

Narrative Cognitive Behavior Therapy for Psychosis

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Abstract

Several controlled studies indicate that cognitive behavioral interventions, in conjunction with antipsychotic medication, reduce positive psychotic symptoms in acute as well as chronic schizophrenia. However, a recent review found that CBT did not reduce relapse and readmission compared to standard care. Nevertheless there is a need for searching for new ways for the CBT therapy for acute psychotic patient. A central claim of narrative therapy is to “narrate” our lives. It means that we form narratives of the past and future these narratives do not only describe but also affect our lives. Psychotic patients have problem-saturated stories and the aim of the therapeutic work is both to articulate negative story and its effects upon the person and then to move on to the constructing and preferred narrative with more positive view on the story and consequently on the self, others and the world. The CBT approach from Padesky has been adapted in narrative cognitive behavioral therapy to use with most patients suffering from psychosis. Patients are asked to state any negative beliefs they have about themselves, others, and world, and then are asked to describe how they would prefer all these things to be. In narrative cognitive behavioral approach the therapist searches, yields to surface and stabilize stories that don't support patients troubleshooting experiencing of the reality, develop alternative stories that lead to new view of things, positive change of themselves – conception and to problem solving that is in contemporary context detected.

INTRODUCTION

Psychosis consists of a combination of an individual's unique genetic, neurobiological, psychological, and environmental factors. The course fluctuates and varies widely, often with remission and relapse cycles. Recent research indicates that about two thirds of all affected will recover or substantially improve with treatment (which includes both medication and psychosocial approaches). Recovery is an arduous biological, psychological, and social journey – a gradual process of restoring connections and health. It is a personal

process of growth and change that typically embraces hope, autonomy, and affiliation as elements of establishing satisfactory and productive lives in spite of disabling conditions and experiences. Although pharmacological treatment remains the front-line treatment for schizophrenia (Lehman *et al.* 2004), limitations such as noncompliance and persistent residual positive symptoms have led researchers to seek out ancillary treatments (Fenton *et al.* 1997). In this regard, cognitive-behavioral therapy (CBT) has

proven to be an effective strategy in the treatment of positive and negative symptoms of schizophrenia (Farhall *et al.* 2007; Pilling *et al.* 2002; Newton *et al.* 2005). Unfortunately, CBT is not widely accessible to persons with schizophrenia. This has prompted researchers to examine more efficient ways of delivering this intervention, such as group therapy (Mueser & Noordsy 2005), which has comparable effect sizes to individual CBT for psychosis (Wykes *et al.* 2008). Group CBT for auditory hallucinations has been shown to reduce negative beliefs about voices (and voice severity) in a pilot open trial (Pinkham *et al.* 2004), to reduce the distress associated with auditory hallucinations in individuals early in their psychotic illness relative to wait-list controls (Newton *et al.* 2005), and to reduce overall symptoms and auditory hallucinations, and increase insight in a chronically ill sample (Wykes *et al.* 1999). However, these findings were not replicated in a follow-up study that compared group CBT to treatment as usual, instead finding that CBT was associated with improved social functioning (Wykes *et al.* 2005).

Stories, experiences and behavior of psychotic patients place the truth to both conceptions. Many aspects of illness can be known only from direct experience. The narratives of those who have recovered from psychosis come from voices not often heard. Like chronic pain, psychosis is often a silent, inner, and invisible experience that leaves observers guessing. Psychotic patients construct reality their original way, his story is sincerely subjective and not clearly understandable for others, however at the same time we're able to disclose, which way the subjective stories were build and why the exact experience and behavior had come. The psychotic people are facing the truth that these metamorphoses are not so correspondent with other people demands and that their world can be relatively inflexible and stereotypical, without any dependence on individual and family needs, or are incomprehensible to others. Nevertheless it is possible to find the connection with the life story, actual context and content of the symptoms.

Narrative psychotherapy and cognitive behavioral therapy are seemingly nonintegrating psychotherapeutic approaches which differ in the basic philosophy of the man. While narrative psychotherapy is based on social constructivism with circular causality and conviction, that people construct their stories and consequently their behaviour based on subjectively experienced world, cognitive behavioural therapy stresses objective reality with its linear causality, in which consequences governs the probability of maladaptive behaviour repeating. Cognitive behavioural therapy also stresses the subjective aspect of experience, because according to the theory, the cognition (subjective thoughts, rules, assumptions) have the main impact on the consequent emotions and behavior. This cognition is formed according to the experienced life stories.

