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## Talking About Life and Finding Solutions to Different Hardships:

### A Qualitative Study on the Impact of Narrative Enhancement and Cognitive Therapy on Persons With Serious Mental Illness

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#### Abstract

There is growing evidence that internalized stigma, or self-stigma, is a unique source of distress in the lives of people with severe mental illness. Narrative Enhancement and Cognitive Therapy is a structured group-based intervention aimed specifically at reducing internalized stigma and promoting recovery. The current study explores the therapeutic elements of the intervention and participants' spontaneous reports of their experiences of the intervention, on the basis of a qualitative analysis of semi-structured interviews conducted with 18 people with severe mental illness who completed Narrative Enhancement and Cognitive Therapy. Qualitative analysis revealed 6 domains of improvement that participants attributed to their engagement in the intervention: Experiential learning, positive change in experience of self, acquiring cognitive skills, enhanced hope, coping, and emotional change. Processes identified as contributing to positive change included the therapeutic alliance and participants' active role. The theoretical and practical implications of these findings are discussed.

#### Keywords

Self-stigma; internalized stigma; severe mental illness; interventions; qualitative

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There is growing recognition that public stigma toward mental illness, among its many devastating consequences, leads many with severe mental illness (SMI) to accept or internalize negative beliefs about themselves. This internalized stigma, or self-stigma, then becomes a unique source of distress and dysfunction in the lives of people with SMI (Corrigan et al., 2006). Over time, it might infect their personal narratives and result in their perception of their past and future in terms of failure and inability (Lysaker et al., 2007a,b). Research has shown that approximately one-third of people with SMI suffer from elevated self-stigma (Ritsher and Phelan, 2004; Brohan et al., 2010; West et al., unpublished) and that self-stigma is associated with impoverished social relationships, low self-esteem, hopelessness, and depression (Lysaker et al., 2007a,b; Yanos et al., 2008).

To address internalized stigma and promote recovery, we have recently sought to develop Narrative Enhancement and Cognitive Therapy (NECT; Yanos et al., in press). NECT is a structured, group-based intervention aimed specifically to help persons recognize stigma, learn how to correct dysfunctional beliefs, and finally create a richer personal narrative in which stigmatizing beliefs are not dominant. The purpose of the present study is to describe the effect of NECT and explore its therapeutic elements on the basis of a qualitative analysis of semi-structured interviews conducted with 18 persons who completed the first trial of NECT in Israel.

NECT is a 20-session manualized intervention that combines psychoeducation to help replace stigmatizing views about mental illness and recovery with empirical findings, cognitive restructuring geared toward teaching skills to challenge negative beliefs about the self, and elements of psychotherapy focused on enhancing one's ability to narrate one's life story (for a fuller description of the intervention, Yanos et al., in press). The intervention includes 4 sections: (1) introduction (which begins the process of assessing where the participant is with regard to experience of self and self-stigma), (2) psychoeducation (which provides participants with information about the inaccuracy of stigmatizing views about SMI), (3) cognitive restructuring (which teaches the basic principles of cognitive restructuring and encourages participants to apply these techniques to self-stigmatizing cognitions), and (4) narrative enhancement (in which participants are encouraged to write and share stories within the group, while focusing on trying to bring together previously fragmented and isolated aspects of the self). It is recommended that the group be conducted by 2 facilitators. The ideal group size is 6 to 8 participants, not including facilitators, and each group meeting should last for 1 hour. The manual features a guide for the practitioner, as well as hand-outs that can be used to guide group discussions. In addition, the manual includes worksheets that can be used to help group members learn and practice skills for coping with internalized stigma. The intervention includes a "user-friendly" manual to enhance its implementation as well as a fidelity scale.

