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## **An Analysis of A Narrative Therapy Group Work Model for Psychosis**

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An Analysis of A Narrative Therapy Group Work Model for Psychosis

by

Abby J. Newberg, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## Abstract

The purpose of this research project was to explore how individuals with psychosis and schizophrenia benefit through participation in a narrative group therapy intervention. Current treatment options for individuals with psychosis and schizophrenia are focused on anti-psychotic medication as a first response to treatment, which has significant negative side-effects for some. Along with medication, a belief exists that individuals with psychosis and schizophrenia lack insight, placing even further dependence on medications and deterring a focus on insight-based therapies. The use of insight-based narrative therapies for individuals with psychosis within a group format is under-researched and lacks discussion in the literature. This qualitative study implemented a secondary data analysis of data collected between November, 2014 and October, 2015 from a current narrative therapy group work program for individuals with psychosis. Using grounded theory, the following two themes were identified: *connection* and *barriers to wellness*, each of which had multiple subthemes. The findings of this study show group process as an effective form of intervention, resulting in cohesion, catharsis, and insight. The results of this study demonstrate that individuals with psychosis are able to participate in insight-based narrative therapy and benefit from a group format. Implications for clinical practice and future research are also discussed.

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# An Analysis of A Narrative Therapy Group Work Model for Psychosis

## **Introduction**

Individuals with schizophrenia and psychosis face many difficulties that affect not only their everyday lives, but also those around them. Schizophrenia and psychosis are devastating and difficult to treat effectively. Although treatment interventions have been both developed and adapted to treat individuals who have experienced psychosis, barriers to understanding their experiences and illness, lack of complete support networks, inadequate standard of care (Carey, 2015), and stigma still remain.

At any given time, an estimated 1.1% of Americans have an active diagnosis of schizophrenia (National Institute of Mental Health [NIMH], 2015). According to the National Alliance on Mental Health (NAMI), 3% of all people will have an incident of psychosis during their lifetime (NAMI, 2016). However, because schizophrenia is an illness that affects not only the individual, but also those connected to the individual, over 2.4 million Americans are being directly impacted by schizophrenia (Treatment Advocacy Center, 2015). Not only are individuals diagnosed and impacted, but outcomes can be grim, with an estimated 40% of individuals with schizophrenia going untreated (Treatment Advocacy Center, 2015). Individuals with schizophrenia are also at high risk of suicide at 10% (Rosenberg, 2009) with an estimated one-third of individuals diagnosed with schizophrenia attempting suicide and one in ten completing suicide (Andreasen & Black, 2014). Schizophrenia is “of unknown etiology. It is a life-long, incurable, chronic disorder with acute intermittent episodes” (McEwens, 1999, p. 3) that are devastating not only the individual, but also to families, communities, and society at large.



Individuals with schizophrenia and psychosis-related disorders in comparison to other mental health disorders are less likely to seek treatment, especially during their first psychotic episode (Treatment Advocacy Center, 2015). Due to the lack of treatment-seeking behavior from this population, they are more likely to experience more symptoms for longer, going without treatment and experiencing other negative effects in their lives (Treatment Advocacy Center, 2015). Few, if any, treatment options –including the use of anti-psychotic medications – have been deemed fully successful in treating schizophrenia and other psychosis-related disorders (Carey, 2015). This is connected to the view of the disorder itself as incurable and lifelong (National Institute of Mental Health [NIMH], 2015), practitioners’ reliance on medications which does not guarantee successful treatment (Lecomte & Lecomte, 2002), and limited treatment modalities – usually first line medication and psycho-education, which can be effective in decreasing symptomology in individuals with schizophrenia (France & Uhlin, 2006; Haddock et al., 1998) but are not intended to process the impact of the psychotic symptom experience itself.

Current treatment approaches for schizophrenia and psychosis-related disorders implement antipsychotics as a first line of defense; however, clinical management of the disease requires more intervention to work towards recovery and improved daily living (Andreasen & Black, 2014). Support systems that move beyond anti-psychotic medications may involve social skills training, day treatment programs, and other psychosocial rehabilitative and intervention techniques (Andreasen & Black, 2014). The International Schizophrenia Foundation (ISF, 2014) recommends psychotherapy be used in tandem with medication; the NIMH (2015) also identifies medication as important for treatment but recommends additional treatment beyond medication.

A common form of psychotherapy used in treating schizophrenia is cognitive-behavioral therapy (CBT), which focuses on reduction of symptoms and behavior in relation to the disorder (Haddock et al., 1998). This is one type of insight-based therapy used with individuals with psychosis and schizophrenia. However, despite recommendations for psychotherapy, individuals with schizophrenia and psychosis are often seen as poor candidates for psychotherapy due to the perception that they are unable to engage in insight or self-reflection practices (Bachmann, Mundt, & Resch, 2003; Lysaker et al., 2013). Therefore, common treatment approaches are not insight-based and are usually within an individual and educational format. An innovative new approach to treatment is group therapy using a narrative approach, which utilized insight-based therapy.

Romness Rosenberg (2007) used narrative therapy approaches in group work as a method to measure group process with adults experiencing mental illness within an outpatient setting. The study found that group process could be measured as an effective form of treatment via themes of cohesion, catharsis, and insight which emerged in group member surveyed responses. Cohesion was identified as “a sense of acceptance, belonging, and value in group membership” (p. 26) Catharsis was described as “feeling and/or opinion of feelings disclosed in the group process” (p. 27). Insight was classified as, “new perceptions of self and/or others” (p. 27).

These findings from Romness Rosenberg’s 2007 study were used to create a specific narrative therapy group work model called SONGS to treat individuals who had experienced psychosis (Romness, 2015). Data was collected by Romness in the Voices of Strength Project (2015) with general findings on benefits of these treatment approaches for this population. Outside of this project, very little has been studied on insight based group

therapy treatment approaches for persons with schizophrenia and psychosis-related disorders (Romness, 2015).

### **Statement of the Study**

This secondary data analysis reviews a new innovative group therapy model called SONGS (Romness, 2015) as an insight-based narrative group therapy treatment approach for the treatment of schizophrenia and psychosis-related disorders. The possible effectiveness of group therapy using narrative approaches for people experiencing psychosis and schizophrenia holds profound implications for the field of clinical social work.

## **Literature Review**

In the following literature review, definitions, and empirical studies relevant to working with individuals with psychosis and schizophrenia from a narrative therapy perspective within a group work context will be presented. First, a history of diagnoses and treatment practices and a synthesis of current literature on schizophrenia and other psychosis-related disorders will be addressed. Second, group work and group psychotherapy will be addressed specifically related to treatment of psychosis and schizophrenia. Third, narrative therapy will be discussed in terms of terminology, practices, interventions and empirical studies. By reviewing these areas, the aim is to draw connections in order to show that narrative group therapy holds potential as an effective treatment practice for individuals with psychosis and schizophrenia.

### **Psychosis-related Disorders and Schizophrenia**

There are multiple factors involved with the complex disorders of schizophrenia and psychosis. The source or origin of schizophrenia is tied to genetics, social environment, and biological brain functioning and chemicals, which manifests in early adulthood (Andreasen & Black, 2011). The worldwide percentage of the population affected is .5-1%; this does not include individuals who will be affected through relationships or society at large being affected by the disorder (Walker, Kestler, Bollini, & Hochman, 2004). Symptoms can be organized into groups of related symptoms. For schizophrenia this includes three dimensions: psychoticism, disorganization, and negative symptoms (Andreasen & Black, 2014, p. 135). Another foundation of schizophrenia is that individuals “lack insight” (p. 139). Insight in schizophrenia is measured and identified corresponding to five dimensions which include awareness: of one’s mental disorder, the social consequences, need for treatment, and

awareness and attribution of symptoms of the disorder (Dobson, Mintz, & Romney, 2003). Symptoms range within the schizophrenia spectrum identified by the Diagnostic Statistical Manual, 5<sup>th</sup> Edition (2013), but are categorized into negative and positive symptoms. These symptoms include “hallucinations, delusions, altered emotions, withdrawal, lack of motivation, disorganization and cognitive symptoms” (We Live With Schizophrenia, 2014). From these symptoms, sub-types of schizophrenia are identified given the presence, absence, and prevalence of the symptoms.

**Treatment history and success.** Pharmacology is the most prevalent and often initial form of treatment for schizophrenia (France et al., 2006; Haddock et al., 1998), but is only one aspect of treatment for individuals. Although medications are vital for some, side effects can be extensive, thus other forms of support and psychosocial treatment are essential (Carey, 2015; NIMH, 2015). A common form of psychotherapy for treating schizophrenia and psychosis is cognitive-behavioral therapy (CBT; Owen, Sellwood, Kan, Murray & Sarsam, 2015). Studies have shown that individuals who are medication resistant may experience better outcomes using CBT intervention in tandem with medication, such as symptom reduction, lower relapse rates and less readmission (Bechdolf et al., 2004). France et al. (2006) also recommended treatments such as dialectic behavioral therapy, interpersonal therapy, family focused therapy, and psychodynamic therapy, but did not identify narrative therapy as a form of insight-based treatment. Little research on narrative therapy in group work for individuals with psychosis and schizophrenia is reflected in the literature.

### **Group Work and Group Psychotherapy**

Group work originated in the United States from the social work case work charity house movement in the 1800s (Horton & Toseland, 2013). The social involvement of group

work spread into the field of therapy during the 50s and 60s to work with children in “guidance clinics and inpatient and outpatient mental health settings” (p. 1). Group psychotherapy grew out of this development of group work in therapy.

One of the most world renowned and influential contributors to the foundation of group psychotherapy is Dr. Irvin Yalom. Yalom (1995) identified group psychotherapy as a “diverse,” “adaptable,” “changing,” and “theoretically emerging” practice with settings for individuals experiencing many different problems (p. xi). Yalom has researched the ever changing nature of group psychotherapy and the theoretical technical styles that have emerged within the field. The theory and practice of group psychotherapy can be summarized using Yalom’s 12 therapeutic factors, instillation of hope, universality, imparting information, altruism, self-understanding, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom, 2005, pp. 1-2). Three of these 12 therapeutic factors—catharsis, insight (self-understanding), and cohesiveness—will be discussed more extensively in this paper.

There are a limited number of studies that link group treatment with the population of individuals with psychosis and schizophrenia. Some studies focus on interventions such as psychoeducation or cognitive behavioral therapy within the group format with individuals with schizophrenia or psychosis.