COGNITIVE BEHAVIORAL THERAPY FOR SCHIZOPHRENIA

Cognitive behavioral therapy (CBT) for schizophrenia focuses on the core psychotic symptoms of hallucinations and delusions (Farhall *et al.* 2007). The observation that symptoms of schizophrenia may be subjectively experienced as a stressor, and trigger coping actions, is as old as the disorder itself (Jaspers 1913/1963), although scientific study of coping has only emerged in the past two decades. Evidence that coping strategies for chronic voices can be learned has led to their inclusion in cognitive behavior therapy for psychosis treatments, and has stimulated their dissemination by training programs (Tarrier *et al.* 1998), and by the self-help literature (Baker 1996; Watkins 1993). The CBT approach to psychotic symptoms comprises two different stands each with their own theoretical basis, although both of late these two approaches have become conjoined in practice:

The first approach – coping strategy enhancement – is inspired by the stress-vulnerability model of psychosis. It is assumed that stressors capable of triggering or exacerbating symptoms may be generated or modulated by the individual (e.g. stressors emanating from the social environment are modulated by the patient's own appraisal of their stressfulness and their coping strategies. Another class of stressors consists of the symptoms themselves. It is assumed that certain strategies used to cope with symptoms are unhelpful and generate stress in the individual, on the contrary exacerbating symptoms. These strategies are conventionally divided into affective strategies (e.g. relaxation, sleep, etc.), behavioral strategies (drinking, being active, etc.), and cognitive strategies (distraction, challenging voices, switching attention away from voices, etc.). This underpins the approach known as Coping Strategy Enhancement (Tarrier *et al.* 1998) whereby patients are offered a range of strategies which are implemented in an empirical fashion to determine their effectiveness in the symptom control. This approach regards the individual as an active agent who attempts to reduce the threat of distress posed by psychotic symptoms, but does not concern itself with the content or meaning that psychotic symptoms may have to the individual. There is also assumed to be a fundamental discontinuity between normal and abnormal functioning that comes about once the biological vulnerability is "online".

The second CBT strand draws its theoretical strength from the cognitive therapy approach (Beck *et al.* 1979). Birchwood and Chadwick (1997) showed that delusions, like everyday beliefs, lead the individual to recruit evidence to support them and to de-emphasize or dismiss contradictory evidence. Authors argued that certain beliefs about voices' power may be considered as a quasi-rational response to anomalous experience. Other work has drawn on the cognitive approach in depression, which emphasizes the importance of

evaluative beliefs about the self, in the genesis and maintenance of depressed mood (Garety *et al.* 1994). The application of this to psychosis also emphasizes evaluative beliefs about the self. Delusions may serve the function of defending the individual from the full impact of low self-worth through blaming others for negative events rather than the self. The content of psychotic thinking often reflects such personal issues. In the cognitive model of psychosis (Garety *et al.* 2001) positive symptoms are hypothesized to begin with basic cognitive disturbances leading to ambiguous sensory input, the intrusion into consciousness of unintended material from memory, or to difficulties with the self-monitoring of intentions and actions, then they are experienced to be alien. This result in anomalous conscious experiences such as action being experienced as unintended, racing thoughts, thoughts appearing to be broadcast, and thoughts experienced as voices. However, the authors argue that such anomalous experiences alone do not develop into full-blown psychotic experiences unless an individual appraises them as externally caused and personally significant. Such appraisals are the results of dysfunctional personal schemas (e.g. low self-esteem born of adverse social experience), emotional states, and appraisal of the experience of illness.

Several controlled studies indicate that cognitive behavioral interventions, in conjunction with antipsychotic medication, reduce positive psychotic symptoms in acute as well as chronic schizophrenia. A review (Tarrier & Wykes 2004) reporting the analysis of 19 CBT of positive symptoms studies found the mean effect size of 0.37. While present evidence does support the use of CBT led interventions in adjunctive management of schizophrenia, the research is flawed and further, well controlled studies are necessary to determine a precise role of CBT. With regard to relapse prevention, CBT appears to be more successful when the intervention is focused on relapse prevention, rather than relapse prevention being on of a series of components (Tarrier & Wykes 2004). However, a Cochrane review (Jones *et al.* 2004) found that CBT did not reduce relapse and readmission compared to standard care (though it did decrease the risk of staying in hospital). There are shown in followed analysis that the results are due the mixing the studies for chronically ill and studies for acutely ill. The effect sizes for CBT versus standard treatment among patients with chronic illness were greater than those among acutely ill patients. Nevertheless there is a need for searching for new ways for the CBT therapy for acute psychotic patient.

NARRATIVE PSYCHOTHERAPY

Narrative has been characterized by the way individuals use language connected to various psychological processes, such as memory, emotion, perception, and meanings (Angus & McLeod 2004; Goncalves *et al.* 2004). Even in the absence of others around, we learn

about ourselves by imaginative listening to our own thoughts through the ears of the other. At the beginning of life, we need a witness to become a self. Later, patients listen to themselves as they imagine their therapist and group hear them, and in this way create new narrative freedom (Stern 2009). Certain dominant narratives play a bigger role than other narratives in organizing perceptions, thoughts, and actions. All what happened in the childhood, at the school and what is happening in the present situation all the time has the influence on human approaches and subsequently behaviour. The social, interpersonal and intrapsychical world of every person has developed in interactions with others, especially with significant others, as well as in interactions with institutions, and it is always in these interactions confirmed.

The main contribution of narrative psychotherapy to the field of psychosis has been the role of the life story in the development of theoretical and empirical approaches to the psychotic patients. It presumes that individual's thinking and acting is based on the stories, which have an external structure and an internal reality. Individuals retell their stories as they progress through their lives to make sense to them, and from a sociological perspective. This retelling when carried out publicly provides considerable insights into various aspects of an individual's experience of psychosis across the life course.