The manual was developed during 2008 and separately piloted by the 3 developers (P.T.Y., D.R., and P.H.L.) during 2008 and early 2009 at 3 different settings: an Assertive Community Treatment program in New York City, a day treatment program in Indianapolis, and a university clinic in Israel. In all 3 locations, group participants were engaged, attendance was generally good, and those who completed the programs reported having been helped and being able to make positive changes as a result. Preliminary empirical support for its effectiveness stems from a separate quantitative analysis of data collected as part of a quasi-experimental study. This study revealed that participants completing NECT improved significantly in quality of life in contrast to the control group and that significantly more NECT participants were categorized as responders when improvement cutoffs on quality of life and internalized stigma were used to categorize participants into "responders" and "nonresponders" (Roe et al., unpublished).

Following these encouraging findings, we conducted a complementary qualitative study to explore the therapeutic elements of the intervention and participants' spontaneous reports of their experiences of the intervention without explicitly referring to any expected specific outcome or change.

## METHOD

### Research Design

The current study included follow-up assessments with 18 people with a case record diagnosis of SMI, who were participating in psychiatric rehabilitation services at 5 different settings in the community and had completed NECT in Israel during 2009. Inclusion criteria

were fluency in Hebrew and sufficient competence to provide informed consent. NECT was provided by practitioners who held degrees in mental health professions (Social Work, Occupational Therapy, and Psychology) and had experience in providing psychiatric rehabilitation services. They were trained in NECT by one of the intervention developers (D.R.), who also provided biweekly supervision together with an experienced social worker. Four of the groups were held at agencies of a large psychiatric rehabilitation employment provider, SHEKULO TOV, and one at the community clinic of Bar-Ilan University. Approval for the study was obtained from the ethics review committee at the Department of Psychology at Bar-Ilan University. After receiving a detailed explanation, a total of 45 consumers who were about to start 1 of the 5 NECT groups provided written informed consent to participate in the study. A total of 21 completed the 5 NECT groups and were offered the opportunity to participate in a semi-structured interview, which asked about their experience of the intervention, and 18 (86%) agreed.

## Participants

Eighteen persons with a case record diagnosis of SMI, who were participating in psychiatric rehabilitation services at 5 different settings in the community and had completed NECT, participated in the study. All participants had at least 40% psychiatric disability determined by a medical committee, composed of a psychiatrist and based on information obtained by specialists and in accordance with the National Insurance regulations. For example, the criteria for 30% disability after a psychotic disorder are when the person is in remission, has medium levels of social impairment and a vocational impairment, whereas the criteria for 50% disability is partial remission and notable social impairment.

The study group participants had a mean age of 36 ( $SD = 7.94$ ), ranging from 24 to 54 years. The group composed mostly of men (61%). The majority of the treatment group participants were single (78%) and the rest were divorced (17%) or married (5%). Most of the treatment group participants had completed 12 years of education (64%), one-fifth (21%) had more than 12 years of education, and 15% had less than 10 years of education.

## Instruments

The Narrative Evaluation of Intervention Interview (NEII) (Hasson-Ohayon et al., 2007) was conducted by 2 graduate students, who were trained in its use, and interviews were taped and transcribed. Interviews took approximately 30 to 40 minutes to complete. The NEII is a 16-question semi-structured interview for people with SMI who have participated in an intervention. The NEII evaluates and describes both the process and outcome of the intervention. These open-ended questions, coupled with a grounded theory analytic approach, elicit participants' spontaneous reports of the experiences of the intervention without explicitly referring to any expected specific outcome or change. This aspect of the assessment encouraged the participants to provide unrestricted and unstructured reports of their experiences of the interventions, thus controlling for researcher expectations and allowing for unexpected findings. This instrument was previously used to assess the experience of participants with SMI and their families in different interventions and was found to be sufficiently informative and sensitive to elicit unique qualities of various interventions (Hasson-Ohayon et al., 2006; Roe et al., 2009).

