporating the values of the recovery movement into clinical practice has also been difficult due to the prominence of the medical model as well as the lack of training for social workers to guide them in providing psychotherapy to individuals with schizophrenia (Torrey, 2001).

Narrative therapy approaches, however, provide a framework that can guide social workers in recovery-oriented clinical practice. Social workers can advocate for mental health policies that support recovery-oriented treatment. These mental health policies can encourage the development of services that recognize that schizophrenia is not always a chronically debilitating illness, as “these prognoses leave little room for hope on the part of those labeled with mental illness and, as such, may become a self fulfilling prophecy” (Carpenter, 2002, p. 88). Social work education should promote awareness about the recovery movement and mental illness, as well as incorporate understanding the possibilities for recovery from schizophrenia (Carpenter, 2002). Social work education should also continue to explore the role of psychotherapy as treatment for individuals with schizophrenia and understand how clinicians can use frameworks, such as narrative therapy, to inform and enrich their practice with individuals with schizophrenia.

Recovery from schizophrenia is an individualized journey, and each person may chose a different path in treatment, whether it is psychotherapy, medication, other

psychosocial interventions, or a combination of these services. Social workers should respect the client's self-determination in treatment and the individual process of recovery. For some individuals with schizophrenia, narrative therapy may be an effective form of treatment, allowing them to "seek an enriched story of themselves in order to better understand what their life, amidst their illness, can become" (Lysaker & Buck, 2006, p. 234). Narrative transformation in psychotherapy shows promise in helping individuals with schizophrenia express thoughts and emotions about their lives, develop agency and hope for the future, and maintain social connections with others, offering a framework that can reflect the goals and vision of the recovery movement and guide mental health practice.

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