A central claim of narrative therapy is that we "narrate" our lives: that we form narratives of the past and future, and that these do not only describe our lives but might also influence our lives (Rhodes & Jakes 2009). For example, after a psychotic episode a patient may form a narrative (assumption) to be the case of this episode – "I must be weak". When this narrative is believed, they can stop the school or job, stop meet with the friends etc. Patient with schizophrenia have problem-saturated stories and the aim of therapeutic work is both to articulate the negative story and its impact upon the patient and then to move on to constructing the alternative narrative with the patient. This can be developed in many ways, but often involves describing events of characteristics that somehow do not fit the negative story (White 2004). It is sometimes useful to investigate the origin of important narratives. The therapist might discuss with the patient how such ideas have entered into the patient's life.

Stories offer insight, understanding, and new perspectives. They educate us and they feed our imaginations. They help us to see other ways of doing things that might free us from self-reproach or shame. Hearing and telling stories are comforting and bonds people together (Divinsky 2007). Story is one of the most potent containers for meaning (Gold 2007). Narrative – a form of personal storytelling – represents a fundamental mode of thought, a way of "ordering experience" and "constructing reality." Narrative gives meaning to personal experiences, and through narrative the speaker discloses personal forms of thought and feel-

ing. Narrative also allows the individual to construct order from the disorder and chaos that sometimes plague our daily lives and to come “to terms ... with a problematic experience” (Jackson 2002). But narrative renderings are not simply free-flowing, disconnected and largely incoherent ramblings. Rather, they tend to be shaped by detailed, cultural, and often context-specific cognitive schemas, “interpretative processes, integral to the constructive nature of cognition, which mediate our understanding of the world,” according to Garro and Mattingly (2000). Schemas, they continue, “are involved in conveying the specifics of a given story but also supply the narrative structures that characterize stories more generally.”

Anthropologists integrate the contextual nature of the patients’ view; but they still largely envision the psychiatric patient as a rational actor producing narratives based on common sense. However, in psychiatric practice, the client’s perspective is not something the patient individually produces; it is rather shaped by and in a context (Lovell 1997; Velpry 2008). Psychiatric patients, however, besides their immediate suffering, also suffer the consequences of being narrated as “outsiders” and as not as “rational” as others (Harper 2004). If patients are “too independent,” they risk being discredited as “irresponsible”. If they don’t show enough independence, they appear to be too passive and therefore “too sick to get well.”

NARRATIVE, STRESS AND TRAUMA

While some families might be negative in their style of interaction, considerable evidence suggests that some families engage in physical, emotional, and sexual abuse, and that this might be a very important contribution to psychosis (Read *et al.* 2004). Many studies have investigated reported abuse and 40% to 70% of psychotic patients report having been abused as children. There is a full range of possible mistreatments, including sexual abuse, excessive violence to children, insufficient feeding or protection, exposure to rejection, humiliation, and neglect. Some patients have also experienced cruel and persistent bullying at school. In addition to abuse in childhood there is also evidence that adults with psychosis suffer an increase of negative events before the onset of psychosis (Bebbington *et al.* 1996) and suffer very elevated levels of trauma related to problems such as domestic violence and other forms of assault (Mueser *et al.* 2004).

Traumatic memories are characteristically not accessible to intentional recall nor integration into the matrix of autobiographical memory. Formally correct narratives are characterized by three functions: orientation, reference and evaluation. Through so-called “memory talk” with socio-culturally competent partners, children learn how to reconstruct memories and to represent experience by narration. It is therefore suggested that narratives are the basic ingredient of autobiographi-

cal memory. The process of re-establishing a sense of coherence after trauma relies on the capacity for coherent narration. This capacity is decreased in schizophrenic patients. Narrative approaches have become a significant means of understanding human experience in difficult circumstances, such as illness and trauma (Becker *et al.* 2000; Foxen 2000). The emotional injury or trauma disrupts the person’s narrative processing (Wigren 1994). The victimization (and also psychotic experiences, stigmatization and self-stigmatization) creates a massive discontinuity in the person’s life narrative and meaning-making processes, breaking the previously unitary life narrative into pre and post-victimization stories. In addition, the trauma narrative itself is likely to contain “narrative defects” (Wigren 1994) in the form of memory gaps and explanatory discontinuities. The result is that the person’s trauma narrative neither sticks together as a story itself nor fits with the interrupted pre-victimization story. Particular features of a situation, sometimes with only a remote similarity to those in the original traumatic event, may elicit and evoke similar feelings. It is often useful for patient to retell stress and trauma-related stories more than once in the course of therapy, because the story will change over time as the patient comes to trust the therapist more, as he or she accesses additional memories and as the meanings of the events in the story evolve and become clearer. In trauma retelling the therapist tries to slow down patient’s recitation, dwelling on the details of the story, letting them sink in, and sometimes asking the patient to back up and go over some things again. At the same time when working with deeply painful experiences, the therapist allows himself to be moved by the story the patient is telling, expressing this in a gentle, affirming manner. Using narrative unfolding responses, the therapist actively helps the patient build exact, visual, and even physical representations of the traumatic event. As the patients recreate the traumatic situation, they begin to remember and re-experience painful and difficult events. The therapist can encourage this by asking questions about the patient’s feelings, by using evocative reflections and by listening for and poignant elements of the narrative. Through dwelling on the traumatic event, the patient gradually becomes more aware of additional aspects of the trauma and what it meant. The therapist listens for, and supports these emerging new experiences and meanings. The resolved retelling is a relatively complete narrative experienced by the patient as making sense or fitting together, with a clear point or overall meaning for the patient (Wigren 1994). Resolved retelling may also be marked by an indication from the patient that he or she has developed a greater awareness or understanding of the story. Another important function of helping patients explore their emotional reactions to traumas is that it can help them get in touch with their needs and goals so that they can develop alternative ways of meeting them in the present and future (Greenberg &