**Empirical study of group treatment of psychosis/schizophrenia.** Bechdolf et al. (2004) conducted a randomized comparison group with inpatient adults ( $n = 88$ ) meeting the criteria for an episode of schizophrenia or related disorder. The study compared the efficacy of group cognitive behavioral therapy with group patient psycho-education, exploring

differences with regards to re-hospitalization, relapse, symptom reduction, and medication compliance rates. Results from this study indicated no significant differences in efficacy between the two groups; however, patients in the CBT group had slightly better outcomes than patients who only received psycho-education.

These results are relevant to the current study in that group therapy was found to be effective in treating individuals with schizophrenia, showing the value of and improvement from participating in group interventions. The study looked at individuals with schizophrenia in groups but is limited in that it did not look at narrative approaches or insight-based therapy. One form of insight-based intervention that can be used with individuals with schizophrenia and psychosis is narrative therapy.

### **Narrative Therapy**

According to the Dulwich Centre (2016), narrative therapy approaches place people as the experts in their own lives and view problems as separate from people. “Narrative approaches assume that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives” (Morgan, 2000, p. 1). In narrative therapy, a storyteller identifies and describes a problem, attributes meaning to the problem, and then works to re-author and develop stories that fit the life they want to live.

**Principles of narrative therapy.** Narrative therapy involves the use of a story or narrative as a means to create change and opportunities for growth. A *story* is “events, linked in sequence, across time, according to a plot,” (Morgan, 2000, p. 5). Stillman (2010) identified this concept as a *narrative*, containing the same four components. The first principle of Narrative Therapy is *externalization* or *externalizing the problem* and can be

conceptualized as separating a person's identity from the problem (Morgan, 2000).

Externalization is a way of speaking about the problem in a way that works best for the storyteller, so as to open up room to explore the problem further. Specific concepts that arise when externalizing a problem in Narrative Therapy include the discovery of the dominant and alternative story lines.

The concept of the *dominant plot/story* in telling a story, is an event that is recalled and has been chosen as having importance over other events. Morgan (2000) described the *dominant plot* as “events selected out and privileged over other events” (pp. 6-7). Stillman (2010) also clarifies this concept stating: “When a person is experiencing problems, it is often the more challenging stories that are remembered and become the dominant plot (often referred to as the problem story)” (p. 3). Michael White (1995), one of the co-founders of narrative therapy, wrote that the dominant shapes both the future and the present, noting that “stories actually shape our lives, constitute our lives and that they ‘embrace’ our lives” (p. 14). The concept of the *alternative story* or *alternative narrative* is a counter-plot and non-problematic story (Morgan, 2000, pp. 69-70). Alternative stories intend to “reduce the influences of the problem” and “create new possibilities for living” (p. 14).

Second, asking questions from the unknown position is another important principle in Narrative Therapy. Stillman (2010) discusses the “influential position” of the therapist and identifies that, “the therapist does this from a de-centered position of keeping the person's story centered and not having a particular agenda or pre-set direction or destination” versus from a centered position, which is common in “traditional training” (p. 9-10).



Third, outsider witnessing is a key principle in narrative therapy, especially within group work. Often times the outsider-witness “retells” or “recounts” what they witnessed in terms of what spoke to them and stood out (White, 2011, p. 129). Michael White writes,

“it is the task of outsider-witnesses to embody their interest in the person’s life by speaking to their understanding of why they were drawn to the expressions that they are re-presenting in their retellings – by speaking to the resonances that these expressions set off in their personal histories” (p. 129-130).

The outsider witnesses participate in the stories in multiple ways. Stillman (2010) notes that no story can exist without being touched by another person. Stillman writes about this influence saying, “First, they can help recover alternative stories and second, they can support the alternative story development into preferred stories” (p. 4). The outsider witness plays an important role in the creation of the preferred narratives for the storyteller(s) in that, “if our preferred story of who we are remains only a conversation in our own heads, it will not have the sense of being ‘real’. This sense of ‘realness’ or ‘authenticity’ only comes when our preferred stories are witnessed and responded to by a significant audience” (Carey & Russell, 2004, p. 67).

Lastly, the principle of preferred narratives or re-authoring of stories in Narrative Therapy are described by Michael White (2011) as being,

“not just about drawing out the alternative stories of people’s lives, but also provide an opportunity for people to participate in the rich description of some of the skills of living and knowledge’s of life that are associated with the alternative stories of their lives and their identities” (p. 9).

The preferred narrative is something which is developed over the process of the narrative and as it is being created and molded, “people reconnect with values, hopes, dreams, and experiences in life that support them” instead of being problematic (Stillman, 2010, p. 19).

**Tools used in narrative therapy.** Many different tools are used in narrative therapy, to help tell a story and re-author/create the preferred narrative. The use of symbols, metaphors, and the whiteboard, assist in mapping a story. After techniques and approaches are addressed, empirical studies will be reviewed.

One important tool used in narrative therapy is the use of the metaphor and symbol. When used as a tool, in narrative therapy it is key that the metaphor is created by the storyteller(s) versus being given by the therapist or facilitator (Romness Rosenberg, p.8). The use of symbols and metaphors is explained by Stillman (2010) as “useful because it provides possible meaning, which leaves recipients with a way to relate to the information and bring it into their lives” (p. xv). August-Scott and Brown (2007) noted that the *narrative metaphor*, “conveys the idea that stories organize, structure, and give meaning to events in our lives and help us make sense of our experiences,” (p. ix). The metaphor is not a form of representationalism but is in fact interwoven with the stories that shape our lives. White (1995) argued that “stories provide the frame that makes it possible for us to interpret our experience, and these acts of interpretation are achievements that we take an active part in” (p. 15). Other tools in narrative therapy may assist in externalizing the problem by drawing images or metaphors on a whiteboard (Romness, 2015).

Now that techniques and approaches of narrative therapy have been touched upon, some empirical studies in literature and research that focus on narrative therapy and groups together will be addressed. Given that this secondary data analysis focuses on group narrative

therapy, articles that focused on groups and narrative therapy were given importance over literature that solely addressed narrative therapy.

Literature on narrative therapy group work focuses on an array of issues. Some available research suggests that group work and narrative therapy combined is a helpful and beneficial treatment (Bechdolf, 2004; Owen et al., 2015) however, these studies do not specifically address the given population of individuals experiencing psychosis and schizophrenia. There is a need for more literature and research when it comes to studying the impact of group narrative therapy on individuals experiencing psychosis and schizophrenia (Vassalo, 1998).

**Empirical studies of group narrative therapy.** In one study, Poole, Gardner, Flower, and Cooper (2009) conducted a qualitative study with older adults experiencing chemical dependency and mental health issues. The study focused on what participants with mental health and chemical misuse histories found to be helpful in narrative group work, using a narrative therapy group for older adults ( $n = 12$ ). Measuring what group members found to be helpful, the study's methodology focused on detailed research field notes and interview transcripts, which were analyzed twice using a constructivist and grounded theory approach. The study indicated that participants found the narrative group to be more helpful than individual intervention and identified the narrative principle of externalization to be beneficial to treatment. In light of the findings that narrative therapy in group work was found to be beneficial for older adults with chemical dependency, the study recommends further research be conducted and that group workers integrate narrative therapy into work with older adults with chemical dependency. Poole and colleagues results are relevant to the

current study in that narrative group therapy was found to be effective with adult populations, showing benefits of narrative therapy in a group format.

In another study, Looyeh, Kamali, and Shafieian (2012) conducted research that explored the use of narrative therapy as a treatment for improving school behavior in young girls diagnosed with attention deficit hyperactivity disorder (ADHD). In their study they noted that the use of narrative therapy had not been fully explored or researched in that area (Looyeh, Kamali, & Shafieian, 2012). The study explored the effectiveness of narrative therapy in a group work format with two treatment groups ( $n = 3$  and  $n = 4$ ) and a wait-list control group ( $n = 7$ ). Intervention groups used six group activities related and narrative therapy techniques such as externalization using pre- and post-tests using the Child Symptom Inventory - 4 (CSI-4) behavior ratings from teachers and parents. Ratings from the two treatment groups were compared with the wait-list group. Results indicated a significant decline in symptoms for participants in the treatment groups, including 30 days after treatment had ended. The wait-list group showed no significant change. In this study, narrative therapy was a significant strategy for improving school behavior in young girls with ADHD. Looyah, Kamali, and Shafieian's results are relevant to the current study in that the study shows group narrative therapy as a form of therapy is effective and helpful (2012).

In yet another study, Uribe (2012) conducted a narrative therapy group with women who have experienced trauma and sexual violence in the nation of Colombia. . The study explored collective narrative practice through a case study and with a small group of women whose specific size was not noted. Uribe provided an example of narrative therapy done collectively and argued that narrative therapy within a group provides effective and helpful benefits to the participants in the study. Again, similar to what other research noted,

recommendation for further work, especially with the population of sexual violence and victims of torture is called for, using narrative therapy as a basis. However, despite a call for more research in this area, results from Uribe are relevant in that it shows another successfully integrated group of individuals not previously aware of narrative therapy, benefiting from a narrative therapy group.

While the group work studies previously mentioned focus on several different problem areas resulting in benefits of group work and narrative therapy, there is little research on narrative therapy in groups for treatment of psychosis and schizophrenia (Vassalo, 1998).

Hill (2011) conducted a case illustration study using a single-session narrative group intervention with adults in a partial hospitalization program treating mental health and substance abuse related problems. Schizophrenia was a common diagnosis of individuals in this study. The study looked at two single-session narrative groups utilizing narrative practices such as externalization, re-authoring, and alternative story development, as well as White and Epston's (1990) approaches of relative influence questioning and mapping the influence of the problem. Case illustration from sessions was used as a measurement tool. Results from this study indicated that group members identified narrative group work as a helpful intervention, showing insight in their responses noting feeling higher self esteem and hope regarding recovery in their lives. Outcomes from this study are relevant to the current secondary data analysis because narrative intervention within a group work setting was found to be beneficial for individuals, some suffering from schizophrenia. The study also revealed that the individuals diagnosed with schizophrenia or related disorders were able to reflect and

show insight into the effects of their illness and differences that they experienced during the study.