## Qualitative Analysis

The analysis of the qualitative data by the interviews was carried out in 3 stages. These stages combined the open step of the grounded theory approach (Strauss and Corbin, 1994) with techniques for the assessment of inter-rater reliability that had been used with content analysis (Lombard et al., 2002). During the first stage, 2 judges (both experienced PhD psychologists) independently read the completed interviews to identify domains of

improvement that participants attributed to NECT and variables and/or processes that were reported to have contributed to improvement. During the second step, the judges discussed and reached agreement on those themes that emerged from the interview data and developed rating anchors and a scoring system, so that each of the interviews could be rated on the presence or absence of each of the themes and for some, the degree to which it was present. During the third stage, the same 2 judges gave consensus scores to each of the interviews, and a third judge, a graduate student, independently scored all of the interviews based on the rating anchors and scoring system. Inter-rater reliabilities for the themes scored along the 1 to 3 continuum were calculated using Pearson correlations and ranged from 0.87 to 0.92. Calculation of the kappa coefficient was used to test the inter-rater reliabilities for the dichotomous coded themes and ranged from 0.64 to 1.00.

## RESULTS

The elicited themes, frequencies, and inter-rater reliabilities are presented in Table 1.

As can be seen in Table 1, NECT completers generally reported that they found the intervention to be beneficial. On the basis of entire interview, judges' ratings of the degree of perceived helpfulness of NECT were strong: 12 participants (67%) were rated a high contribution, 4 participants (22%) were rated a medium contribution, and only 2 participants (11%) were rated a low contribution. None reported (even though asked explicitly) that NECT had an undesirable effect on them. The inter-rater reliability for this scale was 0.87 ( $p < 0.01$ ).

Participants attributed the following 6 domains of improvement to NECT intervention (Table 1): Experiential learning, positive change in experience of self, cognitive skills, hope, coping and emotional change. Brief quotations and excerpts (translated from Hebrew into English) were integrated into the results section for illustration purposes.

### Experiential Learning

Of the participants, 94% ( $n = 17$ ) referred to the positive effect of learning about mental illness and recovery and how this learning experience contributed to their feeling of being less alone and fundamentally different from other human beings. For example, one person reported: "Regular people have problems too, and there is no shame in having a mental illness. There isn't, there is nothing to be ashamed of." Similarly, another participant described: "I feel that there are other people, a lot of people that are like me, living with a mental illness and living alone, renting or in supported housing, working in a regular job, like ordinary people. People with ordinary lives." Importantly, it was not only the information about mental illness, but also the effect of the experience of learning about the possibility of change which was beneficial, as described by the following participant: "Yes, it deals exclusively with mental problems that..., or mental illness and I don't know what manic depression is or schizophrenia, and I think I have it. It focuses more on who you really are, what you are, how you can take part in the things in your life and change them." The learning was not merely a cognitive process, but was also often accompanied by emotional relief induced by the social context in which the learning took place, as the following participant reported: "It gave me a lot of strength and understanding that there are a lot of people like me, thousands just in Israel who live like me, each one is living with it and I am not the only one with problems because of this disease and all..., it's a disease like any disease. Because it is just like anything else... I opened up, like I said, I talked about my hardships and people helped me with their advice, and advised others about what they should do to cope with different things in life, the disease." As evident from these excerpts, participants reported having learned myths about mental illness, and perhaps more importantly, this learning helped them reduce their internalized boundaries between "us"

and “them” by normalizing their experiences and not equating mental illness with the lack of entitlement to hope for a personally meaningful life.

### **Positive Change in Experience of Self**

Eighty-three percent ( $n = 15$ ) of participants reported how participating in the group changed their perception and experience of self. Most notable were participants who perceived themselves as more confident, as evident in the following quotes: “The influence of the group was to start walking on a path, any path. I have the confidence to do whatever ... I am not afraid. I used to say that if I do this, then this will happen to me, now I can walk straight forward, I am not afraid and if it doesn’t work that’s alright. There are ways to cope. That’s what I learned.” Another participant described a similar increase in sense of confidence: “I would sit with these thoughts before, there is also this option, but I wasn’t confident enough to go for it. But now I am confident and there are a lot of ways. I wasn’t confident, and now something has changed. I am confident and now I have the ability to do things.” One person described how, with the support of the group members, and some of the skills and knowledge he acquired during the group, he began to perceive himself as someone who can make positive changes in his life: “So, that was something that was a little hard in my life and I understood, with the group’s help, that I can change.”