Paivio 1997). It is important to help patients re-examine and re-evaluate their actions during the trauma so that they can begin to recover a sense of mastery. The objective is to help them develop safety zones in their world while also protecting themselves by being more aware of their limits and the possible dangers they face (Elliot *et al.* 1998). Re-experiencing is neither an exact reproduction of the original experience nor a “fabrication” instead; it is a reenacted synthesis of recall and imaginative reconstruction of experience.

Meaning creation work is an important tool for the patient facing painful life crisis, including current and past trauma and loss. In such work, patients often raise existential questions about the meaning of what has happened to them. Traumas sometimes act as “limiting situations” in which patients directly encounter major existential issues (Yalom 1980), which may include the possibility of their own or someone else’s death, a painful awareness of issues of powerlessness and responsibility, and existential isolation in the form of abandonment by potentially helpful others. Clarke (1991) referred to these central assumptions as “cherished beliefs”. Cherished belief include implicit, previously taken for granted assumptions, that the world is sensible or just, that we are invulnerable or worthy, or that others will always be there to provide support or protection (Janoff-Bulman 1992). Resolution of such meaning crises occurs when the patient makes changes in the cherished belief or beliefs, which are typically tempered, qualified, or otherwise modified in order to incorporate the discrepant life event. The therapist’s main tasks are to provide a caring, empathic environment and to act as an auxiliary information processor. In part, this means listening for and empathically selecting patient’s experiences of the cherished belief and to challenging life event.

NARRATIVE COGNITIVE BEHAVIORAL THERAPY

Main therapeutic principles, derived from cognitive behavioral therapy (CBT), work at cross-purposes to the attempts of inmates to emplot the stories of their lives and psychiatric symptoms in a manner that makes them personally meaningful. Given the importance of life-events and the very strong likelihood that much psychotic meaning (like delusions, voice content, ideas about voices, meaning elaborated about any unusual experience) relates, in diverse ways, to current and past events, motivations, core beliefs, then all these aspects must be part of understanding, explaining, and working with a person’s reactions and behaviors (Rhodes & Jakes 2000). Many findings point at the fact that the majority of patients have extremely low self-esteem and negative ideas about themselves. These findings suggest the need to help patients build a more realistic and benign set of ideas about themselves.

The narratives that emerge, both in detail and in meaning, cannot be seen as simple reflections of any single individual’s life but, instead, as composites built on, and reflective of, cultural processes somewhat unique to the psychiatric context. Narrative, a fundamental mode of thinking and communication, necessarily challenges the directed nature of autobiographical presentation derived from CBT. Using narrative metaphor is leading to the suggestion that the experiences of people suffering from psychosis, are purposeful and formed on the base of their life stories. The social and interpersonal experiences have strong impact on schizophrenic patients’ perception of themselves (self schemas), others (schemas about others) and the world (schemas about world) and have a strong impact on both the character of their abnormal psychotic experiences and also to their strong human features. The CBT approach from Padesky (1994) has been adapted in narrative cognitive behavioral therapy to use with most patients suffering from psychosis (Rhodes & Jakes 2009). Patients are asked to state any negative beliefs they have about themselves, others, and world, and then are asked to describe how they would prefer all these things to be. For example, patient might say “I am weak!” and would prefer “I am strong enough!” Number of techniques can be used to build upon the preferred option: for example, asking the patient to collect any evidence of being “strong enough”, asking the group to say the patients in which aspects they are strong, asking the stories from the past when patients experienced them as a strong, etc. Padesky’s style base of preferred core belief about self and others is usually carried out without first automatic thoughts examining as it has been traditionally recommended in classical CBT. Therapist does not set out to prove that a specific thought are “false” but better say that another perspective, narrative, is possible.

All mention CBT approaches are combined with ideas from the practice of narrative therapy. Each patient is original and unique and appropriate therapist can use any of CBT techniques to construct a specific approach for an individual. For the phobias there can be used the hierarchic exposure approach, for low mood activity scheduling and planning etc. For working with patients who have described difficult or abusive childhood, it is used narrative exposure therapy (Neuner *et al.* 2002). That is, in the first phase of work therapist attempts to put into a narrative the often disjointed traumatic events memories, but also consider the history of a person’s strengths and ways of coping.