Vassalo (1998) conducted a mixed methods group with individuals with a history of psychosis using narrative therapy approaches with other recovery therapies. The study looked at the notion of recovery in a group work model implementing narrative approaches. The population studied included individuals with severe and persistent mental illness ( $n = 9$ ), a high percentage of whom were individuals with schizophrenia and episodes of psychosis. The study measured eight sessions of narrative approaches using specific techniques and models and used reflections from group members as a means of measurement. Although the study did not claim validity in the evaluation, findings from this group case study offered promise and encouragement to continue narrative forms of treatment in groups. In light of the findings that group members found the group to be helpful and beneficial, the study recommends further groups and research to be conducted. The results of Vassalo's findings are relevant to this research as individuals with psychosis were successfully involved and promoted benefits of a group narrative approach format.

The foundation of the SONGS (Romness, 2015) narrative therapy group work model used in this secondary data analysis, stemmed from Romness Rosenberg's (2007) original research on effectiveness of narrative therapy in group work for adults in an outpatient mental health setting. Romness Rosenberg's (2007) results found three themes (cohesion, catharsis and insight) in the data that indicated effectiveness of narrative therapy in groups. Group protocol, steps of intervention and a specific example of narrative group therapy with expressive art modalities was incorporated into the study. Romness Rosenberg's (2007) research included four current therapy groups using narrative therapy approaches in group

work. There were a total of 25 participants but only 18 voluntarily participated in the study ( $n = 18$ ). Using Curative Climate Instrument (CCI), a semi-structured questionnaire was designed and completed anonymously by participants. Results found benefits of narrative therapy in group work through evidence of therapeutic factors including cohesion, catharsis and insight noted in participants responses. Eighty-eight percent of respondents indicated cohesion, 94 percent demonstrated responses of catharsis, and 94 percent expressed insight.

It is relevant to note that data analysis included the primary investigator's search for the above themes in addition to an independent reviewer's analysis, yielding similar results which demonstrated inner-rater reliability and supported the literature on cohesion, catharsis and insight as a valid measure of group process. Romness Rosenberg's (2007) research led to the development of the narrative therapy group work model SONGS and the Voices of Strength project (Romness, 2015) which focused on narrative therapy in group work for people experiencing psychosis.

### **Research Question**

This secondary data analysis is designed to answer the following research question:  
How do individuals with psychosis and schizophrenia benefit through participation in a narrative group therapy intervention?

## Conceptual Framework

This research study was guided by the theory and lens of constructivism found in poststructuralism, which is closely tied to practice and principles of narrative therapy. The experiences for individuals with psychosis may appear to be beyond reality, but their experience creates reality for them. Constructivism values each individual's reality and sees it as legitimate because there is room for multiple realities and there are no collective truths (Cooper & Lesser, 2008). Constructivism supports the client's experience and view of the problem as unique to the individual but apart from the individual. Narrative therapy separates the person from the problem, therefore allowing for room to explore, recreate, and re-author the story of the client. White (2007) noted, "When the problem becomes an entity that is separate from the person, and when people are not tied to restricting 'truths' about their identity and negative 'certainties' about their lives, new options for taking action to address the predicaments of their lives becomes available" (p.26).

Constructivism questions not only cultural power dynamics but also the power dynamic between practitioner and client. This places importance on the client as expert in their own lives, as is present in narrative therapy. Constructivism highlights the therapeutic relationship as one of joining, entrusting, and respecting, versus being in a position of power as the practitioner. Narrative therapy highlights the strengths and capabilities of individuals as well as ways that they have previously managed problems in their lives (Cooper & Lesser, 2008). This framework identifies strengths and personal resources found in the individual, while the Person in Environment system aligns with social work in that it, "promote(s) a holistic biopsychosocial perspective on human behavior" (Hutchinson, 2008, p. 179). This



fits well within the social work field along with narrative therapy, both of which were considered in the development of this secondary data analysis.

### **Professional and Personal Lens**

The role of the social worker as a professional and clinician is to strive to, “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW Code of Ethics, 2008). To me as a professional, this is not only about providing proper resources and supports to individuals, families, communities and society as a whole, but is about creating space for growth, opportunity and healing in the individual(s) and viewing the individual as a strong and capable despite their circumstances.

My professional motivation for this secondary data analysis arose from my involvement in a narrative therapy group with individuals who had experience with psychosis. I was able to witness and be a part of the group as it was created, used, refined, and solidified. The group had a huge impact on who I am as a clinician as well as personally. I entered the group, as many group members did, knowing little to nothing about narrative therapy. I left the group with a core belief in the process of narrative therapy and group work, but more importantly a belief in the abilities for insight and change of the group members who had experienced psychosis. The stories of their lives that they shared with me and the transformations that I was able to see changed me both as a clinician and as an overall person.

After witnessing the success of the group, I was motivated to show the strengths and insight that the group members had. I wanted the words of the group members to stand for themselves and to live beyond the group that had ended. These were not people who lacked

so much, but in fact were individuals who had so much to offer. Not only as a social worker but as a witness, I was motivated to help support, acknowledge, and honor the stories of these amazing group members and attempt to highlight their strengths.

## **Methods**

### **Research Design and Rationale**

The purpose of this qualitative research was to explore themes found in a narrative psychotherapy group treating individuals who have experienced psychosis. The study is a secondary data analysis from the SONGS model used in the “Voices of Strength: Narrative Therapy in Group Work” (Romness, 2015) project, which found benefits of narrative group therapy for individuals with psychosis and schizophrenia.

### **Sample, Recruitment Process, and Eligibility for Study**

The data examined was from an open and ongoing narrative psychotherapy group with a maximum number of 12 members, aligning with the outpatient programs requirements. Group sizes ranged from two to twelve group members in any given session. There were a total of two separate/independent groups per day; each group met five days a week. Inclusion criteria for participation in the group were a past history of psychosis and current enrollment in the outpatient program at an urban hospital. Referrals to the group often came from mental health providers, many originating from within the hospital inpatient psychiatric treatment teams. Other referral sources were from community mental health organizations such as local clubhouses, community case managers, or mental health residences. Self-referrals were also considered when an individual said they had experience with psychosis in their lives and met outpatient program qualifications.

The sample was obtained through a convenience and availability sample. According to Monette, Sullivan, and DeJong (2008), an availability sample “involves the researcher’s taking whichever elements are readily available [when it is] either difficult or impossible to develop a complete sampling frame” (p. 145). A convenience sample is similar in that

“participants are selected based on their ease of availability” (Given, 2008, p. 124). Group members were already enrolled in the program but the study aimed to accurately represent the population within the group, which is why a convenience and availability sample was employed.

The primary investigator of the Voices of Strength Project provided data that was pulled from a 12-month period (November, 2014 through October, 2015) as outlined in the organization’s Institutional Review Board approval. The project was obtained during group sessions where therapists facilitated the SONGS model, which assisted group members to create between one and four narrative maps, each representing a topic or problem. Whiteboards were used in group sessions to assist in drawing visual dominant, alternative or preferred narratives. In some sessions, symbols, pictures, and metaphors were selected or drawn by group members to enhance visual storytelling. Lastly, for the purpose of transparency and application to life goals outside of group sessions, copies of visual narrative storyboards/maps were provided to group members.

### **Protection of Human Subjects, Ethical Considerations, and Risk of Study**

The initial project received exemption status from the International Review Board (IRB) at the organization as it was determined low risk to human subjects. All data reviewed in the secondary data analysis was de-identified and provided by the primary investigator. After this, the writer of this secondary data analysis was granted permission by the IRB to be added to the project.

All identifying information was removed from data received. In review, this research analysis prevented additional risks based on confidential and secured files remaining

anonymous to the researcher. Lastly, group participation for the initial project included informed consent and signed confidentiality agreements by all participants and facilitators.

### **Data Collection Procedure**

The primary investigator collected data over a time period from November, 2014 to October, 2015. The data was collected using a process combining daily charting quotes from group members and photos of storyboards/maps designed in group sessions. The data was collected by the primary investigator facilitating the narrative psychotherapy group session, with an initial count of slides including 237 slides in total for the length of the project. Of these 237 slides, 19 were removed by the primary investigator because they showed participants' first names, leaving 218 slides remaining. The years 2014 and 2015 were split in two and dates were placed on each of the slides according to their image name. Once renamed according to their date, slides were placed in chronological order to help in the data reduction process.

### **Data Reduction and Data Analysis Procedures**

The massive amount of subject matter at this point was overwhelming and it was difficult to determine which data to analyze in order to best represent the overall data. Therefore, to condense and control representation of the data in relation to the research question, three criteria were set in place in order for slides to be considered for the study. They included: (a) a topic development of a problem, (b) a storyteller or storytellers, and (c) a witness or multiple witnesses participating in the narrative process. All three criteria needed to be present in a single therapy session, but not within a single slide or single day. By these criteria, data was excluded; however, a significant amount still remained with 218 slides. It

was decided that twelve sets of data would be used for this data analysis, which ended up initially being 33 slides.

Data reviewed was analyzed using grounded theory methods, which involved identifying themes and patterns while being open to findings. Initial coding began with descriptive coding, which aimed to describe all of the data in depth. This was completed for all sessions and slides. When completed, initial codes were generated using grounded theory, initial coding, and then *in-vivo* coding. Secondary analysis was implemented and final themes and subthemes were discovered as discussed below.

Descriptive analysis, content analysis, *in-vivo* coding, and axial analysis all produced “connection” as a theme to a varying degree. The procedures are explained below. There were five rounds of analysis completed and the following list is of the procedures with examples of connection being used alongside any other important data, themes, or symbols.

**First level analysis: Descriptive.** First level analysis involved descriptive notes regarding all the data from all 33 slides. The following descriptive analysis was created in response to the data in Figure 1:

“Topic Development surrounding topic of “connection.” Connection is the center focus of the slide and falls in the center of the board, circled and written in blue.

Others terms are written around “connection” in either green or red. Certain phrases and words stand out in this slide, some of which align with “connection” such as, “two things coming together.”

This level of qualitative description for 12 groups was time consuming but important in getting to know all of the data present for future analysis.