### **Cognitive Skills**

Eighty-three percent ( $n = 15$ ) reported acquiring helpful cognitive skills. One participant, for example, described this as follows: “I changed a lot in my thinking, what people think of me that, like what I ultimately think someone said about me. I said: that’s all nonsense, I pay no attention to these people, I move on, go on with my life, feel good about myself, I’m not ashamed that I have a mental illness, there is nothing to be ashamed of because of that, I am not ashamed at all, I can be in a band with normal people right now and fit in with the normal, active society, real easily because of this group.” Another participant described how she applies her newly acquired cognitive skills in everyday life, by telling herself to “think positive, think it will be alright, don’t think that it’s the end of the world or something just because you don’t feel well, nothing happened, you will get over it.”

### **Hope**

Of the participants, 72% ( $n = 13$ ) described various forms of increased sense of hope. One participant described: “Changes? I found a few changes. A person has a lot of abilities, a lot of possibilities to do things, to advance.” Similarly, another reported: “A person has the ability to change it and has to work on it” and yet another: “There were examples of people who succeeded in their life despite the illness. I can’t remember their names...so I told myself that maybe some day I will be a doctor.”

### **Coping**

Sixty-seven percent ( $n = 12$ ) described increased coping abilities. “You hear about other different ways of coping and then you learn from someone else how he copes with a certain problem. So if you encounter that problem, you know that this happened to him and he knew how to get out of it and you take those things and practice them yourself.” Another participant emphasized the important link between the group support and putting the skills into practice in “real life” situations: “We got the tools here, all the information. We have to work with it, really with it, not to leave it here, but take it with us and use it for the rest of our lives, I think. There are groups where you stay in the same class, here we take it with us for the rest of our lives and every day, we encounter those things that we learned.”

The following excerpt helps demonstrate how the combination of learning useful information and practical skills can be successfully applied in real-life situations and generate relief: “I have 3 sisters. We are 4 sisters and I am the eldest. My sisters, even though I have been sick for 18 years, refuse to accept my condition and my disease. Two are married and one lives at home with me. And they always, like if I can’t do something because I am in a bad state, they will call me lazy and spoiled. Like in different situations and when I act strangely because of my disease, they put me down. Now I learned that it was their stigma about my disease. In the group, I learned not to let their stigma of me affect me and kick in. Just to put a distance between it; to put up a barrier and not let their stigma of me affect me. And that’s a great relief. Imagine your sisters whom you see every day, and you encounter the same problems with them every day and it hurts every time. It has stopped hurting completely.”

### Emotional Change

Sixty-one percent ( $n = 11$ ) reported an emotional change. In addition to the changes in perception of self, some reported feeling more open and free, as described by the following participant: “I am more open in sharing hardships and all kinds of things that I have been through. I am more confident, I trust people more. I know better now that you can be helped by others once you share, talk about your problem and work on it. And that’s something you need to do to get help and support to solve a problem you get stuck on.” An additional theme was one of a sense of being liberated, perhaps reflecting the liberating experience of change in the experience of self, as poignantly reported by the following participant: “...it opened my heart! It gave me...after every session, it gave me freedom...I felt more free, I kept waiting for Tuesday when I go...because it gave me...I would unload things also, because we talked in a group and it liberated me...mentally I mean.”

After the presentation of the central themes that emerged from the qualitative analysis of the semi-structured interviews to explore what effect participating in NECT had, we next describe the process, namely, participants’ accounts of how participating in NECT generated its effect. Participants described the therapeutic alliance and their active role in sharing, providing and receiving support, and telling and constructing stories as key processes that contributed to positive change.