Many patients have no job, live alone, or if they live in family, tend to have minimal contact. A great number avoid all social situations and very often they fear being on the street and believe others know they are “insane persons”. Exposure to stigmatizing comments in newspapers and TV is highly stressful and has strong impact on their self-esteem. They are self-stigmatized but also

because of “in-the-corner” life style are stigmatized by others.

Low self-esteem is of fundamental importance to the understanding of affective disturbance in voice hearers. Therapeutic interventions need to address both the appraisal of self and hallucinations in schizophrenia. Measures which ameliorate low self-esteem can be expected to improve depressed mood in this patient group (Fannon *et al.* 2009). Self-esteem has been implicated both in the formation of positive symptoms and in their maintenance (Garety *et al.* 2001). Neuroticism and self-esteem at baseline predict psychotic symptoms, including auditory hallucinations at three year follow-up in people with no previous psychiatric disorder (Krabbendam & van Os 2005) and low self esteem has been shown to be associated with positive symptoms independent of mood (Barrowclough *et al.* 2003). Cognitive and social interventions need to take account of the prominent role of low self esteem in the experience of auditory hallucinations. The association between low self-esteem and neuroticism in predisposing to psychosis (Krabbendam *et al.* 2002) and the prominent role that has been proposed for anxiety processes in the maintenance of psychosis (Freeman *et al.* 1998) suggest that modification of related metacognitive beliefs will be more effective than a focus on the cognitive appraisal of auditory hallucinations alone. Cognitive intervention for dysfunctional core beliefs has been shown to be effective in delusional beliefs (Moorhead & Turkington 2001) and may be usefully applied to those with auditory hallucinations. Working with psychosis the therapist needs to make more effort than usual to understanding the patient, because patients experience phenomena, that often seen almost unique to psychosis and unique to each person (Rhodes & Jakes 2009). In seeking to understand patients the therapist need to understand how a whole range of symptoms and experiences interconnect, how they fuse into a whole, and how these are embedded in the daily world of the patient. For example, delusions are not usually just a set of explicit belief: rather, there is a complex, changing account or narrative of what is going on, and these expressed beliefs link to perceptions of self and other. The concept of “error of judgment” may be helpful in thinking about possible cognitive mechanisms, but is not a useful attitude in approaching a person with psychosis for therapy (Bentall 2003). Sometimes a patient is open to new evidence, but this tends to occur only after there have been great improvement in coping, mood, self-narration, interpersonal relationships, and emotional states. It seems that is better to gently construct on alternative account of what is happening as opposed to a concentrated dismantling of the negative belief system.

Some key features of narrative cognitive behavioral therapy:

1. Borrow techniques and approaches from both narrative therapy and cognitive behavioral therapy;
2. Therapist goes with patient to work on goals what is desired, what is hoped for, as presented by the patient and in the language actually used;
3. Work is narrative – pays attention to a patient story, use of language, metaphor, and complex characterization of self and others. It is also narrative in the sense of seeking an understanding of how problems are seen to develop over time (Rhodes & Jakes 2009);
4. Work also involves the exploration and the emotional expression of experienced difficulties and helps to find new understanding what happened;
5. Strong emphasis is laid on constructing or building something new, or alternative, strengthening and on nonused strength of resource of the patient;
6. Has a strong emphasis on building or rediscovering resources in patient’s life and simultaneously building solutions, benign ideas, and narratives of self and the patient’s world;
7. Psychoeducation is not used first but in the later stages, and only if it is needed.
8. Using the holistic model of explanation with range of simultaneous influences.

Why not just use CBT? There are several reasons the most important is the work with hospitalized severely ill patients in open group. Narrative cognitive behavioral therapy allows the therapist to work in a very flexible way. The therapist can accept the presentation as given, if this is useful, and then work within patient’s view of the world. Narrative cognitive behavioral therapy is systemic; it naturally leads to considering problems in their context. This is crucial when working with serious schizophrenic patients since such difficulties inevitably occur in the context of psychiatric teams, hospital, and of course, often in a context of a family or social relations. Narrative cognitive behavior therapy for psychotic patients makes the possibility to work also with the patients in acute state of the illness, early upon the hospitalization on the psychiatric department. It is also possibility to work with open group, because the stories and their paraphrases is the patients capable to listen also in acute state. Also the patients are capable to understand the others’ stories. There is in fact a change of the core beliefs and conditional rules during the retelling the stories. In addition, in contrast with the psychoeducation or classical cognitive behavioral therapy sessions the patient can concentrate better on the stories than on something else. However therapy must be simple, parts of the life stories retold intelligible way. The aim is that patients paraphrases produce higher self-acceptance and satisfaction with themselves and also increase new understanding of the past and actual context of/in life.

THERAPEUTIC STRATEGIES

After assessment the most useful things to try are therapeutic activities that help the person cope with the present situation, and, if possible, help the person to feel calmer, less overwhelmed by negative emotions (Rhodes & Jakes 2009). Many patients have undergone chronic stresses and various types of trauma. Furthermore, there appear to be gaps in the narrations of patients concerning these areas. Quite often patients do not seem to mention very serious difficulties in their lives. Their narrations appear to be focused on a specific area, for example what a voice says, the attack about to happen. Patients just do not place these experiences in a wider context. These findings point to the need to build narratives of their lives, to place sequences of events within a wider context.