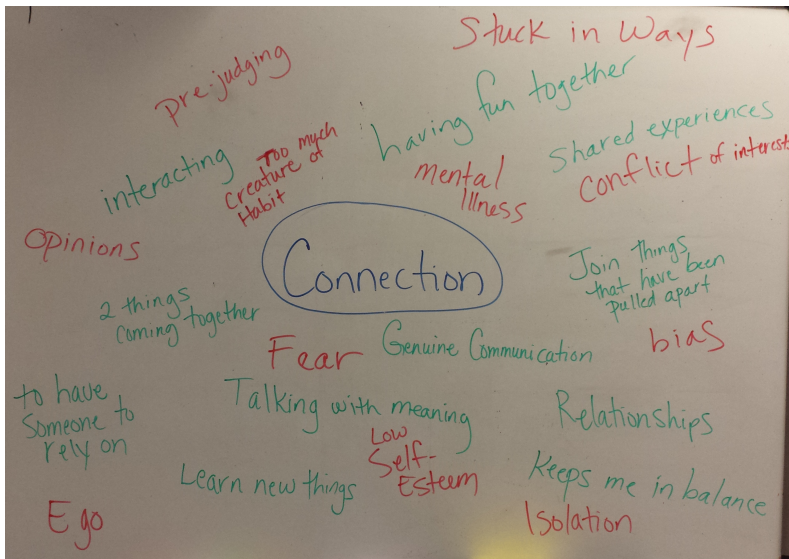


Image © 2015 Romness

Figure 1. Example of whiteboard map after narrative therapy session.

**Second level analysis: Open coding.** The next level of analysis used what is called a first cycle coding method and took the format of “initial coding” or “open coding” using grounded theory terminology. It is often used in the beginning of the data reduction process and “breaks down qualitative data into discrete parts, closely examines them and compares them for similarities and differences” (Strauss & Corbin, as cited in Saldana, 2016, p. 115). Saldana (2016) stated that initial coding, “is an opportunity for you as a researcher to reflect deeply on the contents and nuances of your data and begin to take ownership of them” (p. 115). This was an important step for the researcher to get a better idea of the data present. Using this method of grounded theory the following categories or main themes emerged from the twelve session. They included: “connection,” “symptoms/distress,” “barriers,” “trust,” “gets in the way” of feeling well and balanced, “dis-STRESS,” “agents of stress,” “goals,” “growth,” “connected,” “decreased motivation” and “triangles.” From these categories the following 31 themes (subthemes) arose (see Figure 2).

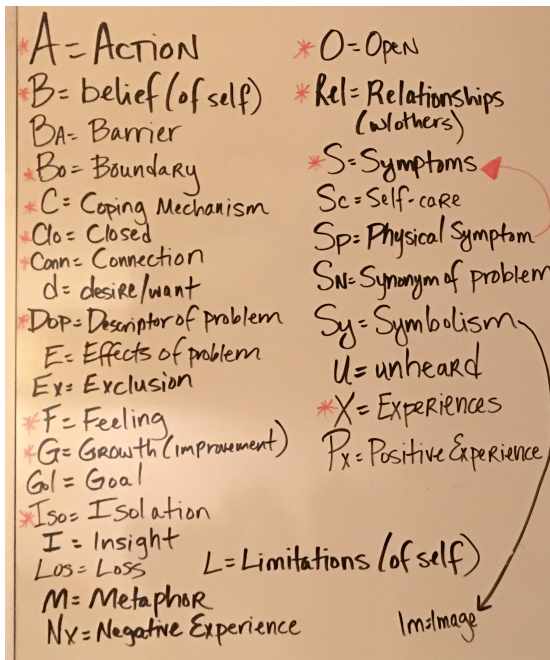


Figure 2. Example of second level analysis (sub)themes.

Some of these subthemes from Figure 2 were removed in the next level of analysis because they too closely resembled another subtheme or came across as being too weak in representing the data. For example, in Figure 2 “Symptoms” encompasses “Physical symptoms” while “Symbolism” is an aspect of “Imagery” that was not a code itself but came forth in the data. Data that was starred for the most part continued onto the next level of analysis.

**Third level analysis: *In-vivo*.** For the third level of analysis, *In-vivo* coding was used which, “as a code refers to a word or short phrase from the actual language found in the qualitative data record” (Saldana, 2016, p. 105). In this method of grounded theory, the codes of each line, word, phrase, symbol and image on each slide are valued. In order to highlight the voices of participants, *in-vivo* was chosen which placed importance on all data present. After highlighting each code the researcher returned and compared *in-vivo* codes to the previous 31 (sub)themes codes to see if there was any overlap and if any codes could be



combined, expanded or eliminated from the *in-vivo* codes. The majority of codes from the second level analysis ended up being verbatim phrases and words used by participants, with only a few exceptions. The next step at this point was to create a chart that highlighted the main theme/category and related subthemes. Two main themes/categories arose: “Self-Development” and “Barriers”. From this point the researcher expanded and rearranged themes, subthemes, and overall concepts from analysis, as seen in the image below (see Figure 3).

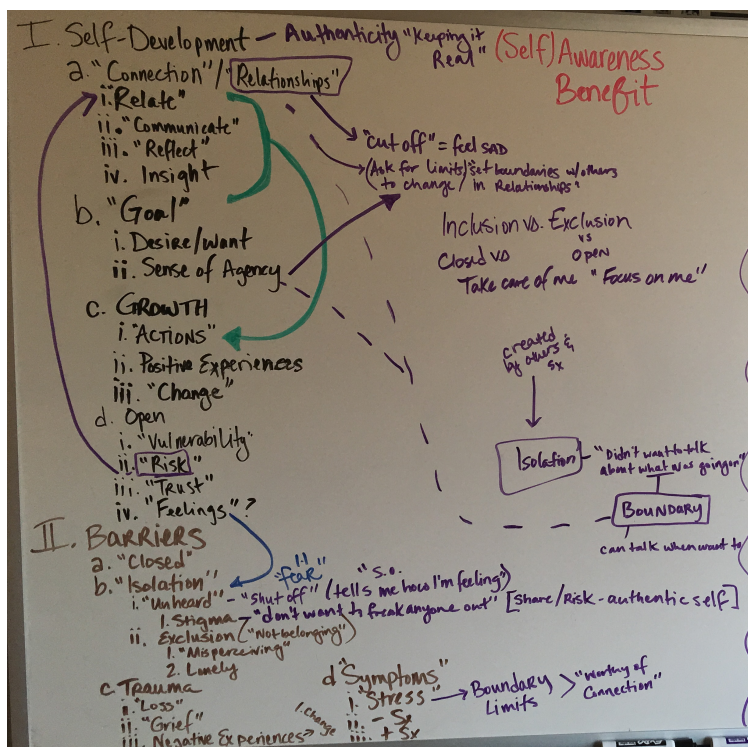


Figure 3. Example of *in-vivo* coding process.

With the use of *in-vivo* coding the focus remained primarily on the participants’ own words in order to honor and highlight their voices. When going through the data the previous themes were taken into consideration after each group session was highlighted for words and phrases that stood out. The following are example *in-vivo* codes that fit within the original codes/themes from the first round of analysis. Exact phrases used in the group by

participants’ are shown in quotation marks; these phrases coincide with the original codes/themes identified in first level analysis. Noting below, if an endash follows the word, phrase, or sentence then the example fits within two or more codes. Again, “Connection” came forth as a strong theme (see Table 1).

Table 1

*Emergent Themes and Sub-Themes from Narrative Therapy Sessions*

“Connection”	“Relationships”	“Closed”	“Isolation”	“Symptoms”	“Open”	Insight
Someone to rely on	I want plenty of warmth in my life for self and others	Stuck – ISO	Loneliness	Schizophrenia (Diagnosis names)	Let yourself be how you want to be – instead of what others want me to be (Genuine)	Disciplined
Share experiences	Loved ones	Closed up	Cutting off contact	Doctors and meds	Opens up my mind to the world	Benefits of symptoms
Join things that have been pulled apart – REL	Family	Not being able to open up	Wanting to be alone	Paranoia		It’s just a moment
Genuine communication	Friends		Space - CLO	Irritation/ Irritability		Makes you want to try harder
Talking with meaning						Sick
Coming together						Loss of energy
Forming a bond						Flashbacks
Bunch of connections – links, some torn or broken						Sensitivity
Show love - deserving – see what other people deal with (empathy)						Hallucinations
						Genetics
						Restless
						Stress
						Voices
						Depression

Table 1 shows a few examples of subthemes that came forth from the data. It was interesting that the majority of the themes from the initial analysis carried over through the different levels of analysis.

**Fourth level analysis.** After the third analysis in which two main themes were categorized (“Self-Development” and “Barriers”), an outline was created for the data (See Figure 4). The majority of subthemes could be placed within one of the two themes identified but some turned into smaller subthemes of subthemes. Throughout, “Connection” had the largest amount of data, however, “Self-Development” was also created to incorporate a larger amount of the data. Exact words used by participants are shown in quotation marks, whereas themes that the researcher created are not.

- I. Self-Development
  - a. “Connection”/“Relationships”
    - i. “Relate”
    - ii. “Communicate”
    - iii. “Reflect”
    - iv. Insight
    - v. “OPEN”
    - vi. Resilience, Strength
  - b. “Goal”
    - i. Desire/Want
    - ii. Sense of Agency
  - c. Growth (Improvement)
    - i. “Actions”
    - ii. Positive experiences
    - iii. “Change”
  - d. “Open”
    - i. “Vulnerability”
    - ii. “Risk”
    - iii. “Trust”
    - iv. “Feelings”
- II. “Barriers”
  - a. “Closed”
  - b. “Isolation”
    - i. “Unheard” -----> yet still trying to connect  
= RESILIENCE (Strength)
      - 1. Stigma
    - ii. Exclusion (“not belonging”) -----> Do well in group format
      - 1. “Misperceive”
      - 2. Lonely
  - c. “Trauma”
    - i. “Loss”
    - ii. “Grief”
    - iii. Negative Experience
      - 1. “Change”
  - d. “Symptoms”
    - i. “Stress”
    - ii. Negative (not specifically coded as such – general symptoms)
    - iii. Positive (not specifically coded as such – general symptoms)

Figure 4. Data outline.

With the use of this outline the next level of analysis began with a review of what second-stage analysis techniques might be compatible with the study and grounded theory. The following were identified by Saldana (2016) and included focused analysis, axial analysis, and theoretical analysis. The researcher used a combination of these three techniques. Theoretical analysis is recognized as a “central/core category” which identifies a “theme of research” as most important. With this technique, the theme of “Connection” came forth. In using the available second-stage analysis techniques to find the best fit, all three were used to some degree. In the last level of analysis, “Connection” was found as the main theme or theory of the data, which continued to emerge through all levels of data analysis.