1. On the basis of entire interview, judges rated the degree of therapeutic alliance as strong. Twelve participants (66%) were rated as “high” therapeutic alliance, 5 participants (28%) were rated as “medium,” and only 1 participant (6%) was rated as low contribution. The inter-rater reliability for this scale was 0.89 ( $p < 0.01$ ). The following quote poignantly described this: “First of all, they (the facilitators) are lovely; very human, really good fun, in terms of opening up to them and telling them about coping with a mental illness. They connected to us in terms of thought and intent; they explained real well. There was a warm and fun place to come to and share every aspect of the disorder.”
2. Judges’ ratings of the active role of participants were relatively high. Seven participants (39%) were rated as “highly active,” 8 participants (44%) were rated as “medium active,” and only 5 participants (28%) were rated as “low active.” The inter-rater reliability for this scale was 0.91 ( $p < 0.01$ ).

One way in which participants were active was by actively sharing. One participant described this as follows: “I found myself not afraid to talk, to open my heart and just talk. Not afraid to say what’s bothering me. Like anything that’s bothering me, if I don’t feel anything, just to say it and not to be afraid. And that I am not the only one experiencing this thing and just to talk about it.”

Considering that storytelling was an important part of the intervention, it is not surprising that the importance of talking was frequently mentioned, as reflected in one of the participants' responses. When asked whether something she did during the group had helped her, she replied: "Talking about... , talking about life and finding solutions to different hardships. My disclosure was up to me and not... , I chose to disclose but I did it without thinking, I was going along with everything, I got carried away with it. I found myself disclosing and I don't know how it happened."

Naturally, disclosing is not easy and does run a risk. The profound benefits of sharing and feeling safe and accepted, however, can be experienced only through such risk taking, as described by one of the group participants: "Yes, because I thought that now the group facilitators know... , and the girls know too many details about me and they can exploit that. But I found out, in the meeting that followed, that they are all on my side and they hugged me and embraced me in a nontangible sense. And that it's alright and that they won't use it against me."

The central role of sharing was made possible, to a large degree, because of peer support, which was perceived as very meaningful: "I would say it's because there are people there who understand you and support you, and bring up sensitive and delicate issues that we wouldn't have thought to touch on and that they were hidden deep down inside us, and here we can talk about them lightly and in a noncomplicated manner and there is company here as well. The group, it also makes you stronger." The experience of a joint meaningful journey came across very powerfully: "I mean, nobody comes here and judges you for what's happening to you, they bring up certain ideas and you go along with them, respond, what else was there? I don't know; it just flowed in a fun way."

Therefore, what comes across is how the accepting and supporting relationships between the NECT participants, along with the alliance with the facilitators, formed a powerful, safe environment, not only to learn information and skills but rather also, to share personal experiences that contributed to an emotionally profound experience.

A key process facilitating change in experience of self was not only sharing of stories but also constructing them. The ability to "use" the group members and facilitators as a supportive audience, who inquires out of curiosity, facilitates the storytelling. Storytelling, in turn, provides an opportunity to search, explore, and construct new narratives. One participant described this as follows: "I talked and talked and talked, I didn't stop talking. And I would figure it out when I got home. I would, like I said, take all of the thoughts and feelings and I would put them in a basket and organize them, by priority, in my soul and in my head." Several participants emphasized the process of integrating between different experiences and times: "I talked about experiences I had before I got sick and when I got sick, I told them that I used to be a singer and that I had some songs." Another person said: "I participated in the group, like I talked about myself and what it was like before the disease and what it is like now, and what I want to do after, like later in life, in the future." Considering the common experience of a split between the self "before" and "after" becoming ill, the opportunity to try to create integration and continuity appeared to be important, as one participant described: "Yes, the group allowed me to see some continuity in my life! That I can, umm... help myself in more practical ways."