When working with patients therapists are thinking about the interactions among stories, which patients experienced in their personal lives and about stories that circulate in the context of their local culture and also in the context of rules and assumptions of the social system. Narratives are conceived as the basic instruments for meaning making. Narrative therapy talks about „deconstruction of the story“. It aims to solve problems by helping patients to describe situations in which the problem does not occur, that is, when there are exceptions to the problem pattern (Rhodes & Jakes 2009). Exceptions might occur spontaneously, or might involve deliberate activities by the patients. By knowing more about exceptions and by thinking together how these might be augmented, it is hoped that the patient can begin to solve the presenting problem. There are many areas of a patient's life and every can be separately viewed as positive or negative (MacLeod & Moore 2000). Areas of "strength" and "resource" may buffer or prevent condition such as anxiety, tension or depression occurring and may prevent relapse. It may be a useful therapeutic strategy to focus on positive or "resource building" changes rather than problems (Padesky 1994; Seligman *et al.* 2005). The therapy should aim at helping a patient to notice and conceptualize any area of strength or positive information, but also to engage in long-term activities which yield a sense of satisfaction, achievement, and so on. Successful therapy might work by strengthening a person's capacity to retrieve positive representations (Brewin 2006). He suggests that this may be influenced by features such as being distinctive, being well rehearsed, or being significant. A therapy produces benign changes for a person when (Rhodes & Jakes 2009):

- a. there is an increase in the retrieval of positive representations and a person's available concepts for making sense of the "positive", and
- b. a person changes their habits, aspects of the self, ways of living, and external environment such that more positive events occur in the person's life.

Narrative cognitive behavioral approach uses all mention strategies. Personal thematic priority of the each therapeutic session, no matter if performed individually or in group, is reserved on patient story or on stories of the group, to what the therapist is fully open. Methods named in classical CBT cognitive restructuring or works with the schemes proceed by helping newly paraphrase patient's story, which patient develops him or her during the Socratic dialogue. Original story is deconstructed using the inductive questioning and step by step the change (restructuring) happened the way, in which the patient can see the connections which old concept was built in and also new story which can help new understanding and experiencing the self, world and future. However deconstruction and reconstruction are not only experiences from the therapeutic session but is followed by homework that further extends or stabilizes the alternative concept.

Roman complains at group session, that he hears always unpleasant voices which dirtily jaw to him. Other members of the group describe the same experiences. One patient says that these voices are not reality; it is the manifestation of the disorder. Roman disagree, it must be reality, because the voices said entire truth, comment his behavior, jaw to him, when he makes mistake or when he is lazy. Therapist asks, whether sometimes Roman himself either alone is jawing or reproaching, when he makes mistake is unsuccessful or is „lazy“. Yes, he jaw himself and criticized himself frequently. On the question, what is the content of his critics to himself, how it sounds Roman says: "You idiot! Bustle up! You are unworthy! You are lazy like a pig!.." Therapist asks, if are these critical sentences similar, what voices say. According to Roman it sounds exactly the same way. He is surprised when realizing, that the voices sound completely the same way, what he says himself. Therapist further asks, whether Roman can recall, if somebody said him similar critical sentences sometimes in past. Yes, it happened. Mother criticized him the same way when he was a child and is still doing this today. But she is doing it less frequently, than he is doing it to himself. Other patient from therapeutic group adds that the he also sometimes has voices that say things just like mother or father say to him. Therapist offers a question to whole group: What do you think, is it truth, that the Roman is nitwit, is lazy as a swine, unworthy and idiot? Or do you see him somewhat otherwise? Two patients who often talk with Roman say, that they see him very different way. He is a good fellow, interesting guy. Therapist asks Roman: What do you mean, are there any experiences in your life which reflect, that you are different, than you are a lazy swine, unavailing, idiot and nitwit? Has there been something other, what shows, that you are not so much lazy and do something well? Yes, I was helping mother and father all my life, and the professor at secondary school, before I started to be ill, told me, that I am clever and handy. So that you were good at school before the illness has come and also mother and father saw you were clever and diligent as a child. Is it

true?, Am I right? Yes it happened, says Roman delightfully. Can we now write it on the table, all facts against assumption, that you are lazy, unworthy, idiot or nitwit? Therapist wrote on the table facts Roman found: is sticky when modeling airplanes, hardworking, assisting on the garden, offers himself to help others, he offers mother to go to the shop and do shopping. At the same time other patient from the group praise Roman: how clever he is, how they like chatting to him, how much he knows about the music, how he trusts them, gives advices, how helping he is etc. Now therapist asks Roman, if somebody from the family praised him anytime. Roman agrees, it happened, for example mummy praises him, when he cleans court or goes shopping and dad always admired, how he elaborated the model of airplane. Therapist writes it also on the positive list about Roman. At the end of the session therapist offers the homework for Roman and also other members of the group. The homework is to make a list of what and how the family is praising or rewarding them.