**Fifth level analysis.** For the last level of analysis, the twelve sessions were examined as a whole instead of as separate sessions. All slides were mixed together and reviewed one by one in random order. While examining the data the natural inclination was to black out or remove data that does not stand out, however this had been done in previous analysis, but not as clearly. A black marker was actually used to cross off lines, phrases, and words so that they were no longer readable and helped focus in on the chosen data. There was less and less data, but it focused more closely on the “true” themes or subthemes within the data.

As certain themes and subthemes were addressed (i.e. connection, stress, open/closed), it was visible that participants were able to identify current effects of the problem in their life. Participants were not only naming the problem, but were able to go in depth and show developed insight and provided rich descriptions. Participants not only explored the problem but were also able to come up with and envision a life without the problem in their life, while identifying with others who had similar problems or “shared experiences.” A connection was occurring on an even deeper level – not just in the data, but

also in the process occurring in sessions. Externalization was occurring with images as well, where participants were externalizing, visualizing, and connecting outside of themselves; concretely in actions, metaphorically through images and symbols and were showing their level of connection with other group members. Group cohesion and group stages are visible in the data.

Another point that arose from the data was that while participants were identifying connections they were also identifying pain such as “loss,” “grief,” and insecurities they experience while opening up and being vulnerable and taking risks. Previous experiences of “isolation” and feeling “unheard” however, were not enough to deter participants from trying to connect. Participants appear to be able to recognize dichotomies between concepts; for instance, “open” vs. “closed,” “joining vs. “isolation,” and “loss” vs. “connection.” Overall, connection and barriers to wellness were the most prevalent themes that emerged in the last level of analysis. Barriers to wellness fit under connection but it was considered a theme in and of itself for the purposes of clarity. These themes will be explored and explained further in the Findings section along with their connection to psychosis and schizophrenia, narrative therapy, groups and overall benefits.

### **Participant Demographics**

The demographics of participants were collected from the initial narrative therapy group work project. While gender was a documented demographic for this study, participants’ age, race, and socio-economic status were not included in this secondary data analysis.

Of the 24 sessions of data reviewed, participation ranged between 4-11 participants per group. The average number of individuals was 6.46 participants per group. There were 25

total participants in the initial study ( $n = 25$ ). Of those 25 participants several participated in more than one session. The ratio between genders was fairly even. Over the 24 sessions, 12 participants were male and 13 were female.

### **Data Set**

The original study of this data included 237 slides. For this secondary data analysis, 19 of those slides were removed as outliers due to identifying information. The remaining 218 slides were reviewed and a design criteria was established with the original researcher for the purpose of the study. This criteria narrowed the data into 33 slides and twelve sessions.

## **Findings**

The following chapter addresses the results of this secondary data analysis of group narrative therapy for individuals with psychosis and schizophrenia. The data analyzed was collected from 24 sessions, which broke down to twelve data sets. Images and written quotes from these sessions highlight strengths, capabilities, and unique voices of participants. The two primary themes that emerged from this data included Connection and Barriers to Wellness. The data in these findings support the original research reviewed in the literature, which measured group effectiveness via themes of cohesion, catharsis, and insight. Participants demographics and information regarding the data set will also be discussed.

Two primary themes emerged from the data; Connection and Barriers to Wellness. The first theme that emerged within the analysis of data was Connection. This theme included 5 subthemes: Relationships, Trust, Metaphors, Openness, and Authentic Self. Additionally, within the subtheme of Trust, Communication and Boundaries/Limits emerged. Sample responses that support these themes are included in Table 2. The second theme that emerged within the analysis of data was Barriers to Wellness. This theme also had 5 subthemes, which included: Isolation, Trauma, Symptoms/Diagnosis, Metaphors/Symbols, and Closed Off. Table 3 shows sample responses that support these themes.

Table 2

*Themes of Connection*

Category	Thematic Category	Sample Response	Cohesion/Catharsis/Insight
Theme 1	Connection	I can tell myself I am worthy of connections	
Subtheme 1	Relationships	Forming a bond	Cohesion
Subtheme 2	Trust	Ask someone if it really happened Ask for help	Cohesion
Subtheme T1	Communication	Talking with meaning	Catharsis
Subtheme T2	Boundaries/Limits	Say what you need over and over again	Cohesion
Subtheme 3	Metaphors/Symbols	Links: Join two things that have been pulled apart	Cohesion
Subtheme 4	Openness	Growth; potential; change; open; willing	Insight
Subtheme 5	Authentic Self	Show authentic self Keeping it real	Insight

Table 3

*Themes of Barriers to Wellness*

Category	Thematic Category	Sample Response	Cohesion/Catharsis/Insight
Theme 1	Barriers to Wellness		
Subtheme 1	Isolation	Cutting off contact Being trapped in a closet	Cohesion
Subtheme 2	Trauma	I felt like it was really happening	Catharsis
Subtheme 3	Symptoms/Diagnosis	Schizophrenia (and) diagnosis names Doctors and meds	Insight
Subtheme 4	Metaphors/Symbols	Ferocious dog	Cohesion
Subtheme 5	Closed Off	Closed up Keeping it inside	Catharsis

**Connection**

The subthemes in Tables 2 and 3 supported the initial research findings of cohesion, catharsis, and insight in narrative therapy group work (Romness Rosenberg, 2007). Cohesion



was identified in the subthemes of relationships, trust, boundaries/limits and metaphors/symbols. Catharsis was identified in the subtheme of communication. Insight was identified in the subthemes of openness and authentic self.

**Relationships.** The subtheme of relationships was noted as group cohesion in the following example “I want people involved.” This quote exemplifies a desire for belonging and involvement of group members and people in the participants’ lives. A desire to form relationships was present. Group members discussed relationships both within the group and outside of the group. Group members identified relationship such as “(being) connected to family,” “grief and loss groups,” “groups” overall, “day treatment,” “therapists,” and “family.” Throughout the majority of sessions in the data, it was apparent that group members were trying to identify current, past and desired relationships in their lives and their place within those relationships.

In the data, clients reference relationships metaphorically and symbolically. The image of links as seen in Figure 5 was described by group members as, “links, some torn, some broken, (the) emotional feelings in close relationships.” Links were described as, “join(ing) things together that have been pulled apart. ”

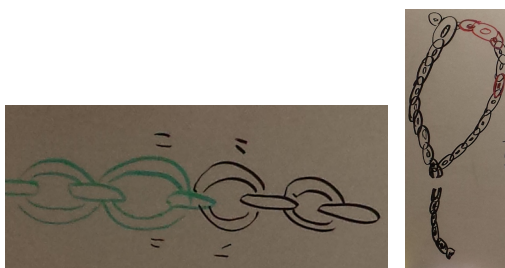


Image © 2015 Romness

*Figure 5.* Drawings of links as metaphors for relationship.

Also in the data group members described relationships as a an ongoing active process, one of “opening up” and “sharing” with others. Descriptions of forming relationships with others

included phrases such as “having someone to rely on” and “talking with meaning.” Relationships were seen as a form of communication that was practiced as well as a deeper agreement or trust between people. Group members noted: “[I can] remind myself I have people who care about me” and “remember others are understanding and kind.” For these group members, relationships were reminders of a “bond” they had with others, that these connections were necessary, and that “[relationships] keep me in balance.” There was reciprocity in relationships. Members described wanting “plenty of warmth in my life for [myself] and others” and explained that relationships gave the group member “someone to rely on.” Finally, relationships were about being vulnerable and, “be[ing] honest about my pain with person(s).”

**Trust.** Trust was described with words such as “vulnerability,” “risk” and the characteristic of “honesty.” The data shows a group member stating that they wanted to, “be honest about their pain with [a] person” which indicates trust.

In the data, trust also appeared to be identified in both a positive and negative view. It appeared group members described times when their trust was taken for granted by “others’ opinions” which affected their “self-esteem” and sense of self. Similarly, it appeared group members didn’t want trust to be broken. Trust was identified as “keep[ing] what you share between each other.” Another aspect of trust in the data indicated difficulty with perception. They expressed difficulty “ask[ing] people what changes they see in me” and “talk[ing] to people to check out my thoughts. Group members identified actions such as “call mom” and “tell staff” as ways to communicate and show or develop trust with others.

**Boundaries/limits.** With the development of trust came the need for boundaries and limits to be set. In the data, group members identified the importance of setting boundaries

noting, “say what I need over and over again” and “ask for limits to change.” Group members discussed “set[ting] boundaries with others in relationships” and noted actions such as “I can tell others what I think” and “I can ask others to ask me how I am feeling, don’t tell me.” In terms of trusting and sharing, group members identify a limit saying, “I can talk about it when I want to.” Often times this was in response to past experiences where a group member felt “manipulated in the situation” or when “family wanted to talk about what’s going on [and I] didn’t want to.”

**Metaphors/symbols.** The use of metaphors and symbols occurred within the development of goals for group members (see Figure 6). These were identified as “growth” within the data analysis and have to do with the ways group members were able to envision the future and their preferred narrative. A few metaphors include “less worry like an eagle” saying that the “eagle [is] in flight and planning my landing.” Another group member’s goal was to “have my own life back” and used a flower metaphor: “a daisy growing and blossoming.” A metaphor in relation to connection is the goal to “be around people and socialize” with the metaphor of “a bee visiting different flowers. I’m flying around doing different things.” Another goal was to “interact with others” with the metaphor of “a rose, peaceful around others.” All of these goals and the metaphoric phrases that accompany them were chosen by the group members.