Finally, as it can be argued that at least 4 of the 6 identified positive changes that emerged from our analysis (experiential learning, positive change in experience of self, hope, and emotional change) could be attributed to the nonspecific factors shared by most psychotherapies, we conducted a content analysis of item number 11 of the NEII, which asks: "Did this intervention help you in a way that was different from other interventions

you attended in the past?” Seventeen of the 18 (94%) mentioned at least one way in which NECT differed from other interventions they attended in the past. Almost half ( $n = 8$ ) of the participants referred in various ways to the group atmosphere, a similar number mentioned the focus and topic of the intervention (self-stigma) to be different. Of the participants, one-third ( $n = 6$ ) referred to the tools they had acquired, and specifically to cognitive skills, and a little less than one-third ( $n = 5$ ) mentioned the exploration and changes in perception of self and others as what was different about this intervention compared with others in which they had participated. Thus, although it seems that the overall atmosphere or tone of the group represents a specific factor which contributed to gains, 3 other specific factors emerged as relevant to outcome. The combined focus on stigma, cognition, and self-reflection may have enabled persons to not only identify mal-adaptive ways that they were seeing their lives but also to replace them with new views they had authored. Possible here is that participants were able to create their own counter response to a life defined by stigma and not just replace a view of self as “dangerous,” for instance, with a global and impersonal view of self as “not dangerous” or any other “canned” optimistic account offered by well-meaning group leaders. Importantly it is unknown though the extent to which these factors interact or effect outcome independently of one another. It is also unknown whether the atmosphere of the NECT groups significantly differed from the atmosphere in other effective therapies and thus was not entirely a general factor.

## DISCUSSION

NECT is a newly developed, structured group-based intervention aimed at reducing internalized stigma among people with SMI. Its goals include helping persons to identify what stigma is, to learn strategies for rejecting beliefs tinged with stigma, and then to construct new life stories. The present study is the first to investigate and describe the effect of NECT and explore its therapeutic elements. Qualitative analysis of the transcribed interviews revealed that participants reported that NECT helped them to understand the concept of stigma and self-stigma. It helped them apply this knowledge and change some of their beliefs about themselves, and finally, to tell a new story about themselves.

Results are consistent with models of recovery, which suggest that wellness in the face of SMI includes not only the reduction of symptoms and the attainment of psychosocial milestones, but also, for some, a reformation of sense of self at the level of narrative identity (Roe and Ben-Yishai, 1999; Slade, 2009). Movement toward wellness in those interview seemed to follow on from developing a different understanding of how their lives had unfolded over time. Despite the fact that there is evidence that psychoeducation and cognitive behavioral therapy are effective interventions for people with SMI (Mueser et al., 2002), NECT is among the first efforts to tailor these strategies specifically to challenge negative beliefs about the self while offering an opportunity to develop alternative ways to make sense of one’s life experiences and reshape one’s life story. Therefore, for instance, the process is not merely replacing one belief with another but reshaping a larger sense of who one is in the world. Results of our study reveal that developing such an attitude through learning and practice is possible and is perceived as important and beneficial.

When we explored what might have facilitated these processes, we found that the interpersonal context, the active process of sharing and narrating with other peers, and emotionally present facilitators were essential mechanisms of change. As participants spontaneously reported, it was not that they decided in isolation how to change the relationship of their core identity to the construct of illness, but that this relationship shifted through relationships with others. Results also supported that altering stigmatizing conceptions of the self was linked to shifts in hope and coping, which is consistent with

theoretically based mechanisms that have been proposed to determine how self-stigma affects outcomes among persons with SMI (Yanos et al., 2010).