Dialogical, or discursive, model of human experience may be useful in helping someone who experiences verbal hallucinations (Davies *et al.* 1999). The model regards verbal hallucinations as a variety of inner speech with dialogical properties (McLeod *et al.* 2007). The explication of these properties in the context of a personal narrative allowed the individual to engage in dialogue with the voices, through the medium of a new, supportive and positive voice. This process made it possible also to introduce moral responses to distressing and potentially dangerous imperative verbal hallucinations, through the mediation of the new voice.

Narrative approach to cognitive behavioral therapy consists of two phases:

1. First phase – elicit patient narratives that have been important in his influence upon patient's life and problems;
2. Second phase – authoring new narratives and re-authoring the old ones that have been too limiting in their possibilities.

Therapist focuses on creating a dialogue in which important personal narratives can be safely expressed, heard, and reflected upon the patient and group members. He asks the questions that elicit forgotten, or unnoticed, narratives of family life that open better possibilities for solving problems with the current narratives that have dominated the patient family dialogues. Narrative therapists, rather than focus upon patient's pathology, have made patient's strengths, skills, resources, competencies and other sources of resilience their center-piece of the therapy. Therapy starts with listening. Listening work takes time, concentration, imagination, a sense of humor, and an attitude that places the patient as hero of his or her own life story. The listener, when hearing the story, experiences the world and the patient himself from the patient's point of view, helping to carry the burden of loss, lightening and transforming the load. Listen for exact usage of language expressed

as metaphors, stories, and beliefs. Listening is healing as well as diagnostic. The best listeners hear both the patient and his story clearly, and regard every encounter as potentially therapeutic. Patients are storytellers primary of their important relationships, that have the hope of being heard and understood. Their hearers are therapists who are expected to listen actively and to be with the patient at a new level of understanding. Therapist notes exceptions, or unique outcomes, when problems might have occurred but surprisingly did not. He notes what is happening at time when problems are absent. Active listening remains one of the central skills of the therapist. The special meanings of words can be the central focus of the treatment. Narrative-experiential listening is based on the idea that all humans are constantly interpreting their experiences, attributing meaning to them, and weaving a story of their lives with themselves as the central character. Listening involves not only hearing and understanding the speaker's words, but attending to inflection, metaphor, imagery, sequence of associations, and interesting linguistic selections. It also involves seeing – movement, gestures, facial expressions, subtle changes in these – and constantly comparing what is said with what is seen, looking for dissonances and comparing what is being said and with what was previously communicated and observed. Metaphors, often repeated phrases, and other evocative uses of language are noted as “doors to be knocked upon” by asking specific questions about patient's stories of lived experiences that gave them meaning. “Unique outcomes” or “exceptions” when problems might have been expected to occur, but did not.

Narrative therapists also encourage patient to become mindful how narratives from the broader culture constraint their lives. They help patients learn from those occasions when the problem is not occurring and to learn from those “exceptions” when the problem might have been expected to occur but did not happen, patients can practice tasks that amplify the frequency and intensity of these “solution sequences”.

Therapy can provide a context in which patient narratives that limit relationships and maintain the symptoms can be identified. Effects of constraining narratives can be attenuated when specific historical, cultural, health providers or political contexts out of which they emerged are discussed, and the interpretive assumptions upon which they rest are made explicit. Alternatively, more useful narratives can be identified that have gone unnoticed with forgotten experiences patient has had.

- Eliciting important narratives. First priority is creation of a therapeutic relationship within which important first narratives can be safely told, acknowledged, and understood.
- Authoring new narratives and reauthoring constraining ones. As narratives important to the problem are told, the therapist craft inductive questions that facilitate:

- a. Retrieval of other forgotten, or unnoticed, narratives that might enhance solving the problem of the therapy, in contrast to a narrative, that has been dominant. For example, a young schizophrenic man might be asked: "In what year of your life did you have? What you prefer in your days that time? Such a question conceivably might bring forth stories of good quality of life, activity and man's preferred identity that had been forgotten in the present area of his life, with voices and delusions, depressed mood, and conflicts with the mother.
 - b. Asking questions about details of a constraining narrative that shift its meaning through expanding awareness of its historical contexts; punctuating differently its time-line; adding forgotten characters whose actions had also contributed to the story.
- Therapist employs such questions as circular, reflexive, unique outcome, or relative influence questions to gather fresh descriptions of patient's life that might constitute an alternative-preferred narrative (White 1989). For example, a unique outcome question such as "Have there been occasions when you had reason to expect your mother to disobey the rules, but to your surprise she did not? can elicit new accounts of a mother at time can display warm and acceptance behavior.
 - Therapist may assign patient the task of studying segments of the time when the problem is not occurring, looking for exceptions. Examples of solution-focused questions include:
 - a. "Between now and the next time we meet, I want you to observe what happens between you and your mother that you do value, would not want to change, and would like to see happen more often in the future."
 - b. The miracle question (de Shazer 1985) – "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? How would other family members know without you even saying a word about it?"
 - c. "If the problems between you and your partner got resolved all of a sudden, what would you do with the time and energy you have been spending on fixing or worrying about the marriage? Describe what you would do instead." (Weiner-Davis 1992).
 - d. "What might be one or two small things that you can do this week that will take you one step closer to your goal?" (Weiner-Davis 1992).
 - e. "What, if anything, might present a challenge to your taking these steps this week, and how will you meet the challenge?"