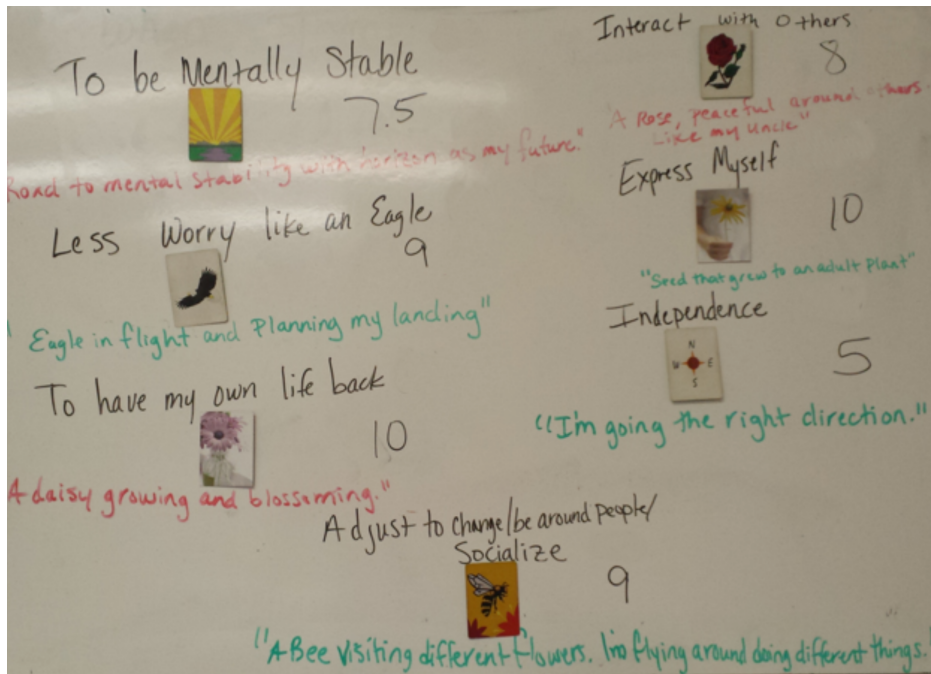


Image © 2015 Romness

Figure 6. Goals.

**Communication.** Group members identified communication under the subtheme of Trust, but communication in itself was closely connected with catharsis. This was demonstrated through actions such as “talk(ing) to people I trust,” “talk about my feelings” and “ask(ing) for help.” All of these actions require trust on the part of the individual as well as those they are entrusting with this information. Overall, communication came in the form of sharing, and being open with others in and outside of group.

**Openness.** Group members identified a metaphor and symbol of a door being “open” as well as “closed up” as an example of their perceptions of self and others. The subtheme of closed off will be addressed under the theme of “barriers to wellness” but the subtheme of “openness” relates to connection and insight.

Group members described their personal door as they envisioned it to be. Some group members created elaborate descriptions of their doors, while others used the door as a

metaphor to discuss connections, along with boundaries, limits, and current or past relationships.

The open door group members noted that the door was used “only to build trust” and that it was “always open but I can kick [people] out.” There was a specific door called the “door of trust” that was described as the frame of a door with a gate and a fence. With this door it “(took) a while to build trust” but was “easy to come in” and acknowledged that “people earn trust on different levels.” With this door “people don’t knock, [they] just come in.”

The door metaphor overall, whether “closed,” “open,” “locked up,” or a “door of trust,” was a symbol of “outside supports” that was “built on expectations” with “two sides.” Some participants said “I want to close my door,” saying “[it’s] hard to ask [people] to leave” while others said “anyone can come in [but I] prefer them to ask.” The door provided a place of “middle-ground” where boundaries and limits could be imagined or put into place as well as develop into the connection that participants wanted.

The use of “Openness” appeared throughout the data. In order to create a connection there needed to be “open” communication and a willingness to be present. Group members identified “practice showing up every day” as “sharing,” which is a practice in being open. One group member noted the benefits of their symptoms were that it, “open(s) up my mind to the world.” Sometimes being open was experienced positively and other times it left group members feeling extremely vulnerable. One striking aspect that was visible within the data was group members’ willingness to remain open or to begin opening up despite past experiences. The problem of “decreased motivation” brought up being “open” in relation to having “closed doors.”

**Authentic self.** Group members also identified connection with themselves, which included new notions of themselves in connection with insight. They used language such as “intentional of your own work” and “keeping it real.” Group members described the “practice [of] showing up every day” and working on themselves, saying “[I] focus on me.” The countless actions that are identified are ways in which group members connect with themselves and the growth they are making in their lives. There is “vulnerability” and “risk” in doing “your own work”; however, the group members show continually that they have the ability to self reflect and make changes to make the connections they want to make with others and themselves. This self reflection is accomplished by identifying ones problems and in turn seeking “wellness” and “balance.”

### **Barriers to Wellness**

The second theme, Barriers to Wellness also supported the initial research findings related to catharsis and insight in narrative therapy group work (Romness Rosenberg, 2007). The subthemes of isolation and metaphors/symbols support cohesion. The subthemes of trauma and closed off support catharsis. The subtheme of symptoms/diagnosis demonstrates insight.

**Isolation.** Group members identified within multiple sessions the subtheme of isolation. Isolation meant isolation from others, often within relationships where group members were “cutting off contact” and “wanting to be alone” or have “space.” This was often in response to group members not being ready to talk about their symptoms or not knowing how to ask for help. A group member noted that, when experiencing symptoms, “[I] don’t want to freak anyone out” so the group member did not always experience enough trust to involve people in spite of “want[ing] people involved.” Although experiencing isolation

and distance from others, group members still attempted to take action and connect with other people despite this barrier; “be honest about my pain with [the] person.”

Sometimes isolation was in response to what others had to say or the way group members were being treated in relationships. One group member noted feeling “shut off” and “unheard” and that this affected their ability to open up and connect with others. Another recurrent theme was that isolation resulted from loss. This was loss due to “death of family and friends” or “losing a job, losing home [and being] homeless.” Multiple group members brought up “homeless[ness]” when discussing stress and change that occurred in their life. This was a barrier that created a physical isolation from others and prevented members from “hav[ing] their own life back.”

For another group member isolation came in the form of a “chemical imbalance” where they “thought everyone was out to get me” and that people were “talking about me, planning against me, my enemy.” Despite this experience full of “fear” and “worry” the group member identified an action of connection where they spoke with people in their lives and tried to break the barrier of isolation. The barrier of isolation took many forms but the overall impact was a lack of connection and ability to feel a part of something.

**Metaphors/symbols.** One way in which metaphors and symbols were used was when group members drew and identified ways they were experiencing “barrier[s] to wellness and recovery.” Some “barrier[s to wellness]” listed included “chemical imbalance,” “mental imbalance,” “stress,” “anxiety,” “side effects of medications” and “thoughts go faster than I can think.”

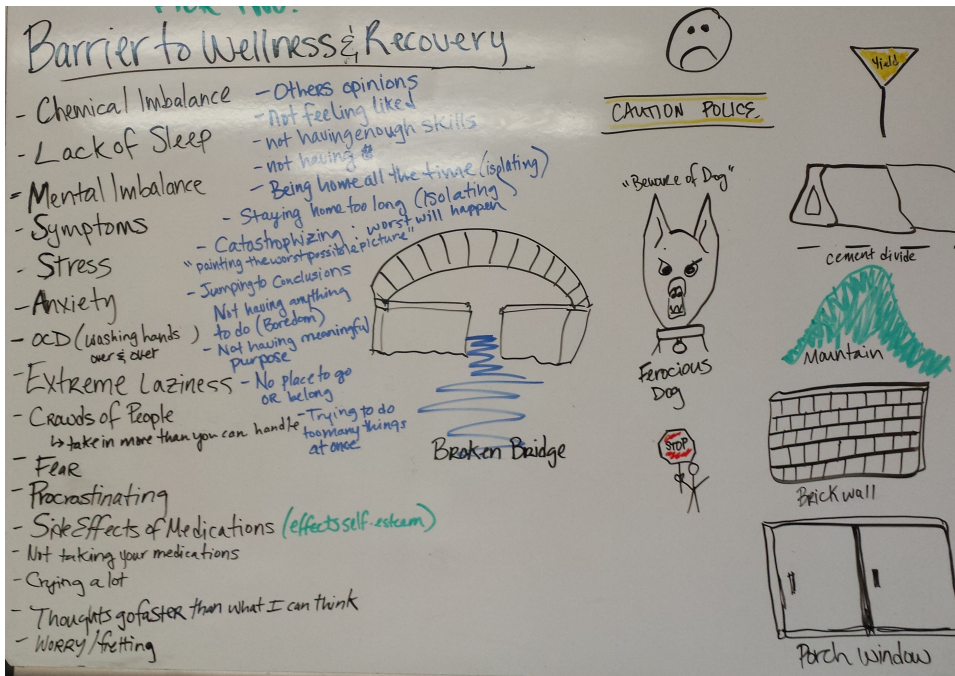


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Figure 7. Barriers to wellness.

The topic for the group regarding barriers was identified as “what gets in the way of being well and balanced?” The group members drew each of the following symbols and described their metaphors with a few words.

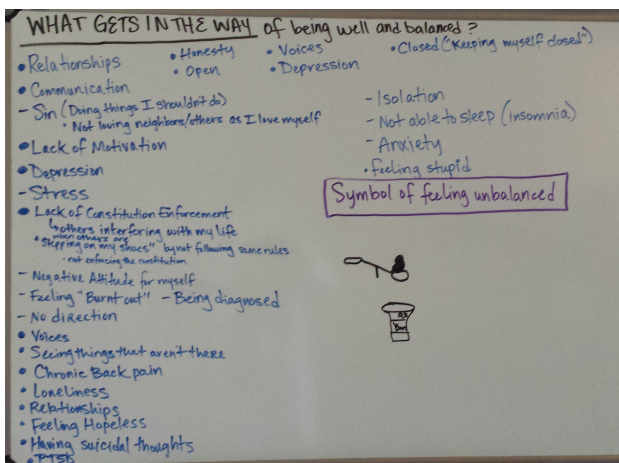


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Figure 8. What gets in the way of being well and balanced.



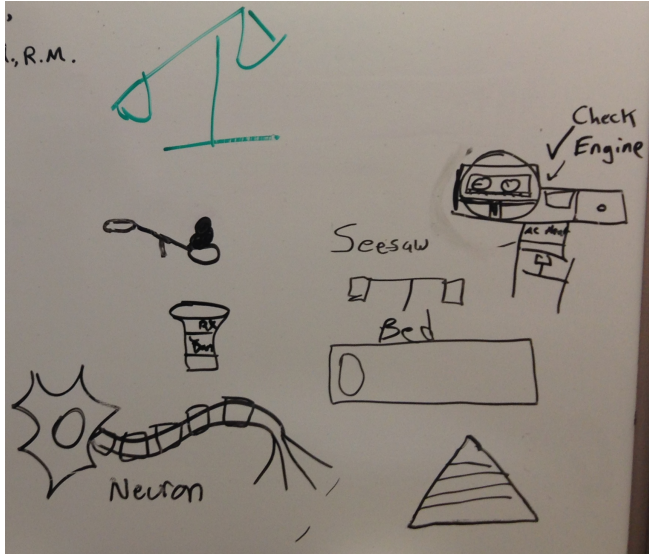


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Figure 9. Symbols of feeling unbalanced.