NECT begins with an invitation to explore the experience of self and experiences with mental illness and psychiatric treatment. The emphasis, from the beginning, is on the potential to shift along the theoretical construct from invalidation to validation (Geekie and Read, 2009), during which one's authority over the interpretation can move from being undermined to being validated. The genuine sharing and acceptance of various forms of experience might have contributed to a genuine dialogue. However, the invitation for "being," or thinking deeply about oneself as a being in the world, is likely to generate anxiety (Yalom, 1980). The metacognitive capacities of persons with SMI might be overtaxed when thinking about their own thinking in unfamiliar ways (Lysaker et al., 2009). At times, this activity might be more painful than pleasurable. Dereflection (Frankl, 1975) might occasionally be needed to avoid "hyper-attention" and "hyper-reflection" and might help participants forget about themselves, rather than constantly observing the self (Frankl, 1975). Although painful, such self-reflexivity (Aron, 2000) also holds the potential for providing and gaining support and creating intimacy, which becomes particularly important in light of the pain of self-reflection. It is thus not surprising that participants used words such as "touched" and "embraced" to express the magnitude of their interpersonal experience within the group, in which the question of "who am I," in relation to and beyond the illness, could be considered. Learning facts about mental illness help to replace stigmatizing myths, but the larger issue identified by participants was what might fill the void left by negative and damning self-appraisals. Consistent with this, it has been emphasized (Davidson and Strauss, 1992; Lysaker et al., 2006; Roe and Ben Yishai, 1999) that developing a sense of self as the agent in life, who can choose what to believe and yet has a perpetually critical stance toward one's own beliefs, is an important part of the recovery process. As noted throughout, NECT adds to the traditional elements of cognitive therapy, by focusing on enhancing one's ability to narrate one's life story (Lysaker et al., 2006). The importance of narration has long been recognized, as Spence (1989; p. 521) wrote: "I think it is a truism that the need for narrative cogency lies deep in all of us....that we are all the time constructing narratives about our past and future, and that the core of our identity is really a narrative thread that gives meaning to our life provided—and this is the big if—that it is never broken....Part of our sense of self depends on our being able to go backwards and forwards in time and weave a story about who we are, how we got that way, and where we are going, a story that is continuously nourishing and self-satisfying."

Qualitative research on narratives has emphasized the potential of the evolution of a narrative that leads to wellness (Roe and Ben Yishai, 1999; Slade, 2009). The development of new stories that help frame life experiences might elevate some of the insults generated by psychiatric illness and its aftermath, and help make sense, consider the possibility of imagining and/or taking concrete action toward a more full and personally meaningful life (Gold, 2007; Roe, and Davidson, 2005; Saavedra, 2009). Analysis of the interviews here provides support for the assumption that narrative aspects of the intervention contribute to the effort to search and form a personally meaningful way of making sense of psychosis, finding meaning (Wagner and King, 2005), linking events together, and creating a coherent account of the aftermath of psychosis (Larsen, 2004) and being able to communicate and earn the respect and validation of others (Geekie and Read, 2009). The mutual creation of stories of human lives, along with the growing awareness of the injustice of stigma, might generate righteous anger as well as empowerment (Corrigan, and Watson, 2002), out of which such human stories can take on even newer directions and induce personal growth.

Although analyses of participants' accounts of their experiences with NECT appear encouraging, these findings must be treated with caution. Not all study participants

completed the interviews, and the reports of those who completed the procedures might have been biased by a desire to please the interviewers. The analyses might also have been biased by preconceived assumptions about treatment. Finally, self-reported improvement upon completing the intervention does not provide information as to whether other important forms of improvement took place and whether any positive changes lasted over time. Replication is needed, along with further research, which investigates the long-term effects of different elements of this intervention on multiple outcomes over time, using control groups and preferably a random design.

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**TABLE 1**

Elicited Themes of the Impact of NECT, Frequencies, and Inter-Rater Reliabilities

Theme	Inter-Rater Reliability	Frequencies
Continuous scoring 1–3 Overall contribution	0.87	—
Dichotomous themes Theme present or not present		
Experiential learning	1.00	94%
Change in the experience of self	0.82	83%
Cognitive change	0.77	83%
Hope	0.87	72%
Coping	0.73	67%

NECT indicates narrative enhancement and cognitive therapy.