Writing about important personal experiences in an emotional way brings about improvements in mental and physical health (Pennbaker & Seagal 1999). Using a text-analysis computer program, authors discovered that those who benefit maximally from writing tend to use a high number of positive-emotion words, a moderate amount of negative-emotion words, and increase their use of cognitive words over the days of writing.

Stiles *et al.* (1999) presented three current, complementary formulations of the assimilation of problematic experiences model: (a) the schema formulation, based on cognitive developmental concepts: (b) the voices formulation, in which assimilation is understood as the construction of a meaning bridge between active internal voices; and (c) the cognitive science formulation, which uses cognitive concepts of memory types to understand the failure of memory in cases of warded-off and avoided experiences. These views of assimilation are used to understand the varied functions that narratives (stories about real or imagined events outside of therapy) may play in psychotherapy, including narratives that avoid encounters with threatening material, narratives that approach such material indirectly or symbolically, narratives by which clients re-experience trauma, and narratives that help construct a mature understanding.

Distress arising from voices was linked to beliefs about voices and not voice content alone (Birchwood *et al.* 2000). Subordination to voices was closely linked to subordination and marginalization in other social relationships. Distress arising from voices was linked not to voice characteristics but social and interpersonal cognition.

For interventions that are complex and require lifestyle modifications, it is worthwhile to address patients' beliefs, intentions, and self-efficacy (perceived ability to perform action). This is because knowledge alone is not sufficient to enhance adherence in recommendations involving complex behavior change. The power imbalance between the individual and his persecutor(s) may have origins in an appraisal by the individual of his social rank and sense of group identification and belonging.

GROUP NARRATIVE COGNITIVE BEHAVIORAL THERAPY

As wounded, people may be cared for, but as storytellers, they care for others. The ill, and all those who suffer, can also be healers. Their injuries become the source of the potency of their stories. Through their stories, the ill create empathic bonds between themselves and their listeners. These bonds expand as the stories are retold. Those who listened then tell others, and the circle of shared experience widens. Because stories can heal, the wounded healer and wounded storyteller are not separate, but are different aspects of the same figure (Gold 2007).

Since narrative is a shared, often public, expression of one's self at a particular moment, it is essentially performative. But it is also intersubjective, and the reaction of the audience to the story being conveyed exists as an important check on the meaning the story has for the teller or the message the teller wishes to convey; in other words, the teller's account is affected by the listeners' reaction (Wikan 2000). The audience has considerable influence in shaping, affirming and even altering that performance, both in form and in content, as it unfolds. Narrative renderings are rarely seamless, and audience interruptions in the telling of a story are common (Linde 1999). In this sense the performance of the autobiographical narrative clearly involves a process of negotiating events (or "facts") and meaning acceptable to both the audience and the narrator. It is not simply the inmate's story, after all, but rather a story that is guided by the narrative schema and created through a group process in which all have a vested interest.

It has been suggested by some that the development of a shared narrative between therapist and patient is necessary for a successful therapeutic outcome (Kirmayer 2000). This kind of therapeutic intersubjectivity is important to achieve in group program. The "shared" meaning of the narratives must not be too forced and artificial. It involves many different actors with their own agendas and it is big task for the therapist to find gentle connections between different stories. The therapists and patients group, operating together as a therapeutic community, work to reshape each personal narrative into a CBT-recognizable genre. CBT theory suggests that this approach will successfully uncover and correct cognitive distortions, especially cognitive schemas, which is groundwork for therapy.

People with psychosis suffer a wide range of interpersonal and emotional difficulties. Patient with psychosis are often isolated, have fewer friends, relationships, and so on, and when they interact with others, this can involve an unending range of difficulties. Many of patients have long-standing social and emotional difficulties which precede their psychotic disorder by several years. It seems probable that this contributes to the content of their psychotic experience (Rhodes & Jakes 2000). It is also probable that psychotic symptoms trigger long-standing emotional and social problems and may also create new difficulties. Given difficulties with social perception many patients try to avoid other people. The more in danger they feel, the more they withdraw from others, and the less chance there is to check out their fears. Birchwood *et al.* (2002) have investigated similarities between a person's relationship to "voices" and his/her social relationships. They found that patients reported the same troubled relationships with their voices as they had with real people. They often felt bullied, inferior, and less powerful than others. These findings stress the importance of treating voices within the context of patient's sense of self and others. That's why working in the supporting group

or community is an important possibility to come back to the people. Universality, the recognition that other people experience very similar problems, was one of the most beneficial factors of the intervention (McLeod *et al.* 2007).

CONCLUSIONS

Story of the patient is an organizing metaphor which can help with understanding, why people experienced them, the others and the world their own way. The patient's story has developed from the experiences he/she had in childhood, parents' and teacher's stories and also from the interaction in the actual context. In narrative cognitive behavioral approach in therapy therapist searches, yields to surface and stabilizes stories that don't support patients troubleshooting experiencing of the reality, but develops alternative stories leading to new view of things, positive change of themselves – conception and to problem solving that is detected in the contemporary context.

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