Another metaphor and symbol that was created by the group members collaboratively was that of a “tree trunk” (see Figure 10). The roots were described as being “genetics, caring, schooling, family, love, creativity, friends, and trauma.” The experiences were described as the “foundation of our root systems” by group members. A hole was created within the tree representing feelings such as “happiness” along with other feelings such as “confusion” and overall “emotion.” Within the “trunk” of the tree is where “symptoms” were placed such as “voices,” “hallucinations,” “not being able to open up,” “restlessness” and “spiritual sensitivity.”

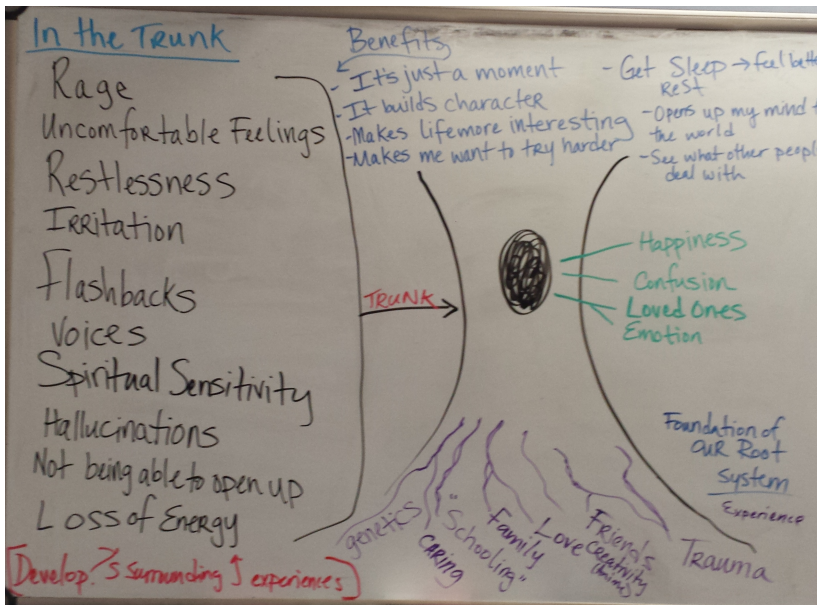


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Figure 10. Tree of symptoms.

**Trauma.** A striking image is that of a group member sharing when they were “being trapped in a closet” a “small space” that felt like an “elevator (with) doors closing” in on them. Not only did this bring up “stress” but also it brought up what a group member called “PTSD” saying it was, “so strong, [I] feel like I am in it again.” Another group member identified the of trauma saying that the experience, “could stop you from functioning.” Some group members in response to trauma noted that they “detach” and “dissociate” while others experienced “flashbacks” as “terrifying” saying, “I felt like it was really happening.” Trauma came along with specific experiences but also phrases and words such as, “grief,” “loss” and “taken away from me.” Many of the group members identified “loss” in their lives and the painful and negative effects this had on them. One group member shared their experience of a flashback where they would, “sit there reliving it, nothing else happens” and “you can’t do anything.” The member continued to say that it “relates to something in the past but is present.” Aspects of trauma were insightfully identified as “triggers” involving “visual,”

“location/experiential,” “hearing,” and the “feelings and behavior response” that may come along with a traumatic experience such as flashbacks. Trauma was combatted with actions such as “asking someone if it really happened” or “identify[ing] triggers” and identifying “what helps [me] step out of it.” These responses indicated catharsis.

**Closed off.** When discussing closed off and lack of connections, phrases and words such as the following came forth: “no place to go or belong,” “loss,” “cutting off contact,” “keeping myself closed,” “closed doors” “keeping it inside,” “detach,” “everything falls,” “isolation,” “not being able to open up,” “stuck” and “disassociate.” Another group member identified “not being able to open up” and feeling “closed up.” One group member identified the subtheme of closed saying, “keeping myself closed.”

When discussing “the trust that I want,” group members identified the metaphor and symbol of a “closed” door as being closed off “to doctors” or “everyone else [but] mom.” In explaining further why a closed door was chosen, a participant said that they, “have more control (and) choice when to let people in.” Another group members door was “locked up”; the participant said, “I lock myself up” and that there was “no door to knock on.” However, the same participant also said, “I want people to knock” but that there are “quite a few locks on [the] door.” The door had a peep hole for “looking” and “curious[ity].” This participant connected their door with trust saying, “(It) takes me a long time to trust and open up because [I] didn’t grow up in a family that communicated [or] talked”; for this participant, opening up and trusting was an “intentional practice.”

**Symptoms/diagnosis.** One group member stated, “I felt like it was really happening” when talking about an experience with hallucinations. Another group member identified a similar experience sharing, “[I] see things other don’t see” then naming this as

“hallucinations.” The symptoms group members experienced were descriptive and provoking, not just placed within the context of a diagnosis. This showed great insight into their experiences. For many group members, side effects played a prevalent role in their experiences with symptoms.

Some side effects came in the form of symptoms while others were the side effect of medications. Group members experienced “nightmares” because of their medications while others felt a “loss of energy” and “loss of appetite.” There were physical symptoms such as feeling “thirsty all the time” or having their “feet hurt.” Other side effects were emotional such as feeling “restless” or experiencing “irritation [and] irritability” along with an overall “sensitivity” that they had not always experienced. Group members identified symptoms being tied to “doctors and meds.” They noted that symptoms were “distress[ing]” and that they felt “sick.” They identified “diagnosis names” such as “schizophrenia” when discussing symptoms.

## **Discussion**

The following section examines the relationship between findings and themes of this secondary data analysis and the published literature on the topic of treatment for psychosis and schizophrenia. The results from this secondary data analysis both supported (e.g., Romness Rosenberg, 2007; Vassalo, 1998) and departed (e.g., Hill, 2011; Looyeh et al., 2012) from literature on the topic of narrative group therapy for individuals with psychosis and schizophrenia. The discussion will also identify implications for future clinical practice, clinical social work practice, strengths and limitations of this secondary data analysis, and future implications for social work practice and research.

As discussed in the findings section, participants identified both connection and barriers to wellness as themes within their narrative group therapy experience. Within the theme of connection, subthemes of relationships, trust, metaphors/symbols, openness, and authentic self were explored. Within the theme of barriers to wellness, subthemes of isolation, trauma, symptoms/diagnosis, metaphors and symbols, and closed off were explored. These themes and subthemes were for the most part not reflected within the literature reviewed, in part because the themes and subthemes of the data reviewed originate from the words of the group members and the concepts derived from group members are therefore not exactly mirrored in the literature. However, the overarching ideas of connection and barriers to wellness are found in some of the literature reviewed, especially with regards to cohesion, catharsis, and insight (e.g., Romness Rosenberg, 2007).

### **Connection**

The literature for the most part did not support the findings of connection and this theme was not emphasized within the literature and/or research. The literature lacked focus

on the population of individuals with schizophrenia and psychosis and the subthemes that were found under the theme of connection were not in any way reflected in the literature. However, it should be noted that the findings add to the literature and research base. Specifically with regards to relationships, group members were searching for connection and actively working to keep relationships, showing the importance of the group format when working with individuals with psychosis and schizophrenia. The literature was not supportive with regards to overall relationships and connections and viewed individuals as being isolated and not wanting to be around others (e.g., Andreasen & Black, 2014). The subtheme of trust was implemented as group members developed relationships within the group and outside of the group. One aspect of trust was the action and process of setting limits and boundaries with others, as a subtheme of connection. Along with this, the use of metaphors and symbols were a successful tool for group members.

### **Barriers to Wellness**

In relation to the findings, barriers to wellness was not supported in the literature. The only literature that briefly addressed these findings were found in the grey literature with regards to symptoms related to the disease (Andreasen & Black, 2014) and the use of medications (Carey, 2015; NIMH, 2015). The grey literature discussed symptoms and diagnosis as well as treatment outcomes over the course of the disease for individuals, and was discussed in terms of the individual. Trauma was a significant subtheme because in sharing within group, members were demonstrating catharsis. Not only was trauma described in detail and personally, it was shared openly and in connection with other people. Symptoms and diagnosis was another subtheme that highlighted great insight from group members.

Group members were able to conceptualize their diagnosis and symptoms while envisioning themselves as more than their symptoms and diagnosis.

Overall, the most important support for the findings of this secondary data analysis were found with relation to cohesion, catharsis and insight. However, literature with regards to psychosis and schizophrenia, and group narrative therapy still hold valuable information in relation to the findings.

### **Psychosis/Schizophrenia Literature**

The literature on psychosis and schizophrenia focused on treatment options (e.g., Bachmann et al., 2003), prevalence of the disease (e.g., Andreasen & Black, 2014; NIMH, 2015), medications (e.g., Carey, 2015), and psychotherapeutic treatments for the population (e.g., Andreasen & Black, 2014). There is a lack of support for the findings in published literature on treatment and interventions. While the findings of this study implied that individuals with psychosis and schizophrenia can benefit from group narrative therapy interventions, the literature only briefly addressed group therapy for individuals with psychosis and schizophrenia (e.g., Vassalo, 1998) and did not look at studies that compared medication to psychotherapeutic interventions. While the literature did not directly address the findings of the study, benefits were still found within the literature with regards to psychosis and schizophrenia and group therapy.

Bechdolf et al. (2004) found group therapy to be effective in treating individuals with schizophrenia and compared cognitive behavioral therapy with psycho-education. The comparison between cognitive behavioral therapy and psychoeducation interventions found limited differences between the two but was able to show support for the use of insight-based therapy for individuals with schizophrenia. Further studies that would compare two insight-

based interventions with individuals with psychosis and schizophrenia would be beneficial in identifying more supporting literature in connection with the findings.

Overall, the literature on psychosis and schizophrenia did not support the findings of this study. The findings of this study ran counter to the existing studies, but offers additional insight into modalities that might be effective in the treatment of individuals with psychosis and schizophrenia. It would be beneficial to see more research on the ability of individuals with psychosis and schizophrenia to show insight, connect, and take an active role in their illness, as the literature reviewed strongly suggests that they lack insight (e.g., Andreasen & Black, 2014; Lysaker et al., 2013). The findings of this study showed that individuals with psychosis and schizophrenia have awareness and insight and are able to participate and benefit from insight-based narrative group therapy.

### **Narrative Group Therapy**

The literature reviewed showed strong evidence that narrative group therapy was a beneficial and helpful intervention (e.g., Hill, 2011; Looyeh et al, 2012; Poole et al., 2009). Four studies in particular – conducted by Hill (2011), Looyeh et al. (2012), Poole et al. (2009), and Uribe (2012) - supported narrative group therapy as both an effective and beneficial intervention for a variety of populations and specific issues. However, individuals with psychosis and schizophrenia were not specifically supported as benefiting from narrative group therapy in the majority of the literature.

One study conducted by Romness Rosenberg (2007) supported the findings of this study, measuring the narrative group therapy process and its effectiveness using cohesion, catharsis, and insight. Narrative group therapy was identified as effective for individuals experiencing mental illness and individuals were able to identify benefits. Measurement of



group process also took place within this study. In correlation with the findings of this secondary data analysis, narrative group therapy intervention benefits for individuals with psychosis and schizophrenia were measured using Romness Rosenberg's (2007) themes of cohesion, catharsis, and insight.

### **Cohesion, Catharsis, and Insight**

The findings of this study are supported by the literature regarding the themes of this secondary data analysis. Cohesion, catharsis, and insight were identified within the themes of the findings of this secondary data analysis (e.g., Romness Rosenberg, 2007). The themes of relationships, trust, boundaries/limits, metaphors/symbols, and isolation were supported by *cohesion*. The themes of communication, trauma, and closed off were supported by *catharsis*. The themes of openness, authentic self and symptoms/diagnosis were supported by *insight*.

Cohesion was identified within the data where group members demonstrated ways in which they connect with one another, feeling a sense of belonging. Group members identified with one another and felt the ability to share their experiences and relate with one another in collaboration. It is likely that group members were in a room with other people who had psychosis for the first time and were able to talk openly and develop a relationship with one another.

Catharsis occurred throughout the group process and was reflected in the findings, where group members shared within the group process, telling their stories and witnessing each others stories and experiences. Group members participated in the creation of stories together and worked not only to identify feelings but to take actions towards their preferred narratives.

Insight was supported within the findings of this secondary data as group members learned more about themselves as well as others, showing acceptance and integration of their illness as well as their capabilities to heal and grow. Group members identified dominant problems in their life but showed insight into their alternative and preferred narratives. Group members showed overall insightfulness and awareness, especially with regards to their mental illness, social consequences, need for treatment, and attribution of symptoms and of the disorder (Dobson et al., 2003).

The findings of this secondary data analysis supported cohesion, catharsis, and insight. Cohesion, catharsis and insight were supported in the group narrative process of externalization, visualizing alternatives and preferred narratives. Group members connected outside of themselves with others and were able to distinctly identify actions to apply to their life including the use of metaphors and symbolism, showing connection not only with themselves but with other group members and significant and constant insight.

With regards to the specific themes of connection and barriers to wellness, there were no studies that specifically focused on these topics, as they are new ideas to this field of research with this population using narrative group therapy. This was both a strength and a limitation within the research and has further implications for the clinical field.

### **Implications for Future Research**

With regards to implications for further research. First, with any initial and upcoming study, further research needs to be completed in order to ensure validity. With this secondary data analysis the benefits of researching narrative group therapy using group measurement of cohesion, catharsis and insight has been shown to be beneficial and needs to be reproduced. More studies to further research surrounding group therapy (e.g., Penn, 2005), narrative

therapy (e.g., Ricks, 2014), narrative group therapy (e.g., Duba, 2010; Poole, 2009) are needed. Specific to this secondary data analysis is the need for further research into treatment options for individuals with psychosis.

Second, other populations who could potentially benefit from narrative group therapy may have been overlooked just as individuals with psychosis and schizophrenia have been. This needs to be addressed because population that have been disregarded are underserved and may benefit from this form of narrative group therapy. The clinical social work field should call for treatment that is informed by research and considers the individual's full spectrum of needs, as this is not always the case with current treatments. This should be the practice for individuals with psychosis and schizophrenia as well as any other population that has been overlooked. Further research is needed to look at populations that may have been overlooked.

### **Implications for Clinical Practice**

The clinical practice implications regarding this secondary data analysis are as follows. First, the clinical social work field strives to provide best treatment for clients, which takes into account all treatment options and possible benefits. Treatment options for individuals with psychosis have been limited. This secondary data analysis aimed to show that treatment options can not only successfully include narrative therapy but can also include group therapy, and that it is beneficial to individuals with psychosis to be treated within a narrative group format. Individuals who were previously seen as lacking insight (Bachmann, 2003) and unfit for group therapy can now be seen through a different lens. As Bachmann (2003) states, treatment needs to,

“consider the indications and contradictions for the different possible elements of treatment and how they best suit the individual situation with its specific problems and developmental needs. . . Treatment should not be method-oriented but rather patient-centered. (p. 166)

Current treatment practices focus primarily on medication and skill-based therapies versus psychotherapies which can be more patient-centered. Owen et al. (2015) calls for a “combined-therapy approach” that moves beyond anti-psychotics. Combined-therapy includes insight based therapies. This secondary data analysis calls for a group therapy using narrative therapy as a treatment for individuals with psychosis, and calls for the consideration of this intervention with other populations that may benefit from group narrative therapy given the findings of this study.

Second, the clinical research field needs to address the reliance on medication as a first-line and sometimes final treatment for individuals with psychosis and schizophrenia. This is especially true when medications, which are primary in treatment, can only be partially beneficial to individuals with psychosis (Lecomte & Lecomte, 2002). It is the responsibility of the clinical social work field to research and integrate the needs of the individuals with available treatment options, especially if studies have shown that individuals benefit from narrative group therapy. This is not only true for individuals with psychosis and schizophrenia, but for other populations that have been disregarded due to perceptions that they lack insight and self-reflection, have a lifelong incurable disease, or are not a good fit for group work, resulting in them being treated primarily with medications.

With regards to group work and group psychotherapy specifically, interventions have focused on individual services instead of the power of group work, even within narrative

therapy (Duba, 2010). Therefore, it is necessary for the clinical field to address ways in which to fully interact, engage and “treat” individuals with psychosis in a group format along with other populations that have been deemed inappropriate for group work.

Given the findings of this secondary data analysis, further research and informed practice is called for both in the clinical social work field and the narrative therapy field in order to support, protect, and empower a population of individuals and provide competent and comprehensive treatment by social workers and clinical practitioners.

### **Strengths and Limitations**

**Strengths.** There were two primary strengths of this study. First, the words of the individual group members were used as much as possible. This is a narrative principle that attempted to respect and implement as much as possible within the data analysis process of collection and reduction. The criteria which were implemented were used as a means of balancing out the voices of group members, making sure that it was not just the storyteller that was speaking, but that the entire group was represented and the entire process was represented to the best of the data’s ability to represent something as unique as a narrative group therapy for individuals with psychosis. Narrative therapy has lacked empirical measurement and empirical ways in which to present what data is created from the process of narrative group therapy. This secondary data analysis has worked to add to the body of knowledge available.

A second strength of this study is that group members were able to show another side of their illness and diagnosis. They did not allow a diagnosis of psychosis or related disorder to identify them as positive and negative symptoms or risk factors such as their illness having a “chronic course” (Andreasen & Black, 2014) but they showed their strengths and abilities

to grow, develop capabilities, strive to get better, heal, and move beyond their barriers towards connection with themselves and others.

**Limitations.** There are two primary limitations of this study. First, the limitations of this secondary data analysis came in the form of time restraints and available resources for the data analysis as well as the limited number of participants. There was only one researcher available to analyze the data so a disadvantage existed in terms of having multiple viewpoints present within the data analysis and summarization. It would be preferred in the future that this data be reviewed by an independent party in order to look for pairing themes that this individual researcher found and discussed in the findings section. Although an attempt was made to use the participant's words as much as possible, there is always bias present within an individual.

A second limitation of the study was the limited number of participants in the study. As in most research, more participants bring forth a larger perspective, but not necessarily a better perspective or more accurate perspective. The number of participants in this secondary data analysis was limited because of the group size limits within the program where participants came from. The number of participants was also limited because the number of individuals with psychosis is a smaller and very specific population of individuals, which are not necessarily easily accessible to do research. The research done was also using secondary data analysis, so the data presented was what was to be used.

### **Conclusion**

Individuals with psychosis have been shown to be at high risk for suicide (Rosenberg, 2009) and experience long-term symptoms (France et al., 2006) and negative side effects due to medications, which for some only partially work (Carey, 2015; Lecomte & Lecomte,

2002). This secondary data analysis aimed to examine a narrative group therapy process with individuals with psychosis with the hope of offering some insight into the benefits of group narrative therapy to individuals in the group.

The findings of this secondary data analysis are derived from a primary source that is one-of-a-kind, with very little other related research surrounding the topic. As a newer treatment modality, narrative group therapy for individuals with psychosis should be considered by the clinical social work field, the narrative therapy field, and overall the clinical research field. Ideally, further research will support the findings of this secondary data analysis: that individuals with psychosis benefit not only from a group format but that they are able to gain from an insight based psychotherapy treatment such as narrative therapy.

Given the findings of this secondary data analysis, further research is called for both in the clinical social work field and the narrative therapy field in order to support, protect, and empower a population of individuals and provide competent and comprehensive treatment by social workers and clinical practitioners.

Finally, the participants in the groups that provided data for the secondary analysis, who have lived with experiences of psychosis, have shown that they are able to recognize symptoms, work towards greater connection with others both in the group and in their individual lives, and envision a future or preferred story of their life which may not have been possible previously. The abilities and risks that group members engaged in during the group narrative process was breathtakingly courageous and showed great awareness. The group showed membership and cohesion, connection and desire for further relationships, and for were able to be in a room where their experiences were embraced as legitimate and

worthwhile, perhaps for the first time in their lives. This group provided a space for belonging, growth, healing, and connection and brought forth a strength in not only the individuals but also the group as a whole. The narrative therapy group work approach that was analyzed in this secondary data analysis highlights the strengths of a population of individuals with psychosis and schizophrenia, but also has significant implications for other populations that face stigma, limited resources, and barriers to treatment